VAN NATTA'S
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(Pages 1675-End)

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

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

OCTOBER-DECEMBER 1999

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CITE AS

51 Van Natta ____ (1999)

In the Matter of the Compensation of
JAMES M. EVANS, Claimant
Own Motion No. 99-0152M
OWN MOTION ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

On July 27, 1999, we withdrew our June 28, 1999 Own Motion Order that declined to reopen claimant's 1993 claim for the payment of temporary disability compensation. We took this action to consider claimant's submission of additional information regarding the issue of whether he was in the work force at the time of his current disability. Having received the insurer's response and completing our reconsideration, we withdraw our prior order and replace it with the following order.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *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).

On April 7, 1999, Dr. Scarborough, claimant's attending physician, recommended that claimant undergo surgery to repair his recurrent hernia. According to Dr. Scarborough's chart note, claimant was instructed not to work until the recommended surgery was done. Claimant underwent surgery on May 28, 1999. Based on Dr. Scarborough's unrebutted opinion, we are persuaded that claimant was unable to work at the time his condition worsened requiring surgery and that it would have been futile for him to seek work due to the compensable condition.

Previously, claimant asserted that he qualified for temporary disability compensation because, subsequent to his May 1998 release from incarceration, he performed odd jobs for his landlord in return for rent. The insurer challenged those assertions, noting that there was no supporting documentation. In our June 28, 1999 Own Motion Order, we found that claimant's challenged general statements, without more, did not meet his burden of proving he was in the work force at the time of his disability.

With his request for reconsideration, claimant submitted an affidavit from his landlord which states in part: "We made an agreement that he would do light maintenance work, some yard work, weeding, trimming shrubs, mowing and litter clean up. [Claimant] did this for rent and food up until April 7, 1999."

In response to claimant's submission, the insurer submitted a print-out of a computer record documenting a July 6, 1999 conversation between claimant and the insurer's representative. In this print-out, the insurer's representative noted claimant's assertion that he had not been employed since 1993. The insurer contends that this sufficiently demonstrates that claimant was not in the work force at the time of his disability.

However, as previously noted, claimant has submitted a statement asserting that he had worked for his landlord in various capacities in exchange for room and board. This statement has been corroborated by his landlord's sworn affidavit. Based on this confirmation from his landlord, we are persuaded that, prior to the worsening of his compensable condition, claimant worked as a "helper" for his landlord and received room and board in exchange for those services. As noted in our prior order, we have previously found that room and board, with or without pay, can equal wages, and thus, qualifies as "wages" under ORS 656.005(29). *See George L. Peachy*, 48 Van Natta 2115 (1996); *Orvel L. Cheney*, 48 Van Natta 612 (1996). Therefore, we find that claimant remained in the work force until his

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning May 28, 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 $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

October 1, 1999 Cite as 51 Van Natta 1676 (1999)

In the Matter of the Compensation of
ROBERT L. FARRAR, Claimant
WCB Case No. 98-09578
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the self-insured employer's denial of his occupational disease claim for his left carpal tunnel syndrome condition. In its brief, the employer contends that claimant's request for review is untimely and should be dismissed for lack of jurisdiction. On review, the issues are jurisdiction and compensability. We deny the motion to dismiss and affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the following clarifications. Dr. Maurer, rather than Dr. Saviers, found that claimant's MRI supported a diagnosis of rotator cuff tear and subsequently recommended surgery. We omit the ALJ's finding that Dr. Saviers reported that no surgery was required for the left median neuropathy.

We add the following supplementation to the ALJ's Findings of Fact. On March 24, 1999, the ALJ issued an Opinion and Order upholding the employer's denial of claimant's left carpal tunnel syndrome. On April 22, 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 April 22, 1999. The employer's attorney received its copy of the request for review on April 26, 1999.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

The employer contends that its attorney did not receive a copy of claimant's request for review until April 26, 1999, which is more than 30 days after the date of the ALJ's letter. Additionally, the employer argues that claimant did not serve a copy of the request for review on the employer or its claims administrator and those parties did not receive actual notice until more than 30 days had passed and it received the Board's acknowledgment letter of the request for review. Consequently, the employer 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

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), *Tommy L. Brown*, 51 Van Natta 497 (1999); *Nancy C. Prevatt-Williams*, 48 Van Natta 242 (1996); *Harold E. Smith, 47 Van Natta 703 (1995).*

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 April 22, 1999. This evidence has not been rebutted by the employer, nor has the employer or claims administrator shown how it has been prejudiced by not timely receiving a copy of the request for review. 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. *See Brown*, 51 Van Natta at 497; *Smith*, 47 Van Natta at 703. Therefore, the employer's motion to dismiss is denied.

Compensability

We adopt and affirm the ALJ's Conclusions of Law and Opinion with respect to the issue of compensability.

ORDER

The ALJ's order dated March 24, 1999 is affirmed.

October 7, 1999 Cite as 51 Van Natta 1677 (1999)

In the Matter of the Compensation of
LELAND N. HANSCOM, Claimant
WCB Case No. C992209
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Robert J. Guarrasi, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On September 17, 1999, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, in consideration for payment of a stated sum, claimant released all rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $2,062.50 and the total due claimant's attorney is $687.50. This would equal a total consideration of $2,750. However, the total consideration recited on the third page of the CDA is "$4,500" instead of $2,750. On page 3, number 14 provides that the amount payable to claimant's attorney is $687.50, which is consistent with the first page.

Based on our review of the entire agreement, we are persuaded that the lone reference on page three of the CDA to a total consideration of $4,500 is a typographical error. Under such circumstances, we rely on the first page of the CDA that particularly describes the amounts payable to claimant and his attorney. Accordingly, we interpret the agreement as providing for a total consideration of $2,750, with $2,062.50 payable to claimant and $687.50 payable to claimant's attorney.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Therefore, the parties' claim disposition agreement is approved. An attorney fee of $687.50, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD L. MERWIN, Claimant
WCB Case No. 98-08699
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
James P. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's degenerative disc disease condition. On review, the issues are issue preclusion and compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in 1984 that was accepted as a low back strain. SAIF eventually accepted lumbar degenerative disc disease as a part of the 1984 claim. (Ex. 3).

In May 1995, claimant sought treatment for low back symptoms diagnosed as a lumbosacral strain. (Ex. 5). On December 8, 1995, SAIF denied the compensability of the "condition diagnosed as lumbar strain." (Ex. 9). Claimant requested a hearing from SAIF's denial and asserted at a hearing in April 1997 that his low back condition was compensable as an occupational disease. A prior ALJ found that claimant's work activity for the employer, "including the previous work injuries," was the major contributing cause of claimant's "low back condition in May 1995." (Ex. 11-2). The prior ALJ ordered SAIF to "accept compensability of and responsibility for claimant's low back condition in May 1995." *Id.* SAIF requested Board review.

In our October 1997 order, we noted that claimant's theory of compensability was not based on a worsening of the 1984 compensable injury, but rather on a contention that his "current low back strain condition" was caused in major part by employment conditions subsequent to the 1984 injury. (Ex. 12-3). Based on the medical evidence, we concluded that claimant had proved that "work conditions were the major contributing cause of his current need for treatment and disability for his low back strain condition." *Id.*[1] Thus, we affirmed the prior ALJ's order.

On August 20, 1998, claimant objected to SAIF's updated Notice of Acceptance for the 1995 claim because, in listing lumbar strain as the only accepted condition, SAIF had failed to include lumbar degenerative disc disease. (Ex. 14). Claimant requested either an expanded acceptance or a denial. SAIF chose the latter course on September 24, 1998, denying degenerative disc disease on the ground that it was not related to the accepted low back strain in the May 1995 claim. In doing so, SAIF noted that claimant's degenerative disc disease was accepted in the 1984 claim. (Ex. 15). Claimant requested a hearing from the September 24, 1998 denial.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial, finding that, as a matter of law, the degenerative disc disease was compensably related to the 1995 occupational disease claim. The ALJ reasoned that the lumbar degenerative disc disease was necessarily found compensable during the litigation concerning the 1995 occupational disease claim.

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[1] In reaching our conclusion, we expressly stated that claimant's occupational disease claim was "not based on a worsened preexisting condition."

On review, SAIF contends that the ALJ's determination was incorrect because the only issue litigated during the 1997 hearing and subsequent appeal was the compensability of a low back strain condition. We agree.

Under the *res judicata* doctrine of "issue preclusion", a party cannot relitigate an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. *Drews v. EBI Companies*, 310 Or 134, 139 (1990). Here, we conclude that the compensability of claimant's lumbar degenerative disc disease as part of the 1995 occupational disease claim was not actually litigated and determined at the 1997 hearing.

In its December 8, 1995 denial, SAIF specifically denied a "lumbar strain." The prior ALJ was not specific as to the "low back condition" he determined was compensable. He ordered, however, SAIF to process "claimant's low back condition in May 1995." (Ex. 11-2). The condition diagnosed in May 1995--and the only condition denied--was a low back strain. (Ex. 5).

Our Order on Review further clarifies the condition litigated at the 1997 hearing. As previously noted, claimant contended on review that his "low back strain" was compensable. Moreover, we expressly concluded that claimant's work conditions were the major contributing cause of claimant's need for treatment and disability for his "low back strain condition." (Ex. 12-3).[2] Finally, we described the prior ALJ's order as having set side SAIF's denial of claimant's occupational disease claim for a "low back strain condition." (Ex. 12-1).

In summary, it is clear from our review of SAIF's denial, the prior ALJ's order and our previous order that the only condition being litigated at the 1997 hearing was a low back strain. Therefore, we find that the previous litigation did not determine the compensability of degenerative disc disease as a part of the 1995 occupational disease claim.[3] It follows that the ALJ improperly found that it did.[4]

Having made the above findings, we now address the merits of the current claim for low back degenerative disc disease. SAIF's September 24, 1998 denial letter denied the compensability of the degenerative disc disease as part of the 1995 claim on the ground that it was not related to the accepted back strain in that claim. (Ex. 15). We find that SAIF's denial was substantively correct because the medical evidence does not establish that the compensable 1995 low back strain caused the degenerative disc disease. Therefore, we reverse the ALJ's decision to set aside SAIF's denial. In so doing, we emphasize that nothing in our decision affects SAIF's concession that claimant's degenerative disc disease remains a compensable part of the 1984 claim. Rather, we have only determined that SAIF is not required to process that condition as part of the compensable 1995 occupational disease claim.

ORDER

The ALJ's order dated April 7, 1999 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] In reaching this conclusion, we expressly determined that claimant's occupational disease claim was "not based on a worsened preexisting condition." This determination further supports a conclusion that claimant's 1995 compensable claim did not include a preexisting degenerative condition.

[3] The ALJ reasoned that, because the prior ALJ concluded that the 1984 injury (which included a degenerative disc disease component) along with other "employment conditions" were the major contributing cause of claimant's low back condition in 1995, the degenerative disc disease was encompassed within the compensable occupational disease condition the prior ALJ determined was compensable. We disagree with that reasoning. The fact that the 1984 injury was included among the "employment conditions" determined to be the major contributing cause of claimant's May 1995 low back condition does not mean degenerative disc disease was a component of the compensable condition. The only condition subject to a compensability determination as a result of the 1995 occupational disease claim was a low back strain. The ALJ confused the factors that were considered in determining major causation with the condition (low back strain) whose compensability was being determined.

[4] The dissent argues that claimant's 1984 injury and accepted degenerative disc disease were component parts of the May 1995 low back condition/occupational disease claim. We respectfully submit that the dissent's analysis ignores the language of SAIF's December 1995 denial, the diagnosis of claimant's low back condition in May 1995 and, most importantly, the multiple references in our prior order to the precise condition whose compensability was being determined--low back strain. We would also note that our prior order (which did not adopt the ALJ's reasoning) was not appealed and is the law of the case.

Member Phillips Polich dissenting.

In upholding SAIF's denial, the majority concludes that the compensability of claimant's accepted degenerative disc disease was not litigated as part of the 1995 occupational disease claim. As set forth below, I would find otherwise. Because I believe we should adopt and affirm ALJ Myzak's order, I respectfully dissent.

As the majority notes, claimant sustained a low back injury in 1984, that SAIF initially accepted as a low back strain. The claim was first closed by Notice of Closure dated April 11, 1984. In 1989, claimant requested that the claim be reopened. In 1990, SAIF agreed to rescind its aggravation denial and accept claimant's degenerative disc disease as part of the 1984 claim. In 1992, claimant was awarded 5 percent unscheduled permanent disability based on his compensable injury.

In May 1995, claimant sought treatment for low back symptoms. In December 1995, SAIF denied the compensability of claimant's then-current low back condition, asserting that his work activity for the employer was not the major cause of his diagnosed lumbar strain condition. Claimant requested a hearing.

At the April 1997 hearing, the issue was the "compensability of an occupational disease claim for claimant's low back condition, denied December 8, 1995."[1] (Ex. 11). ALJ Baker set aside SAIF's denial, finding that "[t]he major contributing cause of claimant's low back condition in May 1995 was claimant's work activity for this employer *including the previous work injuries.*"[2] (Ex. 11-2, emphasis added). SAIF requested Board review. We affirmed ALJ Baker's order in an October 10, 1997 Order on Review. (Ex. 12).

On review of ALJ Baker's order, SAIF argued that claimant's occupational disease claim should be analyzed under ORS 656.802(2)(b) because he had a preexisting condition that had combined with his work activity. SAIF also argued that, because the 1984 claim was reopened and closed by Determination Order in 1991, the Board should only consider claimant's work activity subsequent to the 1991 closure to determine whether a new occupational disease claim had been established. (*See* Ex. 12-2). We rejected both arguments. In affirming the ALJ's order, we explained that ORS 656.802(2)(b) was inapplicable because claimant's theory of compensability was not based on the worsening of his 1984 compensable injury. In other words, we found that the claim was properly analyzed under ORS 656.802(2)(a) because claimant was asserting (and a preponderance of evidence established) that his employment conditions were the major contributing cause of his occupational disease, even though the 1984 injury and subsequently accepted degenerative disc disease had contributed to his condition.[3]

In addition, our prior Order on Review specifically adopted ALJ Baker's "Findings of Fact," which included the "Ultimate Finding" that claimant's prior work injuries contributed to his low back condition in May 1995. Because we adopted this ultimate finding and affirmed the ALJ's order directing SAIF to accept "claimant's low back condition in May 1995," I cannot agree with the majority's

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[1] Although SAIF's December 8, 1995 denial referred to a May 31, 1995 injury to claimant's low back, the parties agreed at hearing to litigate the compensability of claimant's low back condition as an occupational disease. (*See* Ex. 11). Unlike the majority, I believe the parties' at-hearing stipulation to litigate the May 1995 claim as an occupational disease supersedes the language of SAIF's denial.

[2] As ALJ Myzak noted in her order, ALJ Baker cited to *Kepford v. Weyerhaeuser*, 77 Or App 363 (1986) as the rationale for finding claimant's occupational disease claim compensable. *Kepford* holds that the cumulative effects of a compensable injury should be considered along with the employment conditions in determining the major contributing cause of an occupational disease claim.

[3] In concluding that claimant had established the compensability of his current "low back strain condition," we expressly relied on the opinion of Dr. Mavris, claimant's treating physician. We cited to Dr. Marvis' report which indicated that, although claimant's 1984 injury "never really cleared," his physically demanding occupation contributed "more to his current condition than the initial episode in 1984." (*See* Ex. 12-3). Insofar as our prior order specifically acknowledged that claimant's 1984 injury had some continued effect (even though it was not the major contributing cause of claimant's need for treatment in May 1995), I cannot accept the majority's conclusion that our prior order rejected the ALJ's reasoning and concerned only a simple low back strain claim.

conclusion that that the "only condition [] litigated at the 1997 hearing was a low back strain."[4] To the contrary (and like the ALJ), based on my review of ALJ Baker's order and our prior Order on Review, I believe that the "low back strain *condition*" litigated in the 1997 proceeding encompassed claimant's 1984 injury and the degenerative disc disease accepted as part of that injury. Stated differently, on this record, it is apparent to me that claimant's 1984 injury and accepted degenerative disc disease were component parts of his May 1995 low back condition/occupational disease claim, even though his physically demanding employment conditions were the primary cause of the disease.

Because I would find that the previous litigation did determine that claimant's 1984 injury and degenerative disc disease were contributing factors to claimant's low back condition in May 1995, I would affirm ALJ Myzak's order. I would further find, for the reasons articulated by ALJ Myzak, that SAIF is now precluded from denying that claimant's compensable degenerative disc disease condition is related to the 1995 occupational disease claim.

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[4] I believe that, in concluding that a "low back strain" was the only condition subject to a compensability determination in the prior proceeding, the majority disregards the fact that the parties litigated the 1995 claim as an occupational disease and not as a new injury. In the occupational disease context, it is appropriate to consider prior compensable injuries in combination with the work exposure. *See Kepford*, 77 Or App at 366. And in this case, reading ALJ Baker's order in conjunction with our prior Order on Review, it is evident to me that the compensability determination of the occupational disease/low back strain condition at issue in the prior proceeding necessarily included a consideration of claimant's 1984 injury and accepted degenerative disc disease.

In the Matter of the Compensation of
JAMES L. MACK, Claimant
WCB Case No. 98-09860
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) reduced claimant's unscheduled permanent disability from 57 percent (182.4 degrees), as awarded by an Order on Reconsideration, to 37 percent (118.4 degrees); (2) declined to award additional temporary total disability; and (3) declined to award an attorney fee pursuant to ORS 656.382(2) for services at hearing related to the scheduled permanent disability issue. On review, the issues are extent of unscheduled permanent disability, temporary disability, and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

Concluding that the arbiter panel's impairment findings in the low back were not consistent with the compensable injury (*i.e.*, the accepted conditions at the time of claim closure), the ALJ found that claimant was not entitled to a disability rating based on reduced lumbar range of motion (ROM). The ALJ relied on *Kim E. Danboise*, 47 Van Natta 2163, *recon* 47 Van Natta 2281 (1995), *aff'd SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997).

The record indicates that the accepted fractures of the iliac crest, right acetabulum, right sacroiliac joint, left and right superior pubic rami, inferior ischial rami, and inferior pubic ramus are conditions of the hip and pelvis. (Exs. 7, 16). The record also indicates that the accepted fracture of the superior anterior margin of the sacrum is a condition of the low back and pelvis.[1]

Claimant has the burden of establishing that his low back impairment is due to his compensable injury. ORS 656.214(5). If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe the findings as showing that the impairment is due to the compensable injury. *Kim E. Danboise*, 47 Van Natta at 2364; *see also Edith N. Carter*, 46 Van Natta 2400 (1994).

Here, the medical arbiters found diminished low back ROM. (Ex. 24- 35-2). The panel did not attribute the low back findings to causes other than the compensable injury.[2] Moreover, in response to a question about limitations of repetitive use of any body part or area due to a diagnosed chronic and permanent medical condition arising out of the accepted condition, the panel reported that residual loss of ability to use body parts permanently limited claimant's ability to "do repetitive, impact activity or extremes of motion with the right hip, such as jogging or squatting." The panel also permanently precluded claimant from prolonged stooping or lifting with twisting, crawling, and repetitive climbing. (Ex. 24-8, 9).

We find claimant's low back findings to be consistent with his compensable low back and pelvic fractures. Because the medical arbiters made impairment findings and described those findings as consistent with claimant's compensable injury, and did not attribute the impairment to causes other than the compensable injury, we construe the findings as showing that claimant's cervical impairment was due to his compensable injury. *Danboise*, 147 Or App at 553. Therefore, claimant is entitled to a disability rating based on reduced lumbar ROM.

Claimant also contends that he should receive a rating for his residual psychiatric impairment that existed at the time of the Order on Reconsideration, and an adaptability factor of (6) based on the Adaptability Scale in OAR 436-035-0310(8). We do not agree with claimant's contention for the reasons expressed by the ALJ (that claimant has failed to prove *permanent* psychological impairment due to the compensable injury) and adopt and affirm that portion of the order discussing this issue. Consequently, like the ALJ, we apply the adaptability chart in OAR 436-035-0310(6), for an adaptability rating of (3).

We now recalculate claimant's unscheduled permanent disability. Based on the arbiter panel's reduced ROM findings in the low back, the impairment value is 8 percent. OAR 436-035-0360(19), (20), (21). The parties do not challenge the impairment values of 6 percent for reduced cervical ROM, 1 percent for reduced right shoulder ROM, 7 percent for reduced right hip ROM, and 19 percent for pelvic fractures. The spinal ROM findings of 8 percent and 6 percent are combined for a spinal impairment value of 14 percent. OAR 436-035-0350(2). The value of 7 percent is combined with 19 percent for a value of 25 percent for pelvic fractures and hip motions. The impairment values for pelvis (25 percent), spine (14 percent), and right shoulder (1 percent) are combined for a final impairment value of 37 percent.

Neither party challenges the age factor of 1 or the education value of 1. Based on the uncontested findings of "heavy" Base Functional Capacity and "medium" Residual Functional Capacity, the adaptability value is 3. OAR 436-035-0310(6). Adding age and education together results in a value

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[1] The sacrum is the segment of the vertebral column forming part of the pelvis; a broad, slightly curved, spade-shaped bone, thick above, thinner below, closing in the pelvic girdle posteriorly; it is formed by the fusion of five originally separate sacral vertebrae; it articulates with the last lumbar vertebra, the coccyx, and the hip bone on either side. *Stedman's Electronic Medical Dictionary* v .4.0 (1998). *See SAIF v. Calder*, 157 Or App 224 (1998) (it is appropriate for the Board to refer to the medical dictionary for the purpose of determining what the coracobrachial ligament is).

[2] The arbiters noted under "Impression": "Multiple fractures, right pelvis, including the sacroiliac joint, the symphysis pubis and the acetabulum, status post open reduction internal fixation, see surgery times two, without overt findings of avascular necrosis or major arthritis, and *with some heterotopic ossification and low back strain symptoms.*" (Ex. 24-7; emphasis added). The panel also noted that the pelvic fractures had healed with displacement and deformity, and that they were related to *and consistent with the mechanism of injury.* (Ex. 27-8).

of 2, which is multiplied by the adaptability value for a product of 6. OAR 436-035-0300(3)(b). That product is then added to the impairment value of 37 percent, which results in a total unscheduled permanent disability award of 43 percent.[3]

Temporary Total Disability

We adopt and affirm the ALJ's order on this issue. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999) (there is no substantive entitlement to temporary disability for periods not authorized by the attending physician).

Scheduled Permanent Disability and Related Attorney Fee

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

ORDER

The ALJ's order dated May 5, 1999 is modified in part and affirmed in part. In lieu of the Order on Reconsideration's unscheduled permanent disability award, and in addition to the ALJ's award of 37 percent (118.4 degrees) unscheduled permanent disability, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, for a total of 43 percent (137.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation awarded by this order (the 6 percent increase between the ALJ's order and this order), not to exceed $3,800, payable directly to claimant's counsel. The remainder of the order is affirmed.

[3] In regard to the concern raised by the special concurrence that the medical evidence indicates that claim closure was premature and should be set aside, the record establishes that claimant explicitly withdrew the premature closure issue in his closing argument at hearing. (*See* Hearings File). Moreover, claimant has not asserted medically stationary status as an issue on review. In any event, the ALJ would have no authority to make a finding on the merits and the issue is not before us on review. *See Wilfred Oddson*, 47 Van Natta 1050 (1995) (issue withdrawn at hearing no longer before ALJ; therefore ALJ forestalled from making a finding on the merits and without authority to award attorney fee (citations omitted)). In other words, claimant's withdrawal of the premature closure issue in writing constitutes an explicit waiver of the issue, which continues to be binding on appeal or administrative review. *See Wright Suchart Harbor v. Johnson*, 133 Or App 680 (1995) (a waiver is an intentional and voluntary withdrawal of a known right).

Board Member Phillips Polich specially concurring.

I share the majority's conclusion that, on this record, claimant is entitled to increased unscheduled permanent disability. I write separately to express my concern that, as noted by the ALJ, the medical evidence in this case indicates that claim closure was premature and should be set aside. Specifically, the medical arbiter/psychiatrist Dr. Bennington-Davis stated that further psychiatric treatment would improve claimant's depression and restore full psychological function, which is sufficient evidence to establish that claimant was not medically stationary on the date of claim closure.

I reason as follows. 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. Moreover, the Board applies the law as the record and the 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, 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. Therefore, even though claimant withdrew the "premature claim closure" issue that he raised at the reconsideration proceeding, I would nevertheless find, based on the law and the evidence, that the premature closure issue should be addressed on review.

Finally, because there is a reasonable expectation of material improvement from medical treatment, I would find that claimant was not medically stationary[1] on the date of claim closure. Claims

[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).

shall not be closed if the worker's condition has not become medically stationary (with exceptions that do not concern us here). ORS 656.268(1). In accord with the statutory requirement, I would find that claimant's claim was prematurely closed. *See Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985); *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

In the Matter of the Compensation of
STEVEN R. BUCHHOLZ, Claimant
WCB Case No. 94-03550
ORDER DENYING MOTION TO DISMISS
Lundeen, et al, Defense Attorneys

Claimant, *pro se*, has requested Board review of Administrative Law Judge (ALJ) Garaventa's July 22, 1999 Order of Dismissal. Asserting that all issues raised by claimant's March 18, 1994 request for hearing have been resolved by the parties' 1996 Claim Disposition Agreement (CDA), the insurer seeks dismissal of claimant's appeal. The motion is denied.

FINDINGS OF FACT

On March 18, 1994, claimant, through his then-attorney, filed a hearing request from an August 17, 1993 Determination Order, raising the issue of the extent of his scheduled and unscheduled permanent disability. Claimant's claim was reopened for vocational training and the parties agreed to defer the hearing. A May 26, 1995 order deferring the hearing issued.

The parties entered into a CDA, which the Board approved on February 6, 1996.

The ALJ's Order of Dismissal issued on July 22, 1999. The ALJ's order contained a notice advising the parties of appeal rights on the order.

On August 19, 1999, the Board received claimant's August 17, 1999 letter requesting review of the ALJ's order.

A computer-generated acknowledgment of claimant's request for review was mailed by the Board on August 20, 1999. Copies were mailed to all parties to the proceeding and their representatives.

CONCLUSIONS OF LAW AND OPINION

The insurer moves to dismiss claimant's request for review on the basis that there are no issues to be reviewed because the claim, WCB Case No. 94-03350, has been compromised by the CDA. We deny the motion, based on the following reasoning.

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).

Here, the 30th day after the ALJ's July 22, 1999 order was August 21, 1999. Because claimant's request for review was received by the Board on August 19, 1999, it was timely filed with the Board. *See* ORS 656.289(3), 656.295(2); OAR 438-005-0046(1)(a).

Because claimant timely filed his review request with the Board, we are authorized to examine the propriety of the ALJ's decision to dismiss claimant's hearing request. *See Elvia H. Hillner*, 49 Van Natta 567, *recon* 49 Van Natta 584 (1997); *Mike D. Sullivan*, 45 Van Natta 990 (1993); *Donald L. Lowe*, 41 Van Natta 1873 (1989). The insurer does not contend that the CDA deprives the Board of appellate jurisdiction to review the ALJ's dismissal order pursuant to a timely request for review. *See Donald D. Paul*, 51 Van Natta 981 (1999) (Board addressed propriety of ALJ's order dismissing the claimant's request for hearing after the claimant released his rights to all workers' compensation benefits under the claim with a CDA).

Accordingly, the insurer's motion is denied. Because no hearing was convened in this matter, no transcript is available. Consequently, the following briefing schedule shall be implemented.

Claimant's appellant's brief (his written argument explaining why he disagrees with the ALJ's decision and what action he wants the Board to take) must be filed within 21 days from the date of this order. Claimant also should mail a copy of his brief to the insurer's attorney. The insurer's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant may file a reply brief (that responds to arguments made in the insurer's respondent's brief) within 14 days from the date of mailing of the insurer's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
STACIE L. HAYES, Claimant
WCB Case No. 98-07725
ORDER ON REVIEW
Thomas J. Flaherty, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) declined to admit into the record three exhibits[1] submitted by claimant; (2) declined to allow claimant to testify at hearing; (3) declined to address the issue of premature closure of claimant's right upper extremity overuse condition; and (4) affirmed the Order on Reconsideration's award of zero scheduled permanent partial disability for claimant's right upper extremity overuse condition. In addition, claimant moves to strike the insurer's Respondent's Brief.[2] On review, the issues are motion to strike, propriety of evidentiary rulings regarding exhibits and testimony, premature closure, and extent of scheduled permanent disability.

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

Motion to Strike

In response to claimant's request for review, we set up the following briefing schedule: (1) claimant's Appellant's Brief was due on or before May 6, 1999; (2) the insurer's Respondent's Brief was due within 21 days after the date of mailing of claimant's Appellant's Brief; and (3) any Reply Brief from claimant was due within 14 days after the date of mailing of the insurer's Respondent's Brief.

On May 5, 1999, claimant's attorney mailed a copy of claimant's Appellant's Brief to the insurer's attorney via regular mail and included a "certificate of service" certifying that the brief was mailed on that date. On May 25, 1999, the insurer's attorney mailed a copy of the insurer's Respondent's Brief to claimant's attorney via certified mail and included a "certificate of service" certifying that the brief was mailed on that date. The Respondent's Brief was mailed to the address of claimant's attorney's office that was listed on his "certificate of service." There is no contention that this address was incorrect.

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[1] These exhibits consist of: (1) Exhibit 1A, a December 31, 1997 chart note from Dr. Read, treating physician; (2) Exhibit 20A, an April 9, 1998 back-to-work permission slip from Dr. Ballard, treating physician; and (3) Exhibit 1B, a January 19, 1998 back-to-work permission slip from Dr. Ballard. As the ALJ found, Exhibit 1B was admitted to the record as Exhibit 2; therefore, there is no issue on review about the admissibility of Exhibit 1B. Only admissibility of Exhibits 1A and 20A remains at issue on review.

[2] The insurer also moved to strike claimant's Reply Brief. Claimant, however, chose not to submit a Reply Brief. Therefore, the insurer's motion to strike is moot.

On June 12, 1998, the United States Post Office returned to the insurer's attorney's office the unclaimed, unopened envelope containing claimant's attorney's copy of the Respondent's Brief. In an unrebutted affidavit, Mr. Dean Jares, the supervisor of the United States Post Office in Hillsboro, Oregon, explained the commonly used procedure for the delivery of a certified letter, which includes an attempt at actual, physical delivery. If that attempt is unsuccessful, two subsequent notices are delivered to the addressee by the post office notifying the addressee that he/she has certified mail awaiting retrieval. If these notices are unsuccessful, the certified mail is returned to the sender as "unclaimed." Affidavit of Dean Jares, page 1.

Mr. Jares also explained that each time the addressee is given a notice, the outside of the original certified letter envelope is marked with a date indication that notice was given. *Id.* at page 2. He explained that prior to the return of the certified letter to the sender, the outside of the envelope is marked with a final date indicating the date of return. *Id.* He noted that the Form PS3849 contains the following information: the date of attempted delivery; the article number; what the article is, the name and address of the addressee, the name of the sender, where to pick up the certified letter, and the hours of operation of the local post office. *Id.*

A copy of the certified letter envelope indicates that the first notice was given on May 26, 1999, the second notice was given on June 2, 1999, the third notice was given on June 10, 1999, and the envelope was returned marked "unclaimed" on June 12, 1999. Thus, claimant's attorney had over two weeks to retrieve the certified mail before it was returned to the insurer's attorney as "unclaimed."

By letter dated June 17, 1999, the insurer's attorney asserted that claimant's time to reply to the Respondent's Brief had expired and requested that we proceed with our review.[3] In response, by letter dated June 24, 1999, claimant's attorney argued that the insurer's attorney Respondent's Brief should be stricken because it was mailed by "certified" mail rather than "regular" mail, as required by OAR 438-005-0046(1)(a). We disagree.

OAR 438-011-0020(2) outlines the timelines for filing briefs on review and provides, in part, that "[r]espondent(s) shall file its (their) brief(s) within 21 days after the date of mailing of the appellant's brief." OAR 438-005-0046(1) defines "filing" and provides, in relevant part:

> "(1) Filing:
>
> "(a) Except as otherwise provided in these rules, "filing" means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing;
>
> "(b) If filing of a request for hearing or Board review of either an Administrative Law Judge's order or a Director's order finding no bona fide medical services dispute 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. 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;
>
> "(c) Except for the documents specified in subsection (b) of this section, filing of any other thing required to be filed within a prescribed time may be accomplished by mailing by first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. If the thing is not received within the prescribed time and no certificate of mailing is furnished, it shall be presumed that the filing was untimely unless the filing party establishes that the filing was timely."

Thus, "filing" generally means the physical delivery to a staffed office of the Board or the date of mailing. OAR 438-005-0046(1)(a). There is no requirement, however, to file any document by registered or certified mail. But, pursuant to OAR 438-005-0046(1)(b), if a request for hearing or Board review is filed by certified or registered mail, a presumption is available that the request was mailed on the date shown on the receipt for registered or certified mail showing the date of mailing.

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[3] The insurer also argued that any subsequently submitted Reply Brief would be untimely and should not be considered. As noted above, however, claimant chose not to submit a Reply Brief.

Here, the document filed was a Respondent's Brief, not a request for hearing or Board review. Thus, OAR 438-005-0046(1)(c) applies. Contrary to claimant's argument, however, OAR 438-005-0046(1)(c) does not *require* regular mailing to file documents other that those specified in subsection (b). Instead, it *permits* filing by first class, postage prepaid, *i.e.* "regular mail," and provides that an "attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date."

Here, in filing a Respondent's Brief, the insurer's attorney went beyond the permissive filing by first class, postage prepaid and, instead, filed it by certified mail. In addition, the insurer's attorney submitted a certificate stating that the Respondent's Brief was deposited by certified mail on May 25, 1999. Even without considering the method of mailing, *i.e.*, certified or "regular," the insurer's attorney's certificate that the brief was deposited in the mail on a stated date is proof of mailing on that date. OAR 438-005-0046(1)(c). Therefore, the insurer has established that its Respondent's Brief was timely filed. Accordingly, we have considered that brief on review.

Propriety of Evidentiary Rulings Regarding New Exhibits and Testimony

On April 27, 1998, claimant's claim was closed by Determination Order that awarded only temporary disability benefits. Claimant requested reconsideration of that order. On September 3, 1998, an Order on Reconsideration issued that affirmed the Determination Order in all respects. Claimant requested a hearing. The ALJ denied claimant's requests that she be permitted to testify at hearing and allowed to submit new exhibits at hearing. Claimant contends that the ALJ erred in denying those requests. We disagree.

On review, claimant argues that she was denied her constitutional rights under the United States Constitution and the Oregon Constitution by being denied the opportunity to testify and submit new evidence at hearing. We find no merit to claimant's constitutional arguments. *Koskela v. Willamette Industries, Inc.*, 159 Or App 229 (1999) (the administrative review and hearing structure of ORS 656.283(7), which prohibits the admission of evidence at hearing that was not submitted during the reconsideration proceeding, did not violate the claimant's right to due process of law under the 14th Amendment to the U.S. Constitution); *Rogue Valley Medical Center v. McClearen*, 152 Or App 239 (1998) (under ORS 656.283(7), any evidence not submitted during the reconsideration process is inadmissible at a subsequent hearing, including the claimant's testimony).

ORDER

The ALJ's order dated March 12, 1999 is affirmed.

October 6, 1999 Cite as 51 Van Natta 1687 (1999)

In the Matter of the Compensation of
RHONDA G. PREWITT, Claimant
WCB Case No. 98-08095
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside the employer's September 17, 1998 and September 21, 1998 partial denials of chronic pain disorder and right ulnar nerve dysfunction; and (2) awarded claimant's attorney a $2,500 assessed attorney fee. On review, the issues are issue preclusion and, if no preclusion, then compensability.[1]

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[1] Claimant's respondent's brief was due April 15, 1999 (twenty-one days from the date of mailing of K Mart's appellant's brief). Claimant's brief was received on April 20, 1999. Therefore, we determine that claimant's brief is untimely and will not be considered on review. OAR 438-011-0020(2). Furthermore, claimant is not entitled to an attorney fee. *See, e.g., Shirley M. Brown*, 40 Van Natta 879 (1988) (an untimely brief does not qualify as legal representation on review under ORS 656.382(2)).

We adopt and affirm the ALJ's order.

ORDER

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

October 6, 1999 Cite as 51 Van Natta 1688 (1999)

In the Matter of the Compensation of
PATRICIA J. PETTY, Claimant
WCB Case No. 98-03329
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's partial denial of her low back condition; (2) found that claimant was not entitled to additional temporary disability benefits; (3) declined to assess a penalty and/or penalty-related attorney fee for the employer's allegedly unreasonable denial; and (4) declined to assess a penalty for the employer's alleged resistance to the payment of temporary disability benefits. On review, the issues are compensability, temporary disability benefits and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 2, we replace the first three full paragraphs with the following:

> "On February 11, 1997, claimant sought treatment for mid thoracic back pain from Dr. Dietz. (Ex. 11). His examination showed no deformity of the spine, no eccymosis, edema or abrasions. (*Id.*) He found tenderness in the mid to upper thoracic spine and decreased range of motion. (*Id.*) Dr. Dietz diagosed a thoracic contusion/strain and authorized modified work. (Ex. 13).
>
> "After the February 7, 1997 injury, Dr. Page treated claimant from February 18, 1997 until August 18, 1997, when he ceased private practice. (Exs. 32A, 37A). On February 24, 1997, Dr. Page noted that claimant could return to work the following day. (Ex. 17-1). On March 1, 1997, Dr. Page reported that claimant's pain was predominantly lumbosacral with a radicular component. (Ex. 17A).
>
> "Claimant testified that she was initially off work two weeks, from February 12, 1997 until February 26, 1997. (Tr. 16). She received time loss for that two week period, but has not received any since that time. (Tr. 17-18). She continued working until April 20, 1997. (Tr. 17)."

In the sixth full paragraph on page 2, we change the date in the first sentence to "November 14, 1997."

CONCLUSIONS OF LAW AND OPINION

Compensability of Claimant's Low Back Condition

Claimant was injured on February 7, 1997 when a box containing plastic cups fell and struck her between the shoulders. (Ex. 9, Tr. 10). The employer accepted a disabling thoracic contusion. (Ex. 24). On April 23, 1998, claimant wrote to the employer, requesting that it accept "acute contusion of the thoracic back with related muscle strain, secondary aggravation of longstanding lumbo-sacral vertebral and perivertebral pathology, and chronic back pain syndrome with related general debility." (Ex. 40A). The employer responded by amending the acceptance to include a thoracic strain. (Ex. 42). On August 10, 1998, the employer issued a partial denial of claimant's lumbo-sacral vertebral and perivertebral pathology and chronic back pain syndrome. (Ex. 46).

The ALJ concluded that claimant's February 7, 1997 injury was not the major contributing cause of a combined low back condition. He also concluded that claimant's low back condition was not a consequential condition.

On review, claimant argues that the ALJ erred by upholding the insurer's denial. She relies on the opinions of Dr. Page and Armerding to establish compensability. Dr. Page has diagnosed claimant with an acute contusion of the thoracic back with related muscle strain, secondary aggravation of longstanding lumbosacral vertebral and perivertebral pathology and chronic back pain syndrome with related general debility. (Ex. 37A).

Claimant has had four cervical surgeries and six lumbar surgeries. (Tr. 11, 24). She testified that she has had periodic "flare-ups" of her low back condition and intermittent back pain. (Tr. 12, 22). She does not dispute that she has a preexisting low back condition that combined with the February 7, 1997 injury. Although claimant relates her current low back condition to the work injury, she does not explain whether she is relying on a consequential or combined condition theory. We need not decide which causation standard is applicable because, in any event, we find that claimant has failed to satisfy the major contributing cause standard.

Because of the number of potential causes of claimant's current low back 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 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. Page and Armerding are not sufficient to establish compensability of the low back condition.

Dr. Page was claimant's family doctor from 1985 until August 1997. (Ex. 37A, Tr. 16, 19). After the February 7, 1997 injury, he treated claimant from February 18, 1997 until August 18, 1997, when he ceased private practice. (Exs. 32A, 37A).

On April 12, 1998, Dr. Page reported that claimant had an "acute" injury on February 7, 1997 that was the major contributing cause of her current condition. (Ex. 37A-2). On November 2, 1998, Dr. Page reported that claimant's work injury caused direct injuries of thoracic contusion and strain, "which in turn worsened pre-existing chronic back pain" related to the vertebral abnormalities and the surrounding paraspinal musculature. (Ex. 51). He explained that the "worsening of adjacent structures" can occur both because the injuries force the patient to change normal positioning "and/or the vertebral column and paraspinous musculature are forced in a compensatory manner to sustain a greater workload than normal[.]" (*Id.*) He felt that both situations applied to claimant's injury. (*Id.*) Dr. Page said it was "clear" that the acute injuries were the major contributing cause of claimant's combined condition, related disability and need for treatment. (*Id.*) He explained that before February 7, 1997, claimant was employed and very active, but after the injury, her "combined condition" has prevented her involvement in those activities. (*Id.*) He commented that although claimant had "longstanding musculoskeletal abnormalities and related pain, she never before had any significant lifestyle changes or disability." (*Id.*)

Dr. Page's opinion on causation is not persuasive for several reasons. First, we are not persuaded that Dr. Page had an accurate history of claimant's previous low back treatment. On December 28, 1996, approximately six weeks before the February 7, 1997 work injury, claimant was treated by Dr. Armerding for low back pain. (Exs. 8-4, -5). He reported that claimant slipped and fell on ice and now had low back pain, with "burning" down her left leg and pain between her shoulder blades. (*Id.*) Dr. Armerding noted that claimant "had 10 spinal fusions and is susceptible to reinjury and lots of back pain." (*Id.*) In rendering his causation reports, there is no indication Dr. Page was aware of claimant's December 28, 1996 treatment or whether the low back pain from that incident had resolved by the time of the February 7, 1997 injury.

Moreover, the medical record does not support Dr. Page's conclusion that claimant had "never before had any significant lifestyle changes or disability." (Ex. 51). Claimant's previous medical records indicate she had chronic low back pain before and after the work injury. A September 19, 1996 chart note indicated claimant had a "crawling sensation" up the lateral left leg and she reported that she was trying to limit her lifting activities at work. (Ex. 8-2). A June 7, 1995 chart note said that claimant had developed severe lumbar back pain after working in the yard and was in so much pain "she virtually

can't move." (Ex. 3-7). Claimant said that her teeth hurt from clenching them because of the pain. (*Id.*) In light of these medical reports, we are not persuaded that Dr. Page accurately characterized claimant's previous low back problems. *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).

In addition, we are not persuaded by Dr. Page's opinion on causation because he did not comment on claimant's pain behavior and functional behavior noted by other physicians. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause). Dr. Moser treated claimant on January 6, 1998 and reported it was a very difficult case to sort out, in part because of claimant's "obvious functional overlay[.]" (Ex. 29-2). Dr. Moser agreed there was a significant functional component to claimant's problems at that time. (Ex. 53-2). Dr. Farris examined claimant on November 5, 1997 and said she had exhibited moderately severe pain behavior throughout his exam and he felt that psychosocial factors were contributing "significantly" to the current complaints. (Ex. 23-10). Mr. Fiske, a physician's assistant who had treated claimant on numerous occasions, concurred with Dr. Farris' report. (Ex. 27). In addition, Dr. Fuller felt that claimant had "[o]ngoing pain complaints resulting from a combination of depression and chronic pain syndrome which pre-existed the work injury of 1997, noting normal cervical and lumbar MRI's with normal bone scan and normal flexion/extension lumbar films." (Ex. 44-7).

Finally, we are not persuaded by Dr. Page's opinion on causation because he apparently understood that the February 7, 1997 work injury was very traumatic. His reports referred to claimant's "acute injuries." (Ex. 37A, 51). Claimant was injured on February 7, 1997, but did not seek treatment until February 11, 1997 when she was examined by Dr. Dietz. (Ex. 11). Dr. Dietz reported that claimant had mid thoracic back pain. (*Id.*) His examination showed no deformity of the spine, no eccymosis, edema or abrasions. (*Id.*) He found tenderness in the mid to upper thoracic spine and decreased range of motion. (*Id.*) Dr. Dietz diagosed a thoracic contusion/strain. (Ex. 13). After the injury, claimant was off work two weeks, until February 26, 1997. (Tr. 16).

Based on these medical reports, Dr. Farris concluded there was no objective evidence that claimant had sustained any injury of significance to any portion of her spine after the February 7, 1997 injury. (Ex. 54-3). Similarly, Dr. Fuller commented that Dr. Page had ignored the fact that claimant's imaging studies were negative and that there were no objective changes in any of her subsequent examinations. (Ex. 52). Dr. Fuller felt that Dr. Page's conclusions were "highly speculative." (*Id.*) In light of the medical records after claimant's February 7, 1997 injury, we are not persuaded by Dr. Page's conclusion that claimant sustained "acute injuries," including injuries to the lower back area as a result of the work injury.

Similarly, we are not persuaded by Dr. Armerding's opinion on causation. Dr. Armerding examined claimant on April 24, 1998, diagnosing a back injury with chronic pain, spasm and radiculopathy. (Ex. 41). In a later opinion, he said that claimant's work injury caused a "flare-up" of her low back condition that initially contributed to her inability to work. (Ex. 55-2). He explained, however, that after four to six months, the majority of the low back pain was due to her previously existing low back condition. (*Id.*) We find that Dr. Armerding's opinion is not persuasive because he provided no explanation for his conclusion that claimant's work injury caused a "flare-up" of her low back condition. Furthermore, although he had examined claimant on December 28, 1996 and reported she had low back pain with "burning" down her left leg after a fall on the ice, he did not explain whether the low back pain from that incident had resolved by the time of the February 7, 1997 injury. We conclude that Dr. Armerding's conclusory opinion is not sufficient to meet claimant's burden of proving compensability.

The remaining medical opinions on causation do not support compensability. As we discussed, Dr. Farris found no objective evidence to indicate claimant had sustained any injury of significance on February 7, 1997. (Exs. 23-8, 54-3). He felt that, at most, claimant had a thoracic contusion that should have resolved in a matter of weeks. (Ex. 23-8). He noted that claimant had been having chronic low back pain for the past 12 years and, in fact, had been complaining of low back pain, mid back pain and left leg pain on December 28, 1996, less than six weeks before the work injury. (Ex. 23-9). Dr. Farris concluded that claimant's back condition preexisted the work injury and there was no evidence that the incident materially worsened the preexisting condition. (*Id.*) He found that claimant had exhibited moderately severe pain behavior and he felt that psychosocial factors were contributing to the current complaints. (Ex. 23-10).

Dr. Moser examined claimant on January 6, 1998. She reported this was a "very difficult case to sort out because while there is obvious functional overlay, she also obviously has real lumbar spine disease as well." (Ex. 29-2). She recommended further testing, but noted it would be difficult to sort out the old versus the new findings. (*Id.*)

Dr. Fuller concluded that claimant had sustained a mild thoracic contusion in February 1997, which had resolved without impairment. (Ex. 44-7). He also diagnosed "[o]ngoing pain complaints resulting from a combination of depression and chronic pain syndrome which pre-existed the work injury of 1997[.]" (*Id.*)

After reviewing Dr. Page's November 2, 1998 report, Dr. Fuller noted that Dr. Page had ignored the fact that claimant's imaging studies were negative and that there were no objective changes in any of her subsequent examinations. (Ex. 52). He felt that Dr. Page's conclusions were "highly speculative." (*Id.*) Dr. Fuller did not believe that any of Dr. Page's diagnosed conditions had occurred from a bruise caused by a box hitting claimant on February 7, 1997. (*Id.*) In addition, Dr. Dinneen performed a medical arbiter examination and found that the majority of claimant's abnormalities were due to preexisting conditions. (Ex. 56-3).

In sum, we conclude that claimant has failed to establish compensability of her low back condition.

Temporary Disability

The ALJ found that any authorization for time loss after April 22, 1997 was due to factors other than claimant's industrial injury. The ALJ concluded that claimant was not entitled to additional temporary disability benefits.

On review, claimant argues that the ALJ erred in denying additional substantive temporary disability benefits from February 7, 1997 through April 16, 1998. She relies on time loss authorizations from her attending physicians.

By the time of the November 18, 1998 hearing, the employer had issued a Notice of Closure with an award of temporary disability benefits from February 15, 1997 through February 24, 1997. (Ex. 48). An Order on Reconsideration issued on December 29, 1998, affirming the Notice of Closure. (Ex. 57).[1] In order for claimant to be entitled to additional temporary disability, the benefits must have been authorized by claimant's attending physician and the time off work must be due to the accepted injury. *See* ORS 656.245(2)(b)(B); ORS 656.262(4)(a), (g) & (h).

Claimant relies in part on a December 18, 1997 note from Mr. Fiske, physician's assistant, which indicated she "continued to be unable to work for an indefinite period." (Ex. 27A). The note did not indicate why claimant was unable to work. In any event, on November 25, 1997, Mr. Fiske concurred with the November 5, 1997 report from Dr. Farris, in which he had concluded that claimant's current complaints were not related to the February 7, 1997 work injury. (Exs. 23-8, 27). Thus, even if we assume that Mr. Fiske could properly authorize time loss,[2] we are not persuaded that his work release was related to the compensable thoracic injury.

Claimant also relies on time loss authorizations from Dr. Page. As a result of claimant's February 7, 1997 injury, the employer accepted a thoracic contusion/strain. (Exs. 24, 47). Dr. Page noted that she could return to work on February 25, 1997. (Ex. 17-1).

Claimant testified that she was initially off work two weeks, from February 12, 1997 until February 26, 1997. (Tr. 16). She received time loss for that two week period, but has not received any since that time. (Tr. 18). Claimant continued working until April 20, 1997. (Tr. 17).

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[1] We note that the Order on Reconsideration issued after the hearing, but before the record was closed. Claimant requested a hearing on the December 29, 1998 Order on Reconsideration, which was consolidated with this case.

[2] *See Daniel W. Garris*, 50 Van Natta 941, 944 n.2 (1998) (declining the claimant's invitation to find that the physician's assistant was the attending physician).

We agree with the employer that it properly discontinued payment of time loss when Dr. Page released claimant to work on February 24, 1997. (Ex. 17-1). *See* ORS 656.268(3)(a), (b). As we discussed earlier, claimant has failed to establish compensability of her low back condition, which includes Dr. Page's diagnoses of secondary "aggravation of longstanding lumbosacral vertebral and perivertebral pathology" and "chronic back pain syndrome with related general debility." (Ex. 37A-1). We agree with the employer that Dr. Page's subsequent work releases were focused on the low back condition, rather than the accepted thoracic condition. For the following reasons, we are not persuaded that claimant's inability to work beginning in April 1997 was due to the accepted thoracic condition.

On March 1, 1997, Dr. Page reported that claimant's symptoms were becoming predominantly more lumbosacral with a radicular component. (Ex. 17A). Although his chart note indicated claimant was given a "note for no work" (*Id.*), claimant said she continued to work until April 20, 1997. (Tr. 17).

On April 22, 1997, Dr. Page reported claimant could not work until further notice, although his note did not mention the reason for the limitation. (Ex. 17-2). On May 1, 1997, Dr. Page reported that claimant was released from work indefinitely. (Ex. 18-1). At that time, claimant was having severe left leg pain "like fire down the outside of [her] leg." (*Id.*) Dr. Page reported that claimant's back pain and tenderness was not any better and the pain continued to radiated into the lower extremity. (*Id.*) On May 15, 1997, Dr. Page reported claimant felt like she had "fire down both legs." (*Id.*) He indicated claimant was unable to perform any work activities because she had not shown any significant improvement in her back pain and lower extremity findings. (Ex. 18A).

One week later, Dr. Page reported that claimant had fallen while walking down the driveway. (Ex. 18-2). She had problems with her low back and her right lower extremity. (*Id.*) On May 29, 1997, Dr. Page reported that claimant had several subsequent falls with increasing lower extremity symptoms. (*Id.*) He said claimant was unable to work. (*Id.*)

On July 23, 1997, Dr. Page reported claimant could not return to work for the "foreseeable future." (Ex. 18-3). He felt there were a number of factors related to her problems, including her subsequent falls, general debility and localized muscle atrophy in the low back and lower extremity. (*Id.*)

On August 18, 1997, claimant reported to Dr. Page that her legs were worse and her lower back hurt the worst. (Ex. 18-4). Dr. Page reported that claimant was unable to work and had too much pain to maintain activity. (Exs. 18-4, 19). Dr. Page last treated claimant on August 18, 1997. (Ex. 37A).

Based on these medical reports, we agree with the employer that Dr. Page's subsequent work releases were focused on the noncompensable low back condition, rather than the accepted thoracic condition. We conclude that claimant is not entitled to additional temporary disability benefits.

Penalties

At hearing, claimant sought a penalty and/or penalty-related attorney fee for the employer's allegedly unreasonable denial of her low back conditions, as well as a penalty for the employer's alleged resistance to the payment of temporary disability benefits.

We have concluded that claimant's low back condition is not compensable and she is not entitled to additional temporary disability benefits. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The ALJ's order dated May 12, 1999 is affirmed.

In the Matter of the Compensation of
SALVADOR PADILLA, Claimant
WCB Case No. 99-00083
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the self-insured employer's partial denial of claimant's current low back condition both as an injury claim and an occupational disease claim; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm with the following corrections and supplementation.

The last sentence in the fourth paragraph of the findings of fact should read "Dr. Tsang," not "Dr. Stringham." (Exs. 1, 2). We replace the first sentence of the third paragraph of the opinion section with the following sentence: "The record establishes that claimant sustained a lumbosacral strain in a September 1994 noncompensable motor vehicle accident (MVA)." (Ex. 0).

Dr. Stringham, a physician specializing in occupational medicine, served as claimant's treating physician following his MVA. (*Id.*). On April 24, 1998, and again on October 7, 1998, claimant injured his low back at work. Dr. Tsang, a physician specializing in occupational medicine, served as claimant's treating physician following both work injuries. (Exs. 1, 2, 4, 5, 6, 7, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24). Claimant's claim regarding the April 24, 1998 injury was closed by a June 23, 1998 Notice of Closure that awarded only temporary disability benefits. (Ex. 11). On November 16, 1998, Dr. Tsang found claimant medically stationary regarding the October 7, 1998 injury. (Ex. 23). On December 8, 1998, claimant sought treatment from Dr. Stringham, who prescribed medication and additional physical therapy. (Ex. 24a).

Dr. Tsang has a longer treatment history with claimant. Although Dr. Stringham treated claimant after the noncompensable 1994 MVA, he next treated claimant in December 1998 and only saw him four times thereafter before finding him medically stationary on February 19, 1999. (Exs. 24a, 27a, 30, 30a).

Claimant has worked as a mushroom picker for the employer since March 1988. Medical opinions regarding the cause of claimant's current low back condition are provided by Drs. Tsang, Stringham, and Strum, an orthopedist who examined claimant on behalf of the employer. All three physicians agree that claimant has preexisting degenerative disc disease in his lower back that combined with his October 1998 low back injury. (Exs. 24-2, 32-2, 33-9).

Claimant argues that his current low back condition is compensable under either of two theories: (1) his October 1998 low back injury is the major contributing cause of his disability or need for treatment of the combined condition; or (2) his years of work exposure picking mushrooms and his two compensable injuries, (*i.e.*, April 1998 and October 1998), are the major contributing cause of his current condition.

For the reasons given by the ALJ, we agree that claimant has not met his burden of proof under either theory. Only Dr. Stringham's opinion might support compensability of claimant's current condition claim; however, like the ALJ, we do not find Dr. Stringham's opinion persuasive.

Under either of claimant's compensability theories, he must meet the "major contributing cause" standard. ORS 656.005(7)(a)(B); 656.802(2)(b). To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury (and/or work activities) contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). In other words, the persuasive medical opinion must evaluate the relative contribution of different causes and explain why the compensable injury (and/or work activities) contributed more to the claimed conditions than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Furthermore, the fact that a work injury or work activities precipitated the symptoms of a condition does not necessarily mean that the injury or activities were the major contributing cause of the condition. *Id.*; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

Dr. Stringham's opinion does not meet this standard. In this regard, he does not evaluate the relative contribution of the work injury/activities and explain why the work injury and/or activities contributed more to claimant's current condition than all other causes combined, including the preexisting degenerative disc disease. Instead, he bases his opinion on the fact that claimant's low back was asymptomatic before the work injury/activities. (Ex. 32-2). Such "precipitating cause" or "but for" reasoning, without more, does not meet claimant's burden of proving major contributing cause. *See Phillip A. Kister*, 47 Van Natta 905 (1995) (doctor's reasoning that "but for" the work exposure, the claimant would not have developed carpal tunnel, was insufficient to establish that the work was the major contributing cause).

In addition, where, as here, the occupational disease claim is based on the worsening of a preexisting disease under ORS 656.005(7), claimant "must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." ORS 656.802(2)(b). There is no medical evidence indicating that claimant's work activities were the major contributing cause of a pathological worsening of his degenerative disc disease. When specifically asked whether claimant's work injuries pathologically worsened his preexisting degenerative disc disease, Dr. Stringham did not answer in the affirmative. Instead, he responded that claimant's work activities were the major contributing cause for his "development of symptomatic low back condition and his need for treatment." (Ex. 32-2). But development of a symptomatic condition does not establish a pathological worsening of the preexisting condition. Dr. Tsang responded that he could not say that claimant's work activities were the major cause of the pathological worsening. (Ex. 24-2).

On this record, we agree with the ALJ that claimant has not established that his current low back condition is compensable under either an injury or occupational disease theory.

ORDER

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

October 7, 1999 Cite as 51 Van Natta 1694 (1999)

In the Matter of the Compensation of
ROBERT STEMPLE, Claimant
WCB Case No. C992233
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Westmoreland & Mundorff, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On September 20, 1999, the Board received the parties' claim disposition agreement (CDA). 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 approve the proposed disposition.

The proposed agreement provides a total consideration of $40,000. The type-written language of the agreement provides that claimant would receive $33,375 and that claimant's attorney would receive an attorney fee of $6,625 payable out of the CDA proceeds. Nevertheless, by handwritten revision, the attorney fee has been reduced to $5,875, thereby increasing the total amount due claimant to $34,125. Notwithstanding the revision, 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 $6,625 attorney fee.

Upon review of the document as a whole, we conclude that the intent of the parties calls for a total consideration of $40,000, with an attorney fee of $5,875 payable to claimant's attorney and $34,125 payable to claimant.

The agreement, as clarified by this order, is otherwise 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 $5,875, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
WANDA L. TURNER, Claimant
WCB Case No. 98-03818
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of her right knee lateral meniscus tear, right carpal tunnel syndrome, cervical radiculopathy, right shoulder AC joint injury/degenerative arthritis and right rotator cuff tendinitis/ impingement conditions. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation. On page 2, we replace the third paragraph with the following:

> "On December 23, 1996, the insurer accepted a right knee contusion, cervical strain and right shoulder strain. (Ex. 34). On April 30, 1998, the insurer indicated it had previously accepted a right elbow strain and was now accepting right lateral epicondylitis. (Exs. 93, 106)."

In the fifth paragraph on page 2, we change the date in the third sentence to "August 21, 1997." In the sixth paragraph on page 2, we change the date to "September 19, 1997." We delete the last two paragraphs on page 2.

CONCLUSIONS OF LAW AND OPINION

On August 29, 1996, claimant was compensably injured when she fell on a step while on a company errand. The insurer accepted a right knee contusion, cervical strain, right shoulder strain, right elbow strain and right lateral epicondylitis. (Exs. 34, 93, 106). Claimant contends that her right knee lateral meniscus tear, right carpal tunnel syndrome, cervical radiculopathy, right shoulder AC joint injury/degenerative arthritis and right rotator cuff tendinitis/ impingement conditions are also compensable. The ALJ found that claimant failed to establish compensability of those conditions.

To begin, we address claimant's assertion that the insurer's April 30, 1998 denial incorrectly stated that her cervical radiculopathy and rotator cuff tendinitis/impingement of the right shoulder were not diagnosed. (Ex. 93). According to claimant, those conditions had been diagnosed and since the scope of the insurer's denial was limited to the contention that those conditions had not been diagnosed, the insurer's denial should be set aside.

We find no evidence that claimant raised this issue at hearing and, therefore, we are not inclined to address her argument concerning the scope of the denial on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). In any event, even if we assume that claimant properly raised this issue, we are not persuaded by her argument. Claimant does not address the fact that there are two denials at issue in this case. The insurer issued a second denial on September 1, 1998, indicating that it was denying claimant's request to accept a "[r]ight knee lateral meniscus tear; right knee small joint effusion; anterolateral subcutaneous edema." (Ex. 106). The insurer said that, in addition to the right knee condition, "the following conditions have been denied: right side carpal tunnel syndrome, cervical radiculopathy, AC joint injury/degenerative arthritis, right shoulder rotator cuff tendinitis/impingement." (*Id.*) Unlike the insurer's April 30, 1998 denial, the September 1, 1998 denial did not refer to the fact

that the cervical radiculopathy and rotator cuff tendinitis/impingement conditions had not been diagnosed. The insurer's September 1, 1998 letter denied those conditions generally and was not limited in any manner. Claimant's argument regarding the scope of the insurer's denial is not persuasive.

Right knee lateral meniscus tear

Claimant relies on the opinion of her treating physician, Dr. Bosworth, to establish compensability of her right knee lateral meniscus tear.[1]

The ALJ found that claimant's lateral meniscus tear should be analyzed under ORS 656.005(7)(a). We find no medical evidence of a "combined condition" related to the meniscus tear. Therefore, claimant must establish that her work injury is a material cause of the right knee lateral meniscus tear.

In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Absent persuasive reasons to do otherwise, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). In this case, the record indicates that Dr. Bosworth examined claimant on only one occasion before performing right knee surgery. (Ex. 103). Under these circumstances, we do not grant any particular deference to Dr. Bosworth's opinion. Instead, for the following reasons, we are persuaded by Dr. Mandiberg's opinion on causation of the lateral meniscus tear.

We begin by summarizing claimant's right knee treatment after the August 29, 1996 injury. On October 11, 1996, Dr. Barnhouse diagnosed, among other conditions, a right knee contusion. (Ex. 16). He recommended physical therapy. On October 18, 1996, Mr. Eischen, a physical therapist, referred to some "giving away" of the right knee, mild strength deficits and tenderness over the medial joint line. (Ex. 20-1). He referred to a right knee contusion, "rule out medial meniscus irritation." (Ex. 20-2). On October 29, 1996, Dr. Barnhouse examined claimant, but did not refer to any knee complaints. (Exs. 23, 25). He indicated claimant had been released for regular work on October 11, 1996. On November 7, 1996, Mr. Eischen reported that claimant's right knee pain was resolving, but she was mildly tender over the medial joint line. (Ex. 21-2). On the same day, Dr. Barnhouse said the right knee contusion had "resolved." (Ex. 27).

On December 6, 1996, Drs. Reimer and Peterson examined claimant on behalf of the insurer. They reported that claimant's knee symptoms were rather minimal and were only affected when she kneeled on it. (Ex. 31-3). McMurray testing was negative and claimant mild patellofemoral crepitation in both knees, which was not painful. (Ex. 31-4). They diagnosed a resolved right knee contusion. (Ex. 31-5).

Dr. Mandiberg first examined claimant on January 21, 1997. At that time, claimant complained of neck pain, shoulder discomfort and right elbow tenderness. (Ex. 38-2). She had no knee discomfort at that time. (Ex. 38-3). Dr. Mandiberg diagnosed a resolved right knee condition. (*Id.*) He continued treating claimant's shoulder condition. On April 15, 1997, he reported that in the past week claimant had some increasing anterior pain in her right knee and he recommended exercises. (Ex. 49). On May 20, 1997, Dr. Mandiberg reported that claimant's right knee was medically stationary with no impairment. (Ex. 53-2). He found minimal tenderness along the medial joint line, no effusion and no instability in the knee. (*Id.*) On August 14, 1997, Dr. Mandiberg reported that claimant's knee had been "doing fine," but she now had significant patellofemoral discomfort. (Ex 62).

Dr. Bosworth examined claimant on July 23, 1998 and diagnosed a right knee meniscus tear and mild patellofemoral chondromalacia. (Ex. 103). He performed right knee surgery on January 14, 1999. (Ex. 110A).

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[1] At hearing, claimant sought to establish compensability of her right knee lateral meniscus tear, small joint effusion and anterolateral subcutaneous edema. (Tr. 1). A May 5, 1998 MRI of claimant's right knee showed a lateral meniscus tear, small joint effusion and anterolateral subcutaneous edema. (Ex. 94). Claimant's attorney explained that, although a diagnosis had been made of a small joint effusion and anterolateral subcutaneous edema, the "heart of the matter" was the meniscus tear. (Tr. 1). On review, claimant refers only to the right knee lateral meniscus tear. Under these circumstances, we do not separately address compensability of claimant's small joint effusion and anterolateral subcutaneous edema conditions.

Dr. Mandiberg treated claimant's knee condition from January 1997 through August 1997. His opinion on causation of claimant's right knee meniscus tear changed on February 4, 1999, after being provided with a complete history of her right knee symptoms. Claimant relies instead on Dr. Mandiberg's earlier reports. (Exs. 105, 108). On August 20, 1998, Dr. Mandiberg reported that claimant had returned with right knee complaints. (Ex. 105). He indicated he had closed the knee claim on May 25, 1997 because the knee had stabilized. (*Id.*) He explained: "[a]t that time she stated that her knee was doing okay but at the same time she [said] it was going out on occasion." (*Id.*) On October 8, 1998, Dr. Mandiberg indicated that the work injury was the dominant cause for claimant's meniscus tear. (Ex. 108). He explained:

> "When I closed [the claim] in 1997 her knee was doing satisfactory except it was 'going out.' That means, to me, that it was giving out on her and possibly catching on her which could be as a result of a torn meniscus. As time has gone on her knee has gotten worse since 1997 and, therefore, that is why I related her present condition in 1998 back to the injury of 1996." (*Id.*)

On February 4, 1999, Dr. Mandiberg changed his opinion after reviewing additional medical records. (Ex. 111). He referred to the medical records (discussed above) issued shortly after the August 29, 1996 injury. Dr. Mandiberg indicated claimant had no right knee complaints when he first examined her on January 21, 1997. (Ex. 111-1). At that time, he concluded that claimant had sustained a right knee contusion that was resolved. (*Id.*) Dr. Mandiberg did not recall claimant discussing any knee problems until April 15, 1997. (Ex. 111-1, -2). On that date, he reported that claimant had some increasing pain in her right knee which has been anterior. Dr. Mandiberg referred to his May 20, 1997 chart note, which noted some minimal tenderness along the medial joint line and negative McMurray's testing. At that time, Dr. Mandiberg found no indication of any meniscal problems. (Ex. 111-2). He found that claimant first complained of lateral pain in her knee when she was treated by Dr. Bosworth on July 23, 1998. (*Id.*) After reviewing the additional records, Dr. Mandiberg explained:

> "According to the history that I have, the patient had right knee problems that were dissipate[d] by the time I initially saw her. She had one episode of pain during the time that I saw her and when I closed her she had some occasional feeling of her knee going out on her with no significant positive findings, except for some minimal medial joint line tenderness. It appears that her major discomfort, regarding her right knee, by history occurred after my closure." (*Id.*)

Dr. Mandiberg concluded that, based on the physical examinations and clinical history through the time of closure, claimant did not suffer a lateral meniscal tear at the time of the work injury. (Ex. 111-3).

We are persuaded by Dr. Mandiberg's February 4, 1999 opinion because it is well-reasoned and based on complete information. *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). In contrast, Dr. Bosworth examined claimant on one occasion before performing right knee surgery. On July 23, 1998, Dr. Bosworth indicated he had not reviewed earlier reports, but he noted that claimant had injured her knee after falling at work about two years ago. (Ex. 103). He said she "continues to complain of pain both anteriorly and laterally in the knee." (*Id.*) In a later concurrence letter from claimant's attorney, Dr. Bosworth agreed that the August 29, 1996 injury was the major contributing cause of claimant's lateral meniscus tear. (Ex. 110). Dr. Bosworth agreed that the claim was "accepted as a right knee contusion, and she continued with right knee problems." (Ex. 110-1).

At the time of Dr. Bosworth's initial examination of claimant, he had not reviewed any earlier reports and we find no evidence that he was aware of the medical opinions indicating that claimant's knee problems had resolved. Moreover, as Dr. Mandiberg noted, Dr. Bosworth was not aware that claimant first complained of lateral pain in her knee on July 23, 1998, almost two years after the August 29, 1996 injury. Dr. Bosworth's opinion is not persuasive and is entitled to little weight. In addition, we note that Dr. Schilperoort found that the MRI scan of claimant's knee showed a linear horizontal tear of the meniscus, which he said was typical of a degenerative meniscus tear. (Ex. 107-2). He concluded that claimant had a degenerative tear that was not related to any trauma, whether incidental trauma or trauma associated with the August 29, 1996 injury. (Ex. 107-3). Based on the reports from Drs. Mandiberg and Schilperoort, we conclude that claimant's August 29, 1996 injury was not a material cause of the right knee meniscal tear.

Cervical Radiculopathy

Claimant relies on the opinion of Dr. Mandiberg to establish compensability of her cervical radiculopathy condition. For the following reasons, we are not persuaded by Dr. Mandiberg's opinion regarding claimant's cervical radiculopathy.

As a result of the August 29, 1996 injury, the insurer accepted, among other things, a cervical strain. (Ex. 34). On December 13, 1996, Dr. Barnhouse reported that a nerve conduction study showed claimant did not have any cervical radiculopathy. (Ex. 33). When Dr. Mandiberg examined claimant on January 21, 1997, his diagnoses included "[c]ervical strain with improving range of motion." (Ex. 38-3). On August 21, 1997, however, Dr. Mandiberg indicated that claimant was "experiencing what I think may be cervical radiculopathy[.]" (Ex. 64). He felt her cervical problems may be related to the work injury and he said he had ordered a cervical MRI. (*Id.*) Dr. Mandiberg felt claimant should be independently evaluated. (*Id.*)

An August 21, 1997 MRI of claimant's cervical spine was "normal," with no evidence of a herniation or nerve root impingement. (Ex. 65). On August 26, 1997, Dr. Mandiberg referred claimant to a neurologist. (Ex. 69). Claimant was examined by Dr. Rosenbaum, neurologist, on September 29, 1997. (Ex. 77). Dr. Rosenbaum reported that claimant's cervical MRI was negative, although she may have some minimal change at C5-6. (Ex. 77-2). He did not find a clear abnormality to explain her symptoms, although he noted that she had evidence of a minimal right carpal tunnel syndrome that could be accentuating her symptoms. (*Id.*)

On September 19, 1997, Drs. Schilperoort, orthopedic surgeon, and Williams, neurosurgeon, examined claimant on behalf of the insurer. (Ex. 74). They diagnosed a resolved cervical strain. (Ex. 74-6). Drs. Schilperoort and Williams noted that imaging studies showed minor degenerative changes in the mid cervical area. (*Id.*) During claimant's examination, she demonstrated significant symptom magnification and they felt the range of motion in her cervical spine was invalid. (Ex. 74-7). Drs. Schilperoort and Williams found no evidence of a herniated disc in her cervical spine. (*Id.*)

After reviewing the reports from Dr. Rosenbaum and Drs. Schilperoort and Williams, Dr. Mandiberg concluded that claimant was medically stationary. (Ex. 80). Dr. Mandiberg checked claimant's two-point discrimination and found that it was very wide. (*Id.*) He reported that he did not know if that was a true neurological finding or a psychological one. (Ex. 80-1). He indicated he would "leave that up to the neurologist." (*Id.*)

In a later report, Dr. Mandiberg said that claimant's degenerative changes in her cervical spine preexisted her injury and were not worsened by the injury. (Ex. 91-1). He believed claimant had "neurological symptoms secondary to her accident of August 29, 1996." (Ex. 91-1, -2). Dr. Mandiberg explained: "The MRI scan was read as negative by the radiologist but Dr. Robert Rosenbaum who saw the patient on September 29, 1997, stated: 'I do note some vague possible disk material at the C5-6 level, but there is not clear nerve root involvement." (Ex. 91-2).

We find that, at most, Dr. Mandiberg's opinion supports the possibility that claimant has cervical radiculopathy. *See Gormley v. SAIF*, 52 Or App 1055 (1981). In light of the normal cervical MRI, the nerve conduction study showing no cervical radiculopathy and the reports of Dr. Rosenbaum and Drs. Schilperoort and Williams, we are not persuaded that claimant had cervical radiculopathy. Moreover, to the extent claimant has cervical radiculopathy, we find that she has failed to establish that her work injury was the major contributing cause of that condition. *See* ORS 656.005(7)(a)(B).

Right Rotator Cuff Tendinitis and Impingement

Claimant relies on the opinion of Dr. Corrigan to establish compensability of her right rotator cuff tendinitis and impingement conditions. Dr. Corrigan examined claimant on December 30, 1996 and he diagnosed "[s]tatus post contusion and strain, right shoulder, 08/29/96, with probable secondary mild rotator cuff tendinitis and impingement." (Ex. 37-3). He recommended injections for claimant's shoulder and an MRI to determine if she had a partial rotator cuff tear. (*Id.*)

Unlike Dr. Corrigan, Dr. Mandiberg had the opportunity to examine claimant's right shoulder on several occasions. When Dr. Mandiberg first examined claimant on January 21, 1997, his shoulder diagnosis was "[p]ainful right shoulder, rule out AC joint involvement, rule out impingement syndrome." (Ex. 38-3). He recommended injections to help diagnose the problem. (Ex. 38-4). Dr. Mandiberg found that an injection of the AC joint resulted in complete relief of claimant's discomfort

and he felt he had a firm diagnosis of a degenerative AC joint. (Exs. 41, 45, 49). In a later report, Dr. Mandiberg was asked if claimant had rotator cuff tendinitis/impingement. (Ex. 91-2). He responded:

> "This lady has degenerative arthritis in the AC joint. When I injected the AC joint she received excellent relief and I, therefore, do not think she has a significant impingement/rotator cuff tendinitis." (*Id.*)

In light of Dr. Mandiberg's reports, we are not persuaded by Dr. Corrigan's diagnosis of mild rotator cuff tendinitis and impingement. Dr. Corrigan examined claimant on only one occasion and did not have the knowledge, as did Dr. Mandiberg, of claimant's responses to shoulder injections. We find that claimant has failed to establish compensability of mild rotator cuff tendinitis and impingement.

Right shoulder AC joint injury

Claimant relies on the opinion of Dr. Mandiberg to establish compensability of her right shoulder AC joint injury. As a result of the August 1996 injury, the insurer accepted, among other things, a right shoulder strain. (Ex. 34).

The medical evidence establishes that claimant has preexisting degenerative joint disease of the AC joint. (Ex. 91-1). Dr. Mandiberg's April 21, 1998 report indicates that claimant's work injury combined with her preexisting degenerative AC condition to cause her disability or need for treatment. (Ex. 91). Therefore, ORS 656.005(7)(a)(B) applies and claimant must establish that her work injury was the major contributing cause of her disability or need for medical treatment for her right AC joint injury.

As discussed earlier, Dr. Mandiberg found that an injection of the AC joint resulted in complete relief of claimant's discomfort and he felt he had a firm diagnosis of a degenerative AC joint. (Exs. 41, 45, 49). On April 21, 1998, Dr. Mandiberg reported that claimant had degenerative joint disease of the AC joint, which "long predated her injury, but was asymptomatic." (Ex. 91-1). He felt the injury had worsened the AC condition to the point she was now symptomatic. (*Id.*)

In a later concurrence letter from claimant's attorney, Dr. Mandiberg agreed that the August 1996 injury was the major contributing cause of claimant's need for treatment of the right AC joint condition. (Ex. 102-1). His opinion was supported by claimant's history, the mechanism of injury, examination findings, results of treatment and the fact that claimant had "never before experienced any problems into the right shoulder prior to her on the job fall of August 29, 1996." (*Id.*)

The insurer contends that Dr. Mandiberg is not persuasive because he did not have an accurate history of claimant's prior right shoulder problems.

The medical reports indicate that on January 18, 1993, claimant fell on a board at work and injured her right leg and shoulder, left ankle and hip. (Ex. 1). She was diagnosed with a left ankle strain, deep abrasions to her hand and miscellaneous contusions. (*Id.*) Claimant testified that she mainly hurt her hand and ankle in the January 1993 injury. (Tr. 14, 15). She only had one doctor visit after the injury and did not have any ongoing hand or shoulder problems. (Tr. 15).

The medical reports also show that on May 3, 1995, claimant had an epidural injection for muscle spasms in her upper back, shoulders, hand and jaw. (Ex. 2). Claimant explained that she had experienced two falls at work, in January and April 1995. (Tr. 15). In January 1995, she fell on a wet carpet at work and landed on her backside. (*Id.*) In April 1995, she fell on a wet floor at work and again landed on her backside. (Tr. 16). She developed low back problems as a result of those falls and ultimately had low back surgery. (*Id.*) In May 1995, she was given epidurals in her back to help with "charley horses" that started in her back and radiated to her shoulders and hands. (Tr. 16-17). Claimant testified that her shoulder and hand problem after the August 1996 injury was "completely" different than in 1995. (Tr. 17).

We acknowledge that Dr. Mandiberg's statement that claimant had never experienced any previous problems in her right shoulder is not entirely accurate. (Ex. 102-1). Nevertheless, the medical reports do not indicate claimant had previous medical treatment specifically related to a "shoulder" problem. Although the January 1993 chart note indicated claimant injured her shoulder, she was not diagnosed with a shoulder condition at that time. (Ex. 1). Claimant testified that the 1993 injury was minor, without any ongoing problems, and she was diagnosed with a left ankle and hand condition, not a shoulder condition. Likewise, the May 1995 treatment was not directed to a shoulder problem. Rather, claimant had back problems that involved radiated pain to her shoulders. (Tr. 16-17). Based on

our review of the record, we are not persuaded that Dr. Mandiberg lacked material information about claimant's previous shoulder treatment.

We find that Dr. Mandiberg had an accurate understanding that claimant injured her right shoulder as a result of the August 29, 1996 injury. (Tr. 9, Ex. 38). Furthermore, we find that Dr. Mandiberg was in a particularly good position to evaluate claimant's right shoulder condition because he treated on several occasions. We are not persuaded by the insurer's argument that Dr. Mandiberg's opinion was based only on the temporal relationship between the work injury and the ensuing shoulder problems. Rather, Dr. Mandiberg's opinion on causation of the shoulder condition was supported by the mechanism of claimant's injury, his examination findings and the results of treatment. (Ex. 102).

Dr. Mandiberg's opinion on causation is also supported by the report from Drs. Reimer and Peterson, who examined claimant on behalf of the insurer. Drs. Reimer and Peterson examined her on December 6, 1996, before she had any injections to her right shoulder. (Ex. 31). They diagnosed preexisting AC joint arthritis and "[p]ain, right shoulder, probably secondary to post-traumatic inflammatory change, either affecting the rotator cuff of the bicipital tendon or both." (Ex. 31-5). They felt claimant's right shoulder pain was related to the August 29, 1996 injury and the injury was the major contributing cause of her current need for treatment. (Ex. 31-5, -6).

The only contrary medical evidence is from Drs. Schilperoort and Williams, who examined claimant on September 19, 1997 and found significant symptom magnification during her exam. (Ex. 74-7). They felt the ranges of motion in her cervical spine and shoulders were not valid. (*Id.*) They diagnosed a resolved right shoulder strain and mild AC degenerative joint disease. (Ex. 74-6, -7). They concluded that claimant was medically stationary. Because Drs. Schilperoort and Williams examined claimant on only one occasion, we are not persuaded by their opinion. Instead, we are more persuaded by the reports from Dr. Mandiberg, who had the opportunity to treat claimant's shoulder condition on several occasions.

In sum, we conclude that claimant's August 29, 1996 work injury was the major contributing cause of her disability and need for treatment for her right shoulder AC joint injury. Consequently, we set aside that portion of the insurer's denial.

Right Carpal Tunnel Syndrome

Claimant relies on the opinion of Dr. Barnhouse to establish compensability of her right carpal tunnel syndrome (CTS) condition. She relies on an injury theory and contends that her CTS was traumatically induced from the August 1996 accident.

The ALJ found that claimant's right CTS should be analyzed under ORS 656.005(7)(a). We find no medical evidence of a "combined condition" related to claimant's CTS. Therefore, claimant must establish that her work injury is a material cause of the right CTS condition.

Dr. Barnhouse's October 11, 1996 chart note referred to "neck pain to [claimant's] right shoulder, elbow and right hand." (Ex. 16). On November 7, 1996, Dr. Barnhouse reported that claimant had a weak grip in her right hand and had noticed some nocturnal numbness and tingling. (Ex. 27). A nerve conduction study showed mild bilateral CTS. (Exs. 30, 33).

In a concurrence letter from claimant's attorney, Dr. Barnhouse agreed he had first examined claimant on October 11, 1996, when she initially complained of right hand problems due to a fall. (Ex. 101-1). He also agreed that claimant's August 29, 1996 injury was the major contributing cause of her bilateral CTS, even factoring in the elements of age, weight and fibromyalgia. (*Id.*) He agreed that CTS can be traumatically induced and was consistent with the type of trauma claimant sustained in her fall. (*Id.*) Dr. Barnhouse agreed claimant had "exhibited no symptoms in her hands prior to this August 29, 1996 fall onto her hands" and it was not until after the incident that she began having hand problems. (*Id.*)

The insurer argues that Dr. Barnhouse's opinion is not persuasive because he did not have an accurate history of claimant's previous hand symptoms. The insurer relies on chart notes from May 3, 1995 and June 16, 1995. On May 3, 1995, claimant had an epidural injection because she was having muscle spasms in her upper back, shoulders, hands and jaw. (Ex. 2). As we discussed earlier, claimant had epidural injections related to two falls at work in which she injured her back. (Tr. 15, 16). Claimant was given epidurals to help with "charley horses" that started in her back and radiated to her shoulders and hands. (Tr. 16-17). We find no medical evidence to indicate that claimant's "muscle spasms" in her hands on May 3, 1995 were related to CTS.

The insurer also relies on a June 16, 1995 chart note, which indicated claimant had fallen at work and her right foot had been having some numbness and tingling for one week and it was "also moving to right arm and fingers." (Ex. 3). Three days later, Dr. Barnhouse reported that claimant had right-sided radicular pain to her right foot and toe, but he did not refer to any arm or finger symptoms. (Ex. 4). He diagnosed a herniated nucleus pulposus at L5-S1. (*Id.*) Claimant developed low back problems as a result of two falls in 1995 and ultimately had low back surgery. (Tr. 16). We find no medical evidence that the "numbness and tingling" in claimant's hands on June 16, 1995 was related to CTS.

Based on our review of the record, we are not persuaded that Dr. Barnhouse lacked material information about claimant's hand symptoms or her history generally. Dr. Mandiberg deferred to other physicians in determining causation of claimant's CTS. (Ex. 102). Based on Dr. Barnhouse's opinion, we conclude that claimant's August 26, 1996 work injury was a material cause of her disability and need for treatment for her right CTS condition. Consequently, we set aside that portion of the insurer's denial.

Penalties

At hearing, claimant sought penalties for the insurer's allegedly unreasonable denials of her AC joint injury and right carpal tunnel condition. The ALJ did not address the penalty issue. Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

At the time of the April 30, 1998 and September 1, 1998 denials, the insurer had a report from Drs. Schilperoort and Williams, which indicated that claimant's shoulder strain had resolved and there was "significant and substantial symptom magnification and interference" during the exam. (Ex. 74-7). They also found that claimant had AC degenerative joint disease and noted that the range of motion in the shoulder was not valid. (*Id.*) Based on evidence that claimant had a preexisting shoulder condition and Drs. Schilperoort and Williams felt there was significant symptom magnification, we conclude that the insurer had legitimate doubt as to its liability when it issued the denial of the AC joint injury. Therefore, claimant is not entitled to a penalty for the insurer's denial of that condition.

Claimant also sought a penalty for the insurer's allegedly unreasonable denial of her right carpal tunnel condition. Although claimant relies on Dr. Barnhouse's June 1998 concurrence letter to establish compensability, that letter did not exist at the time the insurer issued its denials. Moreover, as we discussed earlier, in light of a previous medical report referring to numbness and tingling of claimant's hand, we find that the insurer had a legitimate doubt as to its liability for the CTS condition. Claimant is not entitled to penalty for the insurer's denial of the CTS condition.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding compensability of the right AC joint injury and CTS. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding compensability of the right AC joint injury and CTS is $4,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record and claimant's appellate briefs), the complexity of the issues, the values of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 30, 1999 is reversed in part and affirmed in part. The portions of the ALJ's order that upheld the insurer's denial of claimant's right AC joint injury and CTS are reversed. The denial of those conditions is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant is awarded a $4,500 attorney fee, payable by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GLORIA J. BRYANT, Claimant
WCB Case No. 98-09131
ORDER OF DISMISSAL
Cathcart & Borden, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer requested review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome and right ring trigger finger conditions. Claimant then moved to dismiss the employer's request for review and asked for the imposition of sanctions. We grant the motion to dismiss and deny the motion for sanctions.

FINDINGS OF FACT

On November 10, 1998, the employer denied compensability of claimant's occupational disease claim for bilateral carpal tunnel syndrome and right ring trigger finger conditions. The ALJ set aside the denial in her July 28, 1999 order. The order included a statement explaining that a request for review of the order had to be mailed to the Board within 30 days of the order.

On August 26, 1999, the Board received the employer's request for review of the ALJ's order. Claimant then moved to dismiss the request for review. Accompanying the motion was a Notice of Acceptance dated August 17, 1999 stating: "Per Opinion and Order of 7-28-99 we are, at this time, accepting your claim as a disabling **bilateral carpal tunnel syndrome**." (Emphasis in original.) Claimant also provided a "Form 1502" dated August 16, 1999 stating: "STATUS OF CLAIM CHANGED TO ACCEPTED (THROUGH LITIGATION)."

CONCLUSIONS OF LAW AND OPINION

Claimant argues that we should dismiss the request for review because, prior to filing the request for review, the employer accepted the claim. Claimant also asserts that, based on the acceptance, the request for review is "frivolous" and we should impose sanctions.

In *SAIF v. Mize*, 129 Or App 636 (1994), the court dismissed the carrier's petition for review after it had accepted the claim that was the basis for its appeal. In rejecting the carrier's argument that its acceptance had been contingent on its right to seek judicial appeal, the court found that, as a factual matter, the carrier's acceptance was "clear and unqualified." 129 Or App at 639.

The court also decided that the acceptance foreclosed the carrier from seeking judicial review because, by accepting the claim, it had obligated itself to provide benefits and, consequently, any opinion would be advisory. *Id.* at 640. Thus, the court dismissed the petition for review.

Following *Mize*, we have found in other cases that, when directed by litigation order to accept a claim, a carrier may issue a "qualified" acceptance of the claim and continue to appeal the litigation order. *E.g., Donna J. Calhoun*, 47 Van Natta 454 (1996). Conversely, consistent with *Mize*, when a carrier unequivocally accepts a claim without making it contingent on the result of an appeal, we find that the controversy sought to be appealed is rendered moot and we dismiss the request for review. *E.g., Sharon L. Erickson*, 51 Van Natta 761 (1999).

Thus, we first address whether, as a factual matter, the employer unequivocally accepted the claim that was the subject of the ALJ's order. In responding to claimant's motion for dismissal, the employer does not challenge claimant's submissions of the Notice of Acceptance and Form 1502. The employer contends, however, that because the Notice of Acceptance stated that it was accepting the claim "at this time" and the Form 1502 indicated that the status of the claim was changed through litigation, its acceptance was qualified and contingent on its appeal.

We disagree with the employer's interpretation of the documents. The reference in the Notice of Acceptance to "at this time" does not indicate that the employer is reserving its right to appeal and is better understood as simply referring to the timing of the acceptance. The information on the Form 1502 also lacks clear language showing that the employer intends to qualify its acceptance; rather, by saying that claim status is changed "through litigation," the form is only explaining why the claim is now accepted. *Compare Valerie Barbeau*, 49 Van Natta 1189 (1997) (at the same time that carrier issued

acceptance it issued a "1502" form specifically explaining that the claim was accepted through a litigation order and the "pre-acceptance" Notice of Closure referenced the appeal and stated that temporary disability compensation had been stayed); *Donna J. Calhoun*, 47 Van Natta at 454 (where the carrier issued a "1502" form explaining that the claim had been ordered accepted by a litigation order that was on appeal and also indicated on the Notice of Closure that it was appealing the ALJ's order, the carrier's "acceptance" was not clear and unqualified).

Consequently, because we do not understand the Notice of Acceptance and Form 1502 as providing a qualified or contingent acceptance, we agree with claimant that the request for review should be dismissed. *SAIF v. Mize*, 129 Or App at 639-40.

We disagree with claimant, however, that this case warrants the imposition of sanctions. If a party requests Board review of an ALJ's order and the Board finds that the appeal was frivolous or filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. ORS 656.390(1). "Frivolous" means that the matter is not supported by substantial evidence or is initiated without a reasonable prospect of prevailing. ORS 656.390(2).

In *Sharon L. Erickson*, we imposed sanctions after finding that the carrier had "unequivocally and clearly accepted" the claim before requesting review. Based on this "clear and unequivocal" acceptance, we further found that the carrier "had no reasonable prospect of prevailing" thus warranting the imposition of sanctions. 51 Van Natta at 762.

We find *Erickson* distinguishable from this case. Although we have interpreted the Notice of Acceptance and Form 1502 as not providing a qualified acceptance, we do not characterize such documents as also showing that the employer "unequivocally and clearly accepted" the claim. Rather, as argued by the employer, both documents contain language that could be understood as showing that the employer intended its acceptance to be contingent on the appeal. Although we did not find that argument persuasive and came to a different conclusion, we also find that the employer's request for review was not "frivolous" because it had a reasonable prospect of prevailing.

In sum, we grant claimant's motion to dismiss and deny the request for sanctions.

IT IS SO ORDERED.

In the Matter of the Compensation of
LISA RILEY, Claimant
WCB Case No. 99-00901
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's low back aggravation claim. On review, the issue is aggravation.

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

The ALJ set aside the employer's aggravation denial, finding that claimant had proved an "actual worsening" of her compensable low back condition. *See* ORS 656.273(1). In so doing, the ALJ declined to address the employer's objection to the form of the aggravation claim pursuant to ORS 656.273(3). *See Ted B. Minton*, 50 Van Natta 2423, 2424 (1998) (aggravation claim procedurally defective when aggravation claim form was not accompanied by an attending physician's report documenting a worsened condition). The ALJ reasoned that neither the employer's denial, nor its response to issues, nor its counsel's opening comments at hearing raised an issue regarding the aggravation claim's compliance with ORS 656.273(1).

On review, the employer asserts that the issue was raised in its denial and during opening statements. We disagree. Based on our review of the language of the denial, as well as employer's counsel's opening statements, we agree with the ALJ that the issue was not raised prior to closing argument.[1] Thus, we find that the ALJ properly declined to address the issue. See *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995).

The employer also contends that claimant failed to prove that she suffered diminished earning capacity as a result of the alleged aggravation. *See Intel Corp. v. Renfro*, 155 Or App 447, 452-53(1998) (to prove a compensable aggravation of an unscheduled condition, a claimant must establish an actual worsening of that condition that results in diminished earning capacity). We disagree.

We find that the record sufficiently establishes that claimant sustained diminished earning capacity. At the time of the March 1998 claim closure, claimant had returned to full-time light duty, albeit with some chronic back pain. (Exs. 39, 40). After her compensable worsening, however, claimant was removed from work. (Ex. 51). Dr. Hill, a consulting neurosurgeon, opined that claimant had enough back pain that she could not do her job and that her restrictions on bending and changing positions would make it very difficult for her to do her usual occupation. (Ex. 58). Dr. Blome, claimant's attending physician, opined that claimant was in need of fusion surgery and that, without it, she would have difficulty returning to work after the worsening of her condition. (Ex. 60). On this record, we find that claimant has satisfied the diminished earning capacity requirement of *Renfro*.

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

ORDER

The ALJ's order dated April 22, 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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[1] The denial merely stated that "The medical information we have received indicates your condition has not worsened since your claim was closed." (Ex. 57). The employer's counsel stated: "the question is, has there been an actual worsening of that [low back] condition?" (Tr. 3).

In the Matter of the Compensation of
GLORIA L. ROSS, Claimant
WCB Case No. 99-00725
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Adminstrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's occupational disease claim for a neck condition (herniated discs at C5-6 and C6-7). On review, the issue is compensability.

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

Relying on the opinion of Dr. Hill, claimant's treating neurosurgeon, the ALJ concluded that claimant had established the compensability of her neck condition. On review, the employer argues that the ALJ erred in relying on Dr. Hill's opinion for two reasons: first, because Hill relied on incorrect information regarding the ergonomic improvements to claimant's workstation during the period that her condition worsened; and second, because Hill agreed that the "precipitation" of claimant's herniated discs was claimant's work activity. We address these arguments in the order presented.

Claimant has the burden to prove that her work activity for the employer was the major contributing cause of the onset or worsening of her neck condition. ORS 656.266 and 656.802. Given the presence of claimant's preexisting degenerative disc disease and the contrary causation opinions of the medical experts, 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). In evaluating expert medical opinion, we rely on those that are both well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we generally 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).

Dr. Hill evaluated the causes of claimant's neck condition, relying on claimant's unrebutted history that she began experiencing neck symptoms after she began working as a secretary at a high school in the 1996-1997 school year. Claimant worked at a computer work station that required her to crane her neck back in order to see the monitor. Dr. Hill was aware that these neck symptoms significantly worsened in October 1998, after a long typing assignment accomplished while claimant sat at a low, student chair with the monitor on a counter, not a desk.[1]

As noted by the ALJ, the primary problem claimant had with her workstation was the placement of the monitor, which was never at eye level, thus requiring her to crane her head back to work at her computer. Although claimant found a more adequate chair and the keyboard and mouse were repositioned, the monitor remained on a counter above eye level until claimant's work station was completely and ergonomically redesigned after her neck surgery. (Exs. 17, 21; Tr. 14, 16, 18, 19). In formulating his causation opinion, Dr. Hill relied on this work history and the fact that claimant's symptom history correlated with her work at the computer, including the absence of symptoms when claimant was off on weekends and during the summers.

Dr. Hill agreed that claimant had naturally occurring degenerative changes in her neck. But, as discussed above, Hill relied on claimant's uncontradicted history of her symptoms, her work station ergonomics, and the correlation between the two in his analysis of the development of claimant's neck condition. In contrast to Dr. Williams and Dr. White, who opined on the basis of the medical records only that claimant's neck condition and need for surgery was due to the natural aging changes in her neck, Hill explained that it took something more than the natural progression of claimant's degenerative condition to result in her herniated discs and need for surgery. Thus, Hill reasoned that, given claimant's history, the major contributing cause of her neck condition was her work activities.

Like the ALJ, we find Dr. Hill's well-reasoned opinion that the major contributing cause of claimant's neck condition was her work to be more persuasive than the opinions of Dr. Williams and Dr. White. Their opinions are conclusory, do not demonstrate an understanding of the ergonomic or symptom history in this case, and do not offer any explanations for their conclusions that work had no part in claimant's neck condition. We find no persuasive reasons, therefore, to disregard Dr. Hill's opinion. *Weiland*, 64 Or App at 814.

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[1] The record shows that, while working at the high school, claimant worked at a computer work station on a daily basis. Her chair was a low, wooden student chair and the keyboard and monitor that claimant used were set up on a counter so that she had to raise her hands to type and had to crane her neck back to see the monitor. When claimant got a secretarial chair in November 1996, her neck pain improved, but she still had to look upward to see the monitor.

When claimant was off work during the 1997 summer break, her symptoms disappeared. But within three weeks of her return to work at the same computer setup, her neck pain returned and spread to her left shoulder and down her left arm into her thumb, and she eventually did not obtain any relief from her symptoms while off work on weekends.

Although changes in the location of the keyboard and mouse placement were implemented, the monitor remained on the counter, requiring claimant to look up. Claimant's symptoms again improved during the 1998 summer break, but significantly worsened after she returned to work. In October 1998, after typing a 28-page report while sitting on a low, student chair with a computer on the counter (not her usual workstation), claimant experienced a marked increase in her pain and sought medical treatment from Dr. Carulli.

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 May 27, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

October 12, 1999 Cite as 51 Van Natta 1706 (1999)

In the Matter of the Compensation of
CAROLYN S. ASTI, Claimant
Own Motion No. 99-0053M
OWN MOTION ORDER
Pozzi, Wilson & Atchison, Claimant Attorneys

The self-insured employer submitted a request for temporary disability compensation for claimant's compensable cervical and shoulder conditions. Claimant's aggravation rights expired on September 16, 1997. The employer 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. 99-01859). We postponed action on the own motion matter until pending litigation before the Hearings Division was resolved.

On September 10, 1999, Administrative Law Judge (ALJ) Herman approved a "Disputed Claim Settlement Stipulation and Order of Approval" which resolved the parties' dispute pending before the Hearings Division.[1] The employer agreed to withdraw its compensability denial and its recommendation against reopening. In addition, the employer agreed to "voluntarily reopen the 1992 claim and will pay all medical bills incurred by claimant related to the left shoulder condition and provide time loss benefits to claimant under and as a part of that reopened claim." In addition, claimant's hearing request was dismissed with prejudice.

Based on the employer's rescission of its denial of claimant's current condition, claimant's current shoulder condition has been determined to be compensable under her 1992 injury claim. Consequently, we address claimant's request for temporary disability compensation under ORS 656.278(1)(a).

On December 17, 1998, claimant underwent left shoulder arthroscopic acromioplasty and debridement. Thus, we conclude that claimant's compensable injury worsened requiring surgery.[2]

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning December 17, 1998, the date she was hospitalized for surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] The employer had also disputed claimant's claim for an occupational disease. The settlement agreement resolved that dispute with the parties' agreeing that the employer's denial of her occupational disease claim would be affirmed and remain in full force and effect. As a result, all disputes concerning claimant's current shoulder condition have been resolved.

[2] 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 shoulder back condition. We interpret the employer's statement "will pay all medical bills incurred by claimant relative to the left shoulder," to mean that it is no longer contesting the appropriateness of claimant's surgery.

In the Matter of the Compensation of
ROBERT W. BANKS, Claimant
WCB Case Nos. 99-00317, 98-06991 & 98-06485
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's "new injury"/occupational disease claim for his current left elbow condition; and (2) upheld Liberty Northwest Insurance Company's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility.

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

SAIF asserts that the ALJ's finding that "[c]laimant's work activities, including his 1996 compensable injury, were the major contributing cause of his current left elbow condition" is inconsistent with his finding that "[c]laimant's current condition ... does not involve the 'same condition' that [Liberty] accepted in 1996." SAIF argues that the current condition is either a "new condition" or a condition to which the 1996 compensable injury contributed and, therefore, must be considered to determine the major contributing cause. SAIF argues that this matter should be determined pursuant to ORS 656.308(1), rather than the last injurious exposure rule (LIER).

ORS 656.308(1)[1] applies if a worker sustains a "new compensable injury" involving the "same condition" as that previously processed as part of an accepted claim. *See SAIF v. Yokum*, 132 Or App 18 (1994). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or treatment involves a condition different that than which has already been processed as part of a compensable claim. *See Armand J. DeRosset*, 45 Van Natta 1058, 1059 (1993).

As the basis of its argument, SAIF contends that the ALJ erroneously gave greater weight to the medical opinion of Dr. Coe. The medical evidence must be weighed in accordance with the physician with the most-well reasoned, complete opinion. *Somers v. SAIF*, 77 Or App 259 (1986). SAIF argues that Dr. Coe is unpersuasive and that we should rely on Dr. Smith's medical opinion.

We generally give the greatest weight to those opinions that are most well-reasoned and that are based on the most accurate information. *See Somers*, 77 Or App at 263. Based on that standard, Dr. Coe's opinion is premised on the greatest access to information and history. In addition, he had more contact with claimant over a longer period of time. Finally, not only was his medical opinion well-reasoned and complete, but he was the only physician who examined claimant in relation to the 1996 injury and the current injury.

Relying on *Moe v. Ceiling Systems*, 44 Or App 429 (1980), SAIF argues that Dr. Coe failed to give a physiological explanation that establishes how his current condition was medically different from the 1996 condition accepted by Liberty. To the contrary, Dr. Coe provided complete medical evidence that claimant suffered a new medical condition that was separate and distinct from the 1996 accepted condition. Finding no persuasive reason to disregard Dr. Coe's opinion, we rely on his conclusions.

Dr. Coe determined that the two conditions were not the same. In 1996, Liberty accepted a lateral epicondylitis; and Dr. Coe diagnosed claimant's current condition as medial epicondylitis and tricep tendonitis. Therefore, this claim does not present the "same" condition. ORS 656.308(1) does not apply when a claimant's further disability or treatment involves a condition different that than which has already been processed as part of a compensable claim. *See Armand J. DeRosset*, 45 Van Natta at 1059. Therefore, LIER is the appropriate analysis.

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[1] ORS 656.308(1) states, in pertinent part:

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

Under LIER, where a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984). The onset of disability is the triggering date for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). If claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to cause or worsen the condition. *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994).

Here, claimant first sought treatment in relation to his current condition in April 1998, while SAIF was "on the risk." In order for responsibility to shift to Liberty, SAIF must establish that it was impossible for claimant's work under its term of coverage to contribute to the current need for treatment or that claimant's work during Liberty's term of coverage was the sole cause of the current condition. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997); *Reynolds Metals v. Rogers*, 157 Or App 147 (1998).

We are not persuaded that it was impossible for claimant's employment conditions during SAIF's term of coverage to cause or contribute to the current new condition. Furthermore, the record does not establish that the working conditions under Liberty's term of coverage were the sole cause of the current new condition. In reaching these conclusions, we are persuaded by Dr. Coe's opinion that the major contributing cause of claimant's current elbow condition are his current repetitive work activities with SAIF's insured.

SAIF argues that claimant is not entitled to attorney fees because it did not raise the issue of compensability on review. However, both compensability and responsibility were decided by the ALJ's. Therefore, by virtue of the Board's *de novo* review authority, compensability remained at risk on review as well. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 248, 252- 53 (1992), *mod on recon*, 119 Or App 447 (1993); *Dilworth v. Weyerhaeuser Co.*, 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by SAIF. *See International Paper Co. v. Riggs*, 114 Or App 203 (1992); *Cigna Insurance Companies v. Crawford & Company*, 104 Or App 329 (1990); *Burton I. Thompson*, 48 Van Natta 866 (1996).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $750. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 7, 1999 is affirmed. For services on review, claimant's attorney is awarded $750, payable by SAIF.

In the Matter of the Compensation of
ELAMUEL C. BARKER, Claimant
WCB Case No. 99-0292M
AMENDED OWN MOTION ORDER
Kryger, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

It has come to our attention that our prior Own Motion Order for the above claimant, which was mailed out on September 29, 1999, awarded an incorrect approved attorney fee. The correct approved attorney fee awarded under the order is "25 percent of the increased temporary disability compensation awarded under this order, not to exceed *$1,500.00*, payable by the insurer directly to claimant's attorney." In order to correct this oversight, we withdraw our prior order. In its place, as

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

IT IS SO ORDERED.

October 12, 1999 Cite as 51 Van Natta 1709 (1999)

In the Matter of the Compensation of
DAVID W. BEENE, Claimant
Own Motion No. 98-0437M
OWN MOTION ORDER
Bischoff, Strooband & Ousey, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's compensable left shoulder condition. Claimant's aggravation rights expired on October 10, 1990. SAIF agreed that claimant's current left shoulder condition was compensably related to his 1982 injury. However, SAIF opposed reopening on the grounds that claimant was not in the work force at the time of his disability.

Taking administrative notice of claimant's pending hearing requests regarding the compensability of and responsibility for his current shoulder condition, we consolidated this own motion matter with the pending litigation. (WCB Case Nos. 98-01909 and 98-08683). If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the 1982 injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time his condition worsened.

On July 28, 1999, Administrative Law Judge (ALJ) Myzak approved a "Stipulation and Order for Disputed Claim Settlement," which resolved the parties' dispute concerning the compensability of claimant's current bilateral shoulder condition. Pursuant to that settlement, claimant agreed that the insurer's (Crawford & Company) occupational disease denial of his current bilateral shoulder condition would remain in full force and effect.

Thereafter, ALJ Myzak issued a "written Recommendation," finding that claimant was in the work force at the time of his disability. ALJ Myzak found that, although claimant was a "retired mill worker," he was engaged in regular gainful employment with a different employer.

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

On November 16, 1998, claimant underwent arthroscopic decompression of the shoulder, rotator cuff tear repair and resection of the distal clavicle. Thus, we conclude that claimant's compensable injury has worsened requiring surgery.[1] 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 his disability.[2]

Accordingly, we authorize the reopening of claimant's 1982 injury claim to provide temporary disability compensation beginning November 16, 1998, the date claimant was hospitalized. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] In light of the settlement between claimant and Crawford, SAIF has not altered its prior position that claimant's current condition is causally related to his compensable injury.

[2] SAIF expressly states that it "will not dispute" the ALJ's findings that claimant "was still in the work force."

In the Matter of the Compensation of
OLIVE M. BONHAM, Claimant
WCB Case No. 97-10265
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by the Board *en banc.*

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denials of her aggravation claim for a low back condition and her "new medical condition" claim for an L4-5 disc protrusion/herniation. On review, the issues are claim preclusion, aggravation and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issue in this case is whether claimant's current low back claim is barred by an October 10, 1997 Opinion and Order from ALJ Hazelett that was not appealed. The ALJ in the present case rejected claimant's argument that the 1997 litigation involved only spinal stenosis and not an L4-5 herniated disc. The ALJ found that ALJ Hazelett had determined that the issues included compensability of claimant's "then-current condition" and not just spinal stenosis. The ALJ concluded that the L4-5 disc herniation/protrusion was or could have been litigated as part of the 1997 proceeding and, therefore, claimant was precluded from relitigating whether the L4-5 disc herniation/protrusion was related to the May 17, 1993 injury.

On review, claimant asserts that the 1997 litigation involved a denial of an aggravation claim of a "low back strain" and a denial of a "current condition (lumbar stenosis)." According to claimant, she did not litigate, or agree to litigate beyond the scope of the denials. She argues that, to the extent the previous ALJ made findings outside the scope of the issues identified by the parties (that is, made findings on compensability of the "current condition"), those findings are "null and void" because the ALJ had no jurisdiction over that issue.

We must first determine what issues were decided as a result of the 1997 litigation. After claimant's May 17, 1993 injury, the employer accepted a low back strain. (Exs. 6, 8). An August 20, 1993 Determination Order closed the claim without an award of permanent disability. (Ex. 21). On February 6, 1997, Dr. Perry, claimant's attending physician, signed a "Notice of Claim for Aggravation of Occupational Injury or Disease." (Ex. 38).

On March 14, 1997, the employer denied claimant's aggravation claim, explaining:

> "In view of the circumstances, it is necessary to deny workers' compensation benefits to you for the following reason(s): You did not sustain a pathological worsening of your accepted condition. In addition, if you are found to have sustained a pathological worsening of your accepted condition, your claim would be denied since the major contributing cause of the pathological worsening was not work related. You have indicated the alleged aggravation occurred while you were at home, reaching for the telephone." (Ex. 40).

On June 6, 1997, the employer issued an amended denial, stating that after it had issued the March 14, 1997 denial, the employer had received additional information that claimant was also requesting benefits for her "current condition diagnosed as lumbar stenosis." (Ex. 43-1). The employer indicated that claimant's lumbar stenosis was unrelated to the May 17, 1993 injury and it amended the March 14, 1997 denial "to include the denial of your current condition (lumbar stenosis) and need for treatment." (*Id.*)

Claimant requested a hearing and ALJ Hazelett issued an Opinion and Order on October 10, 1997. (Ex. 45). ALJ Hazelett referred to the following issues:

> "In WCB Case No. 97-02334, claimant filed a request for hearing on March 18, 1997. Claimant filed a supplemental request for hearing on June 11, 1997, on the record at the hearing. Claimant seeks an award of compensation of her current low back condition as a worsening or continuation of her compensable injury since the last arrangement of compensation and reversal of the denial letters dated March 14, and June 6, 1997." (Ex. 45-1).

ALJ Hazelett listed the issues as "compensability and aggravation." (Ex. 45-2). The employer's March 14, 1997 denial was described as a denial of "compensation for worsening of the compensable back strain and compensability of the current condition." (Ex. 45-3). The employer's June 6, 1997 denial was described as a denial of "compensation for the current condition and lumbar stenosis conditions." (*Id.*) On October 10, 1997, ALJ Hazelett upheld the employer's March 14, 1997 and June 6, 1997 denials and the order was not appealed.

The ALJ in the present case found that it was apparent that ALJ Hazelett had determined that the issues included compensability of the current condition and not just spinal stenosis. The ALJ noted that it was not clear how that determination was made, *i.e.*, whether it was based on ALJ Hazelett's interpretation of the denials or whether the parties had agreed to litigate the "total" current condition. We agree that ALJ Hazelett decided compensability of claimant's entire current low back condition and not just spinal stenosis. Although claimant now argues that the previous ALJ erred by addressing compensability of her "current condition," she did not appeal the October 10, 1997 Opinion and Order.[1] The fact that claimant now asserts that the previous ALJ erroneously addressed an issue does not make that order "null and void."[2]

As a result of the 1997 litigation, ALJ Hazelett determined that claimant did not establish compensability of her "current condition." We must decide whether claimant's current low back claim is precluded by the 1997 litigation.

Res judicata or the doctrine of "preclusion by former adjudication" is a court-created doctrine that includes the doctrines of "issue preclusion" and "claim preclusion." Issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or 134, 139 (1990) (quoting *North Clackamas School Dist. v. White*, 305 Or 48, 53, *modified* 305 Or 468 (1988)).

The Supreme Court has described "claim preclusion" as follows:

> " '[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [i.e., precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.' " *Drews v. EBI Companies*, 310 Or at 140 (quoting *Rennie v. Freeway Transport*, 294 Or 319, 323 (1982)) (brackets in original).

Claim preclusion does not require actual litigation of an issue of fact or law, nor that the determination of the issue be essential to the final result. *Id.* Claim preclusion does require that the opportunity to litigate the issue be present, and claim preclusion requires finality in the former adjudication. *Id.* Thus, under the usual circumstances, the determination of whether claim preclusion applies to preclude litigation of compensability of the L4-5 condition in the present case would turn on whether claimant had an opportunity to litigate the issue of the compensability of her L4-5 disc protrusion/herniation during the 1997 litigation.

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[1] Claimant was represented by a different attorney in 1997.

[2] Furthermore, we note that parties to a workers' compensation proceeding may, by express or implicit agreement, try an issue that falls outside the express terms of a denial. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue).

Claimant, however, contends that the claim is not precluded because she has a statutory right under ORS 656.262(7)(a) to demand acceptance of additional conditions "at any time." She relies on the language in ORS 656.262(7)(a) that a worker may "initiate a new medical condition at any time."[3] We agree with claimant for the following reasons.

The legislature has the authority to create exceptions to the doctrine of claim preclusion by enacting statutory provisions that a determination will not preclude another action or proceeding on the same claim. *Drews v. EBI Companies*, 310 Or at 141-42; *Kmart Corp. v. Lloyd*, 155 Or App 270, 274 (1998) (the court held that such an exception existed for employers under the 1997 amendment to ORS 656.262(10)). For the following reasons, we find that the legislature created an exception to *claim* preclusion in ORS 656.262(7)(a).

In reaching this finding regarding *claim* preclusion, we note that the legislature did *not* create an exception to *issue* preclusion in ORS 656.262(7)(a). In this regard, ORS 656.262(7)(a) provides only for the opportunity to "*initiate* a new medical condition claim at any time." (Emphasis added). Furthermore, issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or at 139. It follows that, where the issue of compensability of a condition is "actually litigated and determined," that issue was necessarily "initiated." Thus, under such circumstances, issue preclusion would apply to preclude later litigation involving the same compensability issue under the provisions of ORS 656.262(7)(a). Here, compensability of claimant's L4-5 disc bulge/herniation and aggravation claims was not "actually litigated and determined" in the earlier proceeding before ALJ Hazelett. Therefore, issue preclusion does not preclude the current claims.

In construing ORS 656.262(7)(a), our task is to discern legislative intent. ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). Text and context includes prior judicial interpretation of the statute. *See State v. King*, 316 Or 437, 445-46 (1993) (when the Supreme Court interprets a statute, that interpretation becomes part of the statute as if written into it at the time of its enactment). The context includes other provisions of the same statute and other related statutes. *PGE* at 611. Only if those sources do not reveal legislative intent do we resort to legislative history and other extrinsic aids. *Id.* at 611-12.

ORS 656.262(7)(a) provides:

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

The last sentence of ORS 656.262(7)(a) creates an exception to the judicially created doctrine of claim preclusion. It is important to note that the last clause of this sentence states the overriding principle of the sentence and explains what the worker may do, *i.e.*, "the worker may initiate a new medical condition claim at any time." The phrase "[n]otwithstanding any other provision of this chapter" merely modifies that last clause. "[T]his chapter" in ORS 656.262(7)(a) refers to ORS chapter 656. *Johansen v. SAIF*, 158 Or App 672, 679 (1999). The function of a "notwithstanding" clause in a

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[3] Claimant also argues that ORS 656.262(6)(d) provides a basis for litigation of her L4-5 disc protrusion/herniation condition. Because we find that claimant is entitled to litigate compensability of her disc condition under ORS 656.262(7)(a), we need not address her arguments regarding ORS 656.262(6)(d).

statute is to except the remainder of the sentence containing the clause from other provisions of a law referenced in that particular "notwithstanding" clause. *O'Mara v. Douglas County*, 318 Or 72, 76 (1993). The "notwithstanding" clause in ORS 656.262(7)(a) excepts the remainder of the sentence (initiation of a new medical condition claim) from the provisions of ORS chapter 656. Thus, the "notwithstanding" clause *overrides* the other statutes and clarifies the scope of the right to initiate a new medical condition claim "at any time." Accordingly, this "notwithstanding" clause *expands* the scope of the remainder of the sentence rather than limits it.

The dissent contends that, because issue and claim preclusion rules are judicial rather than statutory doctrines, the portion of ORS 656.262(7)(a) referring to "[*n*]*otwithstanding any other provision of this chapter*" does not pertain to rules of issue or claim preclusion and, therefore, those judicial doctrines remain effective. But the two concepts are not mutually exclusive. In other words, excluding the remainder of the sentence from ORS chapter 656 does not mean that the judicial doctrine of claim preclusion is not also excluded, particularly when the term "initiate" would be rendered meaningless if the doctrine of claim preclusion were applied, as explained *infra*. Moreover, it is axiomatic that, unless unconstitutional, statutes control over court decisions and doctrines.[4] Therefore, there was no need for the legislature to include the terms "court decisions" and "court-created doctrines" in the "notwithstanding" clause.

On the other hand, we find nothing in the text or context of ORS 656.262(7)(a) that indicates the legislature intended to overrule the judicial doctrine of *issue* preclusion. As explained above, issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or at 139. The language of ORS 656.262(7)(a) provides only for the ability to "initiate" a new medical condition claim. A claim that was "actually litigated" necessarily was "initiated." Thus, the language of ORS 656.262(7)(a) does *not* overrule the doctrine of *issue* preclusion. Nonetheless, that same language *does* overrule the doctrine of *claim* preclusion.

The insurer relies on ORS 656.262(10) as an example of the legislature's knowledge of how to create an exception to the doctrine of claim preclusion by enacting statutory provisions. ORS 656.262(10) provides, in relevant part:

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

The 1997 legislature added the emphasized language to overrule *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, *rev den* 324 Or 305 (1996) (*Messmer II*). In *Messmer II*, the court had determined that the 1995 amendments to ORS 656.262(10) did not effectively overrule its prior decision in *Messmer v. Deluxe Cabinet Works*, 130 Or App 254 (1994) (*Messmer I*), that an employer's failure to challenge a permanent disability award that included an award for a noncompensable condition precluded the employer from contending that the condition was not part of the compensable claim. Thus, *amended* ORS 656.262(10) provides that failure to appeal an order awarding permanent disability benefits for an unaccepted condition does not preclude a *carrier* from later denying compensability of that condition.

By the same token, by providing that a new medical condition claim may be initiated "at any time," ORS 656.262(7)(a) provides that a worker's failure to raise a new medical condition claim in a prior litigation does not preclude the *worker* from later "initiating" that new medical condition claim.[5]

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[4] There is no contention that ORS 656.262(7)(a) is unconstitutional.

[5] Of course, if the worker chose to litigate a "new medical condition" in a prior litigation without formally filing a claim for that condition under ORS 656.262(7)(a) (and the carrier did not contend that compensability of that condition could not be litigated at that time due to the procedural defect regarding claim filing), the doctrine of *issue* preclusion would preclude the worker from later filing a claim for that same condition. *See Thomas v. SAIF*, 64 Or App 194 (1983) (parties may waive procedural defects). In other words, ORS 656.262(7)(a) does not permit a second chance to litigate compensability of a "new medical condition" claim that was previously litigated. But, by providing that a new medical condition claim may be *initiated* "at any time," ORS 656.262(7)(a) does entitle the worker to an *initial* determination of compensability by litigation, if the carrier does not voluntarily accept the claim.

In addition, the legislature has no "standard" statutory language to create exceptions to the judicial doctrine of claim preclusion. In this regard, the legislature created an exception to claim and issue preclusion under ORS 656.268(13), which provides:

> "Any determination or notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid."

In *Cravens v. SAIF*, 121 Or App 443 (1993), the court interpreted *former* ORS 656.268(10) (now at ORS 656.268(13), which contains the same relevant language). In *Cravens*, a prior ALJ's order had determined that SAIF had been paying temporary disability at the correct rate. Subsequent to that hearing, however, SAIF mistakenly began paying temporary disability at a higher rate. The claimant requested a hearing seeking penalties and attorney fees because of SAIF's late payment of the recalculated temporary disability. SAIF and the claimant agreed that SAIF would pay a penalty for its late payment. The ALJ entered a Stipulation and Order to that effect and dismissed the claimant's hearing request with prejudice. SAIF discovered its error before the claim was closed and took an offset against the permanent disability award for the overpayment when it issued its notice of claim closure. *Id.* at 445.

The claimant relied on the doctrine of *res judicata*, contending that SAIF's stipulation to a penalty for late payment of temporary disability necessarily determined that the amount of temporary disability was correct. The court disagreed. First, the court held that claim preclusion did not apply, stating that:

> "TTD [temporary total disability] is not, by itself, a 'claim' that is precluded by former adjudication purposes. *Drews v. EBI Companies, supra.* Rather, it is an issue included in the claim for compensation. Consequently, *claim* preclusion analysis of the *res judicata* doctrine does not apply in these circumstances." *Id.* at 446. (Emphasis in the original).

Second, the court held that issue preclusion did not apply because the amount of temporary disability "was not actually litigated in relation to claimant's request for penalties for late payment. * * * The stipulated settlement of the penalty issue provided for a penalty that was related only to the timeliness of the payments and was not dependent on the amount of TTD." *Id.*

Finally, the court held that the finality required for the application of either claim or issue preclusion was not present, stating that:

> "Here, as in *Drews*, even if SAIF could and should have raised the issue of the correct TTD rate, there is not the finality of adjudication that is required for either claim or issue preclusion to apply. The amounts of compensation are, under *former* ORS 656.268(10) (renumbered ORS 656.268(13)),[6] subject to adjustment until final closure. *See Drews v. EBI Companies, supra.* It was pursuant to that statute that SAIF made the adjustment in the permanent partial disability award. *The statute would have little meaning if the adjustment could be precluded because the correct amount of compensation should have been litigated during the progression of the claim to final closure."* *Id.* at 447 (emphasis added; footnote added).

Thus, the court recognized that, given the language of *former* ORS 656.268(10), which explicitly permitted adjustments at claim closure for compensation paid or payable before claim closure, the statute would be rendered meaningless if the judicial doctrine of claim preclusion could bar such an adjustment at claim closure. The same reasoning applies here.

ORS 656.262(7)(a) explicitly permits a worker to "*initiate* a new medical condition *at any time.*" (Emphasis added). This language would be rendered meaningless if the judicial doctrine of claim preclusion could deny a claimant from initiating a new medical condition claim because it potentially

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[6] The legislature subsequently amended ORS 656.268(13). Or Laws 1995, ch 332, Sec. 30(13) (SB 369, Sec. 30(13)). The relevant language remains the same, however.

could have been brought earlier. In this regard, the rule that "words of common usage typically should be given their plain, natural, and ordinary meaning" is to be weighed in considering the text and context of statutory language. *PGE v. Bureau of Labor and Industries*, 317 Or 611 (citations omitted). The plain and ordinary meaning of the term "initiate" is "to cause to begin." *The New Lexicon Webster's Encyclopedic Dictionary of the English Language* 498 (Deluxe ed. 1989). The plain and ordinary meaning of the term "preclude" is "to prevent * * * to make practically impossible, esp. by anticipatory action." *Id.* at 789. Thus, "preclusion" would render meaningless the clear language of ORS 656.262(7)(a), which mandates that a worker may "initiate" a new medical condition claim at any time.

In addition, ORS 656.262(7)(a) affirmatively allows a worker to "*initiate* a new medical condition *at any time;*" it does not merely allow a worker the "possibility" of initiating such a claim. On the other hand, claim preclusion applies to preclude a party from raising an issue in a subsequent proceeding when that party merely had the *possibility* of raising the issue in an earlier proceeding and did not do so. There is a great difference between being entitled to raise a new medical condition claim at any time as a matter of law and having the "possibility" to raise such a claim at a certain point in time. Thus, if claim preclusion is held to apply to new medical condition claims, a court-created doctrine would overrule the clear language of the statute.

Moreover, in interpreting a statute, we are to "simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted." ORS 174.010. The legislature is certainly aware of the doctrine of claim preclusion. If it had not intended that a worker be permitted to *initiate* a new medical condition *at any time,* it would not have used that explicit language.

The dissent contends that, by finding that ORS 656.262(7)(a) creates an exception to claim preclusion, we are adding language to the statute. We disagree. To the contrary, by finding that ORS 656.262(7)(a) means what it says, *i.e.*, that a new medical condition claim may be initiated "at any time," we are simply declaring what is contained in the statute, without inserting what has been omitted, or omitting what has been inserted. ORS 656.174.010. In other words, we are simply applying the express language of the statute. On the other hand, to find, as the dissent does, that the doctrine of claim preclusion applies to preclude litigation of a new medical condition despite the clear language in ORS 656.262(7)(a) permitting initiation of a new medical condition "at any time" fails to simply declare what is contained in the statute, as mandated by ORS 174.010.

In addition, we disagree with the dissent's contentions that our interpretation of ORS 656.262(7)(a) is contrary to the policies upon which claim preclusion is based, *i.e.*, achieving finality and preventing splitting of disputes into separate controversies, and is inconsistent with ORS 656.012(2)(b), which provides that an objective of the Workers' Compensation Law is "[t]o 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." As explained above, the legislature has the authority to create exceptions to the judicial doctrine of claim preclusion by enacting statutory provisions that a determination will not preclude another action or proceeding on the same claim. *Drews*, 310 Or at 141-42. That is the case here. Although administrative economy is a valid goal, by enacting ORS 656.262(7)(a), which explicitly provides that a "worker may initiate a new medical condition claim at any time," the legislature has determined that other goals, *e.g.*, the opportunity to initiate a new medical condition claim, override the goal of administrative economy in regard to initiating new medical condition claims.

In addition, in examining the context of a statute, we consider relevant rules of statutory construction, such as the statutory mandate that, "where there are several provisions or particulars, such construction is, if possible, to be adopted as will give effect to all." ORS 174.010. The objective stated in ORS 656.012(2)(b) is to provide a fair and just administrative system to deliver benefits to injured workers that "reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable." Thus, by its terms, ORS 656.012(2)(b) does not create an absolute objective of reducing litigation under any circumstances; instead, it provides a qualified objective of reducing litigation "to the greatest extent practicable." Accordingly, our construction of ORS 656.262(7)(a) is consistent with the explicit language of that statute and also gives effect to the objectives stated in ORS 656.012(2)(b).

Furthermore, ORS 656.012(2)(e) provides that "[i]n recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balance manner." Our interpretation of ORS 656.262(7)(a) not only applies the explicit language of the statute, it interprets the statute in an impartial and balanced manner. In this regard, it is important to note that ORS 656.262(7)(a) only gives a worker the right to *initiate* a new medical condition claim at any time. It does *not* determine the compensability of that claim. Claimant must still meet the burden of proving that the new medical condition claim is compensable. ORS 656.266. Moreover, as explained above, *issue* preclusion would continue to apply under the language of ORS 656.262(7)(a). Thus, where the condition has actually been litigated, any claim for that same condition would be barred under issue preclusion. Therefore, the carrier would not be disadvantaged by repeated litigation regarding the same condition. By the same token, a worker would not be disadvantaged by being denied the opportunity to *initiate* a new medical condition claim. Thus, the objectives of ORS 656.012(2)(b) to provide a fair and just administrative system to deliver benefits to injured workers would be met under our construction of ORS 656.262(7)(a).

For all of the above reasons, we find that the text and context of ORS 656.262(7)(a) clearly shows that legislature intended to allow a worker to initiate a new medical condition at any time, without consideration of the doctrine of claim preclusion. Therefore, we need not resort to legislative history and other extrinsic aids to determine legislative intent.

Nevertheless, we find that the legislative history demonstrates the legislature's intent to create an exception to *claim* preclusion in ORS 656.262(7)(a), while retaining application of *issue* preclusion under that statute. In this regard, Senate Bill 369 did not initially include the language that allows a worker to initiate an objection to the notice of acceptance or initiate a new medical condition claim "at any time." This language was added by a later amendment. Representative Mannix, a sponsor of Senate Bill 369, testified in support of this added language, stating:

> "On page 32, at the top of the page, line three, we have change 'L'. After the word "employer" at the end of that sentence, we have a new sentence [in ORS 656.262(6)(d)]. 'Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time.' This is out of concern that somewhere along the pike the worker did not object to the notice of acceptance. *There was a concern that maybe he's going to be precluded later from raising that issue. This makes it clear that the worker can raise that issue at any time, and of course, once it gets litigated, that's another story.* But this made -- makes it clear that the worker is not boxed out by not having objected within a particular time frame.
>
> "Change 'M' is at line 14, and it's also clarification language to show that if the worker -- the worker may initiate a new medical condition claim at any time. *There's no time limitation. You can present this claim saying, 'I have a new condition,' and it can be considered at any time.*" Tape recording, House Committee on Labor, SB 369, March 22, 1995, Tape 63, Side A (emphasis supplied).

Representative Mannix' testimony shows that the legislature intended to make it clear that a worker was *not* to be precluded from presenting an objection to a notice of acceptance or a new medical condition claim, *unless* those issues had already been litigated. In this regard, Representative Mannix stated: *"There was a concern that maybe he's going to be precluded later from raising that issue. This makes it clear that the worker can raise that issue at any time, and of course, once it gets litigated, that's another story."* (*Id.*, emphasis added). Although that comment was made with respect to ORS 656.262(6)(d), there is no indication that the amendment to ORS 656.262(7)(a) was any different. After all, the same relevant language is present in both statutes. In addition, with regard to ORS 656.262(7)(a), Representative Mannix stressed that *"[t]here's no time limitation. You can present this claim saying 'I have a new condition,' and it can be considered at any time."* (*Id.*, emphasis added).

The dissent contends that our reliance on Representative Mannix' testimony is not persuasive because it consists of testimony of one legislator during one committee meeting. But Representative Mannix was a sponsor of Senate Bill 369, which included ORS 656.262(7)(a) as an entirely new provision. In addition, the quoted language represents Representative Mannix' explanation of the meaning of ORS 656.262(7)(a) to the legislative committee. In addition, there is no indication in the legislative history that Representative Mannix' explanation of ORS 656.262(7)(a) was disputed or questioned. Under these circumstances, we find that Representative Mannix' testimony constitutes persuasive evidence of legislative intent in enacting ORS 656.262(7)(a).

Thus, the legislature clearly intended that *issue* preclusion remain viable; in other words, prior litigation of compensability of a condition would preclude the worker from raising that issue again under ORS 656.262(7)(a). On the other hand, the legislature also clearly intended that *claim* preclusion would *not* remain viable under ORS 656.262(7)(a) because the legislature intended that a worker be permitted to initiate a new medical condition claim or an objection to a notice of acceptance "*at any time.*" Thus, legislative history supports our conclusion that ORS 656.262(7)(a) provides an exception to claim preclusion.

Accordingly, for all of the above reasons, we find that ORS 656.262(7)(a) provides a statutory exception to the judicial doctrine of claim preclusion. Therefore, claimant may bring her herniated disc claim without considering the doctrine of claim preclusion. Moreover, having resolved the "claim preclusion" issue in claimant's favor, we find that, on the merits, the record establishes compensability of claimant's L4-5 disc condition and aggravation claim.

Claimant was diagnosed with an L4-5 disc herniation by Dr. Camp within a month after her May 1993 injury. (Ex. 11). Dr. Camp examined claimant again in December 1996. (Ex. 34). At that time, he diagnosed lumbar stenosis at L4-5 and he noted that the "primary abnormality is at L-4, 5 though where there is hypertrophic dorsal element change, short pedicle configuration and a midline disc, resulting in high grade stenotic change." (Ex. 34-5). Dr. Camp recommended conservative treatment, "with the understanding that if she develops spinal claudication or radicular deficits, that consideration of decompression of the canal at L-4, 5 where it is very tight would be likely necessary." (*Id.*)

Dr. Perry began treating claimant on January 8, 1997. (Ex. 35). On February 5, 1997, Dr. Perry reported that claimant had chronic low back pain "with the possibility this is exacerbated by lumbar spinal stenosis[.]" (Ex. 36). He noted that claimant also had evidence of a para-central disc herniation at L4-5. (*Id.*) Although Dr. Perry did not believe claimant's stenosis was related to the May 17, 1993 injury, he felt that the L4-5 disc protrusion "may be related to her injury at that time." (*Id.*) On the same date, Dr. Perry reviewed the November 14, 1996 MRI and noted that she had a central and right para-central disc herniation at L4-5 with some impingement. (Ex. 37-1).

In a concurrence letter from the employer's attorney, Dr. Perry agreed that claimant's present condition was due to lumbar stenosis and he did not believe her present condition had a causal relationship with the May 17, 1993 injury. (Ex. 42). Dr. Perry was deposed on August 20, 1997. (Ex. 44). At that time, he diagnosed a chronic low back strain and spinal stenosis. (Ex. 44-7). He did not agree with the diagnosis of a herniated disc because claimant did not have a lot of neurologic findings. (Ex. 44-7, -8). He felt that claimant had degenerative disc disease. (Ex. 44-8). Dr. Perry explained that at the L4-5 level, claimant had bilateral facet hypertrophy and ligamentum and flavin hypertrophy, which can create a narrow spinal canal. (Ex. 44-10). He felt that the most likely explanation for claimant's chronic back pain was spinal stenosis and the next most likely explanation was facet degeneration or degenerative disc disease. (Ex. 44-14). Dr. Perry did not believe that claimant's work injury caused the spinal stenosis. (Ex. 44-23).

Although Dr. Perry did not believe claimant's lumbar stenosis was related to her work injury, his opinion supports compensability of the L4-5 disc condition. Dr. Perry felt that the L4-5 disc protrusion "may be related" to the May 17, 1993 injury. (Ex. 36). Dr. Camp did not provide an opinion on causation.

On November 12, 1997, claimant was examined by Dr. Misko, who diagnosed a large disc protrusion at L4-5. (Ex. 46). He recommended surgery. He signed a "Notice of Claim for Aggravation of Occupational Injury or Disease" on November 17, 1997. (Ex. 48). On January 20, 1998, he performed a diskectomy at L4-5. (Exs. 53, 54). Dr. Misko reviewed claimant's medical records and explained:

> "It is obvious from the reports, particularly the early MRI done on 6/7/93, that the patient sustained an injury to the central annulus with her work injury of 5/7/93, causing a disc protrusion. This was repeatedly diagnosed and mentioned by a number of physicians who reviewed the MRIs. These reports include the radiologist's on 6/7/93 and a follow-up in 1996 and another follow up in 1997, all discussing a large disc protrusion. It is therefore my conclusion that the patient suffered an annular injury at the time of her Workman's Compensation injury on 5/7/93 followed by a central disc

protrusion that became progressively more severe and was unresponsive to physical therapy and epidural steroids. This injury on 5/7/93 was a major contributing cause to [claimant's] need for surgery on 1/20/98. It was also the cause of her disability at that time following the 5/7/93 injury up until the time of the follow-up exam on 3/4/98." (Ex. 60).

Dr. Misko's opinion is persuasive because it is well-reasoned and based on accurate and complete information. *See Somers v. SAIF*, 77 Or App 259 (1986). Furthermore, as claimant's treating surgeon, his opinion is entitled to deference. *See Argonaut Insurance Co. v. Mageske*, 93 Or App at 702; *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Based on Dr. Misko's opinion, as supported by Dr. Perry's opinion, claimant has established compensability of the L4-5 disc protrusion/herniation.

We also find that Dr. Misko's opinion establishes a compensable aggravation claim. ORS 656.273(1) entitles an injured worker to additional compensation for worsened conditions resulting from the original injury. The statute provides that a worsened condition is established by medical evidence of an "actual worsening" of the compensable condition supported by objective findings. An "actual worsening" is established by direct medical evidence that a condition has pathologically worsened. *SAIF v. Walker*, 145 Or App 294, 305 (1996).

Here, claimant sustained an annular injury at the time of her May 7, 1993 work injury, followed by a central disc protrusion that became progressively more severe, was unresponsive to conservative treatment, and ultimately worsened to the point that it required surgery. (Ex. 60). Dr. Misko's opinion and operative report establishes by objective findings direct medical evidence that claimant's annular injury/L4-5 disc protrusion/herniation pathologically worsened. (Exs. 54, 60). Therefore, we find that claimant met her burden of proving a compensable aggravation claim.

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

ORDER

The ALJ's order dated January 4, 1999 is reversed. The insurer's partial denials dated December 15, 1997 and September 22, 1998 are set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded a fee of $4,000, payable by the insurer.

Board Member Phillips Polich specially concurring.

I agree with the majority's decision that ORS 656.262(7)(a) creates a statutory exception to the court created doctrine of claim preclusion. I write separately to express my opinion that ORS 656.262(6)(d) is also applicable to claimant's L4-5 disc condition claim and also creates a statutory exception to the court created doctrine of claim preclusion.

ORS 656.262(6)(d) provides that a worker "may initiate objection to the notice of acceptance at any time." Nothing precludes claimant from perfecting the original Notice of Acceptance in this case.[1] Furthermore, the relevant language in ORS 656.262(6)(d) is the same as that in ORS 656.262(7)(a). In this regard, ORS 656.262(6)(d) provides that "the worker may initiate objection to the notice of objection at any time," and ORS 656.262(7)(a) provides that "the worker may initiate a new medical condition claim at any time." Thus, it stands to reason that the majority's reasoning that the language of ORS 656.262(7)(a) provides an exception to claim preclusion also applies to ORS 656.262(6)(d). Therefore, I would find that ORS 656.262(6)(d) provides claimant with a separate avenue for making a claim under the circumstances of this case.

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[1] The Notices of Acceptance were issued in June 1993, before the 1995 legislative changes; however, ORS 656.262(6)(d) applied retroactively. Or Laws 1995, ch 332, Sec. 66 (SB 369, Sec. 66).

In addition, even if claim preclusion remains viable in the present case, I would find that it does not apply here. In this regard, the October 10, 1997 Opinion and Order does not precisely describe the medical conditions that were litigated. Although the employer's June 6, 1997 amended denial referred to claimant's "current condition diagnosed as lumbar stenosis" (Ex. 43-1), the ALJ described it as a denial of "compensation for the current condition *and* lumbar stenosis conditions." (Ex. 45-3; emphasis supplied). It is unclear from the current record whether the parties amended the denial at hearing to include claimant's overall "current condition," in addition to lumbar stenosis. The ALJ's order makes no reference to claimant's L4-5 condition. Thus, even if claim preclusion remains viable, and I find it does not, the record is inadequate to find that claimant had the opportunity to litigate compensability of the L4-5 condition in 1997.

Board Member Haynes dissenting.

I agree with part of the majority opinion. I agree that, in the previous litigation, ALJ Hazelett decided compensability of claimant's entire current low back condition and not just spinal stenosis. I also agree with the majority's conclusion that the legislature did not create an exception to issue preclusion in ORS 656.262(7)(a). Nevertheless, I believe the majority has erroneously interpreted ORS 656.262(7)(a) to find an exception to claim preclusion and I respectfully dissent.

Contrary to the majority's holding, neither the text nor context of ORS 656.262(7)(a) indicates that the legislature intended to create an exception to the judicial doctrine of claim preclusion. The focus in this case is on the last sentence of ORS 656.262(7)(a), which provides: "*Notwithstanding any other provision of this chapter,* the worker may initiate a new medical condition claim at any time." (Emphasis supplied). A notwithstanding clause, by its nature, acts as an exception to the other laws to which it refers. *Severy v. Board of Parole*, 318 Or 172, 178 (1993) ("[t]he function of the 'notwithstanding' clause * * * was to make the statute an exception to the provisions of law referenced in that clause"); *O'Mara v. Douglas County*, 318 Or 72, 76 (1993) ("[t]he function of a 'notwithstanding' clause in [a] statute is to except the remainder of the sentence containing the clause from other provisions of a law that is referenced in that particular notwithstanding clause").

Here, ORS 656.262(7)(a) provides that a worker may initiate a new medical condition claim, "[n]otwithstanding any other provision of this chapter[.]" Thus, by its terms, ORS 656.262(7)(a) allows a worker to initiate a new medical condition claim, regardless of what any other provision of "this chapter" may say to the contrary. "[T]his chapter" in ORS 656.262(7)(a) refers to ORS chapter 656. *Johansen v. SAIF*, 158 Or App 672, 679 (1999). Thus, the "notwithstanding" clause in ORS 656.262(7)(a) excepts the remainder of the sentence (initiation of a new medical condition claim) *only* from other provisions of ORS chapter 656.

Claim preclusion rules, however, are not statutory. Rather, they are judicial doctrines. *Kmart Corp. v. Lloyd*, 155 Or App 270, 274 (1998). The portion of ORS 656.262(7)(a) referring to "[*n*]*otwithstanding any other provision of this chapter*" does not pertain to rules of claim preclusion. The majority has essentially rewritten that portion of ORS 656.262(7)(a) to read:

> "Notwithstanding any other provision of this chapter *or the judicial doctrine of claim preclusion,* the worker may initiate a new medical condition claim at any time."

In construing a statute, the legislature has mandated that we are "not to insert what has been omitted, or to omit what has been inserted." ORS 174.010. The majority's interpretation of ORS 656.262(7)(a) is contrary to that mandate.

The legislature may create exceptions to the doctrine of claim preclusion by enacting statutory provisions. One such example is ORS 656.262(10), which creates an exception to claim preclusion for employers. *See Kmart Corp. v. Lloyd*, 155 Or App at 274. That statute provides that "the failure to appeal or seek review of such an order or notice of closure, shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein." ORS 656.262(7)(a) does not contain similar language that creates an exception to the doctrine of issue or claim preclusion.

Furthermore, I disagree with the majority's conclusion that the legislative history demonstrates the legislature's intent to create an exception to claim preclusion in ORS 656.262(7)(a). Even if I assume that the statute is ambiguous and that an inquiry into legislative history is appropriate, the material on which the majority relies does not support its far-reaching result. The majority errs by relying on testimony from Representative Mannix during one committee meeting. *See Errand v. Cascade Steel Rolling Mills, Inc.*, 320 Or 509, 539 n. 4 (1995) (Graber, J., dissenting) ("an examination of legislative history is most fraught with the potential for misconstruction, misattribution of the beliefs of a single legislator or witness to the body as a whole, or abuse in the form of 'padding the record' when the views of only a small number of persons on a narrow question can be found"). In the particular discussion quoted by the majority, Representative Mannix made no reference whatsoever to either claim or issue preclusion. The majority's reliance on the legislative history is not persuasive.

In addition, the majority's interpretation of ORS 656.262(7)(a) is contrary to the policies upon which court-made claim preclusion is based, which include achieving finality to a conclusion of a dispute and preventing splitting of that dispute into separate controversies. *See Drews v. EBI Companies*, 310 Or 134, 141 (1990). Both policies protect limited dispute resolution resources from repeated expenditure upon the same overall dispute. *Id.* The majority's interpretation of the statutes will lead to piecemeal litigation. Furthermore, the majority's reasoning is inconsistent with ORS 656.012(2)(b), which indicates that a legislative objective is to provide an administrative system that "reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable[.]"

Finally, I do not agree with the majority that Dr. Misko's opinion establishes that claimant's L4-5 disc condition is compensable and she has established a compensable aggravation claim. Dr. Misko's opinion is not persuasive because there is no evidence that he considered the medical evidence that the L4-5 disc condition was related to a new injury, rather than the May 17, 1993 work injury. On December 5, 1996, Dr. Camp reported that claimant's symptoms had cleared after the 1993 injury and she had "done pretty well until maybe five or six weeks ago, when she reached over a couch to get a phone and her back popped." (Ex. 34-1).

I am not persuaded that Dr. Misko had an accurate understanding of the onset of claimant's current low back condition. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions based on an inaccurate history entitled to little or no weight). Moreover, in light of claimant's apparent "new injury," Dr. Misko's opinion is not persuasive because it does not address why the work injury was the major contributing cause of her L4-5 disc condition. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (medical opinion must evaluate the relative contribution of different causes and explain why the work exposure or injury contributes more to the claimed condition than all other causes or exposures combined). In sum, even if it is necessary to address the merits in this case, claimant has not established compensability of the L4-5 disc condition or a compensable aggravation claim.

In the Matter of the Compensation of
EUGENIO T. CORONA, Claimant
Own Motion No. 99-0275M
OWN MOTION ORDER
Travelers Ins. Co., 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 November 16, 1988. The insurer opposes authorization of temporary disability compensation, contending that: (1) surgery or hospitalization is not reasonable and necessary for the compensable injury; (2) the current condition is not causally related to the accepted condition; and (3) it is not responsible for claimant's current condition.

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

The insurer contends that it has, on previous occasions, denied compensability and responsibility for claimant's current low back condition and that those denials have become final by operation of law. In addition, the insurer relies on an insurer-arranged medical examination (IME) that concluded that claimant's current low back condition is "unrelated to [claimant's] injury of 1983." Accordingly, the insurer contends that it is "stand[ing] by [its] previous denials of responsibility and compensability of [claimant's] back and complaints." Claimant has not responded to the insurer's contentions.

Thus, the issue of whether claimant's current back condition is related to his compensable left knee condition remains a question which is unresolved at this time. Under such circumstances, we are not authorized to reopen claimant's 1983 injury claim for the payment of temporary disability benefits.[1] *See* ORS 656.278(1)(a). Should claimant's circumstances change, and the insurer accepts responsibility for claimant's current back condition, claimant may again seek own motion relief.[2]

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

IT IS SO ORDERED.

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[1] Our jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. We do not, in our Own Motion authority, have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries excepted). Rather, jurisdiction over these disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 or with the Director under ORS 656.245, 656.260 or 656.327. *See Gary L. Martin*, 48 Van Natta 1802 (1996).

[2] The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial body. The Board cannot extend any advice or relief to claimant. However, because claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. Claimant may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97310

October 12, 1999 Cite as 51 Van Natta 1721 (1999)

In the Matter of the Compensation of
JOYCE M. HALL, Claimant
WCB Case No. 98-06765
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Bock, Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of her claim for her right carpal tunnel syndrome condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

To establish compensability of her occupational disease claim for her right carpal tunnel syndrome (CTS), claimant must prove that employment conditions were the major contributing cause of the right CTS. ORS 656.802(2)(a). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of the disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). When the medical evidence is divided, we give more weight to those opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Here, there are four expert opinions that discuss causation of claimant's right CTS condition. Dr. Rabie treated claimant at an occupational health clinic on referral from her doctors. Dr. Rabie noted that claimant had first been diagnosed with mild bilateral carpal tunnel syndrome by Dr. Nathan in 1979. Dr. Rabie took a history of claimant's work for the employer which began in 1994 and noted that claimant had a past history of hypothyroidism and water retention which were both risk factors associated with CTS.

Dr. Rabie concluded that neither claimant's hand-intensive off work activities nor a change of work activities caused a difference in her symptoms. Because Dr. Rabie found that claimant had many risk factors associated with CTS on an intrinsic basis, as opposed to a work-related basis, he was unable to conclude that work was the major cause of claimant's need for treatment. (Ex. 12-3).

Dr. Nye examined claimant on behalf of the employer and diagnosed right carpal tunnel syndrome. Dr. Nye noted that claimant had similar symptoms on the left side, but nerve conduction studies had not progressed to an abnormal level. Because he believed that claimant's repeated writing was not a cause of her right CTS, Dr. Nye concluded that work was not the major cause of her condition. (Ex. 21-3).

Dr. Norris examined claimant on behalf of the employer and agreed with Dr. Nye's diagnosis. (Ex. 22). Dr. Norris later stated that claimant had given Dr. Rabie a history of symptoms beginning in 1979 while working as a ticket agent. Dr. Norris reported that, "if claimant's (previous) symptoms were minimal and not necessarily treated surgically until her repetitive hand movements of her more recent word processing employment, then I think you probably have a reasonable case that the major contributing cause of her need for treatment was that change in her work duties." Dr. Norris added that his opinion was, however, "entirely speculation based on a completely inadequate history from my perspective." (Ex. 27).

Dr. Buehler examined claimant and reported that she had electrodiagnostic studies in 1979 which were normal on the right and slightly elevated on the left. Dr. Buehler reported that claimant's left hand CTS symptoms had resolved, but she currently had symptoms of right CTS which were exacerbated by her repetitive writing activities. Dr. Buehler opined that, "considering the unilateral nature of her positive electrodiagnostic studies, considering the nature of her right handed activities, and considering the temporal relationship and activity relationship of her symptoms to her right carpal tunnel syndrome, I believe that her work activities are the major contributing cause." (Ex. 28). When subsequently asked whether claimant's hypothyroidism would change his opinion regarding causation, Dr. Buehler reported that the hypothyroid condition was treated and was not a factor. (Ex. 29).

After considering the expert opinions in this case, we agree with the ALJ's conclusion. Only Dr. Buehler's opinion arguably supports compensability. However, for several reasons, we find that his opinion is not persuasive. First, Dr. Buehler examined claimant on only one occasion. Accordingly, we do not find that the special deference typically accorded to a treating doctor is appropriate in this case. Moreover, based on the record, including claimant's own statement, Dr. Buehler took an inaccurate history that claimant's symptoms began in 1994 when she first started working for the employer. (Exs. 19a-4, 28).

We further discount Dr. Buehler's opinion on the basis that he relied on a "temporal relationship" between claimant's symptoms and her work activities. (Ex. 28). *See Gormley v. SAIF*, 52 Or App 1055 (1981); *Beverly J. Kellow*, 49 Van Natta 741 (1997) (Doctor's opinion that the claimant's condition was related to work was not persuasive where the opinion was primarily based on a temporal relationship between the claimant's carpal tunnel symptoms and her work). Moreover, Dr. Buehler's opinion is misguided even in that regard as Dr. Rabie noted that a change in claimant's work activities did not affect her symptoms. (Ex. 12-3).

Finally, we agree with the ALJ's reasoning that Dr. Buehler's opinion does not satisfy the test set forth in the *Dietz* case. *Dietz v. Ramuda, supra.* Specifically, Dr. Buehler has not addressed or weighed the intrinsic and non-work factors identified by other physicians (such as claimant's water retention condition) as possible contributing factors to the CTS condition. Nor has Dr. Buehler discussed Dr. Nye's opinion that repetitive writing does not cause such a condition. Consequently, in light of claimant's prior history of CTS and the non-work factors raised by the experts in this case, we agree with the ALJ that Dr. Buehler's opinion is not sufficient under *Dietz.*

Therefore, because only Dr. Buehler's opinion could arguably be construed to support compensability, and because it is not persuasive for numerous reasons, we find that claimant has not met her burden of proof and we affirm the ALJ's order.[1]

ORDER

The ALJ's order dated April 19, 1999 is affirmed.

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[1] Although the dissent relies on Dr. Buehler's opinion and claimant's testimony that she had no problems with her right hand in 1979, claimant gave Dr. Rabie a history of problems with both hands which "started in the fall of 1979..". Dr. Rabie also took a history that claimant was advised at that time that she had mild "bilateral carpal tunnel syndrome." (Ex.12-1). A Kaiser chartnote dated March 26, 1998 also describes claimant as having a "longstanding problem with numbness and tingling of right hand." (Ex. 15). Claimant did not establish at hearing that Dr. Rabie made a mistake or that he took an inaccurate history. Additionally, claimant's testimony at hearing is inconsistent with her own prior statement which provides that she had previously experienced similar symptoms in her right hand and that she "first noticed problems with the fingers of her right hand back in 1979," when she treated with Dr. Nathan. (Ex. 19a-4).

Board Member Phillips Polich dissenting.

I would reverse the ALJ's order as I disagree with his conclusion that claimant has failed to meet her burden of proof. Although the majority has rejected Dr. Buehler's opinion, claimant's testimony at hearing establishes that she did not previously experience right hand symptoms in 1979. Claimant's testimony is consistent with Dr. Buehler's history and with other exhibits in the record. For example, in 1979 Dr. Long reported that claimant's right median sensory function at the wrist might have been slightly slow but was "probably normal." (Ex. 1). Additionally, in a 1979 report, Dr. Nathan stated that his examination of the "uninvolved right hand is entirely within normal limits." (Ex. 2-2) (emphasis in the original). Furthermore, although the majority contends that claimant did not explain the discrepancy between her prior statement and her testimony at hearing regarding her right hand symptoms, the employer had the opportunity to cross-examine claimant at hearing on the issue but did not choose to do so.

Accordingly, I am persuaded by claimant's testimony describing her repetitive work activity and by Dr. Buehler's opinion. Dr. Buehler considered claimant's job duties and her hypothyroid condition and concluded that claimant's work was the major cause of her condition. Under the circumstances, I do not find any persuasive reasons to discount the opinion of claimant's treating doctor. I therefore disagree with the majority's conclusion that claimant has failed to meet her burden of proof in this case.

In the Matter of the Compensation of
PATRICIA L. HARMON, Claimant
WCB Case No. 98-05687
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the self-insured employer's partial denial of her claim for a C5-6 disc herniation; and (2) upheld the self-insured employer's partial denial to the extent it denied a cervical condition other than the C5-6 disc herniation. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant did not establish that she sustained a C5-6 disc herniation as a result of the January 27, 1997 work injury. We agree with and adopt the ALJ's reasoning with regard to the C5-6 disc herniation. However, the ALJ also concluded that claimant did not sustain any injury to her C5-6 disc. We disagree.

The medical evidence is in disagreement with regard to whether claimant has a preexisting cervical condition. If claimant does not have a preexisting cervical condition, she need only show that the January 27, 1997 work injury was a material contributing cause of her C5-6 disc condition. ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). However, if claimant has a preexisting cervical injury which combined with the January 27, 1997 work incident, it is her burden to prove that the January 27, 1997 work injury was the major contributing cause of her disability or need for treatment for the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997).

Drs. Williams and Fuller, who examined claimant at the request of the insurer, reported that claimant had degenerative changes at C5-6 that were compatible with the aging process. (Ex. 42). The physicians opined that the degenerative changes were not related to the January 27, 1997 injury. (*Id.*)

Dr. Kennen, who performed claimant's cervical surgery, indicated that the surgery was to repair a degenerated disc at C5-6. (Ex. 50-13). Dr. Kennen further indicated that he was unable to determine whether the C5-6 degeneration preexisted the work incident as claimant had not had any prior cervical imaging studies to compare to the surgical findings. (Ex. 50-10). However, because claimant was asymptomatic prior to the work injury and her history of symptoms were consistent with the imaging studies, Dr. Kennen opined that the work injury was the major cause of claimant's need for treatment. (Ex. 50-21).

Similarly, Dr. Long, who treated claimant, indicated that there was no evidence that claimant had a preexisting condition. (Ex. 38). Dr. Long opined that the work injury was the major cause of claimant's cervical condition and need for treatment. (*Id.*). Dr. Hill, who also treated claimant, agreed with Dr. Long's opinion. (Ex. 44).

When medical opinion is divided, greater weight is given to the opinion of the treating physician, absent persuasive reasons not to do so. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to the opinions of Drs. Kennen, Long, and Hill. Moreover, although he did not provide long-term treatment for claimant, Dr. Kennen performed the cervical surgery. Thus, he is in a better position that Drs. Williams and Fuller to provide an opinion on the causal relationship between the January 27, 1997 work incident and claimant's need for medical treatment. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988). Moreover, Dr. Kennen's opinion is well-explained and based on an accurate understanding of claimant's symptoms.

Based on the opinion of Dr. Kennen, as supported by the opinions of Dr. Long and Dr. Hill, claimant established the requisite causal relationship between the January 27, 1997 work injury and her C5-6 disc condition.[1] Accordingly, the insurer's denial must be set aside to the extent it denies a C5-6 disc injury.

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, concerning the C5-6 disc injury is $3,500, payable by the insurer . In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. In addition, we have also considered the fact that claimant did not prevail with regard to the C5-6 disc herniation.

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[1] We need not decide whether claimant had a preexisting cervical condition as the result would be the same under either the "material" or "major" cause standards.

ORDER

The ALJ's order dated April 22, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the insurer's denial to the extent it denied a C5-6 disc injury is reversed. The insurer's denial is set aside to the extent it denies a C5-6 disc injury and the claim is remanded to the insurer for processing according to law. Claimant's counsel is awarded $3,500 as a reasonable assessed attorney fee, payable by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
ROBERT K. LARSON, Claimant
Own Motion No. 99-0342M
OWN MOTION ORDER
Schneider, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on February 14, 1999. The insurer agrees that claimant's current right knee condition is causally related to his accepted condition for which it is responsible. However, the insurer opposes reopening of claimant's claim for the payment of temporary disability compensation, contending that claimant was not in the work force at the time of the current worsening.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *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).

Here, claimant must prove that he was in the work force on September 23, 1999, the date he was hospitalized for surgery. The insurer contends that claimant was not in the force at the time of his current disability because he was enrolled in college and he failed to provide proof that he remained in the work force. In response, claimant reports that he received unemployment benefits until a few days prior to his surgery. In support of his representations, claimant submitted copies of unemployment checkstubs for the period between May 1999 and September 1999.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to September 23, 1999, when he was hospitalized for the proposed 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).

Here, claimant attested that he received unemployment benefits from May 15, 1999 until September 18, 1999, a few days prior to his September 23, 1999 surgery. The receipt of unemployment benefits is *prima facie* evidence that claimant is willing to work and is making reasonable efforts to obtain

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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).

employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991). Therefore, we find that claimant was in the work force at the time of his current worsening which required surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning September 23, 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
MYRNA F. LONG, Claimant
WCB Case No. 98-04546
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's occupational disease claim for her low back and right leg conditions. With her respondent's brief, claimant has attached a medical record not admitted at hearing. We treat such submissions as a motion for remand. On review, the issues are remand and compensability. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

With her respondent's brief, claimant has submitted a "post-hearing" medical report from Dr. Ordonez. The employer moves to strike the report on the ground that the evidence is cumulative and claimant has not shown that the report was not obtainable at the time of hearing.

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

Here, we agree that the proposed evidence is cumulative inasmuch as Dr. Ordonez' report is a reiteration of his prior opinion. Moreover, claimant has not established that the proposed evidence was unobtainable at the time of hearing. Finally, because the evidence is cumulative, we do not find that it would likely affect the outcome of this case. Therefore, remand is inappropriate and we have not considered the report in our review of this matter.

Compensability

The employer contends that the ALJ erred in deferring to Dr. Ordonez. The employer first argues that Dr. Ordonez is not claimant's treating doctor and there has been no Change of Attending Physician form completed as required by OAR 436-010-0220(1). Rather, the employer argues that Dr. Maness is claimant's treating doctor.

We have previously held that whether a physician qualifies as an "attending physician" is a question of fact. *See, e.g., Debbie I. Jensen*, 48 Van Natta 1235, 1236 (1996). Here, the record establishes that claimant saw Dr. Maness in January 1998 when her family physician was not available. (Tr. 23). Dr. Maness referred claimant to Dr. Ordonez in February 1998. (Ex. 7A). Dr. Ordonez subsequently took claimant off work and advised the employer that claimant was under his care. (Ex. 7). Claimant continued to treat with Dr. Ordonez who prescribed physical therapy and antiinflammatories. (Ex. 17). There is no indication that claimant returned to treat with Dr. Maness. Under the circumstances, we conclude that Dr. Ordonez was the physician primarily responsible for claimant's care and we agree with the ALJ that Dr. Ordonez was claimant's treating doctor.

The employer next argues that the ALJ erred in deferring to claimant's treating doctor based on the doctor's status. The employer contends that this case should be analyzed by comparing the expert medical opinions rather than deferring to the treating doctor because of his ability to observe claimant's condition over a period of time. *See, e.g., Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979). However, we find that the ALJ did not defer to claimant's treating doctor solely on the basis of his ability to observe claimant. The ALJ also found that Dr. Ordonez provided the most persuasive medical opinion in light of the fact that Dr. Farris failed to explain her opinion or discuss the L5-S1 disc herniation and Dr. Maness had provided opinions that were inconsistent and unexplained.

Finally, the employer argues that claimant has not established a pathological worsening of her preexisting condition as required by ORS 656.802(2)(d). However, the record does not establish that claimant proceeded on a theory of a worsening of a preexisting condition. (Tr. 3). Furthermore, Dr. Ordonez explained that claimant's prior injury did not play any "part whatsoever in her current condition and need for treatment." (Ex. 27A). Accordingly, we conclude that claimant met her burden of proof by establishing that work activities are the major contributing cause of her low back condition. ORS 656.802(2)(a); *Lisa E. Gilbert*, 50 Van Natta 171 (1998) (The claimant was not required to show a worsening of a preexisting condition where the record showed that she had been asymptomatic prior to working for the employer and there was no prior diagnosis of the condition).

Accordingly, we agree with the ALJ that claimant has met her burden of proof and has established a compensable occupational disease claim. We therefore affirm the ALJ's order.

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

ORDER

The ALJ's order dated March 17, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $400, to be paid by the self-insured employer.

October 12, 1999 Cite as 51 Van Natta 1727 (1999)

In the Matter of the Compensation of
ROGER A. VORPAHL, Claimant
WCB Case No. 98-04713
SECOND ORDER ON REMAND
Max Rae, Claimant Attorney
Snarskis, Yager, et al, Defense Attorneys

Pursuant to our October 7, 1999 order, this matter was dismissed. It has subsequently come to our attention that the parties wish to settle their dispute in accordance with a proposed "Stipulated Order of Settlement." Because we retain authority to reconsider our prior order, we withdraw the order and replace it with the following order.

The parties' stipulation provides that claimant's unscheduled permanent disability "shall be increased by an additional 45% unscheduled permanent partial disability." The parties further agree that

claimant's counsel shall receive an attorney fee in a specific amount that does not exceed the Board's "out-of-compensation" attorney fee rules. Finally, the agreement states that "this matter is hereby dismissed with prejudice."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DORY K. NAUMES, Claimant
WCB Case No. 98-02680
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) admitted Exhibit 19; and (2) upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first full paragraph on page 2, we replace the first sentence with the following:

> "Claimant consulted Dr. Jones on September 12, 1997 with complaints that she was awakening at night with numbness in her hand. (Ex. 4). Dr. Jones referred her to Dr. Young for evaluation. (*Id.*)"

In the third paragraph on page 3, we change the citation after the second sentence to read: "(Ex. 19-7, -8)." In the fifth paragraph on page 3, we change the citation after the second sentence to read: "(Ex. 20-6)." We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant argues that the ALJ abused his discretion by allowing Exhibit 19 in evidence. She contends Exhibit 19 was based on "discoverable" documents in SAIF's possession that were not discovered.

The ALJ admitted Exhibit 19, Dr. Ellison's report, in evidence, but found it was entitled to significantly reduced weight because Dr. Ellison had relied on information in Exhibits 15A and 18A that was not admissible as substantive evidence.

We need not address claimant's evidentiary argument because, even if we disregard Exhibit 19, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused his discretion by admitting Exhibit 19. *See Mario F. Torres*, 49 Van Natta 2074 (1997); *Larry D. Poor*, 46 Van Natta 2451 (1994).

Compensability

Claimant began working for the employer in September 1996. (Ex. 12). She was a counselor assigned to one of the local schools. (Tr. 21, 22). She testified that she began to experience numbness in her hands in spring 1997. (Tr. 20, 60). She was diagnosed with bilateral CTS on October 3, 1997. (Ex. 5). Claimant contends that her work activities, including repetitive keyboarding and repetitive writing, were the major contributing cause of her bilateral CTS condition. She relies on the opinion of her treating physician, Dr. Young, to establish compensability.

The ALJ found that claimant had CTS before she worked for the employer. Because the ALJ found no evidence that Dr. Young had considered the evidence of claimant's pre-employment CTS in reaching his opinion on causation, he concluded that Dr. Young's opinion was not persuasive. Citing ORS 656.802(2)(b), the ALJ was not persuaded that claimant's work activities were the major contributing cause of a pathological worsening of her disease.

On review, claimant argues that the ALJ erred by finding that she had CTS before she began working for the employer. For the following reasons, we need not decide whether ORS 656.802(2)(b) applies. Even if we assume that ORS 656.802(2)(a) applies to this case and if we assume claimant is correct that she did not have CTS symptoms until after she began working for the employer, we conclude that Dr. Young's opinion is not sufficient to establish compensability.

In light of the multiple possible causes of claimant's CTS, 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 279 (1993). In evaluating expert medical opinion, we rely on those that are both well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we generally 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, we find persuasive reasons not to defer to Dr. Young's opinion.

When Dr. Young first examined claimant on October 3, 1997, he reported that she was not clear if her hands went more numb if she had a hard day and he said "[s]he hasn't really noticed any association and is not clear as to what brings it on." (Ex. 5-1). In a letter from claimant's attorney, Dr. Young agreed that claimant's work for the employer was the major cause of her bilateral CTS. (Ex. 18B-1). He believed that the activities causing her CTS were repetitive keyboarding, repetitive writing, a high stress job with increased pressure on her nerves, likely poor ergonomics at her work station and a high stress job with abnormal posture and position that caused increased pressure on her nerves. (*Id.*)

In a deposition, Dr. Young said he did not know how long claimant had been spending two hours a day keyboarding. (Ex. 20-6). He understood claimant had been "working at the same job for quite a while," but he could not say how long. (*Id.*) He agreed that when he first saw claimant, she had been repetitively keyboarding two hours per day for at least several months. (*Id.*) He did not know whether the two hours per day was periodic or occurred mainly at one time. (Ex. 20-7). Dr. Young agreed that the onset of claimant's symptoms was approximately 1992, over a five year period. (Ex. 20-8). During the five year period, he said claimant worked as psychotherapist and went to school from 1991 through 1995, during which time she wrote a lot and did a lot of computer work. (Ex. 20-8, -9). Later in the deposition, Dr. Young was asked by SAIF's attorney about the major cause of the onset of claimant's symptoms:

> "Q. And would you tend to say that her years of going to school part-time and working full time is probably the major cause of her onset of symptoms back in '92?
>
> "A. No, I wouldn't want to be able to answer that without further information.
>
> "Q. What further information would you need?
>
> "A. I don't know, my notes aren't specific enough to when she was working, how much she was working, how much she was at school, so a study of that information would be needed.
>
> "Q. Assuming a full-time job or as full-time as the employment with our employer and a load sufficient at school to get her through in three to four years?
>
> "A. We have been talking and going and you've been asking questions about, you know, how much typing and how much stress, how much writing. It would be good to know that more specifically before beginning to answer." (Ex. 20-21, -22).

We are not persuaded that Dr. Young had an accurate understanding of claimant's work activities. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions based on an inaccurate history entitled to little or no weight). He was not sure how long claimant had been performing her job for employer or how long she had been keyboarding two hours a day. He was apparently under the impression that the onset of claimant's symptoms had been in 1992, although claimant testified that her symptoms began in spring 1997. When asked about the major cause of

claimant's symptoms, Dr. Young said he could not answer that question without more information. Among other things, he did not know when or how much she was working. We conclude that Dr. Young's opinion is insufficient to establish that claimant's work activities were the major contributing cause of her bilateral CTS.

The remaining medical opinions are not sufficient to establish compensability of claimant's CTS. Dr. Ellison believed that claimant's CTS preexisted her employment with the employer. (Ex. 19-7). He did not believe her work for the employer had contributed independently to a pathological progression of CTS, although he said it was "possible" that her work activities contributed to her symptom complex. (Ex. 19-8). Drs. William and Woodward said that claimant "may have had a spontaneous carpal tunnel syndrome or her work related activities may have caused her carpal tunnel syndrome[,]" but it was "impossible" for them to be certain. (Ex. 16-7). In a later report, Dr. Woodward agreed that they were unable to determine that claimant's work exposure with the employer was the major contributing cause of her right CTS. (Ex. 17). The remaining medical opinions are not sufficient to establish compensability of claimant's bilateral CTS.

ORDER

The ALJ's order dated April 16, 1999 is affirmed.

October 12, 1999 Cite as 51 Van Natta 1730 (1999)

In the Matter of the Compensation of
DAVID A. RENNO, Claimant
WCB Case No. 98-09714
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's denial of his head, right arm, back and neck injury claim; and (2) declined to assess penalties for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

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

Claimant worked for the employer as a salesperson of heating and cooling systems. On Thursday, September 17, 1998, claimant met with a potential customer and was driving back to the office to complete the bid for that customer when he was involved in a motor vehicle accident. Claimant, while using his shoulder harness and seat belt, was traveling 35 to 40 miles per hour when his car was struck by a one and a half ton van driven by Mr. Taghon, who was backing out of a diagonal parking space onto the street. Claimant swerved into the oncoming lane of traffic to avoid the van, struck the curb, then swerved back into his own lane of traffic to avoid an oncoming truck. During this process, claimant struck his head against the roof of his car, his right arm slipped through the steering wheel and was twisted by the continuing motion of the steering wheel, causing pain and a "pop" in his right shoulder. After exchanging information with Mr. Taghon, claimant returned to the office and completed the bid.

Mr. Taghon was 19 years old at the time of the accident. The record contains no evidence that Mr. Taghon has any medical expertise upon which to base his opinion that the motor vehicle accident was too minor to cause any injury. Due to the position of his van, Mr. Taghon's vision was limited to that provided by his driver's side mirror both as he backed out of the parking space and at the time of the accident. (Tr. 62-63; 69-71).

As a result of this accident, the full length of the passenger side of claimant's car was damaged. In addition, following the accident, claimant's car pulled severely to the left. Claimant was advised by the estimator for the auto body shop that the motor vehicle accident caused the need for a front end

alignment. Auto body repairs totaled over $2,000, including a front end alignment. The insurer of the van was billed for and paid the auto body work and the front end alignment.

The day after the accident, claimant was unable to raise his right arm and had right neck pain. (Ex. 16-3). Over the next few days, claimant experienced pain in his neck, back, and right arm. On Monday, September 21, 1998, claimant sought treatment from his chiropractor, Dr. Finch. Claimant complained of right neck pain and difficulty raising his right arm. (Exs. 16-3, 17-1). Dr. Finch treated him for acute thoracic and cervical strains and a right rotator cuff strain. (Ex. 17-1). Claimant had objective findings including: loss of range of motion in the cervical and thoracic spine; palpable muscle spasms throughout the cervical and thoracic spine; and loss of range of motion in the rotator cuff. (Ex. 49-2). A November 6, 1998 MRI showed findings compatible with strain and inflammation of the supraspinatus tendon. (Exs. 36).

During his examination on September 21, 1998, Dr. Finch noted that claimant reported he was "some[what] disoriented" after the accident and the following day. (Ex. 16-3). During his examinations on September 24, 25, and 28, 1998, Dr. Finch noted claimant's symptoms of concussion, vertigo, and forgetfulness. (Ex. 17-1).

On October 21, 1998, claimant's attorney submitted a workers' compensation injury claim relating to the motor vehicle accident. On December 18, 1998, SAIF denied claimant's claim on the sole basis that claimant's "injury did not arise out of or occur within the course of [his] employment." (Ex. 46).

On November 21, 1998, claimant went to Gresham Urgent Care and complained of pain in the neck, right arm, and right shoulder. He was diagnosed with cervical and right shoulder strain/sprain and loss of range of motion. Physical therapy was ordered and he was referred to Dr. Witczak, orthopedist. (Exs. 38, 39, 40).

On November 25, 1998, Dr. Witczak examined claimant and diagnosed probable rotator cuff tear, degenerative joint disease at the acromioclavicular joint and cervical spine, and peripheral neuropathy of the right hand median nerve. (Ex. 41). A December 1, 1998 arthogram showed no evidence of a torn rotator cuff or any level of adhesive capsulitis. (Exs. 41, 42). On December 7, 1998, Dr. Witczak found that claimant had clinical evidence of an impingement syndrome and possibly a partial tear of the rotator cuff. Thereafter, claimant stopped treating with Dr. Witczak because he moved his practice out of Oregon.

On February 15, 1999, Dr. Jones, orthopedist, examined claimant on behalf of the insurer of the van. (Ex. 48A). By the time he was examined by Dr. Jones, claimant's complaints were limited to his right shoulder. (Ex. 48A-2-3). Dr. Jones diagnosed a probable motor vehicle accident related subacromial impingement syndrome, without evidence of a rotator cuff tear. (Ex. 48A-4). Dr. Jones noted that claimant did not report swerving over railroad tracks; instead, claimant simply said he was struck. (Ex. 48A-5).

On February 24, 1998, Dr. Gripekoven, orthopedist, examined claimant on behalf of SAIF. (Ex. 50). At the time of Dr. Gripekoven's exam, claimant's complaints were limited to his right shoulder. (Ex. 50-2).

CONCLUSIONS OF LAW AND OPINION

Compensability

At hearing, SAIF conceded that claimant was involved in a motor vehicle accident while in the course and scope of his employment. (Tr. 5, 10, 60). Thus, the sole compensability issue at hearing and on review is whether claimant sustained a compensable injury as a result of the motor vehicle accident. The ALJ did not accept claimant's description of the accident and, consequently, rejected the medical opinions that were based on claimant's description. On review, SAIF relies on the ALJ's reasoning, *i.e.*, the motor vehicle accident was minor and did not result in a compensable injury. We disagree.

A "compensable injury" is defined as "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" ORS 656.005(7)(a). In addition, a "compensable injury" must be "established by medical evidence supported by objective findings[.]" *Id.*

We normally defer to an ALJ's demeanor-based credibility findings. *See Bush v. SAIF*, 68 Or App 230 (1984). But, where, as here, the ALJ's findings are based on an objective evaluation of the substance of a witness's testimony rather than demeanor, the ALJ has no greater advantage in determining credibility than does the Board. *Coastal Farm Supply v. Hultberg*, 84 Or App 282, 285 (1987).

Claimant describes the accident as causing him to swerve into the opposite lane of traffic in an unsuccessful attempt to avoid the van, striking the van along the full length of the passenger side of his car, bumping into a curb or a grate, and swerving back into his lane of traffic to avoid an oncoming truck. During this process, claimant reported that he struck his head against the roof of his car, his right arm slipped through the steering wheel and was twisted by the continuing motion of the steering wheel, causing pain and a "pop" in his right shoulder. A few days later, claimant sought medical treatment from Dr. Finch.

SAIF argues that claimant's description of the accident is inconsistent and unreliable. We disagree. Claimant provided all physicians with essentially the same history, as summarized above. (Exs. 16-3, 41-1, 48A-2, 48A-5, 49-1, 50-2, 50-6). After our review of the record, we do not find sufficient inconsistencies from which to conclude that claimant did not sustain the injuries he claimed as a result of the accident, especially since the record provides independent support for claimant's history.

For example, SAIF notes that claimant reported at one point that the object he bumped into was railroad tracks rather than a curb. Claimant testified that the events happened quickly, he was confused and thought the object he bumped into was railroad tracks because the area of the accident has many railroad tracks. Claimant had also reported the object as a curb. When shown a photograph of the site of the accident, he realized that the object he struck was a curb. We find this explanation for the discrepancy in claimant's description of the accident reasonable. The point is not that claimant was able to identify the specific object he struck, but that he struck an object during the motor vehicle accident, which supports his description of being jostled around inside the car as he attempted to avoid the van.

Furthermore, claimant testified that the estimator at the auto body shop that repaired his car stated that his car needed a front end alignment due to the motor vehicle accident. (Tr. 81). In addition, claimant testified that, after the accident, his car pulled to the left "pretty drastically." (Tr. 23). The front end alignment was performed and billed to the insurer of the van. (Exs. 21, 47-4). SAIF argues that the testimony of Mr. Huddleston, the manager of the auto body shop, is more persuasive. We disagree.

Mr. Huddleston testified that the need for the front end alignment was not due to the motor vehicle accident because the car was hit up high and not in the wheel area. (Tr. 56). But Mr. Huddleston did not examine claimant's car and rendered his opinion based solely on what he assumed the area of impact was to claimant's car. (Tr. 57). When questioned as to why the insurance company would be billed for repairs that were not due to the accident at issue, Mr. Huddleston stated that such billing would occur if the insurance company specifically called and requested such a repair. (Tr. 57-58). But there was nothing in the auto body file on claimant's car indicating that the insurance company made such a request, nor was there anything in the itemized estimate indicating that the insurer requested a front end alignment in addition to any repairs due to the accident. Instead, the front end alignment repair is simply listed as part of the total estimate. (Ex. 47-4).

We find claimant's testimony more plausible. That is, after the accident, his car pulled drastically to the left and the estimator who examined claimant's car determined that it needed a front end alignment due to the motor vehicle accident. The need for this type of repair due to the accident supports claimant's description of the severity of the accident, which, in turn, supports claimant's description that he was bounced/jostled around inside his car during the accident.

SAIF also focuses on the injury to claimant's head, arguing that claimant did not report any head injury in the early medical records. SAIF is incorrect. In this regard, during the four examinations occurring between September 21 and 28, 1998, Dr. Finch discussed claimant's symptoms of concussion, vertigo, disorientation, and forgetfulness. (Exs. 16-3, 17-1). Thus, the medical record shows that claimant contemporaneously reported a head injury as the result of the accident. Therefore, a primary focus of SAIF's contention that claimant's description of the motor vehicle accident was unreliable is incorrect.

Furthermore, SAIF argues that claimant had complained about physical problems before the accident to Mr. Spezza, claimant's employer. But Mr. Spezza did not indicate what physical problems claimant allegedly complained about or even the body parts involved in these "physical problems." (Tr.

75-76). Moreover, the medical reports do not indicate any prior physical problems involving the body parts at issue, with the exception of a prior whiplash injury that had resolved. (Exs. 41, 48A, 50).

SAIF also argues that Mr. Taghon's description of the motor vehicle accident is more reliable than that of claimant. We disagree.

Mr. Taghon testified that he was parked in a diagonal parking space along a road and another van was parked beside him, so his vision was limited to that provided by his driver's side mirror both as he backed out of the space and at the time of the accident. (Tr. 62-63; 69-71). Although admitting that his vision was blocked by the position of his own and another vehicle, Mr. Taghon testified to the events that occurred during the accident. Specifically, he testified that claimant stayed on the road, went straight after the impact, and stopped in the middle of the road about 15 to 20 feet past the back of his van. (Tr. 63-64). He also testified that claimant's vehicle did not "bounce around a lot" in the course of the accident. (Ex. 67). He testified that claimant did not complain about any injuries while they were exchanging insurance information. (Tr. 66). He also stated that he did not ask if claimant was injured because he "couldn't see how someone would be hurt from that impact." (Tr. 67).

Given Mr. Taghon's admitted limited vision, we do not find persuasive his testimony regarding the course of claimant's car during the accident or the absence of any "bouncing" of claimant's car. In addition, we do not find persuasive Mr. Taghon's opinion as to the possibility of an injury being caused by the impact of the accident. In this regard, there is no evidence that Mr. Taghon has the necessary medical expertise to make such a determination.

In contrast, claimant had unimpeded visibility through his windshield at the time of the accident. In addition, Dr. Finch opined that the motor vehicle accident caused injuries that required medical treatment. (Ex. 49). We generally defer to the opinion of the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. Finch's opinion, especially since he had the advantage of examining and treating claimant within days of the accident. Moreover, the examining physicians also stated that, if claimant's history of the motor vehicle accident was correct, claimant sustained injuries caused by that accident.[1] (Exs. 48A-4-5, 50-6-7).

Finally, claimant had objective findings of injury including, in part: loss of range of motion in the cervical and thoracic spine; palpable muscle spasms throughout the cervical and thoracic spine; and loss of range of motion in the rotator cuff. ORS 656.005(19); (Ex. 49-2). Given this record, we find that the preponderance of the evidence supports the conclusion that claimant sustained compensable injuries to his head, right arm, right shoulder, thoracic spine, and cervical spine as a result of the September 17, 1998 motor vehicle accident.

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.

Penalties

The only basis for SAIF's December 18, 1998 denial was its contention that claimant's "injury did not rise out of or occur within the course of [his] employment." (Ex. 46). Claimant requests penalties, contending that SAIF's denial was unreasonable because there was no evidence contradicting the fact that a motor vehicle accident had occurred while claimant was on duty, and no evidence contradicting the fact that claimant needed medical treatment as a result of that accident at the time SAIF issued the denial. SAIF counters that its denial was not unreasonable because it "had ample reason to question whether claimant was injured in the motor vehicle accident." Respondents' Brief, page 6. SAIF does not explain its "ample reason." We agree with claimant.

A penalty for unreasonable denial may be assessed against an insurer for unreasonable delay or refusal to pay compensation. ORS 656.262(11). In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or

[1] By the time claimant was examined by Drs. Jones and Gripekoven, his complaints were limited to his right shoulder. Therefore, their opinions only addressed the right shoulder. (Exs. 48A, 50).

App 107 (1991). If the insurer had a legitimate doubt as to its liability, then denial the was not unreasonable. Unreasonableness and legitimate doubt are to be considered in light of all the evidence available to the insurer at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591-592 (1988).

Here, at the time of the denial, all evidence supported a finding that claimant was in the course and scope of his employment when the motor vehicle accident occurred. Specifically, as the employer stated on the 801 form, claimant was returning to the office after a sales call. (Ex. 27, 31). Furthermore, at the time of the denial, all evidence supported a finding that the motor vehicle accident caused injuries that required medical treatment. (Exs. 16, 17, 27, 28, 35, 36, 38, 39, 40, 41, 42, 45). Thus, this record contains no evidence to support a finding that SAIF had a legitimate doubt as to its liability at the time of the denial.

Accordingly, we find the denial unreasonable and assess a penalty of 25 percent. One half of the penalty is to be paid to claimant's attorney in lieu of an attorney fee regarding this issue. ORS 656.262(11).

ORDER

The ALJ's order is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's December 18, 1998 denial of his head, right arm, back and neck injury claim is set aside. The claim is remanded to SAIF for processing according to law. For SAIF's unreasonable denial, claimant is assessed a penalty of 25 percent of the amounts then due as of the date of hearing as a result of this order. SAIF is ordered to pay one-half of this penalty to claimant and one-half to claimant's attorney. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded a fee of $4,500, payable by SAIF directly to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
LEONARD R. TERRIBLE, Claimant
WCB Case No. 97-04381
SECOND ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

On September 30, 1999, we issued an Order on Reconsideration that republished our August 6, 1999 Order on Review that set aside the self-insured employer's denial of claimant's occupational disease claim for a stress-related mental disorder. In addition, we increased our prior employer-paid attorney fee award under ORS 656.386(1) from $6,500 to $26,250. Noting that our initial order has been appealed and that "appellate mediation" proceedings have been scheduled, the employer asserts that a "jurisdictional error has occurred." Claimant has responded and disagrees with the employer's contention. We treat the employer's submission as a motion for reconsideration of our September 30, 1999 Order on Reconsideration.

We acknowledge that the employer and claimant have filed petitions for judicial review of the Board's August 6, 1999 order. Nevertheless, because that order was abated within 30 days of its issuance, the Board retained jurisdiction under ORS 656.295(8) to issue an Order on Reconsideration further considering this case. *See Haskell Corporation v. Filippi*, 152 Or App 117 (1998); *SAIF v. Fisher*, 100 Or App 288 (1990); *Marietta Z. Smith*, 51 Van Natta 731 (1999). In addition, because our present order is being issued within 30 days of our September 30, 1999 Order on Reconsideration, we likewise retain jurisdiction to address the employer's "jurisdictional" concern.

Accordingly, we withdraw our September 30, 1999 order. On reconsideration, as supplemented herein, we republish our September 30, 1999 Order on Reconsideration in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTIAN W. ANDERSON, Claimant
WCB Case Nos. 99-00485 & 98-07585
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Steven T. Maher, Defense Attorney
Sheridan, Bronstein, et al, Defense Attorneys
Kryger, et al, Claimant Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

ESIS,[1] on behalf of Oakwood Homes, requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its compensability and responsibility denials of claimant's current right knee condition; and (2) upheld Hartford Insurance Company's (Hartford's) responsibility denial, on behalf of Discovery Plastics, for the same condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order.[2]

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

ORDER

The ALJ's order dated June 3, 1999, is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by ESIS.

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[1] As TPA for Zurich Insurance Company.

[2] In its reply brief, Hartford continues to contends that jurisdiction over this matter lies with the Director rather than the Hearings Division. Hartford reasons that, because ESIS/Oakwood had accepted claimant's bilateral knee claim subsequent to Hartford's compensable right knee claim, the issue concerning claimant's ongoing care is a medical services issue, not a compensability issue. We disagree.

Here, as noted by the ALJ (Opinion and Order at 4), the issue raised at hearing was not one for medical services based on the accepted right knee claim. Instead, the employer denied the claim on the ground that its 1998 injury "was not the major contributing cause of [claimant's] *current right knee condition* requiring medical treatment." (Emphasis added.) At hearing, claimant's counsel agreed that the issues were "*compensability* of a current right knee condition * * * ." (Tr. 2). ESIS/Oakwood's counsel stated: "We've denied *compensability* and we've also raised the responsibility issue." (Tr. 3). Based on these statements, we conclude that the compensability of an alleged new right knee condition was at issue. Therefore, compensability of the underlying claim was at issue and jurisdiction over the matter lies with the Hearings Division and the Board. *See* ORS 656.704(3); 656.245(6); *David L. Dylan*, 50 Van Natta 852 (1998); *Leslie D. Hartsough*, 51 Van Natta 1556 (1999).

In the Matter of the Compensation of
BEVERLY J. COFFMAN, Claimant
Own Motion No. 99-0290M
OWN MOTION ORDER

The insurer has submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on January 21, 1999. The insurer 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).

The insurer contends that claimant was not in the work force at the time of the current disability because it has not received "any documentation from the claimant or her representative * * * that [claimant] was in the work force at the time of the request for reopening." However, with its recommendation form, the insurer submitted chart notes from Dr. Wenner, claimant's treating physician, which not only demonstrate claimant's need for surgery, but also show that claimant was in the work force at the time of the current disability. In the May 13, 1999 chart note, Dr. Wenner noted that claimant works "in a bank as a teller where they apparently [are] very good about not requiring her to do any lifting." In a May 25, 1999 "Outpatient Progress" note, Dr. Wenner noted that claimant was concerned about her job at the bank, fearing that as a result of her worsening her job was not secure. On June 23, 1999, Dr. Wenner further noted that claimant was hoping to "put off surgery until fall - didn't want to mess up vacation schedule at bank."

Additionally, the insurer submitted a copy of an insurer-arranged medical examination (IME). Dr. Woodward, the IME physician, noted that claimant worked until July 23, 1999 and "stopped work in anticipation of low back surgery on July 29, 1999." Dr. Woodward further noted that claimant was not working at the job at injury "but has a lighter job as a teller."

Thus, we conclude that claimant was in the work force at the time of her current worsening. *See John R. Kennedy*, 50 Van Natta 837 (1998). Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning July 29, 1999, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL D. CESSNUN, Claimant
WCB Case No. 97-09918
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Cessnun*, 161 Or App 367 (1999). The court has reversed our prior order, *Michael D. Cessnun*, 50 Van Natta 1541 (1998), that affirmed an Administrative Law Judge's (ALJ's) order setting aside the SAIF Corporation's denial of claimant's occupational disease claim for a left shoulder condition. The court concluded that we erred when we determined that, in an occupational disease case, a "preexisting condition" must predate the work exposure that eventually leads to the claim. The court has remanded for reconsideration under the correct legal standard.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the ultimate findings of fact. We repeat the Court of Appeals' summary of the facts.

> "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."

CONCLUSIONS OF LAW AND OPINION

In *Cessnun*, the court agreed that this case involves an occupational disease claim. The court concluded that we erred when we determined that a "preexisting condition" in an occupational disease claim must predate the work exposure that eventually leads to the claim. The court held that, in occupational disease cases, a disease or condition is "preexisting" only if it both 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, whichever occurs first. 161 Or App at 371. Citing *Medford Corp. v. Smith*, 110 Or App 486, 488 (1992), and *Papen v. Willamina Lumber Co.*, 123 Or App 249, 254 (1993), the court noted that the "date of injury" in an occupational disease claim is either the date of disability or the date when medical treatment is first sought. *Cessnun*, 161 Or App at 374. The court has remanded for reconsideration of the case under the correct legal standard.

To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of his left shoulder condition. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

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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 Dictionery*, 19 (unabridged ed 1993).

On reconsideration, we must first determine whether claimant had a disease or condition that contributed or predisposed him to disability or a need for treatment *and* preceded either the date of disability or the date when medical treatment is first sought, whichever occurred first. *Cessnun*, 161 Or App at 371.

The record indicates that claimant's first medical treatment for a left shoulder condition was on April 7, 1997, when he sought treatment for left shoulder pain. (Ex. 1). On July 16, 1997, claimant was diagnosed with "[l]eft shoulder pain - rule-out rotator cuff tear." (Ex. 3). A subsequent arthrogram revealed a large left rotator cuff tear. (Ex. 5). Because there is no evidence that claimant was disabled from a left rotator cuff tear before April 1997, we find that the "onset" of his rotator cuff tear was on April 7, 1997, when he first sought medical treatment for a left shoulder problem. *See Medford Corp. v. Smith*, 110 Or App 486, 488 (1992) (in the absence of disability, the date of the onset of the disease is the date on which the claimant first sought medical treatment).

The next question is whether claimant had a disease or condition that contributed or predisposed him to disability or a need for treatment before April 7, 1997.

Dr. Boughal, claimant's treating physician, performed surgery on claimant's left shoulder on November 11, 1997. (Ex. 9A). He reported that claimant had a prominent anterior acromial spur at the time of surgery, which he felt was a "preexisting" condition that combined with his work exposure. (Ex. 11-1). Dr. Boughal did not explain what he meant by a "preexisting" condition. In a later report, he said that vigorous overhead work activities by an individual with an anterior acromial spur could predispose the patient to develop a degenerative rotator cuff tear or worsen a tear that was already present. (Ex. 14-1). He explained that the anterior acromial spur predisposed claimant to developing a left rotator cuff tear and he said the spur should be considered a "pre-existing" condition. (*Id.*)

Although Dr. Boughal said that claimant's anterior acromial spur was "preexisting," he did not explain what the spur "preexisted." It is unclear from Dr. Boughal's reports whether he meant that the spur preexisted claimant's first medical treatment in April 1997 or whether he meant the spur preexisted the rotator cuff tear itself, or whether the spur preexisted claimant's employment with the employer.

Based on Dr. Boughal's opinion, we find that claimant has an anterior acromial spur that predisposed him to developing a left rotator cuff tear. (Ex. 14-1). Nevertheless, the medical evidence is not sufficient to establish that claimant's acromial spur preceded the "onset" of his left rotator cuff tear on April 7, 1997, when he first sought medical treatment for a left shoulder problem. Moreover, even if we assume that claimant's anterior acromial spur was a "preexisting" condition that contributed or predisposed him to disability or a need for treatment before April 1997, we conclude that ORS 656.802(2)(b) does not apply to this case.

.ORS 656.802(2)(b) provides:

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

Here, if we assume that claimant's anterior acromial spur is a "preexisting disease or condition," his occupational disease claim is not based on the worsening of his anterior acromial spur. *See Muriel D. Nelson*, 48 Van Natta 1596 (1996) (ORS 656.802(2)(b) did not apply because the claimant's occupational disease claim for CTS was not based on a worsening of her alleged "predisposing factors" of "being female and slightly overweight"). Rather, claimant asserts that his employment conditions were the major contributing cause of his left rotator cuff tear. There is no evidence that claimant's acromial spur has worsened or pathologically worsened. Because claimant's occupational disease claim for a left rotator cuff tear is not based on the "worsening of a preexisting disease or condition pursuant to ORS 656.005(7)," ORS 656.802(2)(b) does not apply.

In our previous order, we found that claimant had established a compensable left rotator cuff tear under ORS 656.802(2)(a). We continue to adhere to that conclusion on remand.

In light of the multiple possible causes of claimant's left rotator cuff tear, the causation 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). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we are persuaded by the opinion of Dr. Boughal, claimant's treating physician.

On November 19, 1997, Dr. Boughal said that claimant's work exposure and the anterior acromial spur contributed to his need for treatment. (Ex. 11-1). At that time, he could not determine the major contributing cause of claimant's left rotator cuff tear. (*Id.*) Claimant's attorney subsequently provided Dr. Boughal with detailed information about claimant's work activities as a log truck driver. (Ex. 13). Claimant's attorney explained that the work included a good deal of overhead work related to the loading process. (Ex. 13-1). Among other things, Dr. Boughal was informed that, after the truck trailer is loaded with logs, the driver has to throw a series of chain-and-cable binders over the stacked logs. (*Id.*) The binders must be fastened down using a "swede" pry bar, which required considerable force. (*Id.*) At hearing, claimant reviewed the information about his work activities provided to Dr. Boughal and testified that it was an accurate description. (Tr. 8).

After receiving additional information about claimant's job duties, Dr. Boughal opined that vigorous overhead activities, by themselves, were unlikely to result in a rotator cuff tear. (Ex. 14-1). However, he said that those activities could predispose a patient with a shoulder injury or an anterior acromial spur to "develop a degenerative rotator cuff tear or worsen a tear which had already been present." (*Id.*) Dr. Boughal concluded that claimant's work activities resulted in a degenerative tear of the left rotator cuff. (Ex. 14-2). He noted that claimant's occasional off-work activities of golf, hunting and camping would be unlikely to result in a significant tear of the rotator cuff in the presence of a subacromial spur. (*Id.*) Dr. Boughal felt that claimant's work activities, which required repetitive throwing and overhead work, were "a major contributing cause" of his need for treatment in 1997. (*Id.*) In a later report, Dr. Boughal clarified that claimant's work activities were "the major contributing cause (at least 51%)" of his need for treatment and resulting disability in 1997. (Ex. 15-2). Thus, although Dr. Boughal was initially unsure of the major contributing cause of claimant's left rotator cuff tear, he later reviewed additional information about claimant's work activities and changed his opinion. *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987). (when there was a reasonable explanation for a change of opinion, medical opinion was persuasive).

We are persuaded by Dr. Boughal's opinion because it is well-reasoned and based on accurate and complete information. As the treating surgeon, Dr. Boughal had the opportunity to examine claimant's left shoulder pathology during surgery and, thus, had complete information upon which to base his opinion. *See Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988). Based on Dr. Boughal's opinion, we conclude that claimant's work activities were the major contributing cause of his left rotator cuff tear. There is no contrary medical evidence. We conclude that claimant has established compensability of his left rotator cuff tear under ORS 656.802(2)(a).

Alternatively, even if we assume that ORS 656.802(2)(b) applies, and we assume that claimant's left rotator cuff tear was a "preexisting disease or condition," we find that the medical evidence establishes compensability. Dr. Boughal agreed that, although claimant's anterior acromial spur was a causative factor in his left shoulder condition, his work activities in 1997 as a log truck driver were the major contributing cause of a pathologic worsening of his left rotator cuff tear in 1997. (Ex. 15-1). For the reasons discussed earlier, we are persuaded by Dr. Boughal's opinion because it is well-reasoned and based on accurate and complete information.

Claimant is entitled to an attorney fee for his counsel's services before every prior forum because he has finally prevailed before the Board after remand from the court. *See* ORS 656.388(1). At hearing, the ALJ awarded an assessed fee of $3,000 for services at hearing regarding the left shoulder condition. On review, we awarded a $1,200 assessed attorney fee for services on review. We reinstate those awards. Following SAIF's appeal and the court's remand, we have not disallowed or reduced the compensation awarded to claimant and, therefore, his counsel is also entitled to an assessed attorney fee under ORS 656.382(2) for services before the Court of Appeals. *See* ORS 656.388(1). Under such circumstances, in addition to the attorney fees previously awarded by the ALJ ($3,000) and in our prior order ($1,200), we award a reasonable attorney fee under ORS 656.382(2) for claimant's counsel's services (before the court.)

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at the court level is $3,000, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief to the court), the complexity of the issue, and the value of the interest involved. We note that claimant's attorney did not provide any additional services on remand before the Board.

Accordingly, on reconsideration, and as supplemented and modified herein, the ALJ's order dated March 31, 1998 is affirmed. For services before the court, claimant's counsel is awarded $3,000, to be paid by the SAIF Corporation. This attorney fee is in addition to the $4,200 granted by the ALJ's order and our prior order.

IT IS SO ORDERED.

October 14, 1999 Cite as 51 Van Natta 1740 (1999)

In the Matter of the Compensation of
JOHN R. GRAHAM, Claimant
WCB Case No. 98-07038
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that directed it to reopen and process claimant's "new medical condition" claims to closure, including a determination of permanent disability. On review, the issue is claims processing. We affirm.

As a preliminary matter, claimant requests permission to present oral argument. Whether or not oral argument is permitted is a decision solely within our discretion. OAR 438-011-0031(3). Inasmuch as this matter has been fully developed and briefed, we conclude that oral argument is not necessary. Consequently, claimant's request is denied.

FINDINGS OF FACT

On January 29, 1991, claimant sustained a right knee injury that was accepted by the employer as a nondisabling injury. Claimant's aggravation rights expired under the original claim on January 29, 1996, five years after the date of injury.

On August 27, 1996, claimant requested that the employer accept new medical conditions as part of his claim. On October 4, 1996, the employer expanded its Notice of Acceptance to include the additional medical conditions. Claimant requested that those new conditions be rated and closed. The employer took no action on that request.

Claimant requested a hearing. (WCB Case No. 98-02795). On April 17, 1998, ALJ Mills issued an Order and Opinion that found claimant's claim was in Own Motion status. The ALJ also found that the issue of entitlement to permanent disability was not yet ripe. The order remanded the newly accepted medical condition claims to the employer "for reopening and processing as provided for by Oregon law." That order was not appealed and became final by operation of law.

Thereafter, the employer submitted an Own Motion recommendation to the Board in which it opposed reopening the claim on the grounds that: (1) no surgery or hospitalization had been requested; and (2) surgery or hospitalization was not reasonable and necessary. The employer also requested that the Board authorize it to "reclose the claim without any additional awards of compensation."

On July 31, 1998, the Board issued an Own Motion Order in which it found that, because claimant did not require surgery or hospitalization, the claim did not qualify for reopening under ORS 656.278. *John R. Graham*, 50 Van Natta 1508 (1998). The Board also noted that it could not "authorize" the closure of a claim that had not been reopened under ORS 656.278. It also explained that, pursuant to its rules, claims reopened in own motion are closed by the carrier without the issuance of a Board order.

On September 3, 1998, claimant requested a hearing raising issues of failure to close his claim, penalties, and attorney fees. (WCB Case No. 98-07038).

On September 23, 1998, the employer issued an Own Motion Notice of Closure that stated: "The only accepted conditions which we are closing are: osteocartilaginous loose bodies right knee, degenerative changes articular cartilage medial compartments, sartorius muscle rupture right and right thigh muscle tear. The torn medial meniscus was previously closed." (Ex. 5). This closure awarded no temporary or permanent disability.

Claimant requested that the Board in its own motion authority review the September 23, 1998 Own Motion Notice of Closure.

On December 31, 1998, ALJ Mills issued an order that remanded the new medical condition claims to the employer "for reopening and processing to closure as set forth in this order, to include a determination of claimant's permanent disability with respect to the new medical condition claims." The employer requested review.

CONCLUSIONS OF LAW AND OPINION

Citing ORS 656.262(7)(c)[1] and *Daniel I. Vanwechel*, 50 Van Natta 844 (1998), the ALJ concluded that, notwithstanding the fact that claimant's initial claim was in Own Motion status, he was entitled to the determination of the extent of any permanent disability related to the new medical conditions accepted after claim closure. We agree.

The issues before us are: (1) whether claimant is entitled to have his "new medical condition" reopened under ORS 656.262(7)(c) when the "new medical condition" was accepted after the expiration of his aggravation rights[2] on the related initial claim, *i.e.*, the initial claim is in "Own Motion" status; and (2) if such a "reopening" is required, whether temporary and/or permanent disability benefits are available regarding the "new medical condition." Given the enactment of ORS 656.262(7)(c) in 1997, these are issues of first impression.

In this regard, a crucial distinction exists between the current case and the cases cited by the ALJ and claimant -- those cases all dealt with claimants whose aggravation rights had not yet expired on their initial claims. *See Douglas G. Abbott*, 50 Van Natta 1156 (1998); *Daniel I. Vanwechel*, 50 Van Natta at 844-45 (no indication the claimant's aggravation rights had expired on his initial claim); *Joe M. Mann*, 50 Van Natta 62 (1998); *see also Art L. Wetzel*, 50 Van Natta 1127 (1998); *Mario R. Castaneda*, 49 Van Natta 2135 (1997); *Ronald D. Smith, Sr.*, 49 Van Natta 1807 (1997). On the other hand, here, there is no dispute that claimant's aggravation rights have expired regarding his 1991 right knee injury claim; thus, his initial claim is in Own Motion status. In fact, claimant's initial claim was already in Own Motion status when he requested acceptance of various new medical conditions.

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[1] ORS 656.262(7)(c) was added in 1997 and provides:

"When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

[2] "Aggravation rights" are determined under ORS 656.273(4), which provides:

"(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268.

"(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

A claim made for worsened conditions which arise after the expiration of aggravation rights is solely within the Board's "own motion" jurisdiction. ORS 656.278; *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988).

In construing ORS 656.262(7)(c), our task is to discern legislative intent. ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). Text and context includes prior judicial interpretation of the statute. *See State v. King*, 316 Or 437, 445-46 (1993) (when the Supreme Court interprets a statute, that interpretation becomes part of the statute as if written into it at the time of its enactment). The context also includes other provisions of the same statute and other related statutes. *Id.* at 611. In examining context, we consider relevant rules of statutory construction, such as the statutory mandate that, "where there are several provisions or particulars, such construction is, if possible, to be adopted as will give effect to all." ORS 174.010. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. *PGE*, 317 Or at 611-12.

As for the text of ORS 656.262(7)(c), the relevant portion provides: "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." Thus, the text of ORS 656.262(7)(c) establishes that the carrier is *required* to "reopen" the claim and process a condition found compensable after claim closure. But the term "reopen" is not defined in ORS 656.262(7)(c) or elsewhere in the workers' compensation statutes, although it is used elsewhere in the statutes.[3] Thus, the text of ORS 656.262(7)(c) does not reveal the legislature's intent regarding "reopening" a new medical condition claim accepted after closure.

As for the context of ORS 656.262(7)(c), there are several related statutes. ORS 656.262(7)(a)[4] deals with the requirements of filing and processing a new medical condition claim and ends with the statement that "[n]otwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." Thus, it is clear that expiration of aggravation rights does not affect a worker's right to file a new medical condition claim. Nevertheless, ORS 656.262(7)(a) does not address the benefits that may flow from an accepted new medical condition claim, especially if aggravation rights have expired on the initial claim.

Although not dealing with an initial claim on which the aggravation rights have expired, the court has addressed the meaning of a "new medical condition" claim under ORS 656.262(7)(a). In *Johansen v. SAIF*, 158 Or App 672 (1999), the carrier argued that the claimant's written request for acceptance of a new medical condition was a claim under ORS 656.277 that the original nondisabling claim had become disabling, and that, because this request was made more than a year after the date of injury, the claim must be made as an aggravation claim under ORS 656.273. The court rejected this argument and the insurer's contention that a "new medical condition" claim has no existence independent of the original claim and does not give rise to a processing obligation independent of the original claim. *Id.* at 681; *see also Labor Ready, Inc. v. Mann*, 158 Or App 666 (1999).

The court held that a new medical condition under ORS 656.262(7)(a) "(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." 158 Or App at 679. The court also concluded that a new medical condition claim is subject to the processing requirements of ORS 656.262(4)(a) for the payment of compensation, stating:

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[3] *See* ORS 656.252(2)(c) (notice of attending physician recommendation to reopen a claim); ORS 656.262(15) (sanctions for failure to cooperate in investigation regarding aggravation claim); ORS 656.278(5) (voluntary reopening when claim is in own motion status to provide benefits or grant additional medical care); ORS 656.625 (reimbursement from Reopened Claims Program for own motion awards, including medical benefits for pre-1966 injuries).

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

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

"In the first place, a new medical condition claim, although distinct from an initial claim or an aggravation claim, is nonetheless a claim. Pursuant to ORS 656.262(4)(a), compensation for temporary disability must be paid on a claim upon medical authorization. We construe that general provision for payment of benefits to apply to all claims unless the specific provisions relating to a specific type of claim provide otherwise. Unlike the aggravation statute, ORS 656.262(7)(a), which authorizes new medical claims, does not mention what benefits flow from the claim. The statute, however, also gives no indication of an intention to exclude the new medical condition claim from the processing requirements for claims generally that are provided for in ORS 656.262 and ORS 656.268. If, as SAIF asserts, the legislature intended that there be no independent processing obligation for a new medical condition claim, it was incumbent on the legislature to so provide." 158 Or App at 680-81.

The court went on to explain that:

"Accordingly, a new medical condition claim must relate to, but need not have an impact on, an original nondisabling claim. It is entitled to its own classification as disabling or nondisabling. Thus, contrary to SAIF's contention, the limitations set forth in ORS 656.277 and ORS 656.273 for reclassification of claims and aggravation claims are not affected or negated by our conclusion that a new medical condition claim must be processed as any other claim, because they are not applicable to the new condition claim." 158 Or App at 681.

On the merits, the *Johansen* court determined that the claimant was entitled to temporary disability benefits relating to the new medical condition claim, without establishing an aggravation of the initial claim. *Id.*

Thus, the *Johansen* court interpreted ORS 656.262(7)(a) as creating an entirely new type of claim, the "new medical condition" claim, which is separate from an initial claim and an aggravation claim. *See also Mark A. Baker*, 50 Van Natta 2333, 2336 (1998) (a new medical condition under ORS 656.262(7)(a) is one that "comes into being" following issuance of the Notice of Acceptance).

In *Mann*, the court followed its reasoning in *Johansen*, noting that the duty to pay temporary disability benefits on a new medical condition, "although not expressly referred to in ORS 656.262(7), is encompassed within ORS 656.262(4)(a)." 158 Or App at 669. Applying this reasoning, the *Mann* court determined that the claimant was entitled to interim compensation on his new medical condition claim pending acceptance or denial of that claim by the carrier. 158 Or App at 670. The court noted that the statutory language in ORS 656.262(4)(a) provides no basis to exclude new medical condition claims from the requirement that interim compensation be paid pending acceptance or denial of a claim. *Id.*

In both *Johansen* and *Mann*, the claimants' initial claims were still within their aggravation rights when the new medical condition claims were made. Nevertheless, we find those cases instructive regarding the issue before us. Specifically, it is important that the court determined that a "new medical condition" claim is a *separate claim* from the related initial claim and is entitled to independent processing obligations.

Thus, the context of ORS 656.262(7)(c) does not establish the legislature's intent in ORS 656.262(7)(c) regarding the meaning of the word "reopen" or the effect of "reopening" an "new medical condition." Under such circumstances, we proceed to examine the legislative history to determine the legislature's intent regarding new medical conditions on which the aggravation rights have expired.

ORS 656.262(7)(c) was enacted in 1997. *See* HB 2971, 69th Leg., Reg. Sess., section 1 (July 25, 1997). The legislative history regarding the amendments added in ORS 656.262(7)(c) is as follows.

When asked by Representative Harper to explain the proposed addition of ORS 656.262(7)(c), Ms. Reese, a member of the Management Labor Advisory Committee (MLAC) responded:

MS. REESE: "Okay. The claim is closed for a back strain. At a later point somebody says, 'Wait a minute. I've got pain going down my leg that's a result of my back strain.' If the acceptance letter at the time of closure doesn't take into consideration the leg pain and that is later determined to be part of your back condition, we're saying that with our amendments the claim gets re-opened to address the leg pain. You don't have to go back and deal with all of the considerations given already to the back. It's just for that one component or other components that are later determined to be compensable.

CHAIR HARPER: "And right now the leg pain would not be?

MS. REESE: "Well, it's not clear. And so, what we're trying to do is we're trying to take the guess work out and say if it's gotta be made clear, let's put it in the statute one, two, three, four.

CHAIR HARPER: "Wow, Representative Beck, are you right with us?

REPRESENTATIVE BECK: "Yeah, I'm right there.

CHAIR HARPER: "That was awesome." Tape Recording, House Committee on Labor, May 20, 1997, Tape 84, side A, Testimony of Jan Reese, MLAC member.

In addition, Representative Harper, when questioned by Representative Schrader about the last sentence of ORS 656.262(7)(c), responded: "We would say it only opens the claim for that specific condition." Tape Recording, Tape 143, Testimony of Representative Harper.

Finally, Tom Mattis, Deputy Administrator of the Workers' Compensation Division, testified regarding the proposed amendments and stated that "if the condition should have been included before claim closure, but wasn't found compensable until after the claim was closed, the insurer must reopen the claim and pay the benefits to which the worker would be entitled." Tape Recording, House Committee on Labor, June 11, 1997, Tape 91, Testimony of Tom Mattis.

Thus, the legislative history regarding ORS 656.262(7)(c) consistently provides that, where a new medical condition claim is accepted after claim closure, the claim is to be reopened for the payment of benefits that would have been due if that new medical condition had been accepted.

In order to render all statutes effective to the greatest extent possible, we follow the court's reasoning in *Johansen*, wherein the court determined that the legislature had established a "new medical condition" claim as a new type of claim. In this regard, although finding that a "new medical condition" claim must "relate to" the initial claim, the court determined that a "new medical condition" claim was distinct from an initial claim and an aggravation claim. *Johansen*, 158 Or App at 680-81. Neither *Mann* nor *Johansen* addressed the issue of a "new medical condition" claim related to an initial claim in Own Motion status. But following the *Johansen* reasoning to its logical conclusion, we find that a "new medical condition" claim may be in own motion status or it may remain within the initial claim's aggravation rights.

Furthermore, the legislature has provided the following processing procedures for the various types of claims: (1) initial claims and reopened aggravation claims are processed under ORS 656.262 and 656.268 (aggravation claims must meet the requirements of ORS 656.273 to qualify for reopening; however, once reopened, aggravation claims are essentially processed the same as initial claims); (2) Own Motion claims are processed under ORS 656.278; and (3) "new medical condition" claims are processed under ORS 656.262 and 656.268, whether the aggravation rights have expired on the initial claim or not. After all, as explained above, a "new medical condition" claim constitutes a new type of claim.

These procedures will put into effect the legislature's intent to reopen new medical condition claims to provide the benefits that would have been due if those claims had been accepted and rated. In addition, the legislature provided for no exceptions regarding new medical condition claims where the initial claim is in Own Motion status. Therefore, it follows that this procedure includes such claims. Furthermore, the legislature did not amend the own motion statute; therefore, the requirements to reopen an "Own Motion" claim remain the same, *i.e.*, there must be a worsening of the compensable condition requiring inpatient or outpatient surgery or other treatment requiring hospitalization, and the monetary benefits available in Own Motion remain the same, *i.e.*, temporary disability. ORS 656.278(1)(a).

The employer argues that our decision in *Susan K. Clift*, 51 Van Natta 646 (1999), decides the matter before us and results in a finding that claimant is not entitled to a rating of the extent of any permanent disability related to the new medical condition claim. We disagree.

In *Clift*, we determined that the claimant's "new medical condition" claim was not entitled to separate 5-year "aggravation rights." Instead, we found that her claim was subject to the 5-year "aggravation rights" stemming from the first closure of her initial carpal tunnel syndrome (CTS) claim. Following the closure of the CTS claim, the carrier reopened the claim under ORS 656.262(7)(c) to accept the claimant's "consequential" psychological condition. Subsequently, the claim was closed by Determination Order that retained aggravation rights dating from the initial claim closure. An Order on Reconsideration affirmed the Determination Order. The claimant requested a hearing seeking new 5-year "aggravation rights" for her "new medical condition" claim.

We denied claimant's request. In doing so, we concluded that the claimant's new medical condition was subject to her five-year aggravation rights stemming from the first closure of the original claim.

Our decision in *Clift* was limited to whether a "new medical condition" was entitled to new aggravation rights or retained the aggravation rights attached to the initial claim. Thus, its holding has no effect on a carrier's obligation to reopen and process a "new medical condition" claim.[5]

Finally, the legislature's creation of an entirely new type of claim, classified as a "new medical condition" claim, provides for a meaningful entitlement to reopening of a new medical condition claim when the initial claim is in Own Motion jurisdiction. In this regard, the legislature provided that the *carrier* is required to *reopen* the claim under those circumstances, without limiting the "reopening" in any manner. ORS 656.262(7)(c). And it would be limited if it was processed within the Board's Own Motion jurisdiction. The Board could not authorize "reopening" the new medical condition claim unless the condition required surgery or hospitalization and, even then, the monetary benefits would be limited to temporary disability. ORS 656.278(1)(a). Both results would contravene the unqualified requirement in ORS 656.262(7)(c)[6] that the carrier "reopen" the claim and the legislative intent of rating previously unaccepted conditions. Thus, in order to create a meaningful entitlement to a "reopened" claim, benefits for a new medical condition claim accepted after closure and reopened under ORS 656.262(7)(c) must be provided under ORS 656.262 and ORS 656.268. To paraphrase *Johansen*, if the legislature intended to limit the benefits resulting from "reopening" a new medical condition claim when the initial claim is in Own Motion jurisdiction, it was incumbent on the legislature to so provide. 158 Or App at 681.

Accordingly, we agree with the ALJ that the new medical condition claims should be remanded to the employer for reopening under ORS 656.262(7)(c) and processing to closure under ORS 656.268.

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

ORDER

The ALJ's order dated December 31, 1998 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the self-insured employer.

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[5] As previously noted, the intent of the legislature in enacting ORS 656.262(7)(c) was to provide claimants with the benefits they would have received if the new medical condition claims had been accepted. If new aggravation rights were granted to "new medical condition" claims accepted after claim closure, that would result in *additional* benefits for new medical condition claims that would not have been available to the initial claims.

[6] We note that the legislature provided for a limited exception to the Board's Own Motion jurisdiction in ORS 656.278(3). Thus, it is reasonable to find that ORS 656.262(7)(c) provides another limited exception.

Board Members Biehl and Phillips Polich specially concurring.

We agree with the majority opinion that our decision in *Susan K. Clift* does not control the outcome of this case. The issue in *Clift* was whether acceptance of a new medical condition claim entitled the worker to a new determination of aggravation rights at closure of the new medical condition claim. The question presented in this case is how a "new medical condition" claim should be closed. If we were revisiting the issue presented in *Clift*, we would overturn the decision in reliance on the reasoning in Member Biehl's dissent. *See Susan K. Clift*, 51 Van Natta at 648-49.

In the Matter of the Compensation of
JOHN R. GRAHAM, Claimant
WCB Case No. 98-0240M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Michael A. Bliven, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of the self-insured employer's September 23, 1998 Own Motion Notice of Closure which purported to close his claim with an award of zero temporary disability compensation. Claimant contends that the Notice of Closure is invalid and asserts that the employer should be directed to close the claim pursuant to ORS 656.262(7)(c) and rate any permanent partial disability (PPD) regarding the new medical condition claims. We set aside the Own Motion Notice of Closure.

FINDINGS OF FACT

On January 29, 1991, claimant sustained a nondisabling right knee injury. His aggravation rights on that injury claim expired on January 29, 1996.

After the expiration of his aggravation rights, claimant made several "new medical condition" claims, which were accepted by the employer. After the employer failed to respond to claimant's request that it rate and close those new medical condition claims, he filed a hearing request. (WCB Case No. 98-02795). Following a hearing, Administrative Law Judge (ALJ) Mills determined that claimant's claim was in own motion status, and found that the permanent disability issue was not ripe. The ALJ also remanded the new medical condition claims to the employer "for reopening and processing as provided for by Oregon law." That order was not appealed and became final by operation of law.

Subsequently, the employer submitted an own motion recommendation to the Board, opposing reopening the claim under ORS 656.278 because, *inter alia,* no surgery or hospitalization had been requested. The employer also requested that the Board authorize it to "reclose the claim without any additional awards of compensation."

On July 31, 1998, we issued an Own Motion Order finding that the claim did not qualify for reopening under ORS 656.278 because claimant did not require surgery or hospitalization. *John R. Graham,* 50 Van Natta 1508 (1998). We also noted that we could not "authorize" the closure of a claim that had not been reopened under ORS 656.278. We also explained that, pursuant to our rules, claims reopened in own motion are closed by the carrier without the issuance of a Board order.

On September 3, 1998, claimant requested a hearing raising issues of failure to close his claim, penalties, and attorney fees. (WCB Case No. 98-07038).

On September 23, 1998, the employer issued an Own Motion Notice of Closure that stated: "The only accepted conditions which we are closing are: osteocartilaginous loose bodies right knee, degenerative changes articular cartilage medial compartments, sartorius muscle rupture right and right thigh muscle tear. The torn medial meniscus was previously closed." (Ex. 5). This closure awarded no temporary or permanent disability.

Claimant requested that the Board in its own motion authority review the September 23, 1998 Own Motion Notice of Closure.

On December 31, 1998, ALJ Mills issued an order that remanded the new medical condition claims to the employer "for reopening and processing to closure as set forth in this order, to include a determination of claimant's permanent disability with respect to the new medical condition claims." The employer requested review.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that the September 23, 1998 Notice of Closure is a nullity and argues that the employer should be directed to close his "new medical condition" claim pursuant to ORS 656.262(7)(c). We agree.

On today's date, the Board issued its order in WCB Case No. 98-07038. Specifically, the Board determined a carrier's processing duties under ORS 656.262(7)(c)[1] when a new medical condition claim is accepted after expiration of aggravation rights on the initial claim. The Board determined that the legislature intended to create a new kind of claim when it added the requirement that carriers must reopen a claim when a "new medical condition" claim is accepted.

Here, only claimant's "new medical condition" claims are at issue. Furthermore, by its order issued today, the Board has remanded those claims to the employer for reopening under ORS 656.262(7)(c) and processing to closure under ORS 656.268.

Inasmuch as we have directed the employer to close claimant's "new medical condition" claim pursuant to ORS 656.268, it necessarily follows that the claim should not be closed pursuant to ORS 656.278. In addition, as we found in our July 31, 1998 order, it also follows that because the initial claim did not qualify for reopening under ORS 656.278, the employer's September 23, 1998 Own Motion Notice of Closure did not "close" any "reopened" own motion claim. As we stated in our July 31, 1998 order, "we cannot 'authorize' the closure of a claim that has not been reopened under ORS 656.278." *John R. Graham*, 50 Van Natta at 1508 fn 1. Thus, the employer's "closure" is a nullity.

Accordingly, the employer's September 23, 1998 Own Motion Notice of Closure is set aside.

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

IT IS SO ORDERED.

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[1] ORS 656.262(7)(c) provides, in relevant part: "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

October 14, 1999 Cite as 51 Van Natta 1747 (1999)

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

Claimant requests reconsideration of that portion of our July 14, 1999 Order on Review that she asserts upheld the SAIF Corporation's current condition denials in their entirety. She contends that we were mistaken in finding that her then-current cervical strain and/or bilateral carpal tunnel syndrome (CTS) were no longer being caused in major part by the original compensable claim.[1] Having received and considered SAIF's response to the motion, we now proceed with our reconsideration.

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[1] In our abatement order, we noted that claimant focused on compensability of her bilateral brachial plexus compression/thoracic outlet syndrome in her brief on review. In our prior order, our understanding of claimant's argument was the same as SAIF's, *i.e.*, that she was relying on the compensability of the brachial plexus compression/thoracic outlet syndrome condition as the basis for setting aside SAIF's denials.

Cervical Strain

In March 1994, claimant filed a claim for neck and upper extremity complaints. (Ex. 1). On April 27, 1994, Dr. Bernstein diagnosed cervical strain and bilateral CTS. (Ex. 11-3). In May 1994, SAIF accepted a nondisabling cervical strain and bilateral CTS. (Ex. 14).

On reconsideration, claimant contends that her current cervical strain continues to be caused in major part by the original compensable claim. Although claimant refers to a major contributing cause standard, she does not indicate the theory of her claim. The record indicates that the original cervical strain had a gradual onset and was not related to a particular incident. Claimant's "801" form filed in March 1994 indicated she had experienced symptoms "over the last several months." (Ex. 1). A March 15, 1994 physical therapy chart note indicated claimant's condition had been progressing over the past five years. (Ex. 4). Likewise, on April 27, 1994, Dr. Bernstein referred to a gradual onset of symptoms. (Ex. 11). Thus, the medical evidence indicates that claimant's original accepted cervical strain was based on an occupational disease theory.

The medical reports issued after the claim was accepted in May 1994 do not refer to any new incidents or injuries. Rather, the later reports referred to intermittent cervical pain. (Ex. 20-1). On July 1, 1996, Dr. Adams reported that claimant had "chronic neck pain which has been exacerbated lately by extreme stress on her job." (Ex. 27). In a June 28, 1996 chart note, Dr. Adams explained that "[s]tress 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 said claimant was being treated for headache, cervical strain and stress-related conditions. (Ex. 29a).

Claimant relies on a September 24, 1996 report from Dr. Adams and Mr. Metcalf, nurse practitioner, to establish compensability of her current cervical strain. Dr. Adams and Mr. Metcalf had responded to a September 12, 1996 letter from SAIF. (Exs. 33, 34). SAIF asked whether they agreed that the stress claimant was experiencing had combined with the March 1994 injury to cause her present need for treatment and/or disability. (Ex. 33-1). Dr. Adams and Mr. Metcalf replied that since the initiation of claimant's claim in March 1994, "the injuries have caused her suffering and a general inability to adequately perform her job." (Ex. 34-1). They said both situations had caused stress and the resulting stress caused a further aggravation of her injuries. (*Id.*)

SAIF asked Dr. Adams and Mr. Metcalf if stress was the major contributing cause of claimant's "combined" condition. (Ex. 33-1). They responded:

> "[T]he injury and resulting stress, causing prolongation of the initial injury, are interwoven--not unidirectional. We believe that the initiating problem was the injuries, with exascerbation [sic] of underlying stress factors secondary to this." (Ex. 34-1).

Finally, SAIF asked Dr. Adams and Mr. Metcalf if the combined condition was the major contributing cause of claimant's present need for treatment and/or disability as it related to the cervical condition. (Ex. 33-2). Dr. Adams and Mr. Metcalf said that the "interdependency of the injury followed by increased stress, producing prolongation of the initial injury, is certainly part of [claimant's] current condition." (*Id.*) They believed the two factors both needed to be addressed if recovery was to be expected. (*Id.*)

We find that the September 24, 1996 report from Dr. Adams and Mr. Metcalf is insufficient to establish that claimant continues to have a compensable cervical strain. Dr. Adams and Mr. Metcalf believed that the initiating problem was claimant's injuries, with resulting stress that caused "prolongation" of the injuries. (Ex. 34-1). The medical reports from Dr. Adams and Mr. Metcalf, as well as from Mr. Karnes, indicate that claimant's treatment for her current cervical strain was in part for psychological conditions, which are not accepted conditions. We find that the September 24, 1996 report relied on by claimant is not sufficient to establish that claimant's work activities are the major contributing cause of her current cervical strain.

In contrast, Dr. Tsai concluded that claimant's cervical strain had resolved in May 1994. (Ex. 37-16). Dr. Tsai felt that claimant's preexisting conditions were "overwhelming" in the causation of her cervical condition and he agreed that the accepted cervical strain was no longer a material contributing factor to her ongoing need for treatment and/or disability. (Ex. 37-14, -16). Drs. Olson and Becker

examined claimant on June 10, 1998 and diagnosed, among other things, a cervical dorsal strain. (Ex. 41-5). They did not indicate her strain was related to her work activities. Rather, they said the strain was "more likely the deconditioning everyday stress issue." (Ex. 41-6). Based on the medical evidence in the record, we conclude that claimant has failed to establish compensability of her current cervical strain.

Bilateral CTS

On reconsideration, claimant contends that her current bilateral CTS condition continues to be caused in major part by the original compensable claim. Although claimant refers to a major contributing cause standard, she does not indicate the theory of her claim. The record indicates that the original CTS condition had a gradual onset and was not related to a particular incident. Claimant's "801" form filed in March 1994 indicated she had experienced symptoms "over the last several months." (Ex. 1). An April 21, 1994 chart note indicated claimant had been having problems with her hands going to sleep over the past two to three years. (Ex. 9). Similarly, Dr. Bernstein referred to a gradual onset of symptoms. (Ex. 11). The medical evidence indicates that claimant's original accepted bilateral CTS was based on an occupational disease theory. The medical reports issued after the claim was accepted in May 1994 do not refer to any new incidents or injuries. Consequently, we find that the current CTS condition should be analyzed as an occupational disease.

On reconsideration, claimant relies on the September 24, 1996 report from Dr. Adams and Mr. Metcalf to establish compensability of her current bilateral CTS condition. In July 1996, Dr. Adams had diagnosed claimant with a headache, cervical strain and "stress-related" conditions. (Ex. 29a). We find no evidence that Dr. Adams diagnosed or referred to CTS or a CTS-related condition. Although the September 24, 1996 report from Dr. Adams and Mr. Metcalf referred to claimant's "current condition," we find no evidence that their discussion of claimant's "current" condition included bilateral CTS. We find that the report from Dr. Adams and Mr. Metcalf is not sufficient to establish compensability of claimant's current CTS condition.

Furthermore, the remaining medical opinions are not sufficient to establish that claimant's current CTS is compensable. On August 24, 1994, Dr. Bufton reported that claimant's carpal tunnel symptoms had largely resolved. (Ex. 20-1). On November 6, 1996, Dr. Tsai said that claimant's bilateral CTS was in "stationary status." (Ex. 37-13).

On April 12, 1998, Dr. Konowalchuk diagnosed bilateral brachial plexus compression / thoracic outlet syndrome. (Ex. 40-4). He also noted that claimant had bilateral CTS, which had been confirmed by nerve conduction studies. (*Id.*) He said that the CTS had "overlapping symptoms" with thoracic outlet syndrome. (Ex. 40-7). Dr. Konowalchuk found that claimant's CTS was mild, but her symptoms were "certainly more than mild, and thus one would have to contribute the majority of these to the thoracic outlet condition." (*Id.*) He felt that claimant's work activities were the major contributing cause of her "condition." (Ex. 40-5, -7).

Drs. Olson and Becker examined claimant on June 10, 1998 and included bilateral CTS in their diagnoses. (Ex. 41-5). They concluded that the major contributing cause of claimant's "current issues" was carpal tunnel compromise. (Ex. 41-6). They found no evidence of brachial plexus compression. (Ex. 41-5). Their report, however, did not discuss causation of claimant's current CTS. In a later report, Dr. Olson disagreed with the diagnosis of brachial plexus compression/ thoracic outlet syndrome. (Ex. 43). He explained that the findings of numbness in the fingers, especially when the hands were over the head, were related to CTS. (Ex. 43-2).

Dr. Konowalchuk responded that progressive positional numbness of the fingers when the hands are held over the head was not related to CTS, but was indicative of brachial plexus compression. (Ex. 46-5). In a later report, Dr. Konowalchuk agreed with Drs. Olson's and Becker's diagnosis of CTS (Ex. 47-1), but he did not comment on causation of claimant's CTS.

Although Dr. Konowalchuk and Drs. Olson and Becker reported that claimant had mild CTS, we find that their reports are insufficient to establish that claimant's work activities were the major contributing cause of her current CTS condition. Drs. Olson and Becker did not comment on causation of claimant's CTS. Although Dr. Konowalchuk said that claimant's work activities were the major contributing cause of her "condition" (Ex. 40-5, -7), he did not comment specifically on causation of her CTS condition. There is no evidence that Dr. Konowalchuk was aware of Dr. Bufton's August 24, 1994

report that said claimant's carpal tunnel symptoms had largely resolved or that he was aware of Dr. Tsai's November 1996 report that claimant's CTS was stationary. (Exs. 20-1, 37-13). Moreover, Dr. Konowalchuk's April 12, 1998 report indicated that claimant's CTS symptoms overlapped with her thoracic outlet syndrome symptoms, with the majority of symptoms from the thoracic outlet condition. (Ex. 40-7). We find that Dr. Konowalchuk's discussion of compensability of claimant's CTS is too conclusory to establish compensability of that condition. Based on the medical evidence in the record, we conclude that claimant has failed to establish compensability of her current CTS condition.

In SAIF's response to claimant's motion for reconsideration, it seeks reconsideration of that portion of our July 14, 1999 order finding that claimant's bilateral brachial plexus compression/thoracic outlet syndrome was compensable. After reviewing SAIF's arguments, we have nothing further to add to our prior order concerning this issue. We make one change, however, in the first full paragraph on page 6 of our prior order. In the third sentence of that paragraph, we said

> "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."

We change that sentence to read:

> "Because Dr. Konowalchuk indicated claimant had a congenital abnormality that predisposed her to thoracic outlet syndrome, that abnormality necessarily preceded both the date of disability and the date when medical treatment was first sought. *See SAIF v. Cessnun*, 161 Or App 367, 371 (1999)."

On reconsideration, we withdraw our July 14, 1999 order. As supplemented herein, we adhere to and republish our July 14, 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
WILLIAM T. JOHNSON, Claimant
WCB Case No. 97-09152
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl, Bock, 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 low back disc conditions at L4-5 and L5-S1. 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 regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 22, 1999, as corrected on April 2, 1999, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

Board Member Haynes dissenting.

The majority affirms the ALJ's decision to set aside the employer's denial of claimant's low back disc conditions at L4-5 and L5-S1. In so doing, it approves of the ALJ's finding that claimant's compensable low back injury is the major contributing cause of disc conditions at those levels. Because I would find the medical evidence on which the ALJ relies unpersuasive, I respectfully dissent.

Given that the majority affirms without opinion, it is first necessary to briefly recount the factual background of the case. Claimant compensably injured his low back on March 1, 1996. Dr. Miller, who initially treated claimant, diagnosed a lumbosacral strain. (Ex. 3). A March 6, 1996 MRI was interpreted by a radiologist, Dr. Urman, as showing "very mild" bulges at L3-4 and L4-5 of "questionable significance." (Ex. 4). Dr. Miller emphasized in a March 8, 1996 report that claimant's injury was a lumbosacral strain and that neurological impairment had been ruled out. (Ex. 6-1).

Claimant came under the care of Dr. Reynolds on March 13, 1996. Dr. Reynolds also diagnosed a low back strain. (Ex. 9). X-rays of the lumbar spine taken on March 20, 1996 were interpreted as normal. (Ex. 11). Dr. Reynolds later referred claimant to Dr. Berselli in May 1996 for an evaluation of claimant's continuing low back complaints. Dr. Berselli specifically noted claimant's report that he did not have any lower extremity pain. (Ex. 12-1). Dr. Berselli diagnosed chronic lumbar pain. (Ex. 12-2).

On March 27, 1996, yet another physician, Dr. Smith, concluded that claimant had sustained a back strain. (Ex. 14). As of April 3, 1996, claimant was specifically reported as not having any evidence of nerve root compromise and that the diagnosis was musculoligamentous strain of the low back. (Ex. 15).

Against that backdrop, it is understandable that the employer only accepted a lumbosacral strain. (Ex. 32). It was not until October 16, 1996 that a myelogram was interpreted as showing disc abnormalities at L4-5 and L5-S1. (Ex. 22). Yet, claimant's primary complaints were of low back, not lower extremity pain. (Ex. 26).

On August 20, 1997, the claim was closed with an award of 21 percent unscheduled permanent disability. (Ex. 37). By letters of September 22, 1997 and November 10, 1997, claimant requested that the employer accept disc herniations/bulges at L3-4, L4-5, and L5-S1. The employer denied the requests on December 5, 1997. Claimant then requested a hearing.

The ALJ set aside the employer's denial to the extent that it denied disc conditions at L4-5 and L5-S1. In doing so, the ALJ relied on the medical opinions of Dr. Brett, a neurosurgeon who examined claimant on referral from Dr. Berselli, and Dr. Puziss who evaluated claimant's condition at claimant's attorney's suggestion. The ALJ concluded that their opinions were more persuasive than that of Dr. Woodward, a physician who examined claimant on behalf of the employer. I strongly disagree with the ALJ's (and the majority's) assessment of the medical evidence.

Because of the conflicting medical evidence, 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). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. *Somers v. SAIF*, 77 Or App 259 (1986).

In his initial medical report of March 20, 1998, Dr. Puziss attributed claimant's neurological symptoms to a chronic left lumbosacral facet syndrome. (Ex. 52A-5). Further, Dr. Puziss agreed with Dr. Woodward that disc bulges are common in persons such as claimant who are more than 50 years old and are not necessarily a cause of pain. (Ex. 52A-6). Dr. Puziss indicated that a future MRI would be important in determining whether claimant had more than a simple disc bulge.

Although the record does not contain a report, that MRI was apparently performed. Dr. Brett interpreted it as showing only "minor" disc bulging centrally at L5-S1 "without any nerve root impingement." (Ex. 56-1). Moreover, Dr. Brett described claimant as neurological intact.

Despite the seemingly benign nature of claimant's lumbar spine at the disputed levels, as revealed by the most recent MRI, Dr. Puziss does not mention (or give an indication that he even reviewed) that MRI when, in his final report of February 25, 1999, he concluded that claimant suffers from L4-5 and L5-S1 central disc protrusions of which the compensable injury was the major

contributing cause. (Ex. 59). There is also no mention of the previous facet syndrome diagnosis, let alone any explanation of why that diagnosis had been apparently discarded. Dr. Puziss apparently based his opinion on a review of the October 1996 myelogram. However, that information was already available to, and noted by, Dr. Puziss in his previous report in which attributed claimant's back condition, not to disc protrusions, but rather to the facet syndrome. (Ex. 52A-2).

Given the above deficiencies, I would find Dr. Puziss' opinion unpersuasive because it is inconsistent, poorly reasoned and based on incomplete information. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions based on incomplete or inaccurate information are not afforded persuasive force). It, therefore, provides insufficient support for reversing the employer's denial.

As for Dr. Brett, he did not examine claimant until January 1999, nearly three years after the original injury. For that reason, Dr. Brett was not in a favorable position for rendering an opinion on the causation issue. More importantly, as previously noted, he described claimant's disc bulge as L5-S1 as "minor" and not causing nerve root impingement in his February 9, 1999 report. (Ex. 56). Yet, in a February 24, 1999 report to claimant's attorney, Dr. Brett inflates his description of the L5-S1 disc bulge to "moderate-sized" and abruptly mentions another disc bulge at L4-5 not previously noted in his February 9, 1999 report.

Although the ALJ and the majority may find Dr. Brett's opinion persuasive, to me it is inconsistent and conclusory and, hence, unpersuasive. Moreover, like Dr. Puziss, Dr. Brett gives no consideration to contemporaneous medical records that show only diagnoses of a low back strain and noted no evidence of disc herniations or significant neurological symptoms.

Rather than rely on flawed medical reports of Drs. Puziss and Brett, I would instead find Dr. Woodward's opinion persuasive. He reasonably concluded that claimant' disc bulges were normal, age-related findings. (Exs. 40-6, 50). This opinion was echoed in part by Dr. Puziss in his initial report and several physicians (Drs. Flemming, Berselli, Kaplan and Urman) concurred with it. (Exs. 43, 44, 49, 51).

In conclusion, the most persuasive medical evidence supports the employer's denial. Thus, I respectfully submit the majority errs when it relies on inconsistent, poorly reasoned medical reports in finding that claimant has proved the compensability of disc conditions at L4-5 and L5-S1. For these reasons, I must dissent.

In the Matter of the Compensation of
SHAD A. LOWMAN, Claimant
Own Motion No. 99-0320M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable bilateral inguinal hernia condition. Claimant's aggravation rights expired on November 1, 1993. SAIF opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his current disability.

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

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 employer contended that claimant's failure to provide proof of earnings demonstrated that he was not in the work force. In response to the SAIF's contention, claimant has submitted a copy of his payroll check history report which spans a time period between January 1998 through August 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 March 18, 1999, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] Claimant underwent hernia surgery on March 18, 1999. 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 18, 1999 when he underwent 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
RENATO H. MORALES, Claimant
WCB Case No. 98-07870
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Mannix, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that set aside its December 1998 "back-up" denial of claimant's "new medical condition" claim for upper and lower back strains. Claimant cross-requests review of that portion of the ALJ's order that upheld the insurer's September 1998 aggravation denial. On review, the issues are the procedural validity of the "back-up" denial; if proper, compensability; and aggravation. We affirm.

FINDINGS OF FACT[1]

On October 3, 1997, claimant, who is right hand dominant, compensably injured his right arm. Claimant was examined by Dr. Orwick on October 3, 1997, physician's assistant Hakala on October 10, 1997, and Orwick again on October 15 and October 24, 1997. There is no indication in the examination chart notes that claimant complained of pain in his upper or lower back. (Exs. 1, 2, 6, 7, 8). On November 12, 1997, the insurer accepted a disabling right arm contusion. (Exs. 9, 10, 12).

Claimant failed to attend his November 21, 1997 appointment with Orwick, who found no permanent impairment, stating: "[Claimant] didn't keep his appt of 11/21/97--I presume that is because he has healed well." (Ex. 11). An April 16, 1998 Determination Order closed the claim with an award of temporary disability but no award of permanent disability. (Ex. 13).

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[1] In addition to the exhibits the ALJ listed in the Opinion and Order as admitted into evidence, exhibits d, B and C were also admitted. (*See* Tr. 5). Also, the correct spelling of the interpreter's name is Mimi *Guerra*, not Garrah. (*See* Tr. 17).

On May 7, 1998, claimant returned to Orwick with complaints of pain in his upper back and right rhomboid area that he attributed to the October 3, 1997 work injury. Orwick noted that claimant had been seen between October 3 and October 24, 1997 for a right arm injury and "never did complain of any back pain then. He reports that the back pain started some time later, perhaps November or December, but it was not bad until the past couple of weeks when it has become worse and he's not sure why." Orwick found tenderness in the right rhomboid, thoracic paraspinous, and trapezius muscles, but stated: "I cannot clearly relate[] this to the work injury." Orwick noted that claimant seemed to have fully recovered from the right arm (triceps) injury. (Ex. 14).

On May 20, 1998, claimant sought treatment from Dr. Miller for pain in his right mid-lower back and weakness in the right arm that he related to the October 3, 1997 injury. Miller found a weak grip and reduced brachioradialis reflex in claimant's right arm. He diagnosed a resolving neurapraxia of the right radial nerve, secondary to the contusion in the proximal arm. (Ex. 16). On June 29, 1998, Miller completed a Notice of Claim for Aggravation. (Ex. 32).

As of June 30, 1998, Dr. Stringham began treating claimant after the departure of Dr. Miller from the clinic practice. (Ex. 33). On July 29, 1998, claimant requested acceptance of thoracic and lumbar strains and neurapraxia of the right radial nerve as new medical conditions. (Ex. 48A).

On September 2, 1998, Drs. Olson, neurosurgeon, and Vessely, orthopedic surgeon, examined claimant for the insurer. (Ex. 56).

On September 25, 1998, the insurer issued: (1) a modified Notice of Acceptance, accepting disabling right arm contusion, thoracic strain and lumbosacral strain (Ex. 57); (2) a letter notifying claimant that his claim for neurapraxia was "adequately addressed in the acceptance of the [right arm] contusion"[2] (Ex. 58A); and (3) a denial of claimant's aggravation claim (Ex. 58).

On September 26, 1998, Dr. Stringham wrote a letter to the insurer explaining why he did not concur with the Olson and Vessely report. (Exs. 59, 59A). In that report, Stringham noted that his office had no records regarding claimant's treatment prior to his initial visit on May 20, 1998. (Ex. 59A-1).

On September 30, 1998, Dr. Orwick concurred with the Olson and Vessely report. (Ex. 60).

A December 2, 1998 letter from the insurer's attorney to Drs. Vessely and Olson and a December 10, 1998 letter to Dr. Orwick summarized telephone discussions regarding claimant's claims. (Exs. 64, 65).

On December 15, 1998, after receiving the December 1998 medical opinions from Orwick, Olson and Vessely that claimant's thoracic and lumbosacral strains were not attributable to the October 3, 1997 injury, the insurer revoked its acceptance of those conditions and denied them. (Ex. 66).

On December 19, 1998, Dr. Stringham, after reviewing all claimant's medical records back to October 3, 1997, provided a letter addressing claimant's attorney's questions regarding claimant's claim. (Ex. 67).

CONCLUSIONS OF LAW AND OPINION

Procedural Validity of "Back-up" Denial

The ALJ set aside the insurer's revocation of acceptance and "back-up" denial. In doing so, the ALJ rejected the insurer's arguments that the revocation and denial were proper under ORS 656.262(6)(a) either because claimant had materially misrepresented his medical history, or because the records and reports received after acceptance constituted "later obtained evidence" that the claim is not compensable.

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[2] Despite the insurer's statement that it was neither accepting nor denying the neurapraxia condition, by acknowledging that the neurapraxia was "adequately addressed in the acceptance of the [right arm] contusion," the insurer's letter showed agreement that the neurapraxia was compensable and accepted. *See* ORS 656.262(7)(a) ([t]he insurer * * * is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable condition).

In regard to misrepresentation, the ALJ found that claimant, a non-native speaker of English, and his wife were credible and that the history claimant provided to his physicians beginning in May 1998 and at hearing was not a deliberate misrepresentation of his complaints to his physicians in October 1997. The ALJ concluded that the physicians' failure to record any back complaints was instead due to an accidental, linguistic misunderstanding. We agree with the ALJ's conclusion, but reason as follows.

The portion of ORS 656.262(6)(a) pertaining to misrepresentations provides:

> "The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim."

Under this provision, the insurer first must prove fraud, misrepresentation or other illegal activity by claimant. *See Bauman v. SAIF*, 295 Or 788, 794 (1983). The insurer then must show that such fraud, misrepresentation or other illegal activity "could have reasonably affected" its decision to accept the claim. *See Ebbtide Enterprises v. Tucker*, 303 Or 459, 464 (1987).

Assuming without deciding that the discrepancy between the symptom history claimant provided to Dr. Orwick in October 1997 and the histories provided to his medical providers in May 1998 amounted to "misrepresentation" under the statute, it is apparent from the record that at the time the insurer accepted claimant's back strain conditions in September 1998 it had in its possession Orwick's May 7, 1998 chart note. In that note, Orwick discussed the lack of back symptoms when claimant presented for treatment in October 1997, claimant's May 1998 report that the back pain did not start until November or December 1997, and Orwick's doubt that there was any relationship between claimant's October 1997 injury and his May 1998 back symptoms. (Ex. 14).

What Orwick's chart notes show is that the insurer had information prior to its acceptance that there was a discrepancy between claimant's reported symptoms at the time of injury and the symptom history he provided to Orwick eight months later, and that Orwick did not think that the May 1998 complaints were related to the compensable October 1997 right arm injury.

The insurer, who bears the burden of proof, ORS 656.262(6)(a), offered no evidence or explanation as to why it accepted the "new medical condition" back claim. But the evidence shows that information was available to the insurer *before* it issued its acceptance of the back conditions that there was a discrepancy between the October 1997 and May 1998 symptom histories provided by claimant. This discrepancy was the basis for Orwick's opinion that the back symptoms were *not* caused by the injury. Because the insurer had information of this purported misrepresentation and Orwick's opinion that there was no relationship between the May 1998 back symptoms and the October 1997 right arm injury, but nevertheless issued its acceptance of thoracic and lumbosacral strains without further investigation,[3] we conclude that the insurer has failed to show that claimant's "misrepresentation" could have reasonably affected its decision to accept the new conditions.

However, our inquiry does not end here, as the insurer alternatively contends that it revoked acceptance and issued a denial of claimant's back conditions because it obtained evidence after acceptance that showed the new conditions not to be compensable.

The portion of ORS 656.262(6)(a) pertaining to "later obtained evidence" provides:

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[3] The insurer had a total of 90 days from July 30, 1998, the date it received claimant's request for acceptance of the new medical condition claim, to investigate the claim and respond in accordance with the results of its investigation. ORS 656.262(7)(a). The insurer issued its acceptance on September 25, 1998, more than 30 days prior to the end of the allowed statutory period.

> "If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. * * * "

The requirement of "later obtained evidence" in the statute refers to new material, that is, something other than the evidence that the carrier had at the time of the initial acceptance. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 286 (1993). A reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6)(a). *Id.*

Here, the insurer asserts that its "later obtained evidence" consists of the reports from Drs. Orwick, Olson, and Vessely[4] indicating that claimant did not complain of back symptoms in October 1997 and that the back conditions did not exist at that time. According to the insurer, because these reports were not available until after its acceptance, such evidence satisfies the statute.

We agree that the medical opinions from these physicians were not rendered until after the acceptance and, thus, were not available to the insurer at the time of acceptance. As the ALJ noted, however, the opinions from these physicians relied upon a reinterpretation of the same information available to the insurer when it accepted the back conditions. *See Greenbriar AG Management v. Lemus*, 156 Or App 499 (1998). Specifically, the physicians essentially rely on Dr. Orwick's statement that claimant made no back complaints in October 1997. This is the same information that the insurer had in its possession at the time it issued its acceptance.[5] Therefore, we agree with the ALJ that the medical opinion reports generated after the acceptance constituted a reevaluation of the existing evidence rather than "later obtained evidence." Consequently, we conclude that the "back-up" denial is procedurally invalid and we need not address whether claimant has established compensability.

Aggravation

The ALJ found that claimant did not meet his burden to prove that his accepted right arm condition[6] compensably worsened. On review, claimant argues that there was an actual worsening of his right arm condition resulting from the original injury that is supported by objective findings. We disagree.

To prove his aggravation claim, claimant must establish a worsened condition resulting from his original injury.

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[4] Although the ALJ also considered Dr. Stringham's post-acceptance reports, the insurer does not rely on those documents, apparently agreeing with the ALJ's conclusion that they did not qualify as "later obtained evidence."

[5] The insurer also disputes the ALJ's finding that claimant and his wife testified credibly. According to the insurer, claimant inconsistently reported his symptom history to medical providers, and there was no medical evidence to corroborate claimant's wife's testimony regarding her telephone conversation with Dr. Orwick. The insurer asks us to overturn the ALJ's credibility findings.

We find it unnecessary to address the credibility issue in deciding the propriety of the "back-up" denial. As we discussed above, when the insurer decided to accept the thoracic and lumbosacral strains, the records showing claimant's medical history were available to it. These records showed that claimant had not complained of back symptoms in October 1997, did not seek treatment for his back until May 1998, and that Dr. Orwick did not find a causal connection between the injury and the May 1998 back complaints. These records also showed that Orwick's chart notes and the histories claimant provided to his medical providers beginning in May 1998 demonstrated inconsistencies in the development of his back condition. Despite such evidence, the insurer accepted the back conditions. Because such evidence was available at the time of acceptance, it does not constitute "later obtained evidence" for purposes of the "back-up" denial. *Greenbriar AG Management*, 156 Or App at 499. Thus, whether or not claimant is credible, such a finding does not help the insurer in proving that its "back-up" denial was procedurally proper.

[6] The parties agree with the ALJ's determination that the only condition to be evaluated under the aggravation portion of the proceeding was the accepted right arm injury. Claimant's respondent's brief at 10; insurer's reply/cross-respondent's brief at 7.

> "A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." ORS 656.273(1).

An "actual worsening" is established by medical evidence of a pathological worsening or medical evidence that a symptomatic worsening amounts to a worsening of the condition. *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997) (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 addition, claimant must show that he has lost use or function of his right arm as a result of this worsening. *See Fred Meyer, Inc. v. Farrow*, 122 Or App 164, 167 (1993) (quoted in *Intel Corp. v. Renfro*, 155 Or App 447, 451 (1998)); *Mark T. Kawamura*, 51 Van Natta 682 (1999).

Here, the initial claim was closed in April 1998 with no award for permanent disability. In May 1998, Dr. Miller diagnosed for the first time neuropraxia of the right radial nerve secondary to a contusion in the proximal right arm.[7] Claimant filed an aggravation claim for his right arm condition, which the insurer denied.

Objective medical findings indicate that claimant had an injury to the right radial nerve to the triceps and reduced grip strength on the right in comparison to the left, which Dr. Miller and Dr. Stringham attributed to the accepted right arm contusion. (Exs. 16, 22, 56-4, 59A, 67). However, we agree with the ALJ that Dr. Stringham's opinion is insufficient to establish that claimant's right arm condition has pathologically worsened since the last award of compensation.

Stringham relied on the fact that claimant had no award of permanent disability at the time of claim closure to support his opinion that claimant's condition had pathologically worsened.[8] (Ex. 67-2, -3). But he also stated that claimant's claim was closed prematurely without proper testing to document the nature of his condition. (*Id.*) Although this testing was not performed until May 1997 (after claim closure), the doctor who performed the nerve conduction studies reported at that time that reinnervation of the radial nerve branch appeared complete and that there was no evidence of ongoing denervation. (Ex. 21-3). Dr. Miller, claimant's treating physician at that time, reported that the studies showed a resolving neuropraxia of the right radial nerve, secondary to the right arm contusion. (Ex. 22). Further reports by Miller indicated that claimant's right arm weakness, which was due to a lack of complete recovery of the radial nerve contusion, was in the process of resolving. (Exs. 23, 28, 30, 35, 47).

Even though Dr. Stringham did not have medical information establishing the nature of claimant's right arm condition at the time of claim closure, the medical evidence subsequent to claim closure does not establish that claimant's arm condition pathologically worsened after the last award of compensation. Therefore, Stringham's use of "magic words" is insufficient to establish that claimant's condition actually worsened since the initial claim was closed. Accordingly, we find Dr. Stringham's opinion unpersuasive. *Somers v. SAIF*, 77 Or App 259, 263 (1986).[9]

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

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[7] The insurer explained that it need not accept claimant's neuropraxia as a "new condition," because it was, in effect, subsumed in the accepted right arm contusion. ORS 656.262(7)(a). (*See* Exhibit 58A).

[8] When claimant failed to appear at a November 21, 1997 follow-up appointment with Dr. Orwick, Orwick "presume[d] that is because he has healed well[.]" Orwick pronounced claimant medically stationary as of that date and released claimant to regular work without permanent restrictions. (Ex. 11).

9 We note that Drs. Olson and Vessely, who examined for the insurer, opined that claimant's condition had not pathologically worsened. (Ex. 56).

ORDER

The ALJ's order dated April 23, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
CYNTHIA A. WILKINS, Claimant
Own Motion No. 99-0365M
OWN MOTION ORDER DENYING CONSENT TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Cole, Cary, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under her 1989 injury claim with Liberty Northwest Insurance Company expired September 4, 1995. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. *Id.*

Here, on July 28, 1994, the Board approved the parties' Claim Disposition Agreement (CDA), whereby claimant released her rights to the following workers' compensation benefits: all past, present, and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, "Own Motion" rights per ORS 656.278 in claim number C604232997, and all other workers' compensation benefits except compensable medical services under ORS 656.245.

Claimant's aggravation rights on her 1989 injury claim have expired, thus placing the claim in Own Motion status. ORS 656.273(4); ORS 656.278(1)(a). Furthermore, because of the July 28, 1994 CDA, claimant specifically released her own motion benefits under ORS 656.278, *i.e.*, claimant's released her rights to temporary disability compensation. Thus, her entitlement to any further temporary disability under her 1989 injury claim has been extinguished. *See* ORS 656.236(1)(a); *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996).

Inasmuch as claimant's entitlement to further temporary disability compensation under her 1989 claim has been released, the Board is without authority to consent to an order designating a paying agent for the purposes of paying temporary disability compensation. However, because responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. *See* OAR 436-060-0180(13).

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA J. WILLIAMS, Claimant
WCB Case No. 98-06508
SECOND ORDER ON RECONSIDERATION (REMANDING)
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

On September 21, 1999, we reconsidered our July 26, 1999 Order on Review and remanded to the Administrative Law Judge 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. After our September 21, 1999 order issued, we received another letter from claimant, requesting that we remand to the ALJ to consider a September 14, 1999 letter from Dr. Long.

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 with regard to Dr. Long's September 14, 1999 report. First, the evidence regarding claimant's recovery after 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 find that the new evidence is reasonably likely to affect the outcome of the case. As we explained in our prior Order on Reconsideration (Remanding), we were not previously persuaded by Dr. Long's diagnosis that claimant had C5-6 and C6-7 disc lesions. Dr. Long's September 14, 1999 report indicates claimant was delighted with the results of her cervical surgery and all of her symptoms had diminished. She was recovering her right upper extremity strength and no longer had weakness or discomfort in the right lower extremity. After reviewing the September 14, 1999 report from Dr. Long regarding the results of claimant's cervical surgery, we find 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).

In addition to the additional evidence we referred to in our September 21, 1999 Order on Reconsideration (Remanding), we find that the case should be remanded to ALJ Lipton for the admission of Dr. Long's September 14, 1999 report. 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, our prior orders are withdrawn. On reconsideration, as supplemented herein, we republish our September 21, 1999 Order on Reconsideration (Remanding). 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
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
SECOND ORDER ON RECONSIDERATION
Donald M. Hooton, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Claimant, *pro se*, 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 consider claimant's motion, we abated our August 20, 1999 order on September 20, 1999. Having received SAIF's response to claimant's motion, we proceed with reconsideration.

In his motion, claimant expresses concerns that we may not have reviewed all of his previously submitted arguments. As stated in our earlier orders, we have considered claimant's arguments and have adopted the ALJ's order. With regard to claimant's compensability arguments, we have nothing to add to our previous orders or to the ALJ's order.[1]

We supplement our prior orders only to address claimant's submission of post-hearing medical evidence which we treat as a motion for remand. For the following reasons, we deny the motion to 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. 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).

Claimant has submitted chart notes from a Washington physician, Dr. Remington. Although these chart notes were not in existence at the time of hearing, claimant has not established that they, or similar reports, were "unobtainable" with the exercise of due diligence at hearing. In addition, we find that the reports are unlikely to affect the outcome of this case. In this regard, it is unclear whether the doctor had a correct history of claimant's injury or had reviewed the other medical evidence. Furthermore, the chart notes reference an injury of "6-7-99" and the "history" section of the chart note dated 6-21-99 indicates that the onset of shoulder pain occurred 2 weeks earlier after doing overhead drilling. Thus, we are not persuaded that the chart notes establish that the condition is causally related to the January 1993 injury. For these reasons, we conclude that the chart notes are not reasonably likely to affect the outcome of the case. Because the post-hearing evidence does not meet the criteria for remand, we deny claimant's motion.

As supplemented herein, we republish our August 20, 1999 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant has twice waited until late on the 30th day of the appeal period to submit motions for reconsideration. Claimant is admonished to submit any motions he may have as early as possible in the 30-day appeal period. Claimant is put on notice that any further motions filed near the conclusion of the 30-day appeal period may be denied, which could result in the expiration of the 30-day period without a timely appeal.

In the Matter of the Compensation of
BOBBIE J. BLAKELY, Claimant
Own Motion No. 97-0529M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested Board review of the SAIF Corporation's May 5, 1998 Notice of Closure, which closed her claim with a medically stationary date of April 28, 1998. Although listing entitlement to time loss compensation from November 19, 1997 through April 28, 1998, this Notice of Closure also stated that "[n]o time loss is due from 11/19/97 through 04/28/98 per OAR 438-012-0035(1) (2), as you have withdrawn from the workforce [sic] and [that] issue [is] pending appeal." Claimant contends she is entitled to additional benefits as she was not medically stationary at the time her claim was closed.

Specifically, claimant contends that she needs further treatment in the form of a medication pump which would materially improve her functional status. SAIF disputes the reasonableness and necessity of the medication pump. Pursuant to ORS 656.327, this medical services issue is within the Director's jurisdiction. Claimant requested Director's review of the requested medical treatment. (Medical Review Case No. 12793). On September 16, 1998, we issued an order postponing action on this matter, finding that the Director's decision on this issue could have an effect on the Board's review of the carrier's closure of the claim.

Subsequent events have occurred that affect our decision in this matter. The Court of Appeals reversed our prior order, *Bobbi J. Blakely*, 50 Van Natta 303 (1998)[1], that authorized the reopening of claimant's claim for payment of temporary disability benefits under ORS 656.278(1). *SAIF v. Blakely*, 160 Or App 242 (1999). Concluding that our determination that claimant was willing to work at the time of her November 1997 surgery was not supported by the evidence, the court remanded the case for reconsideration. Following this reconsideration, by an order issued today's date, we determined that we did not have authority to authorize the reopening of this claim because claimant failed to prove that she was in the work force at the time of her disability. Accordingly, we denied claimant's request for own motion relief.

Having denied claimant's initial request for own motion relief, this claim was never authorized to be reopened. Thus, SAIF's May 5, 1998 Notice of Closure is rendered a nullity. Accordingly, SAIF's Notice of Closure is set aside as a null and void.

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] We note that our prior order misspelled claimant's first name. The correct spelling is "Bobbie."

Board Member Biehl dissenting.

The majority notes that, by order issued today's date, they denied claimant's request for own motion relief, finding that claimant failed to prove that she was in the work force at the time of her disability. I direct the parties to my dissent in that order, in which I explain that I would have found that claimant met her burden of proving she was in the work force at the time of disability. Therefore, I would have granted claimant's request for own motion relief.

Under my reasoning, claimant's claim would have been properly reopened. Thus, claimant's current request for review of carrier closure would remain a viable issue. But, this issue would remained postponed pending the Director's decision regarding the reasonableness and necessity of the proposed treatment. After issuance of that decision, under my reasoning, the merits of the premature closure issue would be addressed.

In the Matter of the Compensation of
BOBBIE J. BLAKELY, Claimant
Own Motion No. 97-0529M
OWN MOTION ORDER ON REMAND
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Blakely*, 160 Or App 242 (1999). The court has reversed our prior order, *Bobbi J. Blakely*,[1] 50 Van Natta 303 (1998), that awarded claimant temporary disability benefits under ORS 656.278(1). Concluding that our determination that claimant was willing to work at the time of her November 1997 surgery was unsupported by the evidence, the court has remanded the case for reconsideration.

Claimant's aggravation rights on her 1977 injury claim have expired. Under such circumstances, 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.*

There is no dispute that claimant underwent surgery for her compensable right knee condition on November 21, 1997. *Id.* Nevertheless, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Blakely*, 160 Or App at 244; *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 employed, 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 "time of disability" for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction, is the date of surgery or inpatient hospitalization.[2] *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Furthermore, the relevant time period for which claimant must establish she was in the work force is the time prior to when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App at 414; *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997). Claimant has the burden of proof regarding the work force issue. ORS 656.266.

We adopt and republish those portions of our prior orders that determined that evidence from Dr. Mohler, claimant's treating physician, established that claimant's compensable injury made work search efforts futile during the relevant period, which was at the time of the November *1997* surgery.[3] *See Bobbi J. Blakely, on recon* 49 Van Natta 2111 (1998), *on recon* 50 Van Natta at 304; *John R. Johanson*, 46 Van Natta at 2463-64. But, in order to satisfy the third *Dawkins* criteria and establish entitlement to temporary disability compensation, claimant must also prove her willingness to work during the relevant period. *See Blakely*, 160 Or App at 246-247 ("*Dawkins* is explicit that such futility is distinct from willingness to work - that is, that proof of the former does not, without more, establish the latter").

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[1] We note that our prior order misspelled claimant's first name. The correct spelling is "Bobbie."

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

[3] As the *Blakely* court noted:

> "The circumstances in this case are somewhat confused by the fact that in November *1996*, a year before the surgery involved here, claimant had also undergone arthroscopic knee surgery and had, ultimately, recovered own motion temporary disability benefits with respect to that surgery. In that instance, the Board had concluded that claimant was in the work force at the time of the disability because she had been engaged in regular gainful employment up to the time of the surgery. Claimant's treating physician, Dr. Mohler, rendered an opinion on March 26, 1997, that claimant was medically stationary following the November 1996 surgery, and that claim was closed." 160 Or App at 244-45.

Thus, although claimant's claim had previously been reopened for payment of own motion benefits, *i.e.*, temporary disability benefits, it was subsequently closed. The fact that claimant was in the work force at the time of the November *1996* surgery is not determinative regarding the issue currently before us -- whether claimant was in the work force at the time of her November *1997* surgery.

As a preliminary matter, we address an evidentiary issue raised by the parties. On remand, claimant requested that we allow supplemental briefing and "allow both parties to submit additional evidence, if necessary." In response, we implemented a supplemental briefing schedule and permitted submittal of additional evidence. But, we also informed the parties that our permission to submit additional evidence was not to be interpreted as a ruling that such submission would ultimately be considered when we conducted our reconsideration in accordance with the court's decision. Finally, in submitting their respective positions, we requested that the parties address the question of whether we should consider any further evidence.

Only claimant submitted additional evidence not already in the record. This evidence consisted of her affidavit stating that she was willing to work and describing various activities she has performed over a period of several years.[4] SAIF objects to this new evidence, contending that: (1) claimant has had ample opportunity to submit evidence in this case and should not be granted another; and (2) claimant does not explain why her affidavit was not previously available and why it could not have been submitted earlier. Claimant responds that her affidavit is not new evidence but only "serves to solidify the evidence which is already part of the record." Reply Brief, page 1. For the following reasons, we agree with SAIF.

First, claimant's affidavit is clearly new evidence -- the record does not contain this or any other affidavit from claimant. In addition, contrary to claimant's argument, the affidavit does more than "solidify the evidence which is already part of the record." It also presents new evidence, including a sworn statement from claimant that she "was and [is] willing to work." Affidavit of Bobbie Blakely, page 1.

Second, we decline to consider this new evidence on remand. Claimant contends that the court "felt that the willingness to work issue was in controversy and remanded the case to clarify the issue. * * * [T]he affidavit serves to help clarify the issue." To the extent that claimant is contending that the court directed us to admit additional evidence on remand, we disagree. Instead, the court found that our determination that claimant was willing to work was unsupported by the evidence on which we relied. As a result, the court reversed and remanded our order "to reconsider the 'willingness to work' issue." *Blakely*, 160 Or App at 247. The court did not direct us to admit additional evidence to the record.

Claimant does not indicate why, with due diligence, she could not have produced this "additional evidence" at the time of our prior orders. After all, the evidence in dispute is claimant's own affidavit. Moreover, from the beginning of this matter, the sole issue in dispute has been whether claimant proved she was in the work force at the time of disability, *i.e.*, during the period before her November 21, 1997 surgery. Furthermore, claimant had multiple opportunities to submit evidence regarding the work force issue, including the issue of her willingness to work.

In this regard, claimant had the opportunity to submit work force evidence in response to the November 10, 1997 "Carrier's Own Motion Recommendation" form in which SAIF recommended denying temporary disability benefits based solely on its contention that claimant was not in the work force at the time of disability. (Rec. 2-5).[5] With that form, SAIF indicated that claimant had not responded to its letter requesting proof of employment status. (Rec. 5). This recommendation form is a Board own motion form (Form 440-2806), the third page of which provides information regarding the requirement that a claimant prove he or she was in the work force when that issue is challenged by the carrier. This information includes explanations of each of the three *Dawkins'* criteria, along with suggestions regarding the types of evidence that might meet the burden of proof under each criteria. (Rec. 4). Among the suggestions regarding the willingness to work factor in the third *Dawkins* criteria is listed an "affidavit," along with any supporting evidence. (*Id.*). In addition, by letter dated November 14, 1997, Board staff: (1) notified claimant's attorney that SAIF contended that claimant was not in the work force; and (2) requested that work force evidence be submitted within 14 days. (Rec. 14).

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[4] Although claimant also submitted a copy of an October 13, 1997 chart note, that evidence was already in the record.

[5] References to "Rec." are to pages in the Record for Judicial Review prepared by the Board and transmitted to the Court of Appeals for purposes of the earlier appeal.

Despite these multiple requests for work force information, claimant submitted none. As a result, on December 1, 1997, we issued an order denying own motion relief based on claimant's failure to prove she was in the work force at the time of disability. (Rec. 14-16).

Thereafter, we issued two separate orders on reconsideration dealing with the work force issue before this matter was appealed to the court. (Rec. 46-49; 56-61). With each request for reconsideration, claimant submitted additional evidence regarding her *physical inability* to work, but she did not submit any evidence regarding her *willingness* to work.

In our December 16, 1997 order on reconsideration, we considered the additional medical records submitted by claimant and found that claimant was unable to work due to her compensable injury as of June 30, 1997. *See* 49 Van Natta at 2111. We also found, however, that claimant failed to submit any persuasive evidence regarding whether she was willing to work. Therefore, we concluded that she had not proved that she was in the work force. *Id.* at 2112.

Claimant again requested reconsideration and submitted additional evidence regarding her inability to work due to her work injury. Relying on this evidence, we determined that claimant had met her burden of proving she was in the work force at the time of disability. It was this evidence, however, that the court found did not support our determination, noting that it addressed only claimant's physical ability to work, not her *willingness* to work. Thus, the court concluded that our determination of willingness to work was not supported by the evidence on which we relied.

We find that claimant has had ample opportunity to establish her willingness to work and decline to grant her yet another opportunity to "cure" the record regarding the work force issue. In this regard, we find *Donald P. Bond*, 40 Van Natta 361, *on recon* 40 Van Natta 480 (1988), instructive. In *Bond*, a third party recovery distribution case, we declined to consider the claimant's affidavit first submitted on reconsideration, finding that it was obtainable with due diligence prior to the issuance of our distribution order. In addition, we concluded that "[t]o hold otherwise, would potentially expose the Board to an endless string of reconsideration requests and submissions of additional evidence, all designed to respond to conclusions reached by a previous third party order." 40 Van Natta at 481. The same reasoning applies to the present own motion case. Therefore, we decline to consider claimant's affidavit.[6]

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[6] In any event, even if we considered claimant's affidavit, we would find that it does not meet claimant's burden of proof under the circumstances of this case. On remand, claimant's attorney first contends that claimant is provided with room and board in exchange for work. While work in exchange for room and board, with or without pay, qualifies as "wages" under ORS 656.005(29) and, thus, can establish that a claimant is a member of the work force, there is no evidence supporting claimant's attorney's contention. *See George L. Peachy*, 48 Van Natta 2115 (1996); *Orvel L. Chaney*, 48 Van Natta 612 (1996). Unsupported representations by claimant's counsel do not meet her burden of proof. *Blakely*, 160 Or App at 246 n.3. Furthermore, claimant's affidavit does not state that she exchanged work for room and board. Instead, claimant states that she "keep[s] [herself] busy tending to [her great aunt's] farm when her son Mel is not around, and do[es] house chores since [her great aunt] is blind and unable to do the work herself." Affidavit of Bobbie Blakely, page 2.

In addition, claimant's statements that she was willing to work and performed various activities, including child care, tutoring, and tax preparation for family and friends are all unsupported. Nor is there any indication that these activities were performed during the relevant period, that is, prior to the November 1997 surgery. Furthermore, SAIF contests claimant's statements on those bases. *See James M. Evans*, 51 Van Natta 1046 (1999) (in absence of corroborating evidence, the claimant's contested assertions were not sufficient to establish he was in the work force at the time of disability); *compare Michael D. Demagalski*, 51 Van Natta 1043 (1999) (the claimant's uncontested assertions were sufficient to establish he was in the work force at the time of disability). Therefore, even if we considered claimant's affidavit, we would find it insufficient to meet her burden of proof.

The dissent criticizes our analysis of claimant's affidavit, contending that we are focusing on factors relating to the *first* and *second Dawkins* criteria, rather than the *third Dawkins* criteria, which is the criteria claimant must prove under the facts of this case. We disagree with this criticism. We specifically examined claimant's statements in her affidavit in relation to her contention that she was *willing* to work at the time of disability. In other words, if claimant had persuasively proved those statements, she would have established the willingness to work factor. Because those statements were contested and claimant offered no evidence supporting them, we conclude that she has failed to prove the willingness to work factor.

None of the prior evidence submitted by claimant addressed the willingness to work factor; instead, it all focused on claimant's physical ability to work. Therefore, consistent with the court's holding, we find that the record does not establish that claimant was willing to work at the time of her November 1997 surgery. In light of such circumstances, we cannot authorize reopening the claim for payment of temporary disability compensation because we are unable to find that claimant was "in the work force" at the time of that surgery. *Dawkins v. Pacific Motor Trucking*, 308 Or at 258.

Accordingly, on reconsideration of our December 1, 1997, December 16, 1997, and February 26, 1998 orders, we deny claimant's request for own motion relief.

IT IS SO ORDERED.

Board Member Biehl dissenting.

The majority finds that, in order to prove the work force issue under the third *Dawkins* criteria, claimant must prove both that: (1) the compensable injury made work search efforts futile during the relevant period (the time of the November 1997 surgery); and (2) she was willing to work. The majority also finds that claimant proved the first element. Therefore, the majority finds, the sole issue on remand is whether claimant has established her *willingness* to work at the time of the November 1997 surgery. I agree with all of these findings. But, the majority also declines to consider the affidavit that claimant submits on remand and finds that, even if they considered it, it would not meet claimant's burden of proof. Because I disagree with these latter findings, I respectfully dissent.

I would admit claimant's affidavit on remand. Furthermore, based on that affidavit, I would find that claimant proved the willingness to work factor and, thus, proved that she was in the work force at the time of the November 1997 surgery.

While the Board's decision in our own motion jurisdiction pursuant to ORS 656.278[1] to award temporary disability benefits is not completely discretionary, *i.e.*, a claimant must statutorily qualify for those benefits before we can award them, we nevertheless have great discretion under our own motion jurisdiction to process claims in an equitable manner. *Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990). This discretion extends to our authority to consider new evidence. In this regard, there is no limitation to the submission of evidence to the Board in its own motion jurisdiction. *See* ORS 656.278; OAR 438-012-0001 through 438-012-0065.[2] In contrast, the Board's review in its "regular" jurisdiction, *i.e.*, its review of orders issued by Administrative Law Judges, is limited to the record developed at hearing. ORS 656.295(5).

Furthermore, here, SAIF would not be prejudiced if we considered the new evidence claimant submits on remand. After all, we also provided SAIF with the opportunity to submit additional evidence, and it chose not to do so. Therefore, for all of these reasons, I would consider claimant's affidavit on remand.

In addition, I would find claimant's affidavit sufficient to meet her burden of proving her willingness to work. In their discussion of the persuasiveness of claimant's affidavit, the majority loses sight of the fact that the court specifically instructed us "to reconsider the 'willingness to work' issue." *Blakely*, 160 Or App at 247. Thus, willingness to work is the only issue before us on remand.

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[1] With certain exceptions not applicable here, ORS 656.278(1) provides that "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 justifies[.]"

[2] I note that *former* OAR 438-12-065(3) provided that, if a motion for reconsideration included new evidence, that evidence would only be considered if the Board found that: (1) without this evidence, the record was improperly, incompletely or otherwise insufficiently developed; and (2) the additional evidence was unobtainable with due diligence by the moving party prior to its submission. But, in 1995, the Board deleted these provisions, finding that it was in the "interests of substantial justice to all parties to adopt rules which provide the Board with the discretion to reconsider its decision in appropriate cases." *See* WCB Admin. Order 1-1994, eff. January 1, 1995, Order of Adoption, page 11. Thus, it is within the Board's discretion to consider new evidence on reconsideration and, under the same reasoning, on remand. In fact, as evidenced by the history of the present case, the Board routinely considers new evidence submitted by the parties on reconsideration.

Furthermore, the majority finds, and I agree, that the record proves that, due to the compensable condition, it would be futile for claimant to attempt a job search. Thus, the *third Dawkins* criteria applies to the present case. Moreover, because claimant has established the futility element of the third *Dawkins* criteria, she need only establish that she was willing to work to prove that she remained in the work force at the time of disability.

Although stating that the third *Dawkins* criteria applies, the majority focuses on the alleged inadequacy of claimant's statements regarding working in exchange for room and board, preparing tax returns for family and friends, etc. But that discussion relates to whether claimant established the *first* and *second Dawkins* criteria, *i.e.*, whether claimant was in the work force by virtue of being employed or looking for work. Such issues are not relevant to the *third Dawkins* criteria. After all, here, there is no dispute that any work search would be futile due to the compensable injury. Thus, contrary to the majority's reasoning, the fact that claimant's affidavit does not establish she was employed or looking for work at the relevant time is not fatal to her claim.

Because it relates to claimant's state of mind, willingness to work is necessarily a subjective thing. And claimant is in the best position to reveal her state of mind. In her affidavit, claimant swore that she was and is willing to work but for her compensable injury. Based on this sworn statement, I would find that claimant was willing to work at the time of the November 1997 surgery. Therefore, I would find claimant in the work force and entitled to own motion relief.

October 15, 1999 Cite as 51 Van Natta 1766 (1999)

In the Matter of the Compensation of
DONALD A. KAMBEITZ, Claimant
Own Motion No. 99-0286M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Swanson, Thomas & Coon, Claimant Attorneys
Employers Ins. of Wausau, Insurance Carrier

On July 26, 1999, claimant submitted a request for temporary disability compensation for his compensable low back condition. Claimant also sought penalties and attorney's fees for the insurer's failure to "submit a timely recommendation." Claimant's aggravation rights expired on March 15, 1990. The insurer denied the compensability of claimant's current condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 99-07407).[1]

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that the assigned Administrative Law Judge (ALJ) in WCB Case No. 99-07407 submit a copy of the eventual order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise us of their respective positions regarding claimant's request for own motion relief.

IT IS SO ORDERED.

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[1] The insurer is required to make a written recommendation to the Board within 90 days of receiving claimant's own motion request. OAR 438-012-0030. That recommendation must include the information specified in OAR 438-012-0030. To date, the insurer has not submitted a written recommendation under OAR 438-012-0030(1). The insurer is reminded, pending the resolution of the current litigation, that it must also file a fully *completed* own motion recommendation form.

In the Matter of the Compensation of
DARREL L. ALLEN, Claimant
WCB Case No. 98-06815
ORDER ON REVIEW
Adams, Day, Kangas, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Kekauoha's order that increased claimant's permanent disability award from 11 percent (35.2 degrees), as awarded by an Order on Reconsideration, to 16 percent (51.2 degrees) unscheduled permanent disability for his low back condition. On review, the issue is extent of unscheduled permanent disability.

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

On review, the employer contends that the ALJ erred in finding no evidence that claimant returned to his regular job-at-injury or that his treating doctor released him to his regular job. The employer argues that, because it is claimant's burden of proof, if the record is inconclusive on the issue, claimant should not prevail.

We agree that, claimant, as the party bearing the burden of proof, must present a preponderance of evidence to support a higher level of impairment. ORS 656.266; *Daniel L. Carter*, 50 Van Natta 1145 (1998). We find that, in this case, claimant has met his burden of proof regarding the non-impairment factors. Specifically, the record shows that claimant was working as an off-bearer at the time of injury. The last report from claimant's treating doctor did not change claimant's status or release him to regular work without limitations. (Ex. 3-145). Moreover, although the employer contends that the arbiter's exam is sufficient evidence that claimant is capable of returning to work, the arbiters noted that claimant had curtailed most of the physical activities that he had performed prior to the injury and he was "currently working at a detox center, at sedentary type of work, requiring a lot of sitting."

Under the circumstances, we conclude that claimant has not been released to, nor has he returned to, regular work following the injury. *Cf. James I. Dorman*, 50 Van Natta 1649 (1998) (The worker returned to regular work where he was performing the same truck driver job that he performed at the time of injury, with the same duties, responsibilities, knowledge, skills and abilities). Accordingly, the ALJ properly awarded claimant a value for non-impairment factors.

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we conclude that $350 is a reasonable fee for claimant's counsel's services on review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 4, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $350, to be paid by the self-insured employer.

In the Matter of the Compensation of
ELIZABETH M. BUITRON, Claimant
WCB Case No. 99-00769
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

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

The ALJ upheld SAIF's denial of claimant's right carpal tunnel syndrome. In so doing, the ALJ found the medical opinion of an examining physician, Dr. Farris, more persuasive than that of Dr. Wenner, a surgeon who performed a right carpal tunnel release and who, unlike Dr. Farris, supported compensability of the claim. On review, claimant contends that Dr. Wenner's opinion is sufficient to satisfy her burden of proof. For the following reasons, we disagree.

On March 17, 1999, Dr. Wenner agreed with the contents of a concurrence letter prepared by claimant's attorney. The letter contained the conclusion that claimant's work activities as a pharmacy technician were the major contributing cause of her right carpal tunnel syndrome. The report, however, does not contain an explanation of why those activities were causative, although it does specifically rule out as causal factors various other possible explanations for claimant's condition, including lupus, fibromyalgia, weight, diabetes, use of Prednisone, age and gender. (Ex. 22-1).

It is, therefore, apparent that, while Dr. Wenner weighed other potentially causal factors in reaching his conclusion that work activities were the major contributing cause of the carpal tunnel condition, he did not explain why the work exposure contributed more to the carpal tunnel condition. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (medical opinion must evaluate the relative contribution of different causes and explain why the work exposure or injury contributes more to the claimed condition than all other causes or exposures combined). Dr. Wenner's subsequent report makes clear that he relied on a temporal relationship in determining work activities were the major contributing cause of claimant's condition. Dr. Wenner agreed with the following summary of a conference with claimant's attorney:

> "You [Dr. Wenner] believe it is much more probable [claimant's] work activities for [the employer] as a pharmaceutical technician were the major contributing cause of her right carpal tunnel syndrome even after consideration of the various connective tissues disorders. You believe the fact her connective tissue disorders existed for many years prior to her employment *yet [claimant's] carpal tunnel syndrome did not arise until after working for [the employer] provides a strong indication to you the work activities were the major contributing cause of her current carpal tunnel syndrome and need for surgery.*" (Ex. 24, emphasis added).

Under these circumstances, where Dr. Wenner does not explain how claimant's work activities caused claimant's carpal tunnel condition, except to state that the condition arose after claimant began her employment, we agree with the ALJ that Dr. Wenner's opinion is not sufficient to satisfy her burden of proof. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone).[1] Thus, we affirm.

ORDER

The ALJ's order dated May 28, 1999 is affirmed.

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[1] We note that the evidence from Dr. Wenner is not based on a pattern of diminishment and enhancement of the carpal tunnel condition that correlates to the existence of or lack of exposure to the work place. *See Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996) (causation evidence that goes beyond a mere chronological connection is legally sufficient to carry claimant's burden).

In the Matter of the Compensation of
SEAN J. CLARIDGE, Claimant
WCB Case No. 98-08906
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that awarded an assessed attorney fee for the employer's allegedly unreasonable denial. 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

On reconsideration of her original Opinion and Order, the ALJ found that the employer's denial provided five reasons for its denial of the claim. The ALJ further found that only one of the reasons (an alleged lack of objective findings) was a "legally acceptable" basis for its denial. The ALJ reasoned that, because four of the five reasons for the employer's denials were not appropriate, the denial itself was unreasonable. Consequently, the ALJ awarded an assessed attorney fee pursuant to ORS 656.382(1).

On review, the employer contends that the denial is based solely on a lack of objective findings. The employer argues that a lack of objective findings constituted a legitimate reason for its denial.

The employer's denial reads as follows.

"Dear [claimant]:

"We have now completed our review of the medical records related to your claim of injury to your neck and back on August 26, 1998. Your initial examination by Kurt R. Duffens, M.D. at St. Vincent Medical Center found no objective medical evidence in support of your subjective complaints of cervical thoracic and lumbar strain. On September 2, 1998, you were examined by your attending physician Jeffrey Pierson, M.D., who reported finding no evidence of any serious problem and released you for modified duty work as of September 3, 1998. You failed to return to modified duty work as released. On September 10, 1998, you signed a form at your place of employment stating that modified work was available and specifying the exact duties, time, place and wage of the available work. Again you failed to return to work and on that same day you sought a new attending physician, Stephen J. Thomas, M.D., and told him that no light duty work was available. You were obviously not truthful with Dr. Thomas. As soon as we notified Dr. Thomas of the availability of modified work, he too promptly released you for such duty. Finally you were examined on October 23, 1998, by Stephen Fuller, M.D., who also found no objective findings of pathology and reported that you should be able to resume regular work activity. (Emphasis in the original).

"Our processing of this claim has been unreasonably prolonged by your failure to cooperate with our efforts to return you to work, and by your being untruthful with your second attending physician. During this entire period of time (8/26/98 through 10/22/98), we have been paying you interim time loss benefits. We also agreed to pay your medical bills during this initial phase our your claim while your physicians attempted to diagnose the condition and recommend a treatment plan. That phase of the claim has been completed and we must now inform you that we will be unable to accept your claim. *This is a full denial of your claim based on medical reports which indicates (sic) no objective evidence of any injury to your neck/back caused in any major way by your work activity.* (Emphasis supplied).

"As stated above, we will pay your medical bills as agreed through today's date, but will pay no further benefits related to this claim." (Ex. 24-1).

For purposes of our decision, we assume (without deciding) that a denial based on multiple reasons could be considered unreasonable if one or more bases was not premised on a legitimate doubt regarding the carrier's liability for the claim.

After reviewing the employer's denial in its entirety, we agree that the sole basis for the denial is a lack of objective findings. The letter first explains that a review of the medical records showed no objective medical evidence noted in claimant's initial exam and no evidence of a serious problem found by claimant's attending physician. The letter also explains that Dr. Fuller's examination found no objective findings. Moreover, the letter finally states that the employer was unable to accept the claim and its denial was "based on medical reports which indicates no objective evidence of any injury to your neck/back caused in any major way by your work acitivity." (Ex. 24).

We note that, in reaching her conclusion, the ALJ focused on the sections of the denial letter that discussed claimant's untruthfulness with his attending physician and his failure to cooperate with the employer's efforts to provide modified work.[1] However, after reviewing the denial letter in its entirety, we do not construe those statements as support or reasons for the employer's denial. Rather, we find that those statements refer to the employer's explanation for its inability to promptly process the claim.

Under the circumstances, we conclude that the sole basis for the employer's denial was a lack of objective findings to support the claim. The employer's denial in this regard is supported in the medical record by the report of Dr. Fuller who diagnosed subjective non-verifiable pain in the cervical and lumbar spines, in the presence of positive non-organic testing and multiple contradictions. Dr. Fuller specifically reported that claimant "has no objective findings to support any of his complaints." (Ex. 23-6). Accordingly, based on Dr. Fuller's report which the employer obtained prior to its denial, we conclude that the employer had a legitimate doubt with regard to its liability for the claim. *See Brown v. Argonaut Ins. Co.*, 93 Or app 588, 591 (1988).

Consequently, because we find that the employer had a legitimate doubt at the time it issued its denial, we reverse the ALJ's attorney fee award pursuant to ORS 656.382(1).

ORDER

The ALJ's order dated April 24, 1999, as reconsidered June 15, 1999, is reversed in part and affirmed in part. That portion of the ALJ's order that awarded an assessed attorney fee of $500 for an allegedly unreasonable denial is reversed. The remainder of the ALJ's order is affirmed.

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[1] The ALJ apparently found that the five emphasized (underlined) statements in the letter of denial each constituted a separate reason for the denial. However, after considering the statements in context, we do not assign any weight to the fact that certain portions of the letter are emphasized.

In the Matter of the Compensation of
LEOPOLDO CAMPOS, Claimant
WCB Case No. 97-05391
ORDER ON REVIEW
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) denied claimant's motion to postpone his hearing for a sixth time; and (2) dismissed claimant's request for hearing. On review, the issues are the propriety of the ALJ's postponement ruling and dismissal order.

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

On review, claimant argues that he did not know that he had a scheduled hearing on May 4, 1999. Yet, in response to the ALJ's Order to Show Cause, claimant did not raise this argument. Claimant provides no explanation why he waited until he requested review to raise the issue. Therefore, we are not inclined to consider this argument.

In any event, claimant's April 30, 1999 letter requesting a sixth postponement referred to the upcoming scheduled hearing. (Ex. 21). In addition, there is no contention that claimant did not receive the Board's Notice of Hearing that scheduled the May 4, 1999 hearing. In light of such circumstances, we concur with the ALJ's ruling that claimant did not establish "extraordinary circumstances" to justify a sixth postponement of the hearing or that the ALJ's dismissal for failure to appear at the hearing was improper. *See* ORS 656.283(4); OAR 438-006-0071.

ORDER

The ALJ's order dated June 8, 1999 is affirmed.

October 19, 1999 Cite as 51 Van Natta 1771 (1999)

In the Matter of the Compensation of
JASON W. COUTTS, Claimant
WCB Case No. 98-07569
ORDER ON REVIEW
Juli Point, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

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

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

Relying on claimant's testimony and the medical opinion of Dr. Bert, the ALJ found that claimant suffered a compensable low back injury on April 15, 1998, which was the cause of his low back sprain/strain and L5-S1 disc condition.

Despite the ALJ's finding that claimant was credible based on demeanor, the insurer argues on review that inconsistencies in claimant's account of his injury, specifically his failure to report the April 15, 1998 injury to Dr. Absalon, fatally undermine claimant's credibility.

It is well settled that, unless the substance of the witnesses' testimony and other inconsistencies in the record raise such doubt that we are unable to conclude that the material testimony is credible, we will generally defer to the ALJ's finding that the witness is credible. *See, e.g., Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987); *Gail A. Albro*, 48 Van Natta 41 (1996); *David A. Peper*, 46 Van Natta 1656 (1994). In this case, we find no persuasive reason to overturn the ALJ's demeanor-based credibility determination.

Claimant consistently maintained that his low back and right leg pain had its onset after lifting a heavy garbage can filled with animal food and litter over the side of a four-foot high dumpster on Wednesday morning, April 15, 1998, and that, despite rest and self-treatment, it gradually worsened to the point that he sought medical treatment. The medical record confirms that he was seen by Dr. Absalon on May 13, 1998 for low back and right radicular symptoms. Although claimant did not report the work accident to Absalon, he nevertheless had promptly reported the low back injury to the volunteer supervisor, Thomas Hamilton, the same day it occurred, and to Animal Control Director Charles Hartwell within a week. Both of these witnesses observed that claimant was in pain after the accident, and both provided claimant with somewhat conflicting instructions for formally reporting the incident. The fact that claimant did not report the work accident to Absalon but formally filed a workers' compensation claim two days later does not mean that the April 15, 1998 accident did not occur or that it was not the mechanism of claimant's injury.

Claimant has the burden to prove the compensability of his low back condition by a preponderance of the evidence. ORS 656.266. Like the ALJ, we accept claimant's history of the April 15, 1998 injury. We also find Dr. Bert's medical opinion, based on the history of that injury, to be the most complete and persuasive. *Somers v. SAIF*, 77 Or App 259 (1986). As discussed by the ALJ, Bert was advised of claimant's post-injury off-the-job deck incident and was asked about its contribution to claimant's condition. Bert reasoned that claimant's reported symptoms after the April 15, 1998 incident were consistent with an L5-S1 disc herniation, and that the subsequent deck incident aggravated the pain and possibly worsened the protrusion somewhat. Therefore, we agree with the ALJ that claimant's low back injury claim is compensable.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,350, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (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 June 23, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,350, to be paid by Liberty Northwest Insurance Company.

In the Matter of the Compensation of
HELEN M. FREY, Claimant
WCB Case No. 99-00396
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's aggravation claim. On review, the issue is aggravation.

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

The first two sentences of the second paragraph of the "Opinion" section are replaced as follows.

Based on the opinion of Dr. Bert, treating surgeon, we find that claimant's compensable condition actually worsened after the 1998 Determination Order. (*See* Exs. 60, 61, 62, 64, 68). Dr. Bert's opinion that claimant's condition worsened is supported by findings of lost range of motion and positive test results, and these findings were consistent with claimant's new and increased and symptoms.

We also note that claimant was released to modified work as of the previous claim closure. Dr. Bert's October 1998 time loss authorization persuades us that claimant suffered aggravation-related diminished earning capacity. (*See* Ex. 62).

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

ORDER

The ALJ's order dated May 13, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
ROBERT M. HARDEN, Claimant
WCB Case Nos. 98-09576 & 98-07536
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's right shoulder injury claim; and (2) assessed a 25 percent penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of his statement that Dr. Zelaya's July 23, 1998 chart note is not in the record. (*See* Ex. 69-1).

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Penalties

Claimant claimed that he injured his right shoulder on July 1, 1998. In an August 5, 1998 interview with the employer's claim representative, claimant stated that he had not yet received medical treatment.[1] (Ex. 76-20). On September 9, 1998, the employer denied the right shoulder claim on the ground that claimant had not sought medical treatment. *See* ORS 656.005(7)(a) (requiring medical services, disability or death in order for an injury to be "compensable"). Claimant, however, received treatment on September 22, 1998. (Ex. 86). The employer later amended its denial to include a responsibility defense on December 2, 1998. At hearing, the parties stipulated that the original denial would be further amended to assert that claimant's injury did not arise out of and in the course of employment. (Tr. 6).

Claimant asserted that the employer's denials were unreasonable. The ALJ found that the original September 9, 1998 denial based on a lack of medical treatment was unreasonably issued. The ALJ reasoned that, had the employer waited until the end of the 90-day period in which to accept or deny the claim, it could have called claimant and determined that he had, in fact, sought medical treatment on September 22, 1998.

On review, the employer contends that its September 9, 1998 denial was reasonable in light of claimant's statement and that it was not obligated to wait until the expiration of the 90 day period in order to issue a denial based on lack of medical treatment. 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). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of its denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

Here, the employer conducted an investigation of the claim and obtained a statement from claimant 36 days after the claimed injury. Through that statement, it determined that claimant had not sought medical treatment. On September 9, 1998, over two months after the date of injury, it issued a denial based on lack of medical treatment. At that time, claimant had still not received medical treatment. Therefore, based on the information available at the time of its September 9, 1998 denial, we find that the employer had a legitimate doubt regarding its liability for the claim. Thus, we conclude that the denial was not unreasonably issued. Accordingly, we reverse the ALJ's penalty assessment.

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[1] Claimant continued to work.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services 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 30, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
MARCIE L. HAMLINGTON, Claimant
WCB Case No. 98-09673
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Wallace, Klor, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

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

The last sentence on page one is replaced with: "The employer released all of its temporary workers except for claimant by October 14, 1998."

In addition, we find that claimant had no hand or wrist symptoms or treatment for her hands or wrists before working for the insured. She did not engage in hand intensive off-work activities and her CTS symptoms improved when she was off-work.

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

In the Matter of the Compensation of
CAROLEE J. INGRAM, Claimant
WCB Case No. 97-09737
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The deceased claimant[1] requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a left trigger thumb condition; and (2) upheld the employer's denial of claimant's occupational disease claim for a mental disorder. On review, the issues are compensability of the conditions. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings," except for the last paragraph, with the following supplementation.

Claimant worked as an administrative specialist for the employer beginning in July 1996. Claimant's primary work for the employer involved maintaining the documents for the employer's capital construction projects, including daily filing. After claimant's July 7, 1997 performance review, she was assigned additional filing work and by September she spent several hours a day filing and sorting through files each work day. (*See* Tr. 163-178; 195). To perform this work, claimant repeatedly flexed and extended her left thumb and often used it in an ergonomically awkward manner. Claimant's filing work was also repetitive and strenuous for her left thumb because she often supported stacks of paper with her left thumb in a firmly flexed and awkward position.

CONCLUSIONS OF LAW AND OPINION

Mental Disorder

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

Left Trigger Thumb

The ALJ upheld the employer's denial of claimant's claim for a left thumb condition. Based on Dr. Radecki's opinion and "the medical literature," the ALJ concluded that idiopathic causes, rather than work activities, were the major cause of claimant's condition. We disagree.

The medical evidence regarding the cause of claimant's left thumb condition is provided by Dr. Busby, treating surgeon, Dr. O'Neill, general practitioner, and Dr. Radecki, examining physician.

Dr. Busby considered and ruled out potential predisposing factors because he found no indication that claimant had any such conditions. He also considered and ruled out off-work activities, noting that claimant's off-work crocheting involved a natural pinching motion, unlike her ergonomically awkward filing activities at work. Based particularly on the nature of claimant's filing work, the "offending activity"--as claimant demonstrated it to him, Dr. Busby concluded that claimant's filing work was the major contributing cause of her left trigger thumb condition.[2]

The employer contends that Dr. Busby's causation opinion is unpersuasive because he had an inaccurate history regarding the extent and longevity of claimant's filing. However, Dr. Busby's opinion relied more on the nature of claimant's work than its duration. He admitted that he did not know exactly how many hours claimant spent handling files, but that did not affect his reasoning or conclusion. And claimant did significant document handling for the employer throughout her employment. Moreover, as Dr. Busby explained, claimant used her left thumb in an ergonomically

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[1] Claimant died after the hearing in this matter. Her surviving spouse continues to pursue the claim, as permitted under ORS 656.218(3). *See* ORS 656.204; 656.218(5); *see also SAIF v. Balcom*, 162 Or App 325 (1999); *Timothy W. Stone*, 50 Van Natta 2421 (1998).

[2] Dr. O'Neill reached a similar conclusion. (Ex. 46)

awkward and repetitive manner at work "several hours per day." (Ex. 54A-2). Considering Dr. Busby's opinion as a whole,[3] his observation of claimant's demonstrated thumb use, and the persuasive evidence that claimant's regular work activities did involve handling and sorting papers and files, we conclude that Dr. Busby's history was materially accurate and we find his reasoning and conclusions persuasive. (*See* Exs. 50-10, -54; Tr. 163-178).

Dr. Radecki opined that claimant's trigger thumb was due to idiopathic causes, not work activities.[4] (Exs. 34, 53). We find Dr. Radecki's opinion unpersuasive for several reasons. First, he stated that there was "no repetitive flexion or extension of the thumb" during claimant's filing work, but also inconsistently acknowledged that claimant's thumb *was* flexed, at about 70 degrees, while holding files. (Ex. 34-2). Second, we have found that claimant did handle numerous files regularly at this job from the beginning and she *did* perform repetitive left thumb flexion and extension performing this work. Therefore, Dr. Radecki's statement to the contrary amounts to an inaccurate history. Third, Dr. Radecki related claimant's thumb condition to idiopathic causes (plural), but he acknowledged that no preexisting factors or other pathology contributed, except "aging to middle age." (Exs. 34-5-6). Under these circumstances, we cannot say that Dr. Radecki's opinion is well reasoned or based on an accurate history and we decline to rely on it.

Accordingly, based on Dr. Busby's persuasive opinion, we conclude that claimant has carried her burden of proving that repetitive traumatic work activities were the major contributing cause of her left thumb trigger condition. *See* ORS 656.802.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the left trigger thumb condition. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 30, 1999 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's denial of claimant's claim for a left thumb condition is reversed. The denial is set aside and the claim is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the left thumb claim, claimant is awarded a $3,000 attorney fee, payable by the employer.

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[3] We also note that Dr. Busby's opinion was also based on his surgical experience, his examination of claimant, and his review of her history, as well as an overview of medical literature discussing trigger thumbs. (*See* Ex. 54A-2).

[4] But Dr. Radecki also recorded claimant's history that she had used her thumb in the same manner "for years."

In the Matter of the Compensation of
DENNIS D. HALL, Claimant
WCB Case Nos. 98-04154, 98-03816 & 97-10410
ORDER OF ABATEMENT
Michael A. Bliven, Claimant Attorney
Scheminske, et al, Defense Attorneys

The SAIF Corporation, on behalf of Mt. Hood Metals, Inc. (SAIF/Mt. Hood), requests abatement and reconsideration of our September 24, 1999 order that found claimant's claim for a right knee chondromalacia condition compensable and assigned responsibility for that condition to SAIF/Mt. Hood. Specifically, SAIF/Mt. Hood reiterates its argument that the chondromalacia condition did not result in disability or a need for treatment and also argues that the claim should be analyzed either as an occupational disease claim or under ORS 656.005(7)(a)(B).

In order to allow sufficient time to consider SAIF/Mt. Hood's motion, we withdraw our September 24, 1999 order. Claimant and the Department of Justice, on behalf of the statutory processing agent for the noncomplying employer, are both granted an opportunity to respond to the motion. To be considered, the responses should be filed within 14 days of the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

October 19, 1999 Cite as 51 Van Natta 1777 (1999)

In the Matter of the Compensation of
MICHAEL V. LIM, Claimant
WCB Case No. 99-01672
ORDER ON REVIEW
Lauren Paulson, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of his claim for a syncope/dizziness/fainting condition. In its brief, the employer requests sanctions under ORS 656.390(1) for an allegedly frivolous appeal. On review, the issues are compensability and sanctions.

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

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

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

ORDER

The ALJ's order dated May 4, 1999 is affirmed.

In the Matter of the Compensation of
DENISE K. PIPER, Claimant
WCB Case No. 98-09827
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sherdian, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's right knee injury claim. Claimant cross-requests review of that portion of the order that declined to assess penalties for allegedly unreasonable claims processing. In addition, with her brief, claimant submits copies of the insurer's interim compensation payment records. We treat such a submission as a motion to remand. On review, the issues are remand, compensability and penalties.

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

Claimant was 36 years old at the time of the hearing. While she was in high school, she had bilateral Hauser procedures performed by Dr. Grossenbacher, treating surgeon, for a hereditary condition involving her knees. (Ex. 10-4, Tr. 16). Following that surgery, she did not have any problems with her right knee. (*Id.*).

At hearing, claimant contended that the insurer should be assessed penalties and related attorney fees for: (1) its alleged failure to pay interim compensation in a timely manner; (2) its alleged failure to provide a copy of its denial to claimant; and (3) its alleged failure to provide discovery and an exhibit list to claimant. The ALJ explained why he agreed with the insurer that claimant had not carried her burden of proving these allegations. In addition, the ALJ explained that, even assuming these allegations were proven, there was no persuasive proof that any amounts were due at the time of these alleged claims processing violations. The ALJ also found there was no persuasive proof that those alleged violations actually delayed either the payment of compensation or the hearing. Thus, the ALJ declined to assess either a penalty or a penalty-based attorney fee.

On review, claimant submits copies of the insurer's interim compensation payment records. We treat such a submission as a motion to remand. *Judy A. Britton*, 37 Van Natta 1262 (1985). The Board's review is limited to the record developed by the ALJ. We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986).

After examining claimant's submissions for purposes of determining whether remand to the ALJ is appropriate, we find that no compelling basis to remand this matter. In this regard, the attached payment records indicate that the interim compensation payments were made timely.

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

ORDER

The ALJ's order dated April 2, 1999 is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded $1,500, payable by the insurer directly to claimant's attorney.

In the Matter of the Compensation of
MARK D. STAPLETON, Claimant
WCB Case No. 98-09077
ORDER ON REVIEW
Carney, 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) Martha Brown's order that: (1) found that claimant had not perfected an aggravation claim regarding his accepted right elbow condition with the insurer; (2) rejected claimant's argument that the insurer's letter was an impermissible "back-up" denial; and (3) declined to assess a penalty or attorney fees for the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are jurisdiction, "back-up" denial, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with some minor changes and we repeat them for ease of reference.

Claimant compensably injured his right elbow on February 6, 1992 while working as a planer feeder in the employer's mill. (Ex. 1). On February 20, 1992, the claim was accepted as a nondisabling injury. (*Id.*) On September 19, 1994, the insurer announced that it had knowledge that the nondisabling "tenosynovitis right elbow" had become disabling. (Exs. 12, 12A). The insurer also accepted the "now" disabling claim. A January 31, 1995 Determination Order awarded claimant temporary disability and 4 percent scheduled permanent disability for his right arm. (Ex. 16).

On January 8, 1997, claimant signed a Notice of Claim for Aggravation. (Ex. 18). Dr. Greenleaf signed the form but did not authorize time loss. (*Id.*) On March 3, 1997, the insurer requested further information from Dr. Greenleaf regarding whether claimant's condition had worsened. (Ex. 23). Dr. Greenleaf responded on March 26, 1997 that claimant had suffered a pathologic worsening of the tenosynovitis involving his right elbow. (Ex. 24). On April 23, 1997, the insurer accepted claimant's right elbow tenosynovitis as a disabling aggravation claim. (Ex. 25).

Claimant subsequently underwent right elbow arthroscopy and debridement on September 12, 1997. (Ex. 31).

On March 24, 1998, the insurer issued an updated notice of acceptance at closure, noting that the accepted aggravation condition was post traumatic osteoarthritis of the right elbow. (Ex. 36). A March 26, 1998 Notice of Closure awarded temporary disability benefits and 17 percent scheduled permanent disability for claimant's right arm. (Ex. 38).

The insurer wrote to claimant on October 7, 1998 to advise him that his claim had been processed incorrectly as the attending physician had not perfected an aggravation claim before his aggravation rights expired on February 6, 1997. (Ex. 40). Consequently, the insurer advised claimant that the claim should have been classified as an Own Motion claim. (*Id.*).

On October 12, 1998, the insurer wrote to the Board and requested Own Motion relief for claimant. (Ex. 41). The Board issued an Own Motion order on October 15, 1998 indicating that reopening of the claim was appropriate. (Ex. 42).

An October 21, 1998 Own Motion Notice of Closure awarded temporary disability benefits. (Ex. 44).

On claimant's request, the Board abated the October 15, 1998 Own Motion order on November 16, 1998 and postponed action until pending litigation was resolved. (Ex. 47).

The parties stipulated that the insurer's claims department received Exhibits 18, 19 and 21 on February 3, 1997. The parties further stipulated that the insurer received Exhibit 20 on February 5, 1997.

CONCLUSIONS OF LAW AND OPINION

Perfection of Aggravation Claim

We adopt and affirm the ALJ's reasoning and conclusion that Dr. Greenleaf's report did not satisfy the requirements of ORS 656.273(3) and, therefore, claimant did not perfect an aggravation claim before his aggravation rights expired.

"Back-up" Denial

At hearing, claimant argued alternatively that, because the insurer accepted a disabling aggravation claim and benefits were paid pursuant to a Notice of Closure, the insurer was "estopped" from contending that the claim should be in Own Motion status. Claimant also contended that, because the insurer accepted his aggravation claim, its October 7, 1998 letter stating that the claim was processed incorrectly constituted a "back-up" denial of the claim.

Although the ALJ held that claimant had not perfected an aggravation claim before his aggravation rights expired, she declined to dismiss claimant's request for hearing because his alternative arguments involved a "matter concerning a claim" and, therefore, the Hearings Division had jurisdiction.

We first address claimant's argument that, because the insurer accepted his claim and benefits were paid pursuant to a Notice of Closure, the insurer was "estopped" from contending that the claim should be in Own Motion status. For the following reasons, we agree with the ALJ that the insurer's acceptance and payments of benefits was not dispositive.

The ALJ cited *Bill D. Coleman*, 48 Van Natta 2154 (1996), finding that the insurer is not bound by its actions in a case in which a claimant's aggravation rights under ORS 656.273(4) expired before the acceptance of the claim. The ALJ concluded that the insurer's acceptance and payment of benefits in this case was not dispositive.

In *Coleman*, the claimant compensably injured his back on May 19, 1987 and the carrier accepted the claim as a nondisabling injury on May 22, 1987. The claimant continued to experience low back pain and on November 17, 1992, the carrier accepted the May 1987 claim as a disabling left lumbar strain. On January 15, 1993, a Determination Order issued awarding temporary disability benefits and 40 percent unscheduled permanent disability. The claimant's aggravation rights under ORS 656.273(4) expired on May 19, 1992, five years from the date of injury. In August 1994, the claimant's attending physician submitted a form to the carrier indicating that the claimant's condition had aggravated.

We found that because the claimant's aggravation claim was made after the expiration of his aggravation rights, the claimant's request for reopening of the May 1987 injury claim was within the Board's Own Motion jurisdiction. *Id.* at 2157. We concluded that, although a carrier may voluntarily reopen a claim after a claimant's aggravation rights have run, any such reopening does not give the Hearings Division jurisdiction it would not otherwise have. *Id.* at 2158. We reasoned further that the carrier's award of temporary and permanent disability benefits by a Determination Order after the expiration of aggravation rights was not controlling and a voluntary reopening did not serve to extend the claimant's aggravation rights. *Id.*

We reach the same conclusion in this case. Although the insurer accepted claimant's claim as an "aggravation claim" and awarded temporary disability benefits and 17 percent scheduled permanent disability pursuant to its Notice of Closure, the insurer's acceptance of the "aggravation claim" and permanent disability award did not extend claimant's aggravation rights nor otherwise alter the fact that the "aggravation claim" was accepted after the expiration of claimant's aggravation rights under ORS 656.273(4). In other words, any additional compensation regarding the claim falls under the Board's Own Motion authority under ORS 656.278. *Charles L. Chittim*, 51 Van Natta 764, 765 n. 2 (1999); David L. Dylan, 50 Van Natta 276, *on recon* 50 Van Natta 852(1998).

We turn to claimant's argument that the insurer issued a "back-up" denial of his "aggravation claim" and his request for penalties and attorney fees for the insurer's allegedly unreasonable resistance to the payment of compensation. Even if we assume, without deciding, that the insurer's October 7, 1998 letter was a "denial," that denial, whether it was a "back-up" denial or not, is a nullity and without legal effect. *See Charles L. Chittim, Jr.*, 51 Van Natta at 764 (1999); *Ted B. Minton*, 50 Van Natta 2423

(1998). Because the October 7, 1998 letter is a nullity, we need not address claimant's alternative argument that the letter was an impermissible "back-up" denial of his aggravation claim.[1] *See George G. McCoy*, 50 Van Natta 49 (1998) (because we determined that one of the carrier's denials was a nullity, we did not address the claimant's alternative argument that the denial was an impermissible "back-up" denial). Consequently, we affirm the ALJ's order.

ORDER

The ALJ's order dated March 12, 1999 is affirmed.

[1] In any event, we note that the insurer is not disputing compensability of claimant's original accepted condition of right elbow tenosynovitis.

Board Member Biehl dissenting.

The majority concludes that the insurer's acceptance of claimant's aggravation claim and payment of permanent disability did not extend claimant's aggravation rights or otherwise alter the fact that the aggravation claim was accepted after expiration of claimant's aggravation rights under ORS 656.273(4). I do not disagree with the majority's holding as far as it goes. However, the majority does not address the fundamental issue of whether the insurer properly asserted an overpayment based on its faulty claim processing. By not doing so, it in effect has approved an overpayment to which the insurer is not entitled. For this reason, I must dissent.

The majority opinion adequately recounts the facts, so I will not repeat them here. It must be emphasized, however, that the insurer's October 7, 1998 letter asserted an overpayment based on its allegedly erroneous acceptance of an aggravation claim that had not been perfected prior to expiration of claimant's aggravation rights. Although neither the insurer nor claimant expressly argued the overpayment issue at the hearing (and thus it was not addressed by the ALJ), the insurer did assert an overpayment in its response to claimant's hearing request. Because the ALJ did not disapprove the alleged overpayment, the insurer is now free to recoup its overpayment from future benefits. *See* ORS 656.268(15)(a); *Jerald J. Cooper*, 50 Van Natta 146, *on recon* 50 Van Natta 914 (1998). Because I do not believe that this is a proper result, I would address the overpayment issue and find that the insurer is not entitled to it.

In *Bill D. Coleman*, 48 Van Natta 2154 (1996), we found that, because the claimant's aggravation claim was made after the expiration of his aggravation rights, the claimant's request for reopening of the May 1987 injury claim was within the Board's Own Motion jurisdiction. We concluded that, although a carrier may voluntarily reopen a claim after a claimant's aggravation rights have run, any reopening does not give the Hearings Division jurisdiction it would not otherwise have. We reasoned further that the carrier's award of temporary and permanent disability benefits by Determination Order after the expiration of aggravation rights did not serve to extend the claimant's aggravation rights.

While I agree with the majority's interpretation of *Coleman* insofar as it pertains to the extension of aggravation rights, I would, nevertheless, find *Coleman* distinguishable with respect to whether the insurer in this case could assert an overpayment. In *Coleman*, the precise issue was whether the Determination Order extended the claimant's aggravation rights. We did not, however, address the issue of whether the Determination Order itself was invalid.[1] While it is clear in light of *Coleman* that the insurer's Notice of Closure in this case could not extend claimant's aggravation rights, *Coleman* does not answer the fundamental issue posed in this case, *i.e.*, whether the Notice of Closure and its award of benefits were invalid.

[1] We noted in *Coleman* that the carrier's voluntary acceptance of the claimant's aggravation claim did not extend aggravation rights, nor did it validate the Determination Order. *Id.* at 2159. The validity of the Determination Order, however, was not at issue in *Coleman*. Therefore, our comment regarding the validity of the Determination Order was "dicta" and not dispositive of this case in which the validity of the insurer's Notice of Closure is directly at issue.

Instead, I would look to *SAIF v. Roles*, 111 Or App 597, *rev den* 314 Or 391 (1992) for an answer to that question. In *Roles*, a carrier failed to comply with an ALJ's order setting aside prior Determination Orders that had become final as a matter of law. The carrier argued that, because the appeal of the Determination Orders had not been timely, the ALJ lacked jurisdiction to set aside the Determination Orders. The *Roles* court explained that a judgment is void only when the tribunal rendering it has no jurisdiction over the parties or of the subject matter. The court further explained that subject matter jurisdiction exists when a statute authorizes the tribunal to make an inquiry about the dispute. The court noted that the ALJ had statutory authority under ORS 656.708 and ORS 656.704(3) to decide the issue in dispute. Therefore, the court concluded that, even though the ALJ may have erroneously exercised his authority, his erroneous exercise of that authority did not deprive him of subject matter jurisdiction. 111 Or App at 602.

I would find the circumstances of this case to be analogous to those in *Roles*. Here, the insurer erroneously accepted claimant's claim as a disabling aggravation claim after expiration of his aggravation rights and awarded 17 percent scheduled permanent disability pursuant to its Notice of Closure. While the insurer's claim processing was incorrect, the insurer was statutorily authorized to issue a Notice of Closure under ORS 656.268(4)(a).[2] Accordingly, even though, under *Coleman*, the insurer's acceptance of the aggravation claim and subsequent permanent disability award did not extend claimant's aggravation rights, the Notice of Closure itself was valid. *Compare SAIF v. Reddekopp*, 137 Or App 102, 106, *rev den* 322 Or 360 (1995) (holding that, even assuming the Board was wrong as a factual matter when it determined that the claimant's aggravation rights had expired, the Board had subject matter jurisdiction to determine whether the claimant's claim came within its "own motion" jurisdiction; once the own motion order became final, it was not subject to collateral attack). It, therefore, follows that the insurer's payment of benefits pursuant to that closure notice did not constitute an "overpayment."

Accordingly, I would conclude that the insurer was bound by its acceptance of claimant's aggravation claim and payment of permanent disability.[3] Consequently, I would modify the ALJ's order to find that the permanent disability award in the March 26, 1998 Notice of Closure is valid and not subject to an offset against future benefits.

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[2] That statute provides:

"When the worker's condition resulting from an accepted disabling injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment, or when the worker's accepted injury is no longer the major contirbuting cause of the workers's combined or consequential condition or conditions pursuant to ORS 656.005(7), the claim may be closed by the insurer or self-insured employer, without the issuance of a determination order by the Department of Consumer and Business Services."

[3] Today's decision allows a carrier unlimited freedom to "reconsider" an unappealed Notice of Closure or Determination Order, stating that it erroneously reopened a claim after expiration of aggravation rights. Thus, a carrier is allowed to litigate a question (whether a claim was reopened after expiration of aggravation rights) that should be addressed/resolved contemporaneously with the carrier's claim processing decision. When, as here, a carrier unequivocally accepts a claim as an aggravation and closes the claim under ORS 656.268, the question has been addressed and resolved. To find to the contrary undercuts the notion of "finality" in the workers' compensation system and leaves open the possibility of future litigation of claim processing decisions indefinitely. This is inconsistent with the statutory scheme. The insurer in this case was not obligated to close the claim by Notice of Closure. When it did so, it should be held accountable for its claim processing decision.

In the Matter of the Compensation of
MURLAINE CRAWFORD, Claimant
WCB Case No. 98-08000
ORDER ON REVIEW
Bottini, Bottini, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's current low back condition; and (2) found that claimant's surgery was reasonable and necessary. On review, the issues are compensability, jurisdiction, and, potentially, medical services. We affirm in part and vacate in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant has an accepted claim for "low back strain" as a result of a June 1998 work injury. After her treating surgeon, Dr. Brett, recommended surgery for a disc bulge at L5-S1, SAIF issued a denial of claimant's current low back condition. SAIF then issued a Notice of Closure.

The ALJ set aside SAIF's denial after finding that the preponderance of evidence showed that the compensable injury was the major contributing cause of claimant's current low back condition. *See* ORS 656.005(7)(a)(B). SAIF challenges this conclusion, asserting that the medical opinions supporting causation are not persuasive.

Examining physicians Dr. Reimer, neurologist, and Dr. Peterson, orthopedic surgeon, found that claimant's "current findings are more consistent with excessive pain behavior than they would be related to the mechanism of injury[.]" (Ex. 16-6). The panel also determined that the June 1998 work injury "should not have produced anything more than a soft tissue strain," which should have resolved. (*Id.* at 7).

Dr. Brett disagreed with the panel's report, stating that claimant "clearly has pre-existing degenerative change but has sustained pathologic worsening with her work injury of 6-30-98 with diffuse disc protrusion and now bilateral L5 nerve root impingement[.]" (Ex. 22).

Dr. Strukel, surgeon, performed a record review and concluded that claimant's preexisting degenerative change at L4-5 and L5-S1 combined with the compensable injury and that the preexisting condition was the major contributing cause of claimant's need for treatment of the combined condition. (Ex. 26-3). Dr. Strukel relied on a lack of "objective findings" and inconsistent examinations "suggesting" symptom embellishment. (*Id.*)

Dr. Young, examining radiologist, also reviewed the medical records and agreed that the June 1998 injury combined with a preexisting condition, which was the major contributing cause of the combined condition. (Ex. 29-3).

Dr. Gritzka, orthopedic surgeon, then examined claimant. Based on the medical studies, Dr. Gritzka also found preexisting degenerative changes and stated that "her low back condition is multi-factorial." (Ex. 31-11). After considering all the contributing factors, Dr. Gritzka thought that the June 1998 injury "probably was the major contributing cause of the pathological worsening of the L5-S1 disc bulge." (*Id.* at 12-13).

Dr. Brett subsequently reported that he performed surgery and "observed bilateral L5 nerve root impingement from a combination of pre-existing degenerative change and intervertebral disc space collapse[.]" (Ex. 36-1). Dr. Brett also stated that the compensable injury "is the major contributing cause of the worsened L5-S1 disc protrusion and resultant L5 nerve root impingement bilaterally and her need for treatment and surgery." (*Id.*)

Dr. Reimer was deposed and indicated that claimant's symptoms were more consistent with referred pain from degenerative disc disease than a specific nerve injury or nerve pressure from a bulging disc. (Ex. 40-18).

In evaluating medical opinions, we generally defer to the treating physician, absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. Brett's opinion. Dr. Brett treated claimant extensively for her low back injury and performed surgery to treat the disc bulge. Moreover, Dr. Brett based his opinion on an accurate history and explains his conclusion that the June 1998 injury is the major contributing cause of the need for treatment of the combined low back condition. Thus, we agree with the ALJ that claimant carried her burden of proving compensability. *See* ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review regarding 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 to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Jurisdiction/Medical Services

At hearing, claimant raised the issue of whether the back surgery performed by Dr. Brett was reasonable and necessary. Relying on *SAIF v. Pendergast-Long*, 155 Or App 633 (1998), the ALJ first decided that the Hearings Division had jurisdiction to address the issue because claimant had challenged SAIF's denial of compensability. The ALJ further concluded that the record showed that the surgery was reasonable and necessary. On review, SAIF continues to contend that the Hearings Division and SAIF lack jurisdiction to decide the matter.

In *Pendergast-Long*, the carrier accepted a claim for a back injury. Subsequently, following a recommendation for back surgery, the carrier denied benefits "for treatment or disability related to [the claimant's] disc herniation" based on the ground that the current low back condition was not compensably related to the compensable condition.

The court agreed, finding that the Board and Hearings Division had jurisdiction over the claim because "the parties disputed whether the condition for which claimant sought treatment, the disc derangement at L5-S1, was compensable." 155 Or App at 637. The court thus found the case distinguishable from *SAIF v. Shipley*, 326 Or 557 (1998), where "the hearings division lost jurisdiction of the claim when [the] claimant stated at hearing that her claim was for medical services under ORS 656.245." *Id.* at 635.

Here, SAIF is not contesting that the ALJ could determine the compensability of claimant's current low back condition. It asserts, however, that jurisdiction over that issue did not allow the ALJ to also decide whether particular medical services were reasonable and necessary. We agree with SAIF.

If "a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim," jurisdiction is with the Department. ORS 656.245(6). Under this statute, when a claim is for medical services, the Hearings Division and Board do not have jurisdiction and the proper forum for appeal is with the Director. *Shipley*, 325 Or at 564. Conversely, a matter concerning the compensability of an underlying condition can be addressed by the Hearings Division and Board. *Pendergast-Long*, 155 Or App at 637.

Here, SAIF's denial stated that it "hereby issues a current combined condition denial of your disability and need for treatment on or after September 18, 1998[.] * * * It is our position that after this date, your otherwise compensable injuries ceased to remain the major contributing cause of your combined condition and the disability and need for treatment resulting therefrom." As SAIF agrees, the denial was of the underlying condition. Thus, the ALJ properly addressed the compensability of the current low back condition. *See Pendergast-Long*, 155 Or App at 637.[1]

[1] Effective October 23, 1999, *amended* ORS 656.704(3) provides that the Board is authorized to resolve all "causality-based" medical service disputes (other than MCO disputes arising under ORS 656.260), including disputes pertaining to the compensability of an underlying condition and disputes involving whether treatment is related to an accepted claim. 1999 Or Laws, Ch 926, section 2.

In comparison to SAIF's denial of the underlying condition, CareMark Comp, the managed care organization (MCO) overseeing the claim, denied Dr. Brett's request for certification of the back surgery on the basis that it was not "necessary or appropriate[.]" (Ex. 23). Dr. Brett then wrote to the Department asking for administrative review of CareMark Comp's denial of the back surgery. (Ex. 26C). In response, the Department sent SAIF a "Notice of Required Action on a Medical Dispute" informing SAIF of the request for administrative review of the surgery. (Ex. 33A).

The denial by CareMark Comp, and Dr. Brett's request for administrative review of that denial, is further evidence that, although there was a "claim for medical services" involving the back surgery, such claim involved the MCO and was before the Department. Moreover, the "claim for medical services" was denied for a "reason other than the formal denial of the compensability of the underlying claim" because it was based on the reasonableness and necessity of the procedure. Consequently, the Hearings Division and Board do not have jurisdiction to consider CareMark Comp's denial.

Moreover, even assuming that the scope of *SAIF's* denial included the reasonableness and necessity of the surgery, we find nothing in ORS 656.245(6), *Shipley* or *Pendergast-Long* indicating that a medical services dispute may be resolved by the Hearings Division and Board if it accompanies a matter concerning the compensability of an underlying condition. As ORS 656.245(6) provides, the Department has jurisdiction if "a claim for medical services is disapproved *for any reason other than* the formal denial of the compensability of the underlying claim[.]" (Emphasis added.) Because a dispute over the reasonableness and necessity of the back surgery is a "reason other than the formal denial of the compensability of the underlying claim" for disapproving the claim, we conclude that jurisdiction to decide that dispute is with the Department. *See Shipley*, 325 Or at 564; *Warren N. Bowen*, 48 Van Natta 883, *on recon* 48 Van Natta 1443 (1996) (because Board without authority to address propriety of proposed medical treatment, its determination was limited to resolution of compensability/causation issue); *Lynda Zeller*, 47 Van Natta 1581 (1995) (same).

ORDER

The ALJ's order dated April 5, 1999 is affirmed in part and vacated in part. That portion of the order determining the reasonableness and necessity of medical services is vacated for lack of jurisdiction. The remainder of the order is affirmed. For services on review concerning compensability, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
DENNIS E. BURCH, Claimant
WCB Case No. 98-02111
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

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

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

We find Dr. Van Horne's causation opinion persuasive because it is well-reasoned and based on an accurate history. (Exs. 24, 26, 28). We also note that Dr. Van Horne's opinion is consistent with claimant's history of no prior knee injuries, his sudden onset of symptoms on November 25, 1997, MRI findings "consistent with an interosseus bone bruise," (Ex. 10), and the pathologist's post-surgery findings of "hyaline cartilage showing degenerative and traumatic changes[,]" (Ex. 16).

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 $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 22, 1999 is affirmed. For services on review, claimant is awarded a $3,000 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
BETTI A. HALEY, Claimant
WCB Case No. 99-01003
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
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) Menashe's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Claimant's right shoulder has two preexisting conditions: (1) a small spur on the under surface of the acromion; and (2) a condition revealed by a March 1999 MRI and identified as a "[p]ossible SLAP type lesion of the insertion of the long head of the biceps tendon." (Exs. 123, 125, 128-3).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant proved compensability of her right shoulder condition as an occupational disease. On review, SAIF argues that claimant failed to meet her burden of proof because the medical opinions supporting her claim did not consider claimant's preexisting conditions in determining the major contributing cause of her condition. We agree with SAIF.

To establish a compensable occupational disease claim for her right shoulder condition, claimant must prove that employment conditions were the major contributing cause of the disease or, if the claim is based on the worsening of a preexisting disease, the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(a) and (b). "Major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *See Dietz v. Ramuda*, 130 Or App 387 (1994), *McGarrah v. SAIF*, 296 Or 145, 166 (1983). Pursuant to ORS 656.802(2)(e), "[p]reexisting conditions shall be deemed causes in determining the major contributing cause."[1]

Claimant has the burden of proving compensability of her occupational disease claim for a right shoulder condition. ORS 656.266. As noted above, in order to prove a compensable occupational disease claim, claimant must establish several factors. *See* ORS 656.802. Failure to establish any one of those factors results in the failure of claimant's occupational disease claim.

Claimant has worked as a vehicle emission technician for the Oregon Department of Environmental Quality since 1975. This work involves repetitive use of the arms above shoulder level. Over the years, claimant has filed several workers' compensation claims for the back, shoulders, and knees. On October 26, 1998, claimant filed an occupational disease claim for both shoulders and knees.

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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 an injury or occupational disease, or that precedes a claim for aggravation.

SAIF denied the claim. At hearing, claimant only contested the denial of the bilateral shoulder condition claims. The ALJ upheld SAIF's denial of the left shoulder condition claim and set aside its denial of the right shoulder condition claim. Claimant does not contest the ALJ's order. Thus, on review, the only issue is compensability of the right shoulder condition claim.

Given the multiple possible causes of claimant's right shoulder condition, the causation issue presents a complex medical question. Resolution of the issue, therefore, requires expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). Moreover, we do not give greater weight to the opinion of the treating physician, Dr. Browning, M.D., because resolution of the causation issue in this case involves expert analysis rather than expert external observation. *Allie v. SAIF*, 79 Or App 284 (1986). In any event, Dr. Browning has only examined claimant twice. (Exs. 121, 128). Therefore, she does not have any advantage regarding observation of claimant's condition over time.

Three physicians rendered opinions regarding the cause of claimant's right shoulder condition. Dr. Duff, an orthopedist who examined claimant on SAIF's behalf, opined that claimant's work activities were not the major contributing cause of claimant's right shoulder condition. (Exs. 129, 132). He believed that, at most, claimant's work contributed to temporary symptomatology of an essentially idiopathic chronic condition. (Ex. 132-2). Thus, Dr. Duff's opinion does not support compensability. Only the opinions of Dr. Browning and Dr. Gritzka, an orthopedist who performed a record review on claimant's behalf, might support compensability of claimant's claim.

SAIF argues that the medical opinions of Drs. Browning and Gritzka are not persuasive because they did not consider claimant's preexisting right shoulder conditions in determining the major contributing cause of her condition. In support of its argument, SAIF cites *SAIF v. Cessnum*, 161 Or App 367 (1999), a decision issued after the ALJ's order.

In *Cessnum*, the court rejected our conclusion that, in an occupational disease case, a "preexisting condition" must predate the work exposure that eventually leads to the claim. Instead, the court held 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." 161 Or App at 371 (emphasis in original).

Thus, the focus is not on whether claimant had any preexisting conditions affecting her right shoulder before she began working for the employer in 1975. Instead, the focus is on whether she had any such conditions either at the date of disability or the date medical treatment was first sought, whichever occurred first. Here, that date is October 22, 1998, the date that claimant first sought treatment for her current right shoulder condition. (Ex. 116-1). The medical record shows that claimant had two preexisting conditions in her right shoulder at that time: (1) a small spur on the under surface of the acromion; and (2) a condition revealed by a March 1999 MRI and identified as a "[p]ossible SLAP type lesion of the insertion of the long head of the biceps tendon." (Exs. 123, 125, 128-3). Furthermore, by statutory mandate, these preexisting conditions "*shall be deemed causes* in determining the major contributing cause." ORS 656.802(2)(e) (emphasis added).

Moreover, the court has held that, in determining the major contributing cause of a condition, persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined. *Dietz*, 130 Or App at 401. In addition, the fact that a work activity caused or precipitated a claimant's condition does not necessarily mean that work was the major contributing cause of the condition. *See Robinson v. SAIF*, 147 Or App 157 (1997); *Dietz*, 130 Or App at 401.

Dr. Browning initially examined claimant on January 13, 1999, at which time she diagnosed "[c]hronic right shoulder strain related to work activities." (Ex. 121-2). Dr. Browning also referred claimant for an x-ray, which revealed a small spur on the right acromion, and an MRI, which revealed a condition identified as a possible SLAP type lesion. (Exs. 123, 125). Dr. Browning noted that she did not know if this lesion is "degenerative in nature (age-related) or traumatic (sudden onetime [sic] injury or repetitive strain)." (Ex. 128-3).

Subsequently, Dr. Browning reviewed Exhibits 1 through 124 and opined that claimant had clinical symptoms of chronic right shoulder rotator cuff syndrome and impingement. (Ex. 131). She stated that claimant's work activity was the major contributing cause of those conditions. (Ex. 131-2). She also described the MRI findings, noting the possible SLAP lesion and stating that the etiology of this lesion is unknown. (*Id.*). She did not address the spur on the right acromion.

We do not find Dr. Browning's opinion persuasive because she did not evaluate the relative contribution of the preexisting conditions and the work exposure and explain why the work exposure contributes more to the claimed condition than all other causes combined. *Dietz*, 130 Or App at 401.

Dr. Gritzka performed a record review on behalf of claimant. (Ex. 130A). He noted that there was no evidence in the records he reviewed that claimant ever had a thorough examination of her shoulder. (Ex. 130A-8-9). He explained that an orthopedic evaluation of the shoulder for internal derangement consists of six steps and includes several tests. (Ex. 130A-9). Among the tests he listed were: (1) "Codman's apprehension test," the "sulcus sign," the anterior and posterior drawer signs, and the prone relocation test (tests to determine if the shoulder is unstable); (2) "Speed's and Yergeson's tests" (tests for bicipital tendinitis, which Dr. Gritzka described as a bellwether condition that results from almost any internal derangement of the shoulder); (3) the "lift-off test" (to determine if there is an injury to the subscapularis portion of the rotator cuff); and (4) specific tests for impingement, including impingement in flexion and abduction, the "Hawkin's Kennedy test,""Neer's test" for impingement, and the "crankshaft test," among others. (*Id.*). He noted that the records indicated that claimant had only undergone range of motion testing, some palpation for crepitis, and some tests for impingement. (*Id.*).

Dr. Gritzka also noted that clicking or popping in claimant's right shoulder had variously been described in the records as either a "scapular click" or a "shoulder click." (Ex. 130A-10). He stated that, if claimant has a "scapular click," it might be coming from retroscapular adhesions which develop secondarily to shoulder injuries. (*Id.*). But, if she has a "shoulder click," there are numerous possible causes, "including a small flap tear of the rotator cuff, degenerative changes of the rotator cuff, glenohumeral arthritis, a tear of the glenoid labrum, or a tear of the bicipital tendon." (*Id.*). He concluded that none of these conditions could be ruled either in or out on the basis of the information in claimant's records. (*Id.*).

Based on his review of the medical records, Dr. Gritzka diagnosed "bilateral shoulder internal derangement, not otherwise specified." (*Id.*). Dr. Gritzka concluded that claimant's work activities[2] were the major contributing cause of this condition. He opined that the human shoulder was designed to be used below the horizontal level. He explained the mechanics of raising the shoulder above the horizontal position, noting that in this position the rotator cuff is impinged between the greater tuberosity and the overlying acromion, which results in diminished blood supply to the rotator cuff and likely induces microtrauma and injury. (Ex. 130A-10-11). Dr. Gritzka concluded that claimant's "bilateral shoulder condition (whatever it is)"[3] is due to her work activities and the chronic repetitive use of her arms above shoulder level. (Ex. 130A-11).

We find several inconsistencies in Dr. Gritzka's report that render it unpersuasive. First, Dr. Gritzka did not examine claimant. Ordinarily, that would not necessarily render an opinion unpersuasive. Here, however, Dr. Gritzka went to great length to explain that the medical record was inadequate. He went so far as to list the elements of a thorough orthopedic evaluation of the shoulder for internal derangement and concluded that claimant had not had such an evaluation. In addition, he listed several conditions that claimant may have depending on whether she had a "scapular click" or a

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[2] In his report, Dr. Gritzka variously states that claimant's work activities included lifting hoods of cars overhead 100 to 150 times a day for 20 years and raising her arms above shoulder level 100 to 150 times a day for 20 years. (Ex. 130A-8, -10, -11). SAIF relies on the former statement, contending it demonstrates that Dr. Gritzka has an inaccurate history, given the number of cars claimant processed per day. Claimant relies on the latter statement, contending that it demonstrates that Dr. Gritzka has an accurate understanding regarding the overhead work her job requires. Given the internal inconsistencies in Dr. Gritzka's report, we do not find it persuasive even without considering the accuracy of his history regarding the "hood lifting" requirements of claimant's job.

[3] Although Dr. Gritzka referred to a "bilateral" shoulder condition, we note that only compensability of the right shoulder condition is at issue on review.

"shoulder click," noting that he could not eliminate any of those conditions based on the record before him. Importantly, some of those listed conditions were degenerative conditions. Furthermore, after finding the medical record inadequate, Dr. Gritzka proceeded to reach conclusions based on that record. We do not find conclusions based on an inadequate record persuasive.[4] In addition, like Dr. Browning, Dr. Gritzka does not evaluate the relative contribution of the preexisting conditions and the work exposure. *Dietz*, 130 Or App at 401.

For all of these reasons, we find that the record does not support compensability of claimant's occupational disease claim for a right shoulder condition.

ORDER

The ALJ's order dated May 24, 1999 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial of claimant's occupational disease claim for a right shoulder condition is reversed. The ALJ's attorney fee award of $3,000 is reversed. The remainder of the ALJ's order is affirmed.

[4] In reaching this conclusion, we acknowledge that a specific diagnosis is not required, provided that claimant establishes that her need for medical services and/or disability are related to her work activities. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992); *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988). But, it is not the difficulty that Dr. Gritzka had in arriving at a specific diagnosis that troubles us regarding his opinion. Instead, it is the fact that he acknowledged that he could not eliminate several conditions, some of which were degenerative, based on the medical record yet, without explaining this problem, he concluded that work activities were the major contributing cause of claimant's right shoulder condition.

In the Matter of the Compensation of
CHARLES R. DREW, Claimant
Own Motion No. 98-0491M
OWN MOTION ORDER OF ABATEMENT
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our September 20, 1999 Own Motion Order, that modified the carrier's April 21, 1999 Notice of Closure.

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
BRETT S. HUSTON, Claimant
WCB Case Nos. 98-03521 & 98-00799
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation, on behalf of A & N Construction Flaggers, requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's claim for a right shoulder condition; (2) upheld the Travelers' denial of claimant's claim for the same condition; and (3) awarded a $3,000 attorney fee to claimant's counsel for prevailing over SAIF's denial of compensability. In his brief, claimant argues that extraordinary circumstances justify an attorney fee greater than the $1,000 awarded by the ALJ pursuant to ORS 656.308(2)(d). In addition, claimant asserts an entitlement to an attorney fee greater than the $3,000 fee awarded by the ALJ pursuant to ORS 656.386(1). On review, the issues are responsibility and attorney fees.

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

With regard to the responsibility issue, all of the parties agree that ORS 656.308(1) applies. SAIF argues that the ALJ erred in concluding that the October 6, 1997 work injury was the major contributing cause of claimant's disability or need for treatment of the right shoulder condition. SAIF agrees that it is responsible for claimant's chest wall strain, but argues that the major contributing cause of the right shoulder condition is the preexisting condition. More specifically, SAIF asserts that the right shoulder strain and chest wall strain are separate conditions that did not combine and that Dr. Switlyk's opinion that the work injury was the major contributing cause of claimant's need for treatment was insufficient to establish a new compensable right shoulder injury under ORS 656.308(1) because it took into account the need for treatment of both the chest wall strain as well as the right shoulder condition.

After reading all of Dr. Switlyk's opinions together, we agree with the ALJ that Dr. Switlyk believed that the major contributing cause for the need for treatment of both claimant's chest wall strain and the right shoulder condition was the October 1997 injury. In this regard, Dr. Switlyk opined that the treatment for both conditions was the same and that the injury was the major contributing cause of claimant's need for treatment for a specific period of time after the injury. Under such circumstances, we are persuaded that the major contributing cause of claimant's need for treatment for each of the two conditions was the October 1997 compensable injury at least for the time period specified by Dr. Switlyk. Thus, we agree that SAIF is responsible for the current right shoulder condition as well as the right chest wall strain.

SAIF argues that, in awarding a $3,000 attorney fee under ORS 656.386(1), the ALJ failed to apply the factors in OAR 438-015-0010(4) and make specific findings regarding each factor. Claimant asserts that the ALJ's attorney fee award was inadequate and seeks a fee of $7,200.

In awarding the $3,000 attorney fee, the ALJ considered the factors in OAR 438-015-0010(4) with particular consideration to the time devoted to the issue, the complexity of the issue, the value of the interest involved and the risk that counsel might go uncompensated.

On de novo review, 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.

Having considered the parties' arguments, we turn to an application of the factors to the circumstances of this case. The issues at hearing were compensability of claimant's current condition and responsibility.[1] The hearing lasted 55 minutes. The transcript is 32 pages long and only one witness testified. Approximately 142 exhibits were admitted, including a deposition of Dr. Switlyk. Based on a review of the file, claimant's attorney estimates he spent 32 hours on the case. The case involved issues of average legal and medical complexity as compared with compensability issues generally presented to the Board for resolution. As a result of the denial being overturned, claimant will receive medical and other benefits for his compensable condition. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated. Having considered the circumstances of this case and the factors in OAR 438-015-0010(4), we find that a $3,000 attorney fee is reasonable.

The ALJ also awarded claimant's attorney $1,000, the maximum attorney fee available under ORS 656.308(2)(d), for prevailing over a responsibility denial absent a showing of extraordinary circumstances. On review, claimant argues that the additional work on the Board level (review of exhibits and drafting a respondent's brief) constitutes extraordinary circumstances under ORS 656.308(2)(d). Claimant seeks an additional $1,200 under ORS 656.308(2)(d).

First, we note that claimant's attorney will receive an attorney fee under ORS 656.382(2) insofar as those services are devoted to the compensability issue. In addition, claimant has not demonstrated extraordinary circumstances justifying a fee greater than $1,000 regarding the responsibility issue.[2] In this regard, as we noted above, the transcript of the 55-minute hearing is 32 pages long and only one witness testified. Approximately 142 exhibits were admitted, including a 40-page deposition. Claimant's attorney estimates he spent 32 hours on the case and submitted a 10-page respondent's brief on Board review. The case involved issues of average legal and medical complexity as compared with cases generally presented to the Board for resolution.

Under similar factual scenarios to this case, we have not found extraordinary circumstances. For instance in *Fred L. Dobbs*, 50 Van Natta 2293 (1998), four carriers were joined at the hearing which lasted one hour, 20 minutes. One witness testified. Ninety-six exhibits were received into evidence. There was one deposition, which lasted 55 minutes. Although the value of the claim was above average proportions, the complexity of the issue or value of the benefits did not differ appreciably from those in most cases litigated before this forum. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. There was a significant risk that claimant's counsel's efforts might go uncompensated. On Board review, the claimant's counsel submitted a 4-page respondent's brief. Likewise in *Bill D. Coleman*, 48 Van Natta 2154 (1996), the hearing lasted three hours and had two witnesses, there were 186 exhibits, some of which were procured by claimant's counsel, and there was a 53-page deposition. The claimant filed a 15-page respondent's brief.[3] Because these cases are so factually similar to the present case, and because "extraordinary circumstances" did not exist in those cases, we likewise find that no extraordinary circumstances are present here.

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 which 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). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a

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[1] Claimant received an attorney fee pursuant to ORS 656.308(2)(d) for prevailing on the responsibility denial.

[2] Claimant asserts that the work on Board review constitutes "extraordinary circumstances." However, as explained herein, even if we consider counsel's services at hearing and on review regarding the responsibility issue, we do not find extraordinary circumstances justifying a fee greater than $1,000. In addition, not all of counsel's work at hearing and on review was spent on the responsibility issue. Some of the time was devoted to the other issues of compensability and attorney fees.

[3] Similarly, in *Terry L. Vanyi*, 50 Van Natta 1016 (1998), the hearing lasted one hour and fifteen minutes, there were 53 exhibits, 47 of which submitted by the claimant's attorney, and the claimant submitted a three-page respondent's brief on review.

reasonable fee for claimant's attorney's services on review is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services concerning the attorney fee issues. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated February 9, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by SAIF.

In the Matter of the Compensation of
JAY A. LINGENFELTER, Claimant
WCB Case No. 99-00501
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's *de facto* denial of claimant's alleged cervical radiculopathy condition. Submitting "post-hearing" medical reports from his attending physician, claimant also moves for remand to the ALJ for the taking of additional evidence. On review the issues are remand and compensability.

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

The ALJ found that the preponderance of the medical evidence did not support the conclusion that claimant had cervical radiculopathy. In reaching his conclusion, the ALJ relied, in part, on Dr. Ireland's opinion and the testing Dr. Ireland performed. Claimant moves for remand, submitting post-hearing reports from Dr. Ireland dated July 8, 1999 and July 22, 1999. Claimant argues that the reports show that Dr. Ireland now believes that claimant has C7 nerve impingement causing cervical radiculopathy. Claimant asserts that this evidence was unobtainable at the time of hearing and is reasonably likely to affect the outcome of the case. SAIF opposes claimant's motion for remand, arguing that Dr. Ireland's letters do not address causation and are not likely to affect the outcome of the case.

For the following reasons, we deny the motion for remand.

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we determine that the case was improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

In his post-hearing, July 8, 1999 report, Dr. Ireland appears to change his opinion that claimant does not have cervical radiculopathy. The report indicates that Dr. Ireland would like to review a myelo CT scan that claimant underwent in January 1999 to see if it suggested any nerve root impingement. Dr. Ireland's July 22, 1999 letter was written after discussing the January 1999 myelo CT study with a Dr. Hanson. Because the January 1999 myelo CT scan was in existence at the time of the April 1999 hearing, we are not persuaded that a report from Dr. Ireland addressing the significance of the report could not have been obtained with due diligence at the time of the hearing. On this basis, we deny the motion for remand.

ORDER

The ALJ's order dated May 14, 1999, is affirmed.

In the Matter of the Compensation of
DIANE K. COTTER, Claimant
Own Motion No. 99-0209M
OWN MOTION ORDER OF POSTPONEMENT AND CONSOLIDATION
Kryger, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable right carpal tunnel syndrome (CTS) claim. SAIF opposed authorization of temporary disability compensation, contending that claimant had withdrawn from the work force. Claimant ultimately responded to SAIF's action by submitting copies of several medical reports and an April 29, 1997 "Notice of Claim for Aggravation of Occupational Injury or Disease." Relying on these documents, claimant contends that she timely perfected an aggravation claim and, therefore, her claim is not within the Board's Own Motion jurisdiction. In addition, claimant requests that we "remand" the matter to the Hearings Division for determination. SAIF disputes claimant's contention and contends that she failed to timely perfect an aggravation claim.

The Board's own motion jurisdiction extends only to claims for which the claimant's aggravation rights have expired. ORS 656.278(1)(a); *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). While we have the authority to determine whether a claim comes within our Own Motion jurisdiction, we find the record before us inadequately developed to make such a determination. *SAIF v. Reddekopp*, 137 Or App 102, *rev den* 322 Or 360 (1995). Furthermore, any decision we might make in our own motion authority regarding the jurisdiction issue, once final, would preclude the parties from relitigating that issue in another forum. *Id.* at 137 Or App 107.

Finally, insofar as claimant contends that she timely perfected an aggravation claim for which SAIF has allegedly not properly responded, her submission has been interpreted as a request for hearing under ORS 656.283(1). Consequently, claimant's submission has been referred to the Hearings Division for the creation of a new WCB Case Number and the scheduling of a hearing. *See* WCB Case No. 99-07400.

Under these circumstances, we consider it appropriate to postpone Board action regarding this Own Motion petition and refer this matter to the Hearings Division for consolidation with claimant's hearing request. *See* OAR 438-012-0040(3); *Charles Tedrow*, 48 Van Natta 616 (1996). At the hearing, the Administrative Law Judge (ALJ) assigned to the matter shall make findings of fact and conclusions of law and opinion on the issue of whether claimant's aggravation rights have expired on her claim so as to bring that claim within the Board's Own Motion jurisdiction.

Further, at the hearing, if jurisdiction is found to be under our Own Motion authority pursuant to ORS 656.278(1)(a), the assigned ALJ shall make findings of fact and conclusions of law and issue a separate, unappealable Own Motion Recommendation with respect to whether claimant was in the work force at the time her condition worsened. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *SAIF v. Blakely*, 160 Or App 242 (1999).

At the conclusion of the hearing, the ALJ shall forward to the Board the unappealable Own Motion Recommendation, if any, and a copy of the appealable order issued in response to claimant's hearing request. After issuance of that order, the parties should advise the Board of their respective positions regarding own motion relief.

Finally, since further Board action will be required before resolution of this case, we emphasize that our action today constitutes an interim order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES M. KING, Claimant
Own Motion No. 99-0248M
OWN MOTION ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

On September 24, 1999, we issued an Own Motion Order which declined to reopen claimant's 1977 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization. Claimant requested reconsideration of our September 24, 1999 order and submitted additional medical documentation, which he contends support his contentions. 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. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In order to satisfy the third *Dawkins* criterion, claimant must first establish that 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 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); *Arthur R. Morris*, 42 Van Natta 2820 (1990).

In our prior order we were persuaded that claimant had demonstrated his willingness to work. We based our conclusion on claimant's affidavit and an interview with SAIF. On reconsideration, and based on the record before us, we continue to find that claimant was and is willing to work.[1]

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery 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).

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[1] Claimant submitted 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 were persuaded that claimant was willing to work.

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

On reconsideration, claimant submits Dr. Goldberg's, his treating physician's, response to an inquiry from his attorney regarding the relationship between his May 1999 hospitalization and his compensable condition. Dr. Goldberg responded that the current condition for which claimant was hospitalized in May 1999 was directly related to his compensable heart condition.

However, Dr. Goldberg's response doe snot answer the pivotal question which is whether claimant was unable to work or seek work prior to his May 1999 hospitalization due to his compensable condition. 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. Thus, we continue to find that 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.

Accordingly, our September 24, 1999 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 24, 1999 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

October 21, 1999 Cite as 51 Van Natta 1795 (1999)

In the Matter of the Compensation of
FOREST G. HULL, Claimant
WCB Case No. 97-05568
ORDER ON REMAND
Martin L. Alvey, Claimant Attorney
VavRosky, MacColl, Olson, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's October 5, 1999 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Disputed Claim Settlement/Stipulation & Order of Dismissal"[1] that is designed to resolve all issues raised or raisable between them.

Pursuant to the settlement, the parties agree that the self-insured employer's denial of "claimant's current cervical, thoracic and lumbar conditions shall be affirmed." The parties further stipulate that claimant's "Request for Hearing" shall be "dismissed with prejudice" and the orders from the ALJ and the Board "will be vacated."

We have approved the parties' settlement, thereby resolving this dispute. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] According to the agreement, the "Stipulation and Order of Dismissal" portion of the document relates to a proceeding before the Department of a Determination Order that was issued after the Board affirmed the ALJ's order finding claimant's current condition compensable. In particular, the agreement states that, "by virtue" of the DCS, the Determination Order "shall be vacated as moot."

Because the DCS affirms the employer's denial of claimant's current condition, its practical effect is to "moot" the Determination Order. But because the Determination Order is now pending before the Department, our approval of the DCS does not affect that separate proceeding or vacate the Determination Order. Thus, it is the parties' responsibility to notify the Department of this settlement and seek the termination of the reconsideration proceeding.

In the Matter of the Compensation of
MICHAEL G. MORGAN, Claimant
WCB Case Nos. 99-00941 & 99-00911
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that reduced an Order on Reconsideration award of 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm, to zero. On review, the issue is extent of scheduled permanent disability.

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

We agree with the ALJ's conclusion that this case is analagous to *William L. Fischbach*, 48 Van Natta 1233 (1996), and accordingly, there is no basis for a separate chronic condition award for claimant's left arm. Specifically, we agree that the arbiter's comments regarding claimant's decreased use of the left arm establish that the condition is a result of positioning problems created by his left shoulder impairment, similar to the claimant in *Fischbach*. Therefore, claimant is not entitled to a separate scheduled chronic condition award for a scheduled member, *i.e.*, the left arm.[1]

We also agree, for the reasons stated by the ALJ, that the Board cases cited by claimant are distinguishable from *Fischbach*, and we decline to disavow our decision in that case. Claimant argues that our decision in *Fischbach* is contrary to ORS 656.214, which provides that permanent disability is measured in loss of use and there is no requirement that the loss of use be caused by "referred symptoms." However, the statute also provides that for an award, the loss of use or function of the injured member must be "due to the industrial injury." ORS 656.214(2). Here, as in *Fischbach*, the doctors have not identified any left arm symptoms flowing from the left shoulder injury. Rather, claimant's difficulty using his left arm is a result of positioning problems with the left shoulder. Consequently, we find no basis for a separate chronic condition award for a scheduled body part.

ORDER

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

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[1] The Order on Reconsideration found that claimant was restricted in repetitive activities performed by the accepted left shoulder (an unscheduled body part), and claimant had less than 5 percent ratable impairment from other findings. Accordingly, pursuant to OAR 436-035-0320(5)(b), claimant was awarded 5 percent in lieu of the other impairment. (Ex. 24-3).

In the Matter of the Compensation of
JUNEVA TAYLOR-CHOATE, Claimant
Own Motion No. 99-0368M
OWN MOTION ORDER DENYING CONSENT TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Randy Rice, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under her 1989 injury claim with Liberty Northwest Insurance Company expired May 31, 1991. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. *Id.*

Here, on October 2, 1995, the Board approved the parties' Claim Disposition Agreement (CDA), whereby claimant released her rights to the following workers' compensation benefits: all past, present, and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, "Own Motion" rights per ORS 656.278 in claim number C604242435, and all other workers' compensation benefits except compensable medical services under ORS 656.245.

Claimant's aggravation rights on her 1989 injury claim have expired, thus placing the claim in Own Motion status. ORS 656.273(4); ORS 656.278(1)(a). Furthermore, because of the October 2, 1995 CDA, claimant specifically released her own motion benefits under ORS 656.278, *i.e.*, claimant's released her rights to temporary disability compensation. Thus, her entitlement to any further temporary disability under her 1989 injury claim has been extinguished. *See* ORS 656.236(1)(a); *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996).

Inasmuch as claimant's entitlement to further temporary disability compensation under her 1989 claim has been released, the Board is without authority to consent to an order designating a paying agent for the purposes of paying temporary disability compensation. However, because responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. *See* OAR 436-060-0180(13).

IT IS SO ORDERED.

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 requested medical services are not related to the compensable injury.

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

Claimant responded to SAIF's contentions asserting that he is "sure that the necessary carpal tunnel syndrome surgery on my R[ight] wrist was due to the accident that occurred Feb[ruary] 22, 1961." In response to claimant's contentions, SAIF requested reopening claimant's claim under our own motion jurisdiction to provide reimbursement for a medical file review to determine the compensability of the requested medical services as they relate to his compensable February 22, 1961 injury.

On August 31, 1999, we issued an Own Motion Order which authorized SAIF's request for reimbursement for the costs of a medical file review. We also directed that, when SAIF obtained its medical file review, it supplement the record with a copy of the report as well as its amended own motion recommendation.

At SAIF's request, Dr. McKillop, orthopedist, conducted a medical file review. In reviewing the file, Dr. McKillop noted that the mechanism of claimant's initial injury was unclear. Inasmuch as he was unable to determine what type of injury claimant initially incurred, he found it difficult to relate claimant's current carpal tunnel syndrome to his compensable wrist injury. Dr. McKillop presented several "possibilities" regarding the relationship between claimant's current carpal tunnel syndrome condition and the 1961 work injury. but the existence of a "possible" relationship is not sufficient to meet claimant's burden of proof. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

Furthermore, Dr. McKillop opined that there was "no reason to believe that there is a probable relationship between the 1961 wrist injury and [claimant's] current carpal tunnel syndrome." He further opined that it was more likely that claimant's current carpal tunnel syndrome "has come on spontaneously as it does in most individuals who have it."

Based on Dr. McKillop's unrebutted opinion, the record does not establish that claimant's current carpal tunnel syndrome is causally related to his February 22, 1961 work injury. Accordingly, the request to reopen the claim for medical services allegedly related to the 1961 work injury is denied.[1]

IT IS SO ORDERED.

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[1] We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order; *i.e.*, medical evidence establishing that claimant's current carpal tunnel syndrome and need for medical services is attributable to his work injury (rather than being idiopathic).

In the Matter of the Compensation of
KATHLEEN A. CLIMER, Claimant
WCB Case Nos. 99-00453 & 98-09140
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer, Wal-Mart Stores, Inc. (Wal-Mart) requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's occupational disease claim for an L4-5 and L5-S1 degenerative disc disease; and (2) upheld Travelers Casualty and Surety Company's (Travelers) denials of claimant's aggravation and occupational disease claims for the same conditions. On review, the issues are compensability and responsibility.

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

On review, Wal-Mart contends that ORS 656.308, rather than the last injurious exposure rule (LIER), is applicable. We disagree.

ORS 656.308(1) applies if a worker sustains a "new compensable injury" involving the "same condition" as that previously processed as part of an accepted claim. *See SAIF v. Yokum*, 132 Or App 18 (1994). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or treatment involves a condition different that than which has already been processed as part of a compensable claim. *See Armand J. DeRosset*, 45 Van Natta 1058, 1059 (1993).

Here, Travelers accepted claimant's 1992 claim for "right hip strain and low back strain." (Ex. 37-2). However, claimant's current low back condition involves facet arthrosis at L4-5 and L5-S1. Because claimant's current low back claim does not involve the same condition that was processed as part of the 1992 accepted claim, ORS 656.308(1) is not applicable. When ORS 656.308(1) is not applicable, LIER applies to assign responsibility. *Lyle H. Brensdal*, 47 Van Natta 2209, 2211 (1995), *aff'd mem* 142 Or App 311 (1996).

Wal-Mart also argues that Travelers actually accepted the degenerative disc disease stating that the right hip strain was merely a symptom of the underlying degenerative disc disease. Relying on *SAIF v. Tull*, 113 Or App 449 (1992), Wal-Mart asserts that Travelers is precluded from denying the underlying condition and disavowing any responsibility. However, Wal-Mart neither refers to any medical evidence to support this proposition nor have we found any such evidence. In the absence of persuasive medical evidence, we reject Wal-Mart's contention.

LIER provides that where a worker proves that an occupational disease is caused by work conditions where two or more carriers are at risk, the last employment providing potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984). The onset of disability is the triggering date for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239 (1982).

Wal-Mart argues that claimant first sought treatment of the L4-5 and L5-S1 degenerative disc disease in January 1993, while she worked for Travelers' insured. Wal-Mart asserts that the date of first treatment shifts the responsibility to Travelers.

The date a claimant first receives treatment related to a compensable condition is determinative for assigning initial responsibility for the claim. However, if subsequent employment contributes independently to the cause or worsening of the condition, responsibility shifts to the subsequent employer. *Timm v. Maley*, 125 Or App 396 (1993).

It appears that claimant's first medical treatment for her *current* condition occurred in October 1997, while Wal-Mart was on risk. Because Wal-Mart was unable to prove that claimant's employment under Travelers' coverage was the sole cause or that it was impossible for her employment at Wal-Mart to contribute to the current condition, Wal-Mart is unable to shift responsibility to Travelers. *See Donna M. Johnston*, 51 Van Natta 1414 (1999).

However, we need not conclusively determine responsibility as stated above. In other words, even if the disability date rested with Travelers, persuasive medical evidence establishes that subsequent work activities for Wal-Mart contributed to the pathological worsening of claimant's condition.[1] Therefore, responsibility would shift to Wal-Mart. *See Mark A. Davidson*, 49 Van Natta 1918 (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 $1,000, payable by Wal-Mart. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by record), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 10, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by Wal-Mart Stores, Inc.

[1] In his deposition, Dr. Belza clarified his opinion that there was a subsequent contribution to claimant's condition by his work activities for Wal-Mart.

In the Matter of the Compensation of
RICHARD A. SCHIEL, Claimant
Own Motion No. 97-0374M
OWN MOTION ORDER ON RECONSIDERATION
Glen J. Lasken, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

On December 19, 1998, we referred claimant's request for reconsideration of our August 20, 1998 Own Motion Order to the Hearings Division for a Fact Finding Hearing. In doing so, we found that record insufficiently developed for us to determine whether claimant had established that he was in the work force at the time of his disability.

The parties have now submitted a "Disputed Claim Settlement," which resolves the dispute pending before the Board. Pursuant to that agreement, the parties agree that claimant's current condition, for which he sought own motion benefits, remains in denied status. Furthermore, the agreement resolved all issues raised or raisable between the parties. Finally, the parties agree that the matter is dismissed with prejudice.

Administrative Law Judge (ALJ) Black has approved the parties' settlement agreement. Consequently, the claim on which the request for Own Motion relief is based remains in denied status. Under such circumstances, we are not authorized to grant Own Motion relief. Consequently, the request for Own Motion benefits is denied.

Accordingly, on reconsideration of our prior orders, the request for Own Motion relief is denied. 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
JANICE AUYONG-TITGEN, Claimant
WCB Case Nos. 98-07589, 98-06084 & 98-04245
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) upheld the SAIF Corporation's denial of "reopening" of her accepted 1990 bilateral wrist tendonitis claim; (2) upheld SAIF's denial of her new occupational disease claim for a right hand, right arm, right shoulder and neck condition; and (3) upheld SAIF's denial of a "new injury" claim for the same conditions. On review, the issue is compensability.

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

On review, claimant contends that her current condition is compensable because the medical evidence establishes that it is the same condition as what she suffered from in 1990-93, when her previous claim was accepted as "bilateral wrist tendonitis, resolved." Noting that the prior acceptance was "inappropriate" because she was never diagnosed with bilateral wrist tendonitis, claimant asserts that SAIF should remain responsible for her current condition when the medical evidence indicates her condition is the same condition as the one she had in 1990-93.

Although not directly designated as such, claimant's contention is similar to an objection to SAIF's Notice of Acceptance issued with respect to her 1990-93 occupational disease claim. We note that ORS 656.262(6)(d) addresses circumstances such as these and specifically allows an objection to an acceptance notice to be made at "any time."[1] Claimant, however, must first communicate her objections in writing to the carrier. Inasmuch as the record does not indicate that this was done, we are without statutory authority to address the issue claimant raises.[2]

ORDER

The ALJ's order dated April 9, 1999 is affirmed.

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[1] ORS 656.262(6)(d) provides:

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

[2] Even if we viewed claimant's condition as a "new medical condition" under ORS 656.262(7)(a), the record does not indicate that claimant clearly requested formal written acceptance of the condition. *See Eston Jones*, 50 Van Natta 1407, *on recon* 50 Van Natta 1582 (1998); *Diane S. Hill*, 48 Van Natta 2351, 2352-53 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997). Thus, considering SAIF's opposition to the claim, we would currently lack statutory authority to address the compensability of a "new medical condition" claim.

In the Matter of the Compensation of
RIMM L. BEER, Claimant
WCB Case No. 98-07587
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Randy Rice, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its *de facto* denial of claimant's cervical condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the fifth full paragraph on page 2, we change the citation after the third sentence to "(Ex. 40A-2).

CONCLUSIONS OF LAW AND OPINION

This case involves claimant's August 1998 injury claim for a cervical condition. Claimant has been working for the employer since September 1997. (Tr. 44). His job duties involved driving a truck and loading/unloading retreaded tires. (Tr. 44-45). The tires weighed from 100 pounds to over 200 pounds. (Tr. 45, 49). Claimant testified that he never had any trouble performing his job before he was injured and had never previously injured his neck or shoulders. (Tr. 45, 70).

The ALJ found that claimant sustained an injury while loading tires on August 12, 1998. Claimant was stacking commercial truck tires to ceiling height inside a trailer. (Tr. 48). As claimant attempted to place a final tire (weighing in excess of 100 pounds) in the last position in the upper row, the tire struck the ceiling and jammed his cervical and left thoracic/shoulder area. (Tr. 48-51). Claimant experienced immediate but transitory pain in the neck area. He continued to work in some discomfort, which he believed was in the shoulder region. (Tr. 51).

Claimant continued to work for another two weeks in varying degrees of discomfort. On August 25, 1998, claimant was pushing tires across a tailgate while loading a trailer at work when he experienced pain from his ear down into his arm. (Tr. 48-51). Claimant was unable to continue working and sought medical treatment. (Tr. 52). Although claimant was initially diagnosed with a left shoulder overuse condition (Ex. 3), Dr. Carleton, his family physician, diagnosed probable discogenic pain with nerve root impairment and shoulder tendinitis. (Ex. 8). An MRI showed a C5-6 disc herniation. (Ex. 11). Dr. Keiper reported that the MRI showed a collapsed disc at C5-6 with acute herniated material spilled out into the left neural foramen. (Ex. 15-3). On September 15, 1998, Dr. Keiper performed an anterior cervical diskectomy and fusion of C5-6. (Ex. 19). A later myelogram on October 9, 1998 showed a C6-7 herniation. (Ex. 28).

Claimant signed an "801" form on September 13, 1998. (Ex. 18). He later filed a request for hearing, raising the issue of *de facto* denial of compensability. At hearing, claimant's attorney asserted that the claim involved a C5-6 disc, C6-7 disc and "potential for rotator cuff on the left." (Tr. 3). The ALJ relied on the opinions of claimant's treating physicians and set aside the insurer's denial of claimant's cervical condition requiring treatment at two levels.[1]

Claimant relies on the opinions of Drs. Karasek, Carleton and Keiper, to establish compensability. In contrast, the insurer argues that none of claimant's physicians addressed the "major cause" standard and their opinions support only the conclusion that claimant's job injury was a material cause of his disability or need for treatment.

Claimant does not dispute the ALJ's conclusion that ORS 656.005(7)(a)(B) applies to this case. The medical evidence establishes that claimant has preexisting cervical degenerative disease that combined with his work injury to cause his disability and/or need for treatment. (Exs. 41-4, 49, 50).

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[1] The ALJ said that in closing arguments, the parties agreed that the shoulder condition "was not specifically at issue on grounds that it has effectively fallen by the wayside." (O & O at 1 n.1). Neither party addressed the shoulder claim on review.

Therefore, under ORS 656.005(7)(a)(B), claimant must prove that the August 1998 work injury was the major contributing cause of the disability and/or need for treatment of the combined condition. *See SAIF v. Nehl*, 148 Or App 101, *on recons* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998).

In light 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 Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). We rely on those medical opinions which are well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we generally 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).

Based on Dr. Karasek's opinion, as supported by the opinions of Drs. Carleton and Keiper, we conclude that claimant has established compensability of his cervical condition. Claimant began treating with Dr. Karasek in December 1998. (Ex. 40A). Dr. Karasek reported that claimant had a C6 nerve injury from a disc herniation and a possible problem at C6-7, for which he recommended an MRI. (Ex. 40A-2). On December 8, 1998, Dr. Karasek reported that claimant had a soft disc herniation, which was "almost surely related to his work activities." (Ex. 42A). He recommended epidural steroids to treat both the C6 and C7 nerve root levels. (*Id.*) Injections were later performed with improvement in claimant's pain. (Exs. 48, 48D, 48E, 49A). Dr. Karasek felt that the C6-7 level was the most symptomatic level. (Ex. 50-3).

Dr. Karasek concluded that claimant's need for treatment stemmed from his work accident. (Ex. 50-1). He did not agree with the view that claimant's degenerative change was the primary cause of his need for treatment. (*Id.*) Instead, Dr. Karasek believed claimant had a traumatic activation of his symptoms. (*Id.*) He said that Dr. Young's comment that the vast majority of disc herniations were secondary to degeneration was not applicable in claimant's case. (*Id.*) Dr. Karasek acknowledged that claimant had "preexisting hydration and degradation changes" in his cervical discs, but he said that did not make claimant "immune to a traumatic injury." (*Id.*) Dr. Karasek did not agree with Dr. Young's view that annular fissures are degenerative. (*Id.*) Dr. Karasek felt that the symptomatic annular fissure "is on a traumatic basis in the vast majority of cases." (*Id.*) In addition, Dr. Karasek did not agree with Dr. Farris' view that the mechanism of work injury was not of sufficient force to cause a cervical disc herniation. (Ex. 50-3). Dr. Karasek explained that a cervical disc herniation in a "previously degraded disc could certainly occur with the kind of force [claimant] exerted on a heavy tire slamming it against an immovable object." (*Id.*)

Although Dr. Karasek did not expressly state that claimant's August 1998 work injury was the "major contributing cause" of his cervical condition, it is well settled that "magic words" are not required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *See SAIF v. Strubel*, 161 Or App 516, 521-22 (1999); *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). Dr. Karasek felt that claimant's herniation was "almost surely related to his work activities." (Ex. 42A). After reviewing other medical reports focusing on claimant's cervical degenerative disease as the cause of his cervical condition, Dr. Karasek opined that there was "very little support for their view that degenerative change is the sole and primary cause" of claimant's need for treatment. (Ex. 50-1). Instead, Dr. Karasek focused on the force involved with claimant's injury and its traumatic activation. (Ex. 50). He did not believe claimant's annular fissure was degenerative and he rejected the view that claimant's disc herniation was secondary to degeneration. (Ex. 50). When read as a whole, we interpret Dr. Karasek's reports mean that the August 1998 work injury was the major contributing cause of claimant's cervical condition and his need for treatment for that condition. We are persuaded by Dr. Karasek's opinion because it is well-reasoned and based on accurate and complete information.

Dr. Karasek's opinion is supported by those of claimant's other treating physicians, Dr. Carleton and Keiper. Dr. Carleton, claimant's family physician, initially examined claimant on August 27, 1998, and recommended an MRI, which showed a disk herniation at C5-6. (Exs. 8, 14). On September 9, 1998, Dr. Carleton reported that claimant's disk injury "was caused by his job[.]" (Ex. 14). In a later report, Dr. Carleton said that claimant's cervical problem was "directly caused by the requirements of his employment, and that the lifting, pulling, and overhead work contributed to, if not actually were, the direct cause of the acute herniated disk." (Ex. 43-2). He felt that claimant had an acute herniated disk, not a chronic one. (*Id.*)

Dr. Keiper performed claimant's cervical surgery. (Ex. 19). He removed two large free fragment disk herniations. (Ex. 19-2). On December 7, 1998, Dr. Keiper reported that claimant's mechanism of injury was consistent with an acutely herniated disc. (Ex. 42). He felt it was "more likely than not" that claimant's need for treatment was caused by the activity of lifting tires. (*Id.*) He noted that claimant had no previous pain and, therefore, the injury was the most likely cause of his need for treatment. (*Id.*) On January 18, 1999, Dr. Keiper commented that claimant was asymptomatic until the time of his work injury. (Ex. 49-1). He acknowledged that claimant had preexisting cervical disease, but he said "the immediate need for treatment" was the work-related injury, which caused the free fragment disc herniation. (Ex. 49-2). The opinions of both Drs. Keiper and Carleton support the conclusion that claimant's August 1998 injury was the major contributing cause of the need for treatment of the cervical condition.

In contrast, the insurer relies on the opinions of Drs. Young, Farris and Strum to argue that claimant's preexisting degenerative cervical condition was the major cause of his disability and need for treatment. For the following reasons, we are not persuaded by their reports.

Dr. Young provided a records review on behalf of the insurer. He concluded that claimant's preexisting degenerative condition at C5-6 was the "major predominant cause" of the combined condition, disability and need for treatment. (Ex. 41-4). He explained that the imaging studies showed a preexisting degenerative disc protrustion at C5-6 that "only required a minor additional event of wear and tear to cause symptoms." (*Id.*) Dr. Young said that, given the degree of degenerative disease in the cervical spine and especially at C5-6, the injury was "the last straw that broke the camel's back" that precipitated the symptoms. (*Id.*) He felt the injury was a "very small contribution to the overall problem. (*Id.*) Dr. Young felt that claimant's C5-6 surgery was premature and probably not related to the August 1998 injury. (Exs. 41, 47).

On December 14, 1998, Dr. Farris examined claimant on behalf of the insurer. (Ex. 44). She found the imaging studies showed no evidence of neural compromise. (Ex. 44-9). Dr. Farris concluded that because there was no evidence of an objective medical condition and claimant's examination was notable for marked nonphysiologic findings, she assumed there were psychosocial or motivational issues involved. (*Id.*) She said claimant's mechanism of injury was not of sufficient force to cause a cervical disk herniation in the absence of significant underlying degenerative changes. (*Id.*) Dr. Farris concluded that claimant's current condition was related primarily to idiopathic and preexisting degenerative changes and to nonphysiologic pain behavior. (*Id.*)

Drs. Young and Farris did not believe that claimant needed surgery at C5-6. Dr. Farris found no evidence of neural compromise on the imaging studies and she concluded that it was doubtful that claimant ever required surgical intervention. (Ex. 44-9). Dr. Young felt that claimant's surgery at C5-6 was premature and was not related to the August 1998 injury. (Ex. 47-1). Nevertheless, we note that neither Dr. Young nor Dr. Farris discussed the details of Dr. Keiper's surgical findings in their reports. Dr. Keiper removed two large free fragment disk herniations during claimant's cervical surgery. (Ex. 19-2). Moreover, Dr. Keiper said that claimant's surgery showed a "free fragment disc herniation which occluded the left C5-6 neural foramen and pinched the C6 nerve root." (Ex. 49-1). In light of Dr. Keiper's first-hand exposure to and knowledge of claimant's surgical condition, we are not persuaded by the opinions of Drs. Young and Farris questioning claimant's need for surgical treatment. *See Argonaut Ins. v. Mageske*, 93 OrApp 698, 702 (1988) (deference given to treating surgeon). We find that the causation opinions of Drs. Young and Farris are not persuasive because it is not clear they had an accurate understanding of claimant's surgical findings. *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).

Moreover, we are not persuaded by Dr. Farris' opinion that claimant's current condition was related primarily to idiopathic and preexisting degenerative changes and to nonphysiologic pain behavior. (Ex. 44-9). Dr. Farris reported that claimant's numbness was not dermatomal, but was typical of hysterical or malingering behavior. (*Id.*) Dr. Karasek rejected Dr. Farris' view that claimant's symptoms must be hysterical because there was not a strict dermatomal distribution of his sensory symptoms. (Ex. 50-2). He said that patients frequently have poor sensory localization in the cervical spine with cervical nerve root involvement and he felt that Dr. Farris' conclusion was not supported by the medical literature. (*Id.*) We note that Dr. Farris examined claimant one time. In contrast, we are more persuaded by Dr. Karasek's opinion because he had an opportunity to treat claimant on more than one occasion.

Dr. Strum also examined claimant on behalf of the insurer. (Ex. 45). He diagnosed a cervicothoracic musculoligamentous strain and possible injury to the left rotator cuff. (Ex. 45-4). He believed that claimant may have had an injury to the left rotator cuff and that the shoulder may have been the primary pathology, with the cervical symptoms secondary. (Ex. 45-5). He recommended more testing and his opinion on causation depended on results of further shoulder tests. (*Id.*) He said that if the shoulder testing was negative, the major contributing cause of claimant's cervicothoracic strain was his preexisting cervical degenerative disc disease. (*Id.*) Dr. Strum's opinion is not persuasive because it establishes, at most, a possibility that claimant had a left shoulder condition. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). Furthermore, in light of claimant's surgical findings and the contrary medical evidence, we are not persuaded by Dr. Strum's conclusion that claimant sustained merely a strain as a result of the August 1998 injury.

In sum, based on the opinion of Dr. Karasek, as supported by the opinions of Drs. Carleton and Keiper, we conclude that the August 1998 work injury was the major contributing cause of the need for treatment for claimant's cervical condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the 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 $1,200, payable by the insurer.

October 21, 1999 Cite as 51 Van Natta 1805 (1999)

In the Matter of the Compensation of
DARLENE STANDRIDGE, Claimant
WCB Case No. 99-00141
ORDER OF DISMISSAL
Bischoff, Strooband & Ousey, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

The self-insured employer requested review of Administrative Law Judge (ALJ) Mongrain's order finding that the Hearings Division had jurisdiction to reclassify claimant's claim from nondisabling to disabling. The parties have submitted a proposed "Stipulation and Order of Settlement."

Pursuant to the stipulation, the parties agree that: (1) the "Board shall enter an Order voiding the Opinion and Order";[1] (2) the claim shall be classified as nondisabling; and (3) claimant's counsel shall not receive any fee with regard to the settlement. Finally, the parties stipulate that the employer's request for Board review "is hereby dismissed."

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of the ALJ's order. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] In particular, the agreement states that the Board's order shall "void" the ALJ's order "for want of jurisdiction." Whatever the *parties'* agreement concerning the ALJ's jurisdiction, our order is limited to simply dismissing the employer's request for review and approving the parties' settlement in lieu of the ALJ's order.

In the Matter of the Compensation of
JACQUELINE J. GRIFFIN, Claimant
WCB Case No. 98-09875
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

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

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that the employer's acceptance of a right ankle sprain included right ankle posterior tibial tendinitis; (2) found that claimant was not precluded by a stipulation from asserting a claim for right ankle posterior tibial tendinitis; and (3) awarded an assessed attorney fee of $3,000. On review, the issues are scope of acceptance, the preclusive effect of a stipulation and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. We replace the first full paragraph on page 3 with the following:

> "On November 11, 1998, Dr. Gundry said he saw no reason to differentiate between the diagnosis of posterior tibial tendinitis or ankle strain. (Ex. 39b-1). He felt that the entities basically fell into the same category. (*Id.*) In a later report, Dr. Gundry agreed that it was medically probable that claimant sustained an ankle strain and tibial tendinitis as a result of the June 13, 1997 work injury. (Ex. 45). He agreed that the "tibial tendinitis was not indicated as a separate diagnosis as I consider 'ankle strain' to be the more inclusive diagnosis, which includes the diagnosis of tibial tendinitis." (*Id.*)

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

Neither party challenges that portion of the ALJ's order that concluded claimant was medically stationary on January 20, 1998. We adopt and affirm that portion of the ALJ's order.

Scope of Acceptance

The ALJ found that the employer's acceptance of a right ankle sprain included the diagnosis of posterior tibial tendinitis. Citing *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), the ALJ concluded that the employer's later denial of posterior tibial tendinitis was an attempt to deny what had already been accepted on the employer's own terms by stipulated order.

On review, the employer contends that claimant first raised the argument that the acceptance of a right ankle strain included posterior tibial tendinitis in closing arguments and, therefore, the ALJ should not have addressed that argument. Moreover, the employer argues that the ALJ had no authority to address the "back-up" denial argument because it was not raised at the hearing.

Even if we assume, without deciding, that claimant's arguments were properly raised, we do not agree that the employer's acceptance of a right ankle sprain included the diagnosis of posterior tibial tendinitis.

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); *Douglas Sherman*, 51 Van Natta 1213 (1999). 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 employer in this case accepted a specific condition, not merely symptoms. *See Douglas Sherman*, 51 Van Natta at 1213; *compare Janet R. Christensen*, 50 Van Natta 396 (1998), *aff'd Freightliner Corporation v. Christensen*, 163 Or App 191 (1999) (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, as a result of a stipulation, the employer specifically accepted a "right ankle sprain." (Exs. 16, 18). The stipulation further indicated that claimant's injury resulted in a "condition which is diagnosed properly and fully as a right ankle sprain[.]" (Ex. 16-1).

Moreover, as we explain below, we find that claimant's reliance on *Piwowar* is misplaced because the medical evidence establishes that claimant's right ankle posterior tibial tendinitis is not the same condition as the accepted condition of right ankle sprain. We find that the rule in *Piwowar* does not apply in this case and we conclude that the employer accepted only a right ankle sprain.

Preclusive Effect of the Stipulation

The ALJ concluded the stipulation did not bar claimant from presenting a claim for the tendinitis condition. The ALJ reasoned that in the "absence of a formal claim and a formal denial of the tendinitis claim in light of the stipulated language of the acceptance diagnosis," the acceptance was intended to include the tendinitis condition.

The employer argues that the posterior tibial tendinitis was diagnosed before the parties entered into the stipulation and compensability of that condition could have been negotiated before the approval of the stipulation. The employer contends that the stipulation resolved all issues raised or raisable and, therefore, claimant is precluded from asserting a claim for benefits related to the tendinitis condition. For the following reasons, we agree with the employer.

Neither party contends that the stipulation approved on July 16, 1998 is ambiguous, and we agree that it is not. Therefore, interpreting the stipulation is a matter of law. *Good Samaritan Hospital v. Stoddard*, 126 Or App 69, 72, *rev den* 319 Or 572 (1994). The issue is whether claimant's right ankle posterior tibial tendinitis condition *could* have been negotiated before approval of the stipulation. *Id.* at 73.

Claimant injured her right ankle at work and was diagnosed with an ankle sprain by Drs. Gundry and Buuck. (Exs. 3, 5a, 6, 7, 8, 8a, 8b). On January 20, 1998, claimant was examined by Dr. Gripekoven, orthopedic surgeon, on behalf of the employer. (Ex. 12). He diagnosed "[s]prain, right ankle; posterior tibial tendinitis, right ankle." (Ex. 12-4). He explained that the posterior tibial tendinitis was a "secondary problem" that developed during claimant's recovery. (*Id.*) Exhibit 12 indicates that a copy of Dr. Gripekoven's report was sent to claimant's attorney on April 23, 1998. Claimant does not dispute receiving a copy of that report before the stipulation was approved.[1]

On March 2, 1998, the employer denied compensability of claimant's right ankle sprain. (Ex. 13). Claimant requested a hearing on the denial. The parties subsequently entered into a stipulation, which was approved on July 16, 1998. (Ex. 16). The stipulation indicated that claimant had submitted a claim alleging "that on or about June 13, 1997 she suffered an injury within the course and scope her employment, resulting in a condition which is diagnosed properly and fully as a right ankle sprain[.]" (Ex. 16-1). The stipulation referred to the employer's denial of the claim and claimant's request for hearing to challenge the denial. (*Id.*) The employer agreed to accept a disabling claim for a right ankle sprain. (Ex. 16-2). Claimant agreed that her request for hearing "may be dismissed with prejudice to all issues raised and as to all issues raisable[.]" (*Id.*)

[1] Although Dr. Gundry concurred with Dr. Gripekoven's report on June 25, 1998 (Ex. 15), we do not consider that evidence in making our determination because the concurrence letter indicates that a copy was not sent to claimant's attorney until September 21, 1998 (after the stipulation was approved).

The record establishes that before the parties entered into the July 16, 1998 stipulation, claimant had been diagnosed with both right ankle posterior tibial tendinitis and a right ankle sprain. (Ex. 12-4). Furthermore, Dr. Gripekoven's report indicated that claimant's tendinitis condition resulted from the work injury. He reported that claimant's posterior tibial tendinitis was a secondary problem that developed during her recovery from the right ankle sprain. (*Id.*) Based on Dr. Gripekoven's report, we conclude that the right ankle posterior tibial tendinitis condition was related to claimant's work injury and had been identified at the time of the parties' July 16, 1998 stipulation. *See Marti J. Coleman*, 51 Van Natta 819 (1999); *compare Liberty Northwest Ins. v. Bowen*, 152 Or App at 554-55 (prior stipulation regarding permanent disability for a thoracic compression fracture did not preclude the claimant's current occupational disease claim for degenerative cervical disc disease, which was unrelated to the thoracic compression fracture).

In the July 16, 1998 stipulation, claimant agreed that her request for hearing "may be dismissed with prejudice to all issues raised and as to all issues raisable[.]" (Ex. 16-2). Because claimant's right ankle posterior tibial tendinitis condition had been diagnosed and had been identified before the stipulation as related to the work injury, we conclude that the posterior tibial tendinitis condition was an issue that could have been negotiated before approval of the July 13, 1998 stipulation. Consequently, we conclude that the right ankle posterior tibial tendinitis claim is barred by the stipulation. *See SAIF v. Wolff*, 148 Or App 296, 299-300, *adhered to on recons* 151 Or App 398 (1997) (stipulation dismissing all issues raised or raisable with respect to the claimant's accepted knee contusion barred the claim for an osteochondritis dissecans condition that had been diagnosed before stipulation was executed); *Stoddard*, 126 Or App at 72-73.

Furthermore, we do not agree with claimant's argument that the evidence is "unrefuted" that a diagnosis of posterior tibial tendinitis is part of the accepted ankle sprain. To the contrary, we conclude that the persuasive medical evidence establishes that claimant's right ankle posterior tibial tendinitis is not the same condition as the accepted right ankle sprain condition.

After her ankle injury on June 13, 1997, claimant was treated by Drs. Gundry and Buuck, who diagnosed a right ankle sprain. (Exs. 5a, 6, 7, 8, 8a, 8b). On January 20, 1998, Dr. Gripekoven diagnosed "[s]prain, right ankle; posterior tibial tendinitis, right ankle." (Ex. 12-4). Dr. Gripekoven found that claimant's physical findings were localized to the posterior tibial tendon and he felt that posterior tibial tendinitis was the cause of her ongoing symptoms. (*Id.*) He described "secondary tendinitis" and concluded that claimant's work injury was the major cause of her ankle problems. (*Id.*) Dr. Gripekoven explained that the posterior tibial tendinitis was a "secondary problem" that had developed during claimant's recovery. (*Id.*)

Dr. Gripekoven diagnosed two conditions: right ankle sprain and right ankle posterior tibial tendinitis. He distinguished between the two conditions and explained that the tendinitis condition arose *after* the ankle sprain, during the recovery period. Dr. Gripekoven's report indicates that claimant first sustained an ankle sprain after the work injury and then developed a new condition, "secondary tendinitis."

Similarly, the medical arbiter panel report establishes that claimant's tendinitis and ankle sprain were separate conditions. Drs. Olson, Scheinberg and Vessely found no evidence that claimant's accepted ankle strain was contributing to her current complaints. (Ex. 31-4). They felt that claimant had chronic right ankle pain, which was probably secondary to posterior tibial tendinitis. (*Id.*) They explained that claimant's "complaints are not secondary to the accepted condition, but primarily due to irritation and inflammation of the posterior tibial tendon. (Ex. 31-6).

Claimant relies on the reports of Dr. Gundry to argue that diagnosis of posterior tibial tendinitis is part of the right ankle sprain. Dr. Gundry's chart notes make no reference to a tendinitis condition. Dr. Gundry initially concurred with Dr. Gripekoven's report, in which he had diagnosed two separate conditions. (Exs. 12, 15). Later, however, Dr. Gundry said he saw no reason to differentiate between the diagnosis of posterior tibial tendinitis or ankle strain. (Ex. 39b-1). He felt that the entities basically fell into the same category. (*Id.*) On March 11, 1999, Dr. Gundry agreed that it was medically probable that claimant sustained an ankle strain *and* tibial tendinitis as a result of the June 13, 1997 work injury. (Ex. 45). He agreed the "tibial tendinitis was not indicated as a separate diagnosis as I consider 'ankle strain' to be the more inclusive diagnosis, which includes the diagnosis of tibial tendinitis." (*Id.*)

When medical evidence is divided, we give more weight to those that are well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Here, we are not persuaded by

Dr. Gundry's opinion because it is inconsistent and lacks adequate explanation. Dr. Gundry initially agreed with Dr. Gripekoven, who had diagnosed two separate conditions: ankle sprain and posterior tibial tendinitis. (Exs. 12, 15). Dr. Gripekoven reported that the tendinitis was a "secondary problem" that had developed during claimant's recovery. (Ex. 12-4). In a later report, however, Dr. Gundry said that there was no reason to differentiate between the two diagnoses. (Ex. 39b-1). Because Dr. Gundry did not explain his apparent change of opinion, we do not find his opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

Furthermore, Dr. Gundry did not explain why or whether he disagreed with Dr. Gripekoven's opinion that the tendinitis condition arose *after* the work injury. In addition, Dr. Gundry did not explain why he had not diagnosed posterior tibial tendinitis or why the ankle strain diagnosis necessarily included the diagnosis of tibial tendinitis.

Based on the reports from Dr. Gripekoven and the medical arbiter panel, we conclude that claimant's right ankle posterior tibial tendinitis is not the same condition as the accepted right ankle sprain.[2] *See Douglas Sherman*, 51 Van Natta at 1213 (the rule of *Piwowar* did not apply because the claimant's current degenerative conditions were not the same as the accepted condition).

Next, we address claimant's argument that *Trevisan v. SAIF*, 146 Or App 358 (1997), applies to this case. Claimant's reliance on *Trevisan* is misplaced because that case did not involve a stipulation. Rather, it involved a Disputed Claim Settlement (DCS), which may *only* be used to settle denied claims. *Id.* at 362. Here, in contrast, the terms of the stipulation were not limited to conditions or services that had been denied. Unlike *Trevisan*, the fact that the employer did not deny posterior tibial tendinitis before the stipulation was approved is not dispositive. *See Marti J. Coleman*, 51 Van Natta at 819. The present case involves a stipulation, which may resolve any contested matter, whether denied or not. *See Trevisan*, 146 Or App at 362. In the July 16, 1998 stipulation, claimant agreed that her request for hearing "may be dismissed with prejudice to all issues raised and as to all issues raisable[.]" (Ex. 16-2). The language of the stipulation is not limited to precluding litigation only of a specific claim, *i.e.*, right ankle sprain. Rather, the stipulation pertains to all *issues* raised and raisable. As we discussed earlier, claimant's right ankle posterior tibial tendinitis had been diagnosed and identified before the stipulation as related to the work injury and, therefore, the issue of compensability could have been negotiated before approval of the July 13, 1998 stipulation. The compensability of claimant's right ankle posterior tibial tendinitis may not be raised now, either as a new claim or as a medical sequela to the original accepted condition. *See McGrew v. Express Services, Inc.*, 147 Or App 257 (1997).

Finally, in claimant's letter to the Board written after the employer submitted its reply brief, she contends that if we reverse the ALJ's order, it would undermine ORS 656.262(7)(a), which provides "[n]otwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." We find no evidence that claimant raised an argument regarding ORS 656.262(7)(a) at hearing. Moreover, she did not raise that issue on Board review, until after the employer submitted its reply brief. Consequently, we decline to address this issue because it was raised for the first time on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *see also Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997).

ORDER

The ALJ's order dated April 13, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that directed the employer to accept and process a claim for right ankle posterior tibial tendinitis is reversed. The employer's *de facto* 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.

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[2] The employer also relies on medical dictionary definitions to differentiate between a sprain and tendinitis. Claimant requests that we disregard the employer's argument based on dictionary definitions. However, the Board may refer to a medical dictionary for the purpose of identifying a medical condition because a dictionary definition is a source that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *SAIF v. Calder*, 157 Or App 224, 227 (1998). A "sprain" is defined as a "joint injury in which some of the fibers of a supporting ligament are ruptured but the continuity of the ligament remains intact." *Dorland's Illustrated Medical Dictionary* 1566 (28th ed.1994). "Tendinitis" is defined as "inflammation of tendons and of tendon-muscle attachments." *Id.* at 1667. We agree with the employer that the dictionary definitions support its argument that the sprain and tendinitis are separate conditions. Nevertheless, we need not rely on the dictionary definitions because the medical opinions are sufficient to decide this issue.

Board Member Phillips Polich dissenting.

The majority finds that claimant was diagnosed with right ankle posterior tibial tendinitis before the parties entered into the stipulation and compensability of that condition could have been negotiated before the approval of the stipulation. Because I do not agree with the majority's reasoning or its conclusion that claimant is precluded from asserting a claim for benefits related to the posterior tendinitis condition, I respectfully dissent.

To begin, it is important to note that the physician who referred to tendinitis, Dr. Gripekoven, diagnosed only one condition: "[s]prain, right ankle; posterior tibial tendinitis, right ankle." (Ex. 12-4). He did not distinguish the tendinitis as a separate diagnosis. This conclusion is supported by Dr. Gripekoven's comments and recommendations, which said the major cause of claimant's "ankle problems" was her June 13, 1997 injury. (*Id.*) Furthermore, Dr. Gripekoven's opinion is consistent with the opinion of Dr. Gundry, claimant's attending physician. Dr. Gundry felt there was "no reason to differentiate between the diagnosis of posterior tibial tendinitis, or ankle strain." (Ex. 39B-1). He said "[t]hese entities basically fall into the same category." (*Id.*) Dr. Gundry agreed that tibial tendinitis was not indicated as a separate diagnosis because he considered "ankle strain" to be the more inclusive diagnosis, which includes the diagnosis of tibial tendinitis. (Ex. 45). I agree with claimant that the ankle strain/sprain was intended to encompass claimant's tendinitis condition. I also agree with the ALJ's conclusion that the employer's acceptance of a right ankle sprain included the diagnosis of posterior tibial tendinitis.

If the employer believed there were two different diagnoses, it would have denied both a sprain and tendinitis condition. Instead, the employer denied only a right ankle sprain. (Ex. 13). If the employer only thought claimant had a right ankle sprain, why should claimant be held to a higher standard? Dr. Gundry, claimant's treating physician, did not refer to a separate tendinitis diagnosis. At most, Dr. Gripekoven's report "suggests" posterior tibial tendinitis. Claimant should not be required to request acceptance of a condition under these circumstances.

Finally, the employer's argument regarding the stipulation language is disingenous. The employer contends that claimant agreed in the stipulation that the June 13, 1997 accident resulted in a condition "diagnosed properly and fully as a right ankle sprain" (Ex. 16-1), she agreed to waive any other claims related to that accident that she could have raised at the time of the stipulation. Neither the employer's attorney nor claimant's attorney had Dr. Gundry's concurrence with Dr. Gripekoven's report until *after* the stipulation was negotiated and signed. The date stamps on Dr. Gundry's concurrence letter indicated that the employer's attorney received that letter on September 21, 1998 (Ex. 15) and sent a copy to claimant's counsel on that date, which was *after* the stipulation was approved. If the employer had possession of Dr. Gundry's concurrence letter before the stipulation was negotiated, it failed to timely provide claimant's attorney with a copy of the document. Claimant cannot be found to have stipulated or negotiated a condition of which she had no knowledge, but the employer had knowledge.

In any event, claimant's treating physician, Dr. Gundry, believed that the strain encompassed the tendinitis condition. There is no contrary medical opinion from *any* physician in this case. For the foregoing reasons, I respectfully dissent.

In the Matter of the Compensation of
BRUCE A. FLETCHER, Claimant
WCB Case No. 99-02182
ORDER ON REVIEW
Dale C. Johnson, 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) Livesley's order that affirmed an Order on Reconsideration that awarded claimant 12 percent (18 degrees) scheduled permanent partial disability for loss of use or function of the left leg (knee). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the order of the ALJ. *See, e.g., William A. Hix*, 50 Van Natta 819 (1998) (The claimant's difficulty performing activity entailing frictional or shearing forces to the involved areas constituted evidence of a chronic condition limiting repetitive use of his hands).

Claimant's counsel is awarded an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we conclude that a reasonable fee for claimant's counsel's services on review is $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 June 16, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
CRAIG E. GANGL, Claimant
WCB Case No. 98-08457
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

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

The third sentence of the second paragraph on page 2 should read: He had tightened up and when he went to stretch [not scratch], he felt a pop in his right wrist. In the same paragraph, claimant's regular physician is Dr. Hull [not Hall].

On review, the insurer first contends that we should assume that claimant fell on his hands at some time in the past, as Dr. Nathan and Dr. Nolan hypothesized. We do not agree.

The ALJ explicitly found claimant credible based on his demeanor and conduct during the hearing. Furthermore, claimant credibly testified that he had not experienced any such fall on his outstretched hands. Although not statutorily required, we generally defer 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). Moreover, as the ALJ found, there is no medical evidence in the record to controvert claimant's testimony. 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). Accordingly, like the ALJ, we decline to make the assumption suggested by the insurer, as such an assumption is based solely on Dr. Nathan's and Dr. Nolan's hypotheses, which were derived from a medical text rather than on claimant's own medical history and diagnosis.

Second, the insurer contends that the opinions of Dr. Nathan and Dr. Nolan are more persuasive than those of Dr. Nye and Dr. Gritzka. We do not agree. 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).

As discussed above, both Drs. Nathan and Nolan relate their opinions to a previous hypothetical fall on the hands for which there is no evidence. Moreover, neither doctor considered claimant's eighteen years of heavy, repetitive work as a medical fabricator in their analyses. Consequently, like the ALJ, we find the well-reasoned expert opinion of Dr. Nye, claimant's treating hand surgeon, as supported by Dr. Gritzka, expert consulting physician, more persuasive than the opinions of Drs. Nathan and Nolan. Dr. Nye considered all the other opinions and clearly analyzed the relative contribution of the factors, and, after doing so, determined that claimant's work activities at the employer was the major contributing cause of claimant's bilateral scapholunate dissociation condition. *Dietz v. Ramuda*, 130 Or App 397 (1994); *Somers*, 77 Or App at 263.[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 $1,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 9, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,800, to be paid by the insurer.

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[1] The insurer in its reply brief corrects claimant's references to the test for determining a preexisting condition, citing to *Cessnun v. SAIF*, 161 Or App 367 (1999). The insurer is correct in its citation; however, there is no medical evidence that claimant had a preexisting condition that combined with his work activities to affect his wrists. Therefore, we need not consider the *Cessnun* standard in this case.

In the Matter of the Compensation of
PRISCILIANO E. LOPEZ, Claimant
WCB Case No. 97-04898
ORDER ON REVIEW
Willner, Wren, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that assessed a penalty for an allegedly unreasonable partial denial. Claimant cross-requests review of that portion of the ALJ's order that awarded attorney fees of $6,000 for claimant's attorney's services in setting aside the insurer's partial denial. On review, the issues are penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and provide the following summary.

Claimant was injured while performing work for the employer, a nursery. The insurer accepted claimant's injury claim as a right rhomboid muscle strain. Subsequently, the insurer issued a partial denial denying claimant's injury claim for a clay shoveler's fractures at C7 and T1. That injury claim related to the same work incidents that resulted in claimant's accepted right rhomboid muscle strain. On October 7, 1997, ALJ Spangler issued an order that set aside the partial denial. The insurer requested review of that order.

On review, by order dated March 6, 1998, we reversed ALJ Spangler's order. *Prisciliano E. Lopez*, 50 Van Natta 342 (1998). In doing so, we relied on the opinions of Dr. Gambee and Dr. Marble, examining orthopedists, who concluded that x-rays taken by Dr. Gambee showed that claimant did not have clay shoveler's fractures at C7 and T1. Claimant requested reconsideration, contending that we should have relied on the actual x-rays interpreted by Dr. Owen, treating chiropractor, rather than "secondary medical opinions." On reconsideration, finding that we were without radiological expertise

to interpret x-rays, and continuing to find Dr. Owen's opinion unpersuasive, we declined to alter the holding in our initial order. Consequently, on May 12, 1998, we republished our initial order. *Prisciliano E. Lopez*, 50 Van Natta 893 (1998).

Claimant again requested reconsideration and submitted a medical report from Drs. Reimer and Thomas, examining physicians who performed a "post-hearing" closing examination for the insurer on April 10, 1998. Drs. Reimer and Thomas concluded, based on a review of x-rays taken in Dr. Owens' office, that a "clay shoveler's" fracture was present at C7-T1. Drs. Reimer and Thomas also concluded that the x-ray films taken during Dr. Gambee's March 18, 1997 examination did not show the spinal area in question and, thus, were of little significance. Those x-ray films formed the basis for Dr. Gambee's and Dr. Marble's opinions.

On reconsideration, we determined that the information contained in the Reimer/Thomas report was both unavailable and unobtainable at the time of hearing. Therefore, we found a "compelling" reason to remand to the ALJ for admission of the Reimer/Thomas report. Accordingly, we withdrew our prior orders, vacated the ALJ's order, and remanded this matter to ALJ Spangler for further development of the record, including admission of the Reimer/Thomas report regarding the issue of whether claimant has a "clay shoveler's" fracture. *Prisciliano E. Lopez*, 50 Van Natta 1786 (1998).

On remand, claimant called two witnesses, Dr. Perez, a resident in orthopedic surgery at OHSU, and Dr. Orloff, a surgeon and a professor at OHSU, both of whom testified as to what claimant's various x-rays showed. The ALJ found that claimant had sustained a clay shoveler's fracture at C7 and T1 as a result of the lifting incidents at work. The ALJ ordered the insurer to pay claimant's attorney an assessed fee of $6,000 for his services in setting aside the denial.

CONCLUSIONS OF LAW AND OPINION

Penalty

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

Attorney Fees

The ALJ awarded claimant's attorney an assessed fee of $6,000 for his services in setting aside the denial. On review, claimant's attorney acknowledges that he did not submit a statement of services; however, he contends that $10,000 is an appropriate fee for the services rendered. We disagree. Instead, for the following reasons, we find that $7,000 is a reasonable fee for claimant's attorney's services at both hearings and the initial Board review.[1]

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

The first hearing lasted approximately one hour. Claimant and one of the owners of the nursery testified at that hearing. The record consisted of 34 exhibits, nine of which were submitted by claimant's attorney. In addition, during the first review by the Board, claimant's attorney submitted a respondent's brief. After we initially reversed the ALJ's decision and found the claim not compensable, claimant's attorney filed two separate requests for reconsideration, including supporting arguments. In addition, with the second request for reconsideration, claimant's attorney submitted the medical report from Drs. Reimer and Thomas that was instrumental in ultimately determining that claimant had a compensable clay shoveler's fracture. Claimant's attorney's efforts on reconsideration secured a remand to the ALJ for further development of the evidence.

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[1] Because the only issues raised during the current review were penalties and attorney fees and neither are considered "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on the current review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

This second hearing lasted two hours. Two expert witnesses, Drs. Perez and Orloff, appeared for claimant. Most of the examination was conducted by claimant's attorney. In addition to the 34 exhibits admitted at the first hearing, the record consisted of six additional exhibits, four of which claimant's attorney submitted. This second hearing ultimately resulted in a determination that claimant had a compensable clay shoveler's fracture injury claim.

Based on compensability disputes generally litigated before this forum, we find the issue presented in this case of average complexity. The issue was made more complex, however, by the erroneous reports from Drs. Gambee and Marble that purported to reach a conclusion based on x-rays that did not include the area of the spine in dispute. The value of the interest involved and the benefit secured for claimant are material because the insurer was ultimately directed to accept the clay shoveler's fracture. The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. Furthermore, there was a risk that claimant's counsel might go uncompensated, given the fact that, prior to the Reimer/Thomas report, we reversed the ALJ's initial finding of compensability.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), we find that $7,000 is a reasonable fee for claimant's counsel's services at both hearings and at the first Board review. We therefore modify the ALJ's attorney fee award accordingly.

ORDER

The ALJ's order dated April 29, 1999 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award of $6,000, we award claimant's attorney an assessed fee of $7,000 for services at both hearings and the first Board review. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
DANIEL A. NICHOLSON, Claimant
WCB Case No. 98-01590
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral carpal tunnel syndrome and right lateral epicondylitis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer in 1990 as a mechanic. Prior to working for the employer, claimant had worked as a heavy duty mechanic for a number of years. Claimant's job duties for the employer required him to use various hand tools, including pneumatic tools. In performing these job duties, claimant used his hands and arms to grasp, turn and hold often with both arms overhead. Claimant's work activities required use of his hands and arms approximately 75 percent of the time.

In late 1995, claimant began to experience numbness and pain in his right arm and wrist. In early 1997, claimant's right arm symptoms increased and he sought treatment from Dr. Walters, M.D. On January 30, 1997, claimant was examined by Dr. Potter, M.D., on referral from Dr. Walters. An MRI scan revealed a herniated disc at C6-7. However, claimant's symptoms decreased and he was released from Dr. Potter's care.

In late 1997, claimant returned to Dr. Walters with symptoms of numbness, pain, and tingling in both of his hands and wrists. On October 16, 1997, claimant was examined by Dr. Grant, M.D., on referral from Dr. Walters. Based on claimant's symptoms and nerve conduction studies, Dr. Grant diagnosed bilateral carpal tunnel syndrome. In addition, Dr. Grant also diagnosed right lateral epicondylitis. Thereafter, claimant returned to Dr. Walters for treatment of his symptoms.

On October 17, 1997, claimant filed an 801 Form asserting that his bilateral hand, wrist, arm, and shoulder conditions were related to his work activities with the employer.

On December 4, 1997, claimant was examined by Dr. Radecki, M.D., at the request of the employer.

By letter dated January 7, 1998, the employer denied claimant's bilateral carpal tunnel syndrome condition.

On September 9, 1998, Dr. Nathan, M.D., performed a records review and offered an opinion concerning claimant's bilateral hand and arm condition.

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions and reasoning set forth in the "Opinion" section of the ALJ's order.

ORDER

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

October 26, 1999 Cite as 51 Van Natta 1815 (1999)

In the Matter of the Compensation of
RAUL M. RUBALCABA, Claimant
WCB Case No. 99-00151
ORDER ON REVIEW
Coughlin, Leuenberger, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Davis's order that set aside its denial of claimant's claim for a right arm injury. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was injured while hauling produce for Mr. Nagaki, a farmer. The ALJ found that the "right to control" test was inconclusive, as some evidence supported a finding that claimant was an independent contractor, while other facts suggested that claimant was an employee. Consequently, the ALJ analyzed the case under the "nature of the work" test and concluded that hauling of produce was an integral part of the farmer's business and no special knowledge or skills were required.

The ALJ also reasoned that the farmer set the rate of pay and the haulers could not pass the increased cost of doing business to the customers; therefore, the ALJ concluded that the employer was in a better position to cover the cost of industrial accidents. The ALJ further found that claimant worked only one day during the harvest season that year for another farmer and that was during a time when there was no harvesting on Mr. Nagaki's farm. Under the circumstances, the ALJ concluded that claimant was a subject worker. We disagree.

In *Coghill v. National Council on Compensation Ins.*, 155 Or App 601 (1998), the court relied on established caselaw to analyze whether a claimant was a subject worker or an independent contractor. Specifically, in order to determine whether an individual is a subject worker entitled to benefits under the Workers' Compensation Law, it must first be determined whether an individual is a "worker." *S-W Floor Cover Shop v. Natl' Council on Comp, Ins.*, 318 Or 614, 622 (1994).

"Worker" is defined by ORS 656.005(30), which provides in pertinent part:

> "'Worker' means any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer."

It is the right to control, not actual control, that is dispositive. *Oregon Drywall Systems v. Natl. Council on Comp. Ins.*, 153 or App 662, 666 (1998). Factors bearing on whether a person has the right to control another person include: (1) direct evidence of a right to control; (2) furnishing of tools and equipment; (3) method of payment; and (4) the right to discharge without liability. *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 271 (1989).

In determining the right to control, the court cited to Larson's, which provides that:

> "[F]or the most part, any single factor is not merely indicative of, but, in practice, virtually proof of, the employment relation; while, in the opposite direction, contrary evidence is as to any one factor at best only mildly persuasive evidence of contractorship, and sometimes is of almost no such force at all." 3 Larson, *Workmen's Compensation Law* Sec. 44.31, at 8-90 (1998).

Finally, the court held that, if the "right to control" factors are inconclusive, then it is appropriate to consider the relative nature of the work. *Coghill*, 155 Or App at 607-08.

Here, we agree with the insurer that the right to control factors establish that claimant was an independent contractor, rather than a worker. Specifically, under the facts of this case, we find no evidence of a direct right to control. As the insurer argues, there is no evidence that Mr. Nagaki monitored the method of the hauler's practices. For example, there was no testimony that Mr. Nagaki specified the routes the haulers were to take to the processors, nor were they required to depart or return at scheduled times.

Next, we find that claimant furnished his own equipment, which in this case, was the truck used to haul produce. Claimant also maintained his truck and paid for his own insurance on the vehicle. Accordingly, this factor also supports a finding that claimant was an independent contractor. *See Trabosh v. Washington County*, 140 Or App 159, 167 (1996) (Horse owners that provided a hayride shuttle service at a county fair carried their own liability insurance and partly used their own equipment. The court found that such factors indicated that the fair did not have a right to control the claimant's work).

Mr. Nagaki paid the haulers on a "per load" or "per ton" basis, whereas his employees were typically paid by the hour and received a weekly paycheck. The haulers were paid at the end of a job. Additionally, claimant was not listed on Mr. Nagaki's tax or payroll records as an employee. We conclude that these factors are indicative of independent contractor status, rather than employee status.

Finally, although Mr. Nagaki testified that he could have fired a hauler at any time, he had never done so. We find this factor to be inconclusive evidence of claimant's status.

Under the circumstances, after considering all the factors discussed above, we conclude that Mr. Nagaki did not have the right to control claimant's work. Therefore, claimant is not a subject worker and is not entitled to benefits under the Workers' Compensation Law.[1] Accordingly, the ALJ's order is reversed.

ORDER

The ALJ's order dated May 21, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] In light of our conclusion that there was no "right to control" and claimant was not a subject worker, we do not address the "nature" of claimant's work.

In the Matter of the Compensation of
MELBA WALKER, Claimant
WCB Case No. 98-03940
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's injury claim for a neck condition (C5-6 herniated disc). 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 on the compensability issue. We add the following supplementation.

On review, the employer first argues that claimant's C5-6 herniated disc was not diagnosed until three years after her June 1995 injury. The employer points out that claimant had no radicular symptoms in her arms and that the doctors who treated her prior to Dr. Bert did not attribute any of claimant's cervical problems to the protruding or herniated disc revealed by the July 1995 MRI.

We do not agree with the employer's contentions regarding the facts. As noted by the ALJ, the July 1995 MRI showed evidence of a small posterolateral disc protrusion or herniation at C5-6 that appeared to contact the left anterior spinal cord, and claimant experienced pain in the left neck, shoulder and arm. (Exs. 2, 3, 5). Moreover, when Dr. Keizer examined claimant in August 1995, she was having significant pain in her neck with some tingling in both arms and some weakness and hypesthesia in the left arm. (Ex. 6). After physical therapy was unsuccessful in reducing claimant's symptoms, Keizer suggested decompressive fusion surgery, which claimant was reluctant to undertake before trying conservative treatment. (Exs. 6, 7; Tr. 11).

While being treated conservatively, claimant continued to experience neck symptoms, but her treatment with trigger point injections and physical therapy did not result in improvement. Instead, claimant continued to have severe pain in her neck and trapezii, and a pain management program worsened her pain. (Exs. 8; 9-1; 18-1; 19-5; 21-2, -5; 22-2; 23-2; 24-1, -2.) Finally, upon discharge from the pain program on February 6, 1998, claimant returned to Dr. Gerber for follow-up, stating that she was worse than she had been prior to the program. Gerber, who agreed that claimant's neck should be reassessed, found reduced range of motion and numbness in both upper extremities, which was confirmed by Dr. Bert. (Exs. 17, 27, 32C). Based on this medical record, we conclude, as did the ALJ, that claimant was diagnosed with a disc at C5-6 as early as July 1995. The record also shows that the ongoing conservative treatment failed.[1]

The employer also contends that the ALJ erred in relying on the opinion of Dr. Bert, claimant's treating orthopedic surgeon. The employer argues that Dr. Bert's opinions were discounted in a number of prior cases and should, for that and other reasons, be discounted in this case.

We reject the employer's argument concerning the medical evidence. First, we have adopted the ALJ's order, which provides several reasons for finding Dr. Bert's opinion to be the most persuasive medical opinion in the record. Moreover, the court has held that "the contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medical opinions." *Giesbrecht v. SAIF*, 58 Or App 218 (1982). Therefore, the cases cited by the employer are not relevant to the persuasiveness of Dr. Bert's opinion in this case, as we consider his opinion only as it pertains to this case.

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[1] We also note that, subsequent to removal of the herniated disc at C5-6 by Dr. Bert, claimant's symptoms significantly improved. (Ex. 32D; Tr. 14).

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 May 20, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

October 27, 1999 Cite as 51 Van Natta 1818 (1999)

In the Matter of the Compensation of
ARTHUR D. CARPENTER, Claimant
WCB Case No. 97-10353
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) McWilliams' order that: (1) declined to reopen the record to admit a "post-hearing" medical report offered by the employer; (2) set aside the employer's *de facto* denial of claimant's aggravation claim for his current low back condition; and (3) set aside the employer's *de facto* denial of a degenerated disc at L3-4. On review, the issues are the ALJ's procedural ruling, compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The employer asserts that the ALJ incorrectly allowed claimant to raise a "new issue" during closing argument. The employer contends that the issue of compensability of the degenerative disc at L3-4 was raised for the first time during closing arguments of the hearing. We disagree.

It is well-settled that an issue raised for the first time in closing argument will not be considered on review. *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995). However, claimant submitted Exhibit 35 at the onset of the hearing. Exhibit 35 states, in pertinent part:

> "* * * request the [employer] accept the following conditions from the claim of 1/13/94: a herniated disc at L3-4 with left L3 radiculopathy with residual left thigh atrophy *and a degenerative disc at left L3 secondary to a herniated disc at L3-4.*" (Original emphasis omitted; italicized emphasis added).

Exhibit 35 was submitted to the ALJ for inclusion in the record as follows:

> "[Claimant's Attorney]: [The employer's attorney's] motion to dismiss essentially is the claimant failed to establish a valid aggravation claim, and the course of the one issue regarding that motion is what's the accepted condition. The Board cases talk about the accepted conditions as a question of fact, and I'm willing to argue that, but this morning I gave to [the employer's attorney] to give to [the employer] a request for an expanded acceptance. I'm going to give you this. I don't have a copy, but I think it probably should be part of the record, in light of the fact this is going to be an issue that's going to be litigated.
>
> "ALJ: Is this your only copy?

"[Claimant's Attorney]: Yes, So--

"ALJ: All right. I'll -- at our first break, I'll make copies of this.

"[Claimant's Attorney]: Okay.

"ALJ: [The employer's attorney], do you have any objections to this being entered into the record?

"[The Employer's Attorney]: I don't.

"ALJ: I'm going to suggest that it be 35." (Emphasis added). (Tr. 7).

The employer did not object to claimant's submission of the request for an expanded acceptance nor the statement that the issue would be litigated at the hearing. Therefore, the employer waived its right to raise that objection later in closing arguments. *See Brian M. Eggman*, 49 Van Natta 1835 (1997) ("It is well-established that failure to raise a procedural defect is a waiver of any procedural error.") Accordingly, the compensability issue was properly raised for the ALJ's resolution.

Unless there is persuasive evidence to do otherwise, we give deference to the treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Additionally, we give greater weight to medical opinions that are both well-reasoned and based upon complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

The treating physician, Dr. Brandt, examined claimant on multiple visits in relation to both the 1994 compensable injury and the 1997 incident. Dr. Brandt supported his medical opinion with objective findings. In addition, he examined claimant at the critical times. He had the opportunity to observe claimant's underlying condition before the second injury. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or 416, 421 (1986). His opinions are the most thorough, well-reasoned and based on complete information. We find Dr. Brandt most persuasive.

The employer argues that we should find Dr. Filarski's opinion most persuasive. We disagree. Dr. Filarksi performed a record review of claimant's medical history, but did not conduct a physical examination. Furthermore, unlike Dr. Brandt, Dr. Filarksi did not have an opportunity to examine claimant's condition before the 1997 incident. Because he had no basis of comparison with claimant's previous condition, we are not persuaded by Dr. Filarski's opinion. *See Orman v. SAIF*, 68 Or App 260, 263 (1984).

To prove a compensable aggravation, claimant must prove both of the following two elements: (1) an "actual worsening" of that condition, *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997); that (2) results in diminished earning capacity. *Intel Corp. v. Renfro*, 155 Or App 447, 452-53 (1998).

An "actual worsening" is established by direct medical evidence that a condition has pathologically worsened. *SAIF v. Walker*, 145 Or App at 305. Whether claimant established a pathological worsening of the underlying condition is a medical question that must be answered by expert medical opinion. *Barbara C. Avedovech*, 51 Van Natta 481 (1999). Diagnosing recurrent lumbar radiculopathy, Dr. Brandt concluded that claimant's current back condition was not a new injury, but rather a worsening of the 1994 compensable injury. (Exs. 25, 35A). Dr. Brandt concurred with claimant's counsel's summarization of the doctor's opinion that the symptoms following the 1997 incident demonstrated an objective worsening of the 1994 injury. (Ex. 28A-2). In addition, he concurred that the 1994 injury was the major contributing cause of the 1997 incident and the major contributing cause of the need for his current treatment. (Ex. 35A). *See Roseburg Forest Products v. Glenn*, 155 Or App 318, 321 (1998) (A doctor's concurrence with an attorney's statement in anticipation for litigation is to be evaluated on the same terms as a report prepared by the doctor.)

Based on Dr. Brandt's persuasive opinion, we find that claimant's current condition constitutes a pathological worsening of his 1994 condition. Therefore, we must next determine whether claimant has suffered diminished earning capacity. The test is whether claimant was temporarily or permanently incapacitated from regularly performing work at a gainful and suitable occupation. *Smith v. SAIF*, 302 Or 396, 400-401 (1986); *Intel Corp. v. Renfro*, 155 Or App at 452-453.

Dr. Daugherty first took claimant off work immediately following the July 10, 1997 incident. (Exs. 21, 21A). Claimant was authorized to return to modified work for 4 hours per day on July 25, 1997. (Ex. 23B). On August 20, 1997, claimant was authorized to return to work without limitation. (Ex. 24). On September 3, 1997, Dr. Brandt determined that claimant could perform all of the essential functions of his fireman/EMT job. (Ex. 26). Claimant experienced a diminished earning capacity, if only briefly, due to the restrictions placed on his ability to work by his attending physician.

In light of such circumstances, we find that claimant has proven a pathological worsening of the 1994 compensable injury and has established a diminished earning capacity sufficient to establish a compensable aggravation claim. Therefore, we agree with the ALJ and determine that claimant has proven an aggravation of his 1994 compensable injury.

In regards to the degenerative disc condition at L3-4, the employer argues that under ORS 656.262(7)(a)[1] it had already accepted the condition. Claimant must establish that he suffered a new consequential medical condition that was not encompassed in the employer's acceptance. *See Billy W. Wilson*, 50 Van Natta 1747 (1998).

To begin, there is no indication that the employer raised this "ORS 656.262(7)(a)" issue at hearing. Generally, we do not consider issues that are not raised at hearing. *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).

Nonetheless, even if we consider the issue, including the exhibit offered by the employer (which the ALJ refused to admit), the record does not establish that the degenerative disc condition was encompassed within the accepted condition. The employer relies on Dr. Laycoe's concurrence that the accepted condition was sufficient to apprise medical providers that the degenerative disc at L3-4 was an accepted condition. As we explained above, we give deference to Dr. Brandt.

Because of this deference, Dr. Brandt's opinion that the 1994 compensable injury was the major cause of the degenerative disc condition at L3-4 is persuasive. None of the medical opinions use the terms herniated disc and degenerative disc interchangeably nor does Dr. Brandt's opinion state that the degenerative disc is encompassed within the herniated disc. *See Margaret A. Bengston*, 51 Van Natta 50 (1999). For these reasons, we find that the degenerative disc is a separate, distinct new condition and is not encompassed within the employer's acceptance. Therefore, the degenerative disc condition is compensable, whether the claim is analyzed under ORS 656.005(7)(a)(A) or (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 service on review is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 21, 1998, as amended January 15, 1999 and February 18, 1999, is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the employer.

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[1] ORS 656.262(7)(a) states, in part:

"The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable condition."

In the Matter of the Compensation of
PHILIP D. FEDDERLY, Claimant
WCB Case No. 99-00778
ORDER ON REVIEW
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of claimant's occupational disease claim for inhalation of gasoline fumes and vapors. With his request for review and appellant's brief, claimant has included written materials that were not presented during the hearing. Attached to an October 7, 1999 letter, claimant submitted additional written materials. We treat such submissions as a motion to remand to the ALJ for the taking of additional evidence.[1] On review, the issues are remand and compensability.

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

Our review is limited to the record made at the hearing level. We may remand to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. *Nancy B. Fast*, 50 Van Natta 1210 (1998); ORS 656.295(5). However, to merit remand for consideration of additional evidence it must be clearly shown that relevant, material evidence was not obtainable with due diligence at the time of the hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). In addition, the evidence must be reasonably likely to affect the outcome of the case. *Laurence R. Aites*, 51 Van Natta 807 (1999).

Claimant's "reply" brief did not explain why the submitted documents were not presented or available at hearing. Further, the "new" evidence claimant submitted on review has no relevance to the issue of the major contributing cause of an occupational disease. In light of such circumstances, it is not the type of evidence which is reasonably likely to affect the outcome of the compensability case. Therefore, we decline to remand.

In his "reply" brief, claimant objected to the insurer's "respondent's" brief as untimely mailed to him.[2] Because of a clerical error, the insurer initially erroneously mailed claimant's copy of its respondent's brief to claimant's former attorney on August 18, 1999 (21 days after the July 28, 1999 mailing of claimant's appellant's brief). The next day, when the insurer discovered its error, it mailed another copy of its brief to claimant. Claimant filed his reply on August 24, 1999. Because claimant was able to respond to the insurer's brief in accordance with the briefing schedule, we decline to strike the insurer's respondent's brief. *See David F. Weich*, 39 Van Natta 468 (1987) (motion to strike brief denied where no prejudice resulted from the claimant's failure to fully comply with briefing procedures).[3]

Finally, claimant argues that the ALJ erred in admitting the insurer's proposed exhibits at hearing. After examining the transcript and reviewing the record, we find no abuse of discretion on the ALJ's evidentiary ruling. In any event, even if we disregarded all of the exhibits submitted by the insurer and confined our review to only the exhibits claimant submitted at hearing, the remaining record does not establish that claimant's work exposure was the major contributing cause of his claimed condition. Consequently, even without consideration of the disputed exhibits, the claim does not satisfy the requisite statutory compensability standard.

ORDER

The ALJ's order dated May 20, 1999 is affirmed.

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[1] *See Judy A. Britton*, 37 Van Natta 1262 (1985).

[2] Because claimant is the only party that requests Board review, there are three appellate briefs: (1) claimant's appellant's brief; (2) the insurer's respondent's brief; and (3) claimant's reply brief.

[3] Alternatively, even if we did not consider the insurer's brief, we would continue to reach the same ultimate conclusions regarding the ALJ's order.

In the Matter of the Compensation of
JAMES W. HENRY, Claimant
WCB Case Nos. 99-00553, 99-00552 & 98-08085
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Oregon Health Sciences University (OHSU), requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its responsibility denial of claimant's "new injury" claim for his current right knee condition; and (2) upheld the SAIF Corporation's denials, on behalf of OHSU, of claimant's claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant injured his right knee in December 1994 while employed at OHSU, then insured by SAIF. He was diagnosed with a right medial meniscal tear; an MRI showed that the lateral meniscus, cruciate and collateral ligaments were intact. (Ex. 7). As a result of that injury, surgery was performed to repair the medial meniscus. (Ex. 12).

In November 1995, claimant again injured his right knee. After litigation, SAIF accepted "patella-femoral compression syndrome/chondromalacia of the right knee." (Ex. 37).

In May 1998, claimant sought treatment for increased pain in the right knee, which had been present for about six weeks. Dr. Hoppert found no signs of collateral or cruciate instability, patellar involvement, meniscal tears or other internal derangement and diagnosed general synovitis or early degenerative joint disease. (Ex. 39).

On June 24, 1998, while working at OHSU, now insured by Liberty, claimant's right knee gave way and he injured his knee in a twisting fall. He was diagnosed with an anterior cruciate ligament strain and a medial collateral ligament tear. (Ex.48a). Liberty denied compensability and responsibility. SAIF denied responsibility in relation to each of its prior accepted injuries.

CONCLUSIONS OF LAW AND OPINION

On review, Liberty challenges the ALJ's conclusion that claimant's 1998 right knee anterior cruciate ligament (ACL) strain and medial collateral ligament (MCL) tear is the responsibility of Liberty rather than SAIF. Claimant has a prior accepted injury claim with SAIF for a December 13, 1994 medial meniscus tear. Claimant also has a prior accepted injury claim with SAIF for patello-femoral compression syndrome/chondromalacia of the right knee. Claimant's current right knee condition has been diagnosed as a right knee ACL strain and MCL tear.

At hearing, Liberty conceded compensability and the parties agreed that responsibility was the sole issue to be decided. In reaching his decision regarding responsibility, the ALJ relied on the opinion of Dr. James, who examined claimant and performed a file review for SAIF. The ALJ concluded that the major contributing cause of claimant's right knee ACL strain and MCL tear was the 1998 injury when Liberty was on the risk. The ALJ did not explain whether he was analyzing responsibility under ORS 656.308, the last injury rule under *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984), or actual causation.

On review, relying on the medical opinion of Dr. Hoppert, claimant's attending physician, Liberty argues that it is not responsible for claimant's 1998 right knee condition. We affirm the ALJ's ultimate conclusion. However, we do so based on the following reasoning.

The sole issue to be decided is responsibility. In this case, there has been no prior accepted claim for claimant's right knee anterior cruciate ligament tear and medial collateral ligament strain. Because the claim has not been accepted, ORS 656.308(1) does not apply in determining responsibility. *SAIF v. Yokum*, 132 Or App 18 (1994) (ORS 656.308(1) does not apply to initial claim determinations); *Raymond H. Timmel*, 47 Van Natta 31 (1995). Instead, we generally resort to the judicially created rules governing the initial assignment of responsibility in successive employment cases, *e.g.*, the last injury rule (for injury claims) and the last injurious exposure rule (for occupational disease claims). *See John J.*

Saint, 46 Van Natta 2224 (1994). But, where causation is proven as to a specific employment, we need not resort to those rules. *See Eva R. Billings*, 45 Van Natta 2142 (1993); *Runft v. SAIF*, 303 Or 493, 502 (1987). Rather, we will assign responsibility to the carrier with respect to which actual causation has been established.

In this case, based on Dr. James' opinion, we conclude that actual causation has been established with respect to the 1998 injury when Liberty was on the risk. Based on claimant's history of the injury incident, Dr. James persuasively opined that the 1998 injury was the major contributing cause of claimant's current right knee condition and need for treatment. (Ex. 56).

Claimant testified that the fall occurred when he was walking down the 35 degree inclined ramp on which cars drove up into the OHSU parking structure. (Tr. 13, 14). He also testified that his knee had previously felt weak but that "I had never gone clear down" onto the knee due to a fall before. (Tr. 14, 15). Thus, claimant was not sure exactly what happened when he fell, but he knew that nothing like this had happened before. Claimant acknowledged that Dr. James had taken a thorough history at the time of his examination (Tr. 16, 17), and Dr. James' history was consistent with claimant's testimony. In his opinion, Dr. James persuasively reasoned that claimant's new injury was completely separate from his preexisting right knee conditions.

Moreover, we agree with the ALJ that Dr. Hoppert's opinion was not persuasive, because he discussed the cause of claimant's fall in terms of "possible" scenarios (Ex. 54), as opposed to expressing an opinion based upon a reasonable medical probability. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (medical opinions stated in terms of possibility are not persuasive). Hoppert also vacillated between stating that claimant's June 1998 fall was a new injury (Exs. 50, 54), and indicating that claimant's prior condition might have contributed to his fall in some way (Ex. 54A). His changing opinions are not persuasive to establish that one of SAIF's prior accepted right knee claims was the major (or even material) cause of claimant's right knee ACL and MCL strains. *Somers v. SAIF*, 77 Or App 259 (1986) (we give greater weight to those medical opinions which are both well reasoned and based on the most complete information).

Accordingly, we conclude that Dr. James' opinion establishes that the 1998 incident actually caused claimant's current right knee ACL and MCL conditions. Therefore, we agree with the ALJ that Liberty is responsible.[1]

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

ORDER

The ALJ's order dated May 24, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by Liberty Northwest Insurance Corporation.

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[1] Alternatively, even if we were to apply the "rule," rather than the actual causation analysis discussed above, the medical evidence establishes that Liberty would be responsible. If claimant's condition is an occupational disease, Liberty is presumptively responsible because claimant's date of disability occurred while Liberty was on the risk. *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). The medical evidence shows that Liberty has not proven either that it was impossible for conditions at its workplace to have caused the disease or that the disease was caused solely by conditions at one or more previous employments. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997).

If the claim is analyzed as an injury claim, because there is no accepted claim, the last injury rule under *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984), is inapplicable. Moreover, even if claimant's prior injuries with the previous employers contributed to his condition, the June 1998 injury with Liberty's insured actually contributed to claimant's current condition. Therefore, Liberty would be responsible.

In the Matter of the Compensation of
CHRISTINE M. STROMER, Claimant
WCB Case No. 98-04214
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Phillips Polich, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of claimant's occupational disease claim for a peroneal neuropathy condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked as a home health aide and CNA. In January 1998, claimant sought treatment from Dr. Goldenberg for right leg pain. (Ex. 1). On referral from Dr. Goldenberg, claimant then saw Dr. Lockfeld, neurologist. (Ex. 2B). Claimant eventually was diagnosed with peroneal neuropathy.

After the insurer denied the claim for the peroneal neuropathy condition, claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Analyzing the claim as an occupational disease, the ALJ found that the medical evidence was not sufficient to prove compensability. Claimant disagrees with the ALJ's evaluation of the medical opinion evidence and asserts that she carried her burden of proof.

We first note that, as a claim for occupational disease, claimant must show that employment conditions were the major contributing cause of her peroneal neuropathy condition. ORS 656.802(2)(a). The record contains several medical opinions addressing the issue of causation.

Dr. Goldenberg provided a report stating that, "[a]ccording to the patient worker her workplace exposure is the major contributing cause of her condition" but he had "no way of proving this to be correct or incorrect." (Ex. 5-1).

Examining physicians Dr. Watson, neurologist, and Dr. Neumann, orthopedic surgeon, diagnosed a "[h]istory of transient right common peroneal neuropathy at the fibular hear, right, etiology uncertain, resolved." (Ex. 6-4). In particular, the panel explained that a peroneal neuropathy usually is "considered to be the result of casual, if not compressive trauma, to the nerve over the fibular head" and also noted that there was no history of a specific incident. (*Id.* at 5).

In a follow-up report, after reviewing additional medical records, Dr. Watson found that, in the absence of an injurious incident, "the cause of the disorder is idiopathic and probably related to activities of daily living and not to any specific trauma, work related or otherwise." (Ex. 7).

Dr. Goldenberg concurred with the panel's report. (Ex. 10).

Dr. Lockfeld also first concurred with the panel's report but then explained that he did not agree with Dr. Watson's subsequent report stating that claimant's condition was "not related to any specific trauma[.]" (Exs. 11, 12).

Dr. Lockfeld was then deposed. Dr. Lockfeld first explained that the condition of peroneal neuropathy was most common to "people who do a lot of kneeling or squatting; roofers, carpet layers." (Ex. 13-9). Dr. Lockfeld further explained that the condition is "usually due to repeated trauma over time, not due to a single incident[.]" (*Id.* at 10). Dr. Lockfeld based his opinion of causation on "where [claimant] did the most squatting and crouching. If she performed more squatting and crouching activities at work than when she was off work, then I would say that it was the work that was causative." (*Id.* at 13).

Claimant relies on Dr. Lockfeld's opinion in asserting that she proved that her employment conditions were the major contributing cause of her peroneal neuropathy. Although Dr. Lockfeld explained that prolonged kneeling or crouching was the most potentially likely activity in causing peroneal neuropathy, we do not understand him as indicating that *only* this type of activity caused such a condition. Rather, we agree with the claimant that Dr. Lockfeld also found that repetitive squatting and crouching, whether or not prolonged, caused a peroneal neuropathy.

Claimant testified that, at work, she would kneel once or twice a day and sometimes squat. (Tr. 6). Additionally, claimant stated that, twice a week, she kneeled at home to clean her floor. (*Id.* at 6). Based on such evidence, we find that claimant repetitively crouched and kneeled more frequently at work than at home.

Thus, because we find that Dr. Lockfeld based his opinion on an accurate history and is well-reasoned, we find no persuasive reasons not to defer to it. *See Weiland v. SAIF*, 64 Or App 810 (1983). Consequently, we conclude that claimant carried her burden of showing that her work conditions were the major contributing cause of her peroneal neuropathy, thus proving compensability. *See* ORS 656.802(2)(a).

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

ORDER

The ALJ's order dated June 3, 1999 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded for processing. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,000, to be paid by SAIF.

Board Member Haynes dissenting.

I disagree with the majority that Dr. Lockfeld's opinion is sufficiently persuasive to carry claimant's burden of proof. Thus, I agree with the ALJ that claimant did not prove compensability.

When Dr. Lockfeld was first deposed, he indicated that, if claimant performed more squatting and crouching at work than at home, work activities were the cause of her peroneal neuropathy condition. (Ex. 13-13). Dr. Lockfeld was then asked to distinguish the *frequency* of such activity from the *duration* of it. In response, Dr. Lockfeld stated that the "frequency would not be as important to my mind as the length of time that she maintained that posture." (*Id.* at 16). He added that "[p]rolonged kneeling or squatting is more likely to cause nerve injury." (*Id.*)

Later in the deposition, Dr. Lockfeld stated that "the amount of time spent in that posture, particularly consecutive time -- you know, several minutes or longer consecutively -- any place where she tended to do this would be more likely to cause the neuropathy." (*Id.* at 19). When asked to assume that claimant kneeled or crouched once or twice a day at work to pick up an item and also kneeled to clean the floor of her apartment twice a week, Dr. Lockfeld responded that the "more prolonged squatting would be more likely to cause this condition." (*Id.* at 24).

Although I agree with the majority that Dr. Lockfeld indicated that repetitive kneeling and crouching could cause peroneal neuropathy, Dr. Lockfeld stated several times that the length of time spent in those positions was more important in determining causation. In other words, duration was more important than frequency.

Based on claimant's own testimony, she kneeled once or twice a day at work and "sometimes" squatted. (Tr. 6). Twice a week, claimant stated that she kneeled to clean her floor at home. (*Id.* at 12). This was exactly the history given to Dr. Lockfeld to which he responded that the "more prolonged squatting would be more likely to cause this condition."

Such evidence simply does not show that claimant performed more prolonged kneeling and squatting at work and instead tends to show that such activity occurred at home. Thus, I agree with the ALJ that, because Dr. Longfeld said that *prolonged* kneeling and squatting is more likely to cause claimant's condition and the evidence tends to show that claimant performed such activity at home, claimant did not prove a compensable condition that work activities were the major contributing cause of her condition. *See* ORS 656.802(2).

In the Matter of the Compensation of
RANDAL D. ANDERSEN, Claimant
WCB Case Nos. 99-00724 & 98-08685
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's (Industrial Machine Service's) denial of claimant's low back degenerative disc condition; and (2) upheld SAIF's (McDowell Welding & Pipefitting's) denial of claimant's "new injury" claim for the same condition. Contending that claimant improperly raised additional arguments in his "Reply" brief, SAIF moves to strike his submission. On review, the issues are SAIF's procedural motion, compensability, and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

We agree with the ALJ that claimant has not met his burden of proof on the issue of compensability. However, our conclusion is based on the following analysis.

On review, SAIF moves to strike claimant's "Reply" brief, on the ground that claimant raised the issues of claims processing and a new medical condition for the first time in his reply brief. We need not address SAIF's motion to strike, as we conclude that, even under a "new medical condition" theory, claimant would not prevail on the issue of compensability.

Here, SAIF/Industrial accepted claimant's lumbosacral strain in 1997. Claimant subsequently had an onset of low back pain, diagnosed as a lumbosacral sprain, while working for McDowell, another SAIF insured. Drs. Radecki and Duff examined claimant on behalf of SAIF and reported that there was a relationship between the new injury (i.e., the 1998 incident with SAIF/McDowell) and the prior injury, in that it involved the same area and the same symptomatology. Drs. Radecki and Duff believed that the 1997 injury was aggravated at McDowell but there was not actually a new injury, since there was merely an aggravation of preexisting symptoms. The doctors reported that the "condition now has returned, based on symptoms, to the preexisting level....[thus], the September injury is felt to be the major contributing cause to his current condition and need for treatment, and at this time the condition has resolved close to preexisting level." (Ex. 34-6). Finally, the examiners opined the major cause of the development of claimant's current pathology was the preexisting condition. *Id.* Claimant's treating doctor, Dr. Breen, concurred with the opinion of Drs. Radecki and Duff. (Ex. 38, 41).

The expert medical evidence establishes that the compensable 1997 work injury and, possibly, the 1998 work incident, were the major contributing cause of claimant's need for treatment and or disability for his low back strain. However, those incidents were not the major cause of claimant's disability or need for treatment of the degenerative condition. Rather, the medical evidence shows that claimant's preexisting condition was the major contributing cause of his disability and or need for treatment of that condition. (Ex. 34).

Accordingly, because claimant's preexisting degenerative disc condition is the major cause of claimant's current disability or need for treatment, the condition is not compensable. Moreover, we reach this conclusion whether claimant's condition is based on the 1997 SAIF/Industrial claim or the 1998 SAIF/McDowell claim. ORS 656.007(a)(B). Therefore, we affirm the ALJ's order.

ORDER

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

In the Matter of the Compensation of
CAROL A. BRYANT, Claimant
WCB Case No. 99-00894
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the SAIF Corporation's denial of claimant's current neck condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for "cervical sprain" as a result of an injury occurring on May 24, 1998. On July 12, 1998, claimant again sought treatment, complaining of neck and hand symptoms. Claimant eventually was diagnosed with "cord compression" at C5-6 and underwent surgery.

The ALJ found that claimant did not carry her burden of proving compensability. Claimant challenges this conclusion, asserting that the persuasive medical opinions showed that the May 1998 injury is the major contributing cause of her current low back condition.

The record shows that claimant has preexisting degenerative changes that combined with the May 1998 injury. Thus, we apply ORS 656.005(7)(a)(B) in determining compensability.[1]

When claimant sought treatment on July 12, 1998, she complained of her hands feeling "swollen and on fire" for the "past three mornings." (Ex. 6-1). The next day, claimant's treating nurse practitioner noted that, at the time of the May 1998 injury, claimant had "neck pain but no numbness or tingling her upper extremities" and she "really had no problem since then up until this past Friday when she developed this burning." (Ex. 8).

Claimant then saw Dr. Bert, surgeon, who noted that claimant "basically had neck pain ever since" the May 1998 injury and diagnosed cervical disc syndrome. (Ex. 13).

Claimant also saw Dr. Sandell, orthopedic surgeon. Based on an MRI, Dr. Sandell found degenerative changes and a herniated disc at C5-6. (Ex. 17-2).

Dr. Keiper became claimant's treating neurosurgeon and diagnosed "C5-6 spondylitic degenerative changes with cord compression and early myelopathy." (Ex. 18-3).

Claimant was then examined by Drs. Duff, orthopedic surgeon, and Morton, neurologist. The panel found "severe pre-existing cervical spondylosis at multiple levels" that combined with the May 1998 injury. (Ex. 19-6). The panel also related the current neck condition in major part to the preexisting condition. (*Id.*)

Dr. Sandell responded to questions from claimant's attorney and indicated that claimant's pre-existing condition at C5-6 combined with the injury. (Ex. 24-1). Dr. Sandell also wrote that "the injury brought on the symptoms" and was the "proverbial action that 'broke the camel's back.'" (*Id.* at 2).

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[1] We disagree with the ALJ's application of ORS 656.262(7)(b), rather than ORS 656.005(7)(a)(B) to decide compensability. The former statute pertains to the *processing* of claims and, in particular, allows the carrier to issue a pre-closure denial in certain circumstances. *E.g., Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998). ORS 656.005(7)(a)(B), on the other hand, explicitly relates to when a "combined condition" is compensable. Because the issue in this case is compensability rather than the procedural validity of the denial, ORS 656.005(7)(a)(B) is the appropriate statute for determining compensability.

Dr. Bert also found a combined condition and stated that the May 1998 injury "cause[d] a disc herniation at C5-6." (Ex. 26).

Finally, Dr. Keiper reported that the preexisting condition and injury combined. (Ex. 25-1). The report also stated that "the injury precipitated her need for treatment" and "caused her to become symptomatic." (*Id.*) Dr. Keiper also explained that the preexisting "spondylosis caused compression of the C6 nerve roots" and the injury also resulted in a "flexion/extension injury" that "caused further compression of the nerves[.]" (*Id.*) Furthermore, the report stated that the injury "further exacerbated mild decompression" and did "nothing" to cause a pathologic worsening of the spondylosis. (*Id.*) Although Dr. Keiper indicated that claimant's condition is "equally due to the preexisting condition and the acute injury," he also explained that claimant's symptoms were from "two different causes," including a flexion/extension injury that caused compression of the spinal cord and cervical spondylosis that was previously asymptomatic and worsened by the flexion/extension injury by causing further compression of the nerves. (*Id.* at 2).

Absent persuasive reasons to the contrary, we defer to the treating physician's opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no reasons not to defer to the opinions of Dr. Keiper and Dr. Bert. Claimant was asymptomatic for years until her May 1998 injury, after which she experienced constant radicular symptoms, consistent with nerve root involvement in her neck.

Unlike the ALJ, we do not find Dr. Bert's diagnosis of a herniated disc to be a reason for discounting his opinion because we find that it is consistent with the pathological findings in her neck. Furthermore, although Dr. Keiper said that claimant's condition was "equally due to" her preexisting condition and the injury, he also further explained that the "flexion/extension injury" either caused claimant's pain or worsened the preexisting condition. Thus, viewing his entire report, we consider Dr. Keiper's opinion as showing that the compensable injury is the major contributing cause of claimant's need for treatment of her combined condition. In sum, whether claimant's condition is peripheral nerve entrapment, as diagnosed by Drs. Duff and Morton, or cord compression, we conclude that claimant carried her burden of proving compensability. *See* ORS 656.005(7)(a)(B).

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

ORDER

The ALJ's order dated June 3, 1999 is reversed. SAIF's denial is set aside and the case is remanded for processing. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,000, to be paid by the SAIF Corporation.

Board Member Haynes dissenting.

I disagree with the majority that claimant proved compensability under ORS 656.005(7)(a)(B). The majority bases this conclusion on finding the opinions of Dr. Bert and Dr. Keiper persuasive.

Both physicians had limited contact with claimant; the record shows that Dr. Bert saw claimant on only two occasions while Dr. Keiper had only one appointment with claimant before performing the surgery. Furthermore, their opinions contradict each other. Dr. Bert thought that claimant had a herniated disc at C5-6 and Dr. Keiper diagnosed "C5-6 spondylitic changes with cord compression and early myelopathy." I am unsure why Dr. Bert's opinion is persuasive when he clearly found a different condition than Dr. Keiper, who performed the surgery.

Dr. Bert's opinion also consists of the following: a "yes" response when asked whether the May 1998 injury was the major cause and, in response to the effect of the May 1998 injury to the neck, the statement that it "[c]ause[d] a disc herniation at C5-6." I fail to understand how such an opinion constitutes a well-reasoned and complete explanation for any causal relationship between the May 1998 injury and claimant's condition at C5-6.

With regard to Dr. Keiper's opinion, he explicitly stated that claimant's neck condition "is equally due to the preexisting condition and the acute injury." The majority nevertheless concludes that his opinion establishes compensability when viewed in its entirety. When I look at Dr. Keiper's entire opinion, I see statements such as the injury "precipitated her need for treatment" and "further exacerbated mild compression" without causing any pathologic worsening of the preexisting condition, which I find shows only that the May 1998 injury was merely a precipitating cause of the neck condition. Even assuming that Dr. Keiper meant to say that the May 1998 injury actually did result in cord compression, nowhere does he say that this injury was the major contributing cause; rather, as stated above, he found the neck condition "equally due" to the preexisting condition and the May 1998 injury.

Finally, neither Dr. Bert nor Dr. Keiper indicated an understanding that claimant's symptoms abated following the May 1998 injury until shortly before she sought treatment on July 12, 1998. Rather, Dr. Keiper's chartnote shows that claimant had "continuing problems" after the injury. Consequently, I find that neither physician based his opinion on an accurate history.

In my opinion, Dr. Bert provided an inconsistent diagnosis and no explanation to support his conclusion. Dr. Keiper thought that the neck condition was "equally due" to the May 1998 injury and preexisting condition. Neither physician relied on an accurate history. Based on these problems, I do not find their opinions persuasive and I agree with the ALJ that claimant did not carry her burden of proof.

In the Matter of the Compensation of
MARY A. CROWLEY, Claimant
WCB Case No. 98-05787
ORDER ON REVIEW
Donald M. Hooton, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a skin irritation (pruritic dermatitis). On review the issue is compensability. We reverse.

FINDINGS OF FACT

In 1990, claimant began work for the employer as a secretary. She worked in open floor cubicles in the Public Services building, which was built in 1990. Claimant had no health problems while working in that position. In April 1997, she moved to a plans examiner position on the third floor of the same building.

In May or June 1997, claimant began developing a rash which appeared over her face and arms, worse on the right arm where she rolled up her sleeve, than on the left. The rash had an appearance of water blisters and itched profoundly. When she scratched, the lesions would become secondarily infected. In June 1997, claimant's primary physician, Dr. Gundry, internist, prescribed topical medications and, suspecting rosacea, prescribed tetracycline in July 1997. (Ex. 17). Claimant's condition began to improve, and when she went on vacation in August 1997, her symptoms cleared up almost entirely. (Ex. 40-3).

When claimant returned to work in September 1997, her rash recurred, so Gundry referred her to Dr. Cofield, osteopath/dermatologist, for consultation and diagnosis. (Ex. 18). Dr. Cofield diagnosed rosacea and mild cystic acne, which claimant excoriated (scratched), resulting in post-inflammatory hyperpigmentation and scarring. Dr. Cofield also suspected that the scratching of her arms and chest were the result of xerotic pruritis. (Ex. 21).

On February 4, 1998, the Facilities Manager for the employer issued a letter in which employees were informed that contamination of the heating, ventilation and air conditioning (HVAC) system occurred during construction of the building, allowing debris to enter the system. HVAC system cleaning was begun in 1997 and a higher than normal amount of fiberglass particles was released into

the air, settling on work surfaces in claimant's work area. The letter assured employees that lab results from surface and air samples showed that all contamination had been removed by February 4, 1998. (Ex. 23).

On March 12, 1998, claimant reported that symptoms had returned on the back of her hands, forearm and upper chest. (Ex. 28).

On March 24, 1998, the Facilities Manager notified employees that the Facilities staff was immediately initiating clean-up of a newly discovered source of airborne fiberglass coming from fiberglass blankets that had been placed over the conference room and suspended ceilings in private offices for noise suppression. (Ex. 28).

On the same date, Dr. Gundry filed a claim for claimant's skin condition (dermatitis) and referred claimant to Dr. Bardana, Head of the Division of Allergy and Clinical Immunology at the Oregon Health Sciences University (OHSU), who saw her on April 1, 1998. (Exs. 29, 40). Dr. Gundry, as well as Dr. Bardana, had claimant reassigned to work in a different building until industrial hygiene measures completely cleared the Public Services building of excessive amounts of fiberglass. (Exs. 40-15, 45).

Dr. Bardana examined claimant and performed an extensive medical and environmental testing file review. (Ex. 40). He also had claimant examined by Dr. Parker, dermatologist. A skin biopsy was taken by Dr. White, pathologist. (Exs. 35, 36). Dr. Bardana assessed claimant's condition as follows: "Eruptive, pruritic dermatitis on exposed areas of the body with secondary excoriations and infection probably related to fiberglass exposure and infiltration into the skin at the workplace, i.e., Washington County LUT Building Services Division." (Ex. 40-15).

Claimant returned to Dr. Parker for follow-up on April 29, 1998. (Ex. 41).

On May 12, 1998, Dr. Bardana permitted claimant to return to her regular work station after receiving studies that showed five of six tests to be negative for the presence of surface fiberglass. However, Dr. Bardana was concerned about one positive test and recommended that the employer have the workplace retested in two weeks to ensure the continued absence of the fiberglass contaminant. (Ex. 42).

On May 19, 1998, Dr. Gundry reported that claimant had been in the Public Service Building for three hours, after which her rash returned. Dr. Gundry advised claimant not to return to the Public Service Building until he had assurance that the entire building had been completely cleared of fiberglass. (Ex. 45). On June 12, 1998, Dr. Gundry again reported that claimant had returned to the building for a short time and the rash returned. (Ex. 46-2).

On June 22, 1998, the employer denied claimant's claim for her skin irritation. (Ex. 49).

On October 9, 1998, Dr. Burton, medical toxicologist, performed a file review. (Ex. 53).

On November 25, 1998, Dr. Parker was deposed. (Ex. 58).

On February 1, 1999, Dr. Burton was deposed. (Ex. 59).

In a February 3, 1999 letter, Dr. Bardana provided responses to a summary of a discussion with claimant's attorney regarding her case. (Ex. 60).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's skin condition was not compensable under ORS 656.802. The ALJ reasoned that Dr. Bardana relied on Dr. Parker's earlier assessment that claimant's skin condition "may be" related to fiberglass exposure, although he was not sure, when Dr. Bardana opined that claimant's skin condition was "probably" related to her fiberglass exposure at work. The ALJ also reasoned that, because Dr. Bardana failed to state that the fiberglass exposure in the workplace was the major contributing cause of claimant's skin condition. Accordingly, the ALJ concluded that there was no persuasive medical evidence in the record to establish that claimant's workplace exposure to fiberglass was the major contributing cause of her condition. We disagree.

The record contains several medical opinions concerning causation; there is no evidence that claimant had a prior history of any skin condition. (Exs. 40, 54). Therefore, to prove her occupational disease claim for her skin condition, claimant must establish that substances to which she was exposed during her regular employment were the major contributing cause of that condition. ORS 656.266 and 656.802(1)(a)(A) and (2)(a). Whether claimant's work exposure to airborne fiberglass contamination was the major contributing cause of her skin condition presents a complex medical question requiring expert medical analysis. *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Uris v. Compensation Department*, 247 Or 420, 424-26 (1965). Moreover, as the question before us requires expert medical analysis rather than expert observation, claimant's treating physician is entitled to no special deference. *See Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979). In evaluating expert medical opinion, we rely on those opinions that are both well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

The employer conducted extensive testing of the HVAC system that provided the environmental control for the Public Services Building where claimant worked. Between 1996 and 1998, tests revealed consistent findings of higher than normal concentrations of fiberglass particles, as well as other contaminants. (Ex. 23). Sources of contamination were identified and, beginning in mid-1997, ductwork cleaning was begun. (Ex. 23-3). By May 12, 1998, Dr. Bardana, Head of the Division of Allergy and Clinical Immunology at the Oregon Health Sciences University (OHSU), was satisfied that testing demonstrated that the fiberglass contamination had apparently been eliminated.[1] (Exs. 40, 42). However, claimant's symptoms recurred when she again entered the building. Dr. Gundry, noting that the third floor had been cleaned, but not the entire building, insisted that claimant not return to that building until the remainder of the building had been cleaned and testing showed that the entire building was clean. (Ex. 45).

Opinions regarding the cause of claimant's skin condition were provided by Dr. Cofield, osteopath/dermatologist; Dr. Parker, dermatologist; Dr. Burton, specialist in occupational medicine and medical toxicology; and Dr. Bardana.

Dr. Cofield diagnosed "acne excoriae" but declined to relate the condition to claimant's work exposure to fiberglass because he had no proof of a relationship. We give Dr. Cofield's opinion little weight, as he did not have an opportunity to review the environmental testing data and, therefore, was unaware of the level and duration of exposure. Moreover, Dr. Cofield's concurrence with the opinions of Dr. Parker and Dr. Burton do not cure this defect because neither doctor discussed the testing data in their reports, nor did Dr. Cofield review Dr. Bardana's extensive report regarding the exposure data prior to his concurrences. *Carlos S. Cobian*, 45 Van Natta 1582 (1993) (opinions based on incomplete information not persuasive).

The same deficiency can be attributed to the conclusions drawn by Dr. Parker, as there is no evidence that Dr. Parker reviewed the testing data or Dr. Bardana's report. Dr. Bardana referred claimant to Dr. Parker for the purpose of developing further information on the nature of her dermatological condition. Dr. Parker took a small punch biopsy of one isolated site at Dr. Bardana's request. (Ex. 34-2, -3). The biopsy was examined by Dr. White, pathologist, who concluded that, while there was no definite evidence of fiberglass in the sections examined, the dermatologic changes observed could be caused by external material such as fiberglass. (Ex. 36).

Dr. Parker relied on the absence of fiberglass in the biopsy sample to support his conclusion that a reaction to fiberglass was not a likely cause of claimant's condition (Ex. 55-1), even though he later acknowledged that fiberglass does not penetrate the skin deeply, would not be present at all after a few weeks, and had noted that, at the time of the biopsy, claimant had been removed from the worksite exposure for several weeks. (Exs. 29, 34). Moreover, even though Dr. Parker also relied on the distribution of claimant's rash as being inconsistent with an airborne irritant, he admitted that the distribution of the rash was not entirely helpful in analyzing causation because "you can touch and put those sorts of things in other parts of the body," and that loose clothing would allow a greater probability of contact, even of covered areas. (Ex. 58-9, 58-10). Finally, in concurring with Dr. Burton's report, Dr. Parker relied on Dr. Burton's opinion that none of the industrial hygiene survey sampling revealed elevated airborne concentrations of fiberglass or any other particulates, rather than performing an independent review of the data. (Ex. 53-5).

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[1] Dr. Bardana provided a detailed summation of the testing data in his April 13, 1998 report. (Ex. 40).

We also find Dr. Burton's opinion unpersuasive. As noted above, Dr. Burton, who did not examine claimant, discounted the results of the industrial hygiene tests. He also presumed generally that workers harden with exposure to fiberglass, that fiberglass irritation is of limited duration, and that exposure to airborne fiberglass within the OSHA standard will not result in dermatitis, without considering claimant's individual sensitivity and the length of her work exposure. (Ex. 53).

Rather, Dr. Burton relied upon several medical articles published in respected medical journals to support his conclusion that claimant's skin condition was not caused by airborne fiberglass particles. Inasmuch as none of these articles pertain to claimant or the specific claim that is the subject of this proceeding, we find such foundation less persuasive than Dr. Bardana's personal examination of claimant, his analysis of her work environment, and his accurate history of the clinical course of her skin condition.

Claimant contends that the requisite major causal relationship is established by the opinion of Dr. Bardana, who evaluated claimant on referral from Dr. Gundry, her treating physician. Dr. Bardana specifically discussed the proven exposures to fiberglass, correlated claimant's clinical findings temporally with those exposures and noted that the results of the skin biopsy on claimant's chest were consistent with an external irritant dermatitis. He also demonstrated that other suggested causes of dermatitis would not produce a dermatitis with the same temporal presentation,[2] effectively eliminating non-work causes. (Ex. 60-3, -4). Dr. Bardana also discussed the fact that susceptibility to fiberglass exposure varies from person to person and is transient in nature, which makes the temporal presentation an important element in clinical diagnosis and causation. (*Id.*). He also addressed the results of the negative biopsy, noting that no alternative dermatological diagnosis was found, and that the non-specific process did not exclude a fiberglass pruritogenic dermatosis. (Ex. 60-4).

Finally, Dr. Bardana reported that claimant suffered from "Eruptive pruritic dermatitis on exposed areas of the body with secondary excoriations and infection *probably* related to fiberglass exposure and infiltration into the skin at the workplace." (Emphasis added).[3] (Exs. 40-15; 60). Although Dr. Bardana did not explicitly say that fiberglass exposure at work is the major contributing cause of claimant's skin condition, we find that his reports support such a conclusion. *Freightliner Corporation v. Arnold*, 142 Or App 98 (1996) ("[a]n expert's opinion need not be ignored merely because it fails to include 'magic words' such as 'major contributing cause'"); *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986) (a physician is not required to use "magic words" in a medical report).

Therefore, based on the persuasive expert opinion of Dr. Bardana, we conclude that claimant has established that her exposure to airborne fiberglass in her work environment is the major contributing cause of her skin condition. ORS 656.802.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.[4]

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[2] Claimant's skin condition began during her employment in the Public Services Building at the time that cleaning of the HVAC system began and cleared each time she was away from the building for an extended time, twice for vacations and subsequently when her work site was moved to a different building in response to the redevelopment of skin irritation. (Ex. 40).

[3] Unlike the ALJ, we find that Dr. Bardana's opinion was not based on Dr. Parker's earlier assessment that the condition was only possibly related, but was based on reasonable probability. Dr. Bardana's discussion of the biopsy results indicates that the test itself did not provide an alternative cause for claimant's condition and did not exclude fiberglass as a cause. (Ex. 60). Given the overall comprehensiveness of Dr. Bardana's assessment, we find no reason to infer that when he wrote the word "probably" he meant mere possibility.

[4] We note that a different attorney represented claimant at hearing. We award one attorney fee payable by the employer to claimant's current attorney of record (the attorney who represented claimant on review). The particular manner in which that fee will be subsequently distributed between claimant's current and former attorneys is a matter to be decided between the two of them. *Gabriel Zapata*, 46 Van Natta 403, 405 n.1 (1994).

ORDER

The ALJ's order dated March 11, 1999 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded a fee of $4,500, to be paid by the employer.

In the Matter of the Compensation of
RORY DATTILO, Claimant
WCB Case No. 98-01774
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) found that its partial denial of claimant's cervical condition was not premature; and (2) set aside its partial denial of claimant's injury claim for dysthesias/myalgias and cervical complaints. On review, the issues are the propriety of the insurer's denial and compensability. We affirm.

FINDINGS OF FACT

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

On October 30, 1997, claimant slipped, landing on his buttocks and hitting his right shoulder. Claimant was off work for four days and then returned to his regular work.

About two to two and a half weeks after the incident, claimant noted pain in his neck and shoulders. (Tr. 19). On November 20, 1997, claimant sought treatment from Dr. Thueson, family practitioner, for his low back. Claimant also mentioned his upper back and neck complaints. (Ex. 16-9).

On November 24, 1998, claimant filed a form "801" for the low back injury.

On December 8, 1997, Thueson noted increased bilateral shoulder and neck pain and recommended neurosurgical evaluation. (Exs. 1-2, 16-11). The evaluation did not take place, but Thueson ordered physical therapy for both the low back and the neck. (Ex. 16-12). By January 27, 1998, claimant's neck and shoulder pain had worsened, left greater than right. (Ex. 16-13).

On February 17, 1998, the insurer accepted a disabling claim for low back strain and disc herniation at L4-5. On the same date, the insurer issued a partial denial of "dysthesias/myalgias and cervical complaints."

An April 2, 1998 MRI showed minor degenerative changes in the cervical spine without obvious herniations. An April 15, 1998 EMG found cervical radiculopathy at C6, C7 and C8 on the left.

CONCLUSIONS OF LAW AND OPINION

At hearing, the insurer argued that its partial denial of claimant's neck condition was premature because claimant had not filed a claim for that condition. The ALJ concluded that the partial denial was not premature and that claimant's neck injury was compensable. On review, the insurer continues to argue that its partial denial was premature and a nullity, and, alternatively, that claimant has not proved compensability. We disagree.

Premature Denial

The insurer issued a Notice of Acceptance on the same day it issued its partial denial of claimant's "dysthesias/myalgias and cervical complaints." At hearing, the insurer asserted that claimant had never made a claim for those conditions because he had not written to the insurer objecting to the Notice of Acceptance or requesting acceptance of the additional conditions after the Notice of Acceptance issued. *See* ORS 656.262(6)(d) and (7)(a). We conclude that those statutes are not applicable in this case because claimant filed a claim for those conditions prior to its Notice of Acceptance.

In *Johansen v. SAIF*, 158 Or App 672, 679 (1999), the court held that a new medical condition under ORS 656.262(7)(a) "(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 also Mark A. Baker*, 50 Van Natta 2333, 2336 (1998) (a new medical condition under ORS 656.262(7)(a) is one that "comes into being" following issuance of the Notice of Acceptance).

Here, Dr. Thueson diagnosed claimant with "bilateral anterior shoulder pain likely due to C-spine" on December 8, 1997. (Ex. 1-2, 14A). The insurer did not accept a low back strain and disc herniation at L4-5 with radiculopathy until February 17, 1998. (Ex. 7). Thus, claimant's cervical condition "existed" at the time the employer issued its Notice of Acceptance. Because the cervical condition arose before acceptance of the initial claim, ORS 656.262(7)(a) does not apply to this case and claimant was not required to file a "new medical condition" claim.

Also in *Johansen*, 158 Or App at 678, the court said that, under ORS 656.262(6)(d), once a claim is accepted, a claimant can object to the notice of acceptance and seek to have any omitted conditions included. In *Baker*, 50 Van Natta at 2336, we concluded that a condition that is incorrectly omitted from a Notice of Acceptance under ORS 656.262(6)(d) is a condition that is in existence at the time of the notice, but is not mentioned in the notice or is left out. That particular condition would be part of the initial claim, rather than a "new medical condition," for which a separate claim would be required.

In an initial claim for compensation, a physician's report requesting medical services for a specified condition in addition to medical treatment being provided for the accepted condition constitutes a "claim." *Gustavo B. Barajas*, 51 Van Natta 613 (1999) (citing *Safeway Stores, Inc. v. Smith*, 117 Or App 224, 227 (1992) and *Garnet D. Toll*, 50 Van Natta 1346 (1998)).

Here, on December 8, 1997, Dr. Thueson, claimant's attending physician, noted that claimant was experiencing increased bilateral shoulder and neck pain "likely due to C-spine" and recommended neurosurgical evaluation. (Exs. 1-2, 16-11). Dr. Camaro did not address claimant's neck complaints (Ex. 4), but Thueson ordered physical therapy for both the low back and the neck (Exs. 5-2, 16-12). By January 27, 1998, claimant's neck and shoulder pain had worsened, left greater than right. (Ex. 16-13).

In a February 1, 1998 letter responding to the insurer's inquiry, Thueson reported claimant's current diagnoses and treatment as "Stable but unresolved lumbar disc disease. Also notes upper chest/shoulder symptoms onset about the same time but never evaluated due to the more severe lumbar symptoms. Now having dysthesias/myalgias which may be due to cervical disc problem. Has received some attention to the upper body symptoms with physical therapy but maybe worsened." Thueson also noted that claimant may need an MRI for his cervical spine. (Ex. 7).

These medical records and provision of treatment constitute part of the initial claim under ORS 656.005(6) and that claim was made before the February 17, 1998 Notice of Acceptance issued.[1] Therefore, because the February 17, 1998 partial denial was issued in response to an initial claim being made for these conditions, the insurer's partial denial of claimant's claim for cervical dysesthesias/myalgias was not premature.[2]

Compensability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.

Relying on attending physician Dr. Thueson's opinion, the ALJ found that claimant had proved by a preponderance of the evidence that the material contributing cause of his neck condition was his October 30, 1997 work injury. *See* ORS 656.266; 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113

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[1] We note that medical evidence linking the cervical and dysesthesias/myalgias conditions to work is not required to accompany the "claim" under ORS 656.005(6), *Barbara D. Hodgin*, 51 Van Natta 170, 171 (1999), nor is the carrier's obligation to process it contingent on the carrier's knowledge at the time of the injury that the claim is compensable, *Allied Systems Co. v. Nelson*, 158 App 639 (1999).

[2] We distinguish this case from *Ralph L. Morris*, 50 Van Natta 69 (1998). In *Morris*, we applied ORS 656.262(6)(d) and 656.262(7)(a) to hold that the carrier's denial (that issued the same day as its Notice of Acceptance) was premature. This case, however, involved an initial claim, whereas in *Morris* the claim was analyzed as a new medical condition claim.

Or App 411 (1992). On review, the insurer contends that we should reject Thueson's opinion because of the three-week delay in the appearance of claimant's symptoms and because it does not satisfy the *Dietz v. Ramuda* standard. We disagree.

After *de novo* review, we agree with the ALJ's findings that claimant noted pain in his neck and shoulder about two to two-and-one-half weeks after his compensable October 30, 1997 injury (Tr. 19), and, on November 20, 1997, he reported his upper back and neck complaints to Dr. Thueson during treatment for his low back (Ex. 16-9). This is sufficient to establish the onset of claimant's symptoms as less than three weeks after the injury.

When claimant's condition did not improve after physical therapy and steroid treatment, an MRI was performed that revealed minor degenerative changes in claimant's cervical spine. (Ex. 16-15). Thereafter, an EMG showed abnormalities between C5 and C8 consistent with cervical radiculopathy. Dr. Thueson concluded that claimant had a "little brachioplexis stretch where the nerves are stretched a little bit from the head flopping over" at the time of injury, which was consistent with claimant's mechanism of injury. (Ex. 16-16). Thueson also opined that the minor degenerative changes shown on the MRI did not cause claimant's cervical symptoms. (Ex. 16-17, -18).

In formulating his causation analysis, Thueson considered the mechanism of injury and evaluated the relative contribution of all causative factors, including claimant's degenerative condition and any off-the-job contributors. Thueson is also the attending physician and thus his opinion is entitled to greater weight absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). We find no such persuasive reasons in this record. Therefore, we conclude that Thueson's opinion satisfies claimant's burden of proof by a preponderance of the evidence. ORS 656.266; *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev den* 321 Or 416 (1995) (to be persuasive expert opinion, a doctor must consider or evaluate the relative contribution of all causative factors, including any preexisting conditions, in forming his causation opinion).[3]

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

ORDER

The ALJ's order dated October 21, 1998, as reconsidered April 1, 1999, is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the insurer.

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[3] Although the medical evidence discussed above does not indicate that claimant's degenerative condition combined with his neck injury, the persuasive medical opinion is sufficient to establish compensability under the major contributing cause standard. *See Dietz*, 130 Or App at 401 (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).

October 28, 1999 Cite as 51 Van Natta 1835 (1999)

In the Matter of the Compensation of
MIRCEA GAVRILA, Claimant
WCB Case No. C992316
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Peter O. Hansen, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On September 29, the Board received the parties' claim disposition agreement (CDA). 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.

On October 7, 1999, the Board approved the parties' CDA. On October 14, 1999, we received a letter from the carrier's attorney, requesting reconsideration and amendment of the claim number and date of injury to be disposed of by the CDA. Specifically, the claim number was corrected to C-1160589 and the date of injury to September 25, 1998.

To be considered, a motion for reconsideration of the approved CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Because the request for reconsideration was received within 10 days of the mailing of the order of approval, it is timely. OAR 438-009-0035(1). Thus, we grant the request for reconsideration.

On reconsideration, we find that the amended agreement, as interpreted herein, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). Accordingly, the CDA , as amended by the parties' counsel's letters and this order, is approved.

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

IT IS SO ORDERED.

October 28, 1999 Cite as 51 Van Natta 1836 (1999)

In the Matter of the Compensation of
WILLIAM J. GOHEEN, Claimant
WCB Case No. C992232
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Doblie & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

On September 20, 1999, the Board received the parties' claim disposition agreement (CDA). 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 and assistance under the Re-Employment Assistance Reserve, for the compensable injury. For the following reasons, we approve the proposed disposition.

The first page of the proposed CDA provides that the total proceeds due claimant is $7,500 and the total due claimant's attorney is $2,500, which equals a total consideration of $10,000. However, the total recited on page 3, line 3 of the document is "$10,500" instead of $10,000. On page 3, line 14 of the CDA, the attorney fee (consistent with the first page) is given as $2,500. Thus, the lone reference on page three of the document to a total consideration of $10,500 appears to be an error. Accordingly, we interpret the agreement as providing for a total consideration of $10,000, with $7,500 consideration to claimant, and $2,500 to claimant's attorney.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $2,500, 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
SANDRA K. MITCHELL, Claimant
WCB Case No. 99-00856
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney
Gatti, Gatti, et al, Attorneys

Reviewed by Board Members Biehl, Bock and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of her left wrist injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable left wrist fracture on November 4, 1998. On December 20, 1998, claimant experienced another incident at work that caused left wrist discomfort and prompted her to seek medical treatment the following day from Dr. Neuberg, who had also treated the previous wrist fracture. SAIF denied the December 20, 1998 claim, alleging that it was not supported by "objective" findings. (Ex. 8). Claimant requested a hearing from the denial.

The ALJ upheld SAIF's denial, finding that the alleged injury was not established by medical evidence supported by objective findings as required by ORS 656.005(7)(a). In doing so, the ALJ relied on Dr. Neuberg's opinion/findings regarding the presence of objective findings over that of Dr. Weaver, a chiropractor who evaluated claimant's condition over two months after the December 20, 1998 incident.

On review, claimant contends that the claim was supported by "objective findings." We agree.

ORS 656.005(19) provides:

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

A physician's indication that the worker experiences pain, standing alone, is insufficient to constitute "objective findings." *See Jairo J. Garcia*, 48 Van Natta 235 (1996). But a physician's interpretation of a worker's verifiable subjective response to clinical testing may be sufficient, provided it was "reproducible, measurable or observable." *Tony C. Houck*, 48 Van Natta 2443, 2448-49 (1996), *aff'd mem* 151 Or App 200 (1997). Meeting any one of the latter three requirements satisfies the statute. *Id.* at 2449.

Dr. Neuberg reported on December 21, 1998, the day after the alleged injury, that claimant's left wrist appeared normal (without discoloration), that there was no tenderness on palpation over the distal radius, and that range of motion was "fairly normal." (Ex. 7). It is of some importance that Dr. Neuberg had previously reported on November 24, 1998 (with regard to the wrist fracture claim) that claimant's range of motion was "nearly normal." Claimant argues, based on dictionary definitions of "nearly" and "fairly" that range of motion was reduced as a result of the December 1998 incident and that this constitutes an "objective" finding in support of the claim.

We need not decide whether the distinction claimant draws between the terms "nearly" and "fairly" is persuasive. That is, regardless of whether Dr. Neuberg's findings would qualify as

"objective" under the statute, Dr. Weaver did report findings that satisfy the statutory requirements.[1] On examination, Dr. Weaver stated that claimant had "mild noticeable left wrist edema" and that "supination" was "positive for 2+ pain at 90 degrees." (Ex. 11-2). We, therefore, conclude that Dr. Weaver's report establishes the presence of findings that were observable or measurable and, thus, qualify as "objective findings" under ORS 656.005(19).[2]

Accordingly, we find that the December 20, 1998 left wrist claim was supported by "objective" findings. Because both Dr. Neuberg and Dr. Weaver opined that claimant sustained a left wrist sprain due to the December 20, 1998 incident, we reverse.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated May 25, 1999 is reversed in part and affirmed in part. That portion that upheld SAIF's denial is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

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[1] We agree, however, with claimant that, read in their entirety, Dr. Neuberg's reports support compensability of the claim. For instance, Dr. Neuberg consistently opined that claimant sustained a left wrist sprain as a result of the December 20, 1998 incident. (Exs. 6, 7, 9, 12). In addition, Dr. Neuberg's records document consistent left wrist discomfort during physical examinations of claimant. *Compare Joseph M. Stransky*, 51 Van Natta 143 (1999) (reproducible "tenderness" sufficient to establish "objective findings"). Thus, we concur with claimant's assessment that Dr. Weaver's and Dr. Neuberg's opinions are not divergent regarding the compensability of her left wrist claim.

[2] The ALJ discounted Dr. Weaver's findings because he did not treat claimant and only examined claimant at the request of claimant's counsel. In addition, the ALJ reasoned that Dr. Weaver's findings were deficient because he examined claimant when acute symptoms would not have been present and that Dr. Neuberg's findings were preferable to Dr. Weaver's because the former physician examined claimant both before and after the December 20, 1998 incident. We do not find the ALJ's reasoning persuasive. No adverse effect should be attached to the fact that Dr. Weaver examined claimant at her counsel's request. *See Roseburg Forest Products v. Glenn*, 155 Or App 318, 321-22 (1998) (that a medical opinion is rendered in anticipation of litigation is not a proper basis for giving "little weight" to the opinion). In addition, the medical evidence does not establish the point at which acute symptoms from the alleged injury would have disappeared. Finally, we do not find evidence that a lack of opportunity to observe the left wrist condition both before and after the injury meaningfully affected Dr. Weaver's ability to report observable or measurable findings due to the compensable injury.

Board Member Haynes dissenting.

The majority concludes that claimant's left wrist claim is supported by "objective" findings. Because I would not reach such a conclusion, I respectfully dissent.

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."

As the majority correctly observes, a physician's indication that the worker experiences pain, standing alone, is insufficient to constitute "objective findings." *Jairo J. Garcia*, 48 Van Natta 235 (1996). A physician's interpretation of a worker's verifiable subjective response to clinical testing, however, may be sufficient, provided the response was "reproducible, measurable or observable." *Tony C. Houck*, 48 Van Natta 2443, 2448-49 (1996), *aff'd mem* 151 Or App 200 (1997).

Here, Dr. Neuberg provided the most persuasive medical evidence on the objective-findings issue because she treated claimant both before and after the December 20, 1998 injury. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 421 (1986). Dr. Neuberg reported on December 21, 1998 that claimant's left wrist appeared normal, that there was no tenderness on palpation over the distal radius, and that range of motion was "fairly normal." (Ex. 7). None of these findings qualify as "objective" under the statute.

Claimant, nevertheless, notes that Dr. Neuberg had previously reported on November 24, 1998 (with regard to a previous wrist fracture claim) that claimant's range of motion was "nearly normal." Claimant argues, based on dictionary definitions of "nearly" and fairly," that range of motion was reduced as a result of the December 1998 incident and that this constitutes an "objective" finding in support of the claim.

I am not persuaded by the fine distinction claimant draws between the terms "nearly" and "fairly." In any event, Dr. Neuberg declared prior claimant's left wrist fracture condition medically stationary on January 14, 1999 with loss of range of motion, albeit minimal. (Ex. 9a). Because Dr. Neuberg found reduced range of motion due to the prior injury in an examination that occurred *after* the December 20, 1998 injury, I am not persuaded that, even if claimant experienced reduced range of motion on December 21, 1998, that it was necessarily the result of the December 20, 1998 incident.

Accordingly, because Dr. Neuberg does not document the presence of findings related to the December 20, 1998 incident that were reproducible, measurable or observable, I would find that Dr. Neuberg's opinion/findings do not establish the presence of "objective" findings in support of the claim. I acknowledge, however, that Dr. Weaver did report findings (mild noticeable edema and positive supination) that could qualify as "objective" under the statute. (Ex. 11-2). Although the majority concludes that these findings constitute "objective" findings, there is no indication that they were related to the left wrist injury more than 2 months before Dr. Weaver's examination. Moreover, I agree with the ALJ that Dr. Neuberg's opinion is more persuasive than Dr. Weaver's with respect to whether the December 20, 1998 incident produced "objective" findings, given that Dr. Neuberg treated claimant both before and after the alleged injury and examined claimant contemporaneously with the December 20, 1999 incident.

On this record, I am unable to conclude that the December 20, 1998 left wrist claim was supported by "objective" findings. Because the majority reaches the opposite conclusion, I dissent.

In the Matter of the Compensation of
RAYMOND MONTGOMERY, Claimant
WCB Case No. 98-07112
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that found that he was not entitled to temporary disability benefits beginning July 25, 1998. On review, the issue is entitlement to temporary disability benefits.

We adopt and affirm the order of the ALJ.

ORDER

The ALJ's order dated May 3, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's opinion that adopts the ALJ's order finding claimant not entitled to temporary disability benefits. The ALJ found that claimant was fired for failing to appear for a third drug test as allowed by company policy. Although claimant did not appear for the third drug test, he did have a legitimate reason for failing to do so. Specifically, claimant obtained an attorney who

attempted to discover the reason for claimant's third drug test in light of the fact that the prior two drug tests had been negative. Nevertheless, claimant was fired when he failed to appear. The result of the majority opinion is that claimant is deprived of temporary disability benefits for a justified failure to appear for a drug test. That result allows an employer to avoid paying benefits if it terminates the worker in keeping with its policy, but at the expense of claimant's right to seek counsel.

The objectives of Oregon's Workers' Compensation Law are set forth at ORS 656.012. They specifically state that our laws are intended to accomplish the following:

> "(2)(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."

Additionally, ORS 656.012(3) provides that, "In recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner."

The consequences in this case, the deprivation of claimant's time loss entitlement, are not equitable under the majority's interpretation of the case law and violate the policies set forth by the Legislative Assembly. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
LARRY J. MORGAN, Claimant
WCB Case Nos. 98-09689 & 97-09267
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On September 24, 1999, we abated our August 25, 1999 order affirming the 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 granted by a November 2, 1998 Order on Reconsideration, to zero. We took this action to consider claimant's motion for reconsideration. Having received the insurer's response, we now proceed with our reconsideration.

Contending that the conclusion of the medical opinion on which we relied (Dr. Taylor's) was based on "fictitious" evidence, and that we improperly placed the burden of proof, claimant asserts that the reconsideration order's award of unscheduled permanent disability should be reinstated. For the following reasons, we do not find claimant's contentions persuasive.

In our prior order, we found that Dr. Taylor, claimant's attending physician, provided the most thorough and well reasoned assessment of claimant's injury-related impairment. In doing so, we noted Dr. Taylor's opinion that claimant had not suffered permanent brain damage was based on his understanding that claimant had been performing volunteer firefighting duties since July 1996. Claimant objected to Dr. Taylor's opinion because it was based on hearsay provided by the insurer that was not corroborated by direct evidence in the record. We were unpersuaded by this argument because a prior ALJ had expressly found that claimant had a full-duty release to the fire department from July 8, 1996 to March 20, 1997. In a footnote, we further concluded that it was the "law of the case" that claimant performed firefighting work between July 1996 and March 20, 1997.

Claimant renews his objection to Dr. Taylor's opinion, noting that a release to full duty does not necessarily mean that full duty was actually performed. Claimant further notes Dr. Taylor's initial conclusion on March 7, 1997 that claimant was medically stationary with permanent disability associated with chronic, ongoing headaches related to his compensable concussion. (Ex. 25-1). However, claimant further observes that, after being informed by the insurer's attorney on March 20, 1997 that claimant had been performing "extensive fire fighting work," Dr. Taylor then concluded that claimant was not disabled because of an alleged inconsistency between the information the insurer provided and claimant's statements regarding his inability to work. *Id.*

Claimant alleges that Dr. Taylor's change of opinion was based on "fictitious," uncorroborated information that is contradicted elsewhere in the record by claimant's reported statements that his activity at the fire department was limited to conversing with friends. (*e.g.* Ex. 15-7). Claimant argues that Dr. Taylor's "change of opinion" is, therefore, unreliable and that his initial opinion should be found more persuasive. We disagree.

In this regard, we note that this claim was initially closed by Notice of Closure on June 17, 1997 with no award of permanent disability. (Ex. 29). Claimant requested reconsideration, including promulgation of a temporary rule to address impairment due to chronic, recurrent post-concussion headaches. (Ex. 34). The Department found that the "standards" adequately addressed claimant's disability and that, therefore, there was no reason to promulgate a temporary rule. The October 16, 1997 reconsideration order awarded no permanent disability. (Ex. 35).

Among the documentary records considered by the Department were Dr. Taylor's March 7, 1997 and March 20, 1997 reports, as well as Dr. Taylor's June 2, 1997 letter in which he concluded that claimant had not suffered brain damage. (Ex. 35-1). Claimant would have had the opportunity to correct the information on which Dr. Taylor relied in his March 20, 1997 "change of opinion" (which claimant now contends is "fictitious") prior to the June 1997 closure (as well as during the reconsideration proceedings).[1] Moreover, the prior reconsideration order specifically found the March 20, 1997 report from Dr. Taylor to be "accurate and reliable." (Ex. 35-1). Claimant did not appeal the October 16, 1997 reconsideration order which became final.

Because claimant neglected to "correct" the basis for Dr. Taylor's so-called "change of opinion," we consider claimant's current challenges to Dr. Taylor's opinion to be unpersuasive.[2] Accordingly, we conclude that this record does not establish that the information on which Dr. Taylor relied (although provided by the insurer and not directly corroborated in the record) was incorrect. Thus, we reject claimant's contention that Dr. Taylor's March 20, 1997 opinion was based on "fictitious" information.

Finally, we disagree with claimant's contention that we misallocated the burden of proof. As we acknowledged in our prior order, the insurer had the burden of proving that claimant's unscheduled permanent disability award should be reduced because it requested the hearing challenging the reconsideration order's 14 percent award. *See Roberto Rodriguez*, 46 Van Natta 1722 (1994). Nevertheless, we disagree with claimant's contention that, if there is no persuasive opinion regarding claimant's permanent impairment, then the insurer has failed to satisfy its burden and, therefore, the reconsideration order must be affirmed. To the contrary, we conclude that, because the insurer has established that there is no persuasive medical opinion supporting the presence of permanent impairment, it has proved that the November 2, 1998 reconsideration order's unscheduled permanent disability award was incorrect. *See* OAR 436-035-0007(1) (a worker is entitled to a value under the standards only for findings of permanent impairment).

Therefore, on reconsideration, as supplemented herein, we adhere to and republish our August 25, 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] ORS 656.268(6)(a) provides that "At the reconsideration proceeding, the *worker* or the insurer or self-insured employer may correct information in the record that is erroneous***." (emphasis added)

[2] We agree, however, with claimant that our statement that the "law of the case" was that claimant performed firefighting work between July 1996 and March 20, 1997 was not supported by the prior ALJ's finding that claimant was *released* to full duty. Claimant correctly notes that a full work release does not necessarily mean that full duty was actually performed. Despite this, we find Dr. Taylor's March 20, 1997 opinion is a reliable assessment of claimant's impairment.

In the Matter of the Compensation of
MICHEAL MORROW, Claimant
WCB Case No. 98-09933
ORDER ON REVIEW
Brothers & Ash, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's occupational disease claim for hearing loss. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Since 1971, claimant has worked primarily in lumber/plywood mills. Claimant did not work in the industry between 1976 and 1979, when he worked for a mobile home manufacturer, and between 1979 and 1981, when claimant was attending school. Apparently, the insurer began its coverage of the workplace in 1987, although the present employer did not acquire it until 1991 or 1992. Claimant has not worked since 1996.

Citing ORS 656.802 and the last injurious exposure rule, the ALJ found that claimant proved compensability of his hearing loss condition. In particular, the ALJ found that claimant's treating physician, Dr. Freiss, provided the more persuasive medical opinion and thereby proved that occupational noise was the major contributing cause of claimant's hearing loss. The insurer challenges this conclusion, asserting that Dr. Freiss' opinion was not sufficiently persuasive and that the ALJ's legal analysis was flawed.

Examining otologist, Dr. Hodgson, found that, based on a 1983 audiogram, claimant had significant hearing loss before 1987. (Ex. 10B-6). Based on hearing tests performed during the evaluation, Dr. Hodgson indicated that the "pattern of hearing loss seen in this case is suggestive of noise-induced damage." (*Id.* at 4). Dr. Hodgson, however, also found asymmetric hearing loss, which he explained was "not typical of occupational noise exposure in which the hearing loss is generally symmetric." (*Id.*) Dr. Hodgson was "unable to determine any likely cause of the asymmetry based on [claimant's] history" and there "was nothing in his description of his work-related activities at the various mills that would account for such a discrepancy between the two ears." (*Id.*)

After reviewing the 1983, 1990 and 1998 hearing loss tests, Dr. Hodgson found that each ear demonstrated hearing loss at different time periods. Dr. Hodgson stated that it was "difficult to explain why one ear would be changing at one time period and another ear at another time period on the basis of noise exposure" because "ambient noise exposure tends to cause symmetric hearing loss in both ears and there is no explanation in the work activities as to why the noise exposure at these mills would cause hearing loss only on the left side." (*Id.* at 5).

According to Dr. Hodgson, claimant's hearing loss was caused by "noise exposure[,] idiopathic factors and possible familial factors, both before 1987 and after 1987." (*Id.* at 6). Finally, Dr. Hodgson reported that "it was impossible for work exposure after January 1, 1987 to worsen [claimant's] hearing loss" because the "marked symmetry * * * cannot be explained on the basis of the noise exposure." (*Id.* at 7).

Dr. Freiss reported that claimant "has constantly worked in the lumber mill business" and that claimant's hearing loss was "very characteristic of noise damage." (Ex. 13). Dr. Freiss also found that claimant's "hearing has declined since 1987, and I see no other factors other than very loud noise exposure as a suggestive cause." (*Id.* at 2). According to Dr. Freiss, "[i]n the absence of any other history to suggest a cause for hearing loss, noise exposure is most likely the cause." (*Id.* at 1).

In evaluating the persuasiveness of medical opinions, we generally rely on the treating physician, absent reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Freiss' opinion. First, we find that, because this case involves evaluating hearing loss tests in light of claimant's history of noise exposure, the medical opinions are based on expert analysis rather than external observation; thus, Dr. Freiss' status as the treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284, 287 (1986).

Furthermore, a worker does not carry his or her burden of proving compensability "by disproving other possible explanations of how the injury or disease occurred." ORS 656.266. Thus, the record must contain some affirmative evidence that the condition is caused by the claimant's work exposure. *See Bronco Cleaners v. Velasquez*, 141 Or App 295 (1996). Here, Dr. Freiss in part concludes that noise exposure caused claimant's hearing loss because of "the absence of any other history to suggest a cause for hearing loss," which we find is not affirmative evidence of causation. The only explanation Dr. Freiss provides that affirmatively relates work exposure to claimant's hearing loss is his statement that the pattern of hearing loss was characteristic of noise exposure.

We find such reasoning inadequate in light of Dr. Hodgson's report that claimant demonstrated asymmetrical hearing loss, which was not consistent with noise exposure and led him to conclude that idiopathic and familial factors also contributed to the condition. Dr. Freiss does not address or even acknowledge the asymmetrical pattern of claimant's hearing loss.

Finally, because Dr. Freiss stated that claimant "constantly worked in the lumber mill business," he does not acknowledge claimant's hiatus from the mills from 1976 to 1981. Thus, we find that Dr. Freiss' history was not entirely accurate.

Consequently, at best, we find the medical opinions to be in equipoise. Thus, because we do not find Dr. Freiss' opinion more persuasive, claimant failed to carry his burden of proving compensability. *See* ORS 656.802(2).

ORDER

The ALJ's order dated March 29, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee also is reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority's decision reversing the ALJ's order and concluding that claimant did not prove compensability. Thus, I dissent.

First, I note that claimant was only 46 years old and has worked nearly exclusively in the lumber mill industry. There was no evidence of any off-work noise exposure.

Claimant clearly has hearing loss. Given his work history and lack of any other noise exposure, I find no reason not to defer to Dr. Freiss' opinion that claimant's condition was caused by his work. Although the majority finds that Dr. Freiss did not rely on an entirely accurate history, because claimant worked outside the lumber industry for a short period, this fact does not invalidate Dr. Freiss' opinion. Furthermore, the asymmetry of claimant's hearing loss at the 3000 - 4000 HZ does not undermine Dr. Freiss' opinion because Dr. Hodgson could not explain what that discrepancy means and still concluded that claimant's pattern of hearing loss was suggestive of noise-induced damage. Consequently, I agree with the ALJ's evaluation of the medical evidence and also his conclusion that claimant carried his burden of proof.

Finally, in its brief on review, the insurer argues that it can shift responsibility to a prior employer because it was impossible for exposure during the employer's coverage to have contributed to claimant's hearing loss. First, there is no persuasive medical evidence supporting the insurer's argument. Moreover, the insurer did not issue a disclaimer of responsibility as required by ORS 656.308(2)(a). Based on this failure, I agree with the dissent in *Daniel R. Smith*, 51 Van Natta 694 (1999), that the insurer thus is precluded from disputing responsibility.

In the Matter of the Compensation of
PATRICIA J. SCHILLING, Claimant
WCB Case No. 98-09225
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) upheld the insurer's denial of her injury claim for a fracture at T-10; (2) declined to assess penalties for an alleged failure to timely accept or deny the claim; and (3) declined to assess penalties for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

Claimant argues, relying on Drs. Cummings, Isaacson and Nyquist, that she has established compensability of her T-10 fracture. None of these physicians' opinions persuasively supports compensability.

Dr. Cummings' opinion is inadequate to establish compensability because he does not address the compensability of a fracture at T-10. Instead, his opinion addresses a fracture at T-12. Claimant is not contending that her T-12 fracture is compensably related to the June 8, 1998 injury. Under such circumstances, Dr. Cummings' opinion is not relevant to the compensability issue and certainly cannot establish compensability of the T-10 fracture.

For the reasons set forth by the ALJ and reiterated here, Dr. Isaacson's opinion is legally insufficient to establish compensability of the T-10 fracture. Specifically, Dr. Isaacson opined that claimant's T-10 vertebra fracture was "contributed to by her underlying osteoporosis, but the immediate cause of the injury was her work exposure." Dr. Isaacson's opinion establishes no more than the fact that the injury precipitated claimant's symptoms. Under ORS 656.005(7)(a)(B), evidence that a work injury precipitated the symptoms of a condition does not necessarily mean that the injury was the major contributing cause of the condition. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). A persuasive medical opinion must evaluate the relative contribution of different causes and explain why the compensable injury contributed more to the claimed condition than all other causes or exposures combined. *Id.*

Here, Dr. Isaacson, though acknowledging contribution from the preexisting osteoporosis, did not evaluate the relative contribution of the osteoporosis versus the injury and did not explain that the injury contributed more to the cause of the fracture than the preexisting osteoporosis. Such an opinion is legally insufficient under *Dietz* and ORS 656.005(7)(a)(B) to establish compensability.

Claimant also relies on Dr. Nyquist's opinion to establish compensability in conjunction with Dr. Isaacson and Dr. Cummings (who as previously noted does not even address the claimed T-10 fracture condition). Dr. Nyquist, in Exhibit 68, checked a box indicating that the compensable injury was the major contributing cause of the compression fracture. In rendering his opinion in Exhibit 68, Dr. Nyquist did not mention or discuss claimant's preexisting osteoporosis condition. However, in Exhibit 102, Dr. Nyquist stated that because of preexisting below normal bone density, claimant was more prone to suffering compression fractures or other fractures. Dr. Nyquist opined that claimant's preexisting osteoporosis condition combined with the work injury. The doctor was unable to determine whether the injury or the preexisting condition was the major contributing cause of the fracture.[1] In short, there is no persuasive medical evidence in the record that supports compensability of the T-10 fracture.

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[1] Claimant argues that Dr. Nyquist's opinion in Exhibit 102 addresses the wrong standard because the issue under ORS 656.005(7)(a)(B) is whether the injury is the major contributing cause of claimant's need for treatment or disability rather than the major contributing cause of the combined condition. Thus, claimant urges the Board to rely on Dr. Nyquist's first opinion in Exhibit 68, rather than his opinion in Exhibit 102. Because, however, Dr. Nyquist's first opinion does not even mention the preexisting osteoporosis or its contribution to the T-10 fracture, it does not persuasively establish compensability under ORS 656.005(7)(a)(B).

ORDER

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

Board Member Biehl dissenting.

I would find, based on the opinions of Drs. Cummings, Nyquist and Isaacson, that claimant has met her burden of proof to establish compensability of her T-10 fracture. In this regard, Dr. Isaacson opined that the June 1998 injury resulted in a T10 fracture and stated that, although the injury was contributed to by claimant's osteoporosis, the immediate cause of the injury was her work exposure. In his initial opinion, Dr. Nyquist opined that the injury was more than 51 percent responsible for claimant's need for treatment. Although Dr. Nyquist later opined that he could not determine whether the osteoporosis or the injury was the major contributing cause of the combined condition, the proper inquiry is whether the injury is the major contributing cause of the *need for treatment of the combined condition or the disability of the combined condition.* Thus, Dr. Nyquist's second opinion should be disregarded. Dr. Cummings' opinion likewise supports compensability in that he opined that the work injury was the major contributing cause of claimant's problems, although he did not specifically diagnose the T10 fracture.

Based on this evidence, I would set aside the carrier's denial. In addition, because the carrier acknowledges that its denial was untimely and offers no reasonable explanation, I would assess a penalty pursuant to ORS 656.262(11)(a).

October 28, 1999 Cite as 51 Van Natta 1845 (1999)

In the Matter of the Compensation of
KATHERINE M. TOFELL, Claimant
WCB Case No. 99-02127
ORDER ON REVIEW (REMANDING)
Black, Chapman, et al, 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) Stephen Brown's order that found that it prematurely closed claimant's claim. On review, the issue is premature claim closure. We reverse and remand.

FINDINGS OF FACT

Claimant has an accepted claim for "left shoulder contusion, lumbar strain, left wrist sprain and contusion of the 4th and 5th MP joints of the left hand" as a result of a November 25, 1997 injury. (Exs. 1, 2). On April 27, 1998, Dr. Fowler became claimant's attending physician. (Ex. 3).

In October 1998, Dr. Fowler wrote to the medical services coordinator stating that he had been seeing claimant "for chronic neck and upper back pain ever since an on-the-job injury back in November" and claimant "also had some rotator cuff tendinitis which pre-dated this injury but it has been exacerbated since the injury." (Ex. 5-1). The letter also found that the "chronic pain problem" was "multi-factorial" and that claimant could benefit from treatment at a pain clinic. (*Id.* at 1-2). Finally, Dr. Fowler thought that he "could be helpful" in treating the rotator cuff tendonitis, "but I do not think that was necessarily caused by this injury as she did have some shoulder tendinitis pre-dating the injury." (*Id.* at 3).

On October 25, 1998, Dr. Fowler concurred with a letter from the medical services coordinator stating that claimant was "medically stationary in regards to the accepted condition in this case of left shoulder contusion, lumbar strain, left wrist sprain, and contusion of the 4th and 5th MP joints in the hand." (Ex. 6). Dr. Fowler added that claimant had "calcific tendinitis of her left shoulder which is still symptomatic, but should be stationary with regard to her injury." (*Id.*)

Dr. Fowler than indicated that claimant was not able to return to regular work with no restrictions, adding that claimant was "tolerating her job 6 hrs/day and could go to 8 hrs/day. She cannot tolerate lifting > 15 lbs or any overhead lifting. She states that she can do her job with these restrictions." (Ex. 7).

After issuing an updated Notice of Acceptance, on December 1, 1998, SAIF issued a Notice of Closure awarding only temporary disability.

Claimant requested reconsideration. The Order on Reconsideration first decided that "the claim qualified for closure in so far [sic] as claimants [sic] medically stationary status was concerned." (Ex. 11-1). The order further found, however, that SAIF did not comply with OAR 436-030-0020(4) because the record did not contain "adequate closing information regarding extent of any permanent impairment attributable to the several accepted conditions in this case." (*Id.* at 2). Thus, the Order on Reconsideration found that the claim "was improperly closed" and "rescinded" the Notice of Closure. (*Id.*) For this reason, no medical arbiter examination was scheduled.

CONCLUSIONS OF LAW AND OPINION

The ALJ first found that claimant had a "combined condition consisting of left shoulder rotator cuff tendinitis and left shoulder contusion." The ALJ also decided that there was no evidence that this "combined condition" was medically stationary or "no longer a major cause of her need for treatment." Based on such evidence, the ALJ thought that "the reasons underlying the Director's rule still exist" and "there was no error in the application of the Director's rules."

On review, SAIF objects to the ALJ's finding of a "combined condition" and continues to argue that, because the Department lacks authority to set aside a Notice of Closure based on the absence of a closing examination report under OAR 436-030-0020(4), we should reinstate the Notice of Closure in this case. Furthermore, citing *Nancy Sabin*, 50 Van Natta 508 (1998), SAIF contends that we should remand the case to the ALJ.

We first agree with SAIF that, whether or not claimant has a "combined condition," because such condition was not accepted at the time of claim closure, the issue of whether a "combined condition" was medically stationary at the time of claim closure is not relevant to determining whether the claim was prematurely closed. *E.g., Joseph A. Gerber*, 51 Van Natta 278 (1999). Instead, we consider only those conditions that were accepted at the time of claim closure. *Id.*

Here, based on evidence from Dr. Fowler, the record shows that claimant's *accepted* conditions were medically stationary at the time of closure. (Exs. 6). Moreover, claimant was released for modified work prior to closure. (Ex. 7). Thus, the statutory conditions precedent to issuance of the closure notice were satisfied in this case and SAIF's Notice of Closure is valid. *See* ORS 656.268(4)(a). We turn to whether the Department had authority to rescind the Notice of Closure pursuant to OAR 436-030-0020(4) after finding insufficient evidence of permanent impairment.

The Department is not authorized to set aside a carrier's closure notice as premature on the basis that the carrier did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4). *E.g., Estella M. Rogan*, 50 Van Natta 205 (1998). In coming to this conclusion, we reasoned that, because a closing examination report is not a condition precedent to issuance of a closure notice under ORS 656.268, the absence of such a report is not valid grounds for setting aside a closure notice as "premature." *Id.* Furthermore, to the extent that OAR 436-030-0020(4)(a)[1] requires a closing examination prior to issuance of a valid closure notice, we have found that the rule exceeds the terms of ORS 656.268 and it should be given no effect. *Id.*

Here, the Department found that the claim was improperly closed because Dr. Fowler did not provide a "closing examination/report," as required by OAR 436-030-0020(4). Consistent with *Rogan*, we conclude that the Department lacked authority to set aside the Notice of Closure on this basis.

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[1] Under OAR 436-030-0020(4)(a), when the carrier closes the claim, it shall issue a Notice of Closure to the worker within 14 days after "[e]vidence is received from the attending physician which shows the worker's condition is medically stationary, and information is sufficient to determine the extent of any disability[.]"

In requesting reconsideration of the Notice of Closure, however, claimant also challenged the impairment findings used to rate disability and specifically requested a medical arbiter examination. Thus, although the Department did not schedule claimant for a medical arbiter examination because it rescinded the Notice of Closure, claimant is statutorily entitled to a medical arbiter report. *See* ORS 656.268(7)(a).

Under similar circumstances, we have concluded that the best remedy is to remand the case to the ALJ for deferral pending receipt of a medical arbiter's report pursuant to ORS 656.268(6)(e). *E.g., Nancy L. Sabin*, 50 Van Natta at 508. As in those cases, the parties here shall be responsible for contacting the Director to make arrangements for the appointment of a medical arbiter and preparation and submission of a medical arbiter's report. When the parties are ready to proceed to hearing on claimant's other challenges to the Notice of Closure (including consideration of the medical arbiter's report), they shall contact the ALJ. Thereafter, the ALJ shall conduct further proceedings in any manner that achieves substantial justice.

ORDER

The ALJ's order dated June 11, 1999 is reversed. The Order on Reconsideration's rescission of the Notice of Closure is reversed. This case is remanded to ALJ Stephen Brown for further proceedings consistent with this order.

In the Matter of the Compensation of
WARREN W. WEBBER, Claimant
WCB Case No. 98-07397
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of claimant's aggravation claim for a torn right medial meniscus. On review, the issue is aggravation (compensability). We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except we do not find that arthrograms "tended to be non-diagnostic" for medial meniscus tears "80-90 percent of the time." Opinion and Order, p. 2. (*See* Ex. 54-8-9; *see also* Exs. 47-1, 54-19).

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable right medial collateral knee strain on June 20, 1995. A January 4, 1996 Notice of Closure closed his claim and an April 26, 1999 Order on Reconsideration awarded 2 percent scheduled permanent disability for loss of use or function of claimant's right knee.

Claimant had ongoing right knee pain which worsened in September 1997. Dr. Benz performed an arthroscopy for horizontal and vertical right meniscus tears on November 20, 1997.

Dr. Benz filed an aggravation claim on claimant's behalf and the employer denied the claim.

Claimant argues that his right medial meniscus condition resulted from his compensable June 20, 1995 right knee injury, based on the opinion of Dr. Benz, treating surgeon. (Exs. 38, 47, 55; *see also* Ex. 42). The employer argues that Dr. Tesar's opinion relating claimant's torn meniscus to degeneration is more persuasive. (Exs. 53, 54).

The ALJ found the parties' theories of causation equally plausible and equally persuasive. Therefore, he concluded that the claim failed. We reach the same result.

Dr. Benz related claimant's torn meniscus to the 1995 work injury because claimant had ongoing tenderness over his medial joint after the injury and because surgical findings were consistent with a conclusion that the injury caused a subtle tear that eventually progressed to the condition requiring surgery in 1997. (Exs. 47, 55).

Dr. Tesar disagreed, based on claimant's history, findings, the mechanism of his injury, the course of his disease, and the findings of Drs. Coletti and Martens in 1995 and 1996. Dr. Tesar acknowledged that claimant *could* have torn his meniscus in 1995, because symptoms of a meniscus strain are not easily distinguished from symptoms of a tear. (Ex. 54-10; *see* Exs. 54-24, 54-29). However, he explained that Dr. Coletti's 1995 strain diagnosis was probably accurate--*i.e.*, claimant did not have a torn meniscus at the time, in part because the medical arbiter's March 1996 McMurray's test was negative.[1] (Exs. 54-16, 54-28-30; *see also* Ex. 21). Dr. Tesar noted that claimant's age was consistent with a degenerative or age-related torn meniscus and horizontal tears are more often degenerative than trauma related.[2] (*See* Exs. 54-17, 54-24-25). We find Dr. Tesar's opinion persuasive because it is thorough, well-reasoned, and based on an accurate history. Accordingly, based on Dr. Tesar's opinion, we agree with the ALJ that claimant has not established that his torn right medial meniscus is compensably related to his 1995 injury and he has not therefore proven his aggravation claim under ORS 656.273.

ORDER

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

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[1] Although claimant had tenderness of the medial joint line at claim closure in 1996, he had no rotary instability, a normal arthrogram, and no pain with rotation of the tibia on the femur. Under these circumstances, Dr. Tesar concluded that claimant did not have a torn meniscus after the 1995 work injury. (E. 54-16-17). Dr. Tesar's reasoning in this regard is uncontradicted.

[2] Dr. Tesar also noted that Dr. Benz' surgical observation could establish that claimant's tear was not acute (*i.e.*, not new), but it could not help determine the age of an older tear. Thus, although Dr. Benz' surgical findings were "consistent" with a 1995 tear, those findings would not, in Dr. Tesar's opinion, rule out the possibility that the tear occurred later for reasons unrelated to the 1995 injury. (*See* Ex. 54-15). Dr. Tesar's reasoning in this regard is unrebutted. Under these circumstances, we do not find that Dr. Benz' surgical findings persuasively support his causation conclusion and we do not accord his opinion special deference based on his status as claimant's treating surgeon. *See Jeffrey S. Declue*, 50 Van Natta 2315, 2316 (1998).

Board Member Phillips Polich dissenting.

The employer denied claimant's aggravation claim on causation grounds.

The majority upholds the denial because they discount the opinion of Dr. Benz, treating surgeon, in favor of the opinion of Dr. Tesar, one-time examining physician. I disagree, because I believe the Board should honor the long-standing presumption favoring the treating surgeon's opinion under this case's circumstances. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988).

After repairing claimant's torn right meniscus, Dr. Benz opined that the tear began with the June 20, 1995 work injury and worsened thereafter. Dr. Benz noted that claimant never completely recovered from his June 20, 1995 compensable right knee injury. And, based on the nature of claimant's post-injury symptoms and his surgical findings, Dr. Benz concluded that the work injury was the major contributing cause of claimant's worsened right knee condition.

Dr. Tesar examined claimant once and reviewed his history. He acknowledged that claimant's worsened condition could be due to the work injury, as Dr. Benz opines.

The majority should rely on Dr. Benz' opinion, because that doctor had a unique opportunity to observe claimant's right knee condition firsthand during surgery and his opinion is based in part on his surgical findings. Under these circumstances, I believe that the majority errs in refusing to apply the presumption favoring the opinion of claimant's treating surgeon. *See Mageske*, 93 Or App 698. I would find claimant's aggravation claim compensable, based on Dr. Benz' opinion. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
TIEBO M. MURATHA, Claimant
WCB Case Nos. 98-07872 & 98-07025
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

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

We adopt and affirm the ALJ's order with the following supplementation. We write to address claimant's argument that Dr. Smith-Cupani's opinion establishes compensability of her overuse injury and her assertion that the other medical opinions did not really address that condition. We disagree.

Dr. Smith-Cupani referred claimant to Dr. Noall, hand surgeon, who initially diagnosed chronic tendinitis of both arms, apparently due to repetitive work activity. (Ex. 3-2). He recommended nerve conduction tests, which were normal and there was no evidence of carpal tunnel syndrome. (Exs. 4, 7). Later nerve conduction studies of claimant's ulnar nerves were abnormal. (Ex. 10). Nevertheless, Dr. Noall reported that claimant's physical examination findings were not supported by her laboratory findings. (Ex. 13-1). In a "check-the-box" letter from the insurer, Dr. Noall agreed that claimant did not have a neurological diagnosis. (Ex. 20-1). He agreed that, although the July 31, 1998 nerve conduction studies showed slowing of ulnar motor conduction velocity across the elbows, claimant's clinical presentation, complaints and symptoms did not correlate with a neurological diagnosis. (*Id.*) Although he had originally diagnosed chronic tendinitis relating to work exposure, he no longer believed there was an objective diagnosis regarding claimant's upper extremities. (Ex. 20-2). Dr. Noall agreed that claimant's complaints did not substantiate diagnoses of either tendinitis, repetitive strain, overuse syndrome or cubital tunnel syndrome. (*Id.*) He felt there was insufficient objective medical evidence to support any diagnosis. (*Id.*)

Claimant was also referred to Dr. Cline, neurosurgeon, who examined her on October 5, 1998 and found no objective abnormalities. (Ex. 16-3). Because claimant's symptoms were somewhat vague and her sensory findings were not consistent with any particular abnormality, Dr. Cline did not believe claimant had a neurological diagnosis. (*Id.*) In a "check-the-box" letter from the insurer, Dr. Cline agreed that, based on claimant's complaints and the examination findings, there was no evidence of either tendinitis or overuse syndrome and claimant's symptom presentation was not characteristic of those conditions. (Ex. 17-2, 18).

Contrary to claimant's assertion, Drs. Noall and Cline specifically addressed Dr. Smith-Cupani's diagnosis of an overuse injury. We agree with the ALJ that Dr. Smith-Cupani's opinion is not persuasive, particularly when weighed against the contrary medical reports. We agree that claimant has not established compensability of her bilateral hand condition.

ORDER

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

In the Matter of the Compensation of
WILLIAM S. SHREEVE, Claimant
WCB Case Nos. 98-05762 & 98-05761
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Employers Insurance of Wausau (Wausau) requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld the SAIF Corporation's denial of compensability and responsibility for claimant's low back injury claim; and (2) set aside its denial of responsibility for the same condition. On review, the issues are compensability and, potentially, responsibility. We affirm.

FINDINGS OF FACT

In 1985, while working for Wausau's insured, Taylor Made Builders, claimant compensably injured his low back. That same year, claimant underwent low back surgery. In 1987, the claim closed and then, in 1988, reopened and closed again. In 1989, by Order on Stipulation, Wausau accepted an aggravation claim, which eventually closed in 1991.

In March 1998, claimant filed a "Notice of Claim for Aggravation" with Wausau and Wausau denied the claim, asserting that claimant's "aggravation rights" had expired.[1] Claimant also filed an injury claim with SAIF, the carrier of claimant's present employer, Mark Wendt Homes Inc. SAIF denied compensability and responsibility.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had not proved a "compensable second injury" resulting from his work activities with SAIF and upheld SAIF's denial of compensability. The ALJ then set aside Wausau's denial of responsibility.

On review, Wausau and claimant argue that claimant proved that he sustained a compensable injury while working at SAIF's insured. Both parties also contend that, pursuant to *Barnett v. SAIF*, 122 Or App 279 (1993), expert medical evidence is not required for claimant to carry his burden of proof.

In *Barnett*, the court held that factors for determining whether expert evidence of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. 122 Or App at 283.

Here, claimant contends that he compensably injured his low back on March 24, 1998, when he attempted to pull a pipe from the ground. The record contains no expert medical evidence supporting a causal relationship between the incident and claimant's need for treatment.

We agree with the ALJ that claimant's medical situation is complicated. First, claimant has evidence of degenerative changes in his lower spine. (Ex. 150-15). Additionally, along with his 1995 low back injury and surgery, claimant sought treatment for his low back in 1988, 1989, 1990, and 1994. Claimant saw his treating physician, Dr. Purtzer, approximately three weeks before the March 24 incident, complaining of low back symptoms. (Ex. 196). We find such evidence also shows that claimant was not previously free of the disability involved here.

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[1] The "Notice of Claim for Aggravation" was filed on March 5, 1998, *before* the March 24, 1998 incident with SAIF's insured that, according to claimant, resulted in a compensable injury. Although there was some indication at hearing that Wausau considered its aggravation denial as applying to the March 24, 1998 event, it characterized the case as "SAIF denying responsibility-compensability * * * and Wausau denying responsibility[.]" (Tr. 2). The ALJ similarly characterized the issues. Thus, we have considered Wausau as denying only responsibility.

With regard to the remaining factors, claimant did not immediately seek treatment because, following the March 24 incident, he did not see Dr. Purtzer until March 31, 1998. (Ex. 201). It appears that claimant reported the injury on the same day to a supervisor. Finally, examining physicians Drs. Wilson and Woodward reported that they were "not sure that [claimant] really had a specific injury due to the work activities of March 24, 1998" and "the pre-existing condition is the major contributing cause of his combined condition and disability and need for treatment." (Ex. 214-6).

Based on the complicated medical state of claimant's low back, his extensive previous treatment, and the expert medical evidence that the March 24, 1998 incident is not the major contributing cause of claimant's need for treatment and disability, we agree with the ALJ that expert medical evidence supporting causation is necessary for claimant to carry his burden of proof. Because the record does not contain such evidence, claimant did not prove that he sustained a compensable injury as a result of the March 24, 1998 incident.

Under ORS 656.308(1), the responsible employer remains responsible for benefits relating to the compensable condition "unless the worker sustains a new compensable injury involving the same condition." Based on our conclusion above concerning compensability, claimant did not prove a "new compensable injury." Thus, responsibility remains with Wausau.

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

ORDER

The ALJ's order dated May 28, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by Wausau.

November 2, 1999 Cite as 51 Van Natta 1851 (1999)

In the Matter of the Compensation of
ORVEL L. CHANEY, Claimant
Own Motion No. 99-0250M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 29, 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 SAIF Corporation is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICARDO O. VALENZUELA, Claimant
WCB Case No. 98-09537
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's occupational disease claim for a low back condition. The insurer argues that the ALJ abused her discretion in refusing to admit proposed documentary evidence after the hearing.[1] The insurer also requests remand for admission and consideration of those documents. On review, the issues are evidence, remand, and compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding the evidentiary and remand issues.

The insurer argues that the ALJ abused her discretion in declining to admit two documents after the hearings record closed on March 1, 1999. The insurer asserts that these documents, Proposed Exhibits A1-3 (a chart note and registration form for claimant at the Salem Hospital Urgent Care Center, dated September 10, 1997), were unobtainable at the time of hearing because claimant did not provide them before the hearing and the hospital did not provide them until the day after the hearing (despite the insurer's subpoena). The insurer also contends that the 1997 hospital documents would likely affect the outcome of the case.[2]

We review the ALJ's evidentiary ruling for abuse of discretion. *James D. Brusseau II*, 43 Van Natta 541 (1991).

The ALJ declined to admit Proposed Exhibits A1-3 after the hearings record closed because she found that the documents existed before the hearing and therefore they were available and obtainable. *See* OAR 438-007-0025. The ALJ noted that claimant's counsel did not represent that *all* chartnotes from the Salem Hospital had been provided to the insurer before the hearing. She also reasoned that the insurer's conduct supported her conclusion that the documents were reasonably obtainable at hearing: She acknowledged claimant's testimony that his low back pain began in April 1998 and the proposed evidence predates that onset. But the ALJ noted that reliance on claimant's history in this regard would not explain the insurer's late discovery of the proposed evidence because the insurer had in fact served the hospital with a subpoena to obtain all claimant's records *before* the hearing. Furthermore, the insurer did not ask the ALJ to keep the record open at hearing, even though the hospital had not complied with the subpoena at that time.

Under these circumstances, the ALJ concluded that the proposed evidence was obtainable at hearing and she declined to admit it on that basis. We conclude that the ALJ did not abuse her discretion. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 420 n.2 (1986) (Medical report obtainable because it "only needed to have been requested at the appropriate time.")

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[1] With its brief, the insurer submits Proposed Exhibits A1-3, a chart note and registration form for claimant at the Salem Hospital Urgent Care Center, dated September 10, 1997, totaling three pages. The insurer also attaches an additional 4 pages, "Appendixes A-D," copies of: a February 8, 1999 letter from its attorney to claimant's attorney requesting a list of physicians claimant "sought treatment with in the past"; a subpoena for all of claimant's records served on the Salem Hospital Urgent Care Center on February 17, 1999; an apparent "cover letter," dated February 19, 1999, from claimant's counsel's office to the insurer's counsel, stating that records from the hospital concerning claimant were enclosed; and an affidavit certifying claimant's complete medical records at the Salem Hospital, dated March 1, 1999. We treat the insurer's submissions and attachments as a motion to remand and we consider the proposed evidence only to evaluate the evidentiary and remand issues.

[2] We find that the disputed documents would not likely affect the outcome because they do not undermine claimant's credibility, as explained herein.

The insurer also requests remand for admission and consideration of the proposed evidence, contending that the record is insufficiently developed without it because claimant's credibility is important and the proposed evidence contradicts his reporting to physicians about the onset of his low back symptoms. We disagree.

Our review must be based on the record developed at the hearing before the ALJ. *See* ORS 656.295(5). We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Lyster*, 79 Or App 416. 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. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988). Here, we have determined that the proposed evidence *was* obtainable at hearing; consequently, remand to admit and consider it is not appropriate.

Finally, consideration of the proposed evidence would not likely affect the outcome of the case because we do not agree with the insurer that the September 1997 chartnote reporting low back pain undermines claimant's credibility. First, claimant never said that he was always asymptomatic before 1998. Consequently, we cannot say that pre-1998 back symptoms contradict his reporting that his current problems began insidiously in 1998. *See Barbara Cooper-Townsend*, 47 Van Natta 2381, 2382 (1995) (employer's credibility argument unpersuasive where there was no showing of relevance or materiality). Second, claimant worked as a laborer for the insured since 1995 and 1997 back pain would not therefore cast doubt on the 1998 claim. Accordingly, after considering the record and the parties' arguments, we conclude that the record in this case has not been improperly, incompletely or otherwise insufficiently developed and there is no compelling reason to remand. *See Lyster*, 79 Or App at 420 n.2. Consequently, the insurer's request for remand is denied.

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 24, 1999, as reconsidered May 11, 1999 and May 19, 1999, is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the insurer.

In the Matter of the Compensation of
DAVID K. ROWLEY, Claimant
WCB Case No. 98-03173
ORDER ON REVIEW
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld the insurer's denial of his aggravation claim for a low back injury; and (2) upheld the insurer's partial denial of his claim for an L4-5 facet arthropathy condition. In his brief, claimant requests that the matter be remanded for submission of further evidence. In its brief, the insurer moves to dismiss claimant's request for review on the basis that it was not timely filed. On review, the issues are dismissal, remand, compensability, and aggravation. We deny the motion to dismiss and the motion to remand, and affirm.

FINDINGS OF FACT

We adopt the "Findings" set forth in the ALJ's order with the following supplementation.

The ALJ issued the Opinion and Order on May 20, 1999. Claimant mailed his request for review to the Board, by certified mail, on June 19, 1999. Claimant also mailed a copy of his request for review to the insurer's counsel, by certified mail, on June 19, 1999.

CONCLUSIONS OF LAW AND OPINION

Dismissal

The insurer moves to dismiss claimant's request for review on the basis that it was not timely served on the employer or the insurer. We decline to grant the insurer's motion based on the following reasoning.

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. *Mosely 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); *Tommy L. Brown*, 51 Van Natta 497 (1999); *Nancy C. Prevatt-Williams*, 48 Van Natta 242 (1996); *Harold E. Smith*, 47 Van Natta 703 (1995).

Here, the record contains a certified mail envelope and request for review that are addressed to the insurer's counsel. The envelope is post-marked June 19, 1999. This evidence has not been rebutted by the insurer, nor has the insurer or the employer shown how it has been prejudiced by not timely receiving a copy of the request for review. 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. *See Brown*, 51 Van Natta at 497; *Smith*, 47 Van Natta at 703. Therefore, the insurer's motion to dismiss is denied.

Remand

In his appellant's brief, claimant references certain documentary evidence that he asserts should have been submitted as evidence at hearing. We treat claimant's references to this evidence as a motion to remand.

We may remand a case to the ALJ if we find that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5); *Bailey v. SAIF*, 296 Or 41, 45, n. 3 (1983). To merit remand for consideration of additional evidence, it must be clearly 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. Weyehaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Although claimant references documentary evidence that apparently pre-dates the hearing, he has not shown why such evidence was not obtainable, with due diligence, prior to the hearing. Moreover, claimant has not shown how such evidence would affect the outcome of the case. Under these circumstances, we decline to remand this matter to the ALJ for submission of further evidence.

Aggravation/Compensability

We adopt the conclusions and reasoning set forth in the "Opinion" section of the ALJ's order.

ORDER

The ALJ's order dated May 20, 1999 is affirmed.

In the Matter of the Compensation of
DARREN C. LANEY, Claimant
WCB Case Nos. 98-07937 & 98-07320
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's injury claim for a cervical and thoracic condition; and (2) set aside its denial of claimant's injury or occupational disease claim for a dermatitis condition. The insurer requests remand regarding the back claim, contending that claimant was a nonsubject worker under ORS 656.027(4). On review, the issues are compensability and remand.

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

The insurer argues that we should remand the case to the ALJ for consideration of the parties' alleged post-hearing stipulation that claimant's cervical and thoracic injury claim arises under the United States Longshore and Harbor Workers' Compensation Act (LHWCA). The insurer also contends that claimant is a nonsubject worker under ORS 656.027(4) with respect to that claim.

Claimant argues that any stipulation between the parties regarding LHWCA coverage would be ineffective. And he contends that ORS 656.027(4) does not apply unless and until LHWCA coverage is settled. We agree with claimant and deny the insurer's remand request, based on the following reasoning.

First, "[i]t is well settled that an agency's jurisdiction cannot be conferred by stipulation of the parties." *Diack v. City of Portland*, 306 Or 287, 293 (1988) (citations omitted). Therefore, the alleged stipulation from the parties regarding federal jurisdiction over the cervical and thoracic claim would not affect the result in the Oregon Workers' Compensation case. Under these circumstances, remand to consider any agreement about jurisdiction is not appropriate. *See, e.g., Carol D. Courtwright*, 50 Van Natta 1770, 1771-72 (1998).

Second, the Oregon Workers' Compensation ALJ lacks authority to determine federal jurisdiction and *potential* federal jurisdiction would not be determinative in any event. As the ALJ in this case explained, the insurer's contention that claimant's cervical and thoracic claim arises under the LHWCA is essentially an affirmative defense that can only succeed with evidence that coverage *is provided* under a federal claim. *See William J. Harrison*, 43 Van Natta 1222, 1223 (1991) (The existence of a denied federal claim does not bar an Oregon claim); *Kenneth R. Barker*, 42 Van Natta 2419, 2420 (1990) (In order to escape liability for claimant's otherwise-compensable Oregon claim, the insurer must establish that compensation is provided under the LHWCA). And we agree with the ALJ that the insurer failed to establish that this claim is covered under LHWCA.[1] Under these circumstances, we find no compelling basis for remanding and we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Consequently, the motion to remand is denied. *See* ORS 656.295(5); *Compton v. Weyerhaeuser*, 301 Or 641, 646 (1986); *Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1983).

Finally, we acknowledge the insurer's contention that Dr. Berkeley's causation opinion supporting the cervical and thoracic claim is inadequate because it merely applies a "precipitating cause" analysis. However, considering the context of the doctor's opinion,[2] we agree with the ALJ that Dr.

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[1] The parties' alleged stipulation, in the absence of a declaration from a federal forum acknowledging jurisdiction, does not alter this conclusion.

[2] In this regard, we note that Dr. Berkeley responded affirmatively to claimant's counsel's November 4, 1998 letter asking him to state whether claimant's May 15, 1998 injury "was more than 50 percent responsible for his present symptoms for which you are recommending surgery." (Ex. 21; *see* Ex. 22). Dr. Berkeley acknowledged that claimant's preexisting degeneration contributes to his symptoms (generally). Considering the mechanism of injury, however, he concluded that the work incident was the major contributing cause of claimant's *current* disability and need for surgery because the injury caused a swollen nerve for which claimant required surgery. (*See* Ex. 23-41). *See SAIF v. Strubel*, 161 Or App 516 (1999) (Doctor's opinion evaluated in the context in which it was rendered to determine its sufficiency).

Berkeley's opinion persuasively establishes that claimant's May 1998 work injury was the major contributing cause of his disability and need for surgery under this claim. *See SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated April 16, 1999 is affirmed. For services on review, claimant is awarded an $1,800 attorney fee, payable by the insurer.

In the Matter of the Compensation of
DOUGLAS R. HART, Claimant
WCB Case No. 98-01705
ORDER ON REMAND
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Hart*, 162 Or App 297 (1999). The court has reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order awarding claimant temporary disability benefits from February 23, 1997 to April 15, 1997 and an "out of compensation" attorney fee. The ALJ relied on our decision in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), and 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 in *Kenneth P. Bundy*, 48 Van Natta at 2501, that held that the 14 day limitation on "retroactive" temporary disability authorization from an attending physician set forth in *former* ORS 656.262(4)(g), now subsection (f), 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.

Former ORS 656.262(4)(g), now subsection (f), 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 contemporaneous temporary disability authorization from an attending physician for specific time periods from February 20, 1997 to February 27, 1997, and from April 1, 1997 through April 15, 1997. (Exs. 3, 5, 7). Relying on ORS 656.210(3), both the ALJ and the Appellate Reviewer reasoned that, because claimant was not totally disabled for a period of 14 consecutive days as a result of the compensable injury, no temporary disability compensation was due during the first three calendar days after claimant left work. Therefore, the ALJ and the Appellate Reviewer concluded that initial entitlement to temporary disability began on February 23, 1997. We adopt and affirm that reasoning and conclusion.

Based on claimant's attending physician's contemporaneous temporary disability authorizations, the Order on Reconsideration found claimant entitled to temporary disability compensation for the periods beginning February 23, 1997 and ending February 27, 1997, and beginning April 1, 1997 and ending April 15, 1997, less time worked. (Ex. 18). On the other hand, based on a June 17, 1997 letter from Dr. Hunts, claimant's attending physician, the ALJ found that claimant was at least partially disabled for the entire period from February 20, 1997 to April 15, 1997.[1]

Because the record does not contain a contemporaneous time loss authorization from an attending physician for the period from February 28, 1997 through March 31, 1997, claimant is not entitled to temporary disability benefits for that period.

Accordingly, on reconsideration, the ALJ's July 28, 1998 order is reversed.[2] The February 19, 1998 Order on Reconsideration is reinstated and affirmed.

IT IS SO ORDERED.

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[1] As noted above, relying on ORS 656.210(3), the ALJ awarded temporary disability benefits from February 23, 1997 to April 15, 1997.

[2] Because claimant's award of temporary disability has ultimately been reduced, we also rescind the $500 attorney fee awarded in our prior order pursuant to ORS 656.382(2).

November 4, 1999 Cite as 51 Van Natta 1857 (1999)

In the Matter of the Compensation of
BEVERLY J. COFFMAN, Claimant
Own Motion No. 99-0290M
OWN MOTION ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys

Claimant seeks Board authorization of an approved fee for her attorney's services culminating in our October 13, 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 October 13, 1999 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our October 13, 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
JOHN R. GRAHAM, Claimant
WCB Case No. 98-08943
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) awarded temporary total disability benefits through January 30, 1998; (2) found that claimant's medically stationary date was February 27, 1998; and (3) allowed the employer an offset of benefits paid after January 30, 1998. In his brief, claimant contends that he is entitled to temporary disability benefits until May 13 or 18, 1998. On review, the issues are temporary total disability benefits, medically stationary date and offset. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and summarize the relevant facts as follows.

Claimant was compensably injured in July 1994. Claimant completed a vocational program in August 1997. Claimant's treating physician, Dr. Hill, declined to perform a closing examination. Claimant was examined on behalf of the employer by Dr. Thompson who declared claimant medically stationary on October 24, 1997. Dr. Hill was asked for his opinion regarding Dr. Thompson's report, but did not respond. On January 24, 1998, claimant was examined by Dr. Gritzka who did not specifically state that claimant was medically stationary, but rated claimant's permanent impairment. Dr. Hill, claimant's attending physician, concurred with the report on May 18, 1998. Claimant was examined, on the employer's behalf, by Dr. Farris on May 13, 1998. Dr. Farris opined that claimant's condition was medically stationary.

Claimant's attorney requested claim closure in November 1997. On February 26, 1998, a Determination Order issued which found that the claim did not qualify for closure and stated that "[c]laim closure is premature." (Ex. 81-1). A May 20, 1998 Order on Reconsideration affirmed the February 26, 1998 Determination Order concluding that the carrier's request for claim closure was "premature." (Ex. 85). The May 20, 1998 Order on Reconsideration was not appealed and became final.

Ultimately, the claim was closed by a July 28, 1998 Determination Order which found claimant medically stationary on May 13, 1998 and awarded temporary disability benefits through this date. Both parties requested reconsideration. A November 5, 1998 Order on Reconsideration found that claimant was medically stationary on October 24, 1997 and approved an offset of any overpaid temporary and permanent disability benefits. Claimant returned to work on January 30, 1998.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the May 1998 Order on Reconsideration established that the medically stationary date could not be earlier than February 26, 1998, the date of the Determination Order which found that the request for claim closure was premature. On this basis, the ALJ found that the medically stationary date was February 27, 1998 and that the employer was entitled to offset temporary disability benefits paid after that date.

On review, the employer argues that the May 1998 Order on Reconsideration merely concluded that the claim did not qualify for closure and did not establish a medically stationary date. On this basis, the employer argues that the May 20, 1998 Order on Reconsideration did not preclude a finding that claimant was medically stationary prior to the February 26, 1998 Determination Order. We agree, based on the following reasoning.

A February 26, 1998 Determination Order found that claim closure was premature. A May 20, 1998 Order on Reconsideration affirmed the Determination Order, also concluding that claim closure on February 26, 1998 was premature. Pursuant to ORS 656.268(1), claims shall not be closed if the worker's

condition has not become medically stationary unless circumstances described in ORS 656.268(1)(a) through (c) apply.[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 he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

Here, the February 26, 1998 Determination Order found that claim closure was premature on the date of closure. That Determination Order was affirmed by the May 20, 1998 Order on Reconsideration that became final by operation of law. Finality attaches to unappealed closure orders for the purposes of claim preclusion. *Drews v. EBI Companies*, 310 Or 134, 150 n 13 (1990); *Hammon Stage Line v. Stinson*, 123 Or App 418, 423 (1993). Because review by the Department of such an order is the next step in that administrative proceeding, issue and claim preclusion also apply to uncontested Orders on Reconsideration. *Michele S. Thomas-Finney*, 47 Van Natta 174 (1995).

Here, the unappealed Order on Reconsideration established that claimant's claim was not medically stationary on February 26, 1998. Thus, we agree with the ALJ's conclusion to the extent that the employer cannot argue that claimant's claim was medically stationary *on* February 26, 1998. The Determination Order and Order on Reconsideration, however, *did not address whether claimant was medically stationary on a date before or after* February 26, 1998.

There is evidence from Dr. Thompson that claimant was medically stationary on October 24, 1997. Although Dr. Hill did not expressly concur with Dr. Thompson, he did not expressly disagree either. In addition, Dr. Hill concurred with Dr. Gritzka's January 21, 1998 report that rated claimant's permanent impairment, although it did not specifically state that claimant was medically stationary. Dr. Farris examined claimant on May 13, 1998. Dr. Farris noted that claimant had had no change in symptoms for two years and no treatment for eighteen months. Dr. Farris considered claimant's condition medically stationary. There is no evidence from Dr. Hill or any other doctor that claimant was not medically stationary on October 24, 1997. In addition, Dr. Hill's concurrence with Dr. Gritzka's report rating claimant's impairment is not necessarily inconsistent with Dr. Thompson's opinion that claimant was medically stationary on October 24, 1997.[2] Accordingly, we find that claimant was medically stationary on October 24, 1997. Thus, we affirm the November 5, 1998 Order on Reconsideration finding claimant medically stationary on October 24, 1997 and approving an offset of temporary disability benefits paid by the employer after the medically stationary date.

ORDER

The ALJ's order dated April 19, 1999, as supplemented on April 30, 1999, is reversed. The November 5, 1998 Order on Reconsideration is affirmed. The ALJ's award of an out-of-compensation attorney fee is reversed.

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[1] None of those circumstances exist in this case.

[2] Moreover, even if Dr. Hill, the attending physician, did not concur that claimant was medically stationary, 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 Charlotte A. O'Neal*, 47 Van Natta 1994 (1995); *see also Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980) (the issue of a claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence).

In the Matter of the Compensation of
RONNIE C. FAIR, Claimant
WCB Case No. 99-00399
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's denial of his neck and upper back injury claim; and (2) declined to assess penalties for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

On December 1, 1998, claimant was employed by a temporary agency and was working for an appliance company assisting with deliveries. (Tr. 7). On that day, claimant had been working with Mr. Fern, a delivery driver. The delivery truck was a 24-foot box van that was rated for 26,000 pounds. (Tr. 49). Later in the day, claimant and Mr. Fern had loaded a refrigerator for delivery. (Tr. 34, 35). As they were preparing to leave the store, claimant was getting ready to put his seat belt on when the truck pushed over a concrete post. (Tr. 10, 34, 35; Ex. 17-2). The truck had only moved about two feet before striking the post. (Tr. 36). As a result of the accident, the truck had a crease in the center of the bumper and the two outside corners were bent out. (Tr. 52). Claimant testified that he was shaken up and had pain in his neck and shoulders. (Tr. 11, Ex. 17-2). Claimant and Mr. Fern reported the accident and continued with their deliveries.

Claimant was required to complete time cards on a daily basis. (Tr. 7-8). On December 1, 1998, he answered "yes" to the question "[d]id you get injured on the job today?" (Ex. 5a-4). The time card was signed by Mr. Hilger, the fleet supervisor. (*Id.*) Mr. Hilger testified that when he signed the time card, he did not notice that claimant had indicated that he had been injured that day. (Tr. 51). Although Mr. Hilger saw claimant the evening of the incident, he had no indication claimant had been injured and he said claimant was kind of kidding about the incident. (Tr. 51, 52).

On December 2, 1998, claimant signed an "801" form, indicating that he had injured his neck and upper back the previous day. (Ex. 7). Claimant testified that he went to the emergency room on December 2, 1998, but he was not treated there. (Tr. 10-11). He said the emergency room was crowded and he was asked questions about insurance and he did not know all the answers. (Tr. 11). Claimant left and sought treatment from Dr. Jones, a chiropractor, but he was unable to treat claimant on that day. (Tr. 11-12; Ex. 23). Claimant was later treated by Dr. Jones on December 7, 1998 and on a few occasions thereafter. (Exs. 12, 13, 14, 15). Dr. Jones diagnosed acute cervical, thoracic, lumbar strain/sprain with attendant myofascitis and muscle spasms. (Ex. 23). Claimant was released to regular work on December 11, 1998. (Ex. 16).

At hearing, Mr. Fern, the truck driver, testified that he was not shaken up during the incident. (Tr. 38). He did not testify whether or not he had a seat belt on at the time of the incident. Mr. Fern did not notice claimant "bouncing around" in the truck. (*Id.*) Mr. Fern said claimant did not refer to being hurt and did not appear to be injured. (Tr. 39, 40). Mr. Watkins, store manager, did not witness the accident, but he said that claimant and the driver came into the store after the incident, laughing about it like it was a big joke. (Tr. 44-46).

On December 15, 1998, SAIF denied the claim on the basis that there was insufficient evidence that claimant was injured as a result of the December 1, 1998 work incident. (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that none of claimant's coworkers who saw him after the accident had observed or heard claimant complain of any physical problem. The ALJ found Dr. Jones had not identified any details of claimant's accident and the history Dr. Jones relied upon was inconsistent with the observation of others. The ALJ reasoned that the truck could not have accelerated very much before the impact

occurred and he found no evidence concerning the amount of force needed to bend the truck's bumper. Although claimant asserted that he was "knocked around" and suffered immediate headaches with shoulder and neck pain, the ALJ found that claimant was "unwilling" to obtain medical treatment for over a week and nobody had observed anything wrong with claimant.

Claimant points out there is no dispute that the incident in which the truck hit a concrete post actually occurred. He contends that he reported the injury the day it occurred and the medical evidence establishes that he sustained an injury that required medical treatment.

On the other hand, SAIF argues that the evidence suggests that claimant embellished the intensity and consequences of the December 1, 1998 incident. SAIF contends that claimant failed to prove that he was injured during the incident.

There is no medical evidence that claimant has a preexisting condition that combined with his work injury to cause or prolong his disability or need for treatment. Therefore, claimant must establish that his work injury was a material contributing cause of his disability and/or need for treatment. *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Under ORS 656.005(7)(a), a "compensable injury" is defined as "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" In addition, a "compensable injury" must be "established by medical evidence supported by objective findings[.]" *Id.*

Although the ALJ did not find claimant credible, he made no express credibility findings based upon claimant's demeanor. 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).

As claimant points out, there is no dispute that the incident in which the truck hit a concrete post actually occurred. The issue is whether claimant sustained an injury that required medical services or resulted in disability. On *de novo* review, we find that claimant was injured on December 1, 1998 as a result of the truck incident. Claimant said he was getting ready to put on his seat belt when the truck hit a concrete post. (Tr. 10, Ex. 17-2). He testified he was shaken up and had pain in his neck and shoulders. (Tr. 11, Ex. 17-2). Although Mr. Fern, the truck driver said that he was not shaken up as a result of the incident, there is no evidence as to whether Mr. Fern had his seat belt on at that time. Despite the fact that other people did not observe that claimant was injured, claimant reported on his December 1, 1998 time card that he was injured at work that day. (Ex. 5a-4). On the following day, claimant signed an "801" form and sought medical treatment from two sources that day, albeit unsuccessfully. Although the delivery truck had only moved about two feet before striking the post, the accident caused a crease in the center of the bumper of the truck and caused the two outside corners to bent out. (Tr. 36, 52). We are persuaded by claimant's testimony that he was injured on December 1, 1998 as a result of the truck incident.

In addition, Dr. Jones said that claimant had objective findings of injuries that were consistent with the history of the accident. (Ex. 24). We generally defer to the opinion of the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. Jones' opinion, particularly because he had the advantage of examining and treating claimant within days of the accident. Beginning on December 7, 1998, Dr. Jones treated claimant for injuries to the neck and shoulder with headaches. (Exs. 10, 23-1). His diagnosis was acute cervical, thoracic, lumbar strain/sprain with attendant myofascitis and muscle spasms. (Ex. 23-1). He released claimant to regular work on December 11, 1998. (Ex. 16). Dr. Jones performed a final evaluation on January 6, 1999 and reported that claimant still had tautness in the trapezius muscles and reduced cervical range of motion, although he did not believe claimant had any permanent injuries. (*Id.*) We find that Dr. Jones' opinion is persuasive and is based on an accurate history that claimant's injury was caused by a work-related accident on December 1, 1998 when a truck struck a cement stump. We conclude that claimant has established compensability of his neck and shoulder injuries.

Penalties for Unreasonable Denial

Claimant argues that he is entitled to a penalty for an unreasonable denial because at the time the denial was issued, all medical and other evidence supported that he had been injured in the accident as described.

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

On December 15, 1998, SAIF denied the claim on the basis there was insufficient evidence that claimant was injured as a result of the December 1, 1998 work incident. (Ex. 18). At the time the denial was issued, Ms. Aufranc, SAIF's claims adjuster, said she had spoken to claimant and "Kirk" from the temporary agency. (Tr. 54). She also had the "827" form from Dr. Jones. (Tr. 55). Ms. Aufranc said "Kirk" told her he had spoken to a person from the employer who said claimant had just been sitting in his seat during the incident and had not been thrown around in the cab. (Tr. 56). Ms. Aufranc was also told claimant had not gone to the doctor until December 7, 1998 and she was told that claimant had allegedly offered not to file a claim if the employer bought one of his Christmas trees. (*Id.*)

Based on the inconsistencies and different versions of the work incident that SAIF had at the time it issued the denial, we conclude that SAIF had a legitimate doubt as to its liability. Consequently, its denial was not unreasonable.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). Claimant's attorney submitted an affidavit in support of an award of attorney fees, indicating that he devoted 16 hours to the case at hearing and 8.6 hours on appeal. He requests a fee based upon 24.6 hours at $160 per hour, "multiplied by two based upon the risk of going uncompensated[.]" (Claimant's attorney's affidavit at 2).

SAIF objects to claimant's attorney's fee request on the basis that it is excessive. SAIF asserts that claimant's attorney is not entitled to a specific contingency multiplier. According to SAIF, a reasonable fee for services at hearing and on review would be in the range of $3,500 to $4,000.

We have previously declined to apply a contingency factor or "multiplier" in a strict mathematical sense. *See, e.g., Karen M. Stone*, 51 Van Natta 1560 n.1 (1999); *June E. Bronson*, 51 Van Natta 928, 931 n.5 (1999). Instead, in conjunction with the other relevant factors discussed below, the risk that claimant's counsel might go uncompensated for services rendered in this proceeding is considered in our ultimate determination of a reasonable attorney fee.

In 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). 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 issues at hearing were compensability of claimant's neck and shoulder injuries and penalties. Claimant's attorney devoted 16 hours to the case at hearing and 8.6 hours on appeal. The record contains 29 exhibits, six of which were submitted by claimant's attorney. The transcript is 70 pages long. Claimant testified on his own behalf and five witnesses testified on behalf of SAIF. There were no depositions. On review, claimant's attorney submitted a five page brief and a four page reply brief. We find that the case involved issues of average complexity, considering the range of cases generally submitted to this forum. 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 $4,500 is a reasonable attorney fee for services at hearing and on review regarding the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated. Claimant's attorney is not entitled to an attorney fee for services 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 June 3, 1999 is reversed in part and affirmed in part. SAIF's denial is set aside and the claim remanded to SAIF for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded $4,500, payable by SAIF.

November 8, 1999 Cite as 51 Van Natta 1863 (1999)

In the Matter of the Compensation of
JUAN C. CARBAJAL, Claimant
WCB Case No. 98-07207
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl, Haynes, and Bock.[1]

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) determined that he was not an employee of the putative employer (Professional Drywall); (2) determined that Professional Drywall was not responsible for providing workers' compensation coverage under ORS 656.029(1); (3) upheld the insurer's "de facto" denial of his right knee injury claim; and (4) declined to award penalties and attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are subjectivity, compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In April 1998, claimant, a drywall installer, fell seven feet from a scaffold, fracturing his right knee. On May 14, 1998, claimant's attorney wrote the insurer, advising that its insured (Professional Drywall) had failed to file a form 801. (Ex. 5). The insurer responded on May 21, 1998, stating that the employer had no knowledge that claimant was an employee. (Ex. 6). Claimant eventually filed a form 801 on June 5, 1998. (Ex. 8). A dispute later developed about claimant's cooperation with the insurer's investigation of the claim after an investigator was unable to obtain a statement.

On August 4, 1998, the Department notified the parties that claimant's compensation would be suspended within five days for failure to cooperate with the insurer's investigation. (Ex. 19). Claimant responded on August 5, 1998, agreeing to submit to an interview, but alleging that his failure to cooperate was reasonable. (Ex. 20). The Department, nevertheless, suspended claimant's compensation on August 13, 1998, based on a finding that claimant had not documented that failure to cooperate was reasonable. (Ex. 21). The suspension order also provided that the insurer's obligation to deny the claim within 90 days would be suspended until claimant cooperated with the insurer's investigation by arranging and submitting to an interview. *Id.* That same day, claimant's attorney advised that claimant would be available for an interview, which occurred on September 4, 1998.

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[1] Board Member Phillips Polich has recused herself from participating in the review of this case. OAR 438-011-0023.

On September 11, 1998, claimant requested a hearing alleging a "de facto" denial. When claimant did not appear at the December 8, 1998 hearing, his counsel moved for a postponement. The ALJ denied the request and claimant's attorney chose to proceed without claimant's participation. The employer then orally denied the claim on the ground that claimant was not an employee of Professional Drywall. (Tr. 12). Claimant's counsel neither objected nor moved for continuance of the hearing.

The ALJ found that, while the evidence established the occurrence of a work-related injury, it did not establish that claimant was the employee of Professional Drywall. The ALJ then denied claimant's request for a penalty and/or attorney fee for failure to timely accept or deny the claim. The ALJ reasoned that, even though the denial appeared untimely, there were no "amounts then due" on which to base a penalty because the claim was not compensable.

Claimant requested reconsideration of the ALJ's order, asserting that a postponement should have been granted to join another employer. The ALJ again denied the postponement request, noting that claimant's motion was originally based on a failure to appear at hearing. Because claimant's attorney was unable to provide an explanation for claimant's absence, the ALJ held that there was no basis to grant a postponement.

The ALJ then addressed claimant's argument that Professional Drywall was responsible for worker's compensation coverage for claimant's injury under ORS 656.029(1).[2] Based on the employer's (Mr. Behnke's) testimony, the ALJ found that the employer as general contractor awarded a contract to a subcontractor (Vasquez) involving the performance of labor. The ALJ further determined that claimant's work activities at the time of injury were a normal and customary part of the employer's trade or business. Consequently, the ALJ reasoned that, under ORS 656.029(1), the employer/general contractor Professional Drywall was responsible for providing coverage for workers such as claimant, unless the subcontractor Vasquez provided coverage before labor underthe contract commenced. The ALJ also noted that, under ORS 656.029(2), Vasquez would also be required to provide insurance coverage, even if he was exempt under ORS 656.027, if he employed workers not exempt under ORS 656.027.

The ALJ then observed that it was unknown when the contract was awarded or when labor under the contract commenced. Further, the ALJ noted that it could not be determined whether Vasquez provided worker's compensation coverage or whether Vasquez was exempt under ORS 656.027. Given the circumstances surrounding the contract and the uncertain status of the subcontractor Vasquez, the ALJ concluded that ORS 656.029(1) was inapplicable and that the employer was not responsible for providing coverage under ORS 656.029(1).

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[2] ORS 656.029 provides :

"(1) If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer.

"(2) 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. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person to whom the contract is awarded, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer.

"(3) As used in this section:

"(a) 'Person' includes partnerships, joint ventures, associations, corporations, limited liability companies, governmental agencies and sole proprietorships.

"(b) 'Sole proprietorship' means a business entity or individual who performs labor without the assistance of others."

For the following reasons, we disagree with the ALJ's conclusion that Professional Drywall is not responsible for workers' compensation coverage of claimant's injury under ORS 656.029(1).

Application of ORS 656.029(1)

Under ORS 656.029(1), the person awarding the contract must obtain coverage for all individuals who perform labor under the contract, other than those exempt from coverage under ORS 656.027, unless the person to whom the contract is awarded provides such coverage before labor begins. If the person awarding the contract does not provide such coverage, it will be treated as a noncomplying employer. The burden, therefore, is on the person awarding the contract (in this case, Professional Drywall) either to provide coverage or to make sure that the person to whom the contract is awarded provides coverage for those who are to perform labor under the contract. ORS 656.029(1); *Wood v. Dunn*, 109 Or App 204, 211 (1991).

At the outset, we agree with the ALJ that the evidence establishes that claimant sustained a right knee injury while engaged in work activities as a drywall installer. Moreover, we also agree with the ALJ that Professional Drywall, as a general contractor whose business concerns drywall contracting, awarded a contract involving the performance of labor to a subcontractor, Vasquez, for whom claimant was employed. In addition, we concur with the ALJ that the performance of labor (actual installation of the drywall) under the contract was a normal and customary part of Professional Drywall's trade or business.

Thus, Professional Drywall was presumptively responsible for workers' compensation coverage under ORS 656.029(1), unless the subcontractor Vasquez provided coverage before labor commenced under the contract or Vasquez, as an exempt person under ORS 656.029(2), employed non-exempt workers and thus was required to provide coverage pursuant to subsection (2). Therefore, as the "person" awarding the contract, Professional Drywall was required to either provide coverage or confirm that the person (Vasquez) to whom the contract was awarded provided coverage for those who were to perform labor under the contract. *Wood v. Dunn*, 109 Or App at 211.

The ALJ reasoned, however, that ORS 656.029(1) was inapplicable because the status of the subcontractor and the circumstances of the contract could not be ascertained. We disagree with that interpretation of the statute. We, instead, conclude that ORS 656.029(1) is applicable to the extent that Professional Drywall is responsible for providing workers' compensation coverage unless certain contingencies in subsection (1) and (2) of ORS 656.029 were satisfied.

Here, because the evidence does not establish that Vasquez provided worker's compensation coverage, or that Vasquez was an exempt person under ORS 656.027 and employed nonexempt employees, we find that, by operation of ORS 656.029(1), Professional Drywall, as general contractor, was responsible for providing workers compensation coverage for claimant, an employee of the subcontractor Vasquez. *See Gerald J. Holmes*, 41 Van Natta 2099, 2100-01, *on recon* 41 Van Natta 41 Van Natta 2401 (1989) (placing burden on general contractor to demonstrate that *former* ORS 656.029 was not applicable). Moreover, because we agree with the ALJ that the evidence established that claimant was engaged in work activity when he sustained his injury, we further conclude that claimant's knee injury is compensable and the responsibility of Professional Drywall under ORS 656.029(1).[3]

Claimant's attorney is, therefore, entitled to an assessed fee for services at hearing. ORS 656.386(1).[4] After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $2,500, payable by the insurer. 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.

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[3] Given our resolution of the case, we need not address whether the ALJ properly denied claimant's postponement request so that he could "join" another employer.

[4] Because no brief or written argument was considered on review, we do not award a fee under ORS 656.382(2).

Penalties

As previously noted, the ALJ declined to assess penalties or attorney fees under ORS 656.382(1), even though finding that the insurer's oral denial at the December 8, 1998 hearing was untimely, because there was no amounts due on which to base a penalty. We agree with the ALJ's reasoning that the insurer's denial was untimely. Pursuant to ORS 656.262(11)(a), claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim."

Here, in light of the Department's suspension of claimant's compensation for failure to cooperate, which in turn suspended the insurer's obligation to accept or deny within 90 days, *see* ORS 656.262(15), and given that additional information was apparently still required after claimant submitted to the September 4, 1998 interview (Ex. 25), we do not find that the insurer's claim processing was unreasonable. Thus, we affirm the ALJ's decision declining to assess penalties and attorney fees under ORS 656.382(1).

ORDER

The ALJ's order dated March 1, 1999, as reconsidered June 16, 1999, is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the insurer's "de facto" denial is reversed. The claim is remanded to the insurer for processing in accordance with law. For services at hearing, claimant's attorney is awarded an assessed fee of $2,500, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

November 8, 1999 Cite as 51 Van Natta 1866 (1999)

In the Matter of the Compensation of
DELOS G. DEVINE, Claimant
WCB Case Nos. 99-00315 & 98-06963
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock, and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's L4-5 disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the fo1llowing change. In the last paragraph on page 4, we change the last sentence to read: "Therefore, the opinions of the independent medical examiners are not 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 $2,100, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his attorney's statement's of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 17, 1999 is affirmed. For services on review, claimant's attorney is awarded $2,100, payable by the SAIF Corporation.

Board Member Haynes dissenting.

In adopting and affirming the ALJ's order, the majority holds that claimant has established compensability of his L4-5 disc condition. Because I find the medical evidence does not support that conclusion, I respectfully dissent.

SAIF contends that the ALJ improperly applied a material contributing analysis to determine compensability. I do not believe it is necessary to address that issue, however, because I would find that the medical evidence is insufficient to establish compensability under either a "material" standard or the "major contributing" standard.

It is first necessary to briefly recount the factual and procedural background of the claim. Claimant injured his low back on August 13, 1992, when he twisted and lifted a 50 pound crate at work. (Exs. 1-4). SAIF accepted a disabling lumbosacral sprain. (Ex. 6). Claimant testified that he had time off work and returned to modified duties for three to four months. (Tr. 7). The claim was closed in September 1993 with no award of permanent disability. (Ex. 14).

The ALJ found that claimant had experienced continued and variably severe low back pain since the August 1992 injury. On August 12, 1997, claimant experienced acute low back pain while lifting a chain saw at work. (Tr. 11, Ex. 35). Claimant testified that he had a "knifing pain" that was almost as severe as the pain in 1992. (Tr. 11). He said the pain was so severe that he threw the chain saw away and fell to the ground. (*Id.*) Claimant said it took him an hour before he could get up, and the crew helped him to stand. (*Id.*) He sought medical treatment from Dr. Kitchel, who diagnosed a musculoligamentous injury and recommended an MRI. (Ex. 17). A September 3, 1997 MRI showed mild narrowing at L4-5 with slight central disc bulging. (Ex. 18). Dr. Kitchel said the MRI showed mild L4-5 disc degeneration, but no evidence of significant disc herniation or nerve root compression. (Ex. 19). Dr. Kitchel initially said that, assuming claimant's history was correct, the current problem was a "work-related" injury. (Exs. 17, 19, 21, 23, 25).

Dr. Kitchel referred claimant to Dr. Miller for a second opinion. (Ex. 26). Dr. Miller said that claimant's September 1997 MRI showed "a degenerated disc at L4-5 that has an acute annular fissure centrally with a little bit of protrusion of disc material centrally that migrates down a little bit over the posterior longitudinal ligament." (Ex. 28). He felt that claimant's symptoms were probably due to a central disc herniation or fissure at L4-5. (Ex. 29).

On April 20, 1998, claimant's attorney wrote to SAIF, requesting acceptance of his current condition, "disruption of the L4-5 disc with associated herniation or fissure," as a new and additional condition related to the August 13, 1992 injury. (Ex. 30). On September 28, 1998, claimant's attorney wrote to SAIF regarding a claim for an August 12, 1997 injury, as well as an occupational disease claim. (Ex. 37). SAIF issued denials of the claim. (Exs. 33, 42, 43).

Claimant relies primarily on the opinion of Dr. Karasek to establish compensability. Although claimant asserts that Dr. Karasek's opinion is objective, based on complete information and well-reasoned, I disagree.

Dr. Karasek apparently performed claimant's lumbar discography on February 11, 1999. (Ex. 50-1). There is no evidence that Dr. Karasek examined claimant on any other occasion. In evaluating medical opinions, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, because Dr. Karasek examined claimant on only one occasion, his opinion is not entitled to any particular deference.

The record includes one report from Dr. Karasek, which was issued in response to a letter from claimant's attorney. (Ex. 50). Dr. Karasek said that claimant's attorney had described a "rather severe incident at work" in August 1997 that commenced claimant's current history of care. (Ex. 50-1). Dr. Karasek commented, however, that the notes from Drs. Keiper and Kitchel related that claimant's pain began during a work incident in 1992, with significant episodes of pain intermittently since that time. (*Id.*) Dr. Karasek said the August 1997 seemed to "have caused another exacerbation, this time rather significant." (*Id.*) He explained:

> "There had been no diagnostic studies performed between 1992 and 1997 which would clearly delineate the source of pain as the lumbar discs, as I have concluded after discography. However, with the patient's pattern of pain, it is almost a certainty that his disc abnormalities began during the 1992 injury and were severely exacerbated by his injury in August of 1997. At this point he complains of continued pain. The discogram was diagnostic." (*Id.*)

I am not persuaded by Dr. Karasek's opinion on causation because he did not have a complete and accurate history of claimant's symptoms and diagnostic tests. Dr. Karasek incorrectly stated that no diagnostic studies had been performed between 1992 and 1997. To the contrary, Dr. Bufton examined claimant in November 1994 and recommended an MRI. (Ex. 15). Dr. Bufton reported that claimant's neurologic exam was normal, but he felt claimant should have a lumbar MRI to rule out the possibility of a surgical lesion. (Ex. 15-3). A December 1, 1994 MRI revealed degenerative disc disease at L4-5, slight posterior disc bulging and no definite disc herniation or spinal stenosis. (Ex. 16). Because Dr. Karasek had an inaccurate understanding that no diagnostic tests had been performed since 1992, I do not find his opinion 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).

Furthermore, I am not persuaded that Dr. Karasek had an accurate history of claimant's 1992 injury or his medical treatment following that injury. Dr. Karasek did not describe how claimant's 1992 injury occurred or how that injury caused claimant's disc abnormality. In addition, there is no evidence that Dr. Karasek had reviewed records of claimant's treatment following the 1992 injury or that he was aware that claimant had been diagnosed with a strain, but no disc problems had been reported.

After the 1992 injury, claimant initially treated with Dr. Harding, who diagnosed an acute lumbosacral strain with muscle spasm and back pain. (Ex. 1-2). Dr. Harding noted that claimant denied focal neurologic symptoms and he found no evidence of discogenic disease. (Ex. 1). Claimant then treated with Dr. Adams, who reported that claimant had no leg pain and denied any weakness or significant numbness. (Ex. 4-1). Dr. Adams diagnosed an acute back strain. (*Id.*) On September 21, 1992, Dr. Adams reported that the overall prognosis was "quite good" and claimant should eventually return to full employment. (Ex. 5C). Dr. Adams reported on November 20, 1992 that claimant had a chronic lumbosacral injury with no radiculopathy and no evidence of disc herniation. (Ex. 7). He performed a closing evaluation on July 30, 1993 and found no sciatica, no femoral nerve tension signs and no indication of any impingement symptoms. (Ex. 12-2). In November 1994, Dr. Bufton said claimant's neurological exam was normal. (Ex. 15-3).

Because there is no evidence that Dr. Karasek reviewed claimant's medical records after the 1992 injury, I do not believe his conclusion that claimant's disc abnormalities began during the 1992 injury is persuasive. He did not explain why claimant's disc abnormalities began in 1992, when the medical reports after the 1992 injury had not referred to any disc problems. There is no evidence Dr. Karasek had reviewed claimant's December 1994 MRI. In addition, Dr. Karasek did not explain why the "severe" work incident in August 1997, by itself, did not cause the disc problems. I find that Dr. Karasek's opinion is not persuasive because it is based on an inaccurate history and lacks adequate explanation. His opinion is entitled to little weight and is not sufficient to establish that claimant's 1992 work injury is either a material or the major contributing cause of his L4-5 disc condition.

Similarly, I am not persuaded by Dr. Keiper's opinion. Dr. Keiper first examined claimant in October 1998 and recommended a discogram. (Ex. 39-3). After further testing, Dr. Keiper reported that claimant had a painful disc at L5-S1 and a "severely painful" disc at L4-5. (Ex. 47a). He diagnosed multilevel disc disease and noted there was no surgical option for claimant. (Exs. 47a, 51). On March 26, 1999, Dr. Keiper reported that the major cause of claimant's current condition was his 1992 work injury. (Ex. 51-1). He explained that "[b]ecause he was asymptomatic prior to the injury, I would say that at least 51% of his current problem is related to work injury." (*Id.*)

I am not persuaded by Dr. Keiper's opinion on causation because he did not have a complete and accurate history of claimant's symptoms and diagnostic tests. In his initial October 12, 1998 examination, Dr. Keiper reported that claimant's MRI was unavailable for review, noting that he would like to review it. (Exs. 39-3, -4). There is no evidence whether or not Dr. Keiper had an opportunity to review either claimant's December 1994 or September 1997 MRI. In addition, there is no evidence Dr. Keiper reviewed medical reports after claimant's 1992 injury, which made no mention of a disc problem. Dr. Keiper made no mention of claimant's August 12, 1997 work incident, which claimant said gave him a "knifing pain" that was almost as severe as the pain in 1992. (Tr. 11). I find that Dr. Keiper's opinion is entitled to little weight because it is not clear he had an accurate understanding of claimant's injuries, symptoms or diagnostic tests. *See Miller v. Granite Construction Co.*, 28 Or App at 476.

None of the remaining medical opinions are sufficient to establish compensability. In sum, I would conclude that claimant has failed to sustain his burden of proving compensability under either a material or major contributing cause standard.

In the Matter of the Compensation of
LINDA K. SWANSON, Claimant
WCB Case No. 98-09922
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Sather Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's aggravation claim for a right carpal tunnel syndrome condition. On review, the issues are claim processing and aggravation. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's aggravation claim. In doing so, the ALJ found that claimant had perfected an aggravation claim pursuant to ORS 656.273(3). On review, the employer contends that the ALJ erred in determining that claimant had perfected an aggravation claim. We agree.

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).

There is no dispute that claimant and Dr. Sohlberg submitted a July 6, 1998 completed Director's form to the employer. (Ex. 30). In addition, the Director's form is referenced by Dr. Sohlberg in his chart note dated the same date. (Ex. 31). Assuming arguendo that the July 6, 1998 chart note accompanied the Director's form, it fails to satisfy the statutory requirement. The chart note indicates that claimant is to continue with the same work restrictions and notes that numbness and tingling have disappeared. (Id.). The chart note does report "some tenderness" but Dr. Sohlberg does not indicate that claimant's right carpal tunnel syndrome condition has worsened. (*Id.*) Accordingly, we find that claimant's July 7, 1998 aggravation claim is procedurally defective. *See Chester D. Winter*, 51 Van Natta 1355 (1999).

Because we have found that claimant's aggravation claim was procedurally defective, the employer's aggravation denial is a nullity and without legal effect. *See Charles L. Chittim, Jr.*, 51 Van Natta 769 (1999).

ORDER

The ALJ's order dated April 8, 1999 is reversed. The insurer's aggravation denial is set aside as a nullity. The ALJ's award of a $3,500 assessed attorney fee is reversed.[1]

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[1] Because we have set aside the self-insured employer's denial as a nullity, claimant is not entitled to assessed attorney fee. *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).

Board Member Biehl specially concurring.

The majority's conclusion that claimant had not perfected an aggravation claim is consistent with the Board's precedent and I am constrained to agree with its resolution of this matter.[1] I write to express my concerns regarding the strict application of ORS 656.273(3) to cases such as this one.

In 1995, the legislature amended ORS 656.273(3) and provided additional requirements that an injured worker must meet before a carrier was obligated to process a claim for aggravation. Specifically, there must be a 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. *Ted B. Minton*, 50 Van Natta at 2424. These additional requirements appear to be directed to assisting a carrier in determining when an aggravation claim had been filed. That is, the amendments created another procedural requirement that an injured worker had to satisfy before a carrier was put on notice that it was obligated to respond to a claim for aggravation.

Here, there is no dispute that the self-insured employer was on notice of claimant's aggravation claim. In fact, it issued a formal denial of the aggravation claim. (Ex. 68). When, as here, a carrier has formally denied a claim for aggravation, it serves no purpose to allow the carrier to rely on "notice" provisions as a defense to an aggravation claim that it has formally denied. This is particularly true when the defense is raised in the alternative and the parties have gone forward and litigated the merits of the aggravation claim. Moreover, because the employer's denial is set aside as a nullity, the parties will essentially be returned to the same place that this matter started, *i.e.*, claimant files another aggravation claim, the employer denies the claim and the matter is set for another hearing. This result is contrary to the legislature's express policy of providing a fair and just administrative system that reduces litigation and eliminates adversarial proceeding to the greatest extent possible. *See* ORS 656.012(2)(b).

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[1] Although the majority opinion does not specifically address the issue of whether claimant's aggravation claim form was accompanied by a medical report, I would agree with the ALJ that the aggravation form and medical report do not have to be submitted contemporaneously in order to satisfy ORS 656.273(3). *But see Charles L. Chittum*, 51 Van Natta at 769; *Ted B. Minton*, 50 Van Natta at 2424.

November 5, 1999 Cite as 51 Van Natta 1870 (1999)

In the Matter of the Compensation of
DAVID A. RENNO, Claimant
WCB Case No. 98-09714
ORDER OF ABATEMENT
G. Joseph Gorciak III, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

On October 12, 1999, we issued an Order on Review that: (1) set aside the SAIF Corporation's denial of claimant's head, right arm, back and neck injury claim; and (2) assessed a penalty for an unreasonable denial. After first seeking reconsideration of our penalty assessment, SAIF has provided notification that the parties have settled their dispute and will be submitting a proposed stipulation.

In order to retain jurisdiction to consider the parties' agreement, we withdraw our October 12, 1999 order. On receipt of the parties' stipulation, we will proceed with our review. In the meantime, the parties are requested to keep us advised of any future developments regarding this case.

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 ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requested reconsideration of our July 22, 1999 Own Motion Order Reviewing Carrier Closure, which affirmed the insurer's March 18, 1999 Notice of Closure. On August 12, 1999, we abated our prior order to allow the insurer sufficient time to respond to claimant's motion. The time for a response having expired, we proceed with our reconsideration. On reconsideration, we adhere to our July 22, 1999 order, as supplemented below.

We previously relied on Dr. Nolan's February 25, 1999 medical report, finding that claimant was medically stationary on that date. In reaching this conclusion, we reasoned that Dr. Nolan, an insurer-arranged medical examiner, offered the most well-reasoned and fact-based opinion.

On reconsideration, claimant has submitted a closing report from Dr. Wright, her attending physician. The insurer has not replied.

Claimant argues that we should defer to Dr. Wright, claimant's longtime attending physician. Specifically, she contends that there is no persuasive reason not to defer to Dr. Wright due to his experience with claimant and the particular type of surgery she underwent; *i.e.* he previously operated on her other hand. Claimant refers to Dr. Wright's opinion that she would not reach "maximum recovery" until at least one year post-surgery, which is contained in a June 2, 1999 closing report (one year after her June 1998 surgery) declaring that she is "medically stationary from her bilateral thumb surgeries." Finally, claimant asserts that her IP joint flexion has improved from 55 degrees to 75 degrees since her IME examination.[1]

As noted in our July 22, 1999 order, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). We further give most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Here, opinions have been offered by Dr. Wright, claimant's longtime attending surgeon, and Dr. Nolan, the IME physician. For the following reasons, we continue to find Dr. Nolan's opinion more persuasive.

Although Dr. Wright has not deviated from his opinion that claimant would be medically stationary one year post-surgery, he does not explain the basis for his opinion. He did not indicate that claimant's compensable condition required additional medical treatment in order to materially improve nor has the passage of time caused a material improvement as evidenced by the objective findings. Claimant's IP flexion in her right thumb appears to have improved slightly. Nonetheless, her other objective findings have remained stable and comparable to the findings rendered at the time of Dr. Nolan's examination. In the absence of a further explanation for his conclusion that claimant's condition was not medically stationary, we do not consider Dr. Wright's conclusory opinion to be persuasive.

On the other hand, Dr. Nolan conducted an extensive personal examination of claimant's hands, an in-depth medical file review and an extended interview. Concluding that claimant's was medically stationary, Dr. Nolan observed that she was asymptomatic, functional with her hands and without any significant complaints. Dr. Nolan further noted that no further surgical procedures were either advised or proposed.

After further consideration of this record (including Dr. Wright's opinion), we continue to conclude that Dr. Nolan provides a more persuasive opinion, based on objective findings, regarding claimant's medically stationary status at the time of the insurer's March 18, 1999 closure. Consequently, we find that claimant's condition was medically stationary and affirm the Notice of Closure.

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[1] It is noted that the IP flexion measurement on claimant's *right* thumb is 70 degrees as opposed to 75 degrees as claimant asserts. The IP flexion measurement for claimant's *left* thumb is 75 degrees.

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

In the Matter of the Compensation of
MARIE L. COLOMBO, Claimant
WCB Case Nos. 98-01523 & 97-07384
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's aggravation claim for her current low back herniated disc condition. On review, the issues are compensability and aggravation.[1] We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant to be a credible witness based upon her demeanor and manner of testifying. The ALJ determined that claimant had met her burden of proving the compensability of her claim.

When the ALJ makes specific findings on credibility based upon demeanor and manner at hearing, great weight and deference is given to the ALJ's opinion. *Erck v. Brown Oldsmobile*, 311 Or 519 (1991); *Bush v. SAIF*, 68 Or App 230, 233 (1984); *Chapel of Memories v. Davis*, 91 Or App 232 (1988); However, we are not compelled to defer to the ALJ. In this regard, we have *de novo* review in this matter. *Erck v. Brown Oldsmobile*, 311 Or at 526; *Amy L. Melquist*, 50 Van Natta 368 (1998). Here, after our review of the entire record and consideration of the parties' arguments, we agree with the ALJ's findings and conclusions regarding credibility.

The employer argues that claimant has not proved a worsening of the accepted lumbar strain or the compensability of an annular tear or herniated disc at L4-5. Both parties agree that we are presented with a complex medical issue.

Where compensability involves a complex medical question, we must rely on expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985); *Barnett v. SAIF*, 122 Or App 281 (1993). Where this is a division in the expert opinions, we rely on those opinions that are most well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We accept and adopt the ALJ's reasoning and conclusion for finding Dr. Gritzka most persuasive.

To establish a compensable aggravation, claimant must show an actual worsening resulting from the original injury. ORS 656.273(1); *Gloria T. Olson*, 47 Van Natta 2348 (1995). An aggravation has two components: causation and actual worsening.

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[1] Claimant presented a Motion to Strike regarding the employer's reference to "Exhibit 34H." The employer had submitted arguments based on that exhibit on Page 5, lines 15 - 18. The exhibit had not been offered into evidence and was not included in the record. The employer agrees that the reference was inappropriate and stipulated to the Motion to Strike. Therefore, that portion of the employer's brief was not considered.

We begin our analysis with a determination of whether claimant's current condition (*i.e.*, a disc herniation at L4-5) is a compensable condition. The employer accepted a lumbar strain. If the allegedly worsened condition is not already a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Audrey Keeland*, 50 Van Natta 2041 (1998).

Here, Dr. Gritzka acknowledged that claimant has a degenerative disc disease that preexisted the 1995 injury. Because the evidence indicates that claimant's prexisting condition combined with her work injury, claimant must prove that the 1995 injury was the major contributing cause of the need for treatment and disability of her L4-5 herniated disc. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *recon* 104 Or App 309 (1997), *rev den* 326 Or 389 (1998). The fact that a work injury is the immediate or precipitating cause of a claimant's condition does not necessarily mean that the injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App at 401.

The employer argues that Dr. Woodward's opinion conflicts with Dr. Gritzka's conclusions. However, upon Dr. Woodward's first impression of Dr. Gritzka's presentation of Modic changes in the low back, Dr. Woodward was not familiar with the medical term "Modic changes." Dr. Woodward later stated that he researched articles regarding Modic changes and disagreed with Dr. Gritzka.

Dr. Gritzka, on the other hand, thoroughly explained his opinion based upon the medical evidence and demonstrated a complete understanding and knowledge of Modic changes. After fully considering all of the possible contributing factors, Dr. Gritzka determined that the 1995 injury was the major contributing cause of claimant's current condition. Dr. Gritzka points to the presence of edema at the L4-5 level in the 1995 MRI supported his opinion that the Modic changes evidenced an acute injury to the L4-5 disc at the time of the compensable 1995 injury. Specifically, Dr. Gritzka concluded that claimant suffered a tear or fissure to the annulus fibrosis at the L4-5 level because of the single event of twisting her back during the 1995 injury. Reasoning that the L4-5 disc eventually herniated because of the 1995 tear, Dr. Gritzka opined that the 1995 injury was the major contributing cause of claimant's current condition. Based on this persuasive opinion, like the ALJ, we find claimant has met her burden of proving the compensability of her current claim.[2]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,300, 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 claimant's counsel's request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 4, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $2,300, to be paid by the employer.

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[2] Dr. Gritzka stated that the 1995 MRI showed Modic changes at the L4-5 level, which were indicative of an acute injury that led to the disc herniation. (Ex. 60-9). Based on Dr. Gritzka's opinion regarding the disc herniation, we further determine that claimant's compensable condition has pathologically worsened. Consequently, claimant has established a compensable aggravation claim. *See SAIF v. Walker*, 145 Or App 294, 305 (1996) *rev allowed* 325 Or 367 (1997). In any event, even if no aggravation claim was proven, the employer would still be required to "reopen" and process the claim for claimant's herniated disc condition. ORS 656.262(7)(c); *Douglas G. Abbott*, 50 Van Natta 1156 (1998).

In the Matter of the Compensation of
ROBERT K. LARSON, Claimant
Own Motion No. 99-0342M
OWN MOTION ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

On October 12, 1999, we issued an Own Motion Order in which we authorized reopening of claimant's 1993 claim for the payment of temporary disability compensation. We took this action relying on the information enclosed with the insurer's own motion recommendation. On October 14, 1999, we received a letter in which claimant points out that his current condition for which he seeks own motion benefits involves a different claim.[1] On reconsideration, we withdraw our prior order and issue the following order in its place.

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

Claimant suffered at least three separate injuries while employed by the same employer, who was insured by Liberty Northwest Insurance (LNW). We are concerned only with the injuries to his knees.[2] On or about July 14, 1991, claimant sustained an injury to his *left* knee which was accepted as compensable and assigned the claim number 604328047. Claimant's aggravation rights for this claim expired on March 19, 1997. On or about July 16, 1993, claimant sustained a work injury to his *right* knee which was accepted as compensable and assigned the claim number 604398566. Claimant's aggravation rights for this claim expired on February 14, 1999.

On September 15, 1999, the insurer submitted its recommendation to reopen claimant's 1993 claim for the provision of temporary disability compensation. With its recommendation, the insurer attached medical reports which reference a need for surgery for claimant's *left* knee. Inasmuch as surgery was recommended, we issued our October 12, 1999 Own Motion Order authorizing reopening of claimant's 1993 claim for the provision of temporary disability compensation.

However, in his request for reconsideration, claimant points out that the claim number and injury referenced in our October 12, 1999 order pertains to his *right* knee injury. As noted above, the medical record before us indicates a worsening of claimant's *left* knee condition, which has a different date of injury and claim number. In response to claimant's contentions, the insurer agreed that it had initially submitted an own motion recommendation under the wrong claim number and for the wrong knee. Further, the insurer agreed that the current worsening involves claimant's *left* knee injury. Consequently, it submitted a new own motion recommendation referencing the *left* knee condition. (Claim No. 604328047).

Based on the record, we conclude that claimant is not seeking own motion benefits relating to his *right* knee injury. Therefore, we dismiss the request for own motion relief as it relates to Claim No. 604398566.[3]

IT IS SO ORDERED.

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[1] We treat this letter as a request for reconsideration of our October 12, 1999 order.

[2] Claimant also sustained an injury to his back but that body part is not part of his most recent request for own motion relief.

[3] In a separate order issued on today's date, we address claimant's request for own motion benefits as it relates to the current worsening of his *left* knee injury. (Claim No. 604328047)

In the Matter of the Compensation of
ROBERT K. LARSON, Claimant
Own Motion No. 99-0397M
OWN MOTION ORDER
Schneider, 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 knee condition.[1] Claim No. 604328047. Claimant's aggravation rights expired on March 19, 1997. The insurer agrees that claimant's current left knee condition is causally related to his accepted condition for which it is responsible. However, the insurer contends it is unknown whether claimant was in the work force at the time of the current worsening and "will leave that issue up to the Board's determination."

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 left knee 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).

Here, claimant must prove that he was in the work force on September 23, 1999, the date he was hospitalized for surgery. The insurer has not taken a position regarding whether claimant was in the force at the time of his current disability. However, claimant reported that he received unemployment benefits until a few days prior to his surgery. In support of his representations, claimant submitted copies of unemployment checkstubs for the period between May 1999 and September 1999.

We have previously found that the "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to September 23, 1999, when he was hospitalized for 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).

Here, claimant has established that he received unemployment benefits from May 15, 1999 until September 18, 1999, a few days prior to his September 23, 1999 surgery. The receipt of unemployment benefits is *prima facie* evidence that claimant is willing to work and is making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991). Therefore, we find that claimant was in the work force at the time of his current worsening which required surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning September 23, 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.

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[1] The insurer initially erroneously submitted claimant's request for own motion relief under the claim number relating to his compensable *right* knee injury claim. Claim No. 604298566. That request is addressed in a separate order issued on today's date.

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

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 $1,500, 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
DEAN P. CATCHPOLE, Claimant
WCB Case No. 99-01823
ORDER ON REVIEW
Bottini, Bottini, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of his L4-5 disc herniation injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant proved legal causation in that he established that he had back pain while lifting planks at work in October 1998. We adopt and affirm the ALJ's reasoning and conclusions regarding the legal causation issue. The ALJ also found, however, that claimant failed to prove medical causation under ORS 656.005(7)(a)(B).[1] Claimant argues that, based on the opinion of his treating surgeon, Dr. Brett, he met his burden of proving medical causation. We agree with claimant.

The Board generally gives greater weight to the conclusions of a treating physician, unless there are persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or 810, 814 (1983). In addition, we generally defer to the conclusions of a treating surgeon who was able to observe the affected body part during surgery. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988) (treating surgeon's opinion found persuasive where he was able to observe the claimant's shoulder during surgery and indicated that there was no evidence that the claimant's condition was due to congenital defect); *Givens v. SAIF*, 61 Or App 490, 494 (1983) (treating surgeon's opinion found persuasive where he indicated that he saw no evidence during surgery that the claimant's thoracic outlet syndrome was the result of a congenital defect or a compressed artery). Here, we find no reason not to defer to Dr. Brett.

Dr. Brett examined claimant on referral from Dr. Webb, D.O., claimant's treating physician. (Ex. 11). Based on claimant's clinical presentation, x-rays, MRI, and surgical findings, Dr. Brett concluded that claimant had asymptomatic spondylolytic spondylolisthesis (grade 1) at L4-5 and minor, asymptomatic degenerative changes and intervertibral disc space narrowing at L4-5. He also concluded that, as a direct result of claimant's work injury on October 19, 1998, claimant sustained a disc herniation on the left at L4-5 with left L4 nerve root impingement, radiculopathy, and radicular leg pain, which was superimposed over his preexisting conditions. (Exs. 11, 13, 17A). Taking into account claimant's preexisting conditions, Dr. Brett concluded that the work injury was the major contributing cause of claimant's combined condition and his need for treatment, including the surgery. (Ex. 17A-2). Dr. Webb, who had treated claimant before and after the work injury, concurred with Dr. Brett's opinion. (Ex. 19).

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[1] As the ALJ found, the work incident combined with claimant's preexisting low back condition; consequently, the major contributing cause standard of ORS 656.005(7)(a)(B) applies. Claimant agrees that ORS 656.005(7)(a)(B) applies to his claim.

The other medical opinions are supplied by Drs. Scheinberg, orthopedist, and Williams, neurologist, who examined claimant on behalf of the insurer, and Dr. Young, radiologist, who performed a record review on behalf of the insurer. (Exs. 12, 18). Drs. Scheinberg and Williams found that claimant had a "nonstraightforward presentation" and, as a result, were unable to determine whether or not the L4-5 disc herniation was related to the "alleged specific injury of October 19, 1998." (Ex. 12-7). Thus, Drs. Scheinberg and Williams were unable to offer a causation opinion. Furthermore, as noted above, we agree with the ALJ's determination that claimant established legal causation.

Finally, based primarily on his review of the radiological films, Dr. Young opined that the disc protrusion was adjacent to the L5 nerve root but did not appear to compress it. (Ex. 18-3). This is in direct contrast to Dr. Brett's operative report that showed claimant had a herniated disc at L4-5 on the left with left L4 nerve root impingement within the foramen. (Ex. 13-1). Thus, it is not clear that Dr. Young reviewed Dr. Brett's surgical findings. Dr. Young also opined that claimant had long-standing disc degeneration and his disc protrusion was degenerative in nature, not related to trauma. (Ex. 18-4). He also opined that claimant did not have clinical symptoms that correlated to what was demonstrated on the MRI. (*Id.*). In contrast, Dr. Brett found that claimant had left L4 radiculopathy. (Ex. 11).

On this record, we find Dr. Brett's opinion, as concurred with by Dr. Webb, more persuasive. Dr. Brett's opinion is based on clinical examination and direct observation of surgical findings. In contrast, Dr. Young's findings are based on a record review and it is not clear that he reviewed the entire record. Thus, we find that claimant has met his burden of proving compensability of his L4-5 disc herniation injury claim.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellant's brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 18, 1999 is reversed. The insurer's denial of claimant's L4-5 disc herniation injury claim is set aside, and the claim is remanded to the insurer for processing according to law. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded a fee of $4,500, to be paid by the insurer.

In the Matter of the Compensation of
ELIZABETH M. CARLSON, Claimant
WCB Case No. 99-01219
ORDER ON RECONSIDERATION
Meyers, Radler, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

The insurer requests reconsideration of our October 21, 1999 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's claim for a needle stick injury. Specifically, the insurer contends that, by adopting and affirming the ALJ's order, we have not sufficiently considered or responded to the issues raised by its appeal.

The court has held that a Board order need not set forth its own findings of fact and conclusions if it adopts and affirms a referee's (ALJ's) order that is itself sufficient for substantial evidence review. *George v. Richard's Food Center*, 90 Or App 639 (1988). Accordingly, by adopting the ALJ's order, we have found it sufficient for appellate review and the facts and conclusions in that order express our opinion of the case. *See Forest G. Hull*, 50 Van Natta 1530 (1998).

Consequently, we withdraw our October 21, 1999 order. On reconsideration, as supplemented herein, we republish our October 21, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 10, 1999 Cite as 51 Van Natta 1878 (1999)

In the Matter of the Compensation of
DAWN M. RUNYAN, Claimant
WCB Case No. 98-00254
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) reversed an Order on Reconsideration finding that claimant's claim was prematurely closed; and (2) found that claimant did not timely raise the issue of extent of permanent disability. On review, the issues are premature closure and, if timely raised, extent of permanent disability.

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

Claimant has an accepted claim for right wrist tendinitis. The claim was closed by an August 28, 1997 Determination Order (DO) that awarded no permanent disability benefits. Claimant requested reconsideration of the DO. A medical arbiter was appointed and claimant underwent a medical arbiter examination by Dr. Gritzka. An Order on Reconsideration dated December 19, 1997 set aside the DO as premature.

The insurer requested a hearing regarding the Order on Reconsideration and argued that the claim was not prematurely closed and that the DO should be reinstated. The ALJ discussed the issues and noted that claimant had withdrawn her request for hearing and that this left only the insurer's request for hearing regarding premature closure. (Tr. 2). Claimant's attorney did not raise any other issues or disagree with the ALJ's characterization of the issue.

The ALJ reversed the Order on Reconsideration finding the claim prematurely closed and reinstated the DO. The ALJ found that claimant did not raise the issue of extent of permanent disability until closing arguments. Finding that the extent issue was not timely raised at the hearing, the ALJ declined to address it.

We will not consider an issue raised for the first time during written or oral closing argument regardless of whether an "in-person hearing" is convened. *Amador R. Gallardo*, 51 Van Natta 808 (1999).[1] Here, claimant's attorney had the opportunity to raise the alternative issue of the extent of permanent disability in the event the ALJ agreed with the insurer's argument that the claim was not prematurely closed. Because the extent issue was not timely raised at hearing, we affirm the ALJ's decision declining to address the late-raised issue.

ORDER

The ALJ's order dated March 30, 1999 is affirmed.

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[1] Here, a hearing was convened and the parties and the ALJ discussed the exhibits and issues on the record, but no testimony was taken.

In the Matter of the Compensation of
ROBIN B. BERDAHL, Claimant
WCB Case No. 99-01582
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Kekauoha's order that reversed her award of 3 percent (5.76 degrees) scheduled permanent disability for loss of use or function of the left arm, as granted by an Order on Reconsideration. With her appellant's brief, claimant has submitted documents not admitted into evidence at the hearing. We treat such a submission as a motion for remand for presentation of additional evidence. In addition, claimant has moved to strike the insurer's brief on the ground that it was untimely filed. On review, the issues are extent of scheduled permanent disability, motion for remand and motion to strike.

We deny the motions and adopt and affirm the ALJ's order with the following discussion.

Motion to Strike

Claimant filed her appellant's brief on September 11, 1999. The insurer's respondent's brief was due 21 days later on October 2, 1999. The insurer, however, did not file its brief until October 4, 1999. Nevertheless, we find that the insurer's brief was timely filed because October 2, 1999 was a Saturday, which allowed the insurer's brief to be filed on the following Monday. *See, e.g., Sandy K. Preuss*, 50 Van Natta 1028 (1998); *Anita L. Clifton*, 43 Van Natta 1921 (1991). Accordingly, we deny claimant's motion to strike.

Remand

Our review is limited to the record developed at hearing. ORS 656.295(5). Claimant, nevertheless, has submitted copies of documents not admitted into evidence with her appellant's brief. We have treated this submission as a motion for remand to the ALJ for further development of the hearings record. *See Judy A. Britton*, 37 Van Natta 1262 (1985). We may remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate only upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, claimant has not shown that the submitted records were unobtainable at the time of the hearing. Moreover, even if we considered the records, they would not change the result of this case. Accordingly, we find no "compelling" reason to remand and, therefore, deny claimant's motion.

ORDER

The ALJ's order dated August 25, 1999 is affirmed.

In the Matter of the Compensation of
CARRIE L. ELLER, Claimant
WCB Case No. 99-00946
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that affirmed an Order on Reconsideration that did not award scheduled permanent disability for loss of use or function of claimant's left knee. On review, the issue is extent of scheduled permanent disability.

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

The only question presented to the Board is whether claimant proved a "history of injury" in the left knee joint sufficient to establish permanent impairment of her right knee. OAR 436-035-0007(23)[1] states that "[t]he range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury * * *." We do not reach that issue because we affirm the ALJ's decision on different grounds.[2]

Impairment is a compensable, permanent loss of use or function of a body part/system related to the compensable condition. OAR 436-035-0005(7). Scheduled disability is rated on the permanent loss of use or function of a body part due to an accepted compensable condition. OAR 436-035-0010(2). A claimant is entitled to permanent disability when permanent impairment related to the compensable condition is established. *See* OAR 436-035-0007(1). To be awarded permanent disability under the "standards," a claimant must establish "impairment" as measured by a physician. *William K. Nesvold*, 43 Van Natta 2767 (1991).

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). When rating impairment, only the opinions of the attending physician and the medical arbiter(s), if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1994). Here, neither party requested a medical arbiter exam. Therefore, we rely on the medical opinion of Dr. Wilson, attending physician.

At the time of the closing examination, Dr. Wilson determined that there was "no objective evidence to indicate a permanent medical impairment at this point." (Ex. 15). Thus, Dr. Wilson found no permanent loss of use or function of her left knee due to the compensable condition. In the absence of permanent impairment resulting from her compensable condition, claimant is not entitled to a scheduled permanent disability award under the Director's disability standards.

ORDER

The ALJ's order dated May 20, 1999 is affirmed.

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[1] *Former* OAR 436-035-007(22).

[2] Alternatively, if we analyzed this matter on the same grounds as the ALJ, we would adopt and affirm.

In the Matter of the Compensation of
CHRISTOPHER K. MANGIOFICO, Claimant
WCB Case No. 99-01774
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

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

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Penalty

The ALJ concluded that claimant established that his L2-3 disc herniation was caused by a December 14, 1998 work injury that occurred while moving furniture. The ALJ found that, at the time SAIF issued its denial, there was no medical evidence in the record to suggest the claim was not compensable. Additionally, the ALJ found there was no testimony at hearing to establish that SAIF had a legitimate doubt concerning its liability for the claim. The ALJ assessed a penalty in the amount of 25 percent of the benefits due at the time of hearing.

On review, SAIF disputes only that portion of the ALJ's order that assessed a penalty for its allegedly unreasonable denial. SAIF argues that it had evidence that claimant's L2-3 herniated disc may have been caused from either a non-work-related incident or from a prior injury that resulted in a combined back condition.

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

On February 24, 1999, SAIF denied claimant's low back injury claim on the basis that there was insufficient evidence that his injury arose out of or occurred within the course of his employment. (Ex. 19). At that time, SAIF had a December 18, 1998 report from Dr. Johnson referring to claimant's back pain and explaining: "He was playing with his child where he was down on all 4s and his child was riding him like a hoarse [sic] and he hurt his back." (Ex. 5-1). Dr. Johnson also referred to an injury "years ago," which included a back injury. (*Id.*) Nevertheless, Dr. Johnson did not mention a current work-related injury in that report, although he apparently signed an "827" form in which claimant wrote that he hurt his back moving furniture. (Ex. 4).

Based on Dr. Johnson's inconsistent reports, we find that SAIF had legitimate doubt as to whether claimant's low back injury was work-related. Dr. Johnson's December 18, 1998 report referred to an injury from playing with a child and a back injury from "years ago," but did not refer to a current work-related injury. Furthermore, at the time it issued its denial, SAIF had medical reports indicating claimant had injured his back on November 22, 1998 while giving his daughter a horse-back ride. (Exs. 1, 2, 3). At that time, claimant received emergency room treatment and was diagnosed with a thoracolumbar strain. (Ex. 3). Despite the "827" signed by Dr. Johnson in which claimant referred to an injury moving furniture, Dr. Johnson's December 18, 1998 report indicated claimant injured his back

playing with his child. Under these circumstances, we conclude that SAIF had legitimate doubt regarding its liability for claimant's low back condition at the time it issued its denial. Therefore, we reverse the ALJ's penalty assessment.

ORDER

The ALJ's order dated July 1, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty is reversed. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with the portion of the majority opinion that affirmed the ALJ's conclusion regarding compensability. I disagree, however, with the majority's conclusion that claimant is not entitled to a penalty.

After reviewing the record, I believe that a penalty is appropriate in this case. It is important to assess *all* the evidence that SAIF had available at the time it issued its denial. The fact that a report existed raising a question about compensability is not sufficient to justify SAIF's denial. I agree with the ALJ that, at the time SAIF issued its denial, there was no medical evidence in the record to suggest that the claim was not compensable. The ALJ correctly assessed a penalty in this case.

November 10, 1999 Cite as 51 Van Natta 1882 (1999)

In the Matter of the Compensation of
ROGER S. McINTIRE, Claimant
WCB Case No. 98-02048
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that upheld the self-insured employer's denial of claimant's injury claim for L4-5 disc, spondylolisthesis and/or unstable spondylolisthesis conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order. *See* ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated May 20, 1999 is affirmed.

Board Member Phillips Polich specially concurring.

I write separately to acknowledge the unfortunate posture of this case.

The medical opinions supporting the claim relate claimant's low back condition to *two* work incidents that occurred about a week apart in late October 1995. The first of these incidents clearly contributed to claimant's current condition. But it is time-barred and we may not rely on it to find the claim compensable. Moreover, no medical evidence indicates that the second incident (alone) was the major contributing cause of claimant's combined condition. Under these circumstances, I agree with the employer, the ALJ, and the majority opinion that the claim must fail under ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
LARRY R. PINCOCK, Claimant
WCB Case No. 98-07766
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial of claimant's claim for his low back condition since July 1998. On review, the issue is compensability.

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

Claimant asserts that his current low back condition at L5-S1 and his degenerative condition are compensably related to his August 1988 compensable injury.[1] Only two medical experts addressed compensability. Dr. Rohrer, a neurosurgeon, performed claimant's 1998 surgery. Dr. Rohrer's opinion does not support compensability. Claimant relies on Dr. Craven, who was claimant's treating physician between 1988 and 1992. Dr. Craven opined that claimant's degenerative disc disease had objectively worsened since 1991. Dr. Craven also opined that claimant's August 4, 1988 compensable claim is the major contributing cause of the degenerative disc disease at L5-S1. The ALJ found Dr. Craven's opinion unpersuasive in part because it did not address Dr. Rohrer's opinion that the major contributing cause of the worsening of claimant's degenerative condition was the natural progression of claimant's degenerative disc disease. Dr. Rohrer also indicated that claimant's physical activities and history of smoking could contribute to degenerative disc disease.

We find Dr. Craven's opinion, in the context of this medically complex case, to be conclusory and lacking in explanation and analysis. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980). The doctor does not explain how or why he believes the 1988 injury caused the disc disease and need for treatment at L5-S1 in 1998. He merely concludes that claimant had no sign of the disease in 1988 and after 1988, claimant showed signs of degenerative disease. This opinion is not sufficient to establish causation, because it infers causation based on a mere temporal relationship. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone).[2]

In addition, although Dr. Craven also appears to believe that claimant's work activities after 1988 also contributed to the condition, he does not address what those activities were and how they worsened the disease.

Claimant argues alternatively that claimant's degenerative disease is an accepted part of the 1988 claim. We disagree.

The scope of acceptance is a factual determination. *SAIF v. Tull*, 113 Or App 449 (1992). When the carrier does not identify the specific condition accepted, we look to contemporaneous medical records to determine what condition was accepted. *Mary Marrs-Johnston*, 49 Van Natta 1757 (1997); *Timothy Hasty*, 46 Van Natta 1209 (1994).

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[1] Claimant argues that the ALJ erred in analyzing his claim as a consequential condition under ORS 656.005(7)(a)(A). However, we agree with the ALJ's reasoning and conclusion regarding the applicable standard as set forth in his order.

[2] Citing *SAIF v. Strubel*, 161 Or App 516 (1999), claimant also argues that the ALJ repeatedly refused to read Dr. Craven's opinion in context and ignored it because it failed to include "magic words." We disagree with claimant's argument. The ALJ read Dr. Craven's opinion in the context of this case and found it insufficient to establish compensability. We also find that, in the context of this case which involves a complex medical issue and the major contributing cause standard, Dr. Craven's report is inadequate, for the reasons stated above and in the ALJ's order, to persuasively establish causation.

Here, the contemporaneous medical reports in the record establish that the accepted condition was lumbosacral strain. Thus, we conclude that the degenerative condition was not accepted by the insurer.[3]

ORDER

The ALJ's order dated June 2, 1999 is affirmed.

[3] Claimant argues that the ALJ erred in suggesting that some arguments were abandoned in closing argument. We find this argument moot because, although the ALJ stated he thought the arguments might have been abandoned, he nonetheless addressed them in his order. Specifically, on page 7 of his order, the ALJ alternatively found that the claim was not compensable even if it was analyzed as a combined condition claim or an occupational disease claim.

November 12, 1999 Cite as 51 Van Natta 1884 (1999)

In the Matter of the Compensation of
VICKIE HILLARD, Claimant
WCB Case No. 98-09947
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that dismissed her request for hearing concerning the insurer's denial of a left arm condition on the basis that the hearing request was untimely. On review, the issue is timeliness of the hearing request and, potentially, compensability.

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

As discussed by the ALJ, we understand that claimant mistakenly believed that the insurer had "reopened" her claim to obtain a second opinion when she was instructed to attend a second, post-denial insurer-arranged medical examination (IME) on October 7, 1998. Nevertheless, as the ALJ explained in the order, when a claimant fails to request a hearing challenging a denial within 60 days (but does file the request within 180 days), the claimant is required to show "good cause" for the late filing. *See* ORS 656.319(1).

Under the established law, a claimant's misunderstanding of a carrier's claim processing actions generally does not establish "good cause" in the absence of evidence that the claimant was misled by the carrier. *See, e.g., Edward J. Andrews*, 51 Van Natta 226, *recon* 51 Van Natta 377 (1999); *Randall Davis*, 48 Van Natta 369 (1996); *Wayne A. Moltrum*, 47 Van Natta 955 (1995); *Roger Eli*, 47 Van Natta 1938 (1995). Nothing about the circumstances of this case convinces us to depart from the general principle established by our precedent. Consequently, in this case, claimant's mistaken belief that her claim had been accepted, based on the scheduling of a second IME, does not constitute "good cause" for her failure to request a hearing within 60 days of the mailing of the September 10, 1998 denial.

ORDER

The ALJ's order dated June 4, 1999 is affirmed.

In the Matter of the Compensation of
DIANE L. RAMSEY, Claimant
WCB Case No. 98-09984
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of her claim for a right shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

At the time of her injury, claimant worked for a health insurance provider as a supervisor and as the employer's sole subrogation analyst on a four day, 10-hour-a-day schedule. (Tr. 6, 7). She prepared lien ledgers and other correspondence in her job of investigating third party, accidental injury claims. She worked at her desk 98 percent of the time, and 90 to 95 percent of her work involved use of the computer keyboard, with about 80 percent of the keyboarding on the 10-key. (Tr. 9, 10). Claimant is right hand dominant. (Tr. 10).

Claimant's modular work station consisted of an L-shaped desk with a computer on top. (Tr. 8). In about the third week of June 1998, claimant's work station was dismantled and moved to a different suite in her office building. The desk was installed about two inches higher than it had been before the move. The computer was on top of the desk and the keyboard was on top of the desk directly in front of claimant, with the mouse on top of the desk to the right of the keyboard. (Tr. 8, 17, 18). The increased height of the desk and the placement of the mouse and keyboard required claimant to perform keyboarding and mouse work with her right arm up and extended away from her body. (Tr. 11). Claimant's work station was not readjusted to the proper height until July 1, 1998. (*Id.*).

On June 23, 1998, when claimant first used her newly reassembled work station, her right shoulder began to hurt later that day. (Tr. 10). Claimant worked June 23 through June 26, 1998 and rested and iced her shoulder over her weekend. Her right shoulder gradually got somewhat worse until July 3, 1998, when she awoke with significant pain and was unable to move her shoulder or arm. (Tr. 18, 20).

Claimant sought treatment on July 6, 1998 and was taken off work until July 14, 1998. (Tr. 26). She returned to modified duty until August 13, 1998, when she was released her to an eight hour day that consisted of four hours regular work and four hours modified work.

On August 25, 1998, claimant was treated by Dr. Mandiberg, who diagnosed right shoulder tendonitis and mild right elbow epicondylitis. She received an injection into the right shoulder that eliminated most of the pain.

Claimant had experienced prior right shoulder problems as a result of two automobile accidents in 1990. She treated with Dr. Long through August 28, 1991. (Exs. 1 through 4). She also experienced a right shoulder problem in 1995 that resolved with one doctor visit. (Tr. 5-6).

CONCLUSIONS OF LAW AND OPINION

Finding that claimant had not specifically described the position of her arms at work from June 23 to July 1, 1998 (when her desk was readjusted), and that the desk was only two inches higher than before, the ALJ reasoned that claimant had not worked in an injurious position likely to cause shoulder tendinitis and, therefore, had not carried her burden of establishing either an accidental injury or an occupational disease. On review, claimant argues that her right shoulder condition should be analyzed as an injury rather than an occupational disease,[1] and that she has met her burden of proof. Claimant

[1] The employer contends that claimant argued in her closing argument at hearing that her shoulder tendinitis was an occupational disease, and, therefore, her argument on review is inconsistent with that at hearing. As the employer notes, closing arguments were not recorded. The ALJ recited the standards for both an injury and an occupational disease in the Opinion and Order without clearly indicating which standard he was applying. Because claimant's claim would prevail under either compensability theory, we need not resolve the employer's contention.

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

After being treated by a nurse practitioner and Dr. Davis, claimant was referred to Dr. Mandiberg for evaluation. Claimant reported the following history to Mandiberg:

> "On June 23, 1998, [claimant] began to have right shoulder and right elbow discomfort. She had just moved into a new work station in a new part of the building * * *. She worked one day at the new work station and developed discomfort in her shoulder and elbow. She realized that it was too high. She does a lot of keyboarding and mouse work. She raised her seat to the maximum and used a foot stool but still had problems." (Ex. 11-1).

Mandiberg examined claimant, found objective indications of injury and diagnosed tendinitis of the right shoulder. (Ex. 11-3). X-rays revealed a Type I acromion and possible mild calcific tendinitis. In his discussion of causation, Mandiberg ruled out any contribution by the acromion, degenerative arthritis, age, work history, or genetics. He further found the presence of calcific tendinitis not only questionable but in any case not the major contributing cause of her right shoulder condition. (Ex. 15). He also ruled out any contribution from her 1990 shoulder injuries. (Ex. 17). Mandiberg concluded that claimant's work activities were the major contributing cause of her right shoulder condition. (Ex. 15).

When the employer had the subsequent opportunity to cross-examine Mandiberg, it asked the doctor what position the arms would have to be held in in relation to the shoulder to cause tendinitis. Mandiberg stated that, if claimant had to reach the keyboard and mouse by bringing her arm up into abduction, it would be compatible with her injury. (Ex. 18-7, -9, -10). Claimant credibly testified that, in order to use the keyboard and the mouse, she would have her arm up and extended and away from her body. (Tr. 11). There is no contrary evidence regarding the positioning of claimant's arm. Accordingly, we conclude that the medical evidence persuasively establishes that the major contributing cause of claimant's shoulder tendinitis was her work activities.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 9, 1999 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for further processing in accordance with the law. For services at hearing and on review, claimant's attorney is awarded a fee of $3,500, to be paid by the employer.

November 12, 1999 Cite as 51 Van Natta 1886 (1999)

In the Matter of the Compensation of
BEVERLY J. COFFMAN, Claimant
Own Motion No. 99-0290M
OWN MOTION ORDER OF ABATEMENT
Black, Chapman, et al, Claimant Attorneys

The insurer requests reconsideration of our October 13, 1999 Own Motion Order, that reopened claimant's 1993 claim for the provision of temporary disability compensation. The insurer requests reconsideration asserting that the date of surgery listed in our order was incorrect.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LONNIE S. ANDERSON, Claimant
WCB Case No. 98-07545
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld the SAIF Corporation's denial of his current thoraco-lumbar condition; and (2) upheld SAIF's denial of his hematuria condition. With his brief, claimant attached a July 16, 1999 medical report from Dr. Rand and seeks remand for the admission of this additional evidence. On review, the issues are remand and compensability.

We adopt and affirm the ALJ's order, with the following supplementation to address claimant's request for remand and his arguments on review.

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 16, 1999 medical report from Dr. Rand. This report states that claimant returned to Dr. Rand to discuss his May 12, 1999 MRI. The MRI showed no abnormalities, although claimant reported low back pain that seemed to be decreasing. We decline to remand for admission of Dr. Rand's report into evidence because it is not reasonably likely to affect the outcome of the case.[1]

Claimant argues that there is no mention of a preexisting condition in the record. Claimant is incorrect. In his deposition, Dr. Cook identified claimant's preexisting condition as his emotional state that tends to compound his physical symptoms. Dr. Cook opined that claimant's emotional state combined with his thorocolumbar injury to cause or prolong disability or a need for treatment. In response to SAIF's questioning, Dr. Cook further opined that after October 1998, the major cause of claimant's need for continuing treatment was his emotional makeup and not the thoracolumbar contusion. (Ex. 36-32, -33, -40, -41, -42).

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[1] Claimant also requests an extension of time in order to obtain further medical records. We treat this request as a separate request for remand and deny the request for the following reasons.

The party requesting remand must clearly establish that the evidence was not obtainable with due diligence at the time of the hearing. The only evidence mentioned by claimant is Dr. Rand's medical report, discussed above. Insofar as claimant is requesting remand to reopen the record for other unnamed documents, claimant has provided no information indicating that such documents were not obtainable, with due diligence, at the time of hearing. Absent a compelling reason for remand, we, therefore, deny the request.

Claimant also argues that toxic exposure might have had something to do with the amount of time he needed to heal. SAIF contends that we should not allow claimant to raise the toxic exposure issue on review because the parties agreed at hearing that the compensability of a toxic exposure was not at issue during this hearing. We agree with SAIF's contention. However, the issue before us is not the compensability of a toxic exposure, but whether claimant's current condition is compensable. Therefore, we may consider exposure to a toxic substance insofar as it may have had an effect on the length of time it took claimant to heal. However, there is no medical evidence that a toxic exposure had, or did not have, an effect on claimant's ongoing symptoms or ability to heal. Consequently, claimant's argument has no effect on the outcome of the current condition compensability issue.

Finally, claimant contends that his hematuria condition is compensable. As discussed by the ALJ, although Dr. Cook stated that claimant has had hematuria since the injury, and it *may have been* part of the initial injury, there is insufficient medical evidence to establish that the hematuria was *probably* caused by the injury. *Gormley v. SAIF*, 52 Or App 1055 (1981) (in order to be legally sufficient and persuasive, medical opinions must be stated in terms of probability rather than possibility).

ORDER

The ALJ's order dated May 20, 1999 is affirmed.

November 15, 1999 Cite as 51 Van Natta 1888 (1999)

In the Matter of the Compensation of
KRISHA L. GRUENHAGEN, Claimant
WCB Case No. 98-09134
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's injury claim for a thoracic and right shoulder strain. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. On page 1, in the second sentence of the findings of fact, we change the date to "September 16, 1998."

SAIF argues that the ALJ erred in finding claimant's thoracic and shoulder strains compensable because the medical evidence of these conditions was not supported by objective findings. We disagree.

Under ORS 656.005(19), the term "objective findings" is defined as:

> "[V]erifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

In *Tony D. Houck*, 48 Van Natta 2443 (1996), *aff'd mem Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997), we concluded that "objective findings" included a physician's interpretation of a worker's verifiable subjective response to clinical testing, provided the subjective response was "reproducible, measurable or observable."

For the following reasons, we agree with the ALJ that the opinion of Dr. Davis is sufficient to establish that claimant had "objective findings" of a scapular thoracic strain.

Two days after claimant was injured at work, Dr. Patton examined her and reported that she had pain at the medial scapular margin trigger point and in the right trapezius. (Ex. 5-1). He prescribed medication and recommended exercises.

When claimant was examined by Dr. Davis on September 28, 1998, he reported that she had ongoing muscular pain around the scapula. (Ex. 7-1). He diagnosed a scapular thoracic strain. (*Id.*) On October 15, 1998, Dr. Davis reported that claimant's major pain was at the superomedial border of the scapula. (Ex. 10). In a February 11, 1999 report, Dr. Davis explained that claimant had tenderness at the insertion of the musculature in the superior medial border of her scapula. (Ex. 19). He felt that claimant had objective findings of tenderness at the insertion of the musculature of her scapula, which was consistent with his diagnosis of a scapular thoracic strain. (*Id.*)

SAIF contends that Dr. Davis' February 1999 letter is not sufficient to establish the requirement for "objective findings" because he did not indicate that claimant's complaint of tenderness was the result of a verifiable subjective response to clinical testing that he had performed. If the February 1999 letter from Dr. Davis was the only report from him, we might be persuaded by SAIF's argument. Here, however, Dr. Davis referred to pain and tenderness in claimant's scapular area during examinations. Similarly, Dr. Patton referred to pain at the medial scapular margin trigger point and in the right trapezius. Based on Dr. Davis' findings, as supported by Dr. Patton's report, we find that claimant's pain and tenderness in the scapula area was reproducible and constitutes a valid objective finding. *See Joseph M. Stransky*, 51 Van Natta 143, 144 (1999) (reproducible tenderness was sufficient to establish "objective findings"); *Marilyn M. Keener*, 49 Van Natta 110 (1997) (same). We are persuaded by Dr. Davis' opinion that claimant had "objective findings" of tenderness at the insertion of the musculature of her scapula. We agree with the ALJ that claimant's scapular thoracic strain is compensable.

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

ORDER

The ALJ's order dated June 11, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

November 15, 1999 Cite as 51 Van Natta 1889 (1999)

In the Mattter of the Compensation of
JAMES M. KING, Claimant
Own Motion No. 99-0248M
OWN MOTION ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our October 21, 1999 Own Motion Order on Reconsideration, 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 light of such circumstances, the following briefing schedule shall be implemented. Claimant shall have 28 days from the date of this order to file his opening brief. The SAIF Corporation shall have 28 days from the date of mailing of claimant's brief to file its response. Claimant shall then have 14 days from the date of mailing of SAIF's response to file his reply. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JACK L. SWEET, Claimant
Own Motion No. 99-0071M
OWN MOTION ORDER
Dale C. Johnson, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable right shoulder condition. Claimant's aggravation rights expired on April 2, 1986. 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 is not entitled to temporary disability benefits because he was not in the work force at the time of the current disability.

FINDINGS OF FACT

Claimant sustained a work-related injury to his *right* shoulder on April 2, 1981. That claim was accepted as nondisabling. (Claim No. 4514228L).[1] Claimant subsequently filed a new occupational disease claim for a bilateral shoulder condition sustained in or about January 1998. SAIF denied the claim and claimant requested a hearing appealing the denial.

On October 8, 1998, Administrative Law Judge (ALJ) Myzak approved a "Disputed Claim Settlement Agreement" (DCS), which resolved the parties' dispute concerning the compensability of claimant's bilateral shoulder conditions which was pending before the Hearings Division. Pursuant to that DCS, claimant agreed that SAIF's occupational disease claim denial would remain in full force and effect. In addition, SAIF agreed that if claimant should pursue surgery to his shoulders, it would recommend reopening of one or more of his own motion claims. (Claim Nos. 4514228L and/or 4773854G). Finally, claimant stipulated that his request for hearing "shall be dismissed with prejudice," and that the settlement resolved "all issues raised or raisable."

On January 18, 1999, Dr. Davis, claimant's attending physician, recommended that claimant undergo arthroscopic excision of his right distal clavicle. Claimant requested own motion relief on February 22, 1999. Surgery on his right shoulder took place on April 1, 1999.

On March 23, 1999, a SAIF investigator interviewed claimant by phone. Claimant reported that he was not working and had not worked since his retirement on October 19, 1998. He had not applied for unemployment benefits. He was drawing his retirement pension and Social Security Retirement benefits. Claimant reported that he had not applied for any jobs since he retired, although he would like to find suitable part-time employment.

On July 26, 1999, claimant signed an affidavit in which he stated that he took sick leave and then retirement under Dr. Davis' recommendation. He also stated that he did not leave the work force. He had looked at the local want ads but had not found any suitable work within his doctor's restrictions. Finally, claimant stated that he was willing to work, but given his age (62), education, work experience, and his doctor's restrictions, it was impossible to find suitable work.

On August 23, 1999, SAIF submitted its recommendation to deny reopening of claimant's right shoulder 1981 own motion claim, contending that he was not in the work force at the time of his current worsening.

CONCLUSIONS OF LAW AND OPINION

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

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[1] Claimant sustained a compensable injury to his *left* shoulder on December 21, 1985. (Claim No. 4773854G). That injury claim is not the subject of the current order.

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. SAIF asserts that claimant retired in October 1998 and "has not applied for any jobs or applied for unemployment compensation benefits." Claimant responds that, as a result of the October 1998 settlement agreement, SAIF agreed to recommend reopening of his 1981 right shoulder own motion claim. However, notwithstanding SAIF's "agreement" to recommend reopening of claimant's 1981 claim, our decision in our own motion authority to award benefits is not completely discretionary; a claimant is entitled to benefits for temporary disability only if he statutorily qualifies for those benefits, and this includes being in the work force at the time of disability. *Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *Violet Allquist*, 50 Van Natta 209 (1998). Accordingly, we proceed with our review of the work force issue.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery 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 April 1, 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 submitted an affidavit, stating that "I was willing to work, but given * * * my doctor's restrictions pending surgery, it was impossible to find suitable work." Further, SAIF submitted a summary of an interview conducted by one of its investigators in which claimant states that, although retired, he would like to find suitable part-time work. Based on his affidavit and this interview summary, we are persuaded that claimant was *willing* to work.

However, claimant must also demonstrate that, in addition to being willing to work, he was either seeking work or that such a work search would have been futile due to his compensable condition. *Dawkins*, 308 Or at 258. In his affidavit, claimant asserted that, under his doctor's instructions, he left work on sick leave and eventually retired. He indicated that he left work due to his "worsened conditions." However, claimant does not submit a medical opinion supporting his contentions. The record does not contain medical evidence that claimant was taken off work due to his compensable injury. Thus, the medical documentation contained in the record fails to establish that prior to his April 1, 1999 hospitalization, claimant was unable to work and that it would have been futile for him to seek work due to his compensable condition. *Id.*

Further, claimant contended that he would like to find part-time employment. The only evidence supporting claimant's assertion is his statement in his affidavit that he has "looked at the local want ads." Claimant gives no information regarding any work search other than to state he was looking for work. For example, he does not list the names and addresses of the employers contacted or the dates of such contacts. We are not persuaded that looking at wants ads, without more, demonstrates a reasonable job search. *Linda M. Storms*, 51 Van Natta 876 (1999); *Juana Piper*, 45 Van Natta 553 (1993).

Under such circumstances, we are not persuaded that claimant was in the workforce at the time of his hospitalization. Accordingly, claimant's request for temporary disability compensation is denied. *See id.*

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

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
KAREN M. DOHMAN, Claimant
WCB Case No. 98-01618
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Moscato & Hallock, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition. On review, the issue is compensability.[1]

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated July 19, 1999 is affirmed.

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[1] In a footnote, the employer argues that the ALJ lacked jurisdiction, because claimant's request for hearing was initially dismissed. We disagree, because the prior ALJ withdrew her order dismissing the request for hearing within 30 days, while she still retained jurisdiction over the matter. Therefore, the dismissal order never became final and it has no preclusive effect. *See* OAR 438-007-0025. *See also Drews v. EBI Companies*, 310 Or 134, 140 (1990) (Claim only precluded by a prior *final* judgment that disposes of the matter).

Board Member Phillips Polich dissenting.

The majority declines to rely on the opinion of Dr. Long, treating surgeon, finds the evidence "in equipoise," and therefore concludes that the claim fails.

I would apply the long-standing presumption favoring the treating doctor's opinion, for several reasons. First, Dr. Long's opinion is well-reasoned and based on an accurate history. *See Weiland v. SAIF*, 64 Or App 810 (1983). Second, Dr. Long had the unique opportunity to view claimant's condition firsthand during surgery and his causation opinion *is* based largely on surgical observations. *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698 (1986).

Before performing claimant's right CTS surgery, Dr. Long stated that, with the studies presently available, there was no way to evaluate the relative contributions of the factors involved in claimant's condition. After performing the surgery, he noted that surgical findings do not often help in determining CTS causation. *However*, claimant's surgical findings were so dramatic, that Dr. Long *could* say, with certainty, that claimant's CTS was due to "mechanical" compression, caused by her work activities, rather than metabolic causes, including her diabetes. (If claimant's CTS had been due to metabolic causes, rather than traumatic work activities, Dr. Long explained that her wrist would have appeared "normal" during surgery.) Thus, Dr. Long's opinion satisfies all the requisites for the presumption favoring a treating surgeon's opinion. *See id.*

Considering Dr. Long's well-reasoned opinion and his supporting surgical observations, *Mageske* applies, and the evidence is not "in equipoise." Accordingly, I would find the claim compensable (based on Dr. Long's opinion) and I must respectfully dissent.

In the Matter of the Compensation of
ALLEN D. KUPERSMITH, Claimant
WCB Case No. 98-08800
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that awarded a $2,000 assessed attorney fee pursuant to ORS 656.382(2). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant requested a hearing concerning a February 2, 1999 Order on Reconsideration. The issues before the ALJ were entitlement to temporary and permanent disability benefits. SAIF did not file a cross-request for hearing.

By Opinion and Order dated June 10, 1999, the ALJ modified the Order on Reconsideration awarding claimant temporary disability benefits from July 10, 1998 through August 20, 1998 as well as an additional 2 percent unscheduled permanent disability. The ALJ also awarded claimant's counsel an approved attorney fee payable out of the increased compensation. On June 15, 1999, the ALJ issued an Amended Opinion and Order that awarded claimant's counsel an assessed attorney fee pursuant to ORS 656.382(2).

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded claimant's counsel an assessed attorney fee pursuant to ORS 656.382(2). We reverse.

An assessed attorney fee is available under ORS 656.382(2) where a carrier requests a hearing and an Administrative Law Judge does not disallow or reduce a claimant's compensation. Here, SAIF did not request a hearing and did not challenge the Order on Reconsideration's temporary and permanent disability awards. Rather, this matter was initiated by claimant's request for hearing, who sought increased awards. Consequently, ORS 656.382(2) is not applicable and claimant is not entitled to an assessed attorney fee pursuant to that provision.

On review, claimant appears to concede that he is not entitled to an attorney fee under ORS 656.382(2) as he characterizes the ALJ's reference to that provision as a "typographical error." (Respondent's Brief at p. 1). Claimant now asserts that he is entitled to the assessed attorney fee under either ORS 656.382(1) or ORS 656.386(1).

SAIF contends that claimant neither raised nor preserved the issue of an ORS 656.382(1) fee at hearing. After reviewing the record, we agree with SAIF that claimant did not raise the issue of a ORS 656.382(1) penalty-related attorney fee at hearing. We therefore decline to consider this issue for the first time on appeal. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

Finally, claimant contends that he is entitled to an assessed attorney fee under ORS 656.386(1) based on SAIF's termination of temporary disability benefits.[1]

An assessed attorney fee is available under ORS 656.386(1)(a) if a claimant finally prevails against a denied claim. In this context, a "denied claim" is "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which

[1] We note that the temporary disability benefits at issue (July 10, 1998 through August 20, 1998) were granted by October 26, 1998 Notice of Closure and that award was affirmed by the Order on Reconsideration. (Exs. 45, 50).

compensation is claimed is not compensable or does not otherwise give rise to an entitlement to compensation."[2] ORS 656.386(1)(b)(A).

SAIF did not issue a "denial" that refused to pay compensation on the basis that claimant's injury was not compensable. Rather, SAIF procedurally terminated time loss based on claimant's release to modified work. Accordingly, claimant has not established that there was a "denied claim" that would give rise to an attorney fee under ORS 656.386(1). *See, e.g. SAIF v. Varah*, 160 Or App 254 (1999).

ORDER

The ALJ's order dated June 10, 1999, as amended June 15, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded a $2,000 assessed attorney fee is reversed. The remainder of the ALJ's order is affirmed.

[2] The definitions of a denied claim set forth in ORS 656.386(1)(b)(B) and (C) are not applicable to this case.

In the Matter of the Compensation of
CLYDE A. BEAVERS, Claimant
WCB Case No. C992633
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Stephen V. Piucci, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On November 4, 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 November 4, 1999. The statutory 30th day following the submission is December 6, 1999. Claimant filed his request for disapproval of the disposition on November 15, 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
FREEMAN K. PITT, Claimant
WCB Case No. 99-00428
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that increased his scheduled permanent disability award for loss of use or function of the right hand from 9 percent (13.5 degrees), as awarded by Notice of Closure and affirmed by Order on Reconsideration, to 18 percent[1] (27 degrees). On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the conclusions and reasoning of the ALJ, with the following supplementation. On review, claimant challenges only that portion of the ALJ's order that declined to award impairment for loss of strength in two fingers on claimant's right hand. In reaching his conclusion, the ALJ relied on OAR 436-035-0110(8)(a), which provides that, in rating impairment of the hand, "Loss of strength in a finger or thumb receives a value of zero."

On review, claimant argues that the rule relied on by the ALJ is inconsistent with ORS 656.214(2), which provides that, when permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury. Consequently, claimant contends that the rule should be held invalid.

SAIF argues that claimant has raised the validity of the Department's rule for the first time on review. Accordingly, SAIF contends that claimant's argument should be rejected. In *Sherry L. Berry*, 51 Van Natta 652 (1999), we disagreed with the claimant's contention that a constitutional argument regarding the arbiter's report, the administrative rule and the caselaw could not have been raised prior to the ALJ's order. We held that the facts to support such an argument were evident prior to the request for hearing and the claimant should have been aware of the effect of the rule. Consequently, we found that the claimant improperly raised a constitutional argument for the first time on Board review. 51 Van Natta at 652.

For the reasons expressed in the *Berry* case, we are inclined to agree with SAIF that claimant did not properly raise the issue of the validity of the rule before the ALJ. Although claimant contends that the rule was not raised in the written arguments submitted to the ALJ, the Order on Reconsideration cited the rule as the reason that no award was being made for loss of strength in the fingers. (Ex. 16-2). Consequently, the time to raise the issue was before the ALJ.

Nevertheless, even if the issue were properly before us on review, we would decline to find the rule invalid.[2] Claimant argues that the rule, which provides a value of zero for loss of strength in a finger or thumb, violates the statute that requires a rating for permanent loss of use or function of the injured member. *See* OAR 436-035-0110(8)(a); ORS 656.214(2).

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[1] On reconsideration, the ALJ clarified that the 9 percent awarded by the Opinion and Order was in addition to the previous Notice of Closure award of 9 percent for the right hand.

[2] In *Schultz v. Springfield Forest Products*, 151 Or App 727 (1997), the court held that the Board had the authority to review the validity of a Director's rule to determine if it is consistent with applicable statutes.

Here, claimant has received an award under the standards for loss of grip strength in the right hand. (Ex. 9). OAR 436-035-0010(8). Moreover, although claimant did not have such findings in this case, the standards also provide a value for a chronic condition of the hand. OAR 436-035-0010(5)(c). Considering the fact that the standards provide for such impairment to be rated, we do not find that the rule limiting an award for impairment on a similar basis exceeds the Director's statutory authority to promulgate disability standards.

Accordingly, we conclude that the ALJ properly applied 436-035-0110(8)(a). We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated May 7, 1999, as reconsidered June 4, 1999, is affirmed.

November 24, 1999 Cite as 51 Van Natta 1896 (1999)

In the Matter of the Compensation of
TIMOTHY R. VANZANT, Claimant
WCB Case Nos. 99-01671 & 99-01576
ORDER ON REVIEW
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se,* requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside the SAIF Corporation's denial of claimant's current left shoulder condition; and (2) upheld Business Insurance Company's (BICO's) denial of claimant's new injury or occupational disease claim for the same condition. On review, the issue is responsibility.

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

The ALJ set aside SAIF's denial of responsibility for claimant's current left shoulder condition under its 1986 claim, finding that SAIF failed to prove that claimant sustained a new occupational disease while working for BICO's insured on or after July 1, 1996. On review, claimant contends that insufficient information was introduced at hearing regarding work done in 1996 "out of state" and "under the table." Claimant also argues that the medical evidence failed to take into account lesser disabling conditions.

We note that an order designating a paying agent under ORS 656.307 issued in this case. Thus, there is no dispute that claimant's current condition is compensable. The only issue at hearing was which carrier (SAIF or BICO) was responsible for claimant's claim. We find that the medical evidence does not establish that claimant's "post-July 1, 1996" work activities (whether "under/over the table" or in or out of state) were the major contributing cause of a pathological worsening of claimant's preexisting condition (whether left shoulder or other conditions).

Accordingly, we agree with the ALJ that responsibility remains with SAIF under its 1986 claim. Thus, we affirm.

ORDER

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

In the Matter of the Compensation of
TIMOTHY R. VANZANT, Claimant
WCB Case No. 99-0034M
OWN MOTION ORDER
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation initially submitted a request for temporary disability compensation for claimant's compensable left shoulder condition. Claimant's aggravation rights on that claim expired on July 10, 1992.

On February 19, 1999, SAIF denied the responsibility for claimant's current left shoulder condition. Claimant requested a hearing. (WCB Case No. 99-01671). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated August 23, 1999, Administrative Law Judge (ALJ) Peterson set aside SAIF's February 19, 1999 denial. Claimant requested Board review of ALJ Peterson's order. By an order issued on today's date, the Board affirmed ALJ Peterson's order.

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

On September 23, 1998, Dr. Greenleaf, claimant's treating physician, recommended claimant undergo acromioplasty, debridement of the left shoulder cuff and arthroscopic construction of the joint. Thus, we are persuaded that claimant's compensable injury worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1986 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELAINE M. BAXTER, Claimant
WCB Case No. 98-08751
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

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

FINDINGS OF FACT

Claimant, age 51, worked as a delicatessen clerk at the employer for about three years. One of her job duties was to fry chicken, which included lifting a fryer basket of ten to twenty pounds of cooked chicken out of hot oil and dumping it out of the basket, using both hands. She performed this task every 15-20 minutes for up to 30 to 40 times a day.

On July 25, 1998, claimant sought treatment for non-compensable degenerative joint disease at the carpal metacarpal joint of the left thumb. (Ex. 3). Treatment included the use of a thumb splint. (Ex. 4). Claimant was placed on light duty, which included not lifting the chicken fryer basket. (Exs. 3, 5; Tr. 9, 15).

On August 10, 1998, claimant lifted a basket of chicken out of the fryer with both hands. Because of the pressure on her left thumb splint, she relied primarily on her right arm to lift the basket and dump the chicken out. She immediately felt pain in the right shoulder joint that worsened over the next few hours. (Tr. 8, 9, 10).

Claimant sought treatment from Dr. Cummings, who diagnosed bicipital tendinitis. (Ex. 9). Despite injections and immobilization, claimant continued to have severe pain in the right shoulder. (Ex. 10). Cummings referred her to orthopedic surgeon Dr. Isaacson, whom she saw on August 28, 1998. Isaacson initially diagnosed a right shoulder sprain with a possible rotator cuff tear. (Ex. 11). The tear was ruled out and a September 1, 1998 arthrogram showed calcific tendinitis. (Exs. 12, 14). Dr. Isaacson began treating claimant for right shoulder tendinitis, but injections gave her no relief. (Ex. 17-4, -5).

On September 29, 1998, Drs. Dordevich, rheumatologist, and Gripekoven, orthopedic surgeon, examined claimant for the employer. They concluded that claimant's preexisting calcific tendinitis was not caused by her work injury. (Ex. 17). On October 15, 1998, the employer denied the right shoulder claim. (Ex. 19).

In December 1998, an MRI revealed that claimant had an os acromion defect in her right shoulder. (Ex. 26). Dr. Isaacson performed surgery to unite the os acromion on December 31, 1998. (Ex. 27A).

Subsequent to reviewing Isaacson's surgical report, Dr. Dordevich conferred with the employer's attorney regarding the os acromion defect. (Ex. 29).

Dr. Isaacson's deposition was taken on February 25, 1999. (Ex. 30).

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Isaacson, claimant's treating surgeon, the ALJ concluded that claimant established that the August 10, 1998 work incident was the major contributing cause of her disability and need for treatment for her combined condition and set aside the employer's denial. On review, the employer contends that Dr. Isaacson's opinion is insufficient to carry claimant's burden to prove compensability.[1] We agree.

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[1] Dr. Isaacson's opinion is the only opinion ostensibly supporting compensability.

Claimant has a preexisting os acromion defect of the right shoulder that combined with the August 10, 1998 lifting incident at work.[2] Therefore, in order to establish that her right shoulder injury is compensable, claimant must show that the work incident was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*; 148 Or App 279, 283 (1993).

To satisfy the "major contributing cause" standard, claimant must establish that her compensable injury contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). In other words, the persuasive medical opinion must evaluate the relative contribution of different causes and explain why the compensable injury to claimant's right shoulder contributed more to the claimed conditions than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Moreover, the fact that a work injury precipitated the symptoms of a condition does not necessarily mean that the injury was the major contributing cause of the condition. *Id.; see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

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 persuasive reasons not to defer to the opinion of claimant's treating surgeon, Dr. Isaacson.

Dr. Isaacson began treating claimant on August 28, 1998. Claimant recounted that she first injured her left thumb at work, and, at the time of the August 10, 1998 injury, she had a splint on her left thumb so she could not use it. She grabbed the fryer with her right hand and lifted the container up with her right arm and felt something pull in her right shoulder. (Ex. 12-1).

Dr. Isaacson initially diagnosed and treated claimant for calcific tendinitis, based on a September 1, 1998 arthrogram. (Ex. 12-2). Claimant continued to complain of severe pain in the shoulder, and, in December 1998, an MRI revealed an os acromion defect in the right shoulder. (Ex. 26). Dr. Isaacson performed open reduction and internal fixation of the acromion on December 31, 1998. (Ex. 27A).

On January 4, 1999, Dr. Isaacson agreed with the contents of a concurrence letter prepared by claimant's attorney. (Ex. 28). The letter noted that she did not find calcific tendinitis during surgery.[3] But she did find an os acromion, which she believed to have been stable, nonsymptomatic, and in need of no treatment prior to the August 10, 1998 work injury. The letter contained an explanation that claimant sprained her shoulder at work and that the sprain destabilized the os acromion, which caused her to experience shoulder pain and the need for treatment, including surgery. The letter also contained the conclusion that the work injury was the major contributing cause of a pathological worsening of claimant's preexisting, asymptomatic os acromion.

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

In her December 14, 1998 chart note, Dr. Isaacson stated: "[Claimant] obviously had the os acromion defect before she had her pain, then with the stress at work this asymptomtic condition became symptomatic." (Ex. 26).

In a subsequent concurrence letter from claimant's attorney, Dr. Isaacson agreed:

> "[She] had found "an 'os acromion,' a fairly uncommon variant of the normal shoulder anatomy in which the acromion is composed of two ones rather than one. A false joint is present between the two bones. It is [her] opinion, within a reasonable medical probability, that this anatomical variant was stable prior to [claimant's] August 10 injury, and was causing no symptoms and did not require medical treatment. It is further [her] opinion, within a reasonable medical probability, that [claimant] sprained her shoulder at work on August 10, 1998, and that the sprain and resulting inflammation in the shoulder joint destablized the os acromion * * * ." (Ex. 28-1; *see also* Ex. 30-8, -9, -20).

This medical evidence is sufficient to establish that claimant had a preexisting right shoulder condition that combined with her August 10, 1998 work incident and contributed to her disability.

[3] Dr. Dordevitch agreed that, based on Dr. Isaacson's operative findings, the cause of claimant's symptoms was her os acromion. (Ex. 29-1).

We find Dr. Isaacson's opinion unpersuasive for several reasons. First, she did not weigh other potentially causal factors in reaching her conclusion, which would include the contribution of claimant's preexisting os acromion defect,[4] as required under *Dietz*, 130 Or App at 402-03.

Second, she relied on a temporal relationship in determining that the injury was the major contributing cause of the pathological worsening of the os acromion defect. During her deposition, when she was asked what the "major contributing cause" meant to her, she said: "[Claimant] didn't have a problem until this injury happened." (Ex. 30-10). Later in the deposition, when she was asked whether there was any way to know whether the os acromion was unstable before the injury, she answered: "The only way we know is that she is now symptomatic and she wasn't before. And she's been using her arm--she has to use her arm for the job that she does, and if it was unstable before, it would have hurt before." (Ex. 30-16). Under these circumstances, where Dr. Isaacson's explanation relies on the fact that the condition was not symptomatic until the work incident and became so afterward, her opinion is insufficient to satisfy claimant's burden of proof. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone).

Finally, Dr. Isaacson does not address whether the work incident was the major cause of the disability or need for treatment of the *combined condition*. Her statement that the work incident was the major cause of a *pathological worsening of the preexisting condition* is not determinative because this is an injury claim, not an occupational disease claim based on the worsening of a preexisting disease or condition.[5] Therefore, even if the injury pathologically worsened the preexisting os acromion, and even if Dr. Isaacson used the "magic words," we decline to infer from her statement that the injury was also the major contributing cause of the disability of the combined condition or the need for treatment of the combined condition. Consequently, we find for all the reasons discussed above that Dr. Isaacson's opinion is not sufficient to satisfy claimant's burden of proof. *See Somers v. SAIF*, 77 Or App 259 (1996).

ORDER

The ALJ's order dated April 23, 1999 is reversed. The employer's denial of claimant's right shoulder injury is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[4] Dr. Isaacson admitted that claimant's injury would not have been possible had she not had an os acromion defect. (Ex. 30-22). She also admitted that claimant's injury was not necessarily the result of any abnormal maneuvers. (Ex. 30-17). Without further explanation, these admissions are not supportive of her opinion that the lifting incident at work was the major contributing cause of claimant's need for treatment or disability for her right shoulder condition. Because of our reasoning regarding the unpersuasiveness of Dr. Isaacson's opinion, we need not address the contribution, if any, of claimant's left hand condition to her current claim.

[5] If an occupational disease claim is based on the worsening of a preexisting disease or condition, the claimant must prove both that employment conditions were the major contributing cause of the combined condition and the pathological worsening of the disease. ORS 656.802(2)(b). Here, in contrast, claimant must prove that the otherwise compensable work injury is the major contributing cause of the need for treatment or disability of the combined condition.

In the Matter of the Compensation of
LINDA J. COLLINS, Claimant
WCB Case No. 98-08496
ORDER ON REVIEW
Lauren Paulson, Claimant Attorney
Sather, Byerly & Holloway, 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 injury claim for a thoracolumbar strain. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working as a clerk/cashier for the insured thrift store on January 21, 1998. She helped her supervisor unload a delivery truck at work on June 4, 1998. While unloading, claimant picked up a box or a bag and immediately felt that she had strained her back. Claimant finished helping unload the truck, told her supervisor that she had hurt her back, (Tr. 10, 30), and returned to her regular duties. She experienced back pain after the lifting incident, and it worsened gradually.

About five days later, a co-worker told claimant's supervisor that claimant had hurt her back unloading the truck. Claimant filed a claim.

Claimant first sought treatment for mid-back pain on June 22, 1998. Dr. Gray diagnosed a thoracolumbar strain and provided conservative treatment. Claimant's back condition began improving in November 1998, after she started physical therapy.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Opinion and Conclusion," with the following supplementation.

The ALJ found claimant's reporting credible, based on her demeanor testifying. The ALJ also found claimant's description of her activities at the time of the claimed injury consistent since the inception of the claim. Accordingly, based on claimant's reporting, the ALJ concluded that claimant strained her back at work on June 4, 1998.

The ALJ also reasoned that Dr. Gray relied on claimant's credible history regarding her strain injury. The ALJ inferred that the doctor related claimant's back strain to her June 4, 1998 work activities, even though Dr. Gray did not recite "magic words" to that effect.

The insurer argues that claimant has not established legal causation because she is not credible, based on alleged inconsistencies in her reporting. But we agree with the ALJ that claimant is credible, because potential inconsistencies in the record are either explained or insignificant.

The insurer also contends that claimant has not established medical causation because there is no medical evidence relating her thoracolumbar strain to the claimed work incident. But we agree with the ALJ that Dr. Gray's reports indicate that he accepted claimant's history that she strained her back at work. (*See* Exs. 3-1, 12). Moreover, we are not persuaded that explicit medical evidence addressing causation is required here, because this is essentially a "simple case." Claimant's situation is not complex (her condition is not medically complex); her symptoms appeared immediately; she notified her supervisor promptly; she was previously free of mid back disability; and there is no expert evidence that claimant's injury could not have occurred as she reported it. *See McIntyre v. Standard Utility Contractors*, 135 Or App 298, 301 (1995). Under these circumstances (considering claimant's credible reporting and Dr. Gray's reports), we agree with the ALJ that claimant has carried her burden under ORS 656.005(7)(a).

Finally, claimant is not entitled to an attorney fee on Board review, because no brief was submitted. *Shirley M. Brown*, 40 Van Natta 879 (1988).

ORDER

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

In the Matter of the Compensation of
CAROLYN R. EATON, Claimant
WCB Case No. 97-07173
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
David L. Jorling, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of claimant's occupational disease claims for right rotator cuff tendonitis and right cubital tunnel syndrome. Claimant also objects to the ALJ's admission of certain evidence. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant works as a payroll clerk. In 1994, claimant began seeking treatment for neck and shoulder symptoms. Eventually, in June 1996, claimant saw Dr. Puziss, orthopedic surgeon, who diagnosed right cubital tunnel syndrome and right rotator cuff tendonitis. (Ex. 144A-3). In April 1997, claimant underwent right shoulder decompression and right cubital tunnel release. (Ex. 176).

The ALJ first found that claimant was not credible. The ALJ further decided that, because the medical reports supporting causation of claimant's right cubital tunnel syndrome and right rotator cuff tendonitis conditions relied on her reported history, those opinions were not persuasive and so claimant did not carry her burden of proof under ORS 656.802.

Claimant asserts that the medical opinions supporting compensability rely on an accurate history and are persuasive. Claimant also contends that the ALJ erred in admitting psychological reports and disciplinary action evidence. Relying on OEC 608, claimant contends that such evidence consists of "prior bad acts" and any probative value is outweighed by its prejudicial effect.

We first address the evidence issue. ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

We find no abuse of discretion by the ALJ in admitting the psychological reports. Although there was no psychological claim, even Dr. Puziss noted the possibility of a psychological component to claimant's physical conditions. (Ex. 199-2). Because the reports addressed the psychological effect, if any, on the cause of claimant's cubital tunnel syndrome and rotator cuff tendonitis, we find them relevant to deciding compensability.

We also find no abuse of discretion in admitting the documents showing that claimant was disciplined for tardiness and excessive leave. The employer disputed claimant's credibility, contending that her claim was motivated by a dislike of her job and supervisor. Thus, the evidence was relevant to the credibility issue. The documents also were relevant to the time claimant spent performing her job duties and, thus, additionally provided evidence as to whether the medical opinion evidence was based on an accurate history. Because such evidence is relevant, we disagree with claimant that the

disciplinary evidence constitutes proof of "bad acts" that we generally do not consider. *Compare Richard N. Haag*, 50 Van Natta 268 (1998) (no consideration of false record transactions because not relevant to injury claim); *Robert C. Cook*, 47 Van Natta 723 (1995) (incidents of untruthful statements by the claimant not relevant to claim so no abuse of discretion by ALJ in not admitting evidence).

We now determine whether claimant proved compensability. The record contains opinions from numerous sources.

Examining physicians Dr. Tesar, orthopedic surgeon, and Dr. Wilson, neurologist, recorded that claimant's work consisted of the following: about 30 percent was spent entering written information into binders, which were kept on a shelf above her desk; about 35 percent was spent entering information into a computer; and the remaining 35 percent was "filing, getting up, going to cabinets, updating reports of vacation and sick leave into the computer, answering the telephone, and making photocopies of charts." (Ex. 188-2). The panel found that, because claimant did not perform "excessive overhead work," it was not likely that her employment caused a right shoulder impingement condition. (*Id.* at 9). The panel also thought that claimant's work was not the type to cause cubital tunnel syndrome. (*Id.*) At most, the panel found that work caused claimant's symptoms. (*Id.* at 11).

In September 1997, claimant continued to complain of right shoulder and arm pain. (Exs. 196A, 197AAA). Dr. Puziss again released claimant from work. (*Id.*)

Dr. Puziss concurred with a letter from the employer's lawyer stating that, if claimant actually worked two hours per day with her shoulder abducted 30 to 40 degrees, rather than 4 to 5 hours, claimant's work would not be the major contributing cause of her shoulder condition. (Ex. 199-1). The letter further indicated that, based on claimant's ongoing symptoms and the ergonomic modifications to claimant's work site, there was a "significant possibility" of a psychological component. (*Id.* at 1-2).

Dr. Puziss then reported that claimant's employment was the major contributing cause of her cubital tunnel syndrome because claimant "has kept her elbows bent, and I think this is the proximate cause." (Ex. 204-1). Dr. Puziss also explained that if claimant's "arms are kept in a forward flexed position unsupported for two hours per day, this would be enough to cause rotator cuff tendonitis and impingement" but if "her arms were supported, then likely [the conditions] would be more idiopathic." (*Id.* at 2). According to Dr. Puziss, "[i]t does not require overhead work or even excessive overhead work to cause impingement syndrome, only a sustained position that does not allow the tissues adequate blood supply[.]" (*Id.*)

Dr. Glass, psychiatrist, then saw claimant for a second time (he first examined her in January 1996). He reported that, according to claimant, her symptoms essentially resolved following surgery. (Ex. 204B-1). Based on this information, Dr. Glass did not find a psychiatric condition, although he noted his concerns of a possible "Pain Disorder Associated with Psychological Factors" due to her "past history of significant musculoskeletal complaints" and lack of objective physical findings. (*Id.* at 11).

During a subsequent deposition, after learning that claimant complained of symptoms following the surgery, Dr. Glass stated that he would diagnose claimant with "Pain Disorder Associated with Psychological Factors." (Ex. 226-19).

Dr. Strauss, chiropractor, first examined claimant in January 1998. He provided a report stating that claimant's work was the major contributing cause of her cubital tunnel syndrome because she performed a "considerable amount of data entry to include posting time cards constantly on a daily basis." (Ex. 206-1). Dr. Strauss also thought that the major contributing cause of the rotator cuff tendonitis was the work because claimant performed "constant reaching to flip time cards." (*Id.* at 2).

Dr. Strauss was then deposed and further explained that claimant's repetitive reaching and resting her elbows on the desk caused her conditions. (Ex. 210-17, 25). Dr. Strauss also stated that he understood from claimant that she repetitively reached for 8 hours a day. (*Id.* at 55).

Dr. Quinn, a chiropractor who treated claimant in 1995, indicated that the major contributing cause of claimant's cubital tunnel syndrome and rotator cuff tendonitis was her employment and stated that her condition was "best described as a repetitive stress syndrome." (Ex. 207). During a deposition, Dr. Quinn explained that sitting at a desk put strain on claimant's upper body and then repetitively reaching for her notebooks put a "load" on her neck, creating chronic tension and an overuse syndrome. (Ex. 209-20).

Dr. Puziss also was deposed and explained that keeping the elbow bent for "a lot of hours a lot of days" could cause cubital tunnel syndrome. (Ex. 211-52). In particular, Dr. Puziss stated that "working [on the computer] four or five hours a day intensively" was the major contributing cause of the cubital tunnel syndrome. (*Id.* at 55). Dr. Puziss also explained that, because claimant was symptomatic while working and there was no activity outside work that would cause such a condition, he thought that "typing several hours a day" was adequate to cause cubital tunnel syndrome. (*Id.* at 58-59). With regard to the shoulder condition, Dr. Puziss thought that repetitively "reaching for those notebooks" caused an impingement. (*Id.* at 74).

Claimant's former treating physician, Dr. Meigs, concurred with a "check-the-box" report from claimant's attorney stating that the major contributing cause of claimant's condition was her work. (Ex. 213).

Dr. Tesar was deposed and explained that industries where there is a higher incidence of shoulder impingement conditions are those where workers are performing overhead or shoulder-level work such as welders or drywallers. (Ex. 227-11). According to Dr. Tesar, claimant would have to be reaching every 5 minutes, or 90 times, during a work day in order for such activity to be a causal factor. (*Id.*. at 13). Dr. Tesar also thought that an acromion condition predisposed claimant to impingement and this condition, along with any off-work reaching, prevented work from being the major contributing cause. (*Id.* at 16).

Finally, Dr. Tesar disagreed that keeping the elbows bent at 90 degrees while working on a keyboard damaged the ulnar nerve because it was not a "hyperflexion position." (*Id.* at 17-18).

Dr. Nathan, hand surgeon, testified at the hearing. Dr. Nathan examined claimant in April 1996 and reviewed the subsequent record. Dr. Nathan first disagreed that placing the elbows on a table caused cubital tunnel syndrome because the nerve conduction tests showed no nerve slowing in the areas compressed by such movement. (Tr. 174). Dr. Nathan also disagreed with Dr. Puziss that putting the arms in a 90 degree angle caused such a condition, stating that the medical literature showed that the ulnar nerve was squeezed only "with the elbow fully flexed, and the forearm fully pronated" in a 135 degree position. (*Id.* at 176). According to Dr. Nathan, although people experienced discomfort with certain activity, there was no medical evidence that repetitive activity damaged or altered the ulnar nerve. (*Id.* at 178).

With regard to the shoulder, according to Dr. Nathan, the medical literature showed that the shoulder could be injured by flexing it with the palm down (pronated) and, because claimant did not reach in this manner, her work was not likely to cause impingement and rotator cuff tendonitis. (*Id.* at 205-07).

Following the hearing, claimant's attorney generated reports from Dr. Puziss, Dr. Quinn, and Dr. Strauss reiterating their opinions that claimant's work was the major contributing cause of her conditions. (Exs. 229, 230, 231). Reports from Jan Noland, an industrial physical therapist, and Dr. Berselli, orthopedic surgeon, also expressed this opinion. (Exs. 232, 233).

In evaluating medical opinion evidence, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810, 812 (1983). Furthermore, we find most persuasive those medical opinions that are well-reasoned and based on an accurate history. *See Somers v. SAIF*, 77 Or App 259 (1986).

Claimant relies on opinions from Dr. Puziss, Dr. Quinn, Dr. Strauss, Dr. Berselli, Dr. Meigs and Jan Noland. We are not persuaded by the report from Jan Noland because, in comparison to the other expert opinions provided, we find that, as an occupational therapist, she lacks the medical expertise to evaluate causation.[1] *See Uris v. Compensation Department*, 247 Or 420 (1967) (complex medical issues that

[1] The record contains substantial evidence concerning the ergonomics of claimant's work station since 1994, including the multitude of evaluations and modifications. (*E.g.*, Ex. 198A). Drs. Puziss, Strauss, and Quinn, however, essentially implicated claimant's keyboard work and reaching activities as the causes of her cubital tunnel syndrome and rotator cuff tendonitis. Although there were some comments by the physicians that claimant's desk was too high (based on her report), we find that they did not rely on this factor in attributing claimant's condition to her work activities. Thus, we find the ergonomic evidence to have limited relevance on the issue of medical causation.

must be resolved by expert medical opinion). Furthermore, based on the summary nature of the opinions from Dr. Berselli and Dr. Meigs, we also are not persuaded by those physicians' reports. The record also indicates that the physicians had limited contact with claimant (Dr. Meigs last saw claimant in 1995 and Dr. Berselli saw claimant on only two occasions) and did not review the entire record in formulating their opinions.

We first find that the remaining opinions from Drs. Puziss, Strauss and Quinn do not consider Dr. Glass' diagnosis of "Pain Disorder Associated with Psychological Factors." When claimant first returned to work on June 3, 1997, following her surgery, she sought treatment that day in a hospital emergency room for right shoulder and right arm pain. (Ex. 183). Claimant continued to complain of some symptoms in September. (Ex. 197AAA) The last chartnote from Dr. Puziss in the record, dated December 10, 1997, notes "increased fatigue and pain in the right shoulder, and difficulty elevating it." (*Id.*) Dr. Puziss diagnosed bursitis and stated that he "would be interested in seeing" Dr. Glass' report. (*Id.*)

We find this evidence important because it shows that claimant continued to be symptomatic after her surgery and the removal of the shelf that contained the notebooks. As Dr. Glass stated, such evidence "means that there's a psychosocial component to her need to see herself as having some kind of pain or disability in her shoulder." (Ex. 226-16). Dr. Puziss also provided some evidence in support of Dr. Glass' diagnosis when he agreed that there was a "significant possibility" of a psychological component.

Because we find proof of a psychological factor in claimant's condition, and Drs. Puziss, Strauss and Quinn did not address or quantify this factor, we find that their opinions are lacking in reasoning.

Additionally, like the ALJ, we find reasons for finding claimant not credible. The record contains numerous instances when claimant did not provide accurate information to her physicians. For instance, she told Dr. Puziss that, on her first day back to work after her surgery, she "had to reach upward 30-40 times in two hours, to her in-box" and "raised her arm up 529 times in four hours[.]" (Ex. 183C). Such a history is not consistent with her testimony that she used her notebooks at most 20 times a day. When claimant saw Dr. Glass on December 9, 1997, she told him that her symptoms had resolved, and then the next day saw Dr. Puziss and complained of increasing pain and fatigue in the right shoulder. Finally, while claimant was off work but before her surgery, she sought donated leave from her coworkers by signing a form stating that she had a "non-occupational catastrophic * * * physical or mental condition" but then filed the claim about two months later. (Exs. 169, 184).

Because claimant is not credible, we are not persuaded that Drs. Puziss, Strauss and Quinn relied on an accurate history. Dr. Strauss thought that claimant performed reaching activities for 8 hours a day. Dr. Quinn indicated only a vague understanding of claimant's schedule, stating that he had assumed that claimant performed her regular job the "majority of time." Dr. Puziss referred to a 4 to 5 hour period of typing.[2] Thus, none of the physicians show that they were aware of the time claimant spent in meetings at work. At the hearing, claimant testified that she "spent more time in meetings than I did at my desk." (Tr. 255 (Day II)). Although later conceding that this statement was an "exaggeration," claimant continued to assert that she was involved in "meetings after meetings." (*Id.* at 256).

Similarly, there is no indication that the physicians knew that claimant was off work between September and December in 1995; used almost 97 hours of sick leave and took a 3-week vacation in 1996; and was off work from February 24, 1997 until June 14, 1997, when claimant attempted to return to work and was again taken off work.

Finally, we note that Dr. Strauss did not examine claimant until January 1998, after her surgery and the removal of the shelf containing the notebooks, which further undermines the reliability of his opinion.

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[2] The record is not clear as to the proportion of time claimant spent performing her duties. Claimant told the Tesar/Wilson panel that 35 percent of her day was on the keyboard. Claimant testified at hearing, however, that she typed between 4 and a half and 5 and a half hours per day and subsequently stated that it was between 3 and a half and 4 and a half hours. (Tr. 28 (Day I), 23 (Day II)).

Thus, we agree with the ALJ that claimant did not carry her burden of proving compensability. *See* ORS 656.802(2).

ORDER

The ALJ's order dated January 12, 1999 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority that claimant did not prove compensability of her right rotator cuff tendonitis and right cupital tunnel syndrome condition. The record contained many medical opinions showing that claimant's work activities were the major contributing cause of these conditions. In particular, I find no reason for discounting the opinion from Dr. Puziss, who has treated claimant since June 1996. According to Dr. Puziss, only two hours of abducting the shoulder was necessary to cause claimant's shoulder condition. Furthermore, Dr. Puziss indicated that typing only "several" hours per day was sufficient to cause cubital tunnel syndrome.

Thus, based even on the lowest estimate of the time claimant spent typing and reaching, Dr. Puziss had an accurate understanding of claimant's work activities. Additionally, in light of Dr. Puziss' extensive contact with claimant, his position as the treating physician entitles him to deference.

I also disagree with the majority's reliance on Dr. Glass' opinion in finding that the opinions of Dr. Puziss, Dr. Strauss and Dr. Quinn were "lacking in reasoning." None of the physicians, including Dr. Tesar and Dr. Nathan, disagreed that claimant had the diagnosed conditions of right rotator cuff tendonitis and right cubital tunnel syndrome. If these physicians did not find that claimant had a psychological component, I do not see the basis for our order finding "proof of a psychological factor in claimant's condition[.]"

In the same vein, although, as shown by the majority's order, there were instances when claimant exaggerated, the record shows that her work activities included typing and reaching. It was these activities that numerous physicians found were the major contributing cause of claimant's conditions. I find these opinions sufficiently well-reasoned and based on an accurate history to carry claimant's burden of proof. Because the majority comes to a contrary conclusion, I dissent.

November 26, 1999 Cite as 51 Van Natta 1906 (1999)

In the Matter of the Compensation of
TABBATHA G. HUBBS, Claimant
WCB Case No. 98-07423
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, except No. 5 on Page 2 of the Opinion and Order, with the following supplementation.

On July 29, 1998, claimant told the employer's claim investigator that she had told Beverly Halfhill about the incident on July 8, 1999. Claimant claimed to have shown Ms. Halfhill the large fish she had moved when she first felt pain in her back. In addition, claimant recalled that Ms. Halfhill "yelled" at her for trying to move such a large fish by herself. (*Id.*).

At hearing, Ms. Halfhill denied that claimant had told her about the incident on July 8, 1998 or that she had noticed claimant in any pain. Ms. Halfhill did not corroborate claimant's statement that she had scolded claimant for picking up such a large fish.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not a reliable witness because her descriptions of how the accident occurred were not consistent. The ALJ upheld the employer's denial, reasoning that the persuasive evidence did not establish that claimant sustained a work-related injury.

The central issue in this case is whether claimant injured her back at work on July 8, 1998. The ALJ found claimant to not be a credible witness based on inconsistencies in claimant's own statements. Claimant argues that her statements contained in the record are consistent, with each statement containing varying degrees of detail of the incident.

Although we generally defer to the ALJ's demeanor-based credibility finding, we are in as good a position as the ALJ to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. *Coastal Farm Supply v. Hultberg,* 84 Or App 282 (1987). After *de novo* review, we determine that claimant's testimony is not consistent with the record.

Specifically, we are persuaded by one significant discrepancy, namely: that claimant stated that she had told her co-worker, Ms. Halfhill, about the incident, had shown her the fish and was "yelled at" for lifting such a large fish on her own. Not only did Ms. Halfhill not corroborate claimant's statements, she also denied having any knowledge of the incident prior to July 15, 1998.

Because we deem such an exchange to be significant and one in which Ms. Halfhill would readily recall, we are, therefore, unable to conclude that the material testimony of claimant is credible. *See Gail A. Albro,* 48 Van Natta 41 (1996) (inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if the inconsistencies raise such doubt that we are unable to conclude that material testimony is credible.)

Claimant has the burden of proof. ORS 656.266. Where it is claimant's burden to prove the compensability of her claim by a preponderance of the evidence, corroboration of the circumstances of her injury is both material and relevant to the compensability issue, particularly in light of the employer's countervailing testimony. *Leonel Ramirez,* 50 Van Natta 2174 (1998). Under such circumstances, we find that the preponderance of the persuasive evidence does not establish the compensability of claimant's injury.

ORDER

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

November 26, 1999 Cite as 51 Van Natta 1907 (1999)

In the Matter of the Compensation of
LARRY J. MORGAN, Claimant
WCB Case No. 98-09689 & 97-09267
ORDER OF ABATEMENT
Donald M. Hooton, Claimant Attorney
Lundeen, et al, Defense Attorneys

On October 28, 1999, we issued an Order on Reconsideration that adhered to our August 25, 1999 Order on Review that 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. Reiterating that we erroneously interpreted a previous ALJ's "compensability" decision and improperly imposed a burden of proof on claimant, he seeks further reconsideration of our order.

In order to further consider claimant's contentions, we withdraw our October 28, 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
SHELLEY K. HUMPHREYS, Claimant
WCB Case No. 98-08869
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

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

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

We write only to address the employer's argument that ORS 656.802(2)(b) applies to this case. The employer contends that claimant has preexisting conditions of being overweight and female, as well as her "personal risk factors," such as body mass index (computed on the basis of her height and weight and body habitus) that predisposed her to disability or a need for treatment. Dr. Radecki examined claimant on one occasion and concluded that claimant had preexisting "personal factors" of age, body mass index and wrist ratio. (Ex. 19-4). He opined that these personal factors were the major contributing cause of claimant's median nerve slowing. (Ex. 19-4, -5). Dr. Arthur concurred with Dr. Radecki's opinion. (Ex. 21). Dr. Arthur had previously noted that claimant had a "predisposing factor of obesity and increased risk of carpal tunnel with female gender." (Ex. 10).

On the other hand, Dr. Jamison disagreed with Dr. Radecki's report regarding causation. (Exs. 23A, 25). Dr. Jamison noted that claimant "may have some pre-existing individual susceptibility to carpal tunnel" pertaining to her weight. (Ex. 23A).

Before working for the employer, claimant had not experienced any physical problems or symptoms with her hands or wrists, or any treatment directed to her hands or wrists. Even if we assume that claimant's status of overweight, female and having a particular "body mass index" are "preexisting diseases or conditions," we find no evidence that her occupational disease claim for CTS was based on the worsening of any of those conditions.[1] *See Michael D. Cessnun*, 51 Van Natta 1737 (1999) (claim for a left rotator cuff tear was not based on the worsening of an anterior acromial spur); *Muriel D. Nelson*, 48 Van Natta 1596 (1996) (ORS 656.802(2)(b) did not apply because the claimant's occupational disease claim for CTS was not based on a worsening of her alleged "predisposing factors" of "being female and slightly overweight"). Rather, claimant asserts that her employment conditions were the major contributing cause of her CTS. We conclude that claimant's occupational disease claim for CTS is not based on the "worsening of a preexisting disease or condition pursuant to ORS 656.005(7)" and, therefore, ORS 656.802(2)(b) does not apply.

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

ORDER

The ALJ's order dated June 11, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,400, payable by the self-insured employer.

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[1] ORS 656.802(2)(b) provides:

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

In the Matter of the Compensation of
CRAIG A. MADDUX, Claimant
WCB Case No. 98-08061
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

Claimant has a compensable right ankle injury as a result of an accident on August 6, 1997, when claimant twisted his ankle. Claimant contends that he also injured his right knee during the same accident. The ALJ found that claimant did not prove compensability because the record showed that he did not complain of right knee pain until months after the accident.

Claimant continues to assert that, based on two chartnotes from claimant's treating physician, Dr. Tollerton, he carried his burden of proof. In particular, claimant relies on a September 2, 1997 chartnote relating that, when the right ankle was in a cast, claimant's right knee hurt depending on how he held his foot and January 21, 1998 chartnotes assessing "[k]nee pain, more than likely secondary to ankle injury." (Exs. 9, 25).

The problem with claimant's argument is that he does not acknowledge Dr. Tollerton's subsequent reports regarding claimant's right knee. In February 1998, Dr. Tollerton responded that he "honestly [did] not know" why claimant failed to report right knee problems if he injured it during the August 6, 1997 accident. Dr. Tollerton thought that the "only reason" for coming to this conclusion was because "we have no other injury that would make sense to be the cause of this problem" and that "it is entirely possible that he might have injured it otherwise." (Ex. 29).

Furthermore, in response to an opinion from Dr. Fax, consulting orthopedic surgeon, that claimant injured his right knee on August 6, 1997, Dr. Tollerton stated: "I have my doubts about this." (Ex. 44).

Based on such evidence we find that, although Dr. Tollerton may have initially supported a causal relationship between the right knee condition and the August 6, 1997 accident, based on the absence of right knee complaints until some time after the accident, Dr. Tollerton "doubted" such a relationship.

Dr. Rinehart, who began treating claimant in June 1998, also did not support causation. He first concurred with a report from examining physician Dr. Fuller, orthopedic surgeon, stating that "[o]ne would think that [claimant's] knee complaints would have been quite flagrant and would have been severely aggravated by the short-leg cast which he wore for three weeks. No documented knee complaints were noted during this time * * *." (Exs. 33-6, 36).

Dr. Rinehart later explicitly stated that, because an MRI showed inter substance globular degeneration rather than a meniscus tear, "[i]t appears at this time that there is no evidence to support his claim for a [sic] injury to the meniscus" and that he had advised claimant "that his condition appears to be degenerative." (Exs. 39, 41).

The only physician to support causation is Dr. Fax, who saw claimant on referral from Dr. Rinehart. Dr. Fax thought it was "much more likely that [claimant] twisted his knee at the same time he twisted his ankle." (Ex. 26).

We do not find Dr. Fax's opinion sufficient to carry claimant's burden of proof because it was based on a history that claimant complained of right knee symptoms at the time of the August 6, 1997 accident. For the reasons provided by the ALJ, we find it unlikely that Dr. Tollerton would have failed

to note such symptoms given the extent of his contact with claimant and his practice of dictating his chartnotes while in the presence of his patients. Thus, we find that Dr. Fax relied on an inaccurate history.[1]

In sum, we agree with the ALJ that claimant did not carry his burden of proving compensability.[2] *See* ORS 656.005(7)(a).

ORDER

The ALJ's order dated June 9, 1999 is affirmed.

[1] We note that, although Dr. Swanson does not provide an explicit opinion concerning causation, he appears to support compensability. Because he also relies on an inaccurate history, however, we also do not rely on Dr. Swanson.

[2] In light of this conclusion, we need not address SAIF's objection to claimant's attorney fee request for services on review.

In the Matter of the Compensation of
ANDREA McHONE, Claimant
WCB Case No. TP99007
THIRD PARTY DISTRIBUTION ORDER
Peter O. Hansen, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

State Farm Fire and Casualty Company (State Farm), 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 State Farm's share of the settlement proceeds. For the following reasons, we conclude that a distribution in which State Farm receives reimbursement for its claim costs from the remaining $32,000 balance of settlement proceeds would be "just and proper."

FINDINGS OF FACT

On February 21, 1996, claimant sustained a compensable injury to her right knee when she slipped and fell in water in a restroom. The claim was accepted by State Farm as a tear of the right medial meniscus. The claim was closed on September 3, 1998 through a Determination Order.

On November 16, 1998, the Board approved a Claim Disposition Agreement, in which claimant was paid $41,325 and claimant's attorney was paid $6,675.

Claimant also made additional claims for a right knee anterior cruciate ligament tear, vestibular dysfunction attributable to inner ear damage, septic arthritis of the right knee and depression. Those claims were denied and later settled for $2,000. On November 5, 1998, an Administrative Law Judge approved a Disputed Claim Settlement.

Claimant retained legal counsel to pursue a third party lawsuit against the parties allegedly responsible for the slip and fall accident of February 21, 1996. On May 7, 1999, claimant's attorney wrote to State Farm's attorney and indicated that the third party claim was settled at mediation for $150,000. Claimant's attorney requested State Farm's approval of the settlement and indicated that he would correspond further concerning a "just and proper" distribution.

State Farm approved the $150,000 settlement, stating that its share of settlement proceeds was $61,075.82. Claimant's attorney responded that Qualmed had a lien for $32,000, asserting that Qualmed was also a paying agent because it had paid half of the same bills paid by State Farm. State Farm did not agree to reduce its lien. The parties agreed that $29,075.82 should be distributed to State Farm and $32,000 should be placed in a trust account, pending resolution of the dispute.

State Farm has petitioned the Board for an order of distribution of third party settlement proceeds received by claimant. Having received claimant's response and cross-petition, State Farm's reply and response to the cross-petition, and claimant's reply, we proceed with our review.

CONCLUSIONS OF LAW

To begin, we address claimant's request that we should abate the current action until the Supreme Court decides *Benny H. Rash*, 49 Van Natta 2124 (1997), *aff'd* 160 Or App 131 (1999), *rev allowed* 329 Or 287 (1999). In her brief, claimant asserts that State Farm has objected to her request and we find no contrary evidence. In the absence of an agreement between the parties to hold this matter in abeyance, we decline to do so. *See, e.g., Pamela J. McKiney*, 50 Van Natta 2385 (1998).

The dispute in this case pertains to the disposition of $32,000 from the third party settlement proceeds. Claimant contends that State Farm and Qualmed entered into an agreement to each pay 50 percent for her medical services. Qualmed is apparently claimant's private insurance carrier. According to claimant, Qualmed is a "paying agency" along with State Farm and she asserts that they both paid for the exact same medical services. Claimant argues that she should not be compelled to bear the burden of the cost of State Farm's agreement with Qualmed. She asks the Board to distribute the "lienholder's share" between State Farm and Qualmed to yield a "just and proper" result.

On the other hand, State Farm contends that Qualmed was not a workers' compensation insurer and cannot qualify as a "paying agency." Relying on *Kathleen J. Steele*, 45 Van Natta 21 (1993), State Farm argues that the Board has no authority to direct payment of a share of settlement proceeds to any entity other than the injured claimant, claimant's attorney, or a paying agency.

If a worker sustains a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third party. ORS 656.578. The paying agency has a lien against the worker's cause of action, which lien shall be preferred to all claims except the cost of recovering such damages. ORS 656.580(2). The proceeds of any damages recovered from the third party 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. "Insurer" means the SAIF Corporation or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state. ORS 656.005(14).

Here, claimant sustained a compensable injury as a result of the alleged negligence of third parties. Her workers' compensation claim was accepted by State Farm, which has provided compensation. Because State Farm is an insurer authorized to transact workers' compensation insurance in this state and has paid benefits to claimant as a result of a compensable injury, it is a "paying agency." ORS 656.576; ORS 656.005(14). When claimant chose to seek recovery from third parties, the provisions of ORS 656.580(2) and ORS 656.593(1) became applicable. Thus, the third party settlement became subject to State Farm's lien for its "just and proper" share. *See* ORS 656.593(3).

In *Kathleen J. Steele*, 45 Van Natta at 21, the claimant sought to distribute part of the third party settlement to Allstate as reimbursement for its "PIP" lien. We found that Allstate was not a "paying agency" because it was not the workers' compensation insurer who paid benefits to the claimant for her compensable injury. We concluded that because the statutory scheme for distribution of a third party recovery expressly described three entities as proceeds' recipients (the claimant, the claimant's attorney, and the paying agency), we were without authority to direct the payment of a share of settlement proceeds to a fourth entity (Allstate). *See also Manuel A. Ybarra*, 43 Van Natta 376 (1991) (the paying agency was entitled to recover the unpaid portion of its lien from the claimant's attorney where the attorney paid $750 of the proceeds as reimbursement of a "PIP lien").

After we decided *Kathleen J. Steele*, the court issued its opinion in *Urness v. Liberty Northwest Insurance Corporation*, 130 Or App 454 (1994). In that case, the court held that "ad hoc" distributions are contemplated by ORS 656.593(3) and, therefore, it was improper for the Board to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes. *Id.* at 458. Despite the impropriety of such an automatic method, a distribution that 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 light of *Urness*, we are not limited to applying only the statutory scheme for distribution of a third party recovery. Rather, ORS 656.593(3) specifically contemplates "ad hoc" distributions. Thus, in reaching our determination regarding a "just and proper" distribution, we judge each case based on its own merits. Nevertheless, for the following reasons, we find that a distribution based on the third party judgment scheme is "just and proper" in this case.

To begin, we reject claimant's argument that Qualmed is a "paying agency" pursuant to ORS 656.576 and ORS 656.005(14). Unlike State Farm, Qualmed is not an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state. *See* ORS 656.005(14). Therefore, Qualmed is not a "paying agency" under ORS 656.576.[1] Because Qualmed is not a "paying agency" that may directly receive a portion of the third party recovery, we find that claimant is essentially promoting an allocation in which she receives a larger share of the recovery (at the expense of the paying agency's share) so that she can then provide reimbursement from her share to that private carrier. *See Kathleen J. Steele*, 45 Van Natta at 21.

We disagree with claimant's contention that Qualmed and State Farm both paid for the exact same medical services. Instead, it appears that Qualmed and State Farm entered into an arrangement for sharing costs because some of the medical services were for treatment of the compensable injury and some were for treatment of an unrelated, preexisting right ACL tear.

Under 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).

Here, State Farm contends that it is entitled to full reimbursement of the disputed $32,000 lien in claims costs from the third-party settlement proceeds. Claimant has not contested State Farm's assertion in its petition that it has incurred $177,946.52 in actual claim costs. Also, there is no denial or litigation regarding State Farm's payments of those bills and claim costs. *See Mark S. Randolph*, 43 Van Natta 1770 (1991). We find that State Farm is the only insurer that has provided "compensation," as defined under 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). Because 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 State Farm to receive full reimbursement for these expenses from claimant's third party settlement.[2] *See* ORS 656.593(3); *Norman H. Perkins*, 47 Van Natta 488, 490 (1995). Accordingly, claimant's counsel is directed to pay to State Farm the remaining balance of settlement proceeds ($32,000).

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[1] Claimant relies on *SAIF Corp. v. Wright*, 113 Or App 267 (1992), to argue that an entity paying benefits is a paying agent. Claimant's reliance on that case is misplaced. In the *Wright* case, the court held that, because the SAIF Corporation was not paying benefits at the time of the claimant's settlement, it could not qualify as a "paying agency" under ORS 656.576. In that case, SAIF was an insurer authorized to transact workers' compensation insurance pursuant to ORS 656.005(14), but it had not actually paid any benefits at the time of settlement. Here, in contrast, Qualmed is not an isurer quthorized under ORS Chapter 731 to transact workers' compensation insurance in this state.

[2] As further support for this "just and proper" distribution, we note that State Farm's recovery (including $32,000 disputed in this case) would only constitute approximately 35 percent of its total actual claim costs.

In the Matter of the Compensation of
VALERIE SQUIRES, Claimant
WCB Case No. 99-03408
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Reinisch, et al, Defense Attorneys

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

Claimant requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) declined to admit certain exhibits into evidence; and (2) declined to continue the hearing. Claimant also moves for remand to the ALJ for further testimony. On review, the issues are remand and the propriety of the ALJ's evidentiary rulings.

We deny the motion for remand and adopt and affirm the ALJ's order with the following supplementation.

The issue at hearing was claimant's entitlement to interim compensation in February 1999, which in turn depended on when the self-insured employer had notice or knowledge of the claim. In support of her contention that the employer had notice or knowledge before or during the period in dispute, claimant submitted three "E-mail" letters (Exs. 7, 8, 17) that she alleged established employer notice or knowledge of the claim in January or February 1999.

The ALJ declined to admit the correspondence, reasoning that claimant had failed to establish or lay a foundation as to the identity of the individuals mentioned in the correspondence. (Tr. 7). The ALJ later denied claimant's request for a continuance so that she could present the testimony of a witness (Blum) to lay a foundation for the disputed evidence. (Tr. 25). The ALJ reasoned that claimant had failed to show due diligence, citing *SAIF v. Kurcin*, 160 Or App 489 (1999). At the conclusion of the hearing, however, the ALJ did admit Exhibit 8 for purposes of "impeachment." (Tr. 42).

On review, claimant contends that the ALJ improperly declined to admit the disputed evidence and argues that the case should be remanded for the testimony of Blum. We disagree.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

In this case, we find no abuse of discretion. Claimant alleges that the disputed exhibits were business records and, thus, should be admitted as an exception to the hearsay rule. Claimant, however, presented no evidence to establish that the disputed records were business records. While hearsay is admissible in workers' compensation proceedings, *see Armstrong v. SAIF*, 67 Or App 498, 501 n.2 (1984), we cannot say that the ALJ abused his discretion in declining to admit the records under these circumstances.

Moreover, we agree with the ALJ that claimant failed to establish due diligence in attempting to obtain the testimony of witness Blum, who allegedly could lay a foundation for the admission of the disputed records. Claimant's counsel argued that he could not have anticipated that the E-mail records would be disputed and that, therefore, he took no action to produce witness Blum until during the hearing when Blum was contacted and indicated that she could testify by phone or drive to the hearing. (Tr. 23). Claimant also contended that, due to the expedited nature of the hearing and the fact that he did not receive the E-Mail documents until five days before the hearing, he was justified in failing to produce witness Blum. Claimant conceded, however, that he took no action to produce the witness. (Tr. 24). In addition, claimant's counsel admitted that he had no reason to believe that, if he had called the witness the day before the hearing, she would not have been available to testify. (Tr. 25).

Under these circumstances, we agree with the ALJ that due diligence was not established. Therefore, we find no abuse of discretion in the ALJ's decision to deny claimant's request for a continuance. *See Jerry D. Thatcher*, 50 Van Natta 888 (1998) (review continuance ruling for abuse of discretion).[1]

[1] In light of the foregoing rulings, we also find no "compelling" reason to remand for further proceedings. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). Thus, we deny claimant's remand motion.

ORDER

The ALJ's order dated May 28, 1999 is affirmed.

Board Chair Bock concurring.

I agee with the ALJ's and the majority's conclusion that due diligence was not established in this case. I write separately, however, to emphasize that I may have reached a different conclusion had claimant's counsel made some effort before the hearing to produce witness Blum. While I am fully aware that this was an expedited hearing, I do not believe this excused claimant's attorney from attempting to produce a witness whose testimony, I believe, could reasonably have been anticipated as necessary. The fact that claimant's attorney could easily arrange for Blum's testimony at the hearing indicates to me that this could reasonably have been accomplished before the hearing, even considering the expedited nature of the proceedings. While the amount of benefits at stake in this proceeding was relatively small, I do not believe this justified lesser efforts on behalf of claimant. For these reasons, I concur in today's decision.

Board Member Phillips Polich dissenting.

The majority concludes that the ALJ did not abuse his discretion in declining to admit three "E-mail" letters (Exs. 7, 8, 17) that claimant alleged established employer notice or knowledge of the claim in January or February 1999 and in declining to continue the hearing for the testimony of a witness (Blum) who could provide a foundation for the admission of the disputed exhibits. Because I believe that the ALJ abused his discretion in not continuing the hearing, I would grant claimant's request for remand. I reason as follows.

As the majority correctly observes, ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve "substantial justice." In order for a hearing to be continued, the party requesting the continuance must establish "due diligence." *SAIF v. Kurcin*, 160 Or App at 492. We review the ALJ's ruling on a motion for continuance for abuse of discretion. *See Jerry D. Thatcher*, 50 Van Natta 888 (1998); *Sharron D. Lemley*, 49 Van Natta 1365 (1997).

In determining whether the ALJ abused his discretion, it is important to remember the expedited nature of the hearing in this case. After claimant requested hearing on April 27, 1999, the hearing was held only a short time later on May 19, 1999. The ALJ and the majority give scant consideration to the practical difficulties that an expedited setting can present in terms of case and witness preparation. Moreover, in approving the ALJ's evidentiary rulings, the majority thwarts the purpose of an expedited hearing, which is not only to provide for prompt, informal dispute resolution, but also to "insure fair and just treatment of workers in all proceedings." *See* OAR 438-013-0005. The goal of "fair and just treatment" can hardly be said to have been furthered by affirmation of evidentiary rulings that prevented claimant from presenting his entire case.

In addition, I do not find the circumstances of the continuance request justify such a harsh result. The employer would not have been prejudiced by an hour and one-half continuance so that witness Blum could drive to the hearing and testify regarding the disputed exhibits or by an even briefer continuance so that Blum could testify by telephone. *See* OAR 438-007-0022.[1] Moreover, given the

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[1] That rule provides that:

"When a lay witness is unable to attend the hearing due to extraordinary circumstances beyond the control of the party offering the testimony and the testimony of the witness cannot be taken by deposition, the Administrative Law Judge may allow testimony to be taken in any manner that will afford substantial justice and insure a complete and accurate record of all examination and testimony."

expedited nature of the hearing and claimant's counsel's receipt of the disputed exhibits only 5 days before the hearing, I am not persuaded that due diligence required an attempt by claimant's counsel to contact witness Blum prior to the hearing.[2] *See* 438-006-0091(4); 438-006-0081(4).

Accordingly, I would find an abuse of discretion in the ALJ's decision to deny claimant's request for a continuance. In light of the foregoing, a "compelling" reason exists to remand for further proceedings. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). Thus, I would grant claimant's remand motion.[3] Because the majority concludes otherwise, I respectfully dissent.

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[2] In reaching this conclusion, I agree with claimant's counsel's argument that he could not reasonably have anticipated the employer's objections to admission of the E-Mails, especially considering that the disputed documents were originally obtained via an employer subpoena. (Tr. 5). Expecting claimant's counsel to have divined a need to subpoena a witness (a claims representative from another carrier no less) to authenticate business records under these circumstances is both unrealistic and unfair. Further, imposing such a requirement is also unrealistic and unnecessarily burdensome considering the limited amount of benefits at stake ($410.62).

[3] While the primary focus of my dissent is on the denial of the continuance motion, I would also find that the ALJ abused his discretion in not admitting the disputed documents, even without Blum's testimony. As the majority notes, hearsay evidence is admissible in workers' compensation proceedings. *Armstrong v. SAIF*, 67 Or App 498, 501 n.2 (1984). Because the documents in question have the requisite indicia of reliability, I believe the ALJ erred in not admitting the documents. Finally, I would conclude based on my review of those documents that claimant established employer knowledge of the claim in January or February 1999 sufficient to require payment of the disputed interim compensation.

In the Matter of the Compensation of
WENDY S. WICK, Claimant
WCB Case No. 98-04166
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

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

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

We agree with the ALJ's analysis and conclusion that the opinion of claimant's treating physician, Dr. Brett, was not sufficiently persuasive to show that claimant's low back condition pathologically worsened by sustaining a "reherniation." Claimant further asserts that, whether or not we decide that "Claimant's disc had worsened, Claimant can nevertheless prove the compensability of this aggravation claim if there are other indicia of objective worsening."

Under ORS 656.273(1), "[a] worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." An "actual worsening" may be established by direct medical evidence of a pathological worsening or, for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. *See SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997).

We understand claimant as arguing that, even if she did not prove a "reherniation" of her low back, she proved an "actual worsening" with evidence that her condition worsened in other respects, including a reduction of range of motion and increased radicular symptoms and spasm. The problem with this argument is the lack of medical expert evidence showing that claimant's "symptoms have

increased to the point that it can be said that the condition has worsened." Instead, Dr. Brett found that the "current herniation represents an aggravation of or worsening of [the] compensable condition[.]" (Ex. 27-2). Thus, because Dr. Brett did not rely on "other indicia of objective worsening" in asserting a compensable aggravation, we also do not find that any such evidence satisfies claimant's burden of proof.

ORDER

The ALJ's order dated May 28, 1999 is affirmed.

November 29, 1999 Cite as 51 Van Natta 1916 (1999)

In the Matter of the Compensation of
JACK L. BARBEE, Claimant
Own Motion No. 99-0377M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorneys
Safeco Ins., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable 1989 industrial injury. Claimant's aggravation rights on that claim expired on July 9, 1995. The insurer recommends reopening[1] claimant's claim for the provision of temporary disability compensation.

However, on April 15, 1998, the Board approved the parties' CDA, which fully released claimant's rights to the following "non-medical service" workers' compensation benefits: own motion reopening pursuant to ORS 656.278, temporary disability benefits, permanent disability benefits, vocational rehabilitation, aggravation rights pursuant to 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 his rights to reopening his Own Motion claim for temporary disability compensation as a result of the April 15, 1998 CDA, he is no longer entitled to any temporary disability compensation related to his December 8, 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.

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[1] Although the insurer checked the box on the Own Motion Recommendation Form recommending reopening the claim, it also indicated that a Claims Disposition Agreement (CDA) was approved on this claim.

In the Matter of the Compensation of
SUSIE FIMBRES, Claimant
Own Motion No. 99-0349M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable cervical condition. Claimant's aggravation rights expired on May 1, 1992. The insurer opposes authorization of temporary disability compensation, contending it was unable to determine whether claimant was in the work force.[1]

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

Dr. Purtzer, claimant's treating physician, recommended claimant undergo an anterior spinal decompression fusion at C4-5 and, on June 7, 1999, requested authorization to perform that surgery. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

However, in order to be entitled to temporary disability compensation upon a worsening of a work-related injury, a claimant must be in the work force at the time of disability. *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 submits Dr. Purtzer's October 21, 1999 medical report in support of her contention that she could not work due to the compensable condition and that it would have been futile for her to look for work because of her compensable condition. Dr. Purtzer asserted that "[claimant] has been off work since January 2, 1998 due to an injury to her neck she sustained on the job." Based on Dr. Purtzer's statement, we conclude that claimant was unable to work at the time of her current worsening. *Bethel A. Lamping*, 50 Van Natta 883 (1998); *Barbara M. Johnson*, 50 Van Natta 882 (1998).

Further, in order to satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that she was willing to work. Failing to demonstrate her willingness to work, then she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant submitted a November 1, 1999 statement wherein she asserts: "I * * * was willing to work after January 2, 1998. But could not due to my neck condition." Claimant's statement is unrebutted. Therefore, we are persuaded that claimant is willing to seek employment but unable to do so because of her compensable condition. *Michael D. Demagalski*, 51 Van Natta 1043 (1999) (uncontested affidavit that claimant was doing "odd jobs" for room and board sufficient to prove that claimant was in the work force). Therefore, on this record, we find that claimant has proved she remained in the work force at the relevant time.

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] Specifically, the insurer indicated on its September 23, 1999 Own Motion Recommendation form that it did not agree that claimant was in the work force at the time of the current disability. In a cover letter attached to that form, the insurer explained that it was unable to determine whether claimant remains in the work force.

In the Matter of the Compensation of
MARGARITA GARCIA, Claimant
WCB Case Nos. 99-02843 & 99-01368
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) determined that the Hearings Division lacked "jurisdiction" to decide the compensability of claimant's current cervical condition at C5-6 because of her failure to timely request a hearing from the SAIF Corporation's January 12, 1999 denial; and (2) alternatively upheld SAIF's denials of her current cervical condition on the merits. On review, the issues are the jurisdiction and compensability.

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

The ALJ determined that the Hearings Division lacked "jurisdiction" to decide the compensability of claimant's C5-6 disc herniation with C6 radiculopathy because claimant failed to timely appeal SAIF's January 12, 1999 denial and to show "good cause" for her failure to do so. Alternatively, the ALJ found that the disputed cervical condition was not compensable even if the Hearings Division had jurisdiction to address the issue.

On review, we do not find it necessary to address the jurisdictional issue (consequently, we do not adopt that portion of the ALJ's order). That is, assuming claimant was entitled to litigate the compensability of her cervical condition at C5-6, we agree with the ALJ's reasons for finding that claimant did not satisfy her burden of proof.

In this regard, we specifically agree with the ALJ's reasons for finding the medical opinion of Dr. Golden, claimant's attending physician, not persuasive. In addition, based on our review of Dr. Golden's opinion (Ex. 41), we also find it unpersuasive because it relies too heavily on a temporal relationship between claimant's compensable injury and the onset of cervical symptoms. *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, Dr. Golden opined that claimant's injury caused a "fundamental" change that made her preexisting degenerative condition symptomatic. Dr. Golden does not explain, however, the nature of that "fundamental" change. *See Somers v. SAIF*, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, more weight given to those medical opinions which are both well-reasoned and based on complete information).

For these additional reasons, we do not find the medical evidence sufficient to satisfy claimant's burden of proof. Therefore, we affirm the ALJ's decision on the merits.

ORDER

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

In the Matter of the Compensation of
OLA J. HUNTER-PANTER, Claimant
Own Motion No. 93-0732M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Westmoreland & Mundorff, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Claimant requests review of the insurer's March 3, 1999 Notice of Closure which closed her claim with an award of temporary disability compensation from June 23, 1994 through September 4, 1996. The insurer declared claimant medically stationary as of September 4, 1996. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 3, 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 May 3, 1999 letter, we requested 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 May 11, 1999, however, no further response has been received from claimant. Therefore, we will proceed with our review.

In an October 19, 1998 medical report, Dr. Nash, claimant's attending physician, opined that claimant may "at some later date require stabilization at the L4-5 level." However, he further noted that there was no surgical procedure scheduled at that time. Finally, he noted that claimant would require use of pain modifying and anti-inflammatory medications.

Although Dr. Nash opined that claimant may need surgery in the future, his report does not support a conclusion that, at claim closure, further improvement in claimant's condition was anticipated. Moreover, even if Dr. Nash's medical opinion could be interpreted as supporting a conclusion that claimant may require future ongoing care for her compensable condition, such ongoing care does not necessarily establish that claimant was not medically stationary. *See Maarefi v. SAIF*, 60 Or App 527, 531 (1984). Finally, Dr. Nash's opinion regarding claimant's future surgery is couched in terms of possibility rather than probability, which is not sufficient to meet claimant's burden of proof. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

On January 13, 1999, claimant was examined by Drs. Strum and Berquist, insurer-arranged medical examiners (IME). They stated that based on the medical records, claimant has been medically stationary since Dr. Nash declared her medically stationary on September 4, 1996. They further noted that there were no indications of any need for "either curative or palliative treatment." They opined that there was no indication for further surgical intervention. In a January 25, 1999 follow-up report, Drs. Strum and Berquist noted that review of all radiographic studies confirm the conclusions they reached after their January 13, 1999 examination. These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant has not met her burden of proving that she was not medically stationary on the date her claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's March 3, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALAN D. MISNER, Claimant
Own Motion No. 99-0372M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Juli Point, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a "Carrier's Own Motion Recommendation" form that recommends reopening of claimant's own motion claim for a L4-5 and L5-S1 disc herniation condition under his May 25, 1994 injury claim. In its recommendation form, SAIF agrees that: (1) claimant's current condition requires surgery or inpatient hospitalization; (2) the current condition is causally related to the accepted condition; (3) it is responsible for the current condition; (4) the surgery or hospitalization is reasonable and necessary; and (4) claimant was in the work force at the time of disability. Claimant responds that his claim is not within the Board's Own Motion jurisdiction because his aggravation rights have not expired.

The filing requirements of ORS 656.273[1] are jurisdictional. *SM Motor Co. v. Mather*, 117 Or App 176 (1992); *Timothy D. Beard*, 43 Van Natta 432 (1991). Only if a claim for additional compensation is made outside the time limits of ORS 656.273 does it fall within the Board's Own Motion jurisdiction. *See Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988); *Edward R. Reuter*, 42 Van Natta 19 (1990).

When a claim is within the Board's own motion jurisdiction, we may authorize the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.* On the other hand, if a claimant establishes a compensable aggravation claim prior to the expiration of his or her aggravation rights, he or she is entitled to the full range of workers' compensation benefits, which includes the possibility of benefits in addition to temporary disability compensation, *e.g.*, vocational rehabilitation benefits and permanent disability benefits.

Here, Board staff requested the parties to provide their written positions regarding this jurisdictional question. SAIF responded that claimant's claim had been in nondisabling status for one year or more after the date of injury and, thus, his aggravation rights expired on May 25, 1999, five years after the May 25, 1994 date of injury. Therefore, SAIF argues, claimant's claim was within the Board's Own Motion jurisdiction when Dr. Gray, Jr., filed an aggravation claim on claimant's behalf on August 5, 1999. In reply, claimant initially moved to strike SAIF's argument as untimely. Subsequently, however, claimant submitted copies of several documents, arguing that those documents establish that his aggravation rights have not yet expired.

After reviewing claimant's submittals and the parties' arguments, we find that the record before us remains inadequate to decide whether claimant's May 25, 1994 injury claim is within our Own Motion jurisdiction. Furthermore, under the circumstances of this case, we find that a hearing format would best establish the date claimant's aggravation rights began to run and whether claimant made a timely aggravation claim under ORS 656.273.

On October 14, 1999, SAIF issued a partial denial of a claim for a bulging disc at L3-4 involving Claim No. 7218524B, the same claim number as the claim presently before us. Claimant requested a hearing regarding that denial, which is currently scheduled for hearing before Administrative Law Judge (ALJ) Black on January 27, 2000. (WCB Case No. 99-08355).

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[1] ORS 656.273(4) provides:

"(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268.

"(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury.

Because the record before us is inadequate to decide whether claimant's May 25, 1994 injury claim is within our Own Motion jurisdiction, and as litigation is pending involving this claim, we conclude that it would be in the best interest of the parties to consolidate this Own Motion matter with the pending litigation in WCB Case No. 99-08355. *See Robert E. Morris*, 51 Van Natta 138 (1999). At the hearing, ALJ Black shall make findings of fact and conclusions of law and opinion on the issue of whether claimant's aggravation rights have expired on his May 25, 1994 injury claim so as to bring that claim within the Board's Own Motion jurisdiction.

At the conclusion of the hearing, ALJ Black shall forward to the Board a separate, unappealable recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case No. 99-08355. After issuance of the recommendation and order, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

November 29, 1999 Cite as 51 Van Natta 1921 (1999)

In the Matter of the Compensation of
SHANNON M. JOHNSON, Claimant
Own Motion No. 99-0102M
OWN MOTION ORDER
Ernest M. Jenks, Claimant Attorney

Claimant requested that her 1990 back strain/sprain injury claim be reopened to provide temporary disability compensation. Claimant's aggravation rights expired on June 24, 1996. Based on the following reasoning, we find that claimant's 1990 claim does not meet the requirements for reopening.

Because claimant's aggravation rights have expired on her 1990 compensable injury, 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), 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.

Here, claimant's request for reopening of her 1990 Own Motion claim is based on a "Notice of Claim for Aggravation" and a chart note, both dated October 13, 1998, and submitted by Dr. Takacs, claimant's attending physician. However, neither the chart note nor the aggravation form demonstrate that claimant's current condition requires surgery and/or hospitalization. Instead, Dr. Takacs notes that, per claimant's request, he is filing an aggravation claim to take into account claimant's "problems over the intervening years." Nevertheless, the fact remains that the record does not establish that claimant's condition currently requires surgery or hospitalization. As a result, we are not authorized to grant claimant's request to reopen the claim.

Accordingly, we deny the request for own motion relief. ORS 656.278(1)(a). We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BONNIE M. SMITH, Claimant
WCB Case Nos. 98-00814 & 97-06758
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of her occupational disease claim for a mental disorder. On review, the issue is compensability.

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

To establish the compensability of a mental disorder, claimant must prove that employment conditions were the major contributing cause of the disorder. 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 of 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).

The ALJ upheld the insurer's denial of claimant's occupational disease claim for a mental disorder (adjustment disorder) that allegedly arose out of her employment as an escort driver at a construction project at the Portland airport. Specifically, claimant contended that, as a result of the conduct and behavior of her supervisor (Lisher), she was subjected to sexual harassment, threats, abusive conduct and discrimination.

The ALJ analyzed the alleged stressors and concluded that most did not exist in a real and objective sense. However, the ALJ cited two instances in which Lisher allegedly acted inappropriately and concluded that they did exist in a real and objective sense, were not generally inherent in every working situation or otherwise statutorily excluded from consideration as cognizable stressors. One was an incident on July 8, 1997 when Lisher allegedly grabbed claimant and said "you know what that means don't you Bonnie." The other instance was when claimant felt threatened after Lisher drove by claimant's trailer in September and October 1997.

The ALJ then proceeded to determine whether those cognizable stressors constituted the major contributing cause of her psychological condition. The ALJ determined that they did not, finding that those episodes of inappropriate behavior were not sufficiently related to the instances where claimant sought medical treatment. Rather, the ALJ related claimant's need for treatment to a July 25, 1997 grievance proceeding and the employer's January 1998 decision to lay her off. In addition, the ALJ reasoned that off-the-job stressors played a bigger role in claimant's need for treatment than reflected in the medical record.

On review, claimant disputes the ALJ's conclusion that the grievance proceeding and the January 1998 lay-off were contributory to her mental disorder. Instead, claimant alleges that Lisher's "outrageous" conduct was the major factor in the development of her psychological condition and that there is no medical evidence that off-work stressors played a role in her medical condition.

Based on our *de novo* review of the record, we agree with the ALJ's analysis of the alleged work-related stressors and also with her identification of the two specific instances of inappropriate behavior by Lisher. However, our analysis of the medical causation issue differs from the ALJ's and, thus, we do not adopt that portion of the ALJ's order and instead provide the following alternative analysis of the medical causation issue.

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. *See Lori Ann Wages*, 47 Van Natta 1335, 1337 (1995), *aff'd Bank of Newport v. Wages*, 142 Or App 145 (1996);

See also Merry J. Morgans, 47 Van Natta 147 (1995) (medical opinions based on factors cognizable under ORS 656.802(3)(b) found persuasive); *Cf. Gary W. Helzer*, 47 Van Natta 143 (1995) (medical evidence failed to satisfy the claimant's burden of proof because it did not exclude from consideration noncognizable elements of ORS 656.802(3)(b)).

In this case, three physicians, Drs. McCarthy, Hutchins and Erickson, provided medical opinions on the causation issue. Dr. McCarthy, an examining psychiatrist, opined that, if claimant's allegations against Lisher were valid, then claimant's employment would be the major cause of her adjustment disorder. (Ex. 11-7). Dr. Hutchins, a psychologist who treated claimant on one occasion, concurred with this report. (Ex. 15). Nevertheless, we do not find that this evidence establishes claimant's mental disorder claim.

We reach this conclusion because Dr. McCarthy based her opinion on the validity of the alleged stressors, such as Lisher excluding claimant from job related information necessary for perform her duties, preventing her from working additional overtime, failing to pay her for lunch periods in which she worked overtime, threatening to fire her, and enlisting the aid of subordinates to propagate innuendoes. (Ex. 11-2). Because we agree with the ALJ that these alleged stressors were not proven to exist in a real and objective sense, it is apparent that Dr. McCarthy's opinion, as well as Dr. Hutchins', were based on non-cognizable stressors and, thus, are not persuasive. *See Robert A. Jarvill*, 47 Van Natta 221 (1995) (medical evidence did not sufficiently identify the purportedly unreasonable conduct, or factor out those actions in the process of ascertaining the cause of the claimant's psychological condition).

Finally, Dr. Erickson, a psychiatrist who treated claimant on a couple of occasions, also opined that work events were the major contributing cause of claimant's psychological condition. (Ex. 17-1, 21-33). Like Drs. McCarthy and Hutchins, however, Dr. Erickson also relied on unproven stressors, such exclusion of overtime, failure to pay for overtime, and continued invasion and violation of claimant's work space for non-work reasons. (Ex. 17-1). Therefore, Dr. Erickson's opinion also did not factor out excluded from non-excluded employment conditions under ORS 656.802(3) and, accordingly, his opinion cannot satisfy claimant's burden of proving a compensable mental disorder.[1]

Thus, for these reasons, we agree with the ALJ that claimant has failed to sustain her burden of proving a compensable mental disorder claim. Therefore, we affirm.

ORDER

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

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[1] In reaching this conclusion, we note Dr. Erickson's records, which contain a history that Lisher subjected claimant to "literally thousands of acts of intimidation, debasement, harassment, discrimination and retaliation***." (Ex. 21-50). Even viewing the record in a manner favorable to claimant, we find no support for this history and agree with the insurer that Dr. Erickson too readily accepted her allegations as true.

In the Matter of the Compensation of
STEPHEN D. THOMPSON, Claimant
WCB Case No. 99-01011
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Reinisch, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that declined to direct the self-insured employer to amend its acceptance of claimant's acute low back strain to include chronic low back strain. On review, the issue is scope of acceptance.

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

Claimant, an airline ramp service agent, compensably injured his low back on August 30, 1997, when he lifted a set of golf clubs. He developed pain in his left leg as well as his low back. The employer accepted "acute low back muscle strain." Claimant's condition was slow to respond to conservative treatment, and, on May 19, 1998, Dr. Jacobsen noted that claimant's low back condition was becoming chronic and subsequently diagnosed "chronic lumbar strain." On December 8, 1998, claimant formally requested acceptance of a "chronic low back strain" condition.[1] (Tr. 2).

At hearing, the ALJ concluded that the employer's acceptance of "acute low back strain" reasonably apprised claimant of and his providers of the nature of the compensable condition. In doing so, the ALJ relied on *Webster's Third New International Dictionary*, specifically on the definition of "acute" as coming on suddenly.

On review, claimant contends that the acceptance of an acute low back strain does not encompass claimant's chronic low back strain, because a chronic condition is different from an acute condition. But even if a chronic condition is different from an acute condition,[2] we agree with the ALJ's analysis and offer additional support for his conclusion.

Dr. Jacobsen diagnosed claimant's condition as "chronic" when claimant's low back pain failed to improve after months of conservative treatment. But Jacobson did not indicate in his reports that the condition for which he was treating claimant was a new condition different from the condition accepted by the employer.[3] Accordingly, Jacobsen's report does not persuade us that claimant's chronic low back strain constitutes a new medical condition or distinct diagnosis that must be formally accepted in addition to the acute low back muscle strain injury.[4]

Consequently, on this record, we agree with the ALJ that the employer's acceptance of an acute low back muscle strain 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).

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[1] Claimant also requested that the acceptance be expanded to include lumbar radiculopathy, which the ALJ denied. That issue is not raised on review.

[2] *Dorland's Illustrated Medical Dictionary*, 28th Ed (1994), defines "acute" as "having a short and relatively severe course" (p 23) and "chronic" as "persisting over a long period of time" (p 328).

[3] Our conclusion receives additional support from Dr. Bald, who indicated in a letter to the employer's counsel that the diagnosis of lumbar strain adequately encompassed the diagnosis for claimant's work injury. (Ex. 37).

[4] 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) (emphasis added). Thus, a "new medical condition" is a distinct "condition" that is not encompassed by the carrier's acceptance of the initial claim. *E.g., Terence W. Heureung*, 51 Van Natta 1272, 1274 fn 1 (1999).

ORDER

The ALJ's order dated May 19, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's conclusion that claimant's "chronic" low back strain is not a new medical condition that must be formally accepted in addition to the "acute" low back strain. Therefore, based on the following reasoning, I respectfully dissent.

The majority concludes that the acceptance of an acute low back muscle strain by the employer reasonably apprised claimant and his providers of what condition had been accepted. However, I see a difference between an acute and a chronic condition. I agree that claimant's lumbar strain was "acute" in the sense that it came on suddenly on August 30, 1997. But claimant's low back problems did not resolve. Instead, claimant experienced low back pain with radicular symptoms until May 1998. However, even though the radicular symptoms stopped, the low back pain continued, a fact that led claimant's attending neurologist, Dr. Jacobson, to conclude in June 1998 that his low back problems had become "chronic." In July 1998, almost one year after the August 1997 lifting incident, Dr. Jacobsen diagnosed a chronic lumbar strain. (Ex. 29). Moreover, in an April 10, 1999 letter responding to questions by claimant's attorney, Dr. Jacobsen specifically opined that the injury of August 30, 1997 resulted in "chronic low back strain." (Ex. 34A).

Both *Webster's Third International Dictionary* and *Dorland's Illustrated Medical Dictionary* define "chronic" in terms of duration, including a progressive condition. This distinction is significant, as claimant may need ongoing care in the future for his "chronic" condition.[1] Therefore, I would defer to the medical expert's expertise regarding the proper diagnosis of claimant's condition. Moreover, it is the policy of Oregon's Workers' Compensation Law to reduce litigation, a policy that would be fostered by reducing the conflict between the medical standard and the legal standard in this case. Accordingly I conclude that the employer's acceptance of an "acute" low back strain (which claimant's doctor specifically diagnosed as a "*chronic* lumbar strain" after it continued to be symptomatic for nine months following the injury) did not reasonably apprise claimant and his medical providers of what condition the insurer accepted. For these reasons, I would conclude that the employer should accept "chronic low back strain" in addition to the acute low back muscle strain that has already been accepted.

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[1] Ongoing care for claimant's "acute" low back injury will likely be hotly contested by the carrier, which may contend that, like most "acute" strains, claimant's "acute" low back strain should have resolved in six weeks.

In the Matter of the Compensation of
JUDY TALMADGE, Claimant
WCB Case No. 98-09631
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its partial denial of claimant's injury claim for a current left shoulder rotator cuff impingement syndrome condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following exception: We do not adopt the next-to-last sentence of the last full paragraph on page 5.

We also supplement the ALJ's findings and conclusions as follows.

Claimant's most notable left shoulder pathology is a Type III acromion, with a fairly prominent sharp spur on the anterior *under* surface. (*See* Exs. 20-4, 28, 32-8, -11, -41). She *also* has a "tiny" bone spur *over* her anterior acromion, but it is not identified as contributing to her current disability or need for treatment for her left shoulder. (*See* Exs. 15-3, 32-9).

In addition, we agree with the ALJ that Dr. Teal's opinion is persuasive because it is well-reasoned and based on a materially accurate history *and* surgical observations. *See Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988). Accordingly, based on Dr. Teal's opinion, we conclude that claimant has established that her March 20, 1998 compensable injury remains the major contributing cause of her disability and need for treatment for her combined left shoulder condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,275, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 19, 1999 is affirmed. For services on review, claimant is awarded a $2,275 attorney fee, to be paid by the insurer.

November 29, 1999 Cite as 51 Van Natta 1926 (1999)

In the Matter of the Compensation of
MARK A. TUBRA, Claimant
WCB Case No. 99-03214
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that affirmed the Order on Reconsideration award of 42 percent (63 degrees) scheduled permanent disability for loss of use or function of claimant's right leg. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address SAIF's argument that the ALJ erred in holding that, as the appealing party, SAIF had the burden of proving that claimant's permanent disability award should be reduced. In previous cases, we have declined to revisit our decision in *Roberto Rodriguez*, 46 Van Natta 1722 (1992), and we have consistently relied on it as precedent. *See, e.g., Lori L. Kowalewski*, 51 Van Natta 13 n.1 (1999). We continue to take that approach in this case. In any event, the result in this case would be the same if claimant has the burden of proof.

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

ORDER

The ALJ's order dated June 25, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,300, payable by SAIF.

In the Matter of the Compensation of
INGE C. AGARD, Claimant
WCB Case No. 99-01603
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's right ankle injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address SAIF's argument that claimant was on a "personal mission" at the time she was injured. On February 7, 1999, claimant injured her right ankle when she slipped and fell on ice in the employer's parking lot. When claimant arrived at her car, she was unable to open the doors because the locks were frozen. She proceeded to walk back to the employer's building to get help, but the lighting was poor and she slipped and fell on black ice.

SAIF contends that claimant was on a "personal mission" when she fell because she was returning to the employer's building to get help to unlock her car doors and, therefore, her injury is not compensable. SAIF does not dispute that claimant was injured on the employer's parking lot. After reviewing the record, we are not persuaded that claimant's act of attempting to get into her car was of such a personal nature so as to break the work-connection. *See Boyd v. SAIF Corp.*, 115 Or App 241 (1992) (employer's control over the parking lot, its instructions to its employees to park there and the fact that the claimant was on her way home from work established the work-connection; the claimant's act of getting into her car at the end of her work shift was not of such a personal nature as to break the work-connection).

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

ORDER

The ALJ's order dated June 21, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
NIEL J. BARRETT, Claimant
WCB Case No. 98-08371
ORDER ON REVIEW
Willner, Wren, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of his claim for a left femoral head fracture. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had not established that the September 27, 1993 compensable injuries were the major contributing cause of the left femoral head fracture. We agree.

Claimant does not contend that his left leg injury was a direct result of the 1993 work injury. Rather, claimant asserts that the 1993 work injury resulted in left foot hypethesia and osteopenia which in turn were the major cause of the left femoral head fracture. The left foot hypethesia and osteopenia conditions were not directly related to the original compensable injuries. However, if those conditions were caused in major part by the compensable injuries, then any condition that is caused in major part by the hypthesia and osteopenia may also be compensable as a consequential condition. ORS 656.005(7)(a)(A); *Roseburg Forest Products v. Zimbelman*, 136 Or App 75, 79-80 (1995).

The only medical opinion that supports compensability comes from Dr. Hanesworth, M. D., who began treating claimant in early 1998 after the femoral head fracture. (Ex. 9). Dr. Hanesworth believed that claimant had prolonged periods of bed rest and inactivity following the 1993 compensable injuries that decreased the bone density in claimant's left hip. (*Id.*). Dr. Hanesworth opined that the decreased bone density was the major cause of claimant's hip fracture. (Ex. 10).

Like the ALJ, we do not find Dr. Hanesworth's opinion persuasive. To begin, Dr. Hanesworth's opinion is based on the assumption that claimant's inactivity and disuse in 1993 caused a decrease in bone density. (Exs. 9, 18). However, Dr. Hanesworth did not see claimant until early 1998 and it is not clear if Dr. Hanesworth was aware of how long claimant was inactive following the 1993 compensable injuries. In this regard, we find Dr. Hanesworth's opinion that inactivity cause decreased bone density to be speculative and not well-explained.

In addition, Dr. Hanesworth initially indicated that the bone scan study did not support a causal relationship between decreased bone density and the fracture. (Ex. 8). At that time, Dr. Hanesworth acknowledged that because the fracture took place a year prior to the bone scan, it would be "hard to interpolate back and see what [claimant's] bone density would have been at that time." (*Id.*) In later opinions, Dr. Hanesworth does not acknowledge the difficulty of determining claimant's bone density at the time of the fracture, but concludes that claimant had "markedly" decreased bone density. (Exs. 9, 10, 18). Finally, Dr. Hanesworth does not discuss the contribution of the bicycle incident where claimant fell directly onto his left hip.[1] For these reasons, we agree with the ALJ that Dr. Hanesworth's opinion is not persuasive.

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[1] We also note that claimant contends that left foot hypethesia was related to the 1993 injuries and was causally related to the 1998 fracture. However, Dr. Hanesworth does not discuss this condition or any possible causal relationship between the left foot hypethesia and claimant's left femoral head fracture.

Because we are not persuaded by the opinion of Dr. Hanesworth, and in light of the contrary opinions offered by Drs. Fuller, Bald, and Schilperoort, claimant has not established that the 1993 compensable injuries were the major contributing cause of his left femoral head fracture. Consequently, we agree that the self-insured employer's denial must be upheld.

ORDER

The ALJ's order dated June 4, 1999 is affirmed.

November 30, 1999 Cite as 51 Van Natta 1929 (1999)

In the Matter of the Compensation of
GENE A. FOIDEL, Claimant
WCB Case Nos. 98-09440 & 98-09331
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Safeco Legal, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that: (1) upheld the SAIF Corporation's compensability and responsibility denials of his occupational disease claim for right carpal tunnel syndrome (CTS); and (2) upheld Safeco Insurance Company's compensability and responsibility denials of the same condition. On review, the issues are compensability, and potentially, responsibility.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's arguments on review.[1]

Relying on the opinion of Dr. Fuller, the ALJ found that claimant failed to prove compensability of his right CTS condition as an occupational disease. On review, claimant argues that we should rely on Dr. Harris's and Dr. Bulger's opinions to establish compensability. We do not agree.

Claimant has the burden of proving compensability of his occupational disease claim. ORS 656.266. To establish a compensable occupational disease claim for his right CTS, claimant must prove that employment conditions were the major contributing cause of the disease or, if the claim is based on the worsening of a preexisting disease, the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(a) and (b). "Major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *See Dietz v. Ramuda*, 130 Or App 387 (1994), *rev dismissed* 321 Or 416 (1995). *McGarrah v. SAIF*, 296 Or 145, 166 (1983). In other words, in determining the major contributing cause of a condition, persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined. *Dietz*, 130 Or App at 401. In addition, the fact that a work activity caused or precipitated a claimant's condition does not necessarily mean that work was the major contributing cause of the condition. *See Robinson v. SAIF*, 147 Or App 157 (1997); *Dietz*, 130 Or App at 401.

Claimant, age 39, has worked as a sheet metal worker, specializing in custom fabrications, for 16 years. He is right hand dominant. His work involves the use of 10 different hand tools, including a great deal of hammering and cutting sheet metal with tin snips. Twenty percent of his time is spent on layout and 80 percent on assembly. In September 1998, claimant was diagnosed with right CTS by Dr. Weirich in conjunction with Weirich's examination of claimant's right elbow epicondylitis. The CTS condition was confirmed by nerve conduction studies.

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[1] Safeco has moved to recuse Board Member Phillips Polich from participation in this matter. We need not address Safeco's motion, as Member Phillips Polich did not review this case.

Given the several possible causes of claimant's right CTS condition, the causation issue presents a complex medical question. Resolution of the issue, therefore, requires expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). Moreover, we do not give greater weight to the opinion of Dr. Harris, treating orthopedic surgeon, because resolution of the causation issue in this case involves expert analysis rather than expert external observation. *Allie v. SAIF*, 79 Or App 284 (1986). In any event, Dr. Harris has only examined claimant's right wrist once. (Exs. 33, 35, 36, 39, 43). Therefore, he does not have any advantage regarding observation of claimant's CTS condition over time.

As discussed by the ALJ, four physicians rendered opinions regarding the cause of claimant's right CTS. Dr. Weirich, the orthopedist who first treated claimant's CTS, initially opined that claimant's CTS was not work related. Later, after reviewing claimant's job description, he changed his mind, stating that claimant's work activities were a *possible* cause of his CTS. (Ex. 44). However, 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). Thus, we agree with the ALJ that Dr. Weirich's opinion does not support compensability.

Dr. Fuller opined that claimant's CTS was idiopathic, based on his examination, his review of claimant's history, and the medical records. (Exs. 30, 43, 48). He based his opinion on his findings that claimant's work with his hands did not involve wrist flexion, claimant was of an age (39) to begin to develop CTS, the electrical studies were borderline, and claimant had no symptoms until he presented to Dr. Weirich in September 1998. Thus, Fuller's opinion does not support compensability. Only the opinions of Dr. Harris and Dr. Bulger, family physician, ostensibly support compensability of claimant's CTS. However, we, like the ALJ, find these opinions insufficient to establish compensability.

In addition to the ALJ's analysis of Dr. Harris' and Dr. Bulger's reports, which we adopt, we find that neither report evaluates the relative contribution of the potential causes identified by Dr. Fuller. *See* Exs. 45 and 47. Thus, even though each doctor ascribed to "magic words" in the opinion letter provided by claimant's attorney, neither of their responses is sufficiently explanatory to establish that claimant's work activity was the major contributing cause of claimant's CTS under the *Dietz* standard.

ORDER

The ALJ's order dated June 3, 1999, as amended June 9, 1999, is affirmed.

In the Matter of the Compensation of
GAYLE A. GRANGER, Claimant
WCB Case No. 99-02041
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that upheld the insurer's denial of her current right shoulder condition. On review, the issue is compensability.

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

The ALJ upheld the insurer's denial of claimant's right shoulder subacromial impingement syndrome, finding that she failed to prove that her compensable injury (accepted as a right shoulder strain) was the major contributing cause of her need for treatment of a "combined condition" under ORS 656.005(7)(a)(B). In making this finding, the ALJ determined that the medical opinion of Dr. Teal, the attending physician, was not persuasive.

On review, claimant contends that Dr. Teal's opinion proves that her compensable injury is the major contributing cause of her need for treatment and that the ALJ, therefore, incorrectly held that her impingement syndrome is not compensable. For the following reasons, we agree with the ALJ's assessment of Dr. Teal's opinion.

In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). 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 (1983). Although claimant relies on the opinion of his treating physician, Dr. Teal, we find persuasive reasons not to give greater weight to his opinion.

First, Dr. Teal received a history that claimant's right shoulder symptoms occurred as a result of "re-work" activities during the "whole afternoon" of July 20, 1998. (Exs. 3, 4-2). Claimant testified, however, that these activities lasted about an hour. (Tr. 126). Accordingly, we find that an important aspect of Dr. Teal's history was inaccurate. In addition, Dr. Teal testified in his deposition that patient history was "imperative" in determining causation. (Ex. 17-10). Yet, from our review of Dr. Teal's deposition, it appears that he had only a limited understanding of what claimant's work activities involved. (Ex. 17-6, 12-15). Importantly, Dr. Teal did not demonstrate awareness that the majority of claimant's work time was spent, not in "re-work" activities, but rather in "pre-fry" transfer where her arms usually rested on an ergonomically designed bar. (Tr. 70).

Accordingly, we agree with the insurer that Dr. Teal lacked a complete and accurate history and, thus, his opinion is not entitled to the greater weight generally accorded an attending physician under *Weiland*. Moreover, we find the medical opinions of an examining physician, Dr. Schilperoort, and Dr. Thompson, a physician who reviewed medical records for the insurer more persuasive.

They opined that claimant's preexisting Type III subacromial spur, described by Dr. Teal as "massive," was the major contributing cause of claimant's impingement syndrome and need for decompressive shoulder surgery. (Exs. 18-3, 20-2). According to these physicians, in the absence of the large preexisting subacromial spur, the injury claimant sustained on or about July 20, 1998 would not have caused an impingement syndrome. (Exs. 19-1, 20-3). Both doctors opined that claimant's right shoulder bursa thickened when the preexisting spur impinged on it causing claimant's symptoms and need for treatment. (Exs. 19-3, 20-3).

Because the Schilperoort/Thompson opinions are well-reasoned and based on an accurate and complete history, we find them to be the most persuasive on this record. Therefore, we agree with the ALJ that the ALJ failed to sustain her burden of proof.[1] Thus, we affirm.

ORDER

The ALJ's order dated July 13, 1999 is affirmed.

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[1] Claimant cites *Harold A. Morton, Jr.*, 51 Van Natta 182 (1999), as support for his argument. In *Morton*, we determined that the opinion of the physician supporting compensability was consistent with the claimant's history. 51 Van Natta at 183. In this case we have found that Dr. Teal's history is not complete or accurate. Thus, we find *Morton* distinguishable.

In the Matter of the Compensation of
DENNIS D. HALL, Claimant
WCB Case Nos. 98-04154, 98-03816 & 97-10410
ORDER ON RECONSIDERATION
Michael A. Bliven, Claimant Attorney
Scheminske, et al, Defense Attorneys

The SAIF Corporation, on behalf of Mt. Hood Metals, Inc., requests reconsideration of our September 24, 1999 order that set aside its denial of claimant's right knee chondromalacia condition; and upheld SAIF's partial denial, on behalf of Frank Wade, a noncomplying employer, of the same condition. On reconsideration, SAIF/Mt. Hood renews its argument that claimant's chondromalacia condition is not compensable because it did not require medical treatment or cause disability. In addition, SAIF/Mt. Hood argues that compensability of claimant's chondromalacia condition should be analyzed as a "combined" condition under ORS 656.005(7)(a)(B) or as an occupational disease. We abated our September 24, 1999 order on October 19, 1999 in order to consider SAIF/Mt. Hood's motion. Having received claimant's response to the motion, we proceed with our reconsideration.

SAIF/Mt. Hood argues that Dr. Irvine's opinion is inconsistent or ambiguous regarding whether the chondromalacia condition necessitated medical treatment. We disagree. We read Dr. Irvine's opinion as being that chondromalacia in general and in isolation does not contribute to a need for treatment. In claimant's specific case, however, the chondromalacia does contribute to his need for treatment. (Tr. 79, pages 32-33). Thus, we disagree with SAIF's argument that Dr. Irvine's opinion is either inconsistent or ambiguous.

SAIF/Mt. Hood argues that claimant's chondromalacia preexisted his injury and that compensability of his claim should be analyzed as either an occupational disease or a "combined" condition under ORS 656.005(7)(a)(B). Again, we disagree.

In determining the appropriate standard for analyzing compensability, we note that an occupational disease stems from conditions that develop gradually over time. *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *Active Transportation Co. v. Wylie*, 159 Or App 12 (1999). In contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Wylie*, 159 Or App at 15; *Valtinson v. SAIF*, 56 Or App 184, 188 (1982).

Here, a pile of steel fell on claimant's knee on a particular date. Because this event was sudden, and arose from an identifiable event, we conclude that claimant's claim should be analyzed as an injury claim, not as an occupational disease. Thus, we reject SAIF/Mt. Hood's argument that the claim is for an occupational disease.

SAIF/Mt. Hood also argues that claimant's claim should be analyzed under ORS 656.005(7)(a)(B). In making its argument, SAIF/Mt. Hood asserts that claimant had chondromalacia that preexisted the 1986 injury and combined with that injury. We find insufficient evidence in the record that the chondromalacia preexisted the 1986 injury. For the reasons given in our prior order, we find Dr. Irvine's opinion the most persuasive regarding claimant's chondromalacia condition. He opined that it was impossible to know whether the chondromalacia preexisted the 1986 injury. (Tr. 79-12). In the same testimony, he appeared to suggest that the degree of chondromalacia found in the 1986 surgery was consistent with that caused by a meniscus tear. Dr. Irvine went on to opine that the chondromalacia was the result of the 1986 injury. *Id.* Dr. Irvine was aware of claimant's injury to the right knee in 1978 and still opined that the chondrosis was caused by the 1986 injury. (Tr. 79-26). Given this evidence, we are not persuaded that the chondromalacia preexisted the 1986 injury. Rather, relying on Dr. Irvine's opinion, we find that the chondromalacia did not preexist the 1986 injury, but was caused by it. Thus, ORS 656.005(7)(a)(B) is not applicable to this claim and we continue to adhere to the compensability analysis set out in our September 24, 1999 order.[1]

Claimant's attorney seeks an attorney fee of $1,000 for services on reconsideration. SAIF/Mt. Hood objects, arguing that the request is excessive and that claimant's response on reconsideration duplicates work done on the respondent's brief. Claimant's attorney states that he spent no less than 5 hours on his response to the motion for reconsideration and argues that an hourly rate of $200 is reasonable.

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[1] In our prior order, we analyzed the chondromalacia as a consequential condition of the 1986 injury.

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.

Claimant submitted a nine page response to the motion for reconsideration and his attorney spent approximately 5 hours on the response. The issues involved are of average complexity. As a result of prevailing over the request for reconsideration, claimant's chondromalacia condition is compensable and he will be entitled to medical services and possibly other benefits. Both attorneys involved in the request for reconsideration are skilled and experienced workers' compensation attorneys. In light of SAIF/Mt. Hood's vigorous and skilled defense of the claim, there was a risk that claimant's attorney would go uncompensated.

After considering the above factors, with particular consideration of the time spent on the issue, the benefit secured and the risk that claimant's attorney might go uncompensated, we find a fee of $1,000 to be reasonable.

As supplemented herein, we republish our September 24, 1999 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order. Claimant's attorney is awarded $1,000 for services on reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA M. McKINZEY, Claimant
WCB Case No. 99-01687
ORDER ON REVIEW
Daniel J. DeNorch, Claimant Attorney
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's denial of claimant's occupational disease claim for right shoulder rotator cuff tendinitis and acromioclavicular degeneration conditions. On review, the issues are "back-up" denial, compensability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed an occupational disease claim for a right shoulder condition. She was diagnosed with rotator cuff tendinitis. In September 1998, the insurer accepted a right shoulder strain. After the Notice of Acceptance issued, claimant was also diagnosed with acromioclavicular joint irritation. In January 1999, the insurer denied rotator cuff tendinitis and acromioclavicular joint irritation on the express ground that her work activities were not the major contributing cause of the development of those conditions.

Claimant raised for the first time in closing arguments her contention that the insurer's denial was an improper "back-up" denial of her accepted combined right shoulder strain condition. The ALJ found that the denial was neither a "back-up" nor a "pre-closure" current condition denial and concluded that, because the parties agreed at hearing that the sole issue in the proceeding was the compensability of the two conditions specifically denied, claimant had waived any procedural objections to the denial. The ALJ then concluded that claimant's claims for right shoulder rotator cuff tendinitis and acromioclavicular degeneration conditions were not compensable under ORS 656.802.

We affirm the ALJ's decision, but for the following reasoning.

We will not consider an issue raised for the first time during closing argument. *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995). Consequently, we affirm the ALJ's decision not to address the "back-up" denial issue because this issue was first raised by claimant in her closing argument at hearing.

Compensability

This is an occupational disease claim. Dr. Edelson, claimant's treating orthopedic surgeon, and Dr. Vessely, orthopedic surgeon who examined claimant for the insurer, were in agreement that claimant developed right shoulder tendinitis from holding her arms in an abducted position while performing her work as a hairdresser. (Ex. 15-5). The medical evidence also indicates that claimant's acromioclavicular degeneration is a preexisting condition that combined with her rotator cuff tendinitis condition. (Exs. 5-2, 6, 12, 15-5).

To establish an occupational disease, claimant must prove that her employment conditions were the major contributing cause of her bilateral tendinitis condition. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). 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).

After *de novo* review, we agree with the ALJ's finding that there is no medical evidence in the record to support a finding that claimant's work activity pathologically worsened the preexisting acromioclavicular degeneration condition. Consequently, claimant has failed to prove that her acromioclavicular degeneration is compensable.

Turning to claimant's rotator cuff condition, opinions regarding causation were provided by Dr. Edelson, Dr. Vessely, and Dr. Gripekoven, orthopedic surgeon who performed a medical records review.

Dr. Vessely noted that there were no non-work factors affecting claimant's shoulder condition, explaining that claimant's right shoulder tendinitis developed from holding her arms in an abducted position. He further explained that the tendinitis was significantly aggravated by the degenerative acromioclavicular changes with inferior spurs off both the clavicle and acromion. Finally, he provided several reasons to support his conclusion that the major contributing cause of claimant's symptoms and need for treatment were due to the acromioclavicular degeneration rather than the tendinitis. These reasons included the temporary complete relief from injection into the AC joint, the lack of symptomatic improvement during the period claimant was off work, which should have occurred if the cause was tendinitis, and the surgery that was directed at the preexisting pathology. (Exs. 15, 16, 20).

Dr. Vessely's opinion is supported in the main by Dr. Gripekoven's opinion. Gripekoven concluded that the major contributing cause of claimant's symptoms and need for treatment was the preexisting degenerative acromioclavicular disease. Gripekoven agreed that claimant's repetitive work activities caused her shoulder to become symptomatic, but that the spurring from the acromioclavicular joint was the major cause of the irritation of the rotator cuff. He also opined that, if the spurs were not present, it was probable that claimant would not have developed irritation of her rotator cuff with secondary tendinitis. (Ex. 10).

Dr. Edelson, in contrast to Vessely and Gripekoven, opined that claimant's work was the major contributing cause of claimant's need for treatment, because her degenerative acromioclavicular joint was asymptomatic prior to her repetitive work as a hairstylist, and it was the act of repetitive motion and holding her arm out in a flexed position that caused her symptoms to occur. (Ex. 12).

Although we generally defer to the treating physician's opinion, we find persuasive reasons not to do so in this case. Even though Dr. Edelson's opinion includes "magic words," such as "the major

contributing cause," it is conclusory, without significant explanation. *See Somers v. SAIF*, 77 Or App 259, 262 (1983). Moreover, without more explanation, particularly in light of Dr. Vessely's and Dr. Gripekoven's discussion of the relative contribution of the preexisting acromioclavicular condition and the surgery directed at that condition, we find that Dr. Edelson's opinion establishes only that the work activity was the precipitating cause of the combined condition. Such an opinion is insufficient to establish compensability. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (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).

ORDER

The ALJ's order dated June 30, 1999 is affirmed.

November 30, 1999 Cite as 51 Van Natta 1935 (1999)

In the Matter of the Compensation of
MICHAEL F. RICKS, Claimant
WCB Case No. 98-08768
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of claimant's claim for a left wrist ganglion cyst. On review, the issue is compensability.

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

Claimant argues that records from a March 1998 examination of the left wrist did not mention a ganglion. Based on this fact, claimant argues that the October 1998 incident must have caused the ganglion. We disagree.

Drs. Yarusso and Fuller believed that the ganglion preexisted and was unrelated to the injury. There is no medical opinion that the cyst could not have developed subsequent to the March 1998 treatment and it is not known for certain whether or not the cyst was present in March 1998. Under such circumstances, the fact that the records do not mention a cyst seven months prior to the injury does not necessarily convince us that the medical opinions stating that the cyst preexisted the October 1998 incident are unpersuasive.

Claimant argues that Dr. Fuller's opinion is unpersuasive because he opined in one portion of his report that there is no correlation between trauma and the appearance of a ganglion and then in a different portion stated that if the ganglion was traumatic, there would have been blood in the fluid aspirated by Dr. Yarusso. We do not agree that Dr. Fuller's opinion is inconsistent. In this regard, the doctor stated that: "If the fluid was blood stained or blood tinged I would be persuaded that there was a new traumatic element in this ganglion formation." We do not find this statement to be inconsistent with Dr. Fuller's general statement that there is no correlation between ganglions and trauma. The doctor is merely addressing the possibility of contribution from the work incident and explaining the basis for his belief that trauma did not contribute to the ganglion formation in this particular case.

ORDER

The ALJ's order dated May 20, 1999 is affirmed.

In the Matter of the Compensation of
WILLIAM L. SUTTON, Claimant
WCB Case No. 99-02136
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of his current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial of claimant's current "combined" low back condition, finding that claimant failed to sustain his burden of proving that his compensable injury is the major contributing cause of the disability and medical treatment of the combined condition. *See* ORS 656.005(7)(a)(B). In so finding, the ALJ held that the opinion of an attending physician, Dr. Lewis, was unpersuasive.

On review, claimant contends that the ALJ mistakenly evaluated the medical evidence. Claimant argues that Dr. Lewis' opinion is the most persuasive in this record and satisfies his burden of proof. For the following reasons, we agree with claimant.

First, we briefly review the background of the claim. Claimant injured his low back on June 9, 1998 after moving welding tanks at work. Dr. Ferguson, claimant's initial attending physician, diagnosed a sacroiliac strain. SAIF accepted the claim as a nondisabling lumbosacral strain on June 25, 1998.

Dr. Ferguson later referred claimant to Dr. Lewis, a spine surgeon, in July 1998 because claimant failed to improve. An MRI performed on August 13, 1998 revealed spinal stenosis secondary to a posterior disc bulge and posterior facet hypertrophy at L3-4 and L4-5. Degenerative changes were also noted at L5-S1. (Ex. 11). After reviewing the MRI, Dr. Lewis diagnosed a mechanical low back strain superimposed on a preexisting degenerative spine condition causing L4 nerve irritation. (Ex. 12).

In September 1998, Dr. McNabb, a physical medicine and rehabilitation specialist, began treating claimant. Conservative treatment continued, but claimant's symptoms did not resolve. SAIF denied claimant's current low back condition on February 25, 1999, after Dr. McNabb and Dr. Goodwin, a physician who reviewed medical records for SAIF, opined that claimant's preexisting stenosis was the major contributing cause of claimant's disability and need for treatment. (Exs. 30, 34, 35). Claimant requested a hearing.

On March 24, 1999, Dr. Erkkila performed a decompressive laminectomy with foraminotomies at L3, 4 and 5.

Having summarized the background of the claim, we now proceed with our analysis. To satisfy his burden of proof, claimant must prove that his June 9, 1998 work injury was the major contributing cause of the disability or need for medical treatment for the combined condition.[1] ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997). The fact that a work injury is the immediate or precipitating cause of a claimant's disability or need for treatment does not necessarily

[1] Both parties agree, and we find, that claimant's current low back condition is a "combined" condition. Thus, there is no dispute that ORS 656.005(7)(a)(B) applies to this case.

mean that the injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Id.*

Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. *Somers v. SAIF*, 77 Or App 259 (1986).

Dr. Lewis opined that claimant's compensable injury is the major contributing cause of his need for treatment. (Ex. 37). Acknowledging that claimant had a "significant" preexisting back condition, Dr. Lewis nevertheless noted that claimant had few, if any, back symptoms before he experienced a work-related injury. Dr. Lewis explained that the work injury caused a small disc herniation that combined with preexisting stenosis, which in turn caused "an acute additional stenotic component." This, according to Dr. Lewis, caused a combined condition that was worse and necessitated evaluation and treatment. Without the work injury, Dr. Lewis emphasized, claimant would not have needed medical treatment. *Id.*

The ALJ found Dr. Lewis' opinion unpersuasive because it was based largely on a temporal relationship between the injury and onset of disability; Dr. Erkkila's surgery revealed numerous degenerative changes; and, finally, Dr. Lewis did not specifically discuss or discount the effects of the underlying degenerative condition, other than to suggest that it was not significant.

We disagree with the ALJ's reasoning. Dr. Lewis' opinion was based on more than a temporal relationship. He persuasively explained that the injury caused a small disc herniation, which caused an additional stenotic component, which in turn caused a combined condition requiring evaluation and treatment. In addition, there is no medical evidence from Dr. Erkkila (or from any other physician, for that matter) interpreting the surgical report. Accordingly, we find no medical support for the ALJ's conclusion that the surgery revealed degenerative changes. Thus, we do not discount Dr. Lewis' opinion. Finally, we find that Dr. Lewis sufficiently discussed and considered the effects of the underlying degenerative condition. His opinion satisfies the comparative analysis required to establish compensability.

In summary, we find Dr. Lewis' opinion well-reasoned and based on an accurate history. Therefore, we find it persuasive. Moreover, we find Dr. Lewis' opinion more persuasive that those of Drs. McNabb and Goodwin.

Dr. McNabb, when asked if claimant's compensable injury had ceased to remain the major contributing cause of the claimant's disability and need for treatment, replied: "Yes. As far as I am concerned, his lumbosacral strain/sprain has mostly resolved. He is now faced with stenosis which is a preexisting condition." (Ex. 30). We agree with claimant that Dr. McNabb's opinion is conclusory and, therefore, entitled to less weight than Dr. Lewis' opinion. *See Blakely v. SAIF*, 89 Or App 653, 656, *rev den* 305 Or 972 (1988) (physician's opinion lacked persuasive force because it was unexplained).

Dr. Goodwin agreed with Dr. McNabb's opinion. (Ex. 34-3). We find, however, that Dr. Goodwin gives insufficient consideration to the fact that claimant experienced a specific traumatic injury. Moreover, Dr. Goodwin gives too little consideration in his analysis to the absence of preexisting back complaints and to the ongoing nature of claimant's back discomfort after the June 1998 injury. In light of the above deficiencies, Dr. Goodwin's report does not offset the weight we have given Dr. Lewis' report.

Therefore, based on our *de novo* review, we conclude that claimant has proved by a preponderance of the evidence that the compensable June 1998 injury is the major contributing cause of the medical treatment of the current combined low back condition. Thus, claimant sustained his burden of proof under ORS 656.005(7)(a)(B). Therefore, we reverse.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this

case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 7, 1999 is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by SAIF.

November 30, 1999 Cite as 51 Van Natta 1938 (1999)

In the Matter of the Compensation of
DAVID A. RENNO, Claimant
WCB Case No. 98-09714
ORDER ON RECONSIDERATION
G. Joseph Gorciak III, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

On November 5, 1999, we withdrew our October 12, 1999 order that: (1) set aside the SAIF Corporation's denial of claimant's injury claim; and (2) assessed a penalty of 25 percent for an unreasonable denial. We took this action to await receipt of the parties' proposed stipulation. The parties have now submitted a proposed "Stipulation and Order."

Pursuant to the stipulation, the parties agree that SAIF shall pay claimant a 5 percent penalty of the amounts then due as of the date of hearing. The stipulation also provides that claimant's attorney is entitled to one-half of the penalty amount. The agreement further states that SAIF withdraws its previously filed motion for abatement and reconsideration. Finally, the parties stipulate that the remainder of the Board's order "remains in effect."

We have approved the parties' stipulation, thereby resolving this matter. Accordingly, on reconsideration, we adhere to and republish our October 12, 1999 order except for the penalty portion. 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
HARRY E. KALLAK, Claimant
Own Motion No. 99-0404M
OWN MOTION ORDER

The self-insured employer has submitted a request for temporary disability compensation for claimant's compensable right hip replacement condition. Claimant's aggravation rights expired on May 17, 1987. The employer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *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 employer contends that claimant was not in the work force at the time of the current disability. Claimant has not responded to the employer's contention. 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.

In the Matter of the Compensation of
DOUGLAS L. LEE, Claimant
Own Motion No. 99-0402M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable fractured left ankle condition. Claimant's aggravation rights expired on September 10, 1991. 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. 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.

In the Matter of the Compensation of
EMMIT C. THOMPSON, Claimant
Own Motion No. 99-0411M
INTERIM OWN MOTION ORDER CONSENTING TO
DESIGNATION OF PAYING AGENT (ORS 656.307)

The Benefits Section of the Workers' Compensation Division is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has acknowledged that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1987 injury claim with the Weyerhaeuser Company expired on February 25, 1993. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. *Id.*

The record establishes that there has been a worsening of claimant's compensable injury requiring surgery. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1987 own motion claim, beginning the date claimant is hospitalized for the proposed surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307.

When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if the own motion carrier is found to be the responsible carrier; and/or (2) issue an order denying reopening of an own motion claim, if the own motion carrier is not found responsible, or if a non-own motion carrier is found to be the responsible carrier. Furthermore, if the own motion carrier is determined to be responsible for claimant's current condition, the parties are requested to submit their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS L. HINSON, Claimant
WCB Case Nos. 98-07386 & 98-03373
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld Liberty Northwest's (Liberty's) denial of claimant's aggravation claim for an L4-5 disc condition; (2) determined that Geisy, Greer & Gunn (GGG) was responsible for claimant's current low back condition under a 1988 "Own Motion" claim; and (3) declined to award claimant's counsel attorney fees under ORS 656.386(1) and ORS 656.307(5). GGG cross-requests review, contending that the ALJ erred in finding it responsible for claimant's current low back condition. On review, the issues are responsibility and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a low back injury in July 1988 for which GGG is responsible. A herniated disc at L4-5 was identified. (Ex. 8). Dr. Treible performed an L4-5 discectomy in November 1988. In March 1990, a Determination Order closed the claim with an award of 23 percent unscheduled permanent disability.

In 1992, Liberty's insured hired claimant. Claimant continued to experience low back pain. In March 1994, Dr. Treible performed L4-5 decompressive surgery that was covered under the 1988 GGG claim.

In August 1995, claimant sustained another low back injury. Liberty accepted a herniated disc at L3-4 after Dr. Treible performed a discectomy at that level in September 1995. (Exs. 88, 94). On January 20, 1998, a Determination Order closed the August 1995 claim with an award of 27 percent unscheduled permanent disability.

Claimant's low back pain gradually worsened after claim closure. Dr. Treible recommended an interbody fusion at L4-5 and possibly at L5-S1 and L3-4. (Ex. 113). On May 24, 1998, Dr. Treible filed an notice of an aggravation claim with Liberty, mistakenly referencing the 1988 injury. (Ex. 115). Dr. Treible would later opine that the 1988 injury was the "direct cause" of the deterioration of claimant's back. (Ex. 117-1).

Liberty denied aggravation of the 1995 injury by letter of April 22, 1998, alleging that the 1988 injury was the major contributing cause of claimant's need for surgery. (Ex. 119). Liberty's denial specifically noted that it was not "waiving further questions of compensability." *Id.* Claimant requested a hearing from the denial on April 27, 1998. Liberty subsequently amended its denial on June 24, 1998 to deny responsibility and to notify claimant that a paying agent had been requested pursuant to ORS 656.307. (Ex. 120).

On September 2, 1998, GGG denied the compensability of claimant's current condition on the ground that the 1988 injury was not the major contributing cause of claimant's need for surgery. (Ex. 123). GGG noted that it would not request a paying agent and would recommend to the Board that the 1988 claim not be reopened under the Board's "Own Motion" authority. Claimant requested a hearing from this denial on September 16, 1998.

On November 13, 1998, the Board referred claimant's request for Own Motion relief under the 1988 claim for a hearing, instructing the ALJ to make a recommendation regarding the "Own Motion" matter.

On December 22, 1998, GGG reversed position and notified claimant that it was requesting designation of a paying agent. (Ex. 128). GGG formally requested the ".307" paying agent on January 15, 1999. (Ex. 129).

On February 2, 1999, Liberty conceded compensability of claimant's back condition at L3-4 but reserved the right to contest whether that condition had pathologically worsened. (Ex. 131). An order designating a paying agent then issued on March 8, 1999. (Ex. 133).

The hearing occurred on April 5, 1999. Reasoning that the compensability of the aggravation claim against Liberty must be determined before considering the responsibility issue, the ALJ concluded that claimant failed to prove that his condition at L3-4 had "actually worsened." *See* ORS 656.273(1). Thus, the ALJ upheld Liberty's aggravation denials. The ALJ also found that the 1988 injury for which GGG was responsible was the cause of claimant's need for surgery. Accordingly, the ALJ determined that claimant's remedy was under the Board's "Own Motion" jurisdiction. In making this determination, the ALJ concluded that he was without authority to award benefits or attorney fees.

On review, claimant contends that the ALJ should have applied *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984), and found that Liberty was responsible for his low back condition.[1] Moreover, claimant asserts that he proved a compensable aggravation of his 1995 low back injury against Liberty. Finally, claimant argues that the ALJ should have awarded attorney fees for obtaining rescission of the compensability denials before hearing and for services at hearing regarding the responsibility issue. Contending that the ALJ mistakenly decided that he did not need to conduct a responsibility analysis because the aggravation claim against Liberty was not compensable, GGG also argues that Liberty is responsible under *Kearns*.

For the following reasons, we agree with the ALJ that GGG is responsible for claimant's current low back condition. Our analysis differs from the ALJ's, however.

Conner v. B & S Logging, 153 Or App 354 (1998) involved a claimant who had an accepted 1985 claim with one carrier and a 1991 claim with a second carrier. We had 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 our 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 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.

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[1] In *Kearns*, the court examined responsibility in the context of successive accepted injuries involving the same body part. The court held that there was a rebuttable presumption that the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. In *Raymond H. Timmel*, 47 Van Natta 31 (1995), we held that, encompassed in the "*Kearns* presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. The carrier with the last accepted injury can rebut the "*Kearns* presumption" by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. 70 Or App at 588. In *Timmel*, we decided that the enactment of *former* ORS 656.308(1) did not overrule *Kearns* and, where a claimant has several accepted claims for injuries involving the same body part, but not the same condition as that for which the claimant currently seeks compensation, *Kearns* remained valid law. 47 Van Natta at 32.

Because our first inquiry is whether the current low back condition was previously accepted, it is necessary to determine what conditions were previously accepted. Claimant's diagnosis is lumbar disc instability at L3-4, L4-5 and L5-S1 and facet arthropathy. (Exs. 117, 125-3). Because Liberty expressly accepted only a L3-4 disc herniation, it did not accept the current low back condition. Moreover, although GGG did not accept a specific condition, the medical records concerning the 1988 injury establish that the accepted condition was an L4-5 disc herniation. Consequently, we conclude that the current condition is an unaccepted condition. Under such circumstances, ORS 656.308(1) does not apply in deciding responsibility.

Responsibility must, therefore, be determined either under the *Kearns* presumption or under ORS 656.005(7)(a)(A). For the following reasons, we do not apply *Kearns* and find GGG is responsible in its 1988 claim. We reach this conclusion because the medical evidence establishes that the 1988 injury alone is the major contributing cause of claimant's consequential low back condition, *i.e.*, low back disc instability and facet arthropathy.

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). We rely on those medical opinions that are well-reasoned and based on accurate and complete histories. *Somers v. SAIF*, 77 Or App 259 (1986). Five medical opinions are relevant to the causation issue: those of Dr. Treible, claimant's long-time attending physician and surgeon, Drs. Fuller and Radecki, examining physicians, Dr. Duff, another examining doctor, and Dr. Young, a radiologist who comprehensively reviewed all of claimant's imaging studies.

As previously noted, Dr. Treible initially concluded that the 1988 GGG injury was the "direct cause" of claimant's current low back condition. (Ex. 117). Dr. Treible later opined, however, that the L3-4 herniated disc (which occurred as a result of the 1995 Liberty injury) "triggered" the clinical deterioration that lead to claimant's need for a low back fusion. (Ex. 124A). Claimant's attorney eventually obtained a concurrence report from Dr. Treible in an attempt to reconcile the contradictory opinions. In that report, Dr. Treible agreed that the 1995 injury was the major contributing cause of claimant's low back condition. (Ex. 125). Dr. Treible reviewed medical records, including the medical report of Dr. Fuller who also opined that the 1995 injury was primary factor in claimant's condition. In addition, Dr. Treible noted that claimant's symptoms had increased severely since the 1995 injury.

While Dr. Treible's most recent report does contain an explanation of his current opinion, this report does not explain why, when he originally opined that the 1988 injury was the "direct cause" of the lumbar instability and facet arthropathy, his opinion changed to one that attributes claimant's current condition to the 1995 injury. In other words, there is no explanation of why Dr. Treible discarded his initial causation theory. Given this, we do not find Dr. Treible's change of opinion persuasive.

While Drs. Fuller and Radecki opined that the 1995 injury was the primary factor in claimant's current low back condition, they also noted that they did not have medical records after January 6, 1988. (Ex. 120a-7). Because Drs. Radecki and Fuller did not have complete records, we give their opinion less weight than those of the remaining physicians, Drs. Duff and Young. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

Dr. Duff wrote that the cause of claimant's current low back condition was multifactorial, with both the 1988 and the 1995 injuries contributing to it. (Ex. 124B). Dr. Duff, however, concluded that the 1988 injury was the major contributing cause of claimant's current condition, reasoning that, in the absence of a prior back problem, the 1995 discectomy at L3-4 would probably not have led to the need for a spine fusion. *Id.* Dr. Duff further explained that, even in the absence of the 1995 injury, claimant was headed for a spine fusion. *Id.*

On this record, we find that Dr. Duff's is the most persuasive analysis of the etiology of claimant's current low back condition. It is well-reasoned, thorough and based on a complete and accurate history. Moreover, it is supported by Dr. Young's comprehensive review of the imaging studies generated in this complex claim. Based on that review, Dr. Young opined that there had been no change in the condition at L3-4. (Ex. 121-14). Dr. Young concluded that the major contributing

cause of claimant's current symptoms, disability and need for treatment was the L4-5 level injured in 1988, along with congenital and degenerative changes at the L5-S1 level. Dr. Young specifically ruled out the L3-4 disc level as the major contributing cause of claimant's need for treatment. (Ex. 121-15).

In summary, we find, based on our *de novo* review, that the medical evidence proves that the 1988 injury is the major contributing cause of claimant's current consequential low back condition. Thus, we agree with the ALJ that GGG is responsible. Therefore, we affirm that portion of the ALJ's order.

Attorney Fees

Claimant contends he is entitled to an assessed fees under ORS 656.386(1) for Liberty's and GGG's pre-hearing rescission of their compensability denials. We agree.[2] The record establishes that both Liberty and GGG initially denied compensability, but later conceded the issue.

Based on our review of the record, and after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that $1,000 is a reasonable attorney fee award for claimant's attorney's services in obtaining the pre-hearing rescission of the compensability denial issued by GGG. Moreover, based on those same factors, we find that $1,000 is a reasonable attorney fee award for claimant's attorney's services in obtaining the pre-hearing rescission of Liberty's compensability denial. In reaching these conclusions, we have particularly considered the time devoted to the issues (as represented by the hearing record, including the hearing requests filed by claimant's attorney), the complexity of the compensability issues, the value of the interests involved, and the risk that claimant's counsel might go uncompensated.

We now turn to claimant's entitlement to an assessed fee for his counsel's services at hearing regarding the responsibility issue. This case arises under ORS 656.307 and the fee for services at hearing is authorized under ORS 656.307(5). Pursuant to that provision, claimant is entitled to a reasonable fee for counsel who "actively and meaningfully" participates at the hearing. Because claimant's counsel took a position (contended that Liberty was responsible) and because the temporary disability rates between the Liberty and GGG claim are different, we are persuaded that claimant's counsel "actively and meaningfully" participated at the responsibliity hearing. *See Darrell W. Vinson*, 47 Van Natta 356, 359 (1995). Consequently, claimant is entitled to an assessed fee under ORS 656.307(5).

After considering the factors in OAR 438-015-0010(4), in particular the time devoted by claimant's attorney (as represented by the record), the complexity of the issue, the fact that claimant's argument that Liberty was responsible was unsuccessful, and the value of the interest involved, we find that a reasonable attorney fee for claimant's counsel's services regarding the ".307" responsibility proceeding is $2,000.

We next 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 GGG and it had the lowest rate of compensation. (Ex. 133). *See John H. Kirkpatrick*, 47 Van Natta 2105 (1995).

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[2] The ALJ decided he was without authority under the Board's "Own Motion" referral to make attorney fee awards and could only recommend that such fees be awarded. To the extent that the ALJ's reasoning was confined to claimant's "Own Motion" claim with GGG, such an analysis was accurate. Under our "Own Motion" authority, we are authorized to grant only out-of-compensation awards. *See* OAR 438-015-0080. Nonetheless, in so far as claimant was seeking carrier-paid attorney fees for "pre-hearing" rescissions of denied claims, the ALJ was authorized to consider such a request and, if appropriate, grant such awards.

ORDER

The ALJ's order dated May 6, 1999 is affirmed in part and reversed in part. That portion of the ALJ's order that declined to award assessed fees is reversed. Claimant is awarded a $2,000 attorney fee under ORS 656.307(5), payable by GGG. Claimant is also awarded a $1,000 attorney fee under ORS 656.386(1) regarding Liberty's "pre-hearing" rescission of its compensability denial, payable by Liberty. Claimant is awarded another $1,000 attorney fee under ORS 656.386(1) for GGG's "pre-hearing" rescission of the compensability portion of its denial, to be paid by GGG. The remainder of the ALJ's order is affirmed.

December 6, 1999 Cite as 51 Van Natta 1946 (1999)

In the Matter of the Compensation of
LEONARD R. TERRIBLE, Claimant
WCB Case No. 97-04381
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's November 17, 1999 order, we have been directed to consider the parties' proposed settlement. The parties have submitted a proposed "Disputed Claim Settlement" that is designed to resolve all issues raised or raisable between them, in lieu of all prior orders.

According to the settlement, claimant agrees that the self-insured denial "shall remain in full force and effect." The settlement further provides that claimant's request for hearing "shall be dismissed with prejudice as to all issues raised or raisable between the parties with respect to this claim."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. SUTHERLAND, Claimant
WCB Case No. 98-08838
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's "back-up" denial of claimant's claim for an L5-S1 herniated disc. On review, the issues are the propriety of the "back-up" denial and compensability.

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

On October 27, 1997, claimant twisted stepping off a ladder at work and felt low back pain. Thereafter, he filed a workers' compensation claim. On October 27, 1997, claimant gave a statement to the insurer. Regarding prior low back injuries, claimant acknowledged falling and hurting his hip in August 1996 and some earlier injuries, but denied any other injuries and made no reference to a February 1997 fall or symptoms. The insurer was aware of claimant's treatment with Dr. Akita, a chiropractor, prior to the October 17, 1997 injury.

The insurer's claims examiner learned from a private health insurer that claimant had received medical treatment in the past from several medical providers. On December 31, 1997, the insurer requested claimant's medical records from the providers.

Based on the medical reports in its possession at the time, including an insurer-arranged medical examination (IME) report, the insurer accepted the claim on January 13, 1998, two days prior to the expiration of the 90-day statutory period to accept or deny the claim. The IME physicians were aware that claimant had some chiropractic treatment with Dr. Akita earlier in 1997, but were unaware of claimant's February 1997 fall on ice.

On February 2 and March 2, 1998, the insurer received the medical records it had requested on December 31, 1997. The records included those from Dr. Olkjer, Dr. Byam, Portland Adventist Medical Center, Metro Sport & Spine Clinic and Cascadia Chiropractic. Some of these records established that claimant had slipped and fallen on ice in February 1997 and had sustained a significant back injury and had been unable to work for nearly three months and that an L5-S1 radiculopathy had been suspected during that time. The insurer issued a "back-up" denial of the claim on September 11, 1998.

The ALJ found that claimant's failure to disclose his February 1997 fall on ice causing severe low back and radiating right leg symptoms was a material misrepresentation that reasonably could have affected the insurer's decision to accept the claim. *See* ORS 656.262(6)(a).[1] Noting that the statute shifted the burden back to claimant to establish compensability, the ALJ addressed the merits of the compensability issue and found that claimant had not sustained his burden of proof. On this basis, the ALJ upheld the insurer's "back-up" denial.

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[1] The pertinent portion of ORS 656.262(6)(a) provides:

"The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim."

Under the statute, only a material misrepresentation will support a "back-up" denial. *E.g., Ebbtide Enterprises v. Tucker*, 303 Or 459, 464-65 (1987). To demonstrate materiality, a carrier must show that its decision to accept the claim "could reasonably have been affected" if the true facts had been disclosed. *Id.*

On review, claimant cites testimony from the insurer's claims examiner that the medical records received after acceptance were important because they indicated that claimant had a previous history of radiculopathy in the right leg prior to acceptance. Based on this testimony, claimant argues that his failure to acknowledge the February 1997 injury was not a material misrepresentation because the record prior to acceptance already contained references to right leg pain in the past.

We do not agree with claimant that the failure to disclose the February 1997 injury was not a material misrepresentation. Although the record contained a history of some right leg symptoms from prior injuries, the claims examiner specifically testified that she would not have accepted the claim if she had received the records of the February 1997 injury because they established that claimant had a problem before the October 1997 work injury and because the addendum to the IME report addressing the new records indicated that the February 1997 injury was the major cause for claimant's need for treatment. (Tr. 54). Thus, we are persuaded that the insurer's acceptance could reasonably have been affected if it had been aware that claimant sustained a significant fall in February 1997. The records regarding this injury caused the IME physicians to change their opinion regarding the major cause of claimant's need for treatment. In addition, the claims examiner's testimony also suggests that a history of significant right leg radiculopathy so close in time to the work incident also could have reasonably affected the insurer's decision to accept the claim.

Claimant argues that this situation is similar to that in *Greenbriar AG Management v. Lemus*, 156 Or App 499 (1998). We find that case distinguishable. In *Greenbriar*, the court affirmed the Board's decision that there was no material misrepresentation because the carrier knew that the claimant had been untruthful to his physicians when he told them he had not previously injured his low back and had not informed them of a 1990 low back claim. The carrier was aware of the 1990 claim and had requested (but not received) medical records regarding that claim when it issued its acceptance three weeks before the expiration of the statutory time period to accept or deny the claim.

In the present case, the carrier had no knowledge of the February 1997 fall injury prior to its acceptance (two days before the expiration of the 90-day statutory period). The claims examiner had become aware from a private insurer that there were other medical records involving claimant and had requested the records but had not received them prior to issuing its acceptance. We conclude that here, the carrier was not aware at the time of acceptance that claimant had been significantly injured in February 1997 and had suffered similar symptoms. In addition, based on the claims examiner's testimony, we are persuaded that knowledge of the injury could reasonably have affected the decision to accept the claim. Thus, we agree that the misrepresentation was material.

We adopt the ALJ's reasoning and conclusion regarding the merits of the compensability issue.

ORDER

The ALJ's order dated March 5, 1999, as reconsidered and amended on April 12, 1999, is affirmed.

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 November 8, 1999 Own Motion Order Reviewing Carrier Closure on Reconsideration, that adhered to and republished our July 22, 1999 Own Motion Order Reviewing Carrier Closure.

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
VERNA M. BOLIN, Claimant
WCB Case No. 99-01345
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) Menashe's order that upheld the insurer's denials of her current neck and back conditions, diagnosed as cervical and lumbar degenerative disc disease. 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 briefly recap the factual and procedural background of this case. On January 15, 1987, claimant sustained multiple compensable injuries when a load of boxes on a hand cart shifted. On April 10, 1991, the insurer accepted low back strain, right carpal tunnel syndrome, right supinator syndrome, right radial compression neuropathy, right shoulder impingement and right trigger thumb. (Ex. 2). On the same date, the insurer issued a partial denial for cervical symptoms, stress, arteriosclerosis, thyroid and hypertension. (*Id.*) On August 30, 1991, the insurer also denied claims for stress and depression. (Ex. 3). Claimant requested a hearing challenging the denials.

A "Settlement, Stipulation and Order" approved on May 3, 1993 stated, in part:

> "On December 24, 1991, the self-insured employer, through its claims management agency, withdrew its denial of cervical symptoms and accepted compensability for a chronic cervical strain, neck/shoulder/arm syndrome, and thoracic outlet syndrome and included and processed those conditions as part of the accepted claim." (Ex. 7-1).

The stipulation indicated that claimant's request for hearing was dismissed with prejudice. (Ex. 7-3). The parties also executed a "Joint Petition and Order of Bona Fide Dispute" approved on May 3, 1993. (Ex. 8). The parties agreed to settle "any and all claims for stress, depression, arteriosclerosis, thyroid conditions, hypertension conditions and all other psychiatric, psychological or other related conditions whether specifically mentioned herein or not" with the exception of conditions accepted under claimant's January 15, 1987 claim. (Ex. 8-4).

On September 4, 1997, Dr. Kay submitted a request for palliative treatment, noting that claimant had restricted range of motion in the thoracic and cervical spine, lumbar spine and shoulders. (Ex. 16A). The insurer denied claimant's current need for medical treatment, contending that the treatment was not related to her accepted conditions. (Ex. 25).

On May 12, 1999, the day of hearing, claimant's attorney requested that the insurer accept claimant's degenerative disc disease condition as related to her January 15, 1987 injury. (Ex. 30). The insurer agreed to waive the 90 day processing time for the degenerative disc disease claim, orally deny the claim and litigate that issue.

The ALJ found that the insurer accepted claimant's chronic cervical strain and "neck/shoulder/arm syndrome" on December 24, 1991. The ALJ found no medical evidence before the December 24, 1991 acceptance of "neck/shoulder/arm syndrome" that attributed claimant's neck complaints to degenerative disease. The ALJ reasoned that, because the medical evidence did not establish that degenerative disease was a factor in claimant's neck symptoms in December 1991, the rule in *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), did not apply.

On review, claimant argues that the ALJ erred in finding that the insurer's acceptance of her "neck/shoulder/arm syndrome" did not include acceptance of her cervical degenerative disc disease. According to claimant, the insurer's acceptance of a "syndrome" was an acceptance of a symptom of her underlying degenerative disc disease. She asserts that the lack of evidence establishing a link between the symptoms and the underlying condition at the time of the acceptance is irrelevant.

On the other hand, the insurer argues there is no medical evidence indicating that "neck/shoulder/arm syndrome" are symptoms of some underlying disease. The insurer asserts that, at the time the "neck/shoulder/arm syndrome" was accepted, the only underlying disease identified, *i.e.*, degenerative disc disease, was felt *not* to be the cause of claimant's symptoms. The insurer contends that, because the medical evidence did not show that degenerative disease was the cause of claimant's cervical symptoms when her claim was accepted in December 1991, the rule in *Piwowar* does not apply.

If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. *Piwowar*, 305 Or at 501-02. In *Piwowar*, the carrier accepted a claim for a "sore back." Later, the carrier learned that the claimant's back problems may have arisen from ankylosing spondylitis, and the carrier issued a partial denial of that condition. *Id.* at 497. The Supreme Court explained that an employer is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." *Id.* at 501. The Court concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, it was precluded from denying the underlying condition. *Id.* at 501-02.

Here, at the time of the insurer's December 24, 1991 acceptance of claimant's "neck/shoulder/arm syndrome," we find no medical reports diagnosing or referring to such a condition. We find no medical dictionary definition of a "neck/shoulder/arm syndrome," although we note that a "syndrome" is defined as "a set of symptoms which occur together; the sum of signs of any morbid state; a symptom complex." *Dorland's Illustrated Medical Dictionary* 1623 (28th ed. 1994). Based on this record, we find that the insurer's acceptance of a "neck/shoulder/arm syndrome" is ambiguous.

In previous cases, we have held that when the carrier does not identify the specific condition accepted, we look to contemporaneous medical records to determine what condition was accepted. *See, e.g., Mary Marrs-Johnston*, 49 Van Natta 1757 (1997); *Timothy Hasty*, 46 Van Natta 1209 (1994). Here, although the insurer has accepted a "specific condition," a "neck/shoulder/arm syndrome" had not been diagnosed at the time of the acceptance, based on the record on review. Thus, we examine contemporaneous medical records to determine whether the acceptance of a "neck/shoulder/arm syndrome" was an acceptance of a symptom of claimant's degenerative cervical condition.

After the January 15, 1987 injury, claimant was treated in the emergency room. (Ex. 1HA-2). Dr. Gore first examined claimant on February 11, 1987. He diagnosed a cervical and thoracic strain, possible cervical radiculopathy and lumbosacral and right sacroiliac joint strain. (Ex. 1HA-2). His February 16, 1987 report diagnosed a lumbar and thoracic strain, possible rotator cuff injury, shoulder. (Ex. 1A). Dr. Gore requested a cervical MRI on March 20, 1987, which showed "[d]egenerative anterolisthesis C3 on 4 with minimal central disk protrusion of unlikely significance" and "[s]mall C5-6 disk bulge, unlikely significant as well." (Ex. 1B).

Claimant was referred to Dr. Higgins, who examined her on April 23, 1987 and concluded that her primary problem was right lateral epicondylitis. (Ex. 1C).

On November 9, 1989, claimant was examined by Dr. Wayson, who said she had continued complaints of neck and back pain. (Ex. 1D). He said that a cervical MRI showed "evidence of degenerative disc disease at several levels with a broad based disc bulge at C5-6[.]" (*Id.*) He felt claimant had "anticipated degenerative disc disease at [sic] these small findings on the MRI scans are not the basis of her symptoms." (*Id.*) Dr. Wayson felt claimant's primary problem was musculoskeletal and he recommended physical therapy. (*Id.*) Dr. Wayson referred claimant to Dr. Long for "possible nerve conduction studies and/or EMG's for right upper extremity to see whether in fact we can identify a radiculopathy vs. neuropathy vs. myopathy as the basis of her complaints." (Ex. 1EA).

On December 18, 1989, Dr. Wayson noted that claimant's cervical and lumbar MRI scans showed evidence of degenerative disc disease, but he commented: "I do not feel that the injury is the cause of this degenerative disc disease since it is a natural occurring process in all of us, although it varies in each of us as to its rate and extent of development." (Ex. 1F). Dr. Wayson did not believe claimant's C5-6 bulge or small herniation at L5-S1 were the basis of her current complaints. (*Id.*)

Dr. Long examined claimant on December 18, 1989, noting that she continued to have interscapular and right posterior scapular pain with right shoulder and lateral arm pain. (Ex. 1G). He diagnosed "[c]hronic interscapular and upper extremity pain and numbness, etiology unclear." (Ex. 1G-4). He said claimant's symptoms were complex, with features that suggested the possibility of median compression, but with more signs pointing to ulnar or radial compression at the elbow. (*Id.*)

On January 22, 1990, Dr. Treible diagnosed trigger thumb and possible rotator cuff tear. (Ex. 1H).

Dr. Gore issued a report to claimant's insurance carriers on April 30, 1990, summarizing her medical treatment since the January 15, 1987 injury. (Ex. 1HA). He reported that claimant had surgery on the left trigger thumb, the right carpal tunnel and the right elbow on February 22, 1990. (Ex. 1HA-4, -5). Claimant apparently returned to work on March 22, 1990, but developed increasing pain. (Ex. 1HA-5). Dr. Gore examined claimant on April 23, 1990 and diagnosed "postoperative pain." (*Id.*) He felt claimant was suffering from "multiple overuse injuries which are cumulative and involving repetitive activity at her work." (Ex. 1HA-6).

The remaining medical reports issued before the December 1991 acceptance did not refer to claimant's degenerative condition. Dr. Harrison performed a psychiatric examination in July 1990 and concluded that claimant had major depression. (Ex. 1I-3). Dr. Hoeflich examined claimant on July 16, 1990 and reported that she had a "post work related injury involving both upper extremities, her shoulder and her neck." (Ex. 1J-3). Dr. Hoeflich felt that claimant was "very somatically focused" and "somewhat depressed[.]" (*Id.*) On September 6, 1991, Dr. Gore wrote to the insurer regarding claimant's return to regular employment, noting that claimant had low back and shoulder girdle and upper extremity problems, "all of which were generated by on-the-job injuries." (Ex. 3A-2).

In summary, at the time of the insurer's December 24, 1991 acceptance of claimant's "neck/shoulder/arm syndrome," we find that the medical reports did not attribute her neck, shoulder or arm symptoms to cervical degenerative disease. Although a cervical MRI showed that claimant had cervical degenerative changes, none of the medical reports prior to the insurer's December 24, 1991 acceptance indicated the degenerative changes were causing neck, shoulder or arm symptoms. To the contrary, the only medical reports specifically discussing claimant's degenerative disc disease during that period were 1989 reports from Dr. Wayson. On November 9, 1989, Dr. Wayson said that claimant's cervical degenerative disc disease findings on the MRI scans "are not the basis of her symptoms." (Ex. 1D). Instead, he felt claimant's primary problem was musculoskeletal. (*Id.*) In a later report on December 18, 1989, Dr. Wayson did not believe that claimant's injury had caused her cervical and lumbar degenerative disc disease and he did not feel that claimant's C5-6 bulge or small herniation at L5-S1 were the basis of her current complaints. (Ex. 1F). Similarly, Dr. Long did not believe claimant's history was strongly suggestive of cervical radiculopathy. (Ex. 1G-4).

Although there is medical evidence in the record indicating that claimant's *current* cervical and back symptoms are caused by degenerative disc disease, we find no medical evidence after the January 15, 1987 injury and before the December 24, 1991 acceptance attributing claimant's neck, shoulder or arm symptoms to the degenerative cervical condition. *Compare Freightliner Corp. v. Christensen*, 163 Or App 191 (1999) (the claimant's low back pain was caused in part by spinal stenosis and degenerative disc disease; by accepting low back pain, the employer accepted the underlying cause(s) of symptoms). We note that the only medical report referring to a "neck/shoulder/arm syndrome" is a September 28, 1992 report from Dr. Gore that listed all of claimant's injuries. (Ex. 6A-1). Dr. Gore provided no explanation of that diagnosis and did not attribute it to a degenerative condition. Under these circumstances, we agree with the ALJ that the rule in *Piwowar* does not apply to this case. Consequently, we proceed to examine the merits of the insurer's denial.

On December 31, 1998, the insurer denied claimant's current need for medical treatment on the basis that it was not related to her accepted conditions. (Ex. 25). At hearing, claimant requested that the insurer process her claim for degenerative disc disease of the spine, asserting that it was related to her January 15, 1987 injury. (Ex. 30, Tr. 1). The insurer agreed to waive the 90-day processing time and orally denied the degenerative disc disease claim. (Tr. 1, 2).

The parties agree that the issue of causation involves a complex medical question that must be resolved with expert medical opinion. The parties also agree that claimant has cervical and lumbar degenerative disc disease and that her ongoing symptoms are caused by the degenerative condition.

Claimant argues that the degenerative disc disease in her spine exists as a direct result of the January 15, 1987 injury. Citing *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992), claimant contends that she need only establish that the January 15, 1987 injury was a material contributing cause of her degenerative disc disease. She relies on the opinions of her attending physicians, Drs. Gore, Kay and Hong to establish compensability of her degenerative disc disease.

In evaluating medical opinions, absent persuasive reasons to the contrary, we generally defer to the treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). We rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Here, however, we find that the dispute (*i.e.*, whether claimant's degenerative disc disease is compensable) involves expert analysis rather than expert external observations and, therefore, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979). For the following reasons, we conclude that claimant has not established that the degenerative disc disease is a direct result of the January 15, 1987 injury, nor are we persuaded that the January 1987 injury is the major contributing cause of the cervical and lumbar degenerative conditions.

Dr. Gore treated claimant from 1987 until 1993. He first examined her on February 11, 1987, almost a month after the January 15, 1987 injury. Dr. Gore diagnosed a cervical and thoracic strain, possible cervical radiculopathy and lumbosacral and right sacroiliac joint strain. (Ex. 1HA-2). His February 16, 1987 report diagnosed a lumbar and thoracic strain, possible rotator cuff injury in shoulder. (Ex. 1A). He ordered a lumbar MRI, which was within normal limits, and a cervical MRI, which showed "[d]egenerative anterolisthesis C3 on 4 with minimal central disk protrusion of unlikely significance" and "[s]mall C5-6 disk bulge, unlikely significant as well." (Ex. 1B).

On April 30, 1990, more than three years after claimant's injury, Dr. Gore wrote to several insurance carriers discussing claimant's treatment since the January 15, 1987 injury. (Ex. 1HA). Dr. Gore commented that claimant's low back was deemed stationary on March 9, 1988. (Ex. 1HA-3). On February 22, 1990, claimant had surgery on the left trigger thumb, the right carpal tunnel and the right elbow. (Ex. 1HA-4, -5). Claimant had returned to work on March 22, 1990, but developed increasing pain. (Ex. 1HA-5). Dr. Gore examined claimant on April 23, 1990 and diagnosed "postoperative pain." (*Id.*) He said claimant was suffering from "multiple overuse injuries which are cumulative and involving repetitive activity at her work." (Ex. 1HA-6). Dr. Gore felt that claimant's scheduled acromioplasty of her shoulder should be deferred. (*Id.*) He explained:

> "It is apparent that her symptoms have been referable to the entire upper extremity from the neck to her fingers and it would seem difficult to separate out any of these problems and it would be my opinion that these are all one injury involving the right upper extremity but that her trigger thumb would be a different problem but again arising from similar predisposing, *repetitive, overuse-type activities.*" (*Id.*; emphasis supplied).

In the April 30, 1990 report, Dr. Gore did not relate any of claimant's symptoms to degenerative disc disease.

On September 6, 1991, Dr. Gore indicated that claimant was permanently precluded from returning to her regular employment. (Ex. 3A). He noted that she had low back, shoulder girdle and upper extremity problems, "all of which were generated by on-the-job injuries." (Ex. 3A-2).

On September 28, 1992, Dr. Gore wrote to claimant's attorney, stating that claimant continued to be symptomatic from her "multiple on-the-job injuries, correctly enumerated as low back strain, right carpal tunnel syndrome, right supinator syndrome, right radial compression neuropathy, right shoulder impingement syndrome, right trigger thumb, chronic cervical strain, neck/shoulder/arm syndrome and thoracic outlet syndrome." (Ex. 6A-1). He said claimant continued to experience ongoing symptoms, including chronic aching, stiffness, soreness and pain in the neck, shoulder girdle and scapular regions, as well as residual pain in her low back. (*Id.*) Dr. Gore did not comment on any degenerative conditions. In early 1993, he indicated that claimant was changing to another attending physician. (Ex. 6B).

Although Dr. Gore related claimant's ongoing symptoms to her work injury, his reports do not indicate that her symptoms were related to degenerative disc disease. He did not discuss causation of claimant's degenerative disc disease or indicate that it was caused by the January 1987 injury. To the contrary, Dr. Gore's April 23, 1990 report indicates that claimant's injuries were caused by repetitive work activities, rather than the January 1987 injury. He said that claimant was suffering from "multiple overuse injuries which are cumulative and involving repetitive activity at her work." (Ex. 1HA-6). We conclude that Dr. Gore's opinion is entitled to little weight and is not sufficient to establish compensability of degenerative disc disease, under either a material or major contributing cause standard.

Claimant also relies on the opinion of Dr. Kay, who began treating her in March 1993, more than six years after the January 1987 injury. (Ex. 18-1). He said claimant was injured when she was wheeling a hand truck loaded with boxes weighing about 300 pounds. (*Id.*) He explained that the "hand truck struck a hole and [claimant], attempting to restrain the truck and load, was flipped over the hand truck and landed on the concrete floor on the right side of [sic] her neck and shoulder." (*Id.*) Dr. Kay opined that claimant had degenerative disease of the spine with chronic cervicothoracolumbar pain "related to her OJI." (Exs. 13-1, 18-2). We find that Dr. Kay's understanding of the mechanism of claimant's injury is inconsistent with the descriptions of her injury given to other physicians, which did not refer to being flipped over a hand truck and falling. Claimant's "801" and "827" forms, as well as the medical reports from Dr. Higgins (Ex. 1C), Dr. Wayson (Ex. 1F), Dr. Long (Ex. 1G) and Dr. Harrison (Ex. 1I) did not refer to a fall by claimant.[1] We find that Dr. Kay's opinion is based on an inaccurate history and his opinion entitled to little weight. *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). Moreover, Dr. Kay's opinion is not persuasive because it is conclusory and lacks adequate explanation. We conclude that Dr. Kay's opinion is insufficient to establish compensability of claimant's degenerative conditions.

Claimant also relies on the opinion of Dr. Hong to establish compensability. There is only one medical report in the record from Dr. Hong. He began seeing claimant in August 1998 and had been treating her for pain control by using acupuncture. (Ex. 29). Dr. Hong reported that the process of degenerative disc disease "has been noted since her work injury of 1987." (*Id.*) He said that injuries such as those sustained by claimant can "accelerate" the rate of spine degeneration. (*Id.*) Dr. Hong felt that claimant's work-related injuries of 1987 had not resolved and had "resulted in degenerative disc disease of the spine[.]" (*Id.*)

Dr. Hong's report does not support claimant's argument that the January 1987 injury directly caused the degenerative disc disease of the spine. Rather, Dr. Hong said that claimant's 1987 work-related injuries had "resulted in degenerative disc disease of the spine[.]" (*Id.*) Based on Dr. Hong's opinion, claimant's 1987 injuries "resulted in" degenerative disease and he noted that injuries such as hers can "accelerate" the rate of degeneration. Dr. Hong's opinion does not support the conclusion that the 1987 incident directly caused the degenerative disc disease. Rather, he said the injuries "resulted" in degenerative disc disease. Thus, his opinion indicates that the degenerative disease developed secondarily as a consequence following the 1987 injuries. Based on Dr. Wong's opinion, claimant's degenerative condition would be analyzed as a consequential condition, which requires her to establish that the compensable injuries were the major contributing cause of the degenerative disc disease of the spine. *See* ORS 656.005(7)(a)(A).

Dr. Hong commented that the "process" of claimant's degenerative disc disease "has been noted since her work injury of 1987." (Ex. 29). We do not find his comment persuasive. Dr. Hong did not explain why, if claimant's 1987 injuries caused her degenerative disc disease, none of the medical reports indicated claimant's degenerative conditions were causing her symptoms until June 1995. Although claimant's 1987 MRI referred to degenerative cervical conditions, her lumbar MRI was within normal limits. (Ex. 1B). As discussed earlier, the medical reports after claimant's January 1987 injury and prior to the December 24, 1991 acceptance of "neck/shoulder/arm syndrome" did not attribute her symptoms to degenerative disc disease. In fact, in his 1989 reports, Dr. Wayson did *not* believe that claimant's degenerative findings were the basis of her symptoms and he did not believe the 1987 injury had caused her cervical and lumbar degenerative disc disease. (Exs. 1D, 1F). We find that Dr. Hong's comment that process" of claimant's degenerative disc disease "has been noted since her work injury of 1987" is not accurate. Moreover, the first medical report linking claimant's degenerative disease to her January 1987 injury was Dr. Kay's June 21, 1995 report. (Exs. 13-1, 18-2). Dr. Hong's conclusory opinion lacks adequate explanation and is insufficient to establish that claimant's 1987 compensable injuries were the major contributing cause of her degenerative disc disease.

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[1] To the extent that claimant's testimony at hearing is inconsistent with these reports, we find that the contemporaneous medical records are more reliable.

Likewise, the remaining medical opinions on causation are not sufficient to establish compensability of claimant's degenerative conditions. Dr. Wayson did not believe claimant's injury was the cause of her degenerative disc disease. (Ex. 1F). Dr. Marble examined claimant on December 14, 1998. Although he believed her ongoing complaints were indicative of a degenerative disease process (Ex. 23-8), he could not relate her current complaints in a causal way to the 1987 injury. (Ex. 23-9). Dr. Marble did not believe the 1987 injury produced pathology that would produce her ongoing complaints. (*Id.*) Dr. Baum, who began treating claimant in 1998, concurred with Dr. Marble's report. (Ex. 24).

In sum, we agree with the ALJ that claimant has not sustained her burden of proving compensability of her current back and neck conditions, diagnosed as degenerative disc disease.

ORDER

The ALJ's order dated June 8, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's order, which upheld the insurer's denials of claimant's current neck and back conditions. I believe the majority has erred in concluding that the rule in *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), does not apply to this case. I also disagree with the majority's interpretation of the medical evidence. For these reasons, I respectfully dissent.

I agree with claimant that the insurer's acceptance of her "neck/shoulder/arm syndrome" precludes it from denying compensability of her underlying cervical degenerative disc disease. By definition, the insurer's acceptance of a "syndrome" is an acceptance of a symptom of claimant's underlying degenerative disc disease and not a separate condition. The insurer is now precluded from denying compensabiity of the underlying cervical degenerative disc disease. The *Piwowar* case does not require that there be evidence to establish that a condition was a factor at the time the insurer accepted compensability of a symptom of the underlying disease. I agree with claimant that the lack of evidence establishing a link between the symptoms and the underlying condition at the time of acceptance is irrelevant.

Furthermore, I agree with claimant that the opinions of her attending physicians, Drs. Gore, Kay and Hong, establish compensability of her current back condition. The medical evidence establishes that the degenerative condition in claimant's spine exists as a direct result of the January 15, 1987 injury. Therefore, claimant need only prove that the January 1987 injury is a material cause of her degenerative disease. *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

Dr. Gore was initially responsible for treating claimant's problems associated with the January 1987 injury and he treated her until March 1993. Dr. Gore was consistent in his opinion that claimant's back problems were the result of the January 15, 1987 work injury. (Exs. 1HA, 3A, 6A, 6B).

Dr. Kay became claimant's attending physician in March 1993 and treated her until he retired in August 1998. He described claimant's back problems as degenerative disease of the spine with chronic cervicothoracolumbar strain and he also attributed her condition to the January 1987 work injury. (Exs. 13, 13A, 13B, 14, 16A, 18-4, 18-5, 20, 22).

Claimant was also treated by Dr. Hong. Based on his evaluation of claimant and a review of the extensive charts relating to her treatment, Dr. Hong concluded that claimant had degenerative disc disease of the spine, which was caused by the January 1987 work injury. (Ex. 29). He specifically opined that claimant's work-related injuries of 1987 had not resolved and the injuries had resulted in degenerative disease of the spine. (Ex. 29-3).

In sum, I agree with claimant that her cervical degenerative disease is a compensable component of her January 15, 1987 injury based on the insurer's acceptance of her "neck/shoulder/arm syndrome." I believe that the preponderance of medical evidence establishes that claimant's continued low back problems are the direct result of the January 15, 1987 injury. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
JEFFREY B. KELLEY, Claimant
WCB Case No. 99-00796
ORDER ON REVIEW
Lawrence A. Castle, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Johnson's order that awarded claimant 23 percent (73.6 degrees) unscheduled permanent disability for his low back condition and 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of the right leg, whereas an Order on Reconsideration awarded no permanent disability. On review, the issues are extent of unscheduled and scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

We adopt the ALJ's "Opinion" on the issue of unscheduled permanent disability.

Scheduled permanent disability

The ALJ noted that "claimant has specifically stated he is not seeking an award for any scheduled body part". Opinion and Order, pg. 9. Nevertheless, the ALJ concluded that claimant's leg problems arose from his accepted low back condition, and therefore, an award of scheduled permanent disability was appropriate. The ALJ relied on several cases, including *Leslie J. Kasterko*, 49 Van Natta 1330 (1997); *Alvena M. Peterson*, 47 Van Natta 1331 (1995). The ALJ cited the cases for the proposition that, if an injury to an unscheduled portion of the body results in disability to both unscheduled and scheduled portions, a claimant is entitled to separate disability awards.

We agree with the ALJ that the cases stand for the proposition cited above. However, we find those cases to be distinguishable from the present case. Specifically, in the cases cited by the ALJ, the issue of scheduled permanent disability was raised at hearing and was litigated by the parties. In the present case, however, claimant expressly limited the issue to extent of unscheduled permanent disability.[1]

We have previously held that an ALJ's review at hearing is limited to issues that the parties raised. *See Nikki Burbach*, 46 Van Natta 265, 268 (1994). We have also held that, where the claimant did not challenge the Department's award of permanent disability for loss of sensation and where the claimant confined his argument to a request for an increased loss of strength award, the ALJ erred by addressing the sensory loss issue and by awarding impairment for a chronic condition. *See Leodegario M. Gomez-Martinez*, 51 Van Natta 1251 (1999).

Accordingly, because the issue at hearing was limited to extent of unscheduled permanent disability, we conclude that the ALJ should not have addressed a scheduled permanent disability issue and granted such an award.[2] We therefore reverse the ALJ's award of scheduled permanent disability.

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[1] On review, claimant does not disagree with the ALJ's framing of the issue at hearing as being limited to the sole issue of extent of unscheduled permanent disability. Rather, claimant contends that "the ALJ correctly proceeded to evaluate the scheduled disability that resulted from the compensable condition." Respondent's Brief, pg. 5.

[2] We also agree with the employer that it would be fundamentally unfair to address an issue that had not been raised by a party as the opposing party was not allowed an opportunity to present argument regarding that issue. *See Eileen F. Roberts*, 47 Van Natta 2219 (1995); *Donald A. Hacker*, 37 Van Natta 706 (1985) (Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue; such an opportunity does not exist if there is no notice that the issue is in controversy).

Attorney Fee

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of extent of unscheduled permanent disability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the issue of extent of unscheduled permanent disability is $750, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 26, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of the right leg is reversed. The Order on Reconsideration award of zero percent scheduled permanent disability is reinstated and affirmed. Claimant's out-of-compensation attorney fee, insofar as it is payable from the ALJ's scheduled permanent disability award, is also reversed. The remainder of the ALJ's order is affirmed. For services on review concerning the issue of unscheduled permanent disability, claimant's counsel is awarded an assessed attorney fee of $750, to be paid by the self-insured employer.

December 8, 1999 Cite as 51 Van Natta 1956 (1999)

In the Matter of the Compensation of
VERNA M. BOLIN, Claimant
WCB Case No. 99-0001M
OWN MOTION ORDER
Welch, Bruun & Green, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer initially submitted a request for temporary disability compensation for claimant's compensable cervical condition. Claimant's aggravation rights on that claim expired on April 13, 1993.

On December 31, 1998, the employer denied the compensability of and responsibility for claimant's current condition. Claimant requested a hearing. (WCB Case No. 99-01345). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated June 8, 1999, Administrative Law Judge (ALJ) Menashe upheld the employer's December 31, 1998 denial. Claimant requested Board review of ALJ Menashe's order, and in an order issued on today's date, the Board affirmed ALJ Menashe's order.

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

Here, the current condition and ensuing medical treatment for which claimant requests own motion relief remains in denied status. 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
BILLIE L. LORE, Claimant
WCB Case No. 98-07370
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
James B. Northrop (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) set aside its denial of claimant's current cervical condition; and (2) assessed a penalty for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation. At the beginning of the first full paragraph on page 2, we add the following: "On February 25, 1997, SAIF accepted a disabling cervical strain. (Ex. 17)." In the last paragraph on page 2, we change the date to "May 17, 1999." We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant compensably injured her neck on November 14, 1996. (Ex. 3). SAIF accepted a disabling cervical strain. (Ex. 17). In May 1997, Dr. Buza diagnosed C6 radiculopathy with C5-6 spurring and degenerative disc disease. (Ex. 25). Dr. Buza performed an anterior cervical discectomy and fusion on May 21, 1997. (*Id.*) On February 10, 1998, SAIF modified its acceptance of claimant's claim as follows:

> "Your otherwise compensable cervical strain injury of November 14, 1996, combined at that time with one or more preexisting conditions including, but not limited to, preexisting degenerative disc disease at C5-6, moderate to severe, with desiccation, narrowing, and posterior osteophytes, with bilateral neuroforminal narrowing, right more than left. SAIF accepts this combined condition so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability and/or the need for treatment of the combined condition." (Ex. 37).

On September 9, 1998, SAIF wrote to claimant, indicating that the November 14, 1996 injury was no longer the major contributing cause of her cervical strain combined with preexisting degenerative disc disease at C5-6. (Ex. 48). SAIF said the preexisting condition had become the major contributing cause of claimant's combined condition on August 19, 1998. (*Id.*) SAIF issued a denial of claimant's "current disability and need for treatment effective 8/19/98 and forward." (*Id.*)

Citing ORS 656.005(7)(a)(B), the ALJ relied on Dr. Buza's opinion and concluded that claimant's November 1996 injury was the major contributing cause of her current reduced range of cervical motion (*i.e.* disability) of the combined condition.

SAIF argues that the ALJ erred by applying ORS 656.005(7)(a)(B) instead of ORS 656.262(6)(c). SAIF contends that Dr. Buza's opinion establishes that claimant's 1996 work injury is no longer the major contributing cause of her combined condition. For the following reasons, we agree with SAIF.

In *Croman Corp. v. Serrano*, 163 Or App 136, 140-41 (1999), the court concluded that in order for a carrier to have properly issued a preclosure denial under ORS 656.262(6)(c) and ORS 656.262(7)(b), the carrier must have accepted a combined condition. Here, SAIF modified its acceptance to accept a cervical strain injury combined with preexisting conditions, including degenerative disc disease at C5-6. (Exs. 37, 39). Because SAIF accepted a combined condition, it may properly issue a "preclosure" denial under ORS 656.262(6)(c), which provides:

> "An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

Claimant asserts that ORS 656.262(6)(c) requires a change in her condition or a change in circumstances. She argues there was no change in her accepted combined condition after September 17, 1997. We disagree.

In *Gregory C. Noble*, 50 Van Natta 1469 (1998), *aff'd mem Liberty Northwest Ins. Corp. v. Noble*, 159 Or App 426 (1999), we found that the evidence challenging compensability of the claimant's current right knee condition merely addressed the same condition previously denied and did not suggest that the compensable work injury "was no longer" the cause of the condition. *Compare Evelyn A. Bursell*, 51 Van Natta 373 (1999) (medical evidence indicated that the claimant's compensable injury had ceased to be the major contributing cause of her current combined condition). Unlike *Noble*, we find that the medical evidence establishes that claimant's compensable injury is no longer the major contributing cause of her current combined cervical condition.

The only medical opinion on causation is from Dr. Buza, claimant's attending physician, who performed her May 21, 1997 cervical surgery. Claimant contends that her only disability from the accepted combined condition is reduced range of cervical motion. She relies on Dr. Buza's opinion that this limitation is due to the May 21, 1997 cervical surgery. According to claimant, the sole cause of her current combined condition is her compensable surgery. We disagree with claimant's interpretation of Dr. Buza's opinion.

In February 1998, Dr. Buza agreed that claimant's November 14, 1996 injury was the major cause of her need for cervical surgery. (Ex. 35-2). Dr. Buza determined that claimant was medically stationary from the November 1996 injury on September 17, 1997. (Ex. 44). On August 19, 1998, Dr. Buza agreed that claimant's November 14, 1996 injury was no longer the major contributing cause of her combined cervical condition. (Ex. 47). He reported on November 25, 1998 that claimant's "symptoms seem to be pre-existing and her complaints now are probably because of previous degenerative changes." (Ex. 49).

On December 1, 1998, Dr. Buza reported that claimant was complaining of severe headaches and neck pain. (Ex. 51). He recommended a bone scan and x-rays. (*Id.*) On December 9, 1998, Dr. Buza said claimant's bone scan was negative and the x-rays showed the bone plug was in an excellent position. (*Id.*) He believed there was no reason to consider claimant's current complaints to be secondary to her injury and he felt they were "reflective of musculoligamentous type strain and/or degenerative changes[.]" (*Id.*) Dr. Buza said that claimant's injury had healed and there was no treatment necessary for the injury. Rather, the reason for her treatment was her preexisting condition. (*Id.*)

In a concurrence letter from SAIF signed on December 10, 1998, Dr. Buza agreed that after claimant's cervical surgery, her cervical condition had improved, the fusion was solid and she had minimal symptoms. (Ex. 50-2). He agreed claimant was currently being seen for cervical problems that were unrelated to her previous cervical nerve root condition or cervical strain. (*Id.*) Rather, Dr. Buza agreed that the major contributing cause of claimant's current need for medical treatment and disability was her preexisting cervical degenerative condition. (*Id.*) He relied on the fact that claimant had initially had a good recovery after her cervical surgery and then developed subsequent ongoing cervical problems. (*Id.*)

In a deposition, Dr. Buza testified that, until September 17, 1997, he believed that claimant's work injury was the major contributing cause of her condition. (Ex. 52-6). Dr. Buza said his treatment provided after September 17, 1997 was not related to the injury, the surgery or post-surgery residuals. (Ex. 52-3). He explained that, when he examined claimant in December 1998, he was initially concerned that her symptoms were related to her C5-6 surgery, possibly instability of the fusion. (Ex. 52-4). Based on the studies performed, however, he determined that the fusion area did not demonstrate any abnormalities. (Ex. 52-4, -5).

Dr. Buza explained that claimant's cervical surgery had been necessary to untrap the nerve root and he felt the surgery was successful. (Ex. 52-14). He said that C5-6 area was stabilized by the surgery and he did not believe that level was symptomatic any more because there was no motion. (Ex. 52-15, -16). He did not believe claimant's problems were coming from the same level. (Ex. 52-16, -17). Dr. Buza agreed that, at the time of claimant's compensable injury, she had preexisting cervical conditions that included degenerative disc disease at C5-6 with desiccation, narrowing and posterior osteophytes with bilateral neuroforaminal narrowing. (Ex. 52-10). He said that degenerative conditions are generally progressive. (Ex. 52-11). Dr. Buza felt claimant had the same underlying conditions as before, at other levels. (Ex. 52-15).

Dr. Buza agreed that claimant had decreased cervical range of motion as a result of her cervical surgery. (Ex. 52-6, 16). He said the surgery made her neck a "little stiff," but he felt it was "quite minor." (Ex. 52-15, -16). Dr. Buza agreed that the work injury was the major contributing cause of claimant's limited range of motion. (Ex. 52-18). Nevertheless, he explained that claimant's symptoms in December 1998 were related to degenerative disease of the cervical spine and were not related to her industrial accident and fusion. (Ex. 52-19).

Dr. Buza's recent reports and deposition testimony have consistently attributed claimant's current cervical symptoms to preexisting degenerative changes rather than the compensable injury. Based on Dr. Buza's opinion, we conclude that claimant's compensable November 1996 injury is not the major contributing cause of her current cervical condition. *See* ORS 656.262(6)(c). We are not persuaded by claimant's argument that the sole cause of her current combined condition is her compensable surgery. Consequently, we reverse the ALJ's order and uphold SAIF's denials.

Penalties

The ALJ assessed a penalty for SAIF's allegedly unreasonable denial. On review, we have determined that claimant's current cervical condition is not compensable. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated June 23, 1999 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award and penalty assessment are also reversed.

December 8, 1999 Cite as 51 Van Natta 1959 (1999)

In the Matter of the Compensation of
TRAP V. DANG, Claimant
WCB Case No. 98-06793
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis order that set aside its denial of claimant's injury claim for a current right hip condition. On review, the issue is compensability.

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

Even if Dr. Rabies opinion is materially consistent over time (or any inconsistencies are adequately explained), we agree with the ALJ that Dr. Jacobs causation opinion is more persuasive because it is more consistent with claimant's mild or minimal degenerative findings and his clinical history. (*See* Exs. 25, 44, 51, 52-3, 53, 56; *see also* Exs. 31, 34, 55-33).

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

ORDER

The ALJ's order dated June 21, 1999 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
RITA M. SPEARS, Claimant
WCB Case No. 98-05640
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

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

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

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 3, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority rejects the ALJ's finding that claimant and her witnesses were credible and it concludes that claimant failed to establish compensability of her right elbow condition. For the following reasons, I respectfully dissent.

Claimant testified that she woke up with a sore right elbow the day after she engaged in a few hours doing yard work, consisting of the gathering of twigs and other light debris and placing them in a small bucket, which she carried twenty feet to her compost pile. (Tr. 35, 37, 56). Claimant's supervisor, who was intimately familiar with claimant's work activities, testified that she thought that her condition was work-related.

Based on the minimal amount of light yardwork testified to by claimant, I find Dr. Fuller's conclusion that it caused claimant's condition unpersuasive, as his conclusion was based on his unsupported opinion that claimant strained a muscle by lifting something too heavy for her.

In contrast, Dr. Gritzka explains his opinion, and, rather than engaging in speculation about claimant's yard work activities, he considered her actual activities in concluding that "she gives no history of doing any unusual activity immediately prior to 3/18/98 while cleaning up her yard that could reasonably be expected to produce a lateral humeral epicondylitis." (Ex. 15-11). Finally, Dr. Rabie admits that both experts' opinions are reasonable, which is not a rejection of Gritzka's opinion. Accordingly, based on the record as a whole, I would find claimant's right elbow condition compensable.

In the Matter of the Compensation of
VICKI F. BROWN, Claimant
WCB Case Nos. 99-00335 & 98-08517
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Hoguets order that: (1) set aside its denial of claimant's injury or occupational disease claim for a low back strain; and (2) upheld the self-insured employer's denial of the same condition. On review, the issue is compensability.[1] We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has worked installing auto parts for the employer since 1986. She had 5 work-related low back injuries between July 1987 and August 1997.

Claimant experienced a gradual onset of low back and right leg soreness and aching on Friday, July 24, 1998. Then, while installing an auto alarm at the beginning of her work shift on Wednesday, July 29, 1998, claimant had increased low back pain and right sided symptoms from her right leg to her neck and right arm. She sought medical treatment and a low back strain was diagnosed.

The ALJ found claimant's claim compensable, based on the opinion of Dr. Lorish, treating physician.[2] We disagree.

Liberty argues that claimant is not credible due to inconsistencies in her reporting regarding off-work activities and the onset of her symptoms. Therefore Liberty contends that Dr. Lorishs history is suspect. Liberty also argues that Dr. Lorishs opinion is not persuasive because it is based on nothing more than the temporal relationship between claimant's work activities and the onset of her symptoms (and, because claimant is not credible, any such relationship is doubtful).

We need not address claimant's credibility, because we conclude that the claim fails even if she is credible.

Claimant has preexisting degeneration that contributes to her low back condition. (Exs. 120, 124,130, 131, 133, 135). Therefore, her condition is medically complex and she is subject to the major contributing cause standard of proof (under either ORS 656.005(7)(a)(B) or 656.802).

Dr. Lorish provides the only expert evidence supporting the claim. (*See* Exs. 130, 131, 137 *see also* Ex. 130a-1). Based on claimant's history of being reasonably pain free before the July 1998 work exposure and the temporal relationship between the onset of symptoms and claimant's July 1998 work, Dr. Lorish opined that the exposure of 1998 [] was the major contributor to the 1998 disability. (Ex. 137).

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[1] We do not reach the potential responsibility issue because we find that claimant's condition is not compensable.

[2] The ALJ deferred to Dr. Lorish, finding no persuasive reason to do otherwise. The ALJ also reasoned that the doctor considered all possible causes of claimant's condition and concluded that Dr. Lorishs opinion was sufficient to establish that claimant's work during Liberty's coverage was the major contributing cause of her current low back strain condition.

We do not rely on Dr. Lorish's opinion for two reasons. First, it is based on solely on the temporal relationship between claimant's work and her symptoms. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation may not be inferred from temporal relationship alone); *Pamela A. Burt* 46 Van Natta 415 (1994) (temporal relationship will not, by itself, satisfy claimant's burden of proof). Second, Dr. Lorish does not explain why claimant's 1998 work exposure contributes more to her current problems than does her degeneration. Considering claimant's numerous prior low back injuries and her contributory degeneration, we cannot say that Dr. Lorish opinion is adequately reasoned and we find it unpersuasive. *See Oreste A. Chorney*, 50 Van Natta 498, *on recon* 50 Van Natta 818 (1998) (Physician's opinion inadequately explained because he failed to weigh the contribution of the work injury as compared to the undisputed preexisting degeneration). Accordingly, in the absence of persuasive medical evidence supporting the claim,[3] we uphold Liberty's denial.

ORDER

The ALJ's order dated May 27, 1999 is reversed in part and affirmed in part. That portion of the order that set aside Liberty Northwest Insurance Corporation's denial is reversed. Liberty's denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

[3] We adopt the ALJ's finding that no persuasive evidence relates claimant's current condition to her work exposure with the self-insured employer.

December 9, 1999 Cite as 51 Van Natta 1962 (1999)

In the Matter of the Compensation of
JERAME J. CADEK, Claimant
WCB Case No. 98-07316
ORDER ON REVIEW
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of his left knee injury claim. With his briefs, claimant has submitted documents not admitted into evidence. We treat such submissions as a motion for remand. On review, the issues are compensability and remand.

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

Our review is limited to the record developed at hearing. ORS 656.295(5). Therefore, we treat claimant's post-hearing submission as a motion for remand to the ALJ for further development of the hearings record. *Judy A. Britton*, 37 Van Natta 1262 (1985). However, we may only remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

With his "briefs," claimant submitted a work shift calendar, a check stub, medical records, and a witness statement. There has been no showing, however, that these documents were not obtainable with due diligence at the time of the hearing. In any case, we find that none of the submitted documents is reasonably likely to affect the outcome of this case.

Accordingly, for these reasons, we deny claimant's motion for remand.

ORDER

The ALJ's order dated June 11, 1999 is affirmed.

In the Matter of the Compensation of
APRIL M. SCOTT, Claimant
WCB Case No. C992794
ORDER ON RECONSIDERATION
APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

On December 1, 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 rights to future workers' compensation benefits, except medical services, for the compensable injury.

Thereafter, we received claimant's attorney's addendum to the CDA, which provides the parties' explanation regarding the calculation of the proceeds, including the potential impact of claimant's life expectancy and the possible effect of an offset for social security benefits in the event that claimant had received permanent total disability benefits. The accompanying cover letter provides that the claimant and insurer's counsel have been provided copies of the addendum. The insurer has raised no opposition to claimant's submission. We treat the parties' addendum as a motion for reconsideration of the approved CDA.

In order to be considered, a motion for reconsideration of the approved CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Because the request for reconsideration was received within 10 days of the mailing of the order of approval, it is timely. OAR 438-009-0035(1). Thus, we grant the request for reconsideration.

We find that the agreement, as amended by the parties' addendum, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). We do not find any statutory basis for disapproving the agreement. *Id.* Accordingly, by this order, the CDA is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL A. KURZHAL, Claimant
WCB Case No. 98-09643
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that upheld the SAIF Corporation's denial of claimant's current mid and 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 denial, finding that the medical evidence did not establish that the compensable March 20, 1998 injury was the major contributing cause of claimant's current lumbar and thoracic condition or of his need for treatment of a "combined condition," consisting of preexisting degenerative disc disease and the compensable thoracolumbar strain. *See* ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *recon* 104 Or App 309 (1997), *rev den* 326 Or 389 (1998). In so doing, the ALJ rejected claimant's argument that his current back condition consists of separate lumbar and thoracic components that should be analyzed separately with respect to compensability. Instead, the ALJ reasoned that there was only one injury to the low and mid back, rather than two distinct conditions at issue.

On review, claimant contends that the ALJ's analysis was incorrect and that there were injuries to two separate areas of the spine, thoracic and lumbar. According to claimant, the two areas have different pathology. Thus, claimant argues that it was inappropriate to combine them for the purposes of evaluating the validity of SAIF's denial. For the following reasons, we disagree with claimant's contentions.

SAIF originally accepted a thoracic strain as a result of the compensable March 20, 1998 injury. Claimant's attending physician (Dr. Schepergerdes) however, concurred with the reports of two examining physicians (Drs. Arbeene and Staver), both of whom diagnosed thoracolumbar strain. (Exs. 8-5, 10, 12-5, 13). A medical arbiter, Dr. Filarski, also diagnosed a thoracolumbar stain. (Ex. 17A-4). SAIF eventually modified its acceptance to accept the thoracolumbar strain. (Ex. 21).

Having reviewed this record, we find that this medical evidence establishes that the compensable condition is "thoracolumbar strain" and that there was only one injury to claimant's mid and low back, which cannot be divided into separate lumbar and thoracic components. Thus, we agree with the ALJ's determination that the lumbar and thoracic components should not be analyzed separately with respect to compensability. Finally, for the reasons cited by the ALJ, we agree that claimant's current mid and low back condition is not compensable.

ORDER

The ALJ's order dated July 6, 1999 is affirmed.

In the Matter of the Compensation of
AARON D. TODD, Claimant
WCB Case Nos. 98-09863 & 98-05708
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denials of his occupational disease claim for his low back condition. On review, the issue is compensability.

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

On review, claimant contends that the ALJ erred by not relying on the opinion of his treating physician, Dr. Berkeley. Dr. Berkeley believed that, even though claimant had a preexisting low back condition and had been in a motorcycle accident in 1985 (resulting in an L1 compression fracture) and had been in two motor vehicle accidents and other nonwork accidents, the work activities he performed as a deputy sheriff were the major cause of his current need for treatment. (Ex. 64).

After reviewing the expert medical opinions in the record, we agree with the ALJ that claimant has failed to meet his burden of proving a compensable occupational disease claim. Specifically, as the ALJ noted, Dr. Farris, who examined claimant on behalf of the employer, was the only doctor to review claimant's prior x-rays before giving an opinion on causation. Dr. Farris concluded that, based on claimant's earlier x-rays, 60-70 percent of the degeneration of claimant's disc had taken place by 1990. (Ex. 53, 61). Although claimant argues that Dr. Farris's reading of the x-rays is inconsistent with the interpretation of the radiologists who reviewed the films at the time they were taken, there is no expert opinion to support claimant's contention. In other words, Dr. Berkeley (who conceded at the time of deposition that he had not previously reviewed claimant's films) did not discuss or reject Dr. Farris's measurement of claimant's disc height narrowing. (Ex. 64).

Moreover, Dr. Berkeley admitted that, in arriving at his opinion, he did not have sufficient information to evaluate the extent to which the nonwork 1990 motor vehicle accident contributed to claimant's condition. (Ex. 64-51). Dr. Berkeley also acknowledged that he was not informed about the details of claimant's ladder accident in 1997 and a skiing injury in that same year. (Ex. 64-52, 53). Under such circumstances, we conclude that Dr. Berkeley has not provided a persuasive opinion regarding causation. *See Somers v. SAIF*, 77 Or 259 (1986).

Finally, in analyzing the contribution of the February 1998 work incident to claimant's current condition, Dr. Berkeley stated that the incident was the "proverbial straw that breaks the camel's back." (Ex. 64-68). However, the fact that a work injury is the immediate or precipitating cause of a claimant's disability or need for treatment does not necessarily mean that the injury is the major cause of the disability/treatment for the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995); *R. K. Lock*, 51 Van Natta 128 (1999).

Therefore, we agree with the ALJ that claimant has failed to meet his burden of proof and we affirm the ALJ's order.

ORDER

The ALJ's order dated July 7, 1999 is affirmed.

In the Matter of the Compensation of
TODD J. MARTHOSKI, Claimant
Own Motion No. 99-0388M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable right inguinal hernia condition. Claimant's aggravation rights expired on June 30, 1999. SAIF opposes authorization of temporary disability compensation, contending that: (1) it is unknown whether claimant's current condition requires surgery and/or hospitalization; (2) SAIF is unable to confirm whether the current condition is causally related to the accepted condition; (3) SAIF is not responsible for claimant's current condition; (4) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (5) claimant was not in the work force 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.*

On June 24, 1999, claimant was examined by Dr. Jendre, his attending physician, complaining of right groin pain.[1] Dr. Jendre referred claimant to a surgical specialist. SAIF contends that, because of claimant's failure to follow-up with the surgical specialist, it is unable to determine: (1) whether claimant's current condition is causally related to the accepted injury; or (2) whether his current condition requires surgery or hospitalization. Additionally, SAIF contends that because claimant has failed to respond to its request for work force information, he was not in the work force at the time of his current disability.[2]

Thus, the issues of whether claimant's current right groin condition is related to his compensable right inguinal hernia condition and whether that condition requires surgery or hospitalization remain unresolved at this time. Under such circumstances, we are not authorized to reopen claimant's 1994 injury claim for the payment of temporary disability benefits.[3] *See* ORS 656.278(1)(a). Should claimant's circumstances change, and SAIF accepts responsibility for claimant's current condition, claimant may again seek own motion relief.[4]

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[1] Dr. Jendre submitted an 827 form (a "First Medical Report for Workers' Compensation Claims" form) that was date-stamped as received by SAIF on July 1, 1999. Dr. Jendre's June 24, 1999 chart note was date-stamped as received by SAIF on August 30, 1999.

[2] On October 26, 1999, the Board requested claimant's position regarding SAIF's compensability and work force contentions. The Board requested that claimant's position be received within 21 days from the date of the letter. Inasmuch as the 21 day period has expired without receipt of any response from claimant, we have proceeded with our review.

[3] Our jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. We do not, in our Own Motion authority, have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries excepted). Rather, jurisdiction over these disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 or with the Director under ORS 656.245, 656.260 or 656.327. *See Gary L. Martin*, 48 Van Natta 1802 (1996).

[4] The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial body. The Board cannot extend any advice to claimant. However, because claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. Claimant may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97310

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DENNIS J. MINTEN, Claimant
WCB Case No. 98-0230M
OWN MOTION ORDER ON RECONSIDERATION
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer requests reconsideration of our June 3, 1998 Own Motion Order that authorized reopening of the claim to provide temporary total disability compensation beginning March 5, 1998. The insurer contends that claimant did not undergo surgery until October 13, 1998, and requests that we issue an amended order reflecting authorization of temporary disability compensation to begin on October 13, 1998.

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

Claimant has an accepted injury claim for lacerations of his right middle and ring fingers. The insurer contends that claimant did not undergo surgery on March 5, 1998, the date the surgery was initially scheduled. In support of its position, the insurer submits a copy of the OHSU operative report, which is dated October 13, 1998. That operative report indicated that the surgery was performed by Dr. Seyfer, Chairman, Division of Plastic and Reconstructive Surgery, who was assisted by Dr. Amsberry, Resident, Plastic Surgery. The report described a surgical repair to the nail bed of claimant's right ring finger. It indicated that, although the laceration to claimant's right ring finger nail bed had been repaired previously, claimant still had a split fingernail and had problems with the growth of that fingernail. It described the current surgical procedure, which involved placing a tourniquet on claimant's right upper arm, with a digital block administered to his right ring finger. Thereafter, the nail bed was surgically repaired. The total tourniquet time was listed as approximately 20 minutes.

In response to the insurer's contentions, claimant agreed that he did not undergo surgery on March 5, 1998. He stated that March 5, 1998 was the "date I was supposed to have surgery. It was postponed because I would of had to pay from [sic] expense before surgery." Claimant contends, however, that he underwent surgery on October 12, 1998, rather than on October 13, 1998. In support of his contention, claimant submits a copy of a work release signed by Dr. Amsberry on October 12, 1998, and releasing him from work beginning that date. Claimant contends that, although almost all of the medical records from the hospital indicate that the surgery occurred on October 13, 1998, his work release was completed on the date of surgery and is dated October 12, 1998. Thus, claimant argues that this work release establishes that his surgery occurred on October 12, 1998.

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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."

In extraordinary circumstances, we may, on our own motion, reconsider a prior order. OAR 438-012-0065(2). Here, the parties agree and the supplemented record confirms that our prior order authorized temporary disability compensation to begin before the date claimant was hospitalized for surgery. Under these circumstances, 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.

Claimant's aggravation rights on his compensable right hand injury expired on August 22, 1996. Under ORS 656.278(1)(a), we are limited in our authority to authorize the payment of temporary disability compensation to begin from the time claimant *actually* undergoes surgery or is hospitalized. Here, the insurer alleges that claimant did not undergo surgery until October 13, 1998 and submits an operative report reflecting that date. On the other hand, claimant contends that he *actually* underwent surgery on October 12, 1998 and submits a work release form, releasing him from work effective October 12, 1998, and signed and dated by Dr. Amsberry on that same date.

We find that the operative report establishes that claimant's right hand surgery took place on October 13, 1998. Furthermore, there is no indication that claimant was hospitalized the day before the date the surgery actually took place. The description of the surgery, without more, would not support a finding that claimant was hospitalized the day before the surgery actually took place. In this regard, operative reports shows that the surgery was limited to claimant's right ring finger, took place under a local anesthetic, *i.e.*, a "digital block," and was completed in about 20 minutes. Additionally, the fact that claimant was released from work on October 12, 1998 does not establish that the surgery took place on that date. As explained above, we are limited by statute to awarding temporary disability compensation beginning the date a claimant *actually* undergoes surgery or is hospitalized. Therefore, the date of claimant's work release does not support claimant's position.

On this record, we find that claimant *actually* underwent surgery on October 13, 1998, the date of the operative report. Therefore, temporary disability compensation is authorized to begin on October 13, 1998. ORS 656.278(1)(a).

Accordingly, our June 3, 1998 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our June 3, 1998 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
DELORIS A. KUBIK, Claimant
WCB Case No. C992714
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Biehl and Phillips Polich.

On November 15, 1999 the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, 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.

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 November 15, 1999. The statutory 30th day following the submission is December 15, 1999. Claimant filed a request for disapproval of the disposition on December 6, 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
CASEY L. BEIGHLEY, Claimant
WCB Case No. 97-04780
ORDER ON REVIEW
Black, Chapman, et al, 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) Stephen Brown's order that upheld the SAIF Corporation's denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

On October 15, 1996, claimant experienced low back pain while working. On November 8, 1996, claimant began treating with Dr. Peterson, orthopedic surgeon.

The ALJ, applying ORS 656.005(7)(a)(B), found that claimant failed to prove that the compensable injury was the major contributing cause of claimant's need for treatment and disability. Consequently, the ALJ concluded that claimant did not prove compensability. Claimant continues to argue that, based on Dr. Peterson's opinion, he showed that the compensable injury was the major contributing cause of his need for treatment for four to six weeks following the October 15, 1996 event.

According to Dr. Peterson, claimant's preexisting back condition (consisting of a central herniated disc), combined with the October 15, 1996 event. (Exs. 18, 22-12). Based on such evidence, claimant must show that the major contributing cause of his need for treatment and disability of the combined condition is the compensable injury. *See* ORS 656.005(7)(a)(B).

During a deposition and in response to claimant's attorney's question whether the need for treatment at the time of the incident was caused in major part by the compensable injury, Dr. Peterson stated that he "guess[ed] that's a fair thing to say." (*Id.* at 12). Although also finding it "very subjective or arbitrary" to decide at what point the preexisting condition became the major contributing cause, Dr. Peterson stated that, "if I had to put a point in time, somewhere in the neighborhood of four to six weeks after his lifting injury[.]" (*Id.*)

Claimant relies on this portion of the record in arguing that he proved compensability for the four to six week period following the October 1996 incident. Claimant's argument would be more persuasive if this was the extent of Dr. Peterson's opinion, which also included two reports generated before the deposition.

Dr. Peterson first reported that his diagnosis was "symptomatic central disc protrusion L5-S1, with radicular pain." (Ex. 18-1). He also stated that he did not believe that claimant's "current symptoms are due to a strain." (*Id.*)

After reviewing prior CT and MRI scans and comparing them to the most recent MRI scan, Dr. Peterson reported that "the major contributing cause for his need for treatment is his preexisting L5-S1 central HNP." (Ex. 19). Dr. Peterson also stated that the October 1996 injury "may have aggravated this underlying condition[.]" (*Id.*)

Furthermore, during the deposition and following the statements relied upon by claimant, Dr. Peterson explained that "certainly from the time I had first examined him * * * it was pretty clear then that this was not just a short transient thing, and that his major cause for his symptoms were the preexisting conditions." (*Id.* at 14). Dr. Peterson was then asked whether, during the four to six weeks following the October 1996 incident, the major contributing cause was the compensable injury, Dr. Peterson stated that the "symptoms which he was experiencing were more than the symptoms of a back strain[.]" (*Id.* at 16). Dr. Peterson added that "the way I look at this is there is an event which triggers some kind of increase in symptoms, somehow aggravates it[.]" (*Id.* at 17).

Except for the statements relied upon by claimant, Dr. Peterson consistently indicated that claimant was being treated for a "symptomatic" herniated disc and that the October 1996 incident only "aggravated" his preexisting condition. In light of these statements, we do not find the isolated comments relied upon by claimant to be sufficiently persuasive to carry claimant's burden of proof.[1]

ORDER

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

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[1] For instance, if we found that the compensable injury was the major contributing cause of claimant's need for treatment of his combined condition for the four to six weeks following the incident, it would directly contradict Dr. Peterson's later statement that the preexisting condition "certainly" was the major contributing cause when he first examined claimant on November 8, which is about *three* weeks after the October 1996 incident.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not carry his burden of proving a compensable condition for at least the six weeks following the October 15, 1996 injury.

During his deposition, Dr. Peterson explicitly stated that the underlying condition was the major cause of continued symptoms about four to six weeks after the lifting injury. (*Id.*) Based on such evidence, I would find that claimant proved that the compensable injury was the major contributing cause of his condition for four to six weeks following the October 15, 1996 injury. Thus, I would set aside the denial to this extent.

Because the majority comes to a different conclusion, I dissent.

In the Matter of the Compensation of
CAROL A. LUMBY, Claimant
WCB Case No. 98-07235
ORDER ON REVEIW
Richard M. Walsh, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

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

We adopt and affirm the ALJ's well-reasoned order.

ORDER

The ALJ's order dated May 14, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's reliance on Dr. Button and would, instead, defer to claimant's treating physician, Dr. Hoda. Dr. Hoda identified lifting of cans with her forearm in pronation as the work activity that caused claimant's condition whereas Dr. Button focused solely on whether claimant's job duties were repetitive in nature. Dr. Hoda's opinion is more consistent with claimant's testimony than that of Dr. Button. In this regard, claimant testified that lifting and pulling on the job was the thing that bothered her. (Tr. 32). For this reason, I would rely on Dr. Hoda's opinion and would set aside the denial.

In the Matter of the Compensation of
CHRISTINE M. FLAHERTY, Claimant
WCB Case No. 98-09062
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) Myzak's order that reduced claimant's scheduled permanent disability (PPD) award of 6 percent (9 degrees) for the loss of use and function of the left leg (knee), as awarded by an Order on Reconsideration, to 5 percent (7.5 degrees). On review, the issue is extent of scheduled permanent disability.[1] We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the factual and procedural background of the claim. Claimant compensably injured her left knee on January 26, 1997. SAIF accepted a "left anterior cruciate ligament tear." Dr. Macha, attending surgeon, reconstructed the ligament on August 22, 1997. On May 27, 1998, Macha performed a closing examination and declared claimant medically stationary. (Ex. 5). SAIF closed the claim by a June 23, 1998 Notice of Closure that awarded 17 percent scheduled PPD for the left knee. (Ex. 7).

On August 18, 1998, claimant requested reconsideration. On the "Request for Reconsideration" form, she checked the boxes indicating that she disagreed with the medical impairment findings and the rating of scheduled permanent partial disability. (Ex. 8).

An arbiter panel consisting of Drs. Green, Baker and Coletti examined claimant on October 10, 1998. (Ex. 10). Based on the arbiter panel's report, the November 9, 1998 Order on Reconsideration reduced claimant's scheduled permanent disability award to 6 percent for the *right* knee. (Ex. 11-3).

Claimant requested a hearing. On her request for hearing form, claimant indicated that she was requesting a hearing regarding the Order on Reconsideration, specifically including the scheduled permanent disability award. SAIF neither submitted a "Response to Issues" nor cross-requested a hearing.

Prior to the February 10, 1999 hearing date, the parties agreed to have the case tried on the record with written closing arguments. In her closing argument, claimant, relying on Dr. Macha's findings, requested reinstatement of the Notice of Closure. In its closing argument, SAIF contended that the Appellate Review Unit (ARU) appropriately relied on the arbiter panel's findings to evaluate

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[1] *See* Opinion and Order at 1, fn 1. On review, the parties agreed that the Order on Reconsideration inadvertently referred to the uninjured right knee rather than to the injured left knee.

claimant's injury-related impairment, while noting that the ARU inadvertently ordered the award of compensation for the *right* knee. SAIF requested that the ALJ correct the error and affirm the Order on Reconsideration "in all respects including the 6% total scheduled PPD for the *left* leg (knee)." (Emphasis added). Nonetheless, at a later point in its written closing argument, SAIF challenged the ARU's evaluation of claimant's permanent impairment, contending that the Order on Reconsideration's award of 6 percent scheduled permanent disability for the left knee should be reduced to 5 percent.

The ALJ found that claimant's accepted condition involved her left knee,[2] *i.e.*, that the Order on Reconsideration awarded 6 percent scheduled permanent disability for the left knee. Relying on the arbiter panel's range of motion findings, the ALJ reduced the Order on Reconsideration's award of 6 percent scheduled permanent disability to 5 percent.

On review, claimant first argues that we should rely on the findings of Dr. Macha, her attending physician, rather than the arbiter panel, to establish the extent of scheduled permanent disability for her left knee. Alternatively, in the event that we find that Dr. Macha's opinion does not establish the preponderance of evidence regarding the extent of scheduled permanent disability, claimant contends that SAIF is barred from arguing a reduction from the Order on Reconsideration's award. We agree with the ALJ's reasoning regarding the medical opinions. But we also agree that SAIF is barred from arguing a reduction from the 6 percent awarded by the Order on Reconsideration. We reason as follows.

Claimant contends that the medical arbiter panel's findings are "inherently suspect" because it reported greater range of motion in the left injured knee than in the right non-injured knee. We disagree.

Although Dr. Macha, claimant's attending physician, noted reduced range of motion in left knee extension when he declared claimant medically stationary in May 1998 (Ex. 5), five months later the arbiter panel found anterior cruciate instability on the left, 0 degrees of full extension bilaterally to 132 degrees of flexion on the right and 135 degrees of flexion on the left. Moreover, the arbiter panel's instructions required it to make findings of impairment "resulting from the accepted condition(s)" (Ex. 9-2), and the panel specifically indicated that claimant's findings (including "active (unassisted) ranges of motion [of both knees] expressed in retained degrees of flexion and extension") were valid. (Exs. 9-2; 10-2).

Under these circumstances, including the fact that the panel's findings were rendered five months after the findings made by Dr. Macha and shortly before the Order on Reconsideration, we find the arbiter panel's findings more persuasive.[3] Accordingly, we disagree with claimant's contention regarding the extent of her permanent disability. Nonetheless, we further conclude that the ALJ's further reduction of claimant's scheduled permanent disability below the 6 percent granted by the Order on Reconsideration was inappropriate.

In reaching this determination we conclude that SAIF cannot now argue for a reduction of the 6 percent scheduled permanent disability granted by the Order on Reconsideration. *See Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605 (1995); *Guilebaldo G. Ramirez*, 50 Van Natta 654, *recon* 50 Van Natta 863 (1998). In *Duncan*, the court explained preservation of issues under the "ORS 656.283(7)" reconsideration process:

> "Claimant asserts, and we agree, that employer is barred from challenging the determination order award at a hearing because it did not seek reconsideration. A party may seek review of the order on reconsideration, but when a party objects at a hearing to a part of the reconsideration order that merely affirms the determination order, the party's true objections are to the determination order and ORS 656.268(5) forecloses the objection if no request for reconsideration was made. Thus, the determination order

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[2] *Id.*

[3] The fact that the arbiter examination is performed closer in time to the reconsideration order is not always decisive. *E.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). In this case, however, given the five month gap between Dr. Macha's closing examination (in which he found a reduction in claimant's extension) and the arbiter panel examination (finding no reduction in claimant's extension, but evidence of instability), we consider the panel's findings (based on a thorough and well-reasoned explanation) to be more reflective of claimant's permanent impairment at the time of the November 9, 1998 Order on Reconsideration.

> becomes the instrument that defines the maximum or minimum awards when a party fails to raise its objections through a request for reconsideration. *However, if the reconsideration order changes the determination order, the propriety of that change can be raised by either party at a hearing.* In this case, the determination order served as a floor, and employer could not seek reduction of the temporary or permanent disability benefits below that level because it did not request reconsideration on those issues." *Duncan*, 133 Or App at 610-611 (emphasis added); *see Diane's Foods v. Stephens*, 133 Or App 707 (1995).

We applied the principle enunciated by the *Duncan* court in *Ramirez*. In *Ramirez*, a Determination Order awarded 5 percent scheduled permanent disability. The claimant requested reconsideration, seeking an increased award. The carrier did not raise the issue of permanent disability on reconsideration. The Order on Reconsideration reduced the claimant's scheduled award to 4 percent. The carrier requested a hearing, seeking reduction of the claimant's awards to zero. The ALJ reduced the scheduled award to zero.

Relying on *Duncan*, we concluded that, by virtue of its failure to seek Director reconsideration of the Determination Order, the carrier was precluded from arguing at hearing that the claimant was entitled to no permanent disability. We further concluded that the carrier was not precluded from defending the reconsideration order's 4 percent scheduled permanent disability award on review. Accordingly, we reinstated the Order on Reconsideration's 4 percent scheduled permanent disability, reiterating that the carrier was precluded from arguing for reduction of the claimant's scheduled award beyond the 4 percent "floor" established by its failure to request reconsideration of the Determination Order. *Ramirez*, 50 Van Natta 863, n 2.

Similarly, in this case a Notice of Closure awarded 17 percent scheduled PPD. Claimant requested reconsideration, seeking an increased award. SAIF did not request reconsideration.[4] The Order on Reconsideration reduced claimant's scheduled award to 6 percent. Claimant requested a hearing. In its closing argument, SAIF sought a reduction of claimant's award to 5 percent. The ALJ reduced claimant's scheduled permanent disability award from 6 percent to 5 percent.

We reinstate the Order on Reconsideration's award of 6 percent scheduled permanent disability for the loss of use and function of the left knee because SAIF was precluded from arguing for reduction of claimant's award below the 6 percent award because the Notice of Closure awarded 17 percent.[5]

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[4] There is no statutory authority allowing a carrier to request reconsideration of its own Notice of Closure.

[5] The ALJ relied on *Ricky D. Michael*, 51 Van Natta 673 (1999), to rule that SAIF was not barred from seeking a reduction of permanent partial disability despite not having submitted a cross-request for hearing. Claimant contends that the reasoning in *Michael* is flawed and should not be applied in this case. We find that *Michael* is inapposite and for that reason is not determinative.

In *Michael*, the question was whether the carrier's request for a reduction in the claimant's permanent disability award was a "new issue" raised for the first time in written closing arguments. We found that, by virtue of the claimant's hearing request, the issue of the extent of the claimant's unscheduled PPD had already been placed before the ALJ and was, therefore, not a "new issue" and could be considered by the ALJ. Thus, our order addressed only whether seeking reduction of PPD in a written closing argument when there has been no "hearing" was raising a "new issue." Our order in *Michael* does not address the *Duncan* "floor" issue.

In contrast, the issue in this case is whether SAIF is barred from challenging the Notice of Closure's 17 percent PPD award at a hearing because it did not seek reconsideration. The *Duncan* "floor" principle is just as applicable to Notices of Closure as it is to Determination Orders. Whether self-closed or administratively closed, the *Duncan* rationale supports a conclusion that a carrier cannot challenge an award to reduce it below the initial award when the carrier has not requested reconsideration. Thus, even without a cross-request for hearing (as in *Michael*), or even if SAIF's challenge to the permanent disability award in its written argument could be considered, SAIF is nevertheless barred from contending that the 6 percent scheduled PPD award should be further lowered, because the Notice of Closure served as a floor and SAIF cannot seek reduction of the permanent disability benefits below that level because it did not request reconsideration on that issue. *See Duncan*, 133 Or App at 610-11.

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 5 percent scheduled permanent disability granted by the ALJ's order and the 6 percent scheduled permanent disability granted by our order), not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055. In the event that compensation resulting from this order has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *aff'd on other grounds Volk v. America West Airlines*, 135 Or App 565 (1995), *rev den* 322 Or 645 (1996).

ORDER

The ALJ's order dated April 26, 1999 is reversed. The Order on Reconsideration awarding 6 percent (9 degrees) scheduled permanent disability for the loss of use and function of claimant's left leg (knee) is reinstated and affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event that this compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane Volk*.

December 15, 1999 Cite as 51 Van Natta 1974 (1999)

In the Matter of the Compensation of
DAVID H. FUHRMAN, Claimant
Own Motion No. 99-0212M
OWN MOTION ORDER ON RECONSIDERATION
Susak, Dean & Powell, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On May 21, 1999, the self-insured employer submitted claimant's claim for an alleged worsening of his March 29,1988 compensable bilateral shoulder condition. (Claim No. 88009191225). Claimant's aggravation rights on that claim expired on September 1, 1993. The employer recommended that the claim be reopened for own motion relief. On June 3, 1999, we issued an Own Motion Order that 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 the employer to close the claim pursuant to OAR 438-012-0055 when claimant became medically stationary.

Subsequent to the reopening of claimant's own motion claim, claimant requested a hearing on the employer's denial of his injury claim for a right shoulder injury with a date of injury of July 23, 1998. (WCB Case No. 99-05393). On November 5, 1999, Administrative Law Judge (ALJ) Kekauoha approved a "Stipulation and Order" which resolved the parties' dispute pending before the Hearings Division and dismissed claimant's hearing request. Specifically, the parties agreed, in part, that: (1) the employer would rescind its denial and issue a separate acceptance on the 1998 right shoulder injury claim (claim number 98003336225); and (2) as a result of the employer's acceptance of claimant's right shoulder condition as a new claim, that condition would be processed under the 1998 injury claim (claim number 98003336225), not the 1988 injury claim (claim number 88009191225).

On November 11, 1999, the employer requested that we withdraw our June 3, 1999 Own Motion order because claimant's current right shoulder condition was found to be compensable as a new injury claim under a different claim number. We treat the employer's request as a request for reconsideration.

A request for reconsideration of an Own Motion order must be filed within 30 days after the date the order was mailed, or within 60 days after the mailing date if the requesting party establishes good cause for failing to file the request within 30 days after the mailing date. OAR 438-012-0065(2). Under these guidelines, the employer's request is untimely. In extraordinary circumstances, however, we may, on our own motion, reconsider a prior order. *Id.*

Under the facts of this case we find that extraordinary circumstances exist that justify reconsideration of our prior order. In this regard, a "post-Own Motion Order" determination has been made that a new injury claim is responsible for the condition on which own motion relief was granted. 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).

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

In light of the parties' stipulation, we conclude that claimant's current right shoulder is compensable as a new injury claim. This new injury claim is still within its aggravation rights; therefore, we are without jurisdiction over the 1998 new injury claim. *See Miltenberger*, 93 Or App at 477. In addition, claimant's current right shoulder condition is unrelated to his March 1988 compensable injury. Thus, we are without authority to reopen claimant's 1988 claim. ORS 656.278(1)(a).

Accordingly, on reconsideration, we deny the request for own motion relief. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUDY L. MAGILL, Claimant
WCB Case Nos. 99-00277 & 98-07960
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of claimant's aggravation claim for a current low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her low back on November 11, 1993. Dr. Grewe performed a laminectomy and decompression bilaterally at L4-5 and L5-S1, with removal of a herniated nucleus pulposus at L5-S1 in August 1994. Claimant also had several nerve root block injections and epidural spinal injections for pain since her injury, but her intractable pain continued and worsened.

A January 8, 1998 Determination Order ultimately closed the initial injury claim[1] and a May 29, 1998 Order on Reconsideration awarded 36 percent unscheduled permanent disability for claimant's low back condition.

Dr. Grewe signed a Notice of Claim for Aggravation on August 10, 1998. The employer denied the claim on September 30, 1998. Dr. Grewe performed a lumbar laminectomy at L5, decompression of the nerve root bilaterally, and an interbody fusion on October 22, 1998.

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[1] A June 10, 1999 Board order set aside the initial January 8, 1997 claim closure as premature. *Judy L. Magill*, 51 Van Natta 926 (1999).

The ALJ upheld the employer's denial because, even assuming a pathological worsening, he could not say that any such worsening occurred *after* the January 8, 1998 Determination Order. The ALJ reasoned that claimant's current low back condition existed at the time of claim closure, including her collapsed lumbosacral disc space and an overriding of L5 on the sacrum. (*See* Ex. 90). Further noting that Dr. Grewe had proposed claimant's October 1998 low back fusion surgery before the January 1998 closure, the ALJ was unable to conclude that any worsening occurred after claim closure. We disagree.

ORS 656.273(1) provides, in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." Under the statute, a claim is reopened for an aggravation only if the actual worsening occurred "after the last award or arrangement of compensation[.]" Claimant must also prove "diminished wage-earning capacity" to establish a compensable aggravaton of her unscheduled condition. *Intel Corp. v. Renfro*, 155 Or App 447, 450 (1998).

In this case, claimant's low back condition is compensable. She has progressive low back degeneration and progressive loss of disc space at L5-S1, as well as the L5 overriding of the sacrum. The first issue is whether the condition has pathologically worsened. If it has worsened, the second issue is whether the worsening occurred after the January 1998 Determination Order. The third and final issue is whether claimant suffered diminished earning capacity due to her worsening.

We agree with the ALJ that claimant's collapsed disc space and "L5 overriding" conditions existed before claim closure. However, on this record, we also find that claimant's condition has worsened progressively over time. (Exs. 90, 92-1, 93-1, 95-1, 96-2, 103a, 105-3, 107-6, 109, 112-2, -5, 114a, 116). Considering claimant's progressive degeneration and Dr. Grewe's opinion as a whole, we further find that claimant's condition continued to worsen after claim closure.[2] Accordingly, based on Dr. Grewe's observations and findings, and the consistency between his surgical findings, claimant's symptoms and her progressive disability, we conclude that claimant has carried her burden of proving that her compensable condition pathologically worsened since the January 1998 Determination Order.

The remaining question is whether claimant has diminished earning capacity due to her worsened condition.

The employer argues that claimant has not suffered diminished earning capacity, because she "left work permanently" before her claim was closed and her earning capacity did not change since closure. Claimant responds that a finding of diminished earning capacity is not contingent on claimant's status in the work force, but rather on medical evidence relating to factors addressed by the standards. *See, e.g., Brian M. Eggman*, 51 Van Natta 398 (1999).

Claimant's residual functional capacity was in the "sedentary/light" range, with restrictions, at claim closure. (Ex. 88). Then, on June 29, 1998, after her condition worsened, Dr. Grewe indicated that claimant was unable to work. (Ex. 108). On this evidence, we find that claimant suffered diminished earning capacity since claim closure. *See Brian M. Eggman*, 51 Van Natta at 400. Accordingly, we conclude that claimant has proven her aggravation claim.

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 $4,700 payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services, the record, and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[2] The only evidence arguably contrary to Dr. Grewe's opinion is Dr. Schilperoort's belief that claimant's degenerative change is not sufficient to cause her reported pain. (Ex. 95-2). But Dr. Schilperoort also stated that he was unable to confirm *or rule out* an objective worsening. (Ex. 95-3). Moreover, considering Dr. Grewe's advantageous position as claimant's treating surgeon and his numerous opportunities to evaluate claimant over time, Dr. Schilperoort's uncertainty does not undermine our interpretation of Dr. Grewe's opinion to the effect that claimant's *condition* has worsened progressively.

ORDER

The ALJ's order dated July 2, 1999 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $4,700 attorney fee, to be paid by the employer.

In the Matter of the Compensation of
LAWRENCE L. NICHOLSON, Claimant
WCB Case No. 99-02133
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's opinion, with the following suppementation.

Relying on the opinion of claimant's attending surgeon, Dr. Gallo, the ALJ concluded that claimant's low back injury claim is compensable. The ALJ found that claimant's preexisting degenerative disc condition combined with his September 16, 1998 work injury to result in an L4-5 herniated disc and that the major contributing cause of claimant's combined condition and need for treatment was the work injury.

On review, SAIF contends that Dr. Gallo's opinion was insufficient to support compensability because her analysis was based on incomplete information and a temporal relationship. SAIF also contends that Dr. Gallo failed to sufficiently compare the contribution of the work injury with the preexisting condition to determine which was the primary cause of the combined condition or need for treatment as required under *Robinson v. SAIF*, 147 Or App 157 (1997). We disagree.

In order to establish the compensability of a combined condition, claimant must show that the work injury is the "major contributing cause" of the need for treatment or disability of his combined condition. ORS 656.005(7)(a)(B). In making that determination, we 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 (1997), *rev den* 326 Or 389 (1998); *Dietz v. Ramuda*, 130 Or App 397, 401 (1994). Because that evaluation involves a complex medical question, we generally rely on expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420, 424-26 (1967).

We agree with SAIF that a medical opinion that relies solely on a temporal relationship and 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*, 147 Or App at 162; *Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone). However, we must evaluate Dr. Gallo's opinion 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).

Here, Dr. Gallo rendered her second opinion regarding causation in response to three questions posed by claimant's attorney in a letter that provided a copy of Dr. Schilperoort's report and a more detailed history than that referenced in her January 25, 1999 Neurosurgical Initial Consultation report.[1] This history detailed claimant's pre-injury symptoms, his medical providers' assessments of his condition, and his worsened symptoms after the September 16, 1998 work injury. (Ex. 21). Claimant's attorney asked:

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[1] Although we agree with the ALJ that Dr. Gallo's January 25, 1999 opinion, standing alone, was insufficient because she relied on a history of no prior back or leg symptoms, this defect is cured in her second opinion.

"1. Dr. Schilperoort indicates, in his enclosed IME report, that [claimant's] 1998 fall on a logging-site landing area, 'is considered a low grade injury,' and, per Dr. Schilperoort, would not be expected to cause discal-type problems. Do you agree with Dr. Schilperoort's assessment of the mechanism of injury? Or, do you feel, within reasonable medical probability, that the described fall could cause - or could worsen pathology that was already present - a disc injury and/or a lumbar radiculopathy?

"2. Dr. Schilperoort opines that the 1998 fall at work did not cause any new diagnosable condition; consequently, Dr. Schilperoort reasons that pre-existing degenerative disease is the major cause of [claimant's] current low back condition and need for treatment. It does appear obvious that [claimant] had pre-existing degenerative disease in his lumbar spine (as you noted in your initial evaluation report) - he indicates, however, that his prior low back/lower extremity complaints were minor in nature, and that after his 1998 fall at work his problems intensified, precipitating more involved evaluation and treatment. Thus, it would appear that both pre-existing pathology and the 1998 fall at work combined to cause the present need for treatment. Do you agree with that assessment - specifically, within reasonable probability, do you believe it is likely that the 1998 fall at work was the major contributing cause (some degree greater than 50%) of a pathological worsening of [claimant's] pre-existing condition, and thus the major cause of his current combined low back condition?

"3) Finally * * *, please indicate: Within reasonable medical probability, do you feel [claimant's] fall at work in 1998 is the major contributing cause (some degree greater than 50%) of his current need for treatment with regard to his low back?"

These questions asked Dr. Gallo whether the mechanism of injury was sufficient to cause or worsen claimant's disc condition or radiculopathy and then to weigh the contribution of the work injury against claimant's preexisting condition. Although Dr. Gallo explained that it was less likely that claimant's slip-and-fall injury could cause a previously degenerative disc to herniate than a slip and fall from a log truck (her initial understanding), she averred that it was nevertheless the cause of claimant's disc herniation and need for treatment. Dr. Gallo based her evaluation of the causes of claimant's condition on the history that claimant had not been experiencing significant radicular symptoms until that injury, and that his radicular symptoms had increased in the same consistent distribution since that injury. Moreover, as discussed by the ALJ, the testimonies of claimant, his wife and the employer supported Dr. Gallo's opinion in all respects. Accordingly, we conclude that Dr. Gallo's opinion was not based solely on a temporal relationship and agree with the ALJ that the work injury was not only the precipitating cause but was also the primary cause of claimant's need for treatment for his combined 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 $2,000, 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 July 14, 1999 order is affirmed. For services on review, claimant's attorney is awarded $2,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
LISA A. PRITCHARD, Claimant
WCB Case Nos. 99-01289 & 99-00973
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's claim for a new left wrist injury. On review, the issue is compensability.[1]

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

The employer argues that the ALJ erred because he did not acknowledge that the June 1998 injury combined with claimant's preexisting de Quervain's condition and did not clearly apply the major contributing cause standard. The employer asserts that claimant's de Quervain's condition preexisted the June 22, 1998 injury and should be considered a preexisting condition and that the preexisting condition combined with the injury to cause claimant's disability or need for treatment. We agree with the employer that ORS 656.005(7)(a)(B) applies to this claim and write to clarify the ALJ's order.

Claimant was first injured at work on February 19, 1998 when a 65 pound box fell on her left wrist. Dr. Herman diagnosed "mild de Quervain's tendinitis." However, claimant filed a claim which was accepted by the employer's claims processor as a disabling left wrist contusion. The claim was closed by a June 9, 1998 Notice of Closure with an award of temporary disability benefits.

Claimant reinjured her left wrist at work on June 22, 1998 after lifting a 60 pound object with her left hand. The left wrist condition was diagnosed as de Quervain's tenosynovitis. Claimant filed a claim for the condition which the employer denied.

The ALJ did not specifically discuss the statute under which he analyzed the compensability issue; however, both parties agree that if the claim is analyzed as an injury, ORS 656.005(7)(a)(B) applies. Under that statute, claimant must prove that the compensable injury is the major contributing cause of her disability or need for treatment of the combined condition. 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 left wrist 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).

There are two opinions that address the cause of claimant's de Quervain's condition. Dr. Fuller, an orthopedic surgeon, examined claimant on behalf of the employer and Dr. Reichle, who treated claimant for her left wrist condition after the June 22, 1998 injury. Claimant was seen by Dr. Reichle in consultation with Dr. Van Allen, an orthopedist.

Dr. Fuller examined claimant on September 22, 1998, three months after the injury. By this time, claimant's symptoms had begun to improve. Dr. Fuller felt that there was no firm indication supporting a diagnosis of de Quervain's. He indicated that claimant's complaints had been present since the February 19, 1998 incident, but stated that he could find no objective criteria to indicate any significant pathology related to the complaints. He further indicated that historically, the June 1998 incident exacerbated the February 1998 complaints and the June 1998 event should not be regarded as a "new incident."

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[1] The ALJ's order found that no aggravation claim for the February 19, 1998 injury was filed. The parties do not appear to dispute this portion of the ALJ's order. Consequently, we do not address this issue on Board review.

Dr. Reichle treated claimant for the June 1998 injury and was aware of the February 1998 injury and symptoms. He opined that the major contributing cause of claimant's need for treatment was the June 22, 1998 injury. He also indicated that, while the February 1998 injury might play a factor, he was unable to say that it was the primary reason for claimant's need for treatment. Following the examination by Dr. Fuller, Dr. Reichle's and Dr. Van Allen's chart notes reflected that claimant's condition improved such that surgery was no longer recommended. Dr. Van Allen noted that when claimant was examined in July 1998, claimant had a markedly positive Finkelstein's maneuver and that by the time Dr. Fuller examined claimant, this was not found.

It is well-settled that we generally defer to the treating physician in the absence of persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. Reichle. In reaching his conclusion, Dr. Reichle considered and weighed the possible contribution from claimant's preexisting wrist condition. In addition, Dr. Reichle was also aware of claimant's treatment for psychiatric symptoms, but concluded that such symptoms were not contributing to claimant's need for treatment of the left wrist. Moreover, it appears that by the time Dr. Fuller performed his one-time exam, claimant's de Quervain's tenosynovitis had improved. The improvement in claimant's condition is documented in both Dr. Reichle's and Dr. Van Allen's chart notes and reports. We, thus, conclude that Dr. Reichle's opinion is more persuasive than that of Dr. Fuller.[2]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, 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 June 3, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,500, payable by the employer.

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[2] Claimant alternatively raises the theory that her condition is compensable as an occupational disease. The employer argues in response that this theory was not raised at hearing and should not be considered. Given that claimant's left wrist symptoms arose suddenly following the June 22, 1998 event, we have analyzed the claim as an industrial injury. *Mathel v. Josephine County*, 319 Or 235, 240b (1994) (In determining the appropriate standard for analyzing compensability, the focus is on whether claimant's cervical condition occurred as an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual); *see also James v. SAIF*, 290 Or 343, 348 (1981); *Valtinson v. SAIF*, 56 Or App 184, 187 (1982).

In the Matter of the Compensation of
KIMBERLY R. RICE-HAROLD, Claimant
WCB Case No. 99-02427
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration declining to award additional temporary disability. On review, the issue is entitlement to temporary disability.

We adopt and affirm the ALJ's order with the following supplementation addressing only claimant's motion that we defer our review until the Supreme Court issues its decision in *Fred Meyer v. Bundy*, 159 Or App 44 (1999). We need not rule on the motion based on the Court's recent decision to dismiss the case. *Fred Meyer v. Bundy*, 329 Or 503 (1999).

ORDER

The ALJ's order dated July 19, 1999 is affirmed.

December 15, 1999 Cite as 51 Van Natta 1981 (1999)

In the Matter of the Compensation of
SANDRA L. SHUMAKER, Claimant
WCB Case No. 98-08409
ORDER ON REVIEW (REMANDING)
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denial of claimant's aggravation claim for a right knee condition. Claimant argues that the ALJ's order exceeded the scope of the denial. On review, the issues are the ALJ's procedural ruling and compensability. We vacate the ALJ's order and remand.

FINDINGS OF FACT

The employer accepted claimant's injury claim as a "right knee strain" on February 1, 1995. Dr. Webb performed arthroscopy on April 4, 1995. On April 26, 1995, the employer amended its acceptance to include a torn lateral meniscus. A Determination Order closed the claim in September 1995 with an award of 11 percent scheduled permanent disability for the right knee.

Claimant received no right knee treatment between September 1995 and March 26, 1998, when she returned to Dr. Webb with recurrent right knee symptoms. Dr. Webb filed an aggravation claim on claimant's behalf on June 15, 1998. He operated on claimant's knee again on July 7, 1998, to debride arthrofibrosis (scar tissue) and remove a ganglion cyst.

On September 4, 1998, the employer denied claimant's aggravation claim in two particulars: First, it asserted that "the condition for which [claimant] treated is waxing and waxing [sic] of symptoms anticipated" by the prior permanent disability award; second, it asserted that claimant's ganglion cyst was not related to her 1994 work injury. (Ex. 22). Claimant requested a hearing.[1]

When the hearing convened, the parties and the ALJ discussed the issues to be litigated. Claimant asserted that the denial of the ganglion cyst was premature (because no claim had been made for that condition). The employer agreed to amend its denial by deleting the paragraph denying the cyst on causation grounds. But the employer also stated its intention to deny the aggravation claim on worsening *and* causation grounds. Claimant observed that the amended denial was based on worsening only.[2] She objected to further amending it to allow a causation defense, because she was not prepared to litigate causation. (Tr. 6-8).

The ALJ stated that the effect of omitting the paragraph addressing the cyst from the denial was to delete "the effect, if any, of the ganglion cyst." (Tr. 8). The hearing proceeded.

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[1] Claimant's request for hearing form has boxes checked identifying the issues as compensability ("complete claim denial") and aggravation.

[2] The amended denial (*i.e.*, without the deleted paragraph) reads, in pertinent part:

"Based on information received it is our position that the condition for which you were treated is waxing and waxing [sic] of symptoms anticipated by the permanent partial disability award. Therefore, we must respectfully deny your claim for aggravation." (Ex. 22).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial of claimant's aggravation claim, reasoning that claimant failed to prove "the compensability of her aggravation claim."

Claimant argues that the parties only agreed to litigate worsening, not causation, and therefore the ALJ erred in deciding the case on causation grounds. We treat claimant's argument objecting to the employer's causation defense as a request for a continuance at hearing and a request to remand. Under the circumstances of this case, we find remand appropriate.

At hearing, the employer sought to raise a causation defense to the aggravation claim. Claimant objected, stating that she was not prepared to litigate that issue because the employer's denial was previously based solely on "worsening." The ALJ did not grant the employer's request and the hearing was not continued.[3]

Our rules expressly provide that amendments to the issues raised and relief requested at hearing "shall be freely allowed." OAR 438-006-0031, OAR 438-006-0036; *see SAIF v. Ledin*, 149 Or App 94 (1997) (a carrier may amend its denial at hearing), *on remand Larry L. Ledin*, 50 Van Natta 115 (1998). Where such an amendment is permitted, to afford due process, the responding party must be given an opportunity to respond to the new issues raised. OAR 436-006-0091(3); *John E. Noyer*, 46 Van Natta 395 (1994); *Patricia N. Hall*, 40 Van Natta 1873, 1874 (1988) ("Because claimant has the burden of proving compensability, it is not fair to require claimant to prove a proposition she had no notice of until the hearing convened."). In other words, a party's remedy for surprise and prejudice created by a late-raised issue is a motion of continuance. *Id.*; OAR 438-006-0031, OAR 438-006-0036.

Here, based on *Ledin* and its progeny, the employer should have been allowed to amend its aggravation denial at hearing to include causation grounds. Because claimant lacked pre-hearing notice that causation was an issue in the aggravation context and raised an objection to litigating the issue on that basis, we find that she was surprised by the employer's new issue (defense).[4]

Finally, because claimant was surprised by the employer's new defense at hearing, we also find a compelling basis for remand.[5] *See Neely v. SAIF*, 43 Or App 319, 323, *rev den*, 288 Or 493 (1979) ("If claimant had been given no opportunity to present evidence on [the causation] issue in the hearing below, the proper procedure would be for the Board to remand the case to the referee, ORS 656.295(5), for the taking of evidence on that issue."). Therefore, under the facts of this case, remand for further development of the record will achieve substantial justice and avoid any prejudice against claimant that might result if she is not allowed to address the newly raised issue. *See Gregg Muldrow*, 49 Van Natta 1866, 1896 (1997) (Where the claimant was surprised by the compensability issue at hearing, his request for a continuance should have been granted, and remand for further development of the record was appropriate); *Larry L. Ledin*, 50 Van Natta at 115.

Accordingly, we vacate the ALJ's order dated May 12, 1999 and remand this case to ALJ Brazeau to allow claimant an opportunity to respond to the causation issue. These further proceedings may be conducted in any manner that the ALJ finds will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.

IT IS SO ORDERED.

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[3] The ALJ did approve the parties' agreement to delete the cyst denial, stating *that* "amendment" effectively deleted "the effect, if any," of the cyst. We agree with the ALJ's ruling in this regard. (*See* Tr. 8).

[4] *Compare Pamela S. Smith*, 51 Van Natta 828, 830 (1999) (Where the claimant failed to claim surprise, object to litigation of the issue, or request a continuance, she waived any procedural defect in the denial).

[5] Under the particular circumstances of this case -- lack of pre-hearing notice of the issue -- we cannot say that claimant failed to exercise due diligence in preparing for the hearing and we do not evaluate whether evidence material to the new issue was obtainable at the time of hearing.

In the Matter of the Compensation of
TERESA C. BILLINGSLEY, Claimant
WCB Case No. 99-00292
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that awarded a $2,500 attorney fee under ORS 656.382(2). On review, the issue is attorney fees.

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

We do not adopt findings of fact (6) and (7) in the ALJ's Order on Reconsideration. We provide the following supplementation to the ALJ's order.

The ALJ awarded a $2,500 attorney fee pursuant to ORS 656.382(2). On review, SAIF challenges the fee as excessive.

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.

Claimant's counsel estimates that he spent 8 to 13 hours on the case. The record contains 17 exhibits. Claimant submitted a 3 page written closing argument to the ALJ. The issue was the extent of scheduled permanent disability. Specifically, SAIF unsuccessfully challenged the Order on Reconsideration award of 4 percent scheduled permanent partial disability benefits at hearing. The value of the interest was the $2,724 value of the permanent disability award.[1] The attorneys involved in the hearing are skilled and experienced workers' compensation attorneys and litigated the case in a professional manner. In light of SAIF's vigorous defense of the claim and the conflicting medical evidence, we find that there was a risk that claimant's counsel would go uncompensated. This matter was tried on the written record without an in-person hearing. The parties submitted written closing arguments to the ALJ. No frivolous issues or defenses were asserted.

After considering these factors, we find that a $2,500 attorney fee is reasonable. We reach this conclusion based particularly on the time devoted to the issue, the skill of the attorneys and the risk that claimant's counsel might go uncompensated.

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 14, 1999, as reconsidered July 7, 1999, is affirmed.

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[1] Claimant argued to the ALJ that the value of the interest involved included preserving an opportunity to receive vocational assistance. We conclude that this is of minimal value, however, because there are other factors involved in establishing entitlement to such benefits.

Board Member Phillips Polich specially concurring.

I concur with the lead opinion with the exception of the reasoning regarding the value of the claim. Instead of being the dollar amount of the claim, I regard the "value" factor as referring to the value of the claim as a whole and the value in general of obtaining the unpaid benefits for claimant. With the exception of that portion of the order, I am in agreement with the opinion and result.

In the Matter of the Compensation of
MARY C. MASSEY, Claimant
WCB Case No. 99-02943
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's denial of her right upper extremity condition; and (2) determined that he did not have jurisdiction over claimant's request for penalties under OAR 436-060-0017. On review, the issues are compensability, jurisdiction and, if jurisdiction is established, penalties.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] In the first paragraph of the findings of fact on page 1, we change the third sentence to read: "In 1995, claimant was hired as a permanent part-time employee, working 20 hours per week. (Tr. 5)." At the end of the second paragraph on page 2, we change the citation to read: "(Exs. 6, 8)." In the third paragraph on page 2, we change the second sentence to read: "They diagnosed a median nerve entrapment and noted that impingement tests were negative."

Compensability

We adopt and affirm the ALJ's reasoning and conclusion concerning compensability, with the following change. In the first full paragraph on page 4, we change the date in the first sentence to "July 1, 1999."

Penalties

At hearing, claimant argued that she was entitled to a penalty under OAR 436-060-0017 because the employer failed to provide timely discovery. The ALJ concluded that penalties under OAR 436-060-0017 were available through the Director, not the Hearings Division.

On review, claimant contends that the ALJ erred in holding that the Director has jurisdiction over the penalty issue and she argues she is entitled to either a penalty-related fee or a penalty under ORS 656.262(11). We need not resolve this question because even if the ALJ was authorized to consider the penalty issue, no such assessment would be warranted.

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." OAR 436-060-0155(7) provides: "[w]hen there are no 'amounts then due' upon which to assess a penalty, no penalty will be issued under this rule." In light of our agreement with the ALJ that the underlying claim is not compensable, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Assuming that we have jurisdiction, claimant is not entitled to a penalty or a penalty-related fee.

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[1] We modify the ALJ's order to note that Exhibit 8A, rather than Exhibit AA, was admitted into evidence. (Tr. 1).

ORDER

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

In the Matter of the Compensation of
DALLAS D. ADKINS, Claimant
WCB Case No. 97-07982
ORDER ON REMAND
Glenn M. Feest, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. On April 8, 1999, the court granted the parties' motion to remand this matter for our consideration of their proposed settlement. Additionally, judicial review was "dismissed with leave to seek reinstatement if the Board should fail to approve the settlement."

Subsequent to the court's order, the only communication received by the Board concerning a settlement is a May 25, 1999 letter from SAIF stating that, on November 3, 1998, it had sent "claimant's counsel a proposed Stipulation for signature" but did not receive a response despite "several attempts, by phone and letter, to contact [claimant's attorney] to check the status of the documents[.]"

Neither party responded to a letter from the Board dated August 24, 1999, asking for information concerning the status of the settlement.

Pursuant to the court's remand order, our authority is limited to considering the parties' proposed settlement. *See Aguilar v. J. R. Simplot Company*, 94 Or App 658 (1989) (Board without authority to award attorney fee on remand under ORS 656.388(1) when the court's mandate was to reinstate ALJ's order). Because the parties have not submitted a settlement for approval, we have failed to approve any settlement. Thus, based on the court's order, the parties are authorized to seek reinstatement of judicial review. Finally, because the court neither reversed nor vacated our prior order, it is not necessary to republish our order and it stands as previously issued.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARMEN MENDOZA, Claimant
WCB Case No. 98-03015
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
William J. Blitz, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that declined to award temporary disability benefits after November 24, 1997. On review, the issue is temporary disability. We affirm.

FINDINGS OF FACT

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

On October 29 1997, claimant compensably injured her left knee. On November 6, 1997, she sought treatment from Dr. Dean, who diagnosed a left knee strain and released her to modified work. (Exs. 1, 2, 3). Claimant returned to modified work and worked through November 11, 1997 at her regular wage. (Exs. 4, 15-2).

On November 12, 1997, Dr. Ross (an associate of Dr. Dean) referred claimant to an orthopedist and authorized a modified job at another job site where the wage was less than the wage at her "at-injury" job. (Exs. 4-2, -3; 6-2; 15-2). On November 17, 1997, Dr. Walton, claimant's treating orthopedic surgeon, authorized modified work until an MRI of her knee was performed. On November 20, 1997, after the MRI, Dr. Walton continued the modified work restrictions. Claimant worked at the other job site until November 24, 1997, when she left work for reasons unrelated to her injury. (Ex. 15-2; Tr. 11). The self-insured employer did not pay temporary disability after that date.

Dr. Walton reaffirmed the modified work release on December 4, 1997 and January 9, 1998. On February 2, 1998, the employer accepted claimant's claim as a nondisabling left knee strain. On February 9, 1998, Dr. Walton requested authorization for arthroscopic surgery. (Ex. 8). The surgery was not performed.

On April 7, 1998, Dr. Ferris examined claimant for the employer. He declared claimant medically stationary and found no measurable impairment of claimant's left knee. (Ex. 11). Dr. Walton concurred with Ferris's opinion. (Ex. 12).

On April 16, 1998, claimant requested a hearing on her entitlement to temporary disability commencing on November 24, 1997.

Claimant subsequently requested Director reclassification of the claim as disabling. The Director issued a November 17, 1998 Determination Order denying reclassification. (Ex. 15-1). On November 25, 1998, claimant requested reconsideration of the reclassification request. (Ex. 17).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the employer has submitted a February 24, 1999 Order on Reconsideration issued by the Department of Consumer and Business Services, Workers' Compensation Division, regarding the reclassification status issue. We interpret the employer's submission as a request to supplement the record or take administrative notice of this document.

On review, we are limited to the record developed at hearing. ORS 656.295; *Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985). We may, however, take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(2). The Department's order in this case is an act of a state agency that is expressly subject to judicial notice under ORS 40.090(2). *See Rodney J. Thurman*, 44 Van Natta 1572, 1573 (1992). Therefore, we take official notice of the order's existence. We conclude, however, that the order has limited relevance to the issue before us because we have no authority to award temporary disability benefits. We reason as follows.

Where, as here, a nondisabling claim classification has been challenged, the appropriate statutory route for claimant to seek relief is through her appeal of her reclassification request. *Roberta F. Bieber*, 49 Van Natta 1541, 1543 (1997). We reach this conclusion because claimant is seeking temporary disability benefits payable on a nondisabling claim. As such, we have no authority to create an overpayment by awarding procedural temporary disability beyond that to which claimant is substantively entitled.[1] *See Alfredo Martinez*, 49 Van Natta 67 (1997), citing *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992).

ORDER

The ALJ's order dated February 12, 1999 is affirmed.

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[1] We distinguish this case from *Joseph E. Bridwell*, 49 Van Natta 1061 (1997). In *Bridwell*, the issue was the claimant's entitlement to interim compensation on a nondisabling claim. The ALJ dismissed the request for hearing for lack of jurisdiction of the classification of the claim. Finding that we had original jurisdiction over disputes regarding procedural entitlement to temporary disability benefits, we reinstated the claimant's hearing request and concluded that the claimant was entitled to interim compensation even though fired for reasons unrelated to his injury.

This case differs from *Bridwell*, in that the issue in that case was entitlement to "interim compensation" (temporary disability payments which are required to be made to a claimant who is off work as a result of an injury for the time between the employer's notice of injury and its acceptance or denial of the claim). Entitlement to "interim compensation" is not dependent on classification of the claim. Moreover, the claimant in *Bridwell* had not challenged the classification of the claim. Here, because claimant had challenged the classification of the claim, her entitlement to procedural temporary disability benefits is dependent on her appeal of that classification. *See Roberta F. Bieber*, 49 Van Natta at p. 1543.

December 16, 1999 Cite as 51 Van Natta 1987 (1999)

In the Matter of the Compensation of
LOIS J. SCHOCH, Claimant
WCB Case No. 92-09982
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is on remand from the Court of Appeals. *Schoch v. Leupold & Stevens*, 162 Or App 242 (1999). The court vacated the attorney fee award granted in our prior order, *Lois J. Schoch*, 49 Van Natta 788 (1997). The parties have submitted a proposed "Stipulation and Order" to resolve "all issues raised or raisable[.]"

Pursuant to the stipulation, "the parties agree that claimant's attorney is allowed a fee of $7,500.00 for prevailing on a denied back surgery." Finally, the parties stipulate that the "case is dismissed with prejudice."

We have approved the parties' stipulation, thereby fully and finally resolving this dispute. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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

On August 11, 1999, we withdrew our July 13, 1999 order[1] that: (1) found that the employer's failure to appear at the hearing was unjustified and constituted a "waiver of appearance" under OAR 438-006-0071; and (2) denied the employer's motion to remand for submission of additional evidence. We took this action to consider AIG's, the insurer's claim processing agent's, contention that the employer is not self-insured and that the Hearings Division erred in failing to notify the insurer, a party to the case under ORS 656.005(21), of the request for hearing. Asserting that all parties in interest were not notified of the hearing, the employer requests remand to the ALJ for presentation of its defense. Having received claimant's response, we proceed with our reconsideration.[2]

On September 23, 1998, the parties entered into a Settlement Stipulation and Order of Dismissal (WCB Case No. 98-04441). The stipulation was signed by claimant, claimant's counsel, and the attorney for the employer, the insurer (National Union Fire Insurance Company), and the insurer's claims servicing agent (AIG).

On October 8, 1998, claimant, through her attorney, filed a request for hearing raising the issue of failure to pay compensation due under the stipulation. The request for hearing was received by the Hearings Division on October 9, 1998, and was accompanied by a Certificate of Service representing that copies were mailed to claimant, the employer, and AIG.

On October 19, 1998, the Hearing Division mailed a computer-generated letter to claimant, the employer, and AIG acknowledging the request and setting the hearing for January 6, 1999.

On December 29, 1998, claimant supplemented his hearing request. The supplemental request for hearing and Certificate of Service represented that copies were mailed to claimant, the employer, and AIG.

By letter dated January 5, 1999, claimant submitted Exhibits 1 through 17 to the ALJ. These exhibits were not copied to any party. A hearing was convened on January 6, 1999. Claimant and his counsel were present, but neither the employer, the insurer nor AIG appeared at the hearing, nor were they represented by an attorney. At the hearing, claimant's attorney recited the procedural history of the prior stipulation, which included AIG's alleged failure to process claimant's accepted claim.

In a February 4, 1999 Opinion and Order, the ALJ found that the Notice of Hearing was correctly mailed to the employer and AIG on October 19, 1998. The ALJ then proceeded to determine the merits of the issues raised by claimant.

On March 4, 1999, the attorney who represented the employer/insurer and AIG in WCB Case No. 98-04441 (the stipulation agreement) requested abatement of the ALJ's order, asserting that, although claimant's attorney was aware of his representation in the stipulation, he had not received notice of claimant's requests for hearing or copies of the hearing exhibits. AIG's attorney also stated that he was not aware of any evidence that he had withdrawn from representing the employer and carrier. He requested the opportunity to clarify his legal representation and to reopen the record to allow presentation of the employer's evidence and defenses. The ALJ abated the order.

In a March 10, 1999 letter to the ALJ, claimant argued that AIG had been provided with both of his requests for hearing and that AIG did not use one legal firm or contract with in-house counsel. Claimant argued that there were no extraordinary circumstances to justify a continuance or reopening of the record.

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[1] We note that claimant's name was mispelled as *Kenneth F. Plumber* in the July 13, 1999 order. The correct spelling is *Kenneth F. Plummer*.

[2] Although Member Phillips Polich was a signatory to the July 13, 1999 order, she has recused herself from reviewing this case on reconsideration.

On March 14, 1999, after reviewing the record "in light of the parties' arguments," the ALJ republished the February 4, 1999 Opinion and Order in its entirety.

By a March 23, 1999 letter, AIG's attorney again requested reconsideration. AIG's attorney stated that he had not received a hearing transcript regarding claimant's representations that AIG's attorney had withdrawn his representation nor had claimant provided exhibits to AIG in advance of the hearing. By a second letter of the same date, AIG's attorney notified the ALJ that AIG's claim examiner had represented to him that AIG did not at any time receive a copy of the Notice of Hearing and, because the employer had no notice of hearing, requested that the ALJ reopen the record for presentation of its case.

Claimant responded to the second request for reconsideration, relying on the same argument presented in response to AIG's first request for reconsideration. On March 25, 1999, the ALJ denied AIG's second request for reconsideration on the basis that there was nothing new to consider other than a recitation of an off-the-record telephone conversation that "apparently took place between counsel for each party on March 4, 1999." AIG requested Board review.

With its request for review, AIG submitted affidavits in which AIG and its attorney averred that they had not received notice of the hearing and requested that the record be reopened because AIG did not receive a copy of the notice of hearing. We found that copies of the notice of hearing had been mailed to the employer and AIG at their last known addresses and had not been returned to the Hearings Division by the postal service. We concluded that the employer's failure to appear at the January 6, 1999 hearing was unjustified and constituted a waiver of appearance. We also concluded that an attorney is not a "party," and that, therefore, the lack of mailing a notice to the attorney was not determinative.

Accordingly, we denied remand because the information contained in the affidavits was not likely to affect the outcome of the case, as the justifications contained in the affidavits were not sufficient to excuse the employer's failure to appear. Finally, on the merits, we affirmed the ALJ on all issues raised with the exception of a penalty for failure to pay temporary total disability from May 21, 1998 through May 31, 1998.

Thereafter, AIG requested reconsideration. On reconsideration, AIG again moves for remand to the Hearings Division. Asserting that the employer is insured by National Union Insurance, whose claims servicing agent is AIG, and relying on its affidavit, AIG contends that neither the insurer nor AIG received timely notice of the hearing. Therefore, AIG requests remand to the ALJ for the employer's presentation of its defense.

At least 10 days' prior notice of the time and place of the hearing shall be given to all parties in interest by mail. ORS 656.283(4), (5); OAR 438-006-0020 (the Hearings Division shall, by mail, acknowledge receipt of a request for hearing. * * * The hearing shall be scheduled for a date that is within 90 days of the request for hearing and not less than ten days after mailing of a notice of hearing date). A "party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(21).

Here, the Hearings Division file shows that the notice of hearing scheduled for January 6, 1999 was mailed to claimant, the employer and AIG on October 19, 1998. The file does not establish that a copy of the notice of hearing for January 6, 1999 was mailed to the insurer.

We have previously concluded that, although a claim administrator or processing agent is not technically encompassed within the statutory definition of a "party," it stands as the functional equivalent of an insurer when an employer is self-insured. *See* ORS 656.005(20) (since renumbered (21); *Martin Manning*, 40 Van Natta 374, 375 (1988) (where a copy of a referee's order was not mailed to the self-insured employer's claim administrator, the order was not final because a copy of the order had not been mailed to the functional equivalent of the employer's insurer). Similarly, we conclude that an *insurer*'s claim administrator or processing agent stands as the functional equivalent of an *insurer*.

In reaching this conclusion, we analogize this situation to cases where a claimant appealing an ALJ's order neglects to mail a copy of the request for Board review to an opposing party, but does timely mail a copy of the request to a person or entity in privity with the opposing party; *e.g.*, a copy is mailed to the insurer, but not the employer. *See Alfredo R. Herrera*, 51 Van Natta 1360, *on recon* 51 Van Natta 1427 (1999) (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).[3] In such cases, in the absence of a finding that the opposing party has been prejudiced by not directly receiving a copy of the appealing party's request, timely service of the request on a person or entity in privity with the opposing party is sufficient for the Board to retain jurisdiction over the appeal. *See Argonaut Insurance v. King*, 63 Or App 847, 851-52 (1983); *Nollen v. SAIF*, 23 Or App 420, 423 (1983); *Allasandra W. O'Reilly*, 40 Van Natta 1180, 1181 (1988) (absent prejudice to the insurer, timely actual notice of a request for Board review on the employer is adequate compliance to vest jurisdiction with the Board under ORS 656.295(2)); *Glenn L. Woodraska*, 40 Van Natta 1091 (1988) (same).

Here, neither a copy of claimant's hearing request nor a copy of the notice of hearing was mailed to the insurer. Nonetheless, copies of the hearing request and notice of hearing were mailed to the employer and to the insurer's claim processing agent.[4] Thus, in the absence of prejudice to the insurer, notice of the scheduled hearing on the employer or AIG is sufficient compliance with the statutory prerequisites.

The record does not support a conclusion that the circumstances would have been altered had the insurer been mailed a copy of the hearing request or notice of hearing. In reaching this conclusion, we note that AIG provided with its brief a copy of a Workers' Compensation Division compliance letter that was addressed to the insurer in care of AIG Claim Services at its current address. (*See also* Ex. 8). Therefore, the record supports a conclusion that the insurer would not itself be responding to any claim processing activity; instead, it had assigned such responsibilities to AIG. Accordingly, we find no prejudice to the insurer by not being directly mailed a notice of hearing, because the insurer would have directed any such notice to AIG.

Finally, as noted above, copies of the notice of hearing were mailed to the employer and AIG. The file indicates that these copies were mailed to their correct addresses and were not returned as undeliverable. Because AIG and the employer were mailed copies of the notice and there has been no showing that the insurer was prejudiced by its failure to receive a copy of the request (*i.e.*, the circumstances would not have changed had the insurer been mailed a copy of the notice because it had assigned its claim processing responsibilities to AIG), we conclude that mailing of the notice to AIG and the employer was sufficient for the ALJ to proceed with the hearing.

Accordingly, on reconsideration, as supplemented herein, we adhere to our July 13, 1999 order.

IT IS SO ORDERED.

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[3] In *Herrera*, a case involving two employers insured by the same insurer, the claimant mailed a request for review of an ALJ's order to one employer and the insurer. The insurer moved to dismiss claimant's request for review because the claimant had failed to serve the other employer with notice within the statutory period. Relying on *Argonaut Insurance v. King*, 63 Or App 847 (1983) and *Nollen v. SAIF*, 23 Or App 420 (1975), we concluded that, 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.

[4] It is well-established that notification occurs upon *mailing*, not upon receipt of the notice of hearing, *i.e.*, the key is *mailing*, not receipt. *See generally, Berliner v. Weyerhaeuser Co.*, 92 Or App 264, 266-67 (1988); *Lee R. Jones*, 48 Van Natta 1286 (1996).

In the Matter of the Compensation of
JACK L. SWEET, Claimant
Own Motion No. 99-0071M
OWN MOTION ORDER OF ABATEMENT
Dale C. Johnson, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our November 16, 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 SAIF Corporation is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

December 17, 1999 Cite as 51 Van Natta 1991 (1999)

In the Matter of the Compensation of
FERRAL C. CROWDER, Claimant
WCB Case No. 94-12846
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Abigail V. Marshall, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Crowder v. Alumaflex*, 163 Or App 143 (1999). The court reversed our prior order, *Ferral C. Crowder*, 48 Van Natta 2322 (1996), that had held that, because claimant had not raised the rate of his unscheduled permanent disability award granted by a Determination Order as an issue during the Director's reconsideration proceeding, he was precluded from seeking an increased rate (arising from the "post-reconsideration" 1995 amendments to ORS 656.214(6)) at a subsequent hearing. Noting that the rate for permanent disability awards did not increase until after the Order on Reconsideration had issued, the court concluded that claimant was under no obligation to raise the issue during the reconsideration proceeding and, as such, was not precluded from raising the issue at hearing under ORS 656.283(7). Determining that the new rates applied retroactively to claimant's claim, the court reversed our order regarding the rate at which claimant's 50 percent unscheduled permanent disability award should be calculated and remanded for a determination of the amount of his award based on the current rate.

Consistent with the court's mandate, we find that claimant's unscheduled permanent disability award must be paid at a rate commensurate with the 1995 amendments to ORS 656.214(6). Accordingly, we affirm those portions of the Administrative Law Judge's order that directed the insurer to pay claimant's unscheduled permanent disability at the increased rate and granted an "out-of-compensation" attorney fee payable from this increased compensation.

IT IS SO ORDERED.

In the Matter of the Compensation of
FREDRIC C. FARROW, Claimant
Own Motion No. 96-0152M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
John C. DeWenter, Claimant Attorney
John M. Pitcher, Defense Attorney

Claimant requests review of the self-insured employer's May 21, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from April 18, 1996 through April 21, 1996. The employer declared claimant medically stationary as of April 25, 1997. Claimant does not contend that the employer's closure was premature. Rather, claimant contends that he is entitled to temporary disability compensation from April 18, 1996 through April 25, 1997, less time worked.

The employer denied the compensability of claimant's current right knee condition on which claimant filed a request for hearing with the Hearings Division (WCB Case No. 97-07808). On June 29, 1998, we postponed action on claimant's request for review of the employer's closure. We reasoned that should the Administrative Law Judge (ALJ) find that claimant's current right knee condition was a compensable portion of his 1978 injury claim, that finding could have an impact of our review of the employer's closure.

On April 8, 1999, ALJ Kekauoha approved a "Stipulated Settlement" which resolved the parties' dispute pending before the Hearings Division. The parties agreed that the employer would accept claimant's current right knee condition as a compensable portion of claimant's 1978 claim. The parties also agreed that the denial of claimant's right knee condition as it related to his 1991 claim be affirmed. In addition, the parties agreed that the settlement resolved "only those issues pertaining to acceptance of the current right knee medial compartment degenerative arthritis with partial tear of residual meniscus in the 1978 claim versus the 1991 claim and any related penalty and fee issues specifically related to the acceptance."

Thereafter, the Board staff requested that parties' positions regarding the effect, if any, the Stipulated Settlement had on claimant's request for review of the employer's May 21, 1997 Notice of Closure. Claimant responded that he is entitled to temporary disability compensation from April 18, 1996 through April 25, 1997, less time worked. The employer concurred that claimant should be found medically stationary as of April 25, 1997, and that temporary disability benefits should be paid through that date, less time worked.

ORS 656.278(1)(a) provides that, where there is a worsening of the compensable injury that requires surgery or hospitalization, the Board may authorize payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes surgery until the worker's condition becomes medically stationary.

Here, there is no dispute that claimant underwent surgery for his compensable injury on April 18, 1996. Furthermore, the parties agree, and claimant's attending physician's opinion establishes that claimant became medically stationary on April 25, 1997. Therefore, as the parties agree, claimant is entitled to temporary disability compensation from April 18, 1996 through April 25, 1997, less time worked.[1] ORS 656.278(1)(a).

Accordingly, as modified herein, the employer's May 21, 1997 Notice of Closure is affirmed.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation, if any, 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.

[1] Any dispute regarding the employer's calculation of claimant's temporary disability benefits during the period of April 18, 1996 through April 25, 1997 may be presented to us in our Own Motion jurisdiction for review should claimant disagree with the employer's calculation.

In the Matter of the Compensation of
THOMAS S. FORELL, Claimant
WCB Case No. 98-07260
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

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

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

We do not find that Dr. Wilson's causation opinion is "contrary to ORS 656.266." Nonetheless, we agree with the ALJ's conclusion that Dr. Wilson's opinion is inadequate to carry claimant's burden for two reasons.

First, although Dr. Wilson acknowledged that the most significant work activities known to cause CTS are those involving vibration (Ex. 56-23), he did not address or rule out the potential causal contribution from claimant's use of pneumatic tools off work and at his prior auto detailing job.

Second, Dr. Wilson's reasoning regarding claimant's "bakery operator" work activities is insufficiently explained. Dr. Wilson opined that repetitive hand activity could cause CTS even without vibration, as long as the "positioning is appropriate and the activity done with the digits is appropriate." (Ex. 56-23-24; *see* Exs. 56-17, 56-39-40). And he opined that claimant's bakery work, which he described as "kneading," "grabbing," and "hand intensive," (Exs. 56-32, 56-228) was sufficiently intense and repetitive to cause his CTS. (Ex. 54). But Dr. Wilson did not explain how claimant's bakery work involved the appropriate positioning and digit use that he had identified as important. Under these circumstances, we conclude that Dr. Wilson's opinion is inadequately reasoned and we do not rely on it.

ORDER

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

Board Member Biehl dissenting.

I agree with the majority that the opinion of Dr. Wilson, treating physician is not "contrary to ORS 656.266." However, I would find Dr. Wilson's opinion persuasive and sufficient to carry claimant's burden.

Claimant packaged frozen bread dough for the employer, beginning in 1993. He grasped pieces of dough from a conveyor belt and hand-packed them into boxes or trays, closed and labeled the containers, and carried and stacked them on pallets. His packing work required rapid repetitive use of both hands.

As the ALJ noted, Dr. Wilson considered all possible causes of claimant's CTS and eliminated all known, non-work related causes to reach his conclusion that claimant's condition is due to his work. Based on the rapid, repetitive, hand intensive nature of claimant's work and Dr. Wilson's ruling out of noncompensable contributors, I would find the claim compensable. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
RONDA L. MOFFIT, Claimant
WCB Case No. 98-08983
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich, Bock and Haynes.

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

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

We agree for the reasons given in the ALJ's order that claimant injured the left knee as well as the right when she fell in March 1992.

In addition, although we agree with the ALJ that compensability is a "close question," we likewise agree after our review of the record that the preponderance of the evidence supports compensability. In this regard, claimant's original attending physician, Dr. Treible told her that he was unable to help her with her left and right knees and that she would have to live with the symptoms. This is an adequate explanation for claimant's decision not to pursue treatment for the left knee until seeing Dr. Webb in 1998. We agree with and adopt the ALJ's reasons for deferring to the opinion of Dr. Webb.

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 counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 6, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,500 payable by the insurer.

Board Member Haynes dissenting.

The majority adopts the ALJ's order that relies on Dr. Webb to find claimant's left knee injury claim compensable. For the following reasons, I do not find Dr. Webb's opinion persuasive. To begin, the extensive delay in treatment for the left knee between the 1992 injury and 1998 make a causal connection doubtful. Additionally, the only physician who supports compensability is Dr. Webb.

The orthopedist who treated claimant for his compensable right knee claim is Dr. Treible. Dr. Treible states that the left knee was not significantly injured in the 1992 injury. As the physician who examined and treated claimant at the time of the 1992 injury, Dr. Treible is in a better position than Dr. Webb to address whether the 1992 injury caused a left knee injury. In contrast, Dr. Webb first treated claimant six years after the 1992 compensable injury, and therefore did not examine claimant's left knee at the relevant time. Moreover, Dr. Webb relied on a history that claimant complained of left knee problems at the time of the 1992 injury. The contemporary medical record does not suggest significant left knee complaints after the injury.

Because Dr. Webb did not examine claimant until six years post injury and because he relied on a history that is not supported by the record, the majority errs in relying on his opinion to establish compensability. The remainder of the medical evidence in this case does not support compensability of claimant's claim. Under such circumstances, I would find the record insufficient to meet claimant's burden. Because the majority finds otherwise, I respectfully dissent.

In the Matter of the Compensation of
GLENN S. REUTER, Claimant
Own Motion No. 98-0391M
OWN MOTION ORDER
DENYING RECONSIDERATION

Claimant requests reconsideration of our August 31, 1999 Own Motion Order, which denied his request for reopening of his 1980 injury claim for the payment of temporary disability benefits because the record failed to demonstrate that claimant's current condition required surgery or hospitalization.

Under OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. Claimant's request for reconsideration was received by the Board on November 8, 1999, more than 30 days after the issuance of our August 31, 1999 Own Motion Order. In addition, claimant provides no explanation that might provide "good cause" for his failure to request reconsideration within 30 days. Consequently, claimant's request for reconsideration is denied as untimely.

In any event, if we were to grant claimant's request for reconsideration, he has not provided any new evidence or argument which would persuade us to reach a different conclusion. We are limited by law as to the type of benefits we may grant injured workers and under what conditions we may grant those limited benefits. Specifically, we may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, the record does not contain evidence that surgery or hospitalization has been recommended. Rather, the only medical report which may support claimant's contention that he requires surgery is a November 3, 1998 chart note which states that claimant possibly has cricopharyngeus spasm, which *possibly* is a sequela of his cervical fusion, and *possibly* seeing a surgeon for cricopharyngeus myotomy would benefit him. This medical opinion expressed only the possibility that claimant requires surgery and/or hospitalization. The "possibility" that surgery or hospitalization is requested to treat claimant's condition is not enough. The medical record must establish that such treatment is probable. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). Therefore, the record continues to fail to prove that claimant requires *surgery* or *hospitalization* now or in the near future. As a result, we continue to find that claimant's compensable condition has not worsened requiring surgery or hospitalization, and therefore, we cannot reopen the claim for payment of temporary disability compensation.

Finally, in his request for reconsideration, claimant appears to request additional permanent disability compensation. By law, we are unable to grant that request. Claimant's 1980 claim was first closed on March 5, 1982. Therefore, his aggravation rights expired five years later, on March 5, 1987. ORS 656.273(4)(a). Because claimant's aggravation right have expired, his claim is in own motion status. That means that, although he is entitled to lifetime medical benefits related to his compensable injury, his only entitlement to future monetary compensation is restricted to time loss benefits under the limited circumstances discussed above, that is, when his condition requires surgery or hospitalization. ORS 656.278(1)(a). 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, we cannot award claimant more permanent disability in this claim.

Accordingly, claimant's request for reconsideration is denied. The issuance of this order neither "stays" our prior orders nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656 (1985). However, should claimant's circumstances

change, that is, should he require surgery and/or hospitalization for his compensable condition in the future, he may again request reopening of his claim.[1]

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

IT IS SO ORDERED.

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[1] It appears from claimant's request for reconsideration that he may not understand his rights and benefits under the Workers' Compensation Law. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot give legal advice to either party. However, since claimant does not have an attorney, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

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

December 17, 1999 Cite as 51 Van Natta 1996 (1999)

In the Matter of the Compensation of
SCOTT R. WROOT, Claimant
WCB Case Nos. C970428, C970427, C970426, C970425 & C970424
ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

On March 3, 1997, 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 rights to future workers' compensation benefits, except medical services, for the compensable injury.

On November 9, 1999, we received a letter from the SAIF Corporation, which forwarded claimants letter, requesting review. We treat this letter as a motion for reconsideration.

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

Here, the CDA was approved and mailed on March 3, 1997. We received claimant's letter on November 9, 1999, approximately 2 « years after the CDA was approved. Inasmuch as the motion for reconsideration was untimely, we cannot consider it. OAR 438-009-0035(1),(2); *Edward C. Steele*, 48 Van Natta 2292 (1996); *Paul J. LaFrance*, 48 Van Natta 306 (1996).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSVIN B. RUSSELL, Claimant
Own Motion No. 99-0362M
OWN MOTION ORDER
Doblie & Associates, Claimant Attorneys
Liberty Northwest Ins. Corp., Defense Attorney

The insurer has submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on April 4, 1994. The insurer opposed reopening on the following grounds: (1) no surgery or hospitalization has been requested; (2) it is unknown whether the carrier is responsible for claimant's current condition; (3) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (4) claimant was not in the work force at the time of disability.

The insurer issued an "aggravation denial" based on an aggravation form which was submitted by claimant's attending physician. Claimant timely appealed that denial. (WCB Case No. 99-06111). On October 12, 1999, we consolidated this own motion matter with the pending aggravation hearing. If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the accepted 1987 injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time his condition worsened.

On November 13, 1999, the insurer advised the Board that it mistakenly processed claimant's request as an aggravation claim under ORS 656.268. This processing error resulted in its June 7, 1999 aggravation denial. Acknowledging that claimant's 1987 should be processed under our authority pursuant to ORS 656.278, the insurer asserted that it had not denied claimant's "current condition" and rescinded its aggravation denial. In response to the insurer's submission, claimant confirmed that he had withdrawn his request for hearing and requested we proceed with our review of his request for own motion benefits.

As a result of claimant's withdrawal of his request for hearing, an Order of Dismissal issued on November 2, 1999. This order has not been appealed. Inasmuch as the compensability of claimant's current condition is not in dispute, we proceed with our review of claimant's request for reopening of his 1987 own motion claim.

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

Claimant contends that his "condition has worsened and surgery may be required." However, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment. As a result, we are not authorized to grant claimant's request to reopen the claim.[1]

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

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] Even if the record were to demonstrate that claimant's current condition required surgery and/or hospitalization, we would still reach the same conclusion. 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 contended that claimant was not in the work force at the time of his current disability. In his response to the insurer's work force contention, claimant agrees that "he is not in the work force as he has not been employed since approximately 1991." Thus, because claimant is not in the work force, he would not be entitled to own motion relief under ORS 656.278.

In the Matter of the Compensation of
GERRY L. SCHREINER, Claimant
WCB Case Nos. 98-02703 & 98-02702
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denials of claimant's current neck condition; and (2) awarded an assessed attorney fee of $5,000. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes.[1] We note that the first section of the ALJ's findings are quoted from ALJ Podnar's January 5, 1998 Opinion and Order. (Ex. 77). In the last paragraph beginning on page 2, we change the first sentence to read: "ALJ Podnar found that claimant experienced an injury to his head and cervical spine in the course and scope of his employment on or about April 1, 1997." In the fourth full paragraph on page 3, we change the first sentence to read: "Dr. Bell, who has treated claimant over a course of years, reported that 'this accident where a clamp fell on his head is responsible for his current symptomatology.'" (Ex. 80). We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a welder, filed an injury claim after being struck in the head by a "c" clamp that fell from a height of approximately six feet on April 1, 1997. (Exs. 58, 77). The insurer denied claimant's April 1997 claim on the basis that there was insufficient evidence to establish that he had sustained a compensable injury to his head, neck and upper back. (Ex. 67). On July 9, 1997, claimant experienced sharp pain between his shoulders while picking up a large piece of pipe at work. (Exs. 70, 77). The insurer denied claimant's July 1997 claim on the basis that there was insufficient evidence to establish that his mid back and neck problems were related to a July 9, 1997 injury. (Ex. 76). The insurer's denial said that claimant's current problems were a continuation of his preexisting upper back and neck condition that were denied previously. (*Id.*)

Claimant requested a hearing on both denials, which was held on September 29, 1997, with the record closing on December 24, 1997. On January 5, 1998, ALJ Podnar issued an Opinion and Order setting aside both denials. (Ex. 77). The insurer requested Board review. (Ex. 89-1). The parties subsequently entered into a stipulation, whereby the insurer agreed to dismiss the appeal. (Ex. 89). The parties agreed to modify the January 5, 1998 Opinion and Order to eliminate the award of penalties and related attorney fees. (Ex. 89-2). On March 26, 1998, the insurer's request for review was dismissed with prejudice. (Exs. 89, 90).

On March 25, 1998, the insurer issued acceptances of each of the April 1, 1997 and July 9, 1997 claims as "combined condition of cervico-thoracic strain superimposed upon unrelated and pre-existing degenerative disc disease and narrow intervertebral foramina (cervical)." (Exs. 85, 86). Also on March 25, 1998, the insurer issued two partial denials of claimant's condition. (Exs. 83, 84). The insurer issued partial denials of the "pre-existing degenerative disc disease of the cervical spine with narrow intervertebral foramina (cervical)" as well as a current condition denial on the basis that neither the April 1, 1997 nor the July 9, 1997 injury were the major contributing cause of claimant's current need for medical care and disability. (*Id.*) On March 26, 1998, the insurer issued Notices of Closure for the April 1, 1997 and July 9, 1997 claims, awarding temporary disability benefits, but no permanent disability. (Exs. 87, 88).

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[1] Although the ALJ's order indicates that Exhibit 90B was admitted, the parties have agreed that Exhibit 90B was misidentified in the supplemental exhibit list and Exhibit 91A was actually admitted instead.

At hearing, claimant argued that his condition was unchanged from the conditions previously litigated and his need for treatment continues to be due to the April and July 1997 injuries. The insurer argued that claimant's current condition was no longer related to the compensable injuries. The ALJ relied on Dr. Bell's opinion and found that claimant's ongoing need for treatment continued to be due to the compensable neck and upper back injuries.

Citing ORS 656.262(6)(c), the insurer argues that it has established the requisite change of condition necessary to properly issue a current condition denial. The insurer contends that claimant failed to carry his burden of proving that his compensable work injury is the major contributing cause of his current need for treatment.

On the other hand, claimant cites *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), and contends that the insurer cannot deny compensability of his degenerative disc disease, regardless of the cause. Claimant argues that the involuntary acceptance of his head, neck and upper back problems included his degenerative disease as a matter of law. We disagree.

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. *See Douglas Sherman*, 51 Van Natta 1213 (1999) (rule in *Piwowar* did not apply because the carrier limited its acceptance to a specific condition). Here, the insurer issued acceptances of each of the April 1, 1997 and July 9, 1997 claims as "combined condition of cervico-thoracic strain superimposed upon unrelated and pre-existing degenerative disc disease and narrow intervertebral foramina (cervical)." (Exs. 85, 86). Because the insurer did not accept a claim for symptoms, the rule of *Piwowar* does not apply. *Compare Freightliner Corp. v. Christensen*, 163 Or App 191 (1999) (by accepting the claimant's low back pain, employer accepted the underlying cause or causes of the symptoms).

Furthermore, the insurer limited its acceptance by referring to a cervico-thoracic strain "superimposed upon unrelated and pre-existing degenerative disc disease and narrow intervertebral foramina (cervical)." (Exs. 85, 86). Although the insurer accepted a "combined condition," the language of the acceptance, which referred to "unrelated" and "preexisting" degenerative disc disease does not support the conclusion that the insurer accepted claimant's degenerative disc disease.

In the present case, the insurer issued the partial denials before claim closure. The ALJ relied in part on *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998), in reaching his conclusion on compensability. In *Blamires*, we construed ORS 656.262(7)(b) as providing that, whether or not the carrier has accepted a combined condition, the carrier may avail itself of the "preclosure" denial procedure that statute 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.

After the ALJ issued the order in this case, the Court of Appeals decided *Croman Corp. v. Serrano*, 163 Or App 136 (1999). In *Serrano*, the court concluded that in order for a carrier to have properly issued a preclosure denial under ORS 656.262(6)(c) and ORS 656.262(7)(b), the carrier must have *accepted* a combined condition.

Here, the insurer expressly accepted a "*combined condition* of cervico-thoracic strain superimposed upon unrelated and pre-existing degenerative disc disease and narrow intervertebral foramina (cervical)." (Exs. 85, 86; emphasis supplied). Because the insurer accepted a combined condition, it may properly issue a "preclosure" denial under ORS 656.262(6)(c) and ORS 656.262(7)(b).

We next address claimant's argument that claim preclusion bars the insurer from challenging compensability of his current condition. According to claimant, the March 1998 Stipulation and Order represents a final judgment that his "current condition" and medical services are compensable as of the date of that Stipulation.

In contrast, the insurer contends that neither issue nor claim preclusion apply to this case. The insurer argues there was no "actual litigation" of the current condition issue and the sole issue at the prior hearing was initial compensability of claimant's injuries.

We agree with the insurer that issue preclusion does not apply here. Issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or 134, 139 (1990) (quoting *North Clackamas School Dist. v. White*, 305 Or 48, 53, *modified* 305 Or 468 (1988)).

Here, we are not persuaded that the issue of claimant's current condition was "actually litigated and determined." The prior September 29, 1997 hearing involved issues of compensability of claimant's April 1, 1997 and July 9, 1997 injuries, penalties for the insurer's allegedly unreasonable denials and attorney fees. (Ex. 77). On January 5, 1998, ALJ Podnar issued an Opinion and Order setting aside both denials, assessing a penalty for the insurer's unreasonable denials and awarding an attorney fee of $3,500. (*Id.*) The insurer requested Board review. (Ex. 89-1). The parties subsequently entered into a stipulation, whereby the insurer agreed to dismiss the appeal. (Ex. 89-2). The parties agreed to modify the January 5, 1998 Opinion and Order to eliminate the award of penalties and related attorney fees. (*Id.*) Claimant was awarded $500 in lieu of any claim for penalties and claimant's attorney was awarded an attorney fee of $500. (*Id.*) Issue preclusion applies only to issues that have actually been finally decided between the parties. We agree with the insurer that there was no "actual litigation" of claimant's current condition in the prior proceedings.

The Supreme Court has described "claim preclusion" as follows:

> " '[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [*i.e.*, precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.' "

Drews v. EBI Companies, 310 Or at 140 (quoting *Rennie v. Freeway Transport*, 294 Or 319, 323 (1982)) (brackets in original). Claim preclusion does not require actual litigation of an issue of fact or law, nor that the determination of the issue be essential to the final result. *Id.* Claim preclusion requires the opportunity to litigate, as well as finality. *Id.* Thus, the determination of whether claim preclusion applies to preclude litigation of claimant's current cervical condition depends on whether claimant had an opportunity to litigate that issue in the prior hearing.

We agree with the insurer that the issues at the prior hearing were *initial* compensability of claimant's April 1997 and July 1997 injuries, penalties and attorney fees. There was no opportunity to litigate compensability of claimant's *current* condition during the September 24, 1997 hearing. Therefore, claim preclusion does not apply to the present proceeding.

The question remains as to the effect of the parties March 1998 stipulation. (Ex. 89). Unlike some stipulations, the March 1998 Stipulation and Order did not include any language indicating that the parties agreed to settle all issues that had been or could have been raised. *Compare SAIF v. Wolff*, 148 Or App 296, 299-300, *adhered to on recons* 151 Or App 398 (1997) (stipulation dismissing all issues raised or raisable with respect to the claimant's accepted knee contusion barred the claim for an osteochondritis dissecans condition that had been diagnosed before stipulation was executed).

After examining the terms of the stipulation, we find that it was intended to resolve only the issues expressly addressed, *i.e.*, withdrawal of the insurer's appeal regarding initial compensability of claimant's April 1997 and July 1997 injuries, penalties and attorney fees. Because the stipulation did not refer to claimant's then-current condition or any similar language, it cannot be reasonably construed to have any bearing on whether the parties settled claimant's then-current condition. *See, e.g., International Paper Co. v. Pearson*, 106 Or App 121, 124 (1991) (holding that a settlement agreement resolved that certain medical services were compensable, but did not resolve compensability of the underlying condition because the agreement said nothing about compensability of that condition); *Amber D. Applebee*, 45 Van Natta 2270 (1993) (where the parties' stipulation provided that the carrier agreed to rescind its aggravation denial and reopen the claim, but did not specify the identity of the claimant's then-current condition, the 1988 stipulation did not constitute an acceptance of the claimant's specific 1988 condition), *aff'd mem* 129 Or App 304 (1994).

We proceed to examine the merits of the insurer's current condition denials. The insurer's partial denials denied claimant's preexisting condition and his current condition on the basis that neither the April 1, 1997 injury nor the July 9, 1997 injury were the major contributing cause of his current need for medical care and disability. (Exs. 83, 84).

ORS 656.262(6)(c) provides:

> "An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

As we mentioned earlier, claimant contends that the March 1988 Stipulation and Order "represents a final judgment that claimant's current condition and medical services are compensable as of the date of that Stipulation." (Claimant's br. at 6). Claimant reasons that the insurer is only allowed to deny his current condition if there has been a change in the set of operative facts existing after the March 1998 Stipulation and Order.

Claimant's argument presumes that the March 1988 stipulation pertained to his then-current condition. As we have discussed, because the stipulation did not refer to claimant's then-current condition or any similar language, it cannot be reasonably construed to have any bearing on whether the parties settled his then-current condition. Therefore, we are not persuaded by claimant's argument that the insurer is limited to establishing that a "change" occurred after March 1998.

The previous hearing was held on September 29, 1997 and the record closed on December 24, 1997. The January 5, 1998 Opinion and Order did not refer to the fact that claimant was involved in a motor vehicle accident (MVA) on December 6, 1997.

The insurer argues that claimant's auto accident was a "change" in claimant's condition, although it acknowledges that the change was temporary. We need not address this issue because the medical evidence establishes the requisite "post-July 1997" change of condition or change of circumstances; *i.e.*, a change since claimant's most recent compensable injury. In *Gregory C. Noble*, 50 Van Natta 1469 (1998), *aff'd mem Liberty Northwest Ins. Corp. v. Noble*, 159 Or App 426 (1999), we found that the evidence challenging compensability of the claimant's current right knee condition merely addressed the same condition previously denied and did not suggest that the compensable work injury "was no longer" the cause of the condition. *Compare Evelyn A. Bursell*, 51 Van Natta 373 (1999) (medical evidence indicated that the claimant's compensable injury had ceased to be the major contributing cause of her current combined condition). Unlike *Noble*, we find that the medical evidence in this case establishes that claimant's compensable injury is no longer the major contributing cause of his current combined cervical condition.

Because of the multiple possible causes of claimant's current condition, 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). In evaluating expert medical opinion, we rely on those that are both well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we generally 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, Dr. Bell has been treating claimant at least since 1988. On April 16, 1998, Dr. Bell reported that claimant's current condition was cervical strain with radiculopathy. (Ex. 91). He believed the etiology of claimant's current condition was related to the July 9, 1997 injury. (*Id.*) Dr. Bell acknowledged that claimant had preexisting degenerative disc disease and osteoarthritis of his neck, but noted that he did reasonably well until the April 1, 1997 injury. (*Id.*) He concluded that the April 1, 1997 and July 9, 1997 work injuries were "major contributing causes" requiring claimant's medical treatment. (*Id.*)

On the other hand, Dr. Bell concurred with a February 25, 1998 report from Dr. Zivin, which said the April 1997 and July 1997 injuries were "not felt to indicate a 'major cause of current condition.'" (Exs. 81-12, 82). Dr. Zivin believed claimant's current condition was a "subjective one" and he found no reason to relate claimant's current symptoms to the 1997 incidents. (Ex. 81-12). Dr. Zivin felt the April 1997 and July 1997 injuries did not require any further medical care. (*Id.*) Dr. Bell concurred with Dr. Zivin's report without comment. (Ex. 82).

Dr. Bell's concurrence with Dr. Zivin's opinion is inconsistent with his April 16, 1998 report stating that the April 1, 1997 and July 9, 1997 work injuries were major contributing causes requiring claimant's medical treatment. (Ex. 91). Because Dr. Bell provided no explanation for his change of opinion, his opinion on causation is not persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive). We are unable to determine the reason for Dr. Bell's change of opinion and, therefore, his opinion is entitled to little weight.

Furthermore, we find that Dr. Bell's own opinions on causation appear to be inconsistent. On August 22, 1997, Dr. Bell reported that claimant had a cervical injury with radiculopathy and the "most likely cause" was the work injury when the clamp struck him on his head on April 1, 1997. (Ex. 75-2). In contrast, in his April 16, 1998 report, Dr. Bell said the "etiology of [claimant's] current condition is related to the injury of July 9, 1997." (Ex. 91). He said that the April 1, 1997 and July 9, 1997 work injuries were major contributing causes requiring claimant's medical treatment. (*Id.*) For the foregoing reasons, we conclude that Dr. Bell's opinion on causation was not persuasive.

The remaining medical opinions do not establish compensability of claimant's current cervical condition. Dr. Zivin examined claimant on behalf of the insurer and he also testified at the hearing. Unlike Dr. Bell, Dr. Zivin found no findings to suggest a radiculopathic problem. (Ex. 81-11). He felt that claimant's cervical problem was medically stationary and the cervical findings were "commensurate" with claimant's underlying cervical degenerative change. (Ex. 81-12). He said the April 1997 and July 1997 injuries were "not felt to indicate a 'major cause of current condition.'" (*Id.*) Instead, Dr. Zivin believed claimant's current condition was a "subjective one." (*Id.*) He found no reason to relate claimant's current symptoms to the 1997 incidents. (*Id.*)

At hearing, Dr. Zivin testified that claimant had not told him about his December 6, 1997 MVA at the time of the February 25, 1998 examination. (Tr. 29). He felt that claimant's July 9, 1997 injury was a "nonmeaningful event" in terms of his neck. (Tr. 35). He said that the April 1997 injury caused a contusion and maybe some degree of cervical strain, which cleared up over several weeks or a few months. (Tr. 36). Dr. Zivin did not believe claimant's April 1997 and July 1997 injuries caused any permanent alteration or worsening of claimant's underlying preexisting symptom complex. (Tr. 38).

On January 22, 1998, Dr. Tesar examined claimant on behalf of the insurer and found that claimant had subjective complaints of pain without any objective abnormalities. (Ex. 78-7). He felt claimant was medically stationary and should return to regular employment. (*Id.*) Dr. Tesar provided an additional report on July 2, 1998. He said that claimant appeared to have a chronic cervical strain syndrome before the April 1, 1997 injury. (Ex. 92-2). He felt claimant sustained a cervical strain superimposed on the chronic neck pain complaints as a result of that injury. (*Id.*) Dr. Tesar said that initially the cervical strain injury was the major contributing cause of the combined condition. (*Id.*) He believed that, as claimant recovered from the acute injury, his neck pain and need for treatment would eventually be related to the pre-existing chronic cervical strain syndrome. (*Id.*) Dr. Tesar felt that claimant would recover from the injury in about six months and, after that time, the major contributing cause of the combined condition would become the preexisting chronic cervical strain syndrome. (Ex. 92-3). He said that, even after the July 1997 "exacerbation," claimant's work injury "would still resolve" as the major contributing cause by early October 1997. (*Id.*)

After reviewing the medical evidence, we conclude that claimant has not sustained his burden of proving that his April 1, 1997 injury and/or his July 9, 1997 injury are the major contributing cause of his current cervical condition. *See* ORS 656.262(6)(c). Consequently, we reverse the ALJ's order and uphold the insurer's denials.[2]

ORDER

The ALJ's order dated December 21, 1998 is reversed. The insurer's denials are reinstated and upheld. The ALJ's attorney fee award is also reversed.

[2] In light of our conclusion, we need not address the insurer's argument that the ALJ's attorney fee award was excessive.

December 21, 1999 Cite as 51 Van Natta 2003 (1999)

In the Matter of the Compensation of
CASEY R. SHERRELL, Claimant
WCB Case No. 99-02150
ORDER ON REVIEW
Parker, Bush & Lane, 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) Thye's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On October 27, 1998, claimant sought treatment for low back pain after twisting his back at home. Dr. Balfe diagnosed acute back strain. (Ex. 1).

On November 13, 1998, claimant filed a Form 801 stating that he slipped and fell down some stairs at work, twisting his back. (Ex. 5). Claimant sought treatment on the same day. (Ex. 6). Claimant was also treated in California on November 16, 1998, stating that he bent over and felt a "pop." (Ex. 9). Claimant was diagnosed with a severe back strain. (Ex. 10).

On November 19, 1998, claimant was hospitalized for acute low back pain. (Ex. 14). Claimant left the hospital on November 21, 1998. Claimant was then treated by Dr. Bloom on November 22; Dr. Stone on November 24; and called Dr. Jessick on November 25, reporting severe back pain. (Exs. 18, 20, 21). On November 25, claimant also saw Beverly Search, a nurse practitioner. (Ex. 23).

On December 1, 1998, claimant was treated by Dr. Penner. (Ex. 26). On December 2, 1998, claimant saw Dr. Balfe and reported that, on the same date, he "was doing better" and "sitting at work he developed acute onset of right over left low back pain and spasm[.]" (Ex. 27). Dr. Balfe saw claimant again on December 11, 1998. (Ex. 28).

After examining orthopedic surgeon, Dr. Schilperoort, saw claimant, on January 21, 1999, Dr. Barlow filed a Form 829, indicating that he had "requested all previous medical records." (Ex. 32).

SAIF accepted a "lumbar strain" and then denied "Grade I L5-S1 spondylolisthesis" and also denied treatment as of January 19, 1999, on the basis that the lumbar strain was no longer the major contributing cause of the current low back condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ first found that claimant's preexisting low back condition did not combine with the compensable injury. Thus, applying ORS 656.005(7)(a), the ALJ concluded that claimant carried his burden of proving compensability of his current low back condition. SAIF challenges the order, asserting that the medical evidence is not sufficient to prove compensability.

Although claimant saw numerous physicians, the record contains only two reports concerning the cause of claimant's condition in January 1999, when SAIF accepted a lumbar strain but denied the current low back condition. First, Dr. Schilperoort found that, based on several imaging studies, claimant had preexisting spondylolisthesis. (Ex. 29-6). Dr. Schilperoort explained that claimant sustained a lumbar strain from the November 14, 1998 twisting incident and that the condition had resolved. (*Id.* at 8). According to Dr. Schilperoort, claimant's current need for treatment was due to the preexisting condition. (*Id.*)

The remaining opinion is from claimant's current physician, Dr. Barlow. He reported that, although claimant had spondylolisthesis, it was an "incidental finding." (Ex. 36). According to Dr. Barlow, he was "making a connection to the injury he received on [November 13, 1998] as the major contributing factor to his current pain." (*Id.*)

In assessing the persuasiveness of medical opinions, we find most persuasive those that are based on an accurate history and well-reasoned. *See Somers v. SAIF*, 64 Or App 259 (1986). Here, there is no evidence showing upon what history Dr. Barlow relied for his opinion. The record contains only the Form 829 dated January 21, 1999 providing Dr. Barlow's diagnosis of lumbosacral strain. There is no proof that Dr. Barlow reviewed claimant's previous medical records and imaging studies or even took a history from claimant.

Similarly, Dr. Barlow had limited contact with claimant based on claimant's testimony that he saw Dr. Barlow on only one occasion. (Tr. 17). Thus, when Dr. Barlow provided his opinion on May 31, 1999, it was based on a single examination that took place four months previously.

Finally, Dr. Barlow provides no reasoning for his conclusion that claimant continued to suffer from only a lumbar strain as of January 21, 1999, over two months after the November 13, 1998 injury. Nor does Dr. Barlow explain why the preexisting condition is an "incidental finding" that does not contribute to claimant's current condition. In light of Dr. Schilperoort's conclusion to the contrary, which was in part based on the imaging studies, and the lack of proof that Dr. Barlow saw the imaging studies, we find that the lack of reasoning further undermines the persuasiveness of Dr. Barlow's opinion.

In short, we find that, at best, the medical evidence is in equipoise. Thus, we conclude that claimant did not carry his burden of proving compensability. *See* ORS 656.005(7)(a), 656.005(7)(a)(B).[1]

ORDER

The ALJ's order dated July 16, 1999 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

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[1] We reach this conclusion regardless of whether the injury did or did not combine with claimant's preexisting condition or whether the appropriate compensability standard is material or major contributing cause.

In the Matter of the Compensation of
BONNIE C. McGILVRAY, Claimant
WCB Case No. 99-02399
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denials of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

Generally, we defer to the opinion of 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 reasons not to defer to Dr. Thayer. We give deference to Dr. Thayer in particular because he has had the opportunity to observe claimant's condition during surgery. (Ex. 34). *Argonaut Insurance v. Mageske*, 93 Or App 689, 702 (1988); *William F. Wegesend, III*, 50 Van Natta 1612, 1613 (1998).

Moreover, in contrast to Dr. Thayer's position as the long-time treating physician and surgeon, Dr. Button performed only a records review for the employer. (Ex. 40). Dr. Jewell examined claimant on one occasion on behalf of the employer. (Ex. 29). As the ALJ noted, it is not clear whether or not Dr. Jewell ever saw Dr. Thayer's operative report.

For these reasons, we agree with the ALJ that claimant proved the existence of a work-related bilateral carpal tunnel syndrome by medical evidence supported by objective findings. ORS 656.802(2)(d). Accordingly, the claim is compensable.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,625, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her counsel's uncontested attorney fee request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 28, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,625, to be paid by the employer.

In the Matter of the Compensation of
JOSE R. NAVA, Claimant
WCB Case No. 99-00164
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of his injury claim for an umbilical hernia. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On September 14, 1998, claimant was at work prying pieces of railroad rail into a feed trough when he was injured. (Exs. 2, 4). Claimant testified that he experienced immediate pain in his back and abdomen. (Tr. 7, 8). On the same day, he reported the injury to his supervisor. (Tr. 8). Claimant did not seek medical treatment until the pain bothered him enough to see a physician. (*Id.*)

He was treated by Dr. Silverman on October 8, 1998. (Ex. 3). Dr. Silverman noted that claimant spoke Spanish, with some English. (*Id.*) Claimant testified that no translator was present during the exam and Dr. Silverman spoke "very little" Spanish. (Tr. 9). Claimant testified he can understand a "little" English. (*Id.*) The information at the beginning of Dr. Silvermans October 8, 1998 chart note said that claimant had a strain to stomach and back while lifting at work - injury occurred 9-14-98. (Ex. 3). He diagnosed a lumbar strain. (Exs. 3, 4). The 827 form signed by Dr. Silverman indicated that claimant had strained his stomach area and back while lifting something heavy. (Ex. 4).

On October 15, 1998, claimant sought from Dr. Eichner in the emergency room. (Ex. 6). Dr. Eichner reported that on September 14, 1998, claimant developed low back pain and also noted an umbilical pain along with this protrusion through his navel. (Ex. 6-1). Dr. Eichner diagnosed an umbilical hernia. (Ex. 6-2).

Claimant was referred to Dr. Thrall for treatment. On October 19, 1998, Dr. Thrall reported that claimant developed immediate low back pain at work on September 14, 1998. (Ex. 7-1). Dr. Thrall said that claimant relates the onset of swelling and discomfort in the umbilical area approximately 15 days after his low back injury at work. He has had a bulge in the umbilical area since then. (*Id.*) Dr. Thrall was uncertain about the relationship of claimants hernia condition to his work injury. (Ex. 7-2). Dr. Thrall said that an interpreter was present during claimants September 14, 1998 exam. (Ex. 29-9).

Dr. Thrall referred claimant to Dr. Parshley for treatment of the hernia. Dr. Parshley examined claimant on October 28, 1998 with the assistance of an interpreter. (Ex. 12). He reported that claimant was moving a rail at work when he got a sudden pain in his back and developed an umbilical hernia. (*Id.*) Dr. Parshley recommended surgery. (Exs. 12, 13).

Dr. Thrall referred claimant to Dr. Wong for treatment of the back injury. Dr. Wong reported that claimant was injured when he attempted to lift a heavy rail with a bar and experienced immediate low back and abdominal pain. (Ex. 20-1). Claimant told Dr. Wong that he had onset of abdominal/lumbar pain at the time of injury and also noted the umbilical protrusion. (Ex. 20-3). Dr. Wong believed that claimants hernia was related to the on-the-job injury. (Exs. 21, 22).

On November 24, 1998, the insurer accepted a nondisabling lumbar strain. (Ex. 18). The insurer issued a partial denial of claimants hernia condition, asserting that the "diagnosis and treatment for your umbilical hernia is not related, reasonable or necessary for the accepted condition of lumbar strain." (Exs. 17, 19). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Based on claimants testimony and references in the early medical reports to abdominal pain, the ALJ found that claimant experienced abdominal and low back pain on September 14, 1998. Nevertheless, the ALJ found that the first evidence of a hernia bulge was on September 29, 1998. The

ALJ reasoned that Dr. Thralls opinion on causation was the most thoroughly developed and created substantial doubt as to whether claimant's work injury was either a material or major cause of the umbilical hernia. The ALJ concluded that claimant had failed to prove that the umbilical hernia was compensable.

Claimant argues there is no medical evidence in the record to support the ALJs finding that he had abdominal symptoms on September 14, 1998, but the hernia did not occur until September 29, 1998. Claimant contends that his abdominal symptoms and the umbilical hernia occurred immediately at the time of the original injury. He relies on the opinions of Drs. Parshley and Wong to establish compensability. For the following reasons, we agree with claimant.

To begin, we note that the ALJ did not make any express credibility findings. Nevertheless, the ALJ was persuaded by claimants testimony and the early medical reports that claimant had experienced abdominal pain on September 14, 1998. We agree with claimants argument that Dr. Thralls opinion on causation is inconsistent with the ALJs finding that claimant had abdominal pain on September 14, 1998. Dr. Thrall believed that claimants abdominal swelling and discomfort occurred at the same time he noticed the bulge. (Ex. 29-9). He understood that claimants swelling and discomfort in the umbilical area occurred 15 days after his low back injury at work. (Exs. 7, 29-9).

In a concurrence letter from the insurer, Dr. Thrall agreed that it was highly unlikely for a hernia to occur 15 days after the alleged causal event. (Ex. 24). In a deposition, Dr. Thrall reiterated that he did not believe claimants hernia was related to the September 14, 1998 injury. (Ex. 29-22).

We are not persuaded that Dr. Thrall had an accurate history of claimant's abdominal symptoms.[1] Claimant testified that he experienced immediate pain in his back and abdomen as a result of the September 14, 1998 work injury. (Tr. 7, 8). Claimants testimony is consistent with the medical reports from Drs. Silverman, Eichner, Parshley and Wong, all of whom reported that claimant experienced abdominal pain on September 14, 1998. (Ex. 3, 6, 12, 20). Drs. Eichner, Parshley and Wong all reported that claimant noticed an umbilical protrusion on September 14, 1998. (Ex. 6, 12, 20). Based on claimant's testimony and the other medical reports, we conclude that Dr. Thrall did not have an accurate history and, therefore, his opinion on causation 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).

Based on the opinions of Drs. Parshley and Wong, as supported by the opinions of Drs. Eichner and Silverman, we find that claimant experienced abdominal pain and an umbilical protrusion as a result of the September 14, 1998 injury. Drs. Silverman and Eichner related claimants abdominal pain to the September 14, 1998 incident. (Exs. 3, 6). In a concurrence letter from claimants attorney, Dr. Parshley agreed that, based on his understanding of claimants history, the mechanism of injury and his treatment, it was medically probable that the September 14, 1998 lifting incident was the major contributing cause of claimants umbilical hernia. (Ex. 27-3). Dr. Parshley explained that a significant strain may cause or aggravate significantly preexisting defects at the umbilicus. (*Id.*) He agreed that it was possible claimant could experience both a low back strain and umbilical hernia as a result of the same lifting event. (Ex. 27-2).

Similarly, Dr. Wong believed that claimants hernia was related to the September 14, 1998 on-the-job injury. (Exs. 21, 22, 25). In a concurrence letter from claimants attorney, Dr. Wong agreed that, based on his understanding of claimants history, the mechanism of injury and his treatment, it was medically probable that the September 14, 1998 lifting incident was the major contributing cause of claimants umbilical hernia. (Ex. 28-3). Dr. Wong felt it was reasonably probable that the history discrepancies regarding claimants symptoms were the result of communication difficulties or the vagaries involved in the need to use an interpreter. (Ex. 28-2). He agreed that claimant could experience a low back strain and umbilical hernia concurrently. (*Id.*)

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[1] We note that Dr. Thrall's handwritten October 19, 1998 chart note contains inconsistent histories. One notation states: F/u [follow-up] low back/pain while using a bar to lift a heavy rail caused patient to develop a hernia and now patient states thats causing him to have a back problem feels burning sensation down back in lt leg." (Ex. 9). In different handwriting, another notation on the October 19, 1998 chart note referred to [i]mmediate central LBP and umbilical hernia dev. 15 days later. (*Id.*) It appears that two different histories may have been taken at the time of claimant's October 19, 1998 exam.

In sum, based on the opinions of Drs. Parshley and Wong, as supported by the opinions of Drs. Eichner and Silverman, we conclude that claimant has established that the September 14, 1998 injury is the major contributing cause of the umbilical hernia.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 12, 1999 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $5,500, payable by the insurer.

In the Matter of the Compensation of
GLENN E. WHITLOCK, Claimant
WCB Case No. 93-13776
ORDER ON REMAND
Bennett, Hartman & Reynolds, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Whitlock v. Klamath County School Dist.*, 158 Or App 464 (1999). The court has reversed our prior order, *Glenn E. Whitlock*, 49 Van Natta 835 (1997), that had upheld the self-insured employer's denial of claimant's mental disorder claim. Concluding that we erred in determining that off-duty preparation claimant had to undertake to competently perform his new teaching assignment as a secondary social studies teacher was a condition "generally inherent in every working situation," the court has instructed us to consider whether claimant's preparation time was the major contributing cause of his mental disorder.

FINDINGS OF FACT

We adopt the "Findings of Fact" from our prior order which were taken from the court's previous order. *Whitlock v. Klamath County School District*, 142 Or App 137 (1996) (*Whitlock I*). We republish them here for the reader's convenience.

> "Claimant taught music to elementary school children in the Klamath School District from 1981 until 1993. At the end of the 1992-93 school year, in the wake of Ballot Measure 5, the employer District eliminated all elementary school music positions. Consequently, claimant exercised his "bumping" rights under a collective bargaining agreement and secured a secondary school social studies teaching position. Although claimant had a secondary social studies certification, he had never actually taught that subject.
>
> "For the 1993-94 school year, the [employer] assigned claimant either six or seven class periods a day, in four subject areas: 7th grade social studies, 10th grade global history, 12th grade economics, and 12th grade federal government. Claimant, like all teachers in the District, was allotted one 49-minute preparation period a day.
>
> "Claimant felt overwhelmed and stressed by his new duties. He worked 12 to 14 hours a day, including spending four to six hours a night preparing for the next day's classes. Nevertheless, he received 'considerable' criticism from his students and some criticism

from the school administration.[1] Claimant became very despondent and, at the urging of family and friends, sought treatment from his physician, who referred him for psychiatric treatment. The psychiatrist diagnosed 'a single episode of nonpsychotic major depression due to stress at work.'

"In October 1993, claimant filed a claim for workers' compensation. [The employer] denied coverage." 142 Or App at 139-40 (Footnotes omitted).

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, finding that claimant's stress came about because he was put in a position for which he had neither training nor experience. Reasoning that this situation occurred as a result of the collective bargaining agreement, and finding that the agreement was not generally inherent in every working situation, the ALJ concluded that claimant carried his burden of proving a compensable mental disorder claim under ORS 656.802(3).

On Board review, we reversed. *Glenn E. Whitlock*, 47 Van Natta 179 (1995). Focusing on the portion of ORS 656.802(3)(b) that provides that "[t]he employment conditions producing the mental disorder [must be] conditions other than conditions generally inherent in every working situation," we concluded that the stressors cited by claimant were all conditions which are generally inherent in every working situation. We reasoned that claimant's change of teaching position was caused by financial constraints due to budget cuts and by an employment contract which provided for "bumping" rights; we concluded that both conditions are inherent in every working situation. 47 Van Natta at 181. We also rejected claimant's contention that he lacked training to teach social studies, because he had received certification to teach that subject.

On judicial review, the court in *Whitlock I* reversed our decision. *Whitlock v. Klamath County School District*, 142 Or App at 144. Noting that claimant's claim rested entirely on the premise that his mental disorder was caused by stress he experienced after he assumed the social studies position, the court stated that our consideration of conditions that antedated claimant's assumption of the position was immaterial. In addition, the court stated that we neglected to consider whether claimant's preparation for the social studies position was a condition "generally inherent in every working situation." The court remanded for our consideration of that question.

On remand, we continued to hold that claimant's mental disorder claim was not compensable because his stress resulting from the extensive time needed to prepare for assuming a new teaching position was generally inherent in every working situation. *Glenn E. Whitlock*, 49 Van Natta at 837. We reasoned that the assumption of a new job ordinarily will result in extra work hours to gain experience and proficiency. In some situations, we noted that such extra preparation time may be excessive and, thus, not a condition common to all employments. Nonetheless, reasoning that claimant assumed a new position in the same occupation (teaching) and had met the minimum level of proficiency required to perform the tasks of the new position (he had a secondary school social studies teaching certificate), we concluded that extra time and efforts devoted to gain proficiency in the new position were conditions common to all employments. *Id.* at 836.

Claimant again sought judicial review. The court, *en banc*, reversed. *Whitlock v. Klamath County School District*, 158 Or App at 476 (*Whitlock II*). Citing *Fuls v. SAIF*, 321 Or 151 (1995), and *Housing Authority of Portland v. Zimmerly*, 108 Or App 596, 599 (1991), the court stated that a work-related mental disorder is not compensable if the stress-inducing condition is common to the general range of employments, even if that condition is not necessarily inherent in every job. Although the legislature intended to curtail compensable claims for mental disorders based on on-the-job stressors, the court observed that the legislature intended to do so only if, or to the extent that, the stress-producing condition was common to the full range of employment. 158 Or App at 475.

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[1] As noted in our prior order, the parties stipulated that claimant's interaction with school administrators "falls into the category of reasonable disciplinary, corrective, or job-performance activities," and are not the basis of his claim. (Tr. 6).

The court reasoned that our decision did not comport with the legislature's intent because devoting extra time and efforts gaining proficiency in a new position was not common to the full range of working situations. Indeed, the court noted that most jobs do not require off-duty preparation, much less extra hours of preparation time, to perform the work competently. Concluding that we erred in determining that off-duty preparation claimant had to undertake to perform his job competently was a condition "generally inherent in every working situation," the court reversed and remanded for consideration of whether claimant's preparation time was the major contributing cause of his mental disorder.

We now proceed with that determination. For the following reasons, we conclude that claimant has not carried his burden of proving by clear and convincing evidence that claimant's preparation time was the major contributing cause of his psychological condition. *See* ORS 656.802(2)(a), (3)(d).

Because of the multiple possible causes of claimant's mental disorder, 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 give greater weight to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, causation opinions were offered by Dr. Nagy, the treating psychiatrist; Dr. Turco, examining psychiatrist; Dr. Sasser, examining psychiatrist; and Dr. Davies, examining psychologist. Dr. Nagy opined that "job stress" was the major contributing cause of claimant's mental disorder. (Ex. 21). However, Dr. Nagy provided no reasoning to support his conclusion. *See Lloyd A. Terpening*, 50 Van Natta 799, 800 (1998) (discounting unexplained medical opinion). Moreover, Dr. Nagy did not attribute claimant's mental disorder to lengthy preparation time, but rather to job stress in general. *Cf. 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 these reasons, we find persuasive reasons not to defer to Dr. Nagy's opinion.

We now turn to Dr. Davies' opinion. In concluding that the major contributing cause of claimant's depression was his employment "problems," Dr. Davies explained:

> "[I]t appears that [claimant] was overwhelmed by his employment responsibilities. He perceives himself as a music teacher, not a Social Studies teacher, and he did not feel comfortable in the job and he did not like it. He felt the need to put in long hours, was inefficient, and apparently developed a transient depression." (Ex. 20-8).

Thus, Dr. Davies related claimant's mental disorder to his discomfort with the social studies position *and* his inefficient use of preparation time. Dr. Davies, however, did not conclude that lengthy preparation alone was the major contributing cause of the mental disorder. Instead, Dr. Davies made the general observation that employment "problems" were the major cause. Because Dr. Davies did not distinguish between claimant's discomfort with his job and inefficient use of preparation time with respect to major causation, we also find that Dr. Davies' opinion does not satisfy claimant's burden of proof.

Dr. Sasser wrote: "I do not believe that [claimant's] problem was caused by his work as much as it was his own inabilities to perform in the social studies teacher position." (Ex. 23-4). This opinion, however, does not attribute claimant's mental disorder in major part to work preparation. Rather, Dr. Sasser simply felt that claimant was not prepared to teach social studies. *Id.*

Finally, Dr. Turco attributed claimant's psychological condition, in part, to his interaction with the school administration. He opined that "[t]he major contributing cause of [claimant's] depression and decision to seek treatment was the 'pressure' he was experiencing in the context of teaching social studies and the observations he was placed under [by the school administration]." (Ex. 19-6). Because "observations" by the school administration may not be considered as a work-related stressor under ORS 656.802(3)(b), Dr. Turco's opinion does not establish the compensability of claimant's claim.

Having reviewed the record, we are not persuaded that claimant has proved by clear and convincing evidence that preparation time was the major contributing cause of his psychological condition. Therefore, we again find that his mental disorder claim is not compensable.

Accordingly, on reconsideration, as modified and supplemented herein, we republish our June 24, 1997 order.

IT IS SO ORDERED.

Board Member Biehl dissenting.

The majority concludes once more that claimant's mental disorder claim is not compensable. This time the majority finds that claimant failed to prove by "clear and convincing" evidence that excessive preparation time was the major contributing cause of his mental disorder. Because I disagree with the majority's evaluation of the medical evidence, I must dissent once again.

My previous dissent explained my position regarding the merits of the medical causation issue. *Glenn E. Whitlock*, 49 Van Natta 835 (1997) (Member Biehl dissenting). There, after reviewing the medical record, I concluded that claimant had carried his burden of proving by clear and convincing evidence that his lack of training and overwhelming preparation time were the major contributing cause of his psychological condition. *Id.* at 838. Because it is undisputed that claimant has established the remaining elements of a mental disorder claim, I further wrote that I would find the claim compensable and set aside the employer's denial.

My evaluation of the medical evidence has not changed. All of the physicians who have commented on the causation issue relate claimant's mental disorder to employment conditions. Dr. Nagy, the attending psychiatrist, opined that employment conditions are the major contributing cause of the mental disorder. As the attending physician, Dr. Nagy's opinion should be given the greatest weight. *Weiland v. SAIF*, 64 Or App 810 (1983). In support of Dr. Nagy's opinion, Dr. Davies also opined that the major contributing cause of claimant's depression was his employment problems. Dr. Davies specifically related claimant's condition to his discomfort with the social studies position and his inefficient use of lengthy preparation time.

Dr. Sasser opined that claimant was not prepared to teach social studies. The direct result of that lack of preparation was claimant's need to devote large amounts of time preparing for classes. Thus, Dr. Sasser's opinion also supports compensability.

Dr. Turco attributed claimant's condition, in part, to his interaction with the school administration. He opined that "[t]he major contributing cause of [claimant's] depression and decision to seek treatment was the 'pressure' he was experiencing in the context of teaching social studies and the observations he was placed under [by the school administration]." (Ex. 19-6). Because the "observations" by the school administration may not be considered a work-related stressor under ORS 656.802(3)(b), I agree with the majority that Dr. Turco's opinion alone would not support claimant's claim.

However, as I noted in my prior dissent, Dr. Turco did not render an opinion as to whether claimant's difficulty in teaching social studies would have been a sufficient stressor alone to constitute the major contributing cause of his condition. Therefore, Dr. Turco's opinion does not contradict the opinions of the remaining doctors that claimant's inability to teach social studies was the major contributing cause of his condition. Based on my review of the record, I am persuaded that claimant's inefficient use of lengthy preparation time, which directly resulted from his inability to teach social studies, was the major factor in the development of the mental disorder.

Because the majority too narrowly construes the medical evidence, I cannot agree with their assessment of the medical causation issue. Therefore, I dissent.

In the Matter of the Compensation of
ERIKA W. ORTMAN, Claimant
WCB Case No. 98-06708
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Gilroy Law Firm, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's injury claim for a right hip/femur fracture. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation. In the second paragraph of the findings of fact on page 2, we add the following after the second sentence: "Claimant testified that each glass of wine was "filled up" and held about 12 ounces. (Tr. 33)." In the third paragraph of the findings of fact on page 2, we delete the second sentence. We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issue in this case concerns compensability of claimant's injury claim for a right hip/femur fracture that she sustained on August 29, 1997. Claimant, a school bus driver, went to the employer's office on that day. Although claimant was on a summer layoff, she had been asked to come into the office and review her bus schedule information for the upcoming school year. Before going to the employer's office, claimant had gone to lunch with friends and had 3 glasses of wine. After claimant obtained the information from the employer, she walked on a gravel area that was somewhat gradually sloped when she slid and fell, fracturing her right hip/femur.

The parties agreed that this is an "alcohol defense" case under ORS 656.005(7)(b)(C). The employer agreed that claimant has established a *prima facie* case of compensability. Although the ALJ found that claimant's blood alcohol level was .30 gm/dl at the time of her accident, he explained "there is no question that claimant was able to drive, walk, talk and take care of the employer's business with two of the employer's dispatchers without any evidence that claimant's alcohol consumption factually/physically/mechanically caused her fall." (Opinion and Order at 5). The ALJ found that Dr. Burton's history of claimant's accident was partially incorrect. The ALJ concluded that the major contributing cause of claimant's fall was a combination of the loose gravel on a somewhat gradually sloped surface and not her alcohol consumption.

On review, the employer argues that it met its burden of proving that the consumption of alcohol was the major contributing cause of claimant's injury. The employer relies on the opinion of Dr. Burton, as supported by Dr. Peterson, claimant's treating physician.

Under ORS 656.005(7)(b)(C), claimant must first establish a *prima facie* case of compensability. If established, then to defeat a finding of compensability under ORS 656.005(7)(b)(C), the carrier must prove, by the preponderance of the evidence, that claimant's "consumption of alcoholic beverages or the unlawful consumption of any controlled substance" was the major contributing cause of the injury. For the following reasons, we find that the employer has met its burden of proof.

To begin, we find that the record does not support the ALJ's finding that claimant did not appear drunk or intoxicated during her conversations with two employees on August 29, 1997. (Opinion and Order at 2).

At hearing, only claimant and Ms. Park, the employer's driver supervisor, testified. Claimant said she had lunch with friends on August 29, 1997, from approximately 11:30 a.m. to 12:45 p.m. (Tr. 31-32). She ate Chinese food and drank three "big" glasses of wine. (Tr. 33-34). Claimant said the glasses were "filled up" and contained about 12 ounces each. (Tr. 33). She said she had not eaten breakfast and had not had anything to drink before 11:30 a.m. (Tr. 34, 40). She testified that she did not have anything to drink after leaving the restaurant. (Tr. 35, 40). At that time, claimant weighed 130 pounds. (Tr. 33). She is 5 feet, four and one-half inches tall. (*Id.*)

After lunch, claimant drove home about three miles without any accidents. (Tr. 34). She arrived home about 1:00 p.m. and called Ms. Gainer, a dispatcher for the employer. (Tr. 22, 32). Claimant then drove about one and one-half miles to the employer's office, arriving about 1:30 p.m., without any accidents. (Tr. 35). She was inside the building for 10 to 15 minutes and there was a lot of activity because school was starting soon. (Tr. 38, 39). She spoke to Ms. Gainer and Ms. Park when she went to the office on August 29, 1997. (Tr. 26). Claimant testified that she did not have any problems walking after lunch. (Tr. 35-36).

Ms. Parks is the employer's driver supervisor, operations supervisor and special ed coordinator. (Tr. 53). Ms. Parks saw claimant on August 29, 1997, when she came to pick up her bus routing schedule. (Tr. 55). She talked to claimant "[v]ery, very briefly." (*Id.*) Ms. Parks said claimant was in the office "maybe five to ten minutes." (*Id.*) She believed claimant had also spoken to Ms. Gainer and then left. (Tr. 56). Although claimant had previously indicated she would take a "dry run" of her bus route that day, she came back in the building and said she had decided not to do so on that day because she had shrimp in the car. (Tr. 56-57). Shortly after claimant left the building for the second time, a person came in to report that claimant had fallen outside. (Tr. 59).

Although claimant testified that she spoke to Ms. Gainer and Ms. Parks shortly before she was injured, there is no testimony from either person regarding claimant's appearance and demeanor during the August 29, 1997 office visit. Ms. Gainer did not testify and Ms. Parks only commented that she talked to claimant "[v]ery, very briefly." (Tr. 55). We find that the record does not support the ALJ's finding that claimant did not appear drunk or intoxicated during her conversations with two employees on August 29, 1997. Similarly, the record does not support the ALJ's conclusion that "claimant was able to drive, walk, talk and take care of the employer's business with two of the employer's dispatchers without any evidence that claimant's alcohol consumption factually/physically/mechanically caused her fall." (Opinion and Order at 5). At most, we have claimant's testimony that she did not have any accidents while driving on August 29, 1997 and she did not have trouble walking after lunch. In light of the medical evidence, claimant's testimony is not persuasive.

We find that the cause and effect of the use of alcohol or controlled substances is a medical question requiring expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Grace L. Walker*, 45 Van Natta 1273 (1993), *aff'd mem Walker v. Danner Shoe Manufacturing*, 126 Or App 313 (1994).

Dr. Burton, a board certified medical toxicologist, reviewed the records and provided an opinion on causation. (Ex. 45). He referred to an ambulance report indicating claimant said she had consumed three glasses of wine before the fall. (Exs. 6-2, 45-1). The ambulance report also noted that the "ground was on an incline, uneven, covered with loose rock." (Ex. 6-2). Dr. Burton referred to an emergency report that indicated claimant presented with an "etoh [alcohol] smell." (Exs. 10-1, 45-2). Also, the anesthesia preoperative report on August 29, 1997 referred to "etoh smell." (Ex. 21-4, 45-2).

Dr. Burton analyzed claimant's blood alcohol test and determined that her blood alcohol concentration at the time of the accident was approximately 0.30 gm/dl. (Ex. 45-3). He explained that, based upon a weight of 130 pounds, claimant would experience a rise in blood alcohol concentration of approximately 0.034 gm/dl per drink. (*Id.*) Dr. Burton defined a "drink" as, among other things, four ounces of wine, which would contain approximately 12 gm of alcohol. (*Id.*) He reasoned that, to achieve an alcohol concentration of 0.30 gm/dl, claimant would have had to consume at least nine drinks before the accident (allowing sufficient time for absorption). (*Id.*) Dr. Burton said that claimant exceeded the "legal limit" by more than three-fold at the time of the accident. (Ex. 45-4).

Dr. Burton's findings are consistent with claimant's testimony that she had three "big" glasses of wine, containing about 12 ounces each. (Tr. 33-34). In other words, nine "drinks" as defined by Dr. Burton would be approximately 36 ounces of wine. Claimant's testimony indicated that she indeed consumed about 36 ounces of wine on August 29, 1997.

Dr. Burton explained:

> "A blood alcohol concentration of 0.30 gm/dl would result in severe sensory impairment and impairment of judgement [sic], coordination and the ability to execute motor functions. At the predicted concentration of 0.30 gm/dl, [claimant] would undoubtedly experience significant difficulty walking or standing. Persons under the influence of

> alcohol at concentrations above 0.20 gm/dl are at significant risk of falls (not to mention motor vehicle accidents) and associated injury. The risk is compounded by the inability to perceive the risk or to take protective action once the fall is initiated. Thus, intoxicated persons frequently encounter more severe injuries than would be ordinarily encountered." (Ex. 45-4).

Dr. Burton commented that injuries secondary to falls are a common source of injury among persons intoxicated with alcohol. (*Id.*) He concluded that it was highly probable that alcohol was the major contributing cause of claimant's fall and her subsequent injuries. (*Id.*) Dr. Peterson, claimant's treating physician, deferred to Dr. Burton's opinion. (Ex. 47).

Claimant argues that Dr. Burton had an inaccurate history that she fell on a flat surface and, therefore, his opinion is not persuasive. Dr. Burton commented that "[a] hip fracture in a 47 year-old otherwise healthy and sober woman is an unusual event, particularly when walking on a flat surface, regardless of loose gravel." (Ex. 45-4). On the other hand, Dr. Burton indicated he had reviewed the August 29, 1997 ambulance report, which said the "ground was on an incline, uneven, covered with loose rock." (Ex. 6-2). In light of Dr. Burton's findings regarding the extent of claimant's "severe sensory impairment" and the fact that his findings are consistent with claimant's testimony regarding her alcohol consumption, we find that Dr. Burton's inaccurate reference to a "flat surface" is not particularly important. Instead, we are persuaded by Dr. Burton's well-reasoned opinion that claimant's alcohol consumption resulted in severe sensory impairment and impairment of judgment, coordination and the ability to execute motor functions.

Although claimant asserts that she was able to drive, walk, talk and take care of the employer's business with two employees without any evidence of impairment, we note that the only evidence to support that conclusion is claimant's testimony that she did not have any accidents while driving on August 29, 1997 and did not have trouble walking after lunch. While claimant's lay testimony may be relevant, the cause and effect of the use of alcohol is a medical question requiring expert medical opinion. *See Grace L. Walker*, 45 Van Natta at 1273.

Based on Dr. Burton's opinion, we conclude that the employer has sustained its burden of proving that claimant's consumption of alcohol was the major contributing cause of the August 29, 1997 injury. *See* ORS 656.005(7)(b)(C).

ORDER

The ALJ's order dated June 1, 1999 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Biehl dissenting.

The majority begins its opinion by noting that it is the carrier's burden to prove, by a preponderance of the evidence, that claimant's consumption of alcoholic beverages was the major contributing cause of her injury. *See* ORS 656.005(7)(b)(C). Because the majority has disregarded the burden of proof and ignored a serious problem in Dr. Burton's opinion, I respectfully dissent.

The majority incorrectly finds that the employer has carried its burden of proof on the issue of causation. The majority refers to the lack of lay testimony regarding claimant's impairment and somehow manages to construe that *against* claimant. Our cases clearly state that the *carrier* has the burden of proving that claimant's consumption of alcoholic beverages was the major contributing cause of the injury. *See, e.g., Janice Neuenschwander*, 49 Van Natta 1970 (1997). In my view, the lack of lay testimony that claimant appeared to be impaired or intoxicated actually weighs in claimant's benefit. The majority errs by concluding otherwise. The employer provided no evidence that claimant experienced any sensory impairment, impairment of judgment, or that she had difficulty walking or standing on the day she was injured.

The majority also errs by minimizing the seriousness of Dr. Burton's inaccurate understanding of the circumstances of the injury. Dr. Burton reported that "[a] hip fracture in a 47 year-old otherwise healthy and sober woman is an unusual event, particularly when walking on a flat surface, regardless of

loose gravel." (Ex. 45-4). There is no dispute that the area where claimant fell was somewhat gradually sloped and was *not* a flat surface. I agree with the ALJ that Dr. Burton did not have an accurate history of the circumstances involved in claimant's accident. Dr. Burton did not give adequate consideration in weighing the sloped gravel area in causation. Therefore, his 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). There are no other medical reports to sustain the employer's burden of proof.

After reviewing the record, I agree with the ALJ's reasoning and conclusion that the employer did not meet its burden of defeating compensability. Because the majority concludes otherwise, I respectfully dissent.

December 22, 1999 Cite as 51 Van Natta 2015 (1999)

In the Matter of the Compensation of
JACKIE WENNESON-OCANA, Claimant
WCB Case No. 98-05757
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's claim for a low back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact as summarized and supplemented below.

Claimant lifted a box of jeans at work on July 23, 1996 and felt a pull in her low back. She did not immediately seek treatment for that incident. On September 30, 1996, claimant twisted while reaching overhead at work and hurt her neck and upper and lower back. Claimant initially sought treatment on December 24, 1996, from Dr. Gilliland, but the initial medical records mention only the September 30, 1996 date of injury. The September 30, 1996 claim was subsequently accepted by the employer's claim processor.

In August 1997, claimant was referred to Dr. Hill for treatment. Dr. Hill's chart notes do not contain a history of the July 1996 injury.

A March 1998 MRI revealed diffuse degenerative disease of claimant's spine. Claimant filed a claim for the July 23, 1996 incident on March 24, 1998.

In April 1998, claimant was seen by Dr. Aversano for a neurologic evaluation. Dr. Aversano's report contains the first mention in the medical record of a history of the July 1996 incident.

Claimant began treatment with Dr. Ward in June 1998.

The employer denied the claim for the July 23, 1996 injury on July 7, 1998.

Claimant was examined by Drs. Gardner and Duff on behalf of the employer on August 11, 1998.

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Hill's chart notes, the ALJ found that the July 1996 low back injury was the major contributing cause of the disability or need for treatment of the combined condition from July 23, 1996 until November 17, 1997.

The parties agree that claimant has preexisting degenerative disc disease that contributes to her low back condition. Therefore, claimant must prove that the July 1996 low back injury is the major contributing cause of her disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B).

The examining physicians, Drs. Gardner and Duff, opined that claimant's July 1996 injury is not the major contributing cause of claimant's low back condition and need for treatment. Dr. Ward concurred with the opinions of Drs. Gardner and Duff.

The ALJ found Dr. Aversano's opinion that the low back condition was caused in major part by the July 1996 injury to be unpersuasive. Specifically, the ALJ found that Dr. Aversano's opinion was based on the temporal relationship between the symptoms and the injury and that his opinion was conclusory. The ALJ further noted that Dr. Aversano had only examined claimant on one occasion and was not entitled to special deference. We agree, for the reasons expressed above that Dr. Aversano's opinion is not persuasive. In particular, we find Dr. Aversano's opinion unpersuasive because it is conclusory and lacking in medical explanation and analysis. *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).

The ALJ relied on Dr. Hill to find that the July 1996 injury was the major contributing cause of claimant's low back condition. First, we note that Dr. Hill was not given a history of a July 1996 injury and, consequently, never had the opportunity to specifically address even the possibility of a causal connection between that particular injury and the low back condition. In addition, Dr. Hill did not examine claimant until August 1997, more than a year after the injury. Finally, Dr. Hill acknowledges that preexisting degenerative disease is playing a role in claimant's symptoms. In his final chart note, Dr. Hill states that the degenerative disc disease is "likely playing the biggest role" in claimant's symptoms "at this point." Dr. Hill, however, never addressed the issue of whether the strain was *ever* the major contributing cause of claimant's need for treatment or disability. Under such circumstances, we do not find Dr. Hill's opinion sufficient to establish compensability of claimant's low back condition. In the absence of persuasive medical evidence supporting compensability of claimant's low back injury claim, we must reverse the ALJ's order and uphold the denial.

ORDER

The ALJ's order dated June 23, 1999 is reversed. The employer's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority's analysis and agree with the ALJ that claimant has established compensability of her combined condition from the date of the July 23, 1996 injury until November 17, 1997 when Dr. Hill stated that the degenerative disease rather than the work-related strain was playing the "biggest role" in claimant's symptoms. Although Dr. Hill did not specifically note a history of the July 23, 1996 injury, he did note claimant's change to a different, more strenuous job and her lumbar spine symptoms. This suggests that Dr. Hill was aware of a work-related injury. Dr. Hill specifically attributed claimant's lumbar condition to claimant's work until November 17, 1997. Under such circumstances, Dr. Hill's opinion is sufficient to establish compensability of claimant's low back injury claim for that time period. Because the majority finds otherwise, I respectfully dissent.

In the Matter of the Compensation of
ANTONIO CENTURION, Claimant
WCB Case No. TP99008
THIRD PARTY DISTRIBUTION ORDER
Steven M. Schoenfeld, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant has petitioned the Board to resolve a dispute that concerns a "just and proper" distribution of proceeds from a third-party settlement. *See* ORS 656.593(3). Specifically, the dispute concerns the paying agency's (the SAIF Corporation's) entitlement to a lien for anticipated future medical expenditures. For the following reasons, we conclude that SAIF has not established that it is reasonably certain that it will incur such expeditures.

FINDINGS OF FACT

Claimant was compensably injured on October 8, 1998, when he was involved in a motor vehicle accident. On December 7, 1998, SAIF accepted a lumbosacral sprain/strain and cervical strain.

A March 17, 1999 MRI scan showed claimant had a minor left disc herniation at L4-5 that directly abuts the left L5 nerve root. On March 22, 1999, Dr. Aversano diagnosed lumbar radiculopathy and a cervicodorsal strain and recommended further chiropractic treatment.

Claimant has not yet sought acceptance of the disc herniation. Claimant asserts he has not received treatment for the herniation since August 4, 1999.

On August 10, 1999, claimant initiated a third party action against the party responsible for the motor vehicle accident. The third party defendant's automobile insurance carrier has made a settlement offer of $25,000 to claimant to resolve the lawsuit. Claimant's attorney asked SAIF to provide a notice of lien pursuant to ORS 656.593.

On September 7, 1999, SAIF asserted that its lien was $33,681.83. SAIF explained that the lien amount included "medical aid payments totaling $7,534.83 (cost for independent medical examinations and service charges are not included)" and projected future expenditures of $26,147. SAIF's adjuster indicated that claimant's future medical expenditures are projected to be $26,147 if claimant has back surgery and $5,495 if he does not have surgery.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that SAIF's lien should only include its actual medical aid payments of $7,534.83. He contends that SAIF cannot meet its burden of proving that future surgery is likely to occur and, therefore, its reimbursable lien is limited to actual claim costs ($7,534.83).

SAIF agrees that it is entitled to reimbursement of its actual lien of $7,534.83 and it projects that claimant will receive future medical treatment even if he does not have surgery. According to SAIF, Dr. Aversano's November 5, 1999 report supports its position that future medical costs for office visits, an MRI, chiropractic treatments, prescriptions and mileage are $4,595. SAIF asserts that the remaining balance of the disputed settlement proceeds is $3,092.72 (after disbursement of claimant's attorney fee, litigation expenses, statutory 1/3 share and SAIF's actual claim costs) and contends it is entitled to that entire balance in partial reimbursement for its future projected medical costs.

If a worker sustains a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third party. ORS 656.578. The paying agency has a lien against the worker's cause of action, which is preferred to all claims except the cost of recovering such damages. ORS 656.580(2). If the worker or beneficiaries settle the third party case with the approval of the paying agency, the settlement proceeds are to be distributed pursuant to ORS 656.593(3).

In *Urness v. Liberty Northwest Insurance Corporation*, 130 Or App 454 (1994), the court held that "ad hoc" distributions are contemplated by ORS 656.593(3) and, therefore, it was improper for the Board to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes. *Id.* at 458. Despite the impropriety of such an automatic method, a distribution that 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 light of *Urness*, we are not limited to applying only the statutory scheme for distribution of a third party recovery. Rather, ORS 656.593(3) specifically contemplates "ad hoc" distributions. Although ORS 656.593(1)(c) does not apply when we are determining a "just and proper" distribution, that provision provides some general guidance in determining what portion of the remaining balance of the third party settlement proceeds the paying agency may receive in satisfaction of its lien for future claim costs. *Sharon K. Falsetto*, 49 Van Natta 1202, *on recon* 49 Van Natta 1573 (1997); *Mona R. Skelton*, 47 Van Natta 882 (1995). To support a lien for anticipated future medical expenses, the paying agency must establish that it is reasonably certain to incur such expenditures.

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

Here, SAIF relies on a November 5, 1999 report from Dr. Aversano to support its argument that claimant will receive future medical treatment even if he does not have surgery. In that report, Dr. Aversano referred to claimant's L4-5 disc herniation and said that claimant "will need follow up MRI scans in the future to re-evaluate this should the pain worsen or he develops neurologic deficits." Dr. Aversano noted that presently claimant had been successfully treated with conservative therapies, including a back brace, a home exercise program and occasional anti-inflammatories.

In a "check-the-box" letter from claimant's attorney signed on December 3, 1999, however, Dr. Aversano agreed that claimant will not require any medical treatment in the future if his pain does not worsen and he does not develop any neurologic deficits. Dr. Aversano agreed that claimant had not sought treatment for his back since August 4, 1999, and, based on his treatment history, it was *not* reasonably certain that claimant would develop pain or neurologic deficits in the future that would require treatment.

We agree with claimant that SAIF has not sustained its burden of proving that it is reasonably certain to incur expenditures for claimant's future medical expenses. In his December 3, 1999 report, Dr. Aversano did not believe it was reasonably certain that claimant would develop pain or neurologic deficits in the future that would require treatment. Based on that report, we find that future surgery and future medical treatment is only a possibility and is not reasonably certain to occur. Consequently, we agree with claimant that SAIF is not entitled to recover for future medical expenses and it is "just and proper" for SAIF to receive reimbursement for its actual expenditures, *i.e.*, $7,534.83.

Accordingly, claimant's counsel is directed to forward the remaining balance of disputed settlement proceeds (*i.e.*, $3,092.72, the amount remaining after distribution of SAIF's share for its actual claim costs) to claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES C. KNOWLSON, Claimant
Own Motion No. 99-0348M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

By Own Motion Order dated November 20, 1999, as amended on November 24, 1999, we declined to authorize the reopening of claimant's 1967 injury claim for the payment of temporary disability compensation. Announcing that it had overlooked earnings records submitted by claimant, the SAIF Corporation amends its prior recommendation and requests that the claim be reopened under our Own Motion authority. We treat SAIF's submission as a request for reconsideration of our prior orders. On reconsideration, we withdraw our prior orders and issue the following order in their place.

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

It is undisputed that claimant's compensable condition 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, SAIF initially contended that claimant's failure to provide proof of earnings demonstrated that he was not in the work force. Subsequently, however, SAIF submitted a copy of claimant's paystubs, which span the time period between June 1999 through July 1999.[1] In light of such circumstances, we are persuaded that, at the time of his current disability, claimant was engaged in regular gainful employment and remained in the work force.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning July 31, 1999, the date he was admitted to the hospital. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] 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 is hospitalized or undergoes 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 July 31, 1999, when he was hospitalized for several days for treatment of his compensable condition. *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
STANLEY M. SHAW, Claimant
WCB Case No. 97-08533
ORDER ON REMAND (REMANDING TO APPELLATE UNIT AND TO HEARINGS DIVISION)
Susan L. Frank, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by the Board *en banc.*

This matter is before the Board on remand from the Court of Appeals. *Shaw v. Steinfelds Products, Inc.*, 160 Or App 77 (1999). The court has reversed our prior order, *Stanley M. Shaw*, 50 Van Natta 1056 (1998), that affirmed an Administrative Law Judge's (ALJ's) order finding that the deceased claimant was not entitled to a scheduled permanent disability award for a bilateral foot (heel) injury. Because the deceased claimant died of causes unrelated to his compensable injury before becoming medically stationary and, at the time of his death, did not suffer from any "irreversible impairment findings," we concluded that he had not established his entitlement to a permanent disability award. In reaching this conclusion, we relied on OAR 436-035-0007(23)(b)(A) and (2)(d).[1]

Determining that the Director's rule is inconsistent with ORS 656.218 (because it does not encompass the full benefits to which the worker would have been entitled had he survived), the court has remanded for reconsideration of the deceased claimant's entitlement to benefits under ORS 656.218.

On October 11, 1996, claimant fell six feet off a ladder and shattered the bones of his right foot and broke his left foot while working for the employer as a mustard maker. He was diagnosed with a displaced calcaneal fracture of the right heel, for which he received surgery, and a non-displaced calcaneal fracture of the left heel. The insurer accepted a right calcaneous fracture and a left calcaneous fracture. Claimant returned to regular work but experienced increased foot pain when he had to apply the brakes of his car. His doctor took him off work for ten days and then released him for light duty work. While at home, and before his injuries had become medically stationary, claimant died of heart disease.

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[1] ORS 436-035-0007(23)(b)(A) provides in relevant part:

"When all compensable conditions are not medically stationary pursuant to OAR 436-030-0035 at the time of death * * * [o]nly those impairment findings that are irreversible and are addressed by these rules shall be rated[.]"

ORS 436-035-0007(2)(d) provides in relevant part:

"Workers with an irreversible finding of impairment as noted in this subsection, due to the compensable condition, shall receive the full value awarded in these rules for the irreversible finding. * * * For purposes of this subsection, irreversible findings are:

"* * * * *

"LEG
Knee angulation
Length discrepancy
Meniscectomy
Patellectomy

"* * * * *

"OTHER
Amputations/resections
Ankylosed/fused joints
Displaced pelvic fracture ("healed" with displacement)
Loss of opposition
Organ transplants (heart, lung, liver, kidney)
Prosthetic joint replacements"

Claimant[2] requested reconsideration of a Determination Order that did not award permanent disability benefits. An arbiter panel reviewed claimant's file and determined that, if claimant had lived, he would have suffered permanent disability from loss of range of motion and loss of repetitive use of his right ankle and that he would have been unable to walk or stand more than two hours in an eight hour period. Relying on OAR 436-035-0007(23)(b)(A), the appellate reviewer determined that, because claimant had died of unrelated causes before his injury had become medically stationary, claimant was entitled to benefits only for "irreversible impairment findings." Finding no such impairment in the record, the Order on Reconsideration affirmed the Determination Order. Claimant requested a hearing.

At hearing, claimant requested a 28 percent scheduled permanent disability award based on the medical arbiter's findings that claimant would have had permanent disability from lost range of motion and loss of use of his right ankle. The ALJ affirmed the Order on Reconsideration and we affirmed the ALJ's order, likewise finding that claimant had not established that he had "irreversible findings" pursuant to the aforementioned rules. *Stanley M. Shaw*, 50 Van Natta at 1058. Claimant requested judicial review.

As set forth above, the court held that our order was based on an administrative rule that is inconsistent with ORS 656.218. Noting that the medical arbiters determined that, had claimant survived, he would have experienced permanent loss of range of motion and loss of use of his right ankle, thus entitling him to compensation for his disability, the court has directed us to reconsider claimant's entitlement to benefits. *Shaw v. Steinfelds Products, Inc.*, 160 Or App at 83.

The arbiter panel reported that claimant sustained bilateral calcaneus fractures, with the right comminuted calcaneus fracture requiring open reduction and internal fixation. They found that claimant would have been significantly limited in the ability to repetitively use the right foot for standing and walking, especially on uneven surfaces or at heights, due to the calcaneus fracture. They found no such limitation on repetitive use of the left foot. The panel also found that claimant would be prevented from walking or standing for more than two hours in an eight hour period due to his accepted condition, based on the operative report and the type of fracture. They also opined that there was a 100 percent likelihood that claimant would have developed degenerative arthritis of his subtalar joint on the right, but were unable to grade the type of arthritis, comment on any effusion or varus or valgus deformity. In addition, they found permanent impairment in that claimant's right foot and ankle were permanently enlarged due to soft tissue involvement and significant comminution of his bone. Finally, they found that claimant's permanent impairment would have been based on claimant's loss of motion from his ankle joint and subtalar joint and from the fracture in the interarticular portion of the foot. (Ex. 24).

Thus, the record establishes that, under the Director's rules for living claimants, had claimant survived, he would have experienced a number of permanent impairments resulting from his compensable injury and surgery including, but not necessarily limited to, permanent loss of range of motion, loss of repetitive use, and an inability to walk or stand for more than two hours in an eight hour period. Nonetheless, the Director's rules do not provide for impairment values for such impairments for *deceased* claimants. Instead, the Director has other rules that specifically pertain to impairments to *deceased* claimants. As explained in the Court's decision, the particular rule applicable in this case is inconsistent with ORS 656.218.

In light of such circumstances, we hold that claimant's permanent impairment is not adequately addressed in the disability standards. Accordingly, we must remand to the Director for the consideration of the promulgation of a temporary rule to address the permanent disability of the deceased claimant. *Gevers v. Roadrunner Construction*, 156 Or App 168 (1998) (if a claimant's condition is not ratable under the Director's rules, Board is required, under ORS 656.726(3)(f)(C), to remand to the Director for adoption of a temporary rule which assesses the claimant's disability, regardless of whether the adoption of a temporary rule has been requested).

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[2] Claimant is represented in these proceedings by his beneficiary. For ease of reference, we use the word "claimant" rather than "claimant's beneficiary" in our order.

Finally, on reconsideration of our May 29, 1998 order, we vacate the ALJ's February 20, 1996 order. The remainder of this case is remanded to the Presiding ALJ[3] with instructions to assign the case to another ALJ to hold the case in abeyance to await Director action regarding the promulgation of a temporary rule. Following Director action on the temporary rule matter, the parties shall notify the assigned ALJ of their respective positions concerning the effect, if any, the Director's action has on this case. The assigned ALJ shall then conduct further proceedings in any manner that the ALJ deems will achieve substantial justice. Thereafter, the assigned ALJ shall proceed to resolve the remaining issues and issue a final, appealable order.

IT IS SO ORDERED.

[3] The ALJ who originally heard this case has since retired.

In the Matter of the Compensation of
CATHERINE A. SKINNER, Claimant
Own Motion No. 99-0251M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on November 23, 1984. SAIF opposed reopening the claim on the grounds that surgery or hospitalization is not reasonable and necessary treatment for her compensable condition.

SAIF requested Director's review of the requested medical treatment, as jurisdiction over medical service disputes resides with the director. ORS 656.245(6), 656.260, 656.327 and 656.704(3). On July 7, 1999, the Board issued its order postponing action on the own motion matters pending outcome of the medical services dispute.

On November 10, 1999, the Medical Review Unit (MRU) issued an Administrative Order (Order No. TX 99-680), which found that the recommended low back surgery was appropriate medical treatment for claimant's compensable injury. That order became final on December 10, 1999.

Following the issuance of the MRU order, the Board's staff inquired as to the parties' positions regarding claimant's request for own motion benefits in light of the MRU's decision. In response to the Board's staff's inquiry, SAIF agreed that the recommended surgery was appropriate for claimant's compensable condition and did not oppose reopening of her claim for the provision of temporary disability compensation.

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

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHELLE L. GORHAM, Claimant
WCB Case No. 99-00227
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

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

The ALJ upheld the insurer's denial of claimant's occupational disease claim, finding that the medical evidence did not establish that claimant's work activities as a grocery checker were the major contributing cause of a "combined" condition and a pathological worsening of a preexisting left carpal tunnel condition. *See* ORS 656.802(2)(b); *see Dan D. Cone*, 47 Van Natta 1097, *on recon* 47 Van Natta 2220, *on recon* 47 Van Natta 2343 (1995). In making this finding, the ALJ determined that claimant was not a credible or reliable witness because she denied prior problems with her left hand when the medical evidence indicated that she had been previously diagnosed with bilateral carpal tunnel and had sought treatment for left carpal tunnel symptoms in May 1996. In addition, the ALJ found that, in light of claimant's less than credible testimony, the history of an examining physician, Dr. Stewart, was correct when he reported that claimant's left hand symptoms began in April 1998, just prior to claimant's commencement of employment for this insured in May 1998.

On review, claimant contends that she does not have a preexisting condition within the meaning of ORS 656.005(24) and that, even if she does, the opinion of Dr. Koller, an attending physician, satisfies her burden of proof. Claimant asserts that Dr. Koller was aware of and thoroughly considered the medical evidence documenting the prior left carpal tunnel condition when he stated that her work activities were the major contributing cause of her carpal tunnel condition. (Ex. 54). For the following reasons, we conclude that Dr. Koller's opinion does not satisfy claimant's burden of proof.

At the outset, we agree with the ALJ's reasoning that claimant has a preexisting left carpal tunnel condition. In this regard, we also concur with the ALJ that claimant's testimony that she did not have prior left hand symptoms is not reliable in light of the May 1996 medical evidence indicating that she had left hand symptoms for at least three weeks in connection with her prior employment as a waitress. In light of this determination, we also conclude that Dr. Stewart's history is most likely correct that claimant's most recent bout of left carpal tunnel symptoms began shortly *before* her employment with this insured.

Finally, we acknowledge that Dr. Koller was aware of much of the medical evidence pertaining to the prior diagnosis and treatment of left carpal tunnel. (Ex. 54). However, Dr. Koller was apparently not aware that claimant's symptoms began in April 1998, shortly before she began work for this insured. Therefore, we find that Dr. Koller still did not have a complete and accurate history. Thus, we agree with the ALJ that Dr. Koller's opinion is not persuasive and does not satisfy claimant's burden of proof. *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).

Accordingly, we affirm the ALJ's determination that the occupational disease claim is not compensable.

ORDER

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

In the Matter of the Compensation of
FELIX ROLDAN, Claimant
WCB Case No. 98-08349
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Marshall's order that set aside its denial of claimant's injury claim for a right ankle 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 $1,000, 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 May 5, 1999 is affirmed. For services on review, claimant is awarded a $1,000 assessed attorney fee to be paid by the insurer.

Board Member Haynes dissenting.

The majority adopts the ALJ's order finding claimant's right ankle condition compensable. In so doing, the majority acknowledges that claimant had numerous prior right ankle injuries and several *significant* contributory preexisting right ankle conditions, including arthritis, instability, and loose bodies. (Exs. 6, 8, 12, 14, 17). Claimant also had chronic right ankle pain and swelling for about a year before the 1988 work injury. (Ex. 4).

The medical evidence supporting the claim simply does not explain away the many noncompensable contributors: Drs. Strum and Wilson essentially say that claimant was functional before the 1998 incident, then disabled and in need of surgery after the incident. Without otherwise explaining why the work incident contributes more than all other causes, the doctors conclude that the work incident is the major cause of claimant's current condition. I would find this evidence inadequate to carry claimant's burden. *See Dietz v. Ramuda,* 130 Or App 397, 402 (1994), *rev dismissed* 321 Or 416 (1995) (the relative contribution of each cause, including the precipitating cause, must be evaluated to establish major causation).

Expert evidence based on nothing more than the temporal relationship between an injury and the onset of problems -- that ignores significant noncompensable contributors, cannot be persuasive.[1] Moreover, it is well-settled that even an uncontradicted medical opinion is not binding on the trier of fact.[2] Because the majority in this case accepts evidence that is fundamentally inadequate, I must respectfully dissent.

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[1] *See Elaine M. Baxter,* 51 Van Natta 1898 (1999).

[2] *See William K. Young,* 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive); *Edwin Bollinger,* 33 Van Natta 559 (1981) (uncontradicted medical opinion need not be followed).

In the Matter of the Compensation of
ERIK M. ANDERSON, Claimant
WCB Case No. 98-07755
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Scott Terrall & Associates, 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 set aside its denial of claimant's injury claim for a medial meniscal tear.[1] Claimant cross-requests review, arguing that the ALJ's attorney fee award was inadequate. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant, a moulder operator, has worked for the employer about seven years. (Ex. 5A, Tr. 10). He testified that he injured his knee when he stepped off a platform at work and "popped" his knee when he hit the floor. (Tr. 13). Claimant was not sure when the incident occurred, but thought it was in May or early June 1998. (Tr. 14). After the incident, claimant's knee felt sore, but he continued his shift. (*Id.*) He did not seek medical treatment for about six weeks because he was not certain about the seriousness of the injury. (Tr. 15). Claimant testified that he reported the injury to his immediate supervisor on the day he was injured, but did not fill out a written report at that time. (Tr. 15, 25). Claimant also said he told his friend at work, Mr. Bland, about the incident on the day it occurred. (Tr. 19). Claimant signed an "827" form on July 28, 1998 and an "801" form on August 5, 1998. (Exs. 3, 5, 5A).

Mr. Bland, a coworker, testified that claimant told him about a knee injury in approximately early June. (Tr. 5). Mr. Bland said claimant told him he had stepped off his platform at his work station and hurt his knee. (*Id.*)

On July 6, 1998, Dr. Britsch reported that claimant was seeking treatment because of "left knee pain for the past 6 months." (Ex. 1). Dr. Britsch indicated claimant's left knee made popping noises and occasionally felt like it was giving out. (*Id.*) Dr. Britsch reported that claimant's knee had never locked and "he has no history of injury to that knee." (*Id.*) Dr. Britsch diagnosed possible chondromalacia patellae and referred claimant to Dr. Casey. (*Id.*)

On July 28, 1998, Dr. Casey reported that claimant had been having "medial left knee pain for approximately two months, since a twisting injury at work that happened on two separate occasions approximately one week apart." (Ex. 2). He diagnosed a medial meniscus tear and recommended surgery. (*Id.*) On August 18, 1998, Dr. Casey performed an arthroscopic evaluation and partial medial meniscectomy. (Ex. 7).

The employer denied claimant's left knee claim on the basis that the injury did not arise out of or in the course and scope of his employment. (Ex. 9). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that Dr. Casey's opinion on causation was not persuasive because he referred to a "twisting" injury, rather than a "stepping" injury. Nevertheless, the ALJ determined that this was not a complex case and, therefore, no expert medical opinion was required. The ALJ found that claimant had satisfactorily explained why Dr. Britsch had recorded an "incorrect" history. The ALJ concluded that claimant had sustained his burden of proving medical and legal causation.

The employer argues that the ALJ erred by determining that this case did not require an expert medical opinion. The employer contends that none of the medical opinions are sufficient to establish compensability. In particular, the employer argues that Dr. Casey's opinion was not persuasive because he did not have an accurate history of claimant's injury.

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[1] We modify the ALJ's order to note that 16 exhibits, rather than 15 exhibits, were admitted in evidence: Exhibits 1 through 15 and Exhibit 5A.

On review, claimant does not dispute the employer's argument that this case requires an expert medical opinion. Claimant argues, however, that Dr. Casey's opinion is sufficient to prove compensability.

For the following reasons, we agree with the parties that the issue of causation requires an expert medical opinion. In *Barnett v. SAIF*, 122 Or App 279, 283 (1993), the court held that factors for determining whether expert evidence of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Although claimant testified that his symptoms occurred immediately after the May/early June work incident, he did not seek medical treatment until July 6, 1998. On that date, Dr. Britsch reported that claimant was seeking treatment because of "left knee pain for the past 6 months." (Ex. 1). Dr. Britsch reported that claimant's knee had never locked and "he has no history of injury to that knee." (*Id.*)

In a later report, Dr. Britsch agreed that, based on claimant's history, she could not relate claimant's left knee condition to any work activity or incident. (Ex. 12). Dr. Britsch's reports indicate that claimant's "stepping" incident at work was not the cause of his injury and raise the possibility of another etiology of his complaints. In addition, Dr. Casey's history of claimant's injury is inconsistent with Dr. Britsch's report. Under these circumstances, we find that this case presents a complex medical causation issue and, therefore, the issue of causation requires an expert medical opinion.

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). As we discussed, Dr. Britsch's opinion does not support compensability. Dr. Britsch reported that claimant had been having knee pain for six months and had no history of injury to that knee. (Ex. 1). Dr. Britsch could not relate claimant's left knee condition to any work activity or incident. (Ex. 12).

Claimant relies on Dr. Casey's opinion to establish compensability. Claimant testified that he injured his knee when he stepped off a platform at work and "popped" his knee when he hit the floor. (Tr. 13). At hearing, he agreed that he "kind of just jammed it straight into the ground." (Tr. 25).

Dr. Casey's descriptions of claimant's work injury have been inconsistent. On July 28, 1998, Dr. Casey reported that claimant had been having "medial left knee pain for approximately two months, since a twisting injury at work that happened on two separate occasions approximately one week apart." (Ex. 2). He diagnosed a medial meniscus tear. (*Id.*)

On the other hand, Dr. Casey's August 18, 1998 chart note indicated that claimant's injury occurred when he "stepped down from a step approximately six weeks ago while working, felt a pop in his left knee" and had a feeling of instability since that time. (Ex. 6). On the same date, Dr. Casey performed an arthroscopic evaluation and partial medial meniscectomy. (Ex. 7). His postoperative diagnosis was a posterior horn medial meniscus tear. (*Id.*)

In his September 14, 1998 chart note, Dr. Casey said "[i]n looking back at my records, [claimant] certainly felt that this was due to some twisting episodes at work, but perhaps other records indicate otherwise." (Ex. 4).

On January 7, 1999, Dr. Casey recapped a conversation he had with the employer's attorney. (Ex. 13). Dr. Casey explained:

> "We discussed some discrepancies between Dr. Britsch's history and my own in regard to what injury produced his need for surgery. As you are aware, he related to me that there were some *twisting* incidents at work a couple of months before I saw him. I don't know if he was having some knee problems prior to that, but there is certainly no record that he required medical treatment for problems prior to that, so my personal feeling is that the difference in a 2- or 6- month history is not especially important, and of course, as you understand, I certainly take my patient's word as to where the *twisting* incident happened that caused his problems." (*Id.*; emphasis supplied).

In a later response to a letter from claimant's attorney, Dr. Casey reported that claimant's "lateral" meniscus tear was the result of a traumatic incident and "the mechanism of injury was probably as the patient has described to me as a *twisting* injury at work two to three months prior to that." (Ex. 15; emphasis supplied). Dr. Casey felt that the majority of claimant's symptoms were caused by the traumatic injury, not a degenerative condition. (*Id.*)

On review, claimant states that the terms he has used to describe his injury have not been precise. At hearing, claimant testified that he injured his knee when he stepped off a platform at work and "popped" his knee when he hit the floor. (Tr. 13). He testified that the "801" form saying he "jammed" his knee was the same as "popping" his knee. (Ex. 5A, Tr. 25). Claimant contends that the various terms all describe the same basic mechanism of injury and he asserts that the choice of one term by Dr. Casey does not destroy the significance of his medical opinion. According to claimant, the ALJ's concern that Dr. Casey had focused on a "twisting" rather than a "stepping" history is "beside the point" because both histories probably are true. (Claimant's br. at 5).

Dr. Casey was aware of the different histories of claimant's mechanism of injury. His initial report referred to "a twisting injury at work that happened on two separate occasions approximately one week apart." (Ex. 2). Dr. Casey's August 18, 1998 chart note, however, indicated that claimant's injury occurred when he "stepped down from a step approximately six weeks ago while working, felt a pop in his left knee" and had a feeling of instability since that time. (Ex. 6). Dr. Casey's September 14, 1998 chart note said that perhaps other records indicated a different history than the one he had received. (Ex. 4). Dr. Casey was also aware of the discrepancies between Dr. Britsch's history and his history of an injury. (Ex. 13). Nevertheless, Dr. Casey's two later reports focused on the fact that claimant had sustained a *twisting* injury. His January 7, 1999 report indicated claimant had "related to me that there were some *twisting* incidents at work a couple of months before I saw him." (Ex. 13; emphasis supplied). In a February 5, 1999 report on causation, Dr. Casey reported that claimant's "lateral" meniscus tear was the result of a traumatic incident and "the mechanism of injury was probably as the patient has described to me as a *twisting* injury at work two to three months prior to that." (Ex. 15; emphasis supplied).

Thus, it is clear from Dr. Casey's reports that, although he was aware of the inconsistent reports regarding claimant's mechanism of injury, he believed that claimant had experienced some *twisting* incidents at work. (Exs. 2, 4, 13, 15). We find that Dr. Casey's understanding of claimant's injury is inconsistent with claimant's testimony that he injured his knee on one occasion when he stepped off a platform at work and "popped" his knee. (Tr. 13). In addition, Dr. Casey's understanding of a "twisting" injury is inconsistent with claimant's agreement at hearing that he "kind of just jammed [the knee] straight into the ground." (Tr. 25).

We conclude that Dr. Casey did not have an accurate understanding of the circumstances involved in claimant's accident. Because his opinion is based on an inaccurate history, it is entitled to little weight. *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). There are no other medical reports on causation to sustain claimant's burden of proving compensability. Consequently, we reverse the ALJ's order.[2]

ORDER

The ALJ's order dated May 4, 1999 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[2] In light of our conclusion, we need not address claimant's argument that the ALJ's attorney fee award was inadequate.

In the Matter of the Compensation of
EVA F. GUTIERREZ, Claimant
WCB Case No. 99-02507
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Thye's order that dismissed her request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

FINDINGS OF FACT

On May 13, 1998, claimant signed a retainer agreement employing her then-attorney of record to represent her in connection with her workers' compensation claim. A provision of that retainer agreement stated that: "My attorney is authorized to associate other counsel at no additional expense to me. My attorney is authorized to sign my name and in all other respects to act for me."

On March 23, 1999, claimant, through her then-attorney, requested a hearing regarding an Order on Reconsideration, raising additional penalty and attorney fee issues. A hearing was scheduled for June 29, 1999.

A June 28, 1999 "Docket Action Worksheet" indicated that the hearing was postponed. On July 23, 1999, an attorney wrote a letter using the letterhead of claimant's counsel of record, notifying the ALJ that claimant was withdrawing her hearing request. The ALJ then dismissed claimant's hearing request by Order of Dismissal of August 3, 1999.

In a letter received by the Board on August 9, 1999, claimant requested Board review of her case. Claimant noted that she was still having problems with her back and that she would like someone who could speak Spanish to contact her.

CONCLUSIONS OF LAW AND OPINION

The sole issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order appropriate.

Where a claimant signs a retainer agreement employing an attorney and giving that attorney authority to act on the 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).

Claimant has the burden of proving that the dismissal order was not appropriate. *Donald J. Murray*, 50 Van Natta 1132, 1133 (1998) citing *Harris v. SAIF*, 292 Or 683, 690 (1982) (burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side). However, claimant makes no argument as to why the dismissal order was not appropriate.[1]

Furthermore, the retainer agreement between claimant and her then-attorney authorized that attorney to associate other counsel and to act on claimant's behalf. Claimant does not assert that her attorney did not withdraw her hearing request. Nor does she assert that she was not represented by the attorney who withdrew the hearing request at the time in question. *Cf. Silverio Frias, Sr.*, 49 Van Natta 1514, 1515 (1997) (Board vacated ALJ's dismissal order and remanded to the ALJ to determine if the attorney was authorized to withdraw the request for hearing).

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[1] Claimant has requested that she be contacted by a Spanish-speaking individual. The Workers' Compensation Ombudsman's office is equipped to respond to questions from unrepresented workers. The Ombudsman's phone number is 1-800-927-1271.

Under these circumstances, we find no reason to alter the dismissal order. *Steve L. Paul*, 50 Van Natta 1987(1998); *William A. Martin*, 46 Van Natta 1704, 1705 (1994); *Mike D. Sullivan*, 45 Van Natta 990, 991 (1993).

ORDER

The ALJ's order dated February August 3, 1999 is affirmed.

December 29, 1999 Cite as 51 Van Natta 2029 (1999)

In the Matter of the Compensation of
KURT KONRAD, JR., Claimant
WCB Case No. 99-02987
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) affirmed an Order on Reconsideration that awarded 35 percent (52.5 degrees) scheduled permanent disability for loss of use or function of claimant's right hand; and (2) awarded a $2,000 assessed attorney fee. On review, the issues are scheduled permanent disability and attorney fees.

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

Claimant's attorney is entitled to an assessed fee for services on review regarding the permanent disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the extent of disability issue is $800, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 4, 1999 is affirmed. For services on review, claimant is awarded an $800 attorney fee, to be paid by the self insured employer.

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[1] We are not inclined to address claimant's request for a penalty under ORS 656.268(4)(g) (based on the reconsideration order's increased permanent disability award), because we find no evidence that claimant raised the issue on reconsideration or before the ALJ. *See Phyllis G. Nease*, 49 Van Natta 195, 197 (1997). However, because claimant's reconsideration award was less than 64 degrees of disability (*i.e.*, 52.5 degrees), he would not be entitled to a penalty under the statute in any event. *See SAIF v. Cline*, 135 Or App 155, 157, *rev den* 321 Or 560 (1995).

In the Matter of the Compensation of
LAWRENCE LUTTRELL, Claimant
WCB Case Nos. 98-06039 & 98-03416
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Atwood & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Facts," except for the second sentence of the "Ultimate Findings of Facts," with the following supplementation.

Claimant's primary low back condition is L4-5 *facet* arthropathy. (*See* Exs. 49-10-11, -15-16, -19-20).

CONCLUSIONS OF LAW AND OPINION

Claimant began working as a field maintenance worker for the employer in 1979. For 10 years, his work involved heavy labor, lifting, pulling, and shoveling. Then claimant's job changed and he became a sewer line inspector for the employer. He still performed manual labor on the job, lifting manhole covers and manipulating cameras in confined spaces.

Claimant had compensable low back injuries in 1982, 1984, 1985, and 1989. Although the earlier injuries resolved, claimant has not been entirely pain free since the 1989 injury. His 1989 injury claim was closed with an 8 percent permanent disability award for bulging L4-5 and L5-S1 discs.

After a 7-year treatment hiatus, claimant sought treatment for worsened low back pain in 1997. He filed aggravation and occupational disease claims which the insurer denied.

The ALJ set aside the insurer's denial of claimant's occupational disease claim,[1] finding that claimant's work activities for the employer since 1979 were the major contributing cause of his low back condition. The ALJ relied on the opinion of Dr. Berkeley, treating physician, because he found that Dr. Berkeley was the only physician who had an accurate and complete history. We reach the same result.

The insurer argues that Dr. Berkeley's facet arthropathy diagnosis is inaccurate because it is unsupported by the record. It also contends that the causation opinion of Drs. Farris and Bald is the most persuasive. We disagree.

We note at the outset that several physicians reported claimant's facet arthropathy, or degenerative joint disease.[2] (Exs. 29-3, 39-6, 41A-3, 44-5). We also note that all doctors had essentially the same history regarding claimant's work activities: It is undisputed that claimant performed manual labor for the employer for many years.[3] The doctors disagree regarding the cause and diagnosis for claimant's current problems.

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[1] The ALJ upheld the insurer's denial of claimant's aggravation claim and that portion of the ALJ's order has not been contested.

[2] Facets are the posterolateral joints in the interlocking vertebrae. Facet disease is a degenerative condition with "narrowing of the hole that transmits nerve data." (Ex. 49-11). Based on claimant's neuro-imaging findings, Dr. Berkeley identified overgrowth of claimant's joints, hardening of the joints with calcium deposits, and narrowing of the lateral recesses and the foramina. (Ex. 47-1). He opined that claimant's problems stem primarily from degeneration at the L4-5 level. (Exs. 49-7, -10).

[3] The result would be the same, whether the claim is based on 10 or 20 years of work exposure.

Drs. Farris and Bald opined that claimant's broad-based *disc bulges* (at L4-5 and L5-S1) are "minimal, minor, and clinically insignificant, and are quite normal for his age." (Ex. 44-6). Based on claimant's 1997 CT scan, the examiners also noted that his lumbar facets are mildly hypertrophied bilaterally. (Ex. 44-5). Although the examiners diagnosed chronic low back pain and degenerative joint disease, they concluded that claimant's symptoms are due solely to "unnatural muscle tightness" and related poor body mechanics. (*See* Ex. 44-8-9). The examiners ruled out heavy physical labor as contributing to claimant's degeneration, based on studies indicating that degeneration is "ubiquitous," progressing with age, and not associated with heavy work. (Ex. 44-6).

We do not find the examiners' opinion persuasive because it is based on studies which are general in nature rather than specific to claimant.[4] *See Sherman v. Western Employer's Insurance*, 87 Or App 602 (1987); *Gloria A. Sturtevant*, 51 Van Natta 386 (1999); *Elizabeth Beairsto*, 47 Van Natta 750, 751 (1995) (Where physician discounted 21-year work exposure in favor of statistical "risk factors," his opinion was insufficiently explained).

Moreover, as Dr. Berkeley noted, the examiners did not specifically address the *facet* disease which he believes causes claimant's symptoms. (Ex. 49-14). Dr. Berkeley acknowledged that claimant was probably genetically predisposed to degenerative disease, including that seen in his facets. (Exs. 47-1; 49-6). He explained that claimant's imaging findings must be interpreted in light of his complaints,[5] and opined that repetitive subliminal trauma due to work activities caused claimant's facet degeneration to progress and produce severe symptoms which drove him to seek treatment. (Exs. 47-1-2; 49-18-19). Dr. Berkeley specifically noted that claimant's work required him to do heavy lifting in awkward positions and to manipulate cameras in confined spaces. (Exs. 49-8, -20-21). He disagreed with the examiners' "soft tissue pain" diagnosis, based on claimant's chronic dull backache, with severe episodic sharp pain, explaining that claimant's symptoms are consistent with facet disease, not a muskuloskeletal problem. (Ex. 49-15-16; *see* Ex. 49-19-20). Considering claimant's imaging findings, his symptoms, and his work activities, Dr. Berkeley concluded that claimant's work exposure was the major contributing cause of his degenerative facet arthropathy. (Ex. 49-19).

We find Dr. Berkeley's opinion persuasive because it is well-reasoned, based on an accurate history, and consistent with that history. Accordingly, based on Dr. Berkeley's opinion, we conclude that claimant has carried his burden under ORS 656.802.[6]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,000, payable by 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 26, 1999 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, to be paid by the insurer.

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[4] We also note Dr. Berkeley's response that there is literature indicating that trauma *can* cause degenerative changes. (*See* Exs. 49-14-15).

[5] Dr. Berkeley opined that claimant's subjective complaints were not "at all" out of proportion with his pathology. (Ex. 49-12).

[6] Claimant did not have a preexisting *spinal* condition that contributes to his current L4-5 facet arthropathy, because his 1989 CT scan revealed "intact" facets. (Ex. 14). Although he probably was genetically predisposed to spinal degeneration, his claim is not "based on" a worsening of his predisposition. *See* ORS 656.802(2)(b). Moreover, even if claimant did have a preexisting condition, we would reach the same result, because Dr. Berkeley's opinion persuasively establishes that claimant's work activity is the major cause of his condition, as well as a pathological worsening of that condition.

Board Member Phillips Polich, specially concurring.

I would make the point that claimant's prior compensable injuries do not weigh against his current claim. *Kepford v. Weyerhaeuser*, 77 Or App 363, 366, *rev den* 300 Or 722 (1986) ("The referee should have considered whether the job injuries for which compensation had been paid, along with the conditions of employment were the major contributing cause of the worsening of the disc disease."); *see also William W. Clunas*, 51 Van Natta 765, 766 n.2 (1999) (prior compensable injury does not weigh against occupational disease claim); *John J. Rice, on remand*, 46 Van Natta 2528, 2529 (1994) (claim compensable where preexisting degenerative disease worsened by years of traumatic work exposure, an accepted low back strain, and multiple additional work injuries).

December 27, 1999 Cite as 51 Van Natta 2032 (1999)

In the Matter of the Compensation of
MARGARET M. HINCK, Claimant
WCB Case No. 98-03269
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the insurer's *de facto* denial of claimant's injury claim; and (2) dismissed, as untimely, claimant's request for hearing regarding the insurer's written denial of the same claim. On review, the issues are timeliness (good cause) and whether claimant's injury arose out of and in the course and scope of her employment.

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

Claimant argues that her January 12, 1998 fall on the way to work was job-related because the employer insisted that she go to work that day despite inclement weather. But claimant fell because of the weather, a neutral hazard (not one associated with her work as a sales clerk). Therefore, her injury did not arise out of her employment. *See e.g., Garnette D. Cone*, 51 Van Natta 848, 849 (1999). Moreover, it is undisputed that claimant was off work premises (on her way to work), she was not being paid at the time, and the employer exercised no control over the injury site. Therefore, the injury did not occur in the course and scope of employment. Under these circumstances, we agree with the ALJ that claimant has not carried her burden.

ORDER

The ALJ's order dated May 19, 1999 is affirmed.

In the Matter of the Compensation of
NESTOR P. MARTINEZ, Claimant
WCB Case No. 99-01832
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for his low back condition. On review, the issue is extent of unscheduled permanent disability.

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

The ALJ found that, based on the report of Dr. Thomas, medical arbiter, claimant had failed to prove that he had impairment due to the compensable injury. Specifically, the ALJ reasoned that Dr. Thomas questioned the validity of all of claimant's range of motion findings because of an invalid straight leg raising and positive Waddell's test. On review, claimant argues, however, that the arbiter has not provided a written opinion explaining why the findings are invalid, as required by OAR 436-035-0007(28).

Dr. Thomas reported that claimant "did not pass the straight leg raising validity test and his Waddell's test was positive in both rotation and compression. This would question the validity of his range of motion findings." (Ex. 36-2). Claimant contends that the fact that his Waddell's test is positive does not invalidate the findings, even if the test questions the findings.

We have previously held that the validity of range of motion testing must be determined by the medial examiner performing the tests. *Harvey Clark*, 47 Van Natta 136 (1995). Consequently, we found no basis for an award of permanent disability in a case in which the medical arbiter expressly questioned the validity of the findings. *Dana M. Peterson*, 50 Van Natta 1554 (1998). Here, the medical arbiter has similarly questioned the validity of claimant's range of motion findings. (Ex. 36-2). Moreover, the arbiter's conclusion is consistent with the opinion of claimant's treating doctor who concurred with Dr. Gripekoven's opinion that claimant had "accentuated pain behavior" and "no residual impairment * * *". (Exs. 30-5; 31). Accordingly, we conclude that a preponderance of the evidence does not support a finding that claimant has valid loss of range of motion.

We further disagree with claimant's argument that the arbiter has not provided a written opinion based on sound medical principles which explains why the findings of impairment are invalid. In *Randy P. Nunn*, 51 Van Natta 1305 (1999), a PCE evaluator noted that the claimant failed to meet straight leg raise validity criteria and the claimant failed to follow through during demonstration. The evaluator noted such behavior with a straight leg validity check and a positive response to all Wadell's signs. In *Nunn*, we found that the medical opinions were based on sound medical principles and explained why the findings were invalid. 51 Van Natta at 1305. Similarly, in the present case, we find that the medical arbiter's opinion is sufficiently explained and based on sound medical principles.

Accordingly, for the above stated reasons, we agree with the ALJ that claimant has failed to meet his burden of proving that he is entitled to an award of unscheduled permanent disability.

ORDER

The ALJ's order dated August 2, 1999 is affirmed.

In the Matter of the Compensation of
BARBARA D. REDDING, Claimant
WCB Case No. 99-03213
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that awarded no scheduled permanent disability for loss of use or function of claimant's right forearm, whereas an Order on Reconsideration had awarded 15 percent (22.5 degrees). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated August 12, 1999 is affirmed.

Board Member Phillips Polich dissenting.

This case exemplifies disability evaluation gone awry.

Dr. Neumann performed a medical arbiter's examination, as instructed, and reported claimant's *valid* impairment findings -- without reservation. He specifically opined that claimant's then-current examination findings were valid and due to the accepted condition. He also stated that he found no unrelated causes contributing to her condition. That should have been the end of claimant's travail in this matter.

But the Appellate Review Unit noticed that Dr. Neumann "mentioned a paucity of medical records to review" regarding claimant, apologized for the "omission," and sent a copy of the records to the doctor with instructions to review the material and let the reviewer know if "there is any change in [the doctor's] opinion." (Ex. 24; *see* Ex. 25).

Meanwhile, an Order on Reconsideration awarded claimant 15 percent scheduled permanent disability for loss of use or function of her right forearm (wrist), based on Dr. Neumann's initial report. (Ex. 26).

Dr. Neumann then issued a second medical arbiter's report, stating that his "current impression . . . should replace the . . . original report in light of the additional information just reviewed." (Ex. 27-1). Dr. Neumann opined that claimant did not have valid objective findings of a chronic condition due to the accepted condition, based on "comparisons of my findings with those in the charts." (Ex. 27-2). He also questioned the validity of *his own* March 20, 1999 range of motion findings, "because of inconsistencies noted on examination by myself as compared to those made by others including Dr. Button." (*Id*). Dr. Neumann specifically referred to Dr. Button's observation that claimant had reduced range of motion on examination, but full range of motion when she was "distracted and passively tested." (*Id*). Finally, Dr. Neumann (somewhat inconsistently) stated, "I find no unrelated causes contributing to her condition." (*Id*).

I would find Dr. Neumann's changed opinion entirely unpersuasive: I fail to understand how inconsistencies noted during an October 14, 1998 examination could have any bearing (logical or medical) on the validity of another examination's findings, *five months* later, on March 20, 1999. Dr. Neumann does not explain why or how Dr. Button's findings influenced him to change his interpretation of his own later examination. This is particularly perplexing and unconvincing since Dr. Neumann initially expressed no doubts whatsoever!

I would find Dr. Neumann's changed opinion unpersuasive, because its inconsistencies and lack of cogent explanation cannot be construed as being "based on sound medical principles." *See* OAR 436-035-0007(28). I would rely instead on Dr. Neumann's initial report, because it is not tainted by illogic or influenced by Dr. Button's essentially irrelevant five-month-old findings. Under these circumstances, I must respectfully dissent.

In the Matter of the Compensation of
NANCY L. SABIN, Claimant
WCB Case No. 97-03260
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that declined to address the issue of whether claimant's claim had been prematurely closed. On review, the issues are scope of the issues, remand and premature closure. We reverse that portion of the ALJ's order that did not address the premature closure issue, deny claimant's remand request, and affirm the Notice of Closure.

FINDINGS OF FACT

Claimant sustained a compensable injury on October 27, 1995. On December 12, 1995, the SAIF Corporation accepted the claim for contusion and abrasion of the left knee, a low back contusion, and contusion and abrasion of the right wrist. (Ex. 1). Prior to claim closure on January 6, 1997, SAIF denied a neuroma of the proximal phalanx of the right foot. (Ex. 9-1).[1] Claimant requested a hearing regarding the denial and also reconsideration of the January 6, 1997 Notice of Closure that awarded no permanent disability. Claimant raised numerous issues regarding the Notice of Closure, including appointment of a medical arbiter and premature closure. (Ex. 8-1).

On March 25, 1997, an Order on Reconsideration rescinded the Notice of Closure as prematurely issued because no closing examination had been obtained. (Ex. 9-2). SAIF requested a hearing, contesting the reconsideration order. Both claimant's appeal of SAIF's denial and SAIF's appeal of the reconsideration order were heard by ALJ Stephen Brown.

On September 24, 1997, ALJ Brown issued separate orders that: (1) affirmed the reconsideration order rescinding the Notice of Closure; and (2) upheld SAIF's denial of claimant's right foot neuroma. (Exs. 9A, 9B). SAIF requested review of the ALJ's order pertaining to the reconsideration order and claimant requested review of the ALJ's order pertaining to the neuroma denial.

On March 26, 1998, we issued orders in both cases. We reversed the ALJ's order with respect to the reconsideration order that rescinded the Notice of Closure. *Nancy L. Sabin*, 50 Van Natta 508 (1998). Citing *Estella M. Rogan*, 50 Van Natta 205 (1998), we reasoned that, because a closing examination is not a condition precedent to issuance of a closure notice, the Department had no authority to rescind the Notice of Closure for lack of adequate closing information. Inasmuch as it was undisputed that the attending physician, Dr. Novak, had declared claimant's accepted conditions medically stationary and had released claimant to regular work prior to issuance of the January 1997 closure notice, we held that the claim closure was proper. However, because claimant had challenged other aspects of the closure notice, including the impairment findings used to rate disability, and had requested appointment of a medical arbiter, we remanded the case to ALJ Brown for deferral pending receipt of a medical arbiter's report. We noted that, when the parties were ready to proceed to hearing on claimant's other challenges to the Notice of Closure, they were to contact the ALJ, who was to then conduct further proceedings. (Ex. 9A-3).

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[1] The denial is not included in the record. The record also does not contain the exact date of the denial, but it is apparent that it preceded the claim closure.

In the case regarding the compensability of the right foot neuroma, we reversed the ALJ's order and found that condition compensable. *Nancy L. Sabin*, 50 Van Natta 506 (1998). We remanded the claim to SAIF for processing according to law. (Ex. 9B). SAIF did not appeal that order.

On November 3, 1998, ALJ Brown held the hearing as required by our order pertaining to the claim closure.

CONCLUSIONS OF LAW AND OPINION

The ALJ held that the sole issue on remand was extent of disability and determined that claimant failed to prove that she sustained any permanent impairment as a result of the compensable injury. On review, claimant does not contest that portion of the ALJ's order. Instead, claimant contends that the ALJ should have addressed the issue of premature closure. Because the ALJ did not do so, claimant requests that we remand the case to the ALJ for a determination of whether her compensable neuroma condition was medically stationary when the January 1997 Notice of Closure was issued.

SAIF does not contest claimant's argument that the ALJ should have addressed the premature closure issue. However, SAIF contends that the medically stationary status of the neuroma condition is not relevant to the premature claim closure issue because that condition was not an accepted condition at closure. SAIF asserts that, because the accepted conditions at closure were medically stationary, the claim closure was proper. For the following reasons, we agree with SAIF's contentions.

At the outset, we agree with claimant that the ALJ should have addressed the issue of premature claim closure because claimant raised the issue of premature closure with respect to the January 1997 Notice of Closure. (Ex. 8). In addition, our order remanding to ALJ Brown specifically allowed the parties to proceed to hearing on claimant's challenges to the January 1997 closure notice, which included premature closure. Having made the determination that premature closure was a viable issue before the ALJ, we nevertheless decline claimant's request for remand because we find the record sufficiently developed to address the premature claim closure issue. *See* ORS 656.295(5).

In *James L. Mack*, 50 Van Natta 338 (1998), we held that, under the current statutory scheme, as amended in 1997, a determination of whether a claim has been prematurely closed (because the claimant's compensable condition was not medically stationary) must focus only on those conditions that were accepted at the time of claim closure. We further held that an evaluation of condition(s) accepted after claim closure must await the reopening and processing of the claim for the new condition(s). *Id.* We found support for our conclusion in several provisions of ORS 656.262(7)(c), especially the statement that "[i]f a condition has been found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

We found further support for our conclusion in the provisions of ORS 656.262(7)(c) that provide for the carrier to "issue at claim closure an updated notice of acceptance that specifies which conditions are compensable" and provide that claim closure shall not be delayed due to an objection to the updated notice or an appeal of a denied condition. We found that these provisions also indicated that the focus at claim closure is on accepted conditions. Moreover, we noted that, if a condition is subsequently found compensable, the statute requires reopening for processing of the new condition. *See also Michael C. Reddin*, 50 Van Natta 1396 (1998).

In this case, the neuroma condition was not an accepted condition at the time of the Notice of Closure. In accordance with the *Mack* rationale, we conclude that the stationary status of the neuroma condition is, therefore, irrelevant to the propriety of the Notice of Closure. Claimant argues, however, that *Mack* is distinguishable because, unlike *Mack*, the claim closure here occurred during the period when claimant had the right to appeal the denial of the neuroma condition. Claimant reasons that, because she was successful in overturning SAIF's pre-closure denial, the neuroma condition should be deemed accepted prior to the closure. We disagree.

As previously noted, we relied in *Mack* on the statement in ORS 656.262(7)(c) that "[i]f a condition has been found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." Here, the neuroma condition was found

compensable by our prior order on March 26, 1998, after the January 6, 1997 claim closure. While SAIF was required to reopen the claim for processing of the neuroma condition, it was not an accepted condition at the time of the claim closure. Because of this, the medically stationary status of this condition was not relevant to the propriety of the claim closure.

Because it is undisputed, and we find, that the accepted conditions at closure were medically stationary at the time the January 6, 1997 Notice of Closure issued, we conclude that the claim closure in this case was not premature.

ORDER

The ALJ's order dated August 9, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that declined to address premature claim closure is reversed. The January 6, 1997 Notice of Closure is affirmed. The remainder of the ALJ's order is affirmed.

December 29, 1999 Cite as 51 Van Natta 2037 (1999)

In the Matter of the Compensation of
JEFFERY SABIN, Claimant
WCB Case No. C992772
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

On November 22, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, 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.

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 November 22, 1999. The statutory 30th day following the submission is December 22, 1999. Claimant filed his request for disapproval of the disposition on December 21, 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
LURA F. CARTER, Claimant
WCB Case No. 99-00819
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) awarded a $2,000 carrier-paid attorney fee; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are denial, claim processing, penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

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

In June 1996, claimant compensably injured her right shoulder. By a November 26, 1997 Notice of Closure, the employer awarded temporary disability and 22 percent unscheduled permanent disability for the right shoulder.

On December 1, 1997, claimant reinjured her right shoulder at work. Dr. Laubengayer diagnosed a right shoulder strain. (Ex. 2). On December 17, 1997, Laubengayer reported that claimant's right arm was getting weaker and causing her more pain. (*Id.*) Dr. Laubengayer referred claimant to Dr. Hartmann, who performed a nerve conduction study and concluded that claimant had a mild ulnar palsy at the right elbow. (Ex. 3).

On April 15, 1998, Dr. Laubengayer noted that claimant's right shoulder had limited motion and caused claimant pain with work. He recommended that claimant reduce the number of hours she was working in order to reduce her shoulder pain and need for medication. (Ex. 3A).

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

On June 1, 1998, claimant sought treatment from Dr. Laubengayer for new left elbow and left wrist pain. He diagnosed left elbow and left wrist tendonitis. He reported that claimant was disabled from work because of the left elbow problems that occurred because she was unable to use her right arm at work. (Ex. 4A).

On June 1, 1998, Dr. Laubengayer took claimant off work and filed an aggravation claim. (Ex. 4B).

On August 10, 1998, Dr. Laubengayer reported that claimant continued to have problems with her right shoulder and left elbow. (Ex. 6). 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, and requested vocational rehabilitation. (*Id.*).

On September 4, 1998, the Department issued a Letter of Agreement resolving a vocational assistance dispute. The letter stated that the employer agreed that it had accepted claimant's aggravation claim and would redetermine claimant's eligibility for vocational assistance. (Ex. 6A).

On October 7, 1998, claimant's attorney wrote to the employer requesting that it accept claimant's left elbow condition as part of her claim. (Ex. 7).

Having received no response to his request for acceptance of the left elbow condition, claimant requested a hearing on January 29, 1999, alleging a *de facto* denial.

In a letter to the ALJ, received on April 26, 1999, the employer clarified that claimant's aggravation claim was compensable and included the left elbow condition.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

Claimant moved to dismiss the employer's request for review on the basis that it failed to file an appellant's brief. In its reply brief, the employer requests that claimant's motion be denied. We agree. We have previously held that a party's failure to submit an appellate brief does not result in the dismissal of that party's request for Board review. OAR 438-11-020(1); *Arthur P. Schooley*, 46 Van Natta 2227 (1994); *Bonnie A. Heisler*, 39 Van Natta 812 (1987). Consequently, we deny claimant's motion to dismiss and proceed to our review.

Penalties and Attorney Fees

Based on the employer's clarification, the ALJ found that it conceded that its reopening of claimant's aggravation claim included the left elbow condition. Consequently, the ALJ awarded claimant's counsel a $2,000 attorney fee regarding the *de facto* denial issue. The ALJ then assessed a penalty for unreasonable claim processing.

On review, the employer argues that there was no *de facto* denial because claimant's left elbow condition had been accepted when the employer accepted claimant's aggravation claim. The employer also argues that the ALJ's $2,000 attorney fee award is excessive and that a penalty is unwarranted. We conclude that the employer's failure to respond to claimant's request for acceptance of the left elbow condition entitles claimant to recover a reasonable attorney fee. However, we modify the ALJ's $2,000 attorney fee award. Finally, we conclude that no penalty is warranted. We reason as follows.

First, the record does not support a conclusion that acceptance of the aggravation of claimant's right shoulder claim encompassed the left elbow.[1] Second, on October 7, 1998, claimant's attorney wrote to the employer requesting that it accept claimant's left elbow condition as part of her compensable right shoulder claim. This communication clearly requested formal written acceptance of a new medical condition as required under ORS 656.262(7)(a).[2]

Here, it is undisputed that the employer did not respond to claimant's October 7, 1998 "new medical condition" claim within 90 days, as required under ORS 656.262(7)(a).[3] The employer's failure

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[1] The employer argues that it conceded compensability of the left elbow condition when it accepted claimant's aggravation claim. As evidence, it has provided a copy of the Department's September 4, 1999 Letter of Agreement that resolved a vocational assistance dispute. The letter merely recites that the employer agreed that it had accepted claimant's aggravation claim. (Ex. 6A). We decline to infer from this letter that the aggravation of claimant's right shoulder subsumed the left elbow condition.

[2] 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); *see also Mark A. Baker*, 50 Van Natta 2333, 2336 (1998) (distinguishing between a condition omitted from the initial notice of acceptance under ORS 656.262(6)(d) and a new medical condition under ORS 656.262(7)(a); a new medical condition is one that "comes into being" following issuance of the Notice of Acceptance).

Here, claimant's left elbow condition arose almost a year after her initial right shoulder claim was closed, *i.e.*, it was not in existence at the time of the acceptance of the right shoulder condition. Moreover, it was related to, but was a different condition from, the right shoulder claim. Therefore, claimant's October 7, 1998 letter is a notice of a claim for a new medical condition under ORS 656.262(7)(a) rather than an objection to the acceptance notice.

[3] ORS 656.262(7)(a) provides in pertinent part:

"After claim acceptance, written notice of acceptance or denial of claims for new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims."

to timely respond constitutes a "denied claim" under ORS 656.386(1)(b)(C).[4] Claimant requested a hearing more than 90 days after making the left elbow claim, alleging a *de facto* denial. The employer then clarified its position that the new medical condition was accepted as part of claimant's aggravation claim. Because the carrier did not respond to the left elbow "new medical condition" claim for more than 90 days after claimant's request, that failure to respond constitutes a "denied claim" under ORS 656.386(1), in which claimant's attorney was instrumental in obtaining a rescission prior to hearing.[5] Consequently, claimant's counsel is entitled to a reasonable attorney fee. ORS 656.386(1)(a).[6]

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.

In reviewing the time devoted to the case, we find that claimant's attorney wrote a letter requesting acceptance of a new medical condition. After the employer failed to respond to the request, claimant's attorney filed a hearing request regarding a *de facto* denial. At the time of the employer's acceptance, there were 15 exhibits in the record generated by claimant's attorney.

As compared to typical compensability cases, the issue of claimant's left elbow condition was of average complexity. Because claimant's left elbow condition has been found compensable, she is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are above average. Claimant may receive compensation for medical services and temporary disability, as well as permanent disability. 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, prior to the employer's concession of the compensability of claimant's left elbow condition, there was a risk that claimant's counsel might go uncompensated.

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

We now turn to the penalty issue. 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. ORS 656.262(11)(a). But if there are no amounts then due on which to base a penalty, no penalty is assessable.

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[4] We previously discussed the statutory definition of a "denied claim" under ORS 656.386(1) subsequent to the 1995 legislative amendments in *Chancey F. James*, 50 Van Natta 1370, 1371 fn 6 (1998):

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

[5] Because we have established that claimant made a claim for a new medical condition and that the employer failed to process the claim within the required statutory period, claimant is statutorily entitled to an attorney fee for a "denied claim." ORS 656.386(1)(b)(C). Therefore, we need not address the employer's arguments regarding whether claimant established a "de facto" denial.

[6] ORS 656.386(1)(a) provides in pertinent 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."

Here, there is no evidence of amounts due upon which to base a penalty. Rather, the record supports a conclusion that claimant was receiving compensation pursuant to the employer's earlier acceptance of claimant's aggravation claim. Consequently, we find no basis for a penalty for the employer's untimely acceptance. *See* ORS 656.262(11); *Spivey v. SAIF*, 79 Or App 568 (1986).

ORDER

The ALJ's order dated June 10, 1999 is modified in part and reversed in part. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $1,000, to be paid by the employer. That portion of the order awarding a penalty is reversed.

December 29, 1999 Cite as 51 Van Natta 2041 (1999)

In the Matter of the Compensation of
PAMELA J. VINYARD, Claimant
Own Motion No. 99-0150M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Traveler's Property Casualty, Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable hernia condition. Claimant's aggravation rights expired on July 25, 1990. The insurer issued a denial of the compensability of claimant's current condition on April 19, 1999. Claimant timely appealed that denial. (WCB Case No. 99-03361). In addition, the insurer opposed authorization of temporary disability compensation, contending that: (1) it is not responsible for claimant's current condition; and (2) claimant was not in the work force at the time of disability.

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

Here, claimant did appeal the April 19, 1999 denial; however, she withdrew her request for hearing. An Order of Dismissal issued on November 17, 1999. That order has not been appealed. Thus, the current condition and ensuing surgery for which claimant requests own motion relief remain in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as the insurer has not accepted claimant's current condition as compensable. Should claimant's circumstances change and the insurer accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD R. HAHN, Claimant
WCB Case No. 99-02318
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's injury claim for his right hip condition. On review, the issue is compensability.

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

On review, the insurer argues that the ALJ misapplied the burden of proof in this case. We disagree.

To establish a compensable injury, the claimant must prove both that the injury arose out of and was in the course of his employment. ORS 656.005(7)(a). While both elements of the test must be met to some degree, the ALJ properly noted that when factors supporting one element are many, the factors supporting the other element may be minimal. *Redman Industries, Inc. v. Lang,* 326 Or 32 (1997).

It is undisputed that claimant's injury occurred while he was in the course of his employment, therefore, the focus rests with the first element of the test. The "arising out of employment" element of the test requires that there be a causal connection between the injury and the employment. *Fred Meyer, Inc. v. Hayes,* 325 Or 592 (1997). A causal connection will be found if the conditions of employment put claimant in a position to be injured by a neutral risk. *Phil Livesley Co. v. Russ,* 296 Or 25 (1983). In *Livesley,* the court determined that unexplained injuries are classic examples of neutral risks. *Phil Livesley Co. v. Russ,* 296 Or at 29-30.

The insurer contends that the ALJ improperly assigned it the burden of proof as the ALJ noted that there were no other reasons for claimant's injury. We agree claimant cannot carry his burden of proof "merely by disproving other possible explanations of how the of how the injury...occurred." ORS 656.266. However, the ALJ did not solely rely on the fact that claimant did not have any preexisting condition or significant off-work activities. The ALJ also found that claimant's work included the repetitive motions of lifting, bending, walking, pushing and pulling. Additionally, the ALJ correctly considered Dr. Lee's chart notes that showed a correlation between claimant's work activity of sweeping and his right hip pain. This evidence is sufficient to find that claimant's work activities created a neutral risk. *See David D. Yarmer,* 51 Van Natta 1245 (1999); *Daniel J. Stine,* 50 Van Natta 982 (1998). Lastly, for the reason expressed by the ALJ, we agree that Dr. Arthur's legal conclusions were properly discounted.

Accordingly we agree with the ALJ that claimant met his burden of proof and satisfied both elements of the "work-connection test."

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

ORDER

The ALJ's order dated July 19, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
ROBERT F. MARTINOT, Claimant
WCB Case No. 99-02696
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. The insurer seeks dismissal of claimant's appeal, asserting that the compensability issue is moot or, alternatively, the claim is precluded by its unappealed July 16, 1999 denial of claimant's second claim for the same condition. Claimant objects to the insurer's submission of documents[1] with its motion to dismiss. If we decline to consider the insurer's proposed evidence, the insurer requests remand. We deny the insurer's motions and reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Findings of Ultimate Fact," with the following summary and supplementation.

Claimant worked as a baker for about 20 years before experiencing the onset of CTS symptoms. He worked in the "tail off" position for over a year--mostly in 1998, but also previously, in the "jobber" position. (*See* Tr. 9). This job required repetitive gripping and lifting of pans loaded with bakery items. Claimant loaded trays with product and gripped and lifted loaded trays to place them on 7 foot racks with nine shelves. Loaded trays weighed between 10 and 20 pounds, depending on the product. Claimant placed 5-7 trays per minute onto the racks and he handled between 440 and 1000 trays per hour throughout his work day.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters/Motions

The insurer seeks dismissal of claimant's appeal, asserting that the compensability issue is moot or, alternatively, the claim is precluded by its unappealed July 16, 1999 denial of claimant's second claim for the same condition. Claimant objects to the insurer's submission of "post-hearing" documents, specifically a July 13, 1999 claim by claimant for bilateral CTS and a July 16, 1999 denial of that claim. (*See* n. 1, supra). If we decline to consider the insurer's proposed evidence, the insurer requests remand. We deny the insurer's request for dismissal and its motion to remand, based on the following reasoning.

The insurer relies on *SAIF v. Mize*, 129 Or App 636 (1994), in support of its contention that we should dismiss claimant's request for review as moot. In *Mize*, the carrier accepted the previously denied claim before it petitioned the court for review of our order finding the claim compensable. The court held that the controversy was moot because the claim had been accepted. *Mize*, 129 Or App at 640.

The "post-hearing" denial in this case is quite different from the "post-review" acceptance in *Mize*. The *Mize* acceptance had prospective effect: It ended the existing dispute, rendering it moot.[2] Here, in contrast, the second denial issued during litigation of the first denial (after the hearing and

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[1] With its motion to dismiss, the insurer submits documents that appear to be a July 13, 1999 claim by claimant for bilateral CTS and a July 16, 1999 denial of that claim. We consider the above "post-hearing" evidence only for the purpose of addressing the insurer's motions.

[2] In *Mize*, by accepting the previously denied claim, the carrier effectively rescinded the very denial that was litigated in the case appealed to the court. Here, the insurer has not withdrawn the litigated denial. Furthermore, claimant has neither explicitly nor implicitly withdrawn its appeal of the ALJ's compensability decision.

before Board review). We simply do not see how the second denial could have any affect on the existing, partially litigated first denial and we find no precedent indicating that it would. Moreover, the insurer does not explain how a "post-hearing" denial could render an existing dispute moot--retrospectively.

Under these circumstances, the current claim is not moot and we deny the insurer's motion to dismiss on this basis (assuming the proposed evidence was in the record).

The insurer also argues that this claim is precluded by claimant's failure to appeal its denial of claimant's "post-hearing" claim for the same condition. We disagree.

> "The doctrine of claim preclusion applies in workers' compensation cases when there is an opportunity to litigate an issue before a final determination and the party against whom the doctrine could be applied fails to litigate the issue. *Drews v. EBI Companies*, 310 Or 134, 140, 142, 795 P. 2d 531 (1990). As a court-made doctrine, claim preclusion works to achieve finality in disputes by preventing parties from raising a claim after a final determination has been made and the judicial review rights concerning that determination have expired or been exhausted." *K-Mart Corp. v. Lloyd*, 155 Or App. 270, 274 (1998).

See Popoff v. Newberry's, 117 Or App 242 (1992) (Failure to request a hearing from a prior denial barred the claimant from asserting later claims).

There was no prior final determination that preceded the claim before us. In other words, claim preclusion does not apply here because its prerequisite is missing: There has been no *final determination* following a *prior* opportunity to litigate this claim. Under these circumstances, we do not dismiss claimant's request for review on claim preclusion grounds.

The insurer's alternative argument is that the claim should be remanded to consider "post-hearing" events. However, because those events neither preclude the claim nor render the controversy moot, the proposed evidence would not support a motion to dismiss and it is therefore not likely to affect the outcome of the case. Accordingly, the insurer's alternative motion to remand is denied. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Compensability

The ALJ upheld the insurer's denial of claimant's occupational disease claim for bilateral CTS because he found Dr. Button's causation opinion more persuasive than that of Dr. Harpole, treating physician. We find Dr. Harpole's opinion more persuasive, for the following reasons.

Dr. Harpole considered and ruled out or discounted potentially contributory nonwork causes. He acknowledged that claimant's obesity probably contributed to his CTS. However, considering the nature of claimant's job, Dr. Harpole reasoned that the work activities (not his weight) were the major cause of the condition.

It is essentially undisputed that claimant's work was often hand and wrist intensive and repetitive, particularly at the "tail off" position, racking pans. And we find both doctors' histories materially accurate, because we are not persuaded that it matters whether claimant racked 440 or 1,000 pans per hour.[3]

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[3] Even if claimant exaggerated the number of pans he handled in the "tail off" position (440 versus 1000 per hour), we would find any such discrepancy insignificant. In other words, we would still find that claimant's work was repetitive and hand intensive and Dr. Harpole's history was sufficiently accurate. (*See* Exs. 6a-1, 6ab, 6b, 7). In this regard, we note that Dr. Harpole relied on an *accurate* history that claimant's work required "a great deal of handling of bread pans" and "frequent firm gripping." (Exs. 7-2, 9-21) We also note that Dr. Button primarily discounted claimant's work for lack of "heavy" lifting, not for lack of repetitiveness or gripping. (*See* Exs. 5-5, 10-8-10, 10-16-17). Moreover, we find Dr. Button's opinion unpersuasive because it is inconsistent, as explained herein.

However, we find Dr. Button's reasoning unpersuasive. It incorrectly assumes greater dominant hand usage even though the doctor acknowledges that claimant's "tail-off/racking" work was bilateral. On one hand, the doctor stated that claimant's more severe left-sided CTS findings are incongruous with his right handedness, "if one were considering hand usage as primarily a causative factor" of CTS, apparently because he assumes that claimant used his right hand more than his left at work. (Ex. 5-5). On the other hand, he acknowledged that "racking of pans is of equal degree usage right v. left." (*Id*). We are unable to reconcile Dr. Button's theory that claimant should have more severe right-sided CTS findings--despite the fact that his most repetitive hand intensive recent work required *equal* hand usage, with the doctor's ultimate conclusion that CTS findings should reflect relative usage--even though Dr. Button would *not* attribute claimant's CTS to his hand usage at work. (*See* Exs. 10-7-8; 11).

Dr. Harpole, in contrast, stated that, in his experience, more involvement in one hand than the other did not really "demonstrate anything," because he had seen findings greater in one hand than the other regardless of hand dominance. (Ex. 9-9; *see* Ex. 6a-1). Dr. Harpole concluded that claimant "has significant bilateral positive findings from his bilateral repetitive hand requirements of his job." (Ex. 6a-1). We find Dr. Harpole's opinion persuasive because it is better-reasoned and more internally consistent. Accordingly, based on that opinion, we conclude that claimant has carried his burden under ORS 656.802.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 23, 1999 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $4,500 attorney fee, payable by the insurer.

December 29, 1999 Cite as 51 Van Natta 2045 (1999)

In the Matter of the Compensation of
ROBERT K. YOST, Claimant
Own Motion No. 99-0138M
OWN MOTION ORDER
Richard Adams, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable right arm and left leg conditions. Claimant's aggravation rights expired on April 16, 1985. SAIF issued a denial of the compensability of claimant's current right ankle condition on April 7, 1999. Claimant timely appealed that denial. (WCB Case No. 99-04821). In addition, SAIF opposed authorization of temporary disability compensation, contending that: (1) claimant's current condition is not compensably related to the accepted condition; and (2) it is not responsible for claimant's current condition.

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

Here, claimant did appeal the April 7, 1999 denial; however, he withdrew his request for hearing. An Order of Dismissal issued on September 15, 1999. That order has not been appealed. Thus, the current condition and ensuing surgery for which claimant requests own motion relief remain in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted claimant's current condition as compensable. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DARIUS McKELLIPS, Claimant
WCB Case No. 98-05413
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorneys
Stoel Rives LLP, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside the employer's Notice of Closure as invalid. On review, the issue is the propriety of the Notice of Closure and premature claim closure.

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

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Claimant requests a fee of $1,500, for services on Board review in this case and for services in WCB Case No. 98-07336 which has been consolidated with this case for Board review. Citing the severity of claimant's condition, his need for additional treatment and the complexity of the case as well as the employer's processing of the claim and the "utter frivolity" of the employer's defense of its claim processing. In response, the employer argues that claimant's request does not address the factors set forth in OAR 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).

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 issue on review in this case was the whether the claim was prematurely closed. Claimant's attorney submitted an 11 page respondent's brief that addressed both claims. The record contains approximately 32 exhibits. The transcript is 12 pages long. Only one witness testified. There were no depositions. The case involved issues of above average legal complexity, as compared to similar cases generally presented to the Board for resolution. The value of the claim and the benefits secured are significant to the extent that the current condition could result in temporary or permanent disability. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the carrier's vigorous defense of the claim, 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 $750 is a reasonable attorney fee for services at the board level in this case. In reaching this conclusion, we have 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 counsel might go uncompensated.

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[1] This matter has been consolidated for review with WCB case No. 98-07336. As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. *See, e.g. Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd* 139 Or App 512 (1996). Because the two matters arise out of the same general circumstances and present issues that are inextricably intertwined and because consolidation will further judicial economy and avoid potentially inconsistent rulings, we review the two cases together.

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 3, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $750, payable by the employer.

December 30, 1999 Cite as 51 Van Natta 2047 (1999)

In the Matter of the Compensation of
DARIUS McKELLIPS, Claimant
WCB Case No. 98-07336
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorneys
Stoel Rives LLP, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) ruled that claimant could testify by telephone; (2) denied the employer's motion to dismiss claimant's hearing request based on his failure to appear at the hearing; and (3) set aside the employer's denial of claimant's current low back condition as an invalid preclosure denial. In his respondent's brief, claimant challenges the ALJ's exclusion of Exhibit 1C (a "medical chronology" furnished by the employer to an examining physician). On review, the issues are the ALJ's procedural rulings, claim processing and compensability.[1]

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

Motion for Dismissal/Telephone Testimony

The employer moved for dismissal on the ground that claimant failed to appear at hearing. On review, the employer asserts that the ALJ abused her discretion by allowing claimant to testify by telephone and by denying its motion to dismiss.

First, although claimant did not personally appear at the hearing, claimant did appear by counsel. OAR 438-006-0071 does not provide authority for dismissal of a hearing request for failure of a claimant to appear at hearing if claimant's attorney appears on his or her behalf. *E.g., Richard Ensinger*, 51 Van Natta 956 (1999); *Randall E. Hug*, 45 Van Natta 1802 (1993). Consequently, the ALJ did not err by declining to dismiss the hearing request.

Secondly, we find that the ALJ did not abuse her discretion by ruling that claimant could testify by telephone. In this regard, OAR 438-007-0022(2) provides:

> "When a lay witness is unable to attend the hearing due to extraordinary circumstances beyond the control of the party offering the testimony and the testimony of the witness cannot be taken by deposition, the Administrative Law Judge may allow testimony to be taken in any manner that will afford substantial justice and insure a complete and accurate record of all examination and testimony."

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[1] This matter has been consolidated for review with WCB case No. 98-05413. The hearing was also consolidated, but the ALJ issued separate orders. As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. *See, e.g. Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd* 139 Or App 512 (1996). Because the two matters arise out of the same general circumstances and present issues that are inextricably intertwined and because consolidation will further judicial economy and avoid potentially inconsistent rulings, we review the two cases together.

The record reflects that the ALJ allowed claimant (who lives out-of-state) to testify by telephone based on representations from his attorney that he was destitute, had a 30 year old car that was not suitable for traveling to the hearing and lived in an area that was remote from any airports. Based on the language of the administrative rule, the ALJ had discretion to allow telephone testimony where the witness is unable to attend the hearing due to circumstances beyond the control of the party offering the testimony. Here, we find that extraordinary circumstances beyond claimant's control prevented him from attending the hearing. Thus, we find no abuse of the discretion granted by the rule. Moreover, the employer had an opportunity to take claimant's testimony by telephone, but declined to do so.

Validity of the Denial

We adopt the ALJ's reasoning and conclusion regarding this issue with the following supplementation.

The ALJ set aside the denial as an invalid preclosure denial. In doing so, the ALJ was unable to conclude that the current condition was unrelated to the accepted lumbar strain or that it was completely separate from the accepted condition.[2]

After the date of the ALJ's order, the court issued its decision in *Croman Corp. v. Serrano*, 163 Or App 136 (1999). In *Serrano*, the court addressed a Board order that had set aside a denial as an impermissible preclosure denial of medical treatment. The employer had accepted a "cervical contusion and left shoulder, cervical/back strain."

In *Serrano*, sometime after the claim acceptance, the employer concluded that the claimant's need for ongoing medical treatment was not related to the accepted injury and issued a preclosure denial under 656.262(7)(b). After the denial, the claim was closed. On review, we held that ORS 656.262(7)(b) did not apply because the employer had not accepted a "combined condition" under ORS 656.005(7)(a)(B). We further concluded that the claimant's current conditions were not clearly separate or severable from the accepted conditions. On this basis, we held that the denial was an invalid preclosure denial.

The court affirmed our order holding that, in order for ORS 656.262(7)(b) to apply, the carrier must have accepted a "combined condition." In the present case, because the employer did not accept a "combined condition," we conclude, based on *Serrano*, that ORS 656.262(7)(b) does not apply to allow a preclosure denial. Moreover, for the reasons given by the ALJ, we find that claimant's current condition is not severable from the accepted condition. Under such circumstances, we affirm the ALJ's order concluding that the employer's denial was an invalid preclosure denial.

Exclusion of Exhibit 1C

The ALJ excluded Exhibit 1C (a medical chronology furnished to Dr. Arbeene, an examining physician). Claimant challenges this ruling, arguing that the exclusion of the chronology is inconsistent with the applicable administrative rule.

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[2] Generally, preclosure denials are disfavored but, if they pertain to a condition separate or severable from the accepted condition, they are procedurally valid. *See Connie L. Birrer*, 51 Van Natta 163 *on recon* 51 Van Natta 467 (1999); *Zora A. Ransom*, 46 Van Natta 1287 (1994) (preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition).

Here, even if the preclosure denial had been appropriate under *Serrano*, we would still have found the denial invalid. In this regard, the medical evidence does not "unequivocally" indicate that the current condition is unrelated to the accepted condition. Dr. Arbeene believed that the preexisting condition, rather than the November 1997 injury, was the major contributing cause of claimant's current low back condition and need for treatment. (Ex. 51-6). Dr. Arbeene, however, could not determine whether claimant's injury combined with his preexisting condition and he did not unequivocally indicate that the current condition was not related to the accepted condition and was not contributing to that condition. The remaining medical opinions similarly do not indicate unequivocally that the preexisting condition is not related to the accepted condition. Under these circumstances, we agree with the ALJ's conclusion regarding the medical evidence.

438-007-0015(5)(a) provides:

"For the purpose of this rule, 'documents pertaining to the claim(s)' or any variation thereof means documents and recordings, whether written or electronic or in any other form, which consist of the following items applicable to the workers' compensation claim:

"(a) Medical and vocational reports, including any correspondence to and from the medical and vocational experts who provide the reports or who agree to testify on behalf of the party sending correspondence[.]"

438-007-0015(7)(b) provides:

"Notwithstanding any other provision of this section, the following documents pertaining to the claim(s) are not discoverable:

"* * * * *

"(b) Material which is the work product of any attorney, except that correspondence and any inclusions sent to a medical or vocational expert who writes a report that is otherwise subject to disclosure under these rules or who agrees to testify at the request of the corresponding party shall be discoverable under subsection (5)(a) of this rule[.]"

Exclusion of the "medical chronology" sent by the carrier to Dr. Arbeene appears to be inconsistent with the administrative rule quoted above. Nevertheless, we need not resolve the issue because even if the "medical chronology" was admitted, it would not affect the result in this case. Arguably, the chronology might be used to challenge the accuracy of the history that Dr. Arbeene was given; however, for the reasons given by the ALJ and herein, Dr. Arbeene's report does not establish that claimant's current condition is separable from the accepted condition.

Attorney Fees for Board Review

Claimant requests a fee of $1,500 under ORS 656.382(2), for services on Board review in this case and for services rendered in WCB Case No. 98-05413 which has been consolidated with this case for Board review. In support of the fee request, claimant cites the severity of his condition, his need for additional treatment, the complexity of the case as well as the employer's processing of the claim and the "utter frivolity" of the employer's defense of its claim processing. In response, the employer argues that claimant's request does not address the factors set forth in OAR 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).

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 issue on review in this case was the validity of the preclosure denial as well as procedural and claim processing issues. Claimant's attorney submitted an 11 page respondent's brief. The record contains approximately 53 exhibits. The transcript is 12 pages long. Only one witness testified. There were no depositions. The case involved issues of above average legal complexity, as compared with other denial issues generally presented to the Board for resolution. The value of the claim and the benefits secured are above average to the extent that the current 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 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 $750 is a reasonable attorney fee for services at the Board level in this case. In reaching this conclusion, we have 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 counsel might go uncompensated.

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 4, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $750, payable by the employer.

In the Matter of the Compensation of
GAYANNE MITCHELL, Claimant
WCB Case No. 99-03304
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant was entitled to a higher rate of temporary disability; and (2) assessed a penalty for an allegedly unreasonable failure to pay temporary disability. On review, the issues are rate of temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Disability

We adopt and affirm that portion of the ALJ's order finding that rate of disability should be determined under OAR 436-060-0025(5)(a)(A) rather than 436-060-0025(5)(a)(B)(iii).

Claimant's attorney is entitled to an assessed fee for services on review regarding the temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Penalties

After finding that claimant was entitled to a higher rate of temporary disability because the insurer did not satisfy the requirements under OAR 436-060-0025(5)(a)(B)(iii), the ALJ determined that claimant was entitled to a penalty. The insurer asserts that its action was not unreasonable and, thus, a penalty is not warranted.

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). 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. *See 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).

Here, because the record contains a Form 801 stating that claimant worked a reduced schedule (three to four days per week rather than four to five days per week), and claimant signed and dated the form *after* the employer provided that information, we find that the insurer was not unreasonable in basing the rate of temporary disability on a reduced scheduled. That is, we find evidence that the worker confirmed a new wage agreement and, thus, it had legitimate doubt that it was liable for additional temporary disability. Therefore, although we agree with the ALJ that the insurer did not satisfy the rule, we also conclude that it did not act unreasonably in basing the rate of temporary disability on OAR 436-060-0025(5)(a)(B)(iii).

ORDER

The ALJ's order dated July 27, 1999 is affirmed in part and reversed in part. That portion of the order assessing a penalty is reversed. The remainder of the order is affirmed. For services on review regarding the rate of temporary disability issue, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer.

Board Member Phillips Polich dissenting in part.

I disagree with that portion of the majority's order deciding not to assess a penalty. OAR 436-060-0025(5)(a)(A) clearly provides that insurer may base the rate of temporary disability on the intent of a new wage earning agreement when it is "confirmed by the employer and the worker." Thus, the carrier may not simply rely on information from its insured to determine whether there is a "new wage earning agreement."

Here, the majority finds that, because the Form 801 provides some evidence that a new wage earning agreement was confirmed by claimant, it was not unreasonable in basing the rate of temporary disability on information that claimant had a reduced working scheduled. I find this single piece of information insufficient. The purpose of a Form 801 is for the injured worker to give notice of an injury or occupational disease and file a claim. At least for the worker, it is not used to inform the carrier of its work schedule and pay rate--that portion is provided only by the employer. Thus, I disagree that, because the information concerning her schedule apparently was included when claimant signed the 801, she necessarily endorsed those portions or even read them.

In sum, because I find no evidence showing that claimant "confirmed" a new wage earning agreement, the insurer acted unreasonably in basing the rate of temporary disability on OAR 436-060-0025(5)(a)(A), and a penalty should be assessed.

In the Matter of the Compensation of
DONALD J. MURRAY, Claimant
WCB Case No. 97-09053
ORDER ON REVIEW
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for chemical exposure. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant worked for the employer as a cabinetmaker for approximately four years. On June 12, 1997, claimant sought medical treatment at a hospital emergency room. According to the medical records, claimant had "walked off the job" the previous day and was complaining of "anxiety and job related stressors." (Ex. 2). Claimant did not return to his job.

Claimant then began psychological counseling. Furthermore, on July 10, 1997, claimant saw Dr. Stelson, who prescribed medication to "help anxiety, "improve depression," and "help anger control." (Ex. 5A).

On July 15, 1997, examining psychiatrist, Dr. Turco, saw claimant and diagnosed "personality disorder not otherwise specified with impulsivity, anger, paranoid ideation and a tendency to blame others." (Ex. 6-7). On September 3, 1997, Dr. Glass, examining psychiatrist, also found a "personality disorder not otherwise specified, with passive-aggressive, paranoid, narcissistic and perhaps some schizoid features[.]" (Ex. 8-12).

On September 17, 1997, claimant saw Dr. Christopherson, D.O., for a "psychiatric evaluation." (Ex. 11). Dr. Christopherson diagnosed "adjustment disorder" and "obsessive compulsive personality disorder," and found that "psychosocial stressors" were "extreme." (*Id.* at 2).

On Dr. Stelson's referral, Dr. Harris, occupational medicine specialist, evaluated claimant on February 23, 1999.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant asserted a "physical/mental injury attributed to a lacquer poisoning[.]" Applying ORS 656.802, the ALJ found that the medical evidence was insufficient to prove that "claimant has developed an occupational disease as a result of exposure to laquer [sic] fumes." On review, claimant challenges some of the factual findings and asks the Board to review the record.

Dr. Harris provided the sole opinion concerning claimant's exposure to lacquer paints.[1] Dr. Harris recorded a history that 25 percent of claimant's job consisted of spraying finishes to cabinetry at work. (Ex. 18-1). Claimant also indicated that he used respiratory protection between 10 to 25 percent of the time. (*Id.*)

Dr. Harris diagnosed "[a]cute solvent exposure with acute toxicity -- resolved." (*Id.* at 3). According to Dr. Harris, claimant's reports of "headache, dizziness, and general intoxication are certainly consistent with acute organic solvent intoxication from finishing carpentry." (*Id.*) Dr. Harris added that he did not "anticipate long-term adverse sequelae from this exposure, as the total cumulative dose of organic solvent fumes is probably of not a great enough magnitude to results [sic] in painter's encephalopathy." (*Id.*)

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[1] Other opinions from Drs. Turco and Glass, and chartnotes from Drs. Stelson and Christopherson, primarily addressed claimant's psychological condition without attributing any problems to occupational exposure to lacquer paints. Moreover, claimant indicated at hearing that he was not advancing a "mental stress" claim.

Dr. Harris also discussed claimant's report of "seizures," finding that "there are a number of complicating factors in his history that would cloud causation," including "significant solvent exposure from his alcohol intake." (*Id.*) With regard to claimant's "anxiety disorder," Dr. Harris thought that claimant's symptoms were "not consistent with solvent overexposure or the chronic effects from solvent exposure." (*Id.*) Finally, Dr. Harris found "significant alcohol consumption." (*Id.*)

Thus, although Dr. Harris found acute solvent exposure with acute toxicity, based on his report, this condition was confined to that time when claimant performed the spray finishing work. That is, in discussing claimant's symptoms he experienced after he was no longer working, such as "seizures" and anxiety, Dr. Harris found that occupational solvent exposure was either not the cause or one of many causes. Furthermore, Dr. Harris stated that the acute toxicity condition had "resolved" and exposure was not sufficient to have caused "painter's encephalopathy."

A compensable accidental injury or occupational disease requires medical services or results in disability. ORS 656.005(7)(a), 656.802(2). Here, there is no evidence that claimant sought medical services for, or was disabled from, acute toxicity. Rather, the record shows that claimant was treated for anxiety and psychological symptoms after he left his job. For this reason, we find that Dr. Harris' diagnosis of "acute solvent exposure" does not qualify as a compensable accidental injury or occupational disease.

Furthermore, as noted by the ALJ, Dr. Harris relied on a history that claimant's spraying activities consisted of 25 percent of his work. At hearing, claimant conceded that such activity was only 10 percent of his work. (Tr. 37). Thus, Dr. Harris also relied on an inaccurate history.

In sum, we agree with the ALJ that Dr. Harris' opinion is insufficient to prove a compensable accidental injury or occupational disease. *See* ORS 656.005(7)(a), 656.802(2).

ORDER

The ALJ's order dated July 28, 1999 is affirmed.

In the Matter of the Compensation of
ROBIN L. STEVENS, Claimant
WCB Case No. 98-03511
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Martha Brown's order that set aside its denial of claimant's claim for a back injury. On review, the issue is compensability.

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

The insurer argues that Dr. Keiper's opinion is unpersuasive because the history he relied upon was inaccurate. The insurer specifically argues that claimant had back symptoms prior to the date of the injury. We note that Dr. Keiper was aware of claimant's prior mild low back problems, but still opined that the injury was the major contributing cause of the need for treatment of the disk herniation found at surgery. Under such circumstances, we do not find that the doctor had an inaccurate history.

The insurer also asserts that Dr. Floyd's opinion is unpersuasive because it is "internally inconsistent." In making this argument, the insurer asserts that Dr. Floyd's disagreement in Exhibit 21 with Dr. Farris' opinion that claimant had *significant* preexisting degenerative disc disease at L5-S1 conflicts with his statement in another portion of the report that claimant's findings at L3-4 and L4-5 may or may not be related to preexisting degenerative disc disease. A reading of Dr. Floyd's opinion in Exhibit 21 shows that he agreed that claimant had preexisting mild degenerative disease, but disagreed that the disease was "significant." Dr. Floyd opined that the preexisting mild degenerative disease combined with the compensable injury to cause the herniated disc at L5-S1. Dr. Floyd further opined that the compensable fall injury and not the preexisting disease was the major contributing cause of the disability and need for treatment. Thus, we do not find any inconsistency in Dr. Floyd's opinion. The doctor acknowledged claimant's preexisting disc disease and its contribution to the herniation.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 15, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,800, payable by the insurer.

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Cite as 163 Or App 20 (1999) September 22, 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.
On respondent's petition for reconsideration filed July 21, 1999. Opinion filed July 7, 1999, 161 Or App 262, ___ P2d ___.
Mark Johnson and Bennett, Hartman & Reynolds for petition.
Timothy R. Volpert and Davis Wright Tremaine, LLP, for response.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
DEITS, C. J.
Reconsideration allowed; decision modified; judgment for damages on age discrimination claim affirmed; judgment for plaintiff otherwise reversed and remanded.

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163 Or App 22> Plaintiff petitions for reconsideration of our decision in which we reversed and remanded the judgment in her favor in this action arising out of her discharge by the defendant employer and related conduct by the individual defendant. *Sleigh v. Jenny Craig Weight Loss Centres, Inc.*, 161 Or App 262, ___ P2d ___ (1999). The judgment was entered on a jury verdict which, in response to special interrogatories, found for plaintiff on her separate claims for discrimination based on her "injured worker status" and discrimination based on age. The error on which our disposition was predicated pertained to the admission of evidence that went only to the injured worker claim. Plaintiff argues that we should therefore modify our opinion to reverse and remand only on that claim and that we should affirm the judgment for plaintiff on the age discrimination claim. Under the circumstances of this case, we agree with plaintiff and modify our decision accordingly.

There are three general reasons for our disposition of the petition. First, the relief that the judgment grants plaintiff on the respective claims is discrete and easily separable. She was awarded $37,500 in compensatory damages against the employer on the age discrimination claim. All other damages, compensatory and punitive, against the employer and the individual defendant, were awarded in connection with the injured worker claim.

Second, defendants' contentions on appeal were also such that there is no necessary connection between the disposition of the two claims. Defendants made six assignments of error. The first two related to the evidentiary error on which we based our reversal and, therefore, pertained directly only to the injured worker claim. The last two assignments related to the awards of punitive damages against one or both defendants. As noted, the judgment awards punitive damages only in connection with the injured worker claim. The third assignment challenges the trial court's refusal to give a requested instruction. Although that assignment arguably has bearing on both claims, it is of no moment because we held that the refusal to give the instruction was not erroneous. Similarly, the fourth assignment, in which defendants **<163 Or App 22/23>** contended that the award of attorney fees against them was error, also bears on both claims. However, whether our remand were to include one claim or both, our disposition automatically vacates the award of attorney fees *in toto*. Hence, as with the relief under the trial court's judgment, the relief on appeal does not require any continuing linkage between the two claims.

Finally, this is an appropriate case for a remand that is limited to the claims and issues that are directly affected by the error. *See Baker v. English*, 134 Or App 43, 48-50, 894 P2d 505 (1995), *rev'd on unrelated grounds*, 324 Or 585, 932 P2d 57 (1997), and cases there cited. Although defendants assert that the erroneously admitted evidence affected their credibility in the eyes of the jury in a way that could have had an impact on the findings on both claims, as in *Baker*, the connection that defendants discern is wholly hypothetical. *See id.* at 50. As explained in our original opinion, evidence of precisely the same kind that we held to be improperly admitted in connection with the injured worker claim, except that it

was favorable to defendants, was offered by defendants and was admitted in connection with the age discrimination claim. Further, the jury found for defendants on a separate intentional infliction of emotional distress claim that plaintiff alleged in conjunction with the same underlying events. Given those indications that the jury gave independent consideration to the various claims, we conclude that there is no reason to assume that plaintiff's contrary hypothesis is correct or to require a retrial of any claim that was not directly implicated by the error.

Plaintiff also argues in her petition that we erred by awarding costs to defendants as the prevailing parties on appeal, as opposed to making the award of costs contingent on the final outcome of the litigation. Even with the modification that we now make, we adhere to our decision to award costs.

Reconsideration allowed; decision modified; judgment for damages on age discrimination claim affirmed; judgment for plaintiff otherwise reversed and remanded.

Cite as 163 Or App 136 (1999) September 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Juan Serrano, Claimant.

CROMAN CORPORATION, Petitioner,
v.
JUAN SERRANO, Respondent.
(95-02746; CA A101466)

Judicial review from Workers' Compensation Board.
Argued and submitted on January 26, 1999.
Elliott C. Cummins argued the cause for petitioner. With him on the brief was Cummins, Goodman, Fish & Platt, P. C.
Bruce D. Smith argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judge.
EDMONDS, P. J.
Affirmed.

*Deits, C. J., *vice* Warren, P. J., retired.

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163 Or App 138> Employer seeks review of a Workers' Compensation Board order in which the Board set aside employer's denial of claimant's claim as an impermissible preclosure denial of medical treatment. We review for substantial evidence and errors of law, ORS 183.482(7) and (8), and affirm.

In October 1994, claimant injured his back and left shoulder and suffered a cervical strain from a fall at work. Employer accepted the claim as a disabling injury and specified the accepted conditions as: "[c]ervical contusion and left shoulder, cervical/back strain." Sometime thereafter, employer concluded that claimant's need for ongoing medical treatment was not related to the accepted injury. Employer based its conclusion on an examination and report by Dr. Dickerman. In his report, Dickerman concluded that the work-related injuries had been resolved and that claimant's subjective complaints were inconsistent with his physical injuries. In February 1995, employer issued a post-acceptance, preclosure denial under ORS 656.262(7)(b):

> "It is [Dr. Dickerman's] opinion, and we agree, the conditions you received from your fall * * * are completely resolved and you are no longer in need of medical treatment. We must, therefore, deny ongoing medical treatment as not being related to your claim of October 25, 1994."

After the denial, other physicians continued diagnostic testing and treatment of claimant for the shoulder injury. Some of the evaluations done after February 1995 indicate that claimant exhibited a pain disorder or was malingering. In October 1995, a determination order closed the claim with no award of permanent disability. The closure was affirmed by a medical arbiter on reconsideration.

Claimant requested a hearing, contesting the denial. An administrative law judge concluded that the denial was procedurally proper and that claimant's complaints were "no longer related to the effects of his compensable injury." On review, the Board disagreed. It said, in part:

> "ORS 656.262(7)(b) applies only if the accepted condition, whether voluntary or by litigation, was a 'combined **<163 Or App 138/139>** condition.' Under ORS 656.005(7)(a)(B), a 'combined condition' exists when a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment. A 'combined condition' is compensable 'only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause' of the disability or need for treatment of the combined condition. Here, the employer accepted a cervical contusion and left shoulder, cervical/back strain. There is no evidence that the employer accepted a 'combined condition.' Therefore, ORS 656.262(7)(b) does not apply.
>
> " * * * * *
>
> "Here, the employer accepted a cervical contusion and left shoulder, cervical/back strain. On February 28, 1995, before the claim was closed, the employer denied claimant's current conditions on the basis that the conditions had 'completely resolved' and he was no longer in need of medical treatment. The employer denied ongoing medical treatment as unrelated to the October 25, 1994 injury. Although the employer argues that psychological factors had taken over as the driving factor for claimant's claim, the employer's February 28, 1995 denial only mentions that claimant's accepted conditions had resolved. The denial makes no reference to any psychological factors affecting claimant's conditions.
>
> " * * * * *
>
> "After reviewing the record, we conclude that the medical evidence establishes that claimant's current conditions as of the February 1995 denial were not clearly separate or severable from the accepted cervical contusion and left shoulder, cervical/back strain. At the time the denial was issued, the claim was not yet closed. Under these circumstances, we conclude that the employer's partial denial with respect to claimant's current conditions was an invalid preclosure denial of accepted conditions and must be set aside.
>
> "Furthermore, we conclude that the employer's preclosure denial of claimant's conditions as 'completely resolved' is an impermissible denial of future responsibility with respect to the compensable cervical contusion and left shoulder, cervical/back strain. * * * The effect of the employer's denial was to limit its acceptance to a 'resolved' cervical contusion and left shoulder, cervical/back strain **<163 Or App 139/140>** and to deny future medical treatment for those conditions." (Citations omitted.)

Accordingly, the Board set aside the denial and ordered that the claim be remanded to employer for processing.

Employer first assigns error to the Board's conclusion that ORS 656.262(7)(b) does not apply to this case.[1] The gist of employer's argument, as we understand it, is that the legislature intended that,

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

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

"ORS 656.262(7)(b) is a notice statute. Its purpose is to ensure that, if an insurer is going * * * to deny an accepted condition [under ORS 656.262(6)(c)]," it gives notice of that action to the claimant. *SAIF v. Beldon*, 155 Or App 568, 574, 904 P2d 300 (1998), rev den 328 Or 330 (1999) (footnote omitted).

ORS 656.262(6)(c) provides:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

when a non-work-related condition combines with a work-related condition *after* acceptance, the statute provides a means by which an employer can deny the condition if the work related cause is no longer the major contributing cause of the combined condition. Employer makes several statutory construction arguments and asserts that the Board's decision is contrary to the legislature's intent. Employer says that the Board erred in ruling that "[t]he combining must have occurred by the time of the original acceptance. In so concluding, the Board has impermissibly rewritten the statute."

First, the Board correctly concluded that in order for employer to have issued properly a preclosure denial under ORS 656.262(7)(b) and ORS 656.262(6)(c), it must have *accepted* a combined condition. Under ORS 656.005(7)(a)(B), a combined condition exists when a compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment. When ORS 656.005(7)(a)(B) is read with the language of ORS **<163 Or App 140/141>** 656.262(6)(c), it is clear that the combined condition must have been accepted before it may be denied under the statute.

Here, the Board found that employer accepted a cervical contusion and left shoulder, cervical/back strain. Employer does not contend that any of those conditions constituted a preexisting condition. Rather, employer asserts that claimant had a preexisting psychological condition that combined with the accepted condition and that became the major cause of the need for treatment after acceptance. The Board's finding that there is no evidence that employer ever accepted a combined condition that included the preexisting psychological condition is supported by substantial evidence. Accordingly, the Board did not err in concluding that ORS 656.262(7)(b) did not apply to this case at the time of employer's denial because there had not been an accepted combined condition.

In its second assignment of error, employer argues that the Board improperly "focused entirely upon the medical evidence that had been obtained by [e]mployer *prior* to the issuance of its denial. * * * From this finding, the Board then jumped to the conclusion that the denial dealt with the *same* condition that had been accepted in November, 1994." (Emphasis in original.) Employer's third assignment of error is in a similar vein. It asserts that "[t]he Board erred when it failed to determine that the record, viewed as a whole, could only permit the conclusion that Claimant's need for treatment was based upon a different condition than that accepted by the Employer." In determining whether the February 1995 denial was proper under ORS 656.262(6)(c) and ORS 656.262(7)(b), we fail to understand how medical evidence that claimant's psychological condition combined with his accepted conditions after the denial bears on the authority of employer to properly deny the accepted condition when such evidence did not exist before the denial.

In addition, the February 1995 denial by its terms was an attempt to deny future medical treatment on an accepted claim on the ground that ongoing medical treatment was not related to the compensable injury. If employer believed that the accepted conditions were resolved and that **<163 Or App 141/142>** claimant was no longer in need of medical treatment for those conditions as it stated in its denial, it could have closed the claim. ORS 656.268(1). *Altamirano v. Woodburn Nursery, Inc.*, 133 Or App 16, 889 P2d 1305 (1995); *Evanite Fiber Corp. v. Striplin*, 99 Or App 353, 357, 781 P2d 1262 (1989). Accordingly, we conclude that the Board did not err in focusing on the evidence before the February 1995 denial in determining whether to set aside employer's denial of claimant's claim as an impermissible preclosure denial of medical treatment for an accepted condition.

Affirmed.

Cite as 163 Or App 143 (1999) September 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ferral C. Crowder, Claimant.

FERRAL C. CROWDER, Petitioner,
v.
ALUMAFLEX and EMPLOYERS INSURANCE OF WAUSAU, Respondents.
(94-12846; CA A95865)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 8, 1998.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Abigail V. Marshall argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong, Judge, and Warden, Senior Judge.
ARMSTRONG, J.
Reversed on determination of PPD rate and remanded for determination of amount of PPD based on current rate; otherwise affirmed.

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163 Or App 145> Claimant seeks review of a decision by the Workers' Compensation Board that denied his claim for increased permanent partial disability (PPD) benefits under the 1995 amendment to ORS 656.214(6). The Board denied the claim on the ground that claimant had not raised the issue of the PPD rate on reconsideration of the determination order in which the PPD rate had been applied. Claimant also challenges the Board's determination that he failed to prove that his compensable injury was the major contributing cause of his current psychological condition.[1]

The following facts are undisputed. Claimant was injured on February 1, 1990, while working as a patio cover/awning installer for employer. As a result of his compensable injury, claimant underwent low back surgery in March 1990 and April 1993. After a comprehensive pain evaluation, claimant was declared medically stationary in May 1994. Claimant's claim was closed by a determination order in August 1994 that awarded him 50 percent, or 160 degrees, of unscheduled PPD. The order awarded claimant $16,000 for the 160 degrees of PPD, based on the existing statutory rate for such awards of $100 per degree of disability. *See former* ORS 656.214(5) (1995). Claimant requested reconsideration but did not challenge the rate at which his PPD benefits had been calculated. An order on reconsideration was issued on May 12, 1995, affirming the 50 percent unscheduled PPD and adding an award of 26 percent scheduled PPD. Claimant previously had requested a hearing and, on May 15, 1995, he **<163 Or App 145/146>** filed a notice of his intention to raise the following additional issues at that hearing: "Appeal order on reconsideration for time loss, premature closure, additional permanent partial disability, permanent total disability, penalties and fees."

On June 7, 1995, an amendment to the Workers' Compensation Law took effect that changed the rate at which PPD benefits were to be calculated. Or Laws 1995, ch 332, sections 17-18; ORS 656.214(6). Under the new law, which was made applicable to cases pending at the time that it took effect, Or Laws 1995, ch 332, section 66, the rate at which PPD benefits were to be calculated was changed from a flat $100 per degree to a grid system based on the total degrees of a worker's disability. On November 30, 1995, claimant designated the change in PPD rates as an additional issue for the scheduled hearing.

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[1] Claimant also assigns error to the Board's conclusion that he was not entitled to permanent total disability (PTD) benefits and its conclusion that his claim was not prematurely closed. Claimant concedes that we need not reach those assignments of error if we affirm the Board's conclusion that his compensable injury was not the major contributing cause of his current psychological condition, because those assignments are based on an assumption that the psychological condition is compensable.

Claimant also had assigned error to the Board's conclusion that it did not have jurisdiction over his claim for vocational assistance, but he withdrew that claim in light of *Sweisberger v. Manchester District, Inc.*, 151 Or App 508, 948 P2d 1261 (1997), in which we affirmed without opinion the Board's determination that it did not have jurisdiction over such claims. We note that that case is not a precedential decision of our court. *See Nero v. City of Tualatin*, 142 Or App 383, 386 n 2, 920 P2d 570 (1996).

At the hearing, the Administrative Law Judge (ALJ) determined that claimant's unscheduled disability had been miscalculated and awarded him four percent more of unscheduled disability. The ALJ also concluded that the new statutory rate applied to all of claimant's scheduled and unscheduled PPD benefits and ordered employer to recalculate those benefits under the new rates. The ALJ rejected claimant's contentions that his claim had been prematurely closed and that his current psychological condition was a consequence of his compensable injury.

Employer appealed to the Board, contending that the ALJ had erred in applying the new statutory rate for PPD, because claimant had not raised the rate issue on reconsideration. Claimant cross-appealed, raising the issues of the compensability of his psychological condition, the denial of PTD benefits, and premature claim closure.[2] The Board affirmed the ALJ's decisions as to claimant's psychological condition, PTD benefits and claim closure but concluded that claimant was not entitled to have his 50 percent unscheduled PPD paid at the new rate, because he had not raised that issue on reconsideration. ORS 656.283(7). However, because the 26 percent scheduled PPD and the extra <163 **Or App 146/147>** four percent unscheduled PPD had been awarded at reconsideration, the Board concluded that claimant was entitled to have those awards paid at the new rate.

On review, claimant contends that ORS 656.283(7) applies only to issues that actually existed at the time of reconsideration. He points out that the new rates, which were intended to apply retroactively, did not become effective until *after* the reconsideration process had been completed. He argues that once those new rates became effective, he was entitled to be paid at the new rate and, accordingly, that he had raised the issue at the first possible moment, which was at his scheduled hearing.

Employer counters that, even though the new law had not been enacted at the time of reconsideration, there was sufficient information available to put claimant on notice that the law might change, so that claimant could have raised the rate issue on reconsideration. Employer argues that, because claimant *in theory* could have raised on reconsideration the issue of the rate at which his PPD was to be paid, even though the rate set at closure was proper under the existing law, claimant was precluded from raising it later. We are not persuaded. We conclude that an issue that, because of the state of the relevant statutes, did not exist at the time of reconsideration but which, because of a change in those statutes, became an issue before hearing is not barred by ORS 656.283(7) from being raised at hearing.

ORS 656.283(7) provides in relevant part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

Although we look first to the text of a statute when we seek to discern the intent of the legislature, we analyze that text in context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). "[T]he context of the statutory provision at issue * * * includes * * * *preexisting common law* and the statutory framework within which the law was enacted." *Denton and Denton*, 326 Or 236, 241, 951 P2d 693 **<163 Or App 147/148>** (1998) (emphasis added; citations omitted). In this case, ORS 656.283(7) speaks of issues that must be raised or lost. That language invokes the common-law principles of claim preclusion and preservation and, consequently, it is those principles that inform our understanding of the legislature's intent.

Preclusion and preservation serve to "protect limited dispute-resolution resources from repeated expenditure upon the same overall dispute." *Drews v. EBI Companies*, 310 Or 134, 141, 795 P2d 531 (1990). The principle embodied in the rules on preclusion and preservation, including statutes such as ORS 656.283(7), is that, when the opportunity arises to raise an issue or claim, a party may be required to raise it or risk losing it. Accordingly, we conclude that, when the legislature referred in ORS 656.283(7) to issues that must be raised on reconsideration, it intended the reference to include only those issues that could have been raised at that point.

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[2] Claimant also appealed the ALJ's conclusion that the Board had no jurisdiction over claimant's vocational assistance claim. *See* note 1.

The question becomes, then, whether claimant had to raise the issue of the new PPD rates on reconsideration. We conclude that he did not. At the time that claimant requested reconsideration of the determination order, claimant's PPD award had been set at the proper statutory rate. Consequently, claimant had no ground on which to question or challenge the award at that time. We find untenable employer's argument that claimant should have taken the proposed legislation into account. Although a litigator might choose to anticipate future legislation that could create an issue where none now exists, there is nothing in ORS 656.283(7) to indicate that the legislature intended to require parties to anticipate such changes by requesting reconsideration to address them before they exist. Hence, we conclude that claimant was not required to raise the issue of the new rates at a time that the new rates did not exist.

Although we conclude that we need not look beyond the text of ORS 656.283(7), in context, to decide this case, we note that our reading of that text is supported by the legislative history of the statute. In a letter to the Senate Labor Committee, Virlena Crosley, Administrator of the Workers' Compensation Division, wrote that the 1995 amendment to the statute was designed to streamline the appeals process **<163 Or App 148/149>** and to reduce litigation costs. She wrote, "[t]o reduce litigation costs, it is important that issues be raised at the *lowest possible level* for resolution." Testimony, Senate Committee on Labor, SB 369, February 8, 1995, Ex. A. The "lowest possible level for resolution" is the level at which the issue first exists. If it does not yet exist, it cannot be resolved.[3] Because claimant was under no obligation to raise the issue, the preclusive principle embodied in ORS 656.283(7) did not operate to prevent him from raising the issue when it finally did arise.[4]

Because we conclude that claimant was not precluded from raising the issue of the new PPD rates at hearing, and because the new rates apply retroactively to his claim, we reverse the Board's order as to the rate at which claimant's 50 percent unscheduled award should be calculated.

Claimant's second assignment of error is that the Board erred when it found that his compensable injury was not the major contributing cause of his current psychological condition. We will not disturb the Board's findings if there is substantial evidence in the record to support them. Substantial evidence exists to support a finding when the record, viewed as a whole, would permit a reasonable person to make the finding. ORS 183.482(8)(c).

Claimant contends that he suffers from depression caused by his compensable injury and that the depression renders him permanently and totally disabled. Claimant's **<163 Or App 149/150>** treating physician, Dr. Maletzky, diagnosed claimant as suffering from major depression and stated that he believed that the depression was "entirely secondary to his 1990 work related injury." Dr. Turco examined claimant on behalf of employer and determined that claimant's condition was "consistent with an individual who has physical disability, is depressed and requires psychiatric pharmacological intervention." Although Turco attributed some of claimant's depression to his compensable injury and subsequent unemployment, Turco also concluded that claimant had other possible sources of depression. He noted that a substantial factor in claimant's depression was the fact that claimant had suffered a large financial loss, or at least perceived that he had suffered such a loss, when he sold his farm. Claimant told Turco that he had been misinformed by his realtor and escrow agent and, as a result, faced a capital gains tax penalty of over $100,000. Turco stated that he could not apportion a specific causation percentage as to claimant's overall psychological condition between the depression caused by the injury and that attributable to claimant's tax concerns.

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[3] The purpose of the reconsideration process is to correct errors and thereby make it unnecessary to devote resources to litigation to correct them. Here, reconsideration concluded before the legislature had amended the statute to increase the disability rates, so there was no error on that issue to be corrected on reconsideration. If employer were right that ORS 656.283(7) is intended to require parties to seek reconsideration of any issue that might arise as a result of future changes in the relevant rules or statutes in order to preserve the right to a hearing on the issue, it would have the perverse effect of increasing the cost of claim processing. That is because parties would routinely ask for reconsideration of everything in order to avoid having ORS 656.283(7) bar them from litigating an issue that might later arise as a result of such changes.

[4] The parties do not dispute that, apart from the possible preclusive effect of ORS 656.283(7), claimant is entitled to have his PPD benefits paid at the increased rate because his case was still pending at the time that the 1995 changes to ORS 656.214(6) took effect. *See Volk v. America West Airlines*, 135 Or App 565, 569, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

Relying on Turco's opinion, the Board found that claimant's compensable injury was not the major contributing cause of his depression. We conclude that the record supports that finding. In addition to Turco's report, claimant testified at the hearing that, although he was not upset about the sale of the farm itself, the perceived capital gains liability was a "big" factor in his depression. Claimant has not argued on appeal that that liability should somehow be seen as a direct consequence of his injury. Accordingly, we conclude that the Board did not err in finding that claimant's psychological condition was not compensable. Therefore, we need not reach claimant's other assignments of error.

Reversed on determination of PPD rate and remanded for determination of amount of PPD based on current rate; otherwise affirmed.

Cite as 163 Or App 151 (1999) September 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert C. Gray, Claimant.

ROBERT C. GRAY, Petitioner,
v.
WESTERN PANEL MFG and EBI COMPANIES, Respondents.
(96-08812; CA A100948)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 26, 1999.
David C. Force argued the cause and filed the brief for petitioner.
Howard R. Nielsen argued the cause for respondent. With him on the brief was Zimmerman, Rice & Nielsen.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
ARMSTRONG, J.
Affirmed.

*Kistler, J., *vice* Warren, P.J., retired.

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163 Or App 153> Claimant seeks review of an order of the Workers' Compensation Board that partially denied his claim for medical services for a combined condition. He assigns error to the Board's decision to determine compensability when the Administrative Law Judge (ALJ) had made no findings on that issue. He also assigns error to the Board's conclusion that his injury was not compensable. We affirm.

Most of the relevant facts are not in dispute. Claimant was employed as a millwright at employer's manufacturing facility. In July 1995, he slipped while climbing down a ladder from employer's cyclone collector[1] and fell two feet to the ground. He landed on his right side with his right knee underneath him. The fall caused excruciating pain in his right knee as well as other symptoms.

Claimant had had right knee surgery 20 years earlier to remove torn portions of his right medial meniscus. However, in the months leading up to the 1995 accident, claimant had experienced only occasional pain in his right knee, which did not require medical attention.

The 1995 fall caused tears in the remaining posterior rim of the medial meniscus and in the anterior cruciate ligament of claimant's right knee. An operation was performed to remove damaged cartilage and to repair other portions of the injured knee. While at home recovering from the operation, claimant's right knee gave out and he fell. Claimant's doctor, Dr. Jones, believed this second fall to be a result of the recent injury at employer's facility. Dr. Weintraub, who examined claimant on behalf of employer, substantially agreed with that assessment. By all accounts, the second fall caused further damage to claimant's right knee, including an osteochondral fracture of the patella and lateral meniscus tears.

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[1] A "cyclone collector" is a centrifugal device that is used to separate solids from liquids or gases. *Webster's Third New Int'l Dictionary*, 564 (unabridged ed 1993).

After the second 1995 fall, claimant underwent a second operation to repair the damaged tissues but remained **<163 Or App 153/154>** unable to climb stairs or walk more than a block. Because of those symptoms, Dr. Mohler, a specialist to whom Dr. Jones had referred claimant, deemed claimant to be a reasonable candidate for a total right knee replacement. Claimant wished to undergo that surgery and sought compensation from employer for it. Employer denied compensation for the surgery on the ground that claimant's preexisting condition, specifically his degenerative joint disease, was the major cause of his need for the total knee replacement. ORS 656.005(7)(a)(B).

After employer denied the compensability of the total knee replacement surgery, claimant requested a hearing before the Board to challenge the denial. After the hearing, the ALJ determined the claim to be solely for medical services and therefore under the exclusive jurisdiction of the Director of the Department of Consumer and Business Services. ORS 656.245(6). Claimant sought review, and the Board reversed the ALJ's conclusion that it lacked jurisdiction of the claim. On the merits, it concluded that the claim was not compensable because the preexisting condition was the major contributing cause of the need for surgery. ORS 656.005(7)(a)(B).

On review, claimant argues that the Board erred in deciding compensability when the ALJ had not found any facts bearing on that issue. Alternatively, claimant argues that the Board erred in holding that claimant had not met his burden of proving that the major contributing cause of his need for knee replacement surgery was the 1995 workplace injury. Employer contends that the ALJ did enter findings of fact and that the Board was correct in its conclusion on compensability. We address claimant's arguments in turn.

Claimant is correct that the ALJ failed to find any facts bearing on compensability. However, compensability was an issue at the hearing, and both claimant and employer submitted numerous exhibits, including affidavits from doctors, that addressed whether the major contributing cause of claimant's need for a total knee replacement was the 1995 workplace injury. Claimant does not assert that the ALJ barred him from submitting evidence that would help him meet his burden on that issue. Because the record was fully **<163 Or App 154/155>** developed, the Board was entitled to find its own facts relevant to compensability.

OAR 438-011-0015(1) specifically provides that "[r]eview by the Board is de novo upon the entire record." That language implies that the Board is not bound in any way by the findings of fact entered by the ALJ. It follows that the Board is entitled to find its own facts based on the record developed by the ALJ.

That conclusion is reinforced by the discretionary language in Oregon's statutes and administrative rules with respect to the Board's authority to remand cases to the ALJ. OAR 438-011-0015(1) states that "[t]he Board *may* remand a matter to the Hearings Division to take additional evidence, report findings to the Board or to enter an Opinion or Order on remand." (Emphasis added.) Similarly, ORS 656.295(5) provides that "if the board determines that a case has been improperly, incompletely, or otherwise insufficiently developed or heard by the Administrative Law Judge, it *may* remand the case to the Administrative Law Judge for further evidence taking, correction, or other necessary action." (Emphasis added.)

Claimant urges us to interpret "may" as "shall," suggesting that the legislature never contemplated that the Board might decide an issue in spite of the ALJ's having made no findings with respect to it. We decline to consider what the legislature contemplated, because the language of the statute is clear.

Finally, claimant contends that the Board found no facts to support its ruling on compensability, because it simply adopted the ALJ's very limited findings of fact. ORS 183.470(2) supports claimant's argument that the Board's order must contain findings of fact. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). It provides that

> "[a] final order shall be accompanied by findings of fact and conclusions of law. The findings of fact shall consist of a concise statement of the underlying facts supporting the findings as to each contested issue of fact and as to each ultimate fact required to support the agency's order."

163 Or App 156> Thus, if the Board found no facts to support its decision, we would have to remand the case to the Board for it to make findings. ORS 183.482(8)(b)(C). We conclude, however, that the Board actually made findings and listed them in the "Conclusions of Law and Opinion" section of its order. Those findings briefly list the statements of claimant's doctors of their opinions about the major contributing cause of his need for a total knee replacement. Based on those medical opinions, the Board concluded that claimant had not met his burden to show that the compensable injury was the major contributing cause of his disability or his need for a knee replacement. While the basis for the order would have been clearer if the Board's findings had been specifically set out as findings, we do not consider that shortcoming to violate ORS 183.470(2) in this case.

Claimant also contends that the Board erred in determining that his combined condition was not compensable. Based on ORS 656.005(7)(a)(B) and *SAIF v. Nehl*, 148 Or App 101, 939 P2d 96, *on recons* 149 Or App 309, 942 P2d 859 (1997), *rev den* 326 Or 389 (1998), claimant argues that the Board improperly focused only on whether the 1995 workplace accident was the major contributing cause of the disability, rather than also addressing whether it was the major contributing cause of the need for treatment. We disagree.

Under ORS 656.005(7)(a)(B), a combined condition is compensable only if "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 its order, the Board addressed both whether the compensable injury was the major contributing cause of the claimant's disability and whether it was the major contributing cause of his need for treatment. It found in the negative as to both issues. We cannot conclude that the Board failed to apply the standard that it explicitly set out in its order.

Claimant also asserts that *Nehl* significantly broadened the situations in which a combined injury would be compensable and, therefore, that this case should be remanded so that the parties can submit arguments based on the new law established in *Nehl*. The holding in *Nehl*, however, simply **<163 Or App 156/157>** explains the language in the statute. It is not new law as claimant contends.

In modifying our original opinion in *Nehl*, 148 Or App 101 (*Nehl I*) we stated that, under ORS 656.005(7)(a)(B), the "extent of claimant's preexisting condition is weighed against the extent of his on-the-job injury in determining which of the two is the primary cause of his need for treatment of the combined condition." *Nehl*, 149 Or App at 312 (*Nehl II*). We further clarified that "a claimant needs to establish more than the fact that a workplace injury precipitates a claimant's need for treatment in order to establish the compensability of his combined condition." *Id.* at 313. In effect, claimant appears to be arguing, based largely on language in *Nehl I*, that the fact that his on-the-job injury precipitated his need for treatment should render the requested treatment compensable. That argument is in direct conflict with *Nehl II*. We conclude that the Board applied the proper standard in evaluating claimant's combined condition and that *Nehl II* did not alter that standard.

We next address claimant's contention that the Board's finding is not supported by substantial evidence. Under ORS 656.266, a claimant has "[t]he burden of proving that an injury or occupational disease is compensable." As noted previously, ORS 656.005(7)(a)(B) sets out the specific showing required for combined conditions:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong a 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."

Dietz v. Ramuda, 130 Or App 397, 401, 882 P2d 618 (1994), *rev dismissed*, 321 Or 416 (1995), and *Nehl II*, clarify that "major" is equivalent to "primary" and that the statute requires the fact finder to quantify the causes to see which is the primary one. In this case, we conclude that a rational person could determine, based on the record, that claimant had **<163 Or App 157/158>** not met his burden to establish that his workplace injury was the primary cause of his need for a total knee replacement.[2]

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[2] Claimant does not allege that the 1995 workplace injury was the major contributing cause of the disability of the combined condition.

According to the record, Drs. Jones and Mohler had first discovered the degenerative joint disease in claimant's right knee during treatment of claimant's 1995 injuries. Dr. Weintraub also diagnosed claimant with the condition. In denying claimant's request for total right knee surgery, employer relied on Weintraub's statement that the preexisting condition was the major cause of his current combined condition. Jones subsequently concurred with that statement. Jones also stated that the injuries sustained from the 1995 fall at the workplace would have been much less likely to occur in the absence of the preexisting condition, that the preexisting condition may have eventually required a total knee replacement (even if the 1995 workplace fall had never occurred), and that claimant's current symptoms, which are the reason that he would benefit from a total knee replacement, increased markedly as a result of the 1995 fall.

Many of the doctors' statements directly support the Board's conclusions. Specifically, Jones concurred with Weintraub's statement that the major contributing cause of claimant's condition was the preexisting degenerative condition. Moreover, unlike the situation in *Nehl*, the Board could conclude that the preexisting condition could well have caused claimant's current symptoms even without any additional injury. Admittedly, it is also possible that claimant would not have needed the knee replacement were it not for the compensable injury. However, none of the doctors indicated that that was the case, and the burden to make that showing rested with claimant. A rational person could conclude, based on the record, that claimant had failed to prove that it was more probable than not that the 1995 workplace injury was the major contributing cause of his need for a total knee replacement.

Affirmed.

Cite as 163 Or App 165 (1999) September 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Samuel S. Garber, Claimant.

MACMILLAN PLUMBING and TIG INSURANCE CO., Petitioners,

v.

SAMUEL S. GARBER; WILLAMETTE INDUSTRIES, NOE PLUMBING, INC., and SAIF CORPORATION; and ADVANCED PLUMBING AND HEATING and SAIF CORPORATION, Respondents.

(WCB 96-06257, 96-01910, 95-13580, 95-09850; CA A101359)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 19, 1999.

David L. Johnstone argued the cause for petitioners. With him on the brief was VavRosky, MacColl, Olson, Busch & Pfeifer, P.C.

No appearance by respondent Samuel S. Garber.

Brad G. Garber argued the cause and filed the brief for respondent Willamette Industries.

Julene M. Quinn argued the cause and filed the brief for respondents Noe Plumbing, Inc. and SAIF Corporation.

Thaddeus H. Hettle argued the cause and filed the brief for respondents Advanced Plumbing and Heating and SAIF Corporation.

Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.

ARMSTRONG, J.

Affirmed.

* Kistler, J., *vice* Warren, P.J., retired.

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163 Or App 168> Employer seeks review of an order of the Workers' Compensation Board that applied the last injurious exposure rule to assign responsibility to employer for claimant's occupational disease. We affirm.

Claimant began to experience a locking sensation in his right middle finger while employed by Willamette Industries in the 1980s. He also injured his back at Willamette and received treatment for that injury from a neurosurgeon, Dr. Newby. During a 1987 appointment for his back, claimant reported his finger problem to Newby. The doctor noted that problem in a report to Willamette:

> "[T]hree weeks ago [claimant] began to experience numbness in his hands, primarily at night, as well as with driving. He also noticed a catching sensation when he tries to extend his right middle finger. [B]elieve he is now having symptoms of carpal tunnel syndrome."

Newby referred claimant to another doctor to perform nerve-conduction studies to determine whether claimant suffered from carpal tunnel syndrome. Claimant later filed a claim for carpal tunnel syndrome, which was accepted by Willamette. Nothing further was done at that time about the reported finger condition.

In January 1994, claimant changed occupations and began work as an apprentice plumber. He initially worked for Advanced Plumbing. In February 1994, claimant went to work full time with Noe Plumbing. Claimant considered Noe to be his primary employer, but he also worked intermittently for Advanced. The condition of claimant's wrists and finger deteriorated while claimant worked for the two employers. He was diagnosed in June 1995 with a trigger finger condition in his right middle finger, and surgery for the condition was recommended at that time.[1] Throughout the remainder of 1995, claimant was examined and treated by a number of doctors, all of whom agreed that claimant had a trigger finger condition and that he needed surgery for it. **<163 Or App 168/169>** In December 1995, claimant went to work full time for MacMillan Plumbing. In May 1996, claimant had surgery for his trigger finger condition. He thereafter filed a claim for the condition, which all four employers denied.

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[1] Claimant also experienced problems with his wrist and a worsening of his carpal tunnel syndrome. Those conditions are not relevant to our review.

After a hearing on the claim, an Administrative Law Judge (ALJ) determined that claimant's trigger finger condition was work related and, hence, compensable. He further found that claimant had first sought medical treatment for the condition in 1987 while working for Willamette, thereby making Willamette the employer that was initially responsible for the condition. Based on a report by Dr. Button, a hand surgery specialist, the ALJ concluded that Willamette was able to shift responsibility for the condition to the three subsequent plumbing employers. In his report, Button had stated that claimant's plumbing employment was the major contributing cause of the worsening of claimant's trigger finger condition. The ALJ then determined that all of the plumbing employments were concurrent, so all three plumbing employers were jointly responsible for the condition.

On review, the Board agreed with the ALJ's determination that Willamette was initially responsible for claimant's condition. Relying on *SAIF v. Kelly*, 130 Or App 185, 188, 880 P2d 970 (1994), the Board reasoned that the dispositive date for assigning initial responsibility for the condition was the date that claimant first sought treatment for symptoms of it, even if the condition was not correctly diagnosed until later. The Board agreed with the ALJ that claimant had first sought treatment for symptoms of his trigger finger condition in 1987, while employed at Willamette.

The Board reached a different conclusion from the ALJ on responsibility. It disagreed with the ALJ's conclusion that the plumbing employments were concurrent and, thus, that all three plumbing employers were jointly responsible. The Board reasoned that, although the employments overlapped, they were not simultaneous, in that claimant began and ended his employment with each of the employers at different times. Thus, the Board concluded that the concurrent employment rationale did not apply. It instead applied the last injurious exposure rule to assign liability among the **<163 Or App 169/170>** three plumbing employers. Using that rule, the Board determined that responsibility for the condition would shift to the last plumbing employer, MacMillan.

On review, MacMillan argues that the Board erred in two respects. First, it contends that the Board erred in assigning initial responsibility to Willamette, and second, that it erred in shifting responsibility for claimant's condition to MacMillan. The last injurious exposure rule assigns initial responsibility for a claimant's occupational disease to the last employer for whom the claimant worked before the claimant became disabled by or sought treatment for the disease whose work conditions could have caused the disease. The Board found that claimant first sought treatment for his trigger finger condition in 1987 when he was employed by Willamette, which led the Board to assign initial responsibility for the condition to Willamette. MacMillan contends that the Board erred in doing that, because it did not also find that claimant's work at Willamette could have caused the condition to develop or worsen. We need not decide whether MacMillan is correct on that point, because the Board concluded on reconsideration that it would shift responsibility for the condition to MacMillan even if initial responsibility for the condition were assigned to Noe, the plumbing employer that MacMillan contends should have been assigned that responsibility. Hence, we turn to the last issue that MacMillan raises, which is whether the Board erred in shifting responsibility for claimant's condition to it.

Once initial responsibility for a condition is assigned, an employer may shift responsibility for the condition to a subsequent employer by establishing that the later employment contributed independently to the cause or worsening of it. *Timm v. Maley*, 125 Or App 396, 401, 865 P2d 1315 (1993), *rev den* 319 Or 81 (1994). The Board found on reconsideration that each of claimant's plumbing employments had actually contributed to a worsening of claimant's finger condition and, thus, that responsibility for the condition could shift to the last of them, MacMillan.

MacMillan attacks that finding on two grounds: first, that there is not substantial evidence to support it and, second, that it conflicts with the Board's finding that Noe, **<163 Or App 170/171>** rather than MacMillan, was the last of claimant's plumbing employers.[2] As to the first point, we conclude that there is substantial evidence to support the Board's finding that the work conditions at each plumbing employer contributed to a worsening of claimant's finger condition.

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[2] MacMillan raises a third issue about the application of the last injurious exposure rule, but we conclude that it reduces to a contention that there is not substantial evidence to support a finding that claimant's employment at MacMillan worsened his trigger finger condition.

As to the second, the Board did recite employment dates in its discussion about concurrent employment that conflict with its express findings on the same issue and with its conclusion that MacMillan is the employer that is responsible for the condition. We do not believe, however, that that conflict causes the Board's opinion to lack substantial reason. The discussion about concurrent employment is distinct from the discussion about whether MacMillan is responsible for claimant's condition, and nothing suggests that the Board considered the dates that it recited in its discussion about concurrent employment to have any bearing on its decision about whether MacMillan is responsible for the condition because it was the last of claimant's plumbing employers. The Board's decision on the latter issue is consistent with its express findings about the dates of claimant's employment and with the evidence in the record. Consequently, the Board did not err in assigning responsibility for the condition to MacMillan.

Affirmed.

Cite as 163 Or App 179 (1999) September 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

THOMAS WILLIAMS, Respondent,
v.
AMERICAN STATES INSURANCE COMPANY, Appellant.
(9712-10069; CA A102719)

Appeal from Circuit Court, Multnomah County.
Kristena A. LaMar, Judge.
Argued and submitted April 16, 1999.
Brian J. Scott argued the cause for appellant. With him on the opening brief was Law Offices of Thomas Kranovich.
Steven Kahn argued the cause for respondent. With him on the brief was Kahn & Kahn, P.C.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded.

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163 Or App 181> Defendant argues that the trial court should have deducted a workers' compensation settlement plaintiff received as a result of an automobile accident from the damages the trial court awarded him for the same accident. We agree and reverse.

Plaintiff was injured in an automobile accident. The other driver was at fault but had no insurance. As a result of the accident, plaintiff filed two claims. One was a workers' compensation claim. Although SAIF initially denied the claim, SAIF and plaintiff later entered into a disputed claim settlement pursuant to ORS 656.289(4). Plaintiff received a total of $8,600 from SAIF. The settlement agreement stated that a percentage of those proceeds would be paid to plaintiff's attorney as his fee.

Plaintiff also brought a claim against defendant on uninsured motorist coverage defendant had issued. Defendant's policy contained a $25,000 limit on liability for uninsured motorist coverage. Plaintiff's claim against defendant was submitted to arbitration, which resulted in an arbitration award to plaintiff of $14,375.[1] Although defendant argued that the $8,600 workers' compensation settlement should be deducted from the $14,375 in damages the arbitrators awarded plaintiff, the arbitrators expressly declined to decide that issue. When plaintiff filed the arbitration award with the trial court, defendant raised the same issue before the trial court. The trial court disagreed and entered judgment for plaintiff for the full amount of the award.

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[1] So far as the record shows, the arbitrators determined that $14,375 was the total amount of plaintiff's damages arising from the accident, less personal injury protection benefits that plaintiff had already received.

On appeal, defendant argues that the workers' compensation settlement should be deducted from the $14,375 in damages the arbitrators awarded plaintiff, while plaintiff argues that the settlement should be deducted from the $25,000 policy limit on liability.[2] Defendant argues that the **<163 Or App 181/182>** text of ORS 742.504(7)(c)(B) supports its position, while plaintiff responds that our decisions interpreting that statute support his position. In analyzing the parties' claims, we consider the terms of the insurance policy before reaching the statutory issue they raise. *See Vega v. Farmers Ins. Co.*, 323 Or 291, 297-98, 918 P2d 95 (1996); ORS 742.038(2). We follow that methodology because an insurer may provide more favorable uninsured motorist coverage than ORS 742.504 requires, but it may not provide less favorable coverage. *Vega*, 323 Or at 301-02.

In its policy, defendant agreed to pay all sums that the insured is legally entitled to recover as compensatory damages from the owner or driver of an uninsured motor vehicle up to the $25,000 limit of insurance stated in the policy. The policy provides, however, that the "limit of insurance" shall be reduced by "[a]ll sums paid or payable under any workers' compensation, disability benefits or similar law[.]" It also provides that "[i]n no event will an 'insured' be entitled to receive duplicate payment for the same element of loss."

The provision in the policy that the limit of insurance will be reduced by payments under any workers' compensation law is consistent with plaintiff's position. The second provision, however, is not. It recognizes that "[i]n no event" will the insured be entitled to receive "duplicate payment for the same element of loss." The phrase "[i]n no event" makes clear that the prohibition against double recovery requires that the workers' compensation settlement be deducted from the $14,375 in damages the arbitrators awarded plaintiff, at least to the extent it represents a duplicate payment for the same element of loss.

On the last point, defendant, as the proponent of the offset, had the burden of proving that if no deduction were made, plaintiff would receive duplicate payment for the same element of loss. Defendant made out a *prima facie* case when it submitted the disputed claim settlement to the trial court to show that plaintiff had received $8,600 in compensation for the same injuries for which the arbitrators had awarded **<163 Or App 182/183>** plaintiff compensation. At trial, plaintiff raised primarily one argument in response.[3] He argued that because the settlement provided that a percentage of the proceeds would be paid to his attorney, that portion of the settlement does not reflect compensation for his injuries and should not be deducted from the arbitrator's award. The disputed claim settlement, however, states that the attorney fees will come out of the award of compensation; they are not in addition to it. Nothing in the terms of the settlement suggests that the fees, which were based on a percentage of the proceeds awarded plaintiff, differ in any respect from a traditional contingency fee. The fact that the fees were deducted from the settlement does not mean that the entire amount of the settlement was not intended to compensate plaintiff for his injuries. There is no reason supported by the record why the entire amount of the workers' compensation settlement does not reflect compensation for the same elements of loss covered by the arbitrators' award.[4]

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[2] If the settlement were deducted from the limit of liability, plaintiff would be entitled to all the damages the arbitrators awarded because the settlement and the damages add up to less than the $25,000 policy limit. If the settlement were deducted from the damages award, plaintiff would be entitled to $5,775.

[3] Plaintiff also argued that because the employer denied his claim, the settlement could not represent compensation for his injuries. The settlement, however, reflects the parties' compromise of the likelihood that plaintiff would be compensated for his injuries. The employer's denial does not suggest that the settlement does not represent compensation for plaintiff's injuries.

[4] Plaintiff also raises a new issue on appeal. He argues that the settlement could have included compensation for some elements of loss different from those covered by the arbitrators' award. Plaintiff, however, did not make that argument below, nor did he submit any evidence to the trial court from which that determination could be made. Even though plaintiff won below, there is no basis for saying that the arbitrators' award does not compensate him for the same damages that the workers' compenstion settlement did. In these circumstances, we cannot say that the trial court was right (or at least partially right) for the wrong reason.

We accordingly conclude that the terms of defendant's policy require that the workers' compensation settlement be deducted from the total damages awarded when the total damages are less than the limit of liability. The remaining issue is whether the policy provides less coverage than the statute requires. ORS 742.504 establishes the minimum terms for uninsured motorist coverage. Subsection (7)(c)(B) authorizes an insurer to reduce "[a]ny amount payable under the terms of [uninsured motorist] coverage because of bodily injury sustained in an accident" by "[t]he amount paid and the present value of all amounts payable on account of such **<163 Or App 183/184>** bodily injury under any workers' compensation law, disability benefits law or any similar law."

The statutory text unambiguously authorizes insurers to deduct the amount paid "under any workers' compensation law" from the "amount payable" under uninsured motorist coverage, not from the limit on liability. *See Estate of Linda Greenslitt v. Farmers Ins. Co.*, 156 Or App 75, 80, 964 P2d 1129 (1988). Plaintiff, however, argues that in *California Casualty Indemnity Exchange v. Maritzen*, 123 Or App 166, 860 P2d 259, *rev den* 318 Or 97 (1993), we held that, under ORS 742.504(7)(c)(B), the settlement should be deducted from the limit of liability rather than the total damages the plaintiff in that case received. Plaintiff divorces our reasoning in *Maritzen* from the context in which it arose.

The primary focus in *Maritzen* was whether the statement in the policy that the "loss payable" should be reduced by the amount of workers' compensation benefits referred to the total damages the plaintiff sustained or the "amount that is payable *up to* the policy limits under the terms of the policy." 123 Or App at 170 (emphasis added). Because the total damages that the plaintiff sustained in *Maritzen* far exceeded the limit of liability, there was no practical difference between the "limit of liability" and the "amount that is payable up to the policy limits." On the facts of that case, both concepts accurately described the "loss payable" from which the workers' compensation benefits should be deducted.

In agreeing with the insurer in *Maritzen* that the policy term "loss payable" means the "amount that is payable up to the policy limits under the terms of the policy," we did not hold that if the loss payable (or the "amount payable" in statutory terms) was less than the limit of liability, any workers' compensation benefits should be deducted from the limit of liability rather than the amount the insurer was obligated to pay. That holding would have been contrary to both the terms of the policy in *Maritzen* and the statutory text.[5] **<163 Or App 184/185>** Because the total damages plaintiff sustained in this case were less than the limit of liability, the $8,600 workers' compensation settlement plaintiff received should have been deducted from $14,375 in damages the arbitrators awarded him.

Reversed and remanded.

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[5] We followed *Maritzen* in *Pitchford v. State Farm Mutual Auto Ins. Co.*, 147 Or App 9, 14, 934 P2d 616, *rev den* 325 Or 621 (1997). Because the total damages in *Pitchford* far exceeded the limits of liability of the uninsured motorist coverage, see 147 Or App at 11, we had no occasion to consider how the reasoning in *Maritzen* would apply to the issue presented by this case.

Cite as 163 Or App 191 (1999) September 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Janet R. Christensen, Claimant.

FREIGHTLINER CORPORATION, Petitioner,

v.

JANET R. CHRISTENSEN, Respondent.

(97-04701; CA A101687)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 27, 1999.

Deborah L. Sather argued the cause for petitioner. With her on the briefs were Tracy J. White, Krishna Balasubramani and Sather, Byerly & Holloway, LLP.

Meagan Flynn argued the cause for respondent. On the brief were Michelle K. McClure and Pozzi Wilson Atchison, LLP.

Before Edmonds, Presiding Judge, and Armstrong, Judge, and Warren, Senior Judge.

WARREN, S. J.

Affirmed.

Edmonds, P. J., dissenting.

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163 Or App 193> Employer seeks review of an order of the Workers' Compensation Board setting aside employer's denial of claimant's degenerative disc disease, spinal stenosis and herniated discs. We conclude that the Board's finding that employer accepted the conditions is supported by substantial evidence and that the Board correctly held that employer may not now deny claimant's conditions. Accordingly, we affirm.

In May 1996, claimant injured her back while working for employer. She sought treatment from Dr. Yarusso, who ordered multiple scans, including a CT scan and an MRI. The testing revealed that claimant had many problems. On May 28, 1996, Yarusso diagnosed spinal stenosis and herniated or bulging discs at L3, 4 and 5, compromising her spinal canal and a possible herniation at L5-S1. On May 29, 1996, Dr. Tanabe diagnosed chronic lumber strain, superimposed upon spondylitic changes in the lumber spine and mild to moderate lumbar stenosis.

Claimant filed a Form 801, indicating that the nature of the injury was "HNP Back." "HNP" means "herniated nucleus pulposus," or herniated disc. Employer checked the "accepted" box on the Form 801. On May 31, 1996, employer issued a notice of acceptance for "low back pain r/o HNP." Over the course of several months, doctors consistently diagnosed a herniated disc at L5-S1 with nerve root encroachment on the right side. Claimant began to undergo conservative treatment and ultimately received authorization to return to work. Medical opinions differ as to whether claimant's May 1996 injury is a contributing factor in her ongoing symptomatology.

Before claim closure, on June 4, 1997, employer issued a denial stating, in part:

> "[Employer] has accepted and processed your lumbar sprain/strain resulting from the May 16, 1996 injury. Drs James Yarusso and Franklin Wong both indicate that your injury combined with preexisting conditions (degenerative disc and joint disease, stenosis and herniation), that your condition is medically stationary, and the injury is no **<163 Or App 193/194>** longer the major contributing cause of the combined condition. Pursuant to ORS 656.262(7)(b), [employer] is hereby denying that your accepted injury is the major contributing cause of your combined condition and submitting your claim for closure."

Claimant protested the denial, and the Board set it aside, holding that employer had not accepted claimant's lumbar sprain/strain as a "combined condition," so it could not deny the preexisting conditions pursuant to ORS 656.262(7)(b). Rather, the Board held that, by accepting a claim for "back pain," employer had accepted outright the underlying conditions causing the pain, including each of claimant's preexisting back conditions. Employer seeks review of the Board's order, making the alternative arguments that its acceptance did not include the underlying conditions or that, even after acceptance, it could deny those conditions pursuant to ORS 656.262(6) and (7). We consider each argument in turn.

We first consider the scope of employer's acceptance. The Board rejected employer's argument that the language of the acceptance, "r/o HNP," indicated an intention to exclude a herniated disc or claimant's degenerative conditions from the scope of the acceptance and to accept only a back sprain/strain. The Board found that employer accepted a claim for "low back pain" and that claimant's low back pain was caused in part by spinal stenosis and degenerative disc disease, including herniated or bulging discs. Relying on *Georgia-Pacific v. Piwowar*, 305 Or 494, 501, 753 P2d 948 (1988), the Board held that, by accepting claimant's claim for low back pain, employer accepted the underlying cause or causes of the symptoms. The Board's findings as to the scope of employer's acceptance are supported by substantial evidence, and its conclusion with regard to the effect of *Piwowar* is correct. The question that remains is whether statutory provisions enacted since Piwowar provide authority for employer's denial of the previously accepted conditions.

ORS 656.262(6)(a) provides, in part:

> "If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and *later obtains evidence that the claim is not compensable* or evidence that the **<163 Or App 194/195>** insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of acceptance and denial, the insurer or self-insured employer must prove, by a preponderance of the evidence, that the claim is not compensable or that the insurer or self-insured employer is not responsible for the claim." (Emphasis added.)

Employer asserts that the quoted portion of subsection (6)(a) provides a ground for its denial of claimant's herniated discs and that the Board erred in failing to consider that statute. In light of employer's acknowledgment that it was aware of the possibility that claimant had herniated discs at the time it issued its acceptance of the claim, there was no error on the part of the Board in rejecting employer's assertion that the claim could be denied on the basis of newly discovered evidence. For the same reason, we reject employer's assertion that its denial is authorized by ORS 656.262(6), which provides, in part:

> "(b) The notice of acceptance shall:
>
> "* * * * *
>
> "(F) Be modified by the insurer or self-insured employer from time to time as medical or other information changes a previously issued notice of acceptance."

Employer asserts that, even assuming that the original acceptance included claimant's herniated discs and her other degenerative conditions, those conditions were accepted as preexisting conditions that "combined" with claimant's "otherwise compensable" injury of back strain, and that, under ORS 656.005(7)(a)(B),[1] ORS 656.262(6)(c)[2]

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[1] ORS 656.005(7)(a)(B) provides:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

[2] ORS 656.262(6)(c) provides:

> "An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

163 Or App 195/196> and ORS 656.262(7)(b)[3], employer may deny those conditions when the "compensable injury," *i.e.*, back strain, is no longer the major contributing cause of claimant's combined condition. Employer asserts, further, that medical records shows that claimant's back strain has resolved and causes less than 50 percent of her current condition. Accordingly, employer contends, its denial is valid, because the accepted injury is no longer the major contributing cause of the worker's combined condition.

Employer misunderstands the effect of *Piwowar* and the significance of the scope of its acceptance. By accepting claimant's low back pain, employer accepted all the conditions that the medical evidence shows underlie the low back pain, including claimant's preexisting degenerative back conditions. Those conditions are accepted as compensable conditions in and of themselves, independent of the back strain. Although they may, in fact, combine with her back strain or sprain, it does not follow that employer's acceptance was of a combined condition as a matter of law. Employer did not accept only claimant's back sprain/strain. If it had, then claimant's preexisting conditions could properly be viewed as preexisting conditions that combine with the accepted injury. Employer accepted claimant's low back pain. Under *Piwowar*, employer's acceptance encompassed each condition causing the pain. They are, in and of themselves, independently compensable because they were accepted. The statutes that employer cites in support of its position are dependant on the existence of a combined condition in the legal sense. A combined condition in the legal sense is a compensable injury that combines with a preexisting condition or **<163 Or App 196/197>** conditions. ORS 656.005(7)(b)(B). Here, the accepted conditions are each of the conditions that are deemed accepted under *Piwowar*. Although, as a matter of fact, the preexisting conditions did combine to give rise to claimant's need for treatment, they are compensable in their own right as a matter of law under *Piwowar* and may not be denied.

For the reasons explained, we conclude that the Board did not err in setting aside employer's denial of claimant's condition.

Affirmed.

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

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

EDMONDS, P. J., dissenting.

The majority, in arriving at the conclusion that ORS 656.262 does not permit employer to deny compensation for claimant's previously-accepted degenerative back conditions, says,

> "[b]y accepting claimant's low back pain, employer accepted all the conditions that the medical evidence shows underlie the low back pain, including claimant's preexisting degenerative back conditions. Those conditions are accepted as compensable conditions in and of themselves, independent of the back strain. * * * Employer accepted claimant's low back pain. Under [*Georgia Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988)], employer's acceptance encompassed each condition causing the pain. They are, in and of themselves, independently compensable because they were accepted." 163 Or App at 196.

Nonetheless, the majority concludes,

> "The statutes that employer cites in support of its position are dependent on the existence of a combined condition in the legal sense. A combined condition in the legal sense is a compensable injury that combines with a preexisting condition or conditions. ORS 656.005(7)(b)(B). Here, the accepted conditions are each of the conditions that are deemed accepted under *Piwowar*. Although, as a matter of fact, the preexisting conditions did combine to give rise to claimant's need for treatment, they are compensable in their own right as a matter of law under *Piwowar* and may not be denied." 163 Or App at 196-197.

163 Or App 198> According to the majority, what employer accepted were uncombined conditions or degenerative conditions that existed "independently." Apparently the majority understands employer to have accepted each of those conditions separately, but not their combined effect. An example of "accepted independent conditions" would be if an employer accepted the disability from a broken leg and a broken arm arising out a work-related incident. Each acceptance of those conditions would constitute the acceptance of discrete conditions. Here, however, "low back pain" was the condition expressly accepted the employer. Thus, the evidence is contrary to the majority's assertion that what were accepted were independent conditions.

In addition, the underlying conditions, the lumbar sprain/strain from the work-related injury and degenerative injuries that preexisted the injury, are also deemed accepted by operation of law under the rule of *Piwowar* because the work-related injury and the preexisting degenerative diseases combined to cause the low back pain. A "combined condition" exists when a compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment. ORS 656.005(7)(a)(B). Thus, by statutory definition, the low back pain condition accepted by employer was a "combined" condition that included the strain/sprain and the degenerative diseases. Unlike the example of an acceptance of disability from a broken leg and a broken arm, the strain/sprain and the preexisting degenerative conditions are no more "independent" of the low back pain or of each other than any other underlying conditions that combine to cause an expressly accepted condition.

The majority's true concern arises from its unwillingness to recognize that the legislature decided in 1995 and 1997 to permit employers to deny accepted conditions when the work-related injury no longer is the major contributing cause of the combined condition. *See SAIF v. Belden*, 155 Or App 568, 573-74, 964 P2d 300 (1998), *rev den* 328 Or 330 (1999) (explaining that the purpose of the amendments to ORS 656.262(6) is to authorize a preclosure denial of an accepted combined condition when there has been the requisite change of circumstances). In substance, the majority carves out an exception to the amendments by treating **<163 Or App 198/199>** acceptances under *Piwowar* differently under the amendments than other acceptances of combined conditions. Thus, it necessarily concedes that as "a matter of fact," the underlying conditions combined to cause the accepted condition.

Further, the majority's "matter of law" reasoning is contrary to the legislature's intent when the legislature amended ORS 656.262 in 1995 and 1997. The majority's reasoning must mean that the acceptance of a "combined condition" has different meanings, depending on the circumstances of the acceptance. When the issue is one of statutory interpretation, the first level of analysis is the text and context of the statutes themselves. We are bound to carry out the legislature's intention, and we have no authority to change or add to the meanings of statutes. ORS 174.010 and 174.020. Moreover, when the Supreme Court interprets a statute, that interpretation becomes part of the statute as if it were written into the statute at the time of its enactment. *Holcomb v. Sunderland*, 321 Or 99, 105, 894 P2d 457 (1995). There is only one definition of a "combined condition" in ORS chapter 656. See ORS 656.005(7)(a)(B). Nowhere in the statutory language that controls this issue does the distinction that the majority makes between acceptances under *Piwowar* and other acceptances of combined conditions appear.

The understanding that acceptances of combined conditions under *Piwowar* are acceptances for purposes of ORS 656.262(6)(c), which incorporates ORS 656.005(7) by reference, is further supported by the Supreme Court case law interpreting the statute. The holding in *Piwowar* reflects an interpretation of ORS 656.262(2) (1987).[1] 305 Or at 499-50. In *Bauman v. SAIF*, 295 Or 788, 793-94, 670 P2d 1027 (1983), the court, in interpreting ORS 656.262 (1981), held that once an employer accepts a claim, it must compensate for that claim and whether the claim turns out to have arisen from a noncompensable cause is irrelevant. Then, the court held in *Barrett v. D & H Drywall*, 300 Or 325, 330-31, 709 P2d 1083 (1985), that the disability from a compensable **<163 Or App 199/200>** injury included the loss of earning capacity arising from a previously asymptomatic osteoarthritis that had become symptomatic because of the compensable injury. Next, the court held in *Johnson v. Spectra Physics*, 303 Or 49, 58, 733 P2d 1367 (1987), that an employer could partially deny a claim if it specifies which injuries or conditions it accepts and which it denies.

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[1] ORS 656.262(6) (1987) provided, in relevant part: "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employee within 60 days after the employer has notice or knowledge of the claim. * * *"

In *Piwowar*, the court considered its interpretations of ORS 656.262(6) in *Johnson* and *Bauman* and held that, when read together, they require the employer to compensate the claimant for the specific condition in the notice of acceptance, regardless of the causes of the condition accepted. 305 Or at 501. Thus, by accepting the condition "sore back," after the claimant had strained her back during work, it also accepted the preexisting ankylosing spondylitis that was contributing to the condition of the sore back. The court reasoned,

> "Allowing an insurer to deny compensation for a previously-accepted condition once it learns that the condition is attributable to a specific noncompensable disease opens the door to instability, uncertainty and delay. This is precisely the kind of vacillation which this court found unacceptable in *Bauman*[.]" 305 Or at 501 (citation omitted).

The enactment of ORS 656.262(6)(c) in 1995 reflects an intention by the legislature to permit under certain circumstances what had been forbidden before: the denial of an accepted combined condition. *SAIF v. Belden*, 155 Or App at 573. ORS 656.262(6)(c) now provides,

> "An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

As is evident from the above analysis, the acceptance of a combined condition under the rule of *Piwowar* is treated no differently by the applicable statutes from the express **<163 Or App 200/201>** acceptance of combined conditions. When "an otherwise compensable injury combines *at any time* with a preexisting condition to cause * * * *disability* * * * the combined condition is compensable only [for] so long as" the compensable injury is the major contributing cause of the disability of the combined condition or the need for treatment of the combined condition. ORS 656.005(7)(a)(B) (emphasis added). Merely because the acceptance of a combined condition under *Piwowar* occurs by operation of law does not make it any less of a combined condition under the statutory definition. The majority errs by not giving effect to ORS 656.262(6)(c) as intended by the legislature.

The law is clear that an employer is permitted to deny an accepted combined condition when a compensable injury ceases to be the major contributing cause of the combined condition. *Belden*, 155 Or App at 574. The Board did not reach that issue in this case because of its conclusion that there was no combined condition. For the reasons stated above, I would remand to the Board for reconsideration of that issue.

Cite as 163 Or App 397 (1999) October 13, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth D. Long, Claimant.

KENNETH D. LONG, Petitioner,
v.
TUALATIN VALLEY FIRE and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(WCB 95-12983; CA A100748)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 4, 1999.
Montgomery W. Cobb argued the cause for petitioner. With him on the brief was Cobb & Woodworth, LLP.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
LINDER, J.
Affirmed.

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163 Or App 399> Claimant seeks judicial review of an order of the Workers' Compensation Board (Board) denying compensation for his heart condition. At issue in this case is the application of ORS 656.802(4), commonly known as the "firefighter's presumption." Claimant argues that the Board erred in determining that employer rebutted the presumption by clear and convincing evidence. We affirm.

Claimant was a firefighter for nearly 25 years. In 1995, however, he experienced an episode of atrial fibrillation while he was at home. Claimant visited his family practitioner, who advised him to retire from fire fighting because of the risks he would pose to himself and others if he suffered an episode while on the job. Claimant retired and subsequently filed a workers' compensation claim with employer, Tualatin Valley Fire Department, and its insurer. Three doctors examined claimant and concluded that he suffered from atrial fibrillation, the cause of which is idiopathic--that is, unknown. All three doctors also expressed the opinion that the cause, although unknown, is not related to claimant's employment as a firefighter. Employer's insurer denied the claim, and claimant requested a hearing before an administrative law judge (ALJ). The ALJ upheld the denial, concluding that employer "established by clear and convincing evidence that the cause of claimant's condition was unrelated to his employment." On review, the Board adopted and affirmed the ALJ's order.

Under ORS 656.802(4),[1] if a firefighter becomes disabled or impaired as a result of heart or lung disease, then **<163 Or App 399/400>** the condition is presumed to have resulted from employment as a firefighter. The presumption arises if two conditions are met: (1) the firefighter has worked as a firefighter for at least five years; and (2) a medical examination reveals that the condition did not preexist employment. *Id.* If the employer does not present opposing evidence, then the presumption binds the trier of fact. *Wright v. SAIF*, 289 Or 323, 331, 613 P2d 755 (1980). The presumption, however,

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[1] ORS 656.802(4) provides:

"Death, disability or impairment of health of firefighters of any political division who have completed five or more years of employment as firefighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as firefighters is an 'occupational disease.' Any condition or impairment of health arising under this subsection shall be presumed to result from a firefighter's employment. However, any such firefighter must have taken a physical examination upon becoming a firefighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment. Denial of a claim for any condition or impairment of health arising under this subsection must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the firefighter's employment."

is rebuttable. If the employer introduces opposing evidence, the trier of fact must give the presumption the "value of evidence." *Id.* To overcome the presumption, the employer must establish by "clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the firefighter's employment." ORS 656.802(4).

Citing our opinion on remand in *Wright v. SAIF*, 48 Or App 867, 618 P2d 18 (1980), claimant argues that the Board was bound to find in claimant's favor because employer did not present the type of evidence legally required to rebut the presumption. According to claimant, employer can rebut the presumption only by coming forward with evidence of an alternative cause of the condition. Claimant, however, misunderstands the statute and misreads our decision in *Wright*.

ORS 656.802(4) requires an employer to present "medical evidence that the cause of the condition or impairment is unrelated to the firefighter's employment." On remand in *Wright*, our charge was to determine whether, in light of the Supreme Court's decision, the employer presented opposing evidence and, if so, whether that evidence overcame the presumption. In our review of the evidence, we noted that the claimant's treating doctor initially had reported that the claimant's condition was not caused by his work as a firefighter. *Wright*, 48 Or App at 871-72. That doctor later reported, however, that he was unable to make that determination because medical research in the area had not yet ruled out the possibility that the condition could be related to fire fighting. *Id.* We concluded that the subsequent report significantly diluted the evidentiary value of the first report and that the doctor's initial report therefore was insufficient to overcome the presumption. *Id.* at 872. We did not, **<163 Or App 400/401>** as claimant suggests, hold that the employer must demonstrate an alternative cause of claimant's condition. Here, the doctors' opinions provided affirmative medical evidence that claimant's condition is unrelated to his employment. Accordingly, the Board was not bound by the presumption to find in claimant's favor.

Claimant nonetheless argues that, even if the Board was not bound by the presumption, the record does not support its finding that employer *overcame* the presumption by clear and convincing evidence. We disagree. Here, in contrast to *Wright*, all three doctors determined that the cause, whatever else it is, is not related to claimant's employment. Nothing in this record, other than the presumption, diminishes or dilutes those conclusions. The Board's conclusion that employer overcame the presumption by clear and convincing evidence is correct.

In the alternative, claimant argues that he is nonetheless entitled to compensation because his symptom (*i.e.*, atrial fibrillation as a symptom of an unknown, underlying disease) precludes him from working as a firefighter. As the Supreme Court noted in *Wright*, a claimant may be entitled to compensation for "impairment of health" even if the underlying disease is not employment related. 289 Or at 335. "Impairment of health" encompasses the worsening of symptoms, including pain. *Id.* Symptoms of the underlying disease become compensable if (1) the symptoms are worsened by employment, and (2) the employment-related worsening causes a disability or requires medical services. *Lines v. SAIF*, 54 Or App 81, 85, 634 P2d 262 (1981). *If* evidence in the record demonstrated that claimant's condition became worse due to his work as a firefighter, he might be entitled to compensation. Here, however, claimant does not contend that he *actually* experienced any compensable worsening of symptoms due to work. Nor would this record support that contention. The fact that claimant's work as a firefighter *could* trigger an episode of atrial fibrillation does not entitle claimant to compensation under the statute.

Affirmed.

Cite as 164 Or App 6 (1999) November 3, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Iris K. Scott, Claimant.

DESCHUTES COUNTY, Petitioner,
v.
IRIS K. SCOTT, Respondent.
(97-10026; CA A104728)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 18, 1999.
Brad G. Garber argued the cause for petitioner. With him on the brief was Meyers, Radler, Replogle, Roberts & Miller.
Janet H. Breyer argued the cause for respondent. With her on the brief were Philip H. Garrow and Philip H. Garrow, Attorneys at Law.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Reversed and remanded for reconsideration.

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164 Or App 8> Employer seeks review of an order of the Workers' Compensation Board awarding claimant scheduled permanent partial disability benefits. Employer contends that the board erred in finding that employer failed to file a timely request for reconsideration of the Determination Order awarding the disability benefits. We agree and reverse and remand for reconsideration.

The relevant facts are not disputed. Claimant developed compensable carpal tunnel syndrome. Her claim was accepted, treated, and ultimately closed by a July 14, 1997, Determination Order awarding her permanent partial disability benefits. On September 9, 1997, employer sent a letter to the Department of Consumer and Business Services Benefit Consultation Unit (BCU) stating that "we are requesting reconsideration of the Determination Order." On September 30, 1997, employer filed a second reconsideration request with the Department of Consumer and Business Services Appellate Review Unit (ARU), labeled as such and containing, among other things, claimant's name, social security number, and other identifying information. Claimant filed a "cross-request" for reconsideration, which, among other things, challenged the timeliness of employer's reconsideration request.

The ARU issued an Order on Reconsideration reducing claimant's award. The order did not address the timeliness of employer's request for reconsideration. Claimant requested a hearing on that order.

The Administrative Law Judge (ALJ) vacated the Order on Reconsideration on the ground that employer had failed to file a timely request for reconsideration. The ALJ concluded that the September 30 request was untimely because it was sent more than 60 days after the issuance of the Determination Order and that the September 9 letter sent to the BCU was inadequate because it did not contain all of the information required by rule to be contained in a valid reconsideration request. The ALJ further found that the letter actually was not intended to act as a reconsideration **<164 Or App 8/9>** request, only a notice of employer's intention to file such a request some time in the future.

Employer appealed the ALJ's decision. The board affirmed, but in doing so it declined to review the ALJ's conclusion that the September 9 letter to BCS was legally insufficient and adopted instead what it characterized as the ALJ's "alternative reasoning" that the letter was never intended to constitute a request for reconsideration.

On review, employer contends that the board erred in rejecting its September 9 letter on the ground that it was not intended to be a request for reconsideration. According to employer, the applicable administrative rules contain the requirements for a valid request for reconsideration, and an employer's intent is not among the listed requirements. Claimant acknowledges that an employer's intent is not among the requirements listed in the administrative rule, but argues that "the board did not

add an 'intent' requirement to the reconsideration request procedures. Instead, the board looked to employer's 'intent' with respect to the September 9 letter as an analytic tool." In any event, claimant argues, the September 9 letter did not comply with the requirements of the rule.

ORS 656.268(5)(b) provides that a party seeking review of a Determination Order must request reconsideration within 60 days of the date of the Determination Order. What constitutes a valid request for reconsideration is defined by administrative rule. OAR 436-030-0125 provides that a valid request for reconsideration must contain, among other things, the worker's name, WCD file number, and date of injury. The rule also requires that the request be labeled in bold print "REQUEST FOR RECONSIDERATION" and that it include a signed certification stating that the party has supplied copies of the request along with supporting documentation to all other interested parties.

An agency must follow its own rules. *Aetna Casualty & Surety Co. v. Sue A. Blanton, D.C.*, 139 Or App 283, 287, 911 P2d 363 (1996). Although we will defer to an agency's plausible construction of its own rules, we may not permit an agency to read into its rules requirements that are inconsistent with their wording, their context, or any other source of **<164 Or App 9/10>** law. *Don't Waste Oregon Comm. v. Energy Facility Siting Council*, 320 Or 132, 142, 881 P2d 119 (1994).

In this case, the applicable administrative rules set forth the requirements for a valid reconsideration request. The board found it unnecessary to review the ALJ's conclusion that employer's September 9 letter to BCS did not satisfy those requirements. Instead, the board found that, regardless of whether the letter satisfied the formal requirements of the administrative rule, it must be rejected because it was not intended to be a reconsideration request. In so finding, the board erred. OAR 436-030-0125 says nothing about the intentions of the individual submitting a reconsideration request, and nothing in the language of the rule can be read implicitly to permit the board to add such a requirement. Either the requirements of the rule have been satisfied or not. On remand, the board must determine which is the case, without reference to employer's intentions.

Reversed and remanded for reconsideration.

Cite as 164 Or App 209 (1999) November 24, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Daryl D. McClure, Deceased, Claimant.

CARLING NATIONAL BREWERIES, Petitioner,
v.
DELLA M. McCLURE, Respondent.
(97-05597; CA A103700)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 5, 1999.
Jerald P. Keene argued the cause and filed the brief for petitioner.
Dale C. Johnson argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Affirmed.

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164 Or App 211> Employer seeks review of an order of the Workers' Compensation Board (Board) awarding widow's benefits to claimant, the surviving spouse of a worker who committed suicide during a time when he was receiving permanent total disability benefits. We affirm.

The relevant facts are not in dispute. Daryl McClure fell at work and broke his back in several places. He was awarded permanent total disability benefits. Some years later, McClure committed suicide. There is no connection between the suicide and claimant's work-related injury; the suicide apparently was the result of McClure's depression over marital problems.

Claimant claimed surviving spouse benefits under ORS 656.208(1), which provides:

> "If the injured worker dies during the period of permanent total disability, whatever the cause of death, leaving a spouse * * *, payment shall be made in the same manner and in the same amounts as provided in ORS 656.204 [describing benefits for worker's death from accidental injury]."

Employer declined to pay the benefits, arguing that, because McClure had taken his own life, his widow is not entitled to benefits, as provided in ORS 656.156(1):

> "If the injury or death results to a worker from the deliberate intention of the worker to produce such injury or death, neither the worker nor the widow * * * of the worker shall receive any payment whatsoever under this chapter."

A divided Board, sitting en banc, set aside employer's denial. Two members concluded that the two statutes appeared to be in irreconcilable conflict and that, under ORS 174.020, the more specific of the two statutes should control. The two members concluded that ORS 656.208(1) is the more specific statute, because it applies only to cases in which the worker dies during a period of permanent total disability, while ORS 656.156(1) applies generally to cases in which an injury or death results to a worker from the deliberate intention of the worker to produce such injury or death. **<164 Or App 211/212>** One Board member concurred, concluding that the unqualified language of ORS 656.208(1)--requiring payment of spouse's benefits when the worker on permanent total disability dies "whatever the cause of death"--in effect "trumps" ORS 656.156(1). Two members dissented, concluding that the unqualified language of ORS 656.156(1)--prohibiting a spouse or dependent from receiving "any payment whatsoever under this chapter" when the worker dies by his or her own intentional act--in effect trumps ORS 656.208(1).

On review, employer argues that the dissenting Board members were correct. We agree with the conclusion of the Board majority, although for reasons different from those expressed in either the lead or concurring opinion.

At issue is the proper construction of the relevant statutes, which we determine by reference to their language in context and, if necessary, their enactment histories and other aids to construction. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). In referring to the language of a statute, we also take into account prior judicial construction of it. *Mendieta v. Division of State Lands*, 148 Or App 586, 594, 941 P2d 582 (1997).

In *Ahn v. Frito-Lay, Inc.*, 91 Or App 443, 756 P2d 40, *rev den* 306 Or 661 (1988), we addressed the scope of the prohibition contained in ORS 656.156(1). In that case, the worker suffered from a work-related emotional condition. When the worker committed suicide, his children claimed, among other things, the continued payment of his workers' compensation benefits to which he had been entitled before the suicide. The employer argued that, under ORS 656.156(1), the children were prohibited from receiving *any* workers' compensation benefits, because the worker had taken his own life. We rejected employer's assertion, holding instead that "[w]e understand the statute to apply only to benefits for injury or death resulting from the deliberate act" of suicide, not to benefits that related to the worker's otherwise compensable conditions. *Ahn*, 91 Or App at 447.

In light of *Ahn*--the correctness of which is unchallenged--employer's argument cannot be sustained: Claimant is not requesting benefits that result from McClure's deliberate act of suicide, but rather is asking for the permanent **<164 Or App 212/213>** total disability benefits related to his compensable condition, as provided in ORS 656.208(1). As we held in *Ahn*, nothing in ORS 656.156(1) precludes claimant from obtaining those benefits.

Affirmed.

Cite as 164 Or App 214 (1999) November 24, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John W. Wantowski, Claimant.

JOHN W. WANTOWSKI, Petitioner,
v.
CROWN CORK & SEAL, TRAVELERS CASUALTY & SURETY CO., CIGNA INSURANCE CO., CONTINENTAL CAN CO., SIMS, INC., and AMERICAN MOTORIST INS. CO., Respondents.
(97-10451, 97-05551, 97-08102, 97-06580; CA A103971)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 14, 1999.

Robert Pardington argued the cause for petitioner. On the brief were Nicholas M. Sencer and Pozzi Wilson Atchison, LLP.

Jerald P. Keene argued the cause and filed the brief for respondents Crown Cork & Seal and Travelers Casualty & Surety Co.

Vera Langer argued the cause for respondents Crown Cork & Seal and CIGNA Ins. Co. With her on the brief was Scheminske, Lyons & Bussman LLP.

Thaddeus J. Hettle argued the cause and filed the brief for respondents Continental Can Co. and SIMS, Inc.

Richard D. Barber argued the cause for respondents Continental Can Co. and American Motorist Ins. Co. With him on the brief was Sheridan, Bronstein & Levine, LLP.

Before Landau, Presiding Judge, and Linder and Brewer, Judges.

LANDAU, P. J.

Affirmed.

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164 Or App 217> Claimant, a 64-year-old metal worker, seeks review of an order of the Workers' Compensation Board (Board) holding that his bilateral hearing loss is not compensable. We affirm.

We take the facts from the Board's unchallenged findings. Since 1964, claimant has worked for employer or its predecessor as a scroll shear operator. A scroll shear is a machine that cuts sheet metal and places the metal into a press to make cans and other metal objects. The work environment is loud.

Beginning in 1969, employer required all employees exposed to noise to wear ear protection. Claimant wore ear protection. In the early 1980s, however, he noticed that he had hearing loss. He first sought medical attention for hearing loss in 1997. At that time, he saw his family physician, who recommended a hearing aid. Claimant filed an occupational disease claim for bilateral hearing loss.

Dr. Hodgson, a consulting physician for one of employer's insurers, examined claimant. Hodgson concluded that age, chronic occupational noise, and cochlear Meniere's disease in the left ear all contributed to claimant's hearing loss, but that the major contributing cause was age-related hearing loss, or "presbycusis." Employer, through the various insurers who provided workers' compensation insurance coverage over the years of claimant's employment, denied the claim.

The Board upheld the denials. The Board found persuasive Hodgson's opinion that the major contributing cause of claimant's hearing loss was presbycusis. It rejected claimant's contention that he is required only to prove the major contributing cause of his hearing loss unrelated to age.

On review, claimant argues that the Board erred in taking into account his age-related hearing loss. In the alternative, he contends that taking into account his age-related hearing loss conflicts with the Oregon Constitution, Article I, section 10; the Americans with Disabilities Act, 42 USC section 12102; and the Age Discrimination in Employment Act, 42 **<164 Or App 217/218>** USC section 623(a). He also contends that the Board erred in failing to assign responsibility for his claim among employer's various insurers.

Claimant's hearing loss is treated as a disease under the workers' compensation statutes. Under ORS 656.802(2)(a), "[t]he worker must prove that employment conditions were the major contributing cause of the disease." Nothing in the statute expressly or implicitly limits the Board's authority to consider the effect of age-related causes in evaluating whether occupational conditions constitute the major cause of a disease.

We reached the same conclusion in a slightly different context in *Brown v. A-Dec, Inc.*, 154 Or App 244, 961 P2d 280 (1998). In that case, the Board upheld the denial of an occupational disease claim for certain cervical symptoms because the current condition had combined with a preexisting age-related degenerative cervical condition, and the age-related cervical condition was the major contributing cause of the condition. The claimant argued that her degenerative cervical condition could not properly be considered a preexisting condition, because, having been caused by the natural process of aging, it was not an "injury" or a "disease" that may be considered a preexisting condition within the statutory definition of the term. *See* ORS 656.005(24) (defining "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"). We rejected the argument, holding that nothing in the statute evinced an intention to exclude "naturally occurring" conditions from the meaning of the term "disease." *Brown*, 154 Or App at 248.

Claimant acknowledges *Brown*, but argues that it was incorrectly decided and urges us to reconsider it. We decline claimant's invitation and conclude that the Board did not err in considering his presbycusis in evaluating whether he had shown that employment exposure was the major contributing cause of his hearing loss.

As for claimant's alternative argument that such a conclusion runs afoul of the Oregon Constitution and various **<164 Or App 218/219>** federal statutes, we note that he failed to raise those arguments below. We further note that, in any event, we rejected similar arguments as to the state constitution and the Americans with Disabilities Act in *Bailey v. Reynolds Metals*, 153 Or App 498, 959 P2d 84, *rev den* 327 Or 432 (1998).

Because we affirm the Board's determination that claimant's hearing loss is not compensable, we do not address his contention that the Board erred in failing to assign responsibility for the claim.

Affirmed.

Cite as 164 Or App 288 (1999) December 8, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Denise L. Allen, Claimant.

BI-MART CORPORATION, Petitioner,
v.
DENISE L. ALLEN, Respondent.
(98-02759; CA A104789)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 1, 1999.
Michael G. Bostwick argued the cause and filed the brief for petitioner.
Charles L. Lisle argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
EDMONDS, P. J.
Affirmed.

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164 Or App 290> Employer seeks review of a Workers' Compensation Board order denying its motion for sanctions after claimant sought to enforce a penalty award. ORS 656.295 and 656.298. We review for errors of law, ORS 183.482(8)(a), and for abuse of discretion, ORS 183.482(7), and affirm.

Claimant has an accepted claim for a back strain with employer and a herniated disc condition that employer denied on the ground that it was unrelated to the accepted claim. In a previous hearing, an administrative law judge (ALJ) set aside the denial and assessed a twenty-five percent penalty pursuant to ORS 656.262(11). However, there was no penalty owed if no amounts were due on the claim at the time of the denial. Two years later, claimant filed a request for hearing, seeking enforcement of the penalty. However, claimant was unable to establish at the hearing that any compensation was due. Thereafter, employer moved for sanctions under ORS 656.390.[1]

Employer's sole assignment of error is that "[the] Board erred when it failed to address the statutory definition of 'frivolous' in considering the employer's request for sanctions pursuant to ORS 656.390, and instead used a test of 'colorable argument' in determining whether or not claimant's actions were frivolous." Thus, the question presented by the assignment is "[w]hether or not the [Board] used the proper legal test to determine if sanctions should be awarded pursuant to ORS 656.390." In addition, employer argues that the *only* evidence claimant produced to support her request **<164 Or App 290/291>** for hearing was evidence that demonstrated that she had no chance of prevailing and that, therefore, the Board was *required* to award sanctions as a matter of law.

ORS 656.390(2) provides that "'frivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." In its order, the Board quoted the statutory definition verbatim. It then said:

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[1] ORS 656.390 provides:

"(1) Notwithstanding ORS 656.236, if either party requests a hearing * * *, and the Administrative Law Judge, board or court finds that the appeal or motion for reconsideration was frivolous or was filed in bad faith or for the purpose of harassment, the Administrative Law Judge, board or court may impose an appropriate sanction upon the attorney who filed the request for hearing, request for review, appeal or motion. The sanction may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the request for hearing, request for review, appeal or motion, including a reasonable attorney fee.

"(2) As used in this section, 'frivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing."

> "[W]e do not find claimant's hearing request to be frivolous. In this regard, we agree with and have adopted the ALJ's conclusion that the fact that the earlier ALJ awarded a penalty and the Board affirmed the penalty award, gave claimant a colorable argument that she was entitled to enforcement of the penalty. Accordingly, we do not find claimant's hearing request to be frivolous and we deny the motion for sanctions."

Because it is apparent from the Board's order that it applied the correct statutory definition, the Board did not err in that regard.

Second, the Board's refusal to award sanctions is within its discretion, and it was not required to award a sanction under the language of the statute. ORS 656.390(1) provides that, if the Board finds that the request was frivolous, then the Board "*may* impose an appropriate sanction upon the attorney who filed the request for hearing[.]" (Emphasis added.) Nothing in the language of the statute compels the Board to award sanctions even when it finds the request to be frivolous. Here, the Board reasoned that claimant's hearing request was not frivolous because of the prior award. Assuming that employer is correct that claimant offered no evidence that employer owed compensation at the time of the denial, there still was no abuse of discretion. An abuse of discretion occurs when the Board exceeds the legal bounds of its authority. Because the Board applied the correct legal test under ORS 656.390, and then exercised its discretion not to award sanctions as the statute authorized, it did not err.

Affirmed.

Cite as 329 Or 503 (1999) December 3, 1999

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth P. Bundy, Claimant.

FRED MEYER, INC., Respondent on Review,
v.
KENNETH P. BUNDY, Petitioner on Review, and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.
(WCB 95-07510; CA A95905; SC S46365)

On Appeal from the Court of Appeals.*

Argued and submitted November 8, 1999.

Roger Ousey, of Bischoff, Strooband & Ousey, P.C., Medford, argued the cause and filed the brief for petitioner on review Kenneth P. Bundy.

Craig A. Staples, Vancouver, Washington, argued the cause and filed the brief for respondent on review.

Megan A. Flynn, of Pozzi Wilson Atchison, LLP, Portland, filed a brief for *amicus curiae* Oregon Trial Lawyers Association.

David L. Runner, Lead Appellate Counsel, Salem, filed a brief in the Court of Appeals for *amici curiae* SAIF Corporation and Timber Products Company.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Durham, Leeson, and Riggs, Justices.**

MEMORANDUM OPINION

The petition for review is dismissed as improvidently allowed.

*Judicial review from the Workers' Compensation Board. 159 Or App 44, 978 P2d 385 (1999).

**Kulongoski, J., did not participate in the consideration or decision of this case.

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