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

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

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CITE AS

52 Van Natta ____ (2000)

In the Matter of the Compensation of
SHERRYL A. BRONG, Claimant
WCB Case No. 99-01868
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl 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 cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working in the employer's pharmacy section in October 1996. She worked as "floater," at various locations until June 1997, when she became a full time pharmacy technician at one location. As a technician, claimant initially spent about 4 hours per shift on the telephone at work, interspersed with other activities. Claimant did not use a telephone headset; she held the phone between her ear and right shoulder so that her hands were free to use a computer keyboard.

On July 4, 1997, claimant moved furniture at home. She experienced right shoulder pain, beginning the next day. She sought treatment on July 24, 1997 and shoulder x-rays were normal.

In October 1997, claimant again sought treatment for ongoing right shoulder pain with numbness extending down her left arm. Cervical degeneration was suspected but not indicated by x-ray. Claimant's shoulder symptoms resolved, but she had intermittent ongoing neck pain.

From late 1997 until 1998, claimant's work time on the telephone increased until she was on the telephone most of her shift. Sometimes she worked from 9 in the morning until 9 or 9:30 at night. After 6 months of increasing neck and shoulder pain, claimant again sought treatment in October 1998. X rays, a CT scan, and an MRI revealed cervical degeneration and Dr. Schmidt suspected that claimant had a "soft" cervical disc and/or bone spurring. By November 1998, claimant had so much pain that she left work.

Claimant filed an occupational disease claim, which the employer denied. Dr. Schmidt performed a C5-6 and C6-7 microlaminotomy and foraminotomy on February 8, 1999. His operative report described a "very large eburnated ridge" at C5-6, but he did not find a "soft disc." (Ex. 19).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial because he found Dr. Gritzka's opinion supporting the claim unpersuasive. The ALJ reasoned that Dr. Gritzka's history was incorrect because he assumed that claimant spent at least four hours per day cradling a telephone between her head and right shoulder since she began working for the employer. Further reasoning that claimant did not perform this activity long enough to support Dr. Gritzka's causation hypothesis -- or to cause her degenerative condition, the ALJ concluded that the claim failed. We disagree.

Dr. Gritzka opined that claimant's neck flexing to hold the telephone at work was the major contributing cause of the development of her cervical osteophytes.[1] (Ex. 26-8). He explained that claimant's telephone-holding caused a narrowing of the cervical foramen and pinching of the nerve in the foramen. Dr. Gritzka further explained that attenuated pinching over time causes progressive spur formation *via* "wearing away" of the articular cartilage in the facet, an inflammatory response that provokes formation of new bone, and chronic enthesiopathy (irritation due to abnormal traction where the ligament inserts in the bone), causing spurlike calcification. (Exs. 30-31-32, 30-41-43, 30-64). Thus, claimant's repeated maneuver holding the phone either caused her degeneration initially or caused her worsened condition -- even though physical change in the osteophytes, or spurs, was initially less than appreciable by x-ray. (*Id.* at 44-45; *see also id.* at 37, -65, -72-73). Dr. Gritzka also explained that

[1] He cited medical literature indicating that chronic static constrained cervical posture caused "degenerative," or post-traumatic, cervical spondylosis among dental workers. (Ex. 26-8-9).

claimant probably had incipient spurring when she began working as a pharmacy technician, but she performed the injurious maneuver with the telephone long enough so that her work was the major cause of the spondylosis (arthritic reactive bone spur changes) that required surgery. (Ex. 30-48, *see id.* at 22-23, -28-32, -46-47, -57-58, -71-73). We find Dr. Gritzka's opinion persuasive because it is well-reasoned and based on an accurate history.[2]

Drs. Arbeene, Radecki, Yoshinaga, and Schmidt provide the remaining medical evidence addressing causation. These doctors opined that claimant's cervical condition is due to "preexisting" degeneration rather than cradling the telephone between her head and shoulder at work. (Exs. 15-5-6, 20, 21, 24-2, 25, 29). Drs. Arbeene and Radecki initially offered no reasoning to support their causation conclusions and Drs. Schmidt and Yoshinaga concurred with those opinions. (Exs. 15, 20, 21). We find these opinions unpersuasive because they are entirely conclusory.

Later, Dr. Radecki stated, "Cradling the phone is a low-velocity, low force, nonrepetitive action which does not cause either degenerative change or disk herniation." (Ex. 24-2). But Dr. Gritzka's opinion persuasively rebuts Dr. Radecki's reasoning and Dr. Gritzka's opinion is more consistent with claimant's history. Therefore we find Dr. Radecki's opinion unpersuasive.

Dr. Arbeene opined that claimant's cervical degenerative changes could not have developed "within one year," because that was "not enough time," and "spurs take years to develop." (Ex. 29-2-3). He asserted that "bending over" does not cause spurs to form and asked how Dr. Gritzka's contrary reasoning would explain claimant's similar osteophytes on the left side. (Ex. 29-5). Dr. Arbeene also stated that there was no evidence of a pathological worsening of claimant's condition, based on a comparison of her October 1997 and November 1998 x-ray findings. (Exs. 29-3, -5).

We find Dr. Arbeene's opinion unpersuasive for several reasons. First, claimant's degeneration did not "develop" in one year; it progressed during the time claimant performed the injurious telephone maneuver -- from mid 1997 until her February 1999 surgery. Moreover, as Dr. Gritzka explained, as little as 6 months of this activity would be sufficient to cause claimant's pathology. Second, we find Dr. Gritzka's explanation for the mechanism of "injury" more persuasive than Dr. Arbeene's assertion to the contrary. And we rely on Dr. Gritzka's opinion that claimant's neck flexion to the right contributed to her left-sided cervical degeneration, because traction tension on the left caused enthesiopathy, just as compression caused it on the right. (Ex. 30-38-39). Finally, we are persuaded that claimant's cervical condition *did* worsen pathologically over time, with her ongoing work exposure, based on Dr. Gritzka's explanation for the mechanism of her disease and his interpretation of claimant's films. (*See* Ex. 30-56; *see also id.* at 37-38, -65-66).

Accordingly, based on Dr. Gritzka's persuasive opinion, we reach the following conclusions: Claimant's work activities were the major contributing cause of her degenerative disease at C5-6 and C6-7, with foraminal narrowing secondary to osteophytes at these levels. And, insofar as claimant's condition preexisted her disability and treatment,[3] her claimant's work activities were the major contributing cause of her combined condition (preexisting or "incipient" spurs combined with work exposure) and a pathological worsening of the disease. *See* ORS 656.802(2)(b).[4] Consequently, we conclude that claimant's occupational disease claim is compensable.

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[2] During his deposition, Dr. Gritzka considered a "hypothetical" that mirrors claimant's relevant work history and found the posited exposure sufficient to "add to degenerative changes." (Ex. 30-57-58). Under these circumstances, we conclude that Dr. Gritzka had a materially accurate history and his opinion supports a conclusion that claimant's work caused her condition to worsen pathologically.

[3] "[I]n 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." *SAIF Corp. v. Cessnun,* 161 Or App. 367, 371 (1999) (emphasis in original).

[4] Claimant's pathological worsening is established by medical evidence supported by objective findings. (*See* Exs. OD, 3, 11, 12). *See* ORS 656.802(2)(d).

Claimant's attorney is entitled to an assessed fee for services at hearing.[5] ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $3,500, payable by the employer. 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.

ORDER

The ALJ's order dated October 27, 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, claimant is awarded a $3,500 attorney fee, payable by the employer.

[5] Claimant submitted no argument on review.

In the Matter of the Compensation of
GEORGE M. BROWN, Claimant
Own Motion No. 99-0335M
OWN MOTION ORDER
Patrick Mackin, Claimant Attorney

The self-insured employer submitted a request for temporary disability compensation for claimant's compensable 1985 injury.[1] The employer issued a denial of the compensability of claimant's current condition on October 26, 1999. Claimant timely appealed that denial. (WCB Case No. 99-10024).

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 October 26, 1999 denial; however, he withdrew his request for hearing. An Order of Dismissal issued on January 27, 2000. That order has not been appealed. Thus, the current condition for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as the employer has not accepted claimant's current condition as compensable. Should claimant's circumstances change and the employer 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.

[1] Because the employer has not submitted a completed Own Motion Recommendation Form, it is unknown when claimant's aggravation rights expired.

In the Matter of the Compensation of
DONALD J. CRUZ, Claimant
WCB Case No. 99-04344
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

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

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

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

The ALJ concluded that claimant failed to establish that Dr. Unger's diagnosis of a lumbosacral strain was supported by objective findings. On review, claimant contends that the observations by Nurse Practitioner Braaten and Dr. Gripekoven establish the necessary objective findings. We disagree.

Claimant sustained a compensable low back injury in 1995 that resolved with residual waxing and waning of symptoms. In April 1999, claimant sought treatment for upper back complaints.[1] When he saw Dr. Gripekoven in May 1995, claimant complained of mid back pain extending from the scapulae to the mid back. Claimant reported that he had only occasional low back discomfort.

Claimant asserts that Dr. Gripekoven's finding of decreased range of motion of the dorsal and lumbar spine is an objective finding supporting claimant's low back strain claim. But Dr. Gripekoven does not correlate his finding with a lumbar strain caused by claimant's work. Rather, he considered it an objective finding (along with 1995 and 1996 imaging that revealed degenerative changes at multiple levels of claimant's spine) in supporting his diagnosis of degenerative disc disease.[2]

Dr. Unger was the only physician to diagnose a low back strain, and, as discussed in the ALJ's order, it was evidenced only by claimant's subjective complaints. As such, Dr. Unger's opinion is insufficient to carry claimant's burden of proof.

ORDER

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

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[1] Nurse practitioner Braaten's findings of a tender spine in the mid-thoracic region are not objective findings of a low back strain.

[2] Dr. Gripekoven opined that claimant had diffuse degenerative disc disease through his dorsal and lumbar spine that was related to a wear-and-tear aging process and not to any specific work activity. Dr. Gripekoven opined that, although claimant's work activities may have rendered his preexisting condition symptomatic, there had been no material worsening of the condition in his dorsal and lumbar spine from his work activities. Dr. Gripekoven concluded that the major contributing cause of claimant's combined condition was the preexisting degenerative process and not any occupational disease or work exposure. Dr. Gripekoven's report does not establish a compensable occupational disease in claimant's low back.

Board Member Phillips Polich dissenting.

The Board affirmed the ALJ's order upholding SAIF's denial of claimant's occupational disease claim for a lumbosacral strain after concluding that claimant failed to establish that Dr. Unger's diagnosis of a lumbosacral strain was supported by objective findings. For the following reasons, I respectfully dissent.

First, the parties stipulated that claimant's lumbosacral strain was the result of the combining of his work activity and his preexisting degenerative lumbar disc disease. Consequently, the majority's conclusion that there were no objective findings disregards the parties' stipulation that claimant does have a combined low back condition.

In his discussion of causation, Dr. Gripekoven attributed claimant's low back condition to his documented degenerative changes in the lumbar spine. (Ex. 8-6). However, Dr. Gripekoven's evaluation took place in relation to claimant's mid back condition and before he experienced the low back strain diagnosed by Dr. Unger. Therefore, because Dr. Gripekoven did not have a complete history of claimant's current low back condition, I would find his opinion less persuasive than that of Dr. Unger.

In his report, Dr. Unger noted that claimant has underlying degenerative arthritis of the lumbosacral spine that predisposes him to injury. However, Dr. Unger also indicates that claimant's current problems that require treatment are related to his work activities. (Ex. 10). Moreover, in a subsequent letter, Dr. Unger agreed with the statement that it was probable that claimant suffered a lumbosacral strain as a result of his work activities as a service station attendant and that, although his preexisting degenerative arthritis of the lumbosacral spine no doubt contributed to the severity and duration of his lumbosacral strain, his work was the major contributing cause of the strain. (Ex. 11). Accordingly, based on attending physician Dr. Unger's opinion, I would conclude that claimant has carried his burden under ORS 656.802.[1] *Weiland v. SAIF*, 64 Or App 810 (1983).

[1] Although claimant has a preexisting degenerative condition due to a wear-and-tear aging process that predisposes him to injury, his claim is not "based on" a worsening of his predisposing condition. *See* ORS 656.802(2)(b).

In the Matter of the Compensation of
DENICE K. DRASHELLA, Claimant
WCB Case Nos. 99-03676 & 98-03957
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

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

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's "left upper extremity symptom complex." On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact on page 1, we replace the first three sentences with the following:

> "Claimant testified that she began working for the employer in 1985 as a part-time massage therapist. (Tr. 29). After two years, she became the manager of the massage department and also worked as a massage therapist. (Tr. 30)."

In the first paragraph on page 2, we change the date in the first sentence to "January 1996." Also on page 2, we replace the fifth paragraph with the following:

> "Claimant has reduced her work load as a massage therapist and has occasionally stopped performing massage therapy altogether. Although claimant felt her condition generally improved when she was away from work, she said that her elbow continued to get worse, even when she was not working at all. (Tr. 32, 33, 36). She also had difficulty performing household activities. (Tr. 33)."

On page 3, we delete the seventh paragraph.

CONCLUSIONS OF LAW AND OPINION

In 1985, claimant began working for the employer as a part-time massage therapist. (Tr. 29). After two years, she became the manager of the massage department and also worked as a massage therapist. (Tr. 30). She worked two to three days a week, five to seven hours a day. (*Id.*) Approximately 80 percent of her work involved deep-tissue work. (Tr. 31).

In December 1995, she began developing pain in her neck, upper back and rib area, as well as the left elbow. (*Id.*) She sought treatment from Dr. Loebner in January 1996. (Ex. 27). Claimant reduced her hours at work. (Tr. 32).

On August 20, 1996, claimant signed an "801" form for left elbow tendinitis and fibromyalgia. (Ex. 18). In August 1996, claimant received an injection for the left elbow pain and was off work for approximately two months. (Exs. 16, 27, 34). In December 1996, Dr. Loebner reported that claimant had "reinjured" the left elbow. (Exs. 26, 27, 34).

In April 1997, a stipulation was approved whereby SAIF agreed to accept left lateral epicondylitis and the denial of fibromyalgia was upheld. (Ex. 37). SAIF then accepted a disabling claim for left lateral epicondylitis. (Ex. 38, 40).

Claimant continued to have left upper extremity symptoms and has sought many types of treatment, including chiropractic and naturopathic treatment. On January 20, 1999, claimant's attorney requested that SAIF accept claimant's "upper left extremity symptom complex." (Ex. 90). On April 21, 1999, SAIF issued a partial denial of costochondritis. (Ex. 93). At hearing, the parties agreed that SAIF had "*de facto*" denied claimant's left upper extremity symptom complex. (Tr. 2-3).

The ALJ relied on the opinions of Drs. Achterman and McKinstry to conclude that claimant's work exposure was the major contributing cause of her left upper extremity symptom complex.

On review, SAIF first argues that the ALJ erred by failing to address its "claim preclusion" argument. According to SAIF, the compensability of the symptoms in claimant's neck, upper back and shoulders could have been negotiated before the April 1997 stipulation and, therefore, claimant is barred from raising the issue of compensability of those symptoms.

On the other hand, claimant contends that SAIF only made a cursory reference to the claim preclusion issue during closing argument and, therefore the issue was not properly raised by SAIF at the hearing. Alternatively, claimant argues that the doctrine of claim preclusion does not apply in this case.

We need not address the timeliness of SAIF's claim preclusion argument because, for the following reasons, we find that the claim is not compensable on the merits.

Claimant seeks to establish compensability of her left upper extremity symptom complex as an occupational disease. She must therefore establish that her employment conditions were the major contributing cause of that condition. ORS 656.802(2)(a). Claimant relies on the opinion of her treating physician, Dr. Achterman, to establish compensability. On the other hand, SAIF contends that claimant failed to prove that her work activity was the major contributing cause of her pain complaints.

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). Here, we find persuasive reasons not to rely on the opinion of Dr. Achterman.

Claimant had been having elbow, neck and upper back symptoms since 1995. (Tr. 34-35). She said her current left upper extremity symptoms were basically the "same problem" she had since 1995, but they were "much more intense." (Tr. 41, 42).

Dr. Achterman first examined claimant in April 1997. (Ex. 36). Dr. Achterman's diagnosis of claimant's condition has changed over time. He initially diagnosed residual left lateral epicondylitis and [s]ymptoms suggestive of either a low grade reflex sympathetic dystrophy and/or thoracic outlet syndrome on the left side. (*Id.*)

On October 7, 1997, Dr. Achterman still believed claimant had findings suggestive of thoracic outlet syndrome, despite the fact that circulation studies did not show any abnormality. (Ex. 66-1). In August 1998, Dr. Achterman said that claimants work was a "greater" contributing cause of the thoracic outlet syndrome. (Ex. 83). One month later, he adhered to his opinion that claimant had a component of thoracic outlet that was contributing to her overall symptomatology. (Ex. 86).

On November 17, 1998, Dr. Achterman described claimant's "presenting symptom complex as upper extremity pain related to shoulder girdle posture." (Ex. 89). He believed her symptom complex was related in a major way to her occupational activities. (*Id.*) He explained that, although claimant's findings did not meet the classic diagnosis of thoracic outlet syndrome, the symptom complex was "based on the motor activities which were required because of the nature of her occupation." (*Id.*)

On May 5, 1999, Dr. Achterman said that "some of [claimant's] symptoms with regard to her shoulder and back should be regarded as part of the workman's comp claim." (Ex. 95). He felt that "thoracic outlet" was probably inaccurate, but he felt that "the activities of a masseuse could tend to produce some shoulder symptoms." (*Id.*)

Dr. Achterman opined in August 1999 that claimant's epicondylitis and "periscapular pain" were "related to her work environment." (Ex. 101-1). He explained that, although he had previously diagnosed "thoracic outlet syndrome," it had not been demonstrated that claimant had obstruction of structures in the thoracic outlet. (*Id.*) He felt claimant's "symptom complex" would be recognized by most practitioners and most "would recognize that this patient had muscle fatigue or symptoms relative to activity whether or not they met the criteria" of either thoracic outlet syndrome or fibromyalgia. (*Id.*) Dr. Achterman concluded that claimant's work was the major contributing cause of the "symptom complex." (Ex. 101-2).

We acknowledge that a specific diagnosis is not required to establish compensability, provided that claimant establishes that her symptoms are attributable to 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). Although Dr. Achterman initially diagnosed a thoracic outlet syndrome, he later opined that claimant had an upper extremity "symptom complex." (Exs. 89, 101).

For the following reasons, we are not persuaded by Dr. Achterman's opinion on causation. In his November 17, 1998 report, he indicated claimant's "symptom complex" was "based on the motor activities which were required because of the nature of her occupation." (Ex. 89). In a May 5, 1999 report, however, he said that "the activities of a masseuse *could* tend to produce *some* shoulder symptoms." (Ex. 95). In that report, he said that "*some* of [claimants] symptoms with regard to her shoulder and back should be regarded as part of the workman's comp claim." (*Id.*) The May 5, 1999 report suggests only the possibility that claimant's work activities "could" produce "some" of her symptoms. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). In light of the equivocal nature of the May 5, 1999 report, Dr. Achterman's subsequent report that claimant's work was the major contributing cause of her symptom complex is not particularly persuasive.

Moreover, we find that Dr. Achterman's reports on causation lack adequate explanation and does not meet the requisite standard of proof. A determination of the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). The fact that work activities precipitated a claimant's injury or disease does not necessarily mean that work was the major contributing cause of the condition. *Id.*

Claimant had been having elbow, neck and upper back symptoms since 1995. (Tr. 34-35). Although claimant felt her condition had improved when she was away from work, she said her elbow continued to get worse, even when she was not working at all. (Tr. 32, 33, 36). Claimant testified that in 1997, she worked as a massage therapist about two to three hours per week. (Tr. 40). In 1998, she worked about four to five hours a month as a massage therapist. (Tr. 39). At the time of hearing, claimant still managed the massage department, but she did not perform any massage work unless she had to fill in for someone, which was only about one to two hours a month. (Tr. 38, 41). Claimant testified that her current left upper extremity symptoms were basically the same problem she had since 1995, but they were "much more intense." (Tr. 41, 42).

The medical reports indicate that claimant's symptoms increased even when she was off work. Dr. Moneta reported that claimant said she had "bilateral arm fatigue with any repetitive work, such as washing windows or scrubbing the floors, as well as working as a masseuse." (Ex. 80-2). Dr. Cline said that, even when claimant quit performing massages, it seemed as though her symptoms increased. (Ex. 81-1). Dr. Cline reported that claimant's arms would become numb if she held a phone to her ear and it was difficult to hold a shopping bag in her hand for any length of time. (Ex. 81-2). Claimant's

symptoms were aggravated by doing a lot of housework. (*Id.*) Similarly, Dr. Ploss reported that claimant's symptoms were "made worse with any upper body activity, doing massage, yard work, carrying packages, vacuuming, household chores and lying down." (Ex. 98-7). Dr. Smith reported that claimant indicated her pain increased while reclining, particularly while reclining at night and sleeping. (Ex. 98-10).

In addition, the medical evidence from Dr. Smith, psychologist, indicated that claimant had somatization personality characteristics. (Ex. 98-13). Dr. Smith agreed that claimant's generalized upper extremity complaints were likely the result of the underlying somatization condition, rather than her work exposure. (Ex. 100). Similarly, Dr. Mayhall questioned whether claimant had a "somatoform pain disorder" or a regional pain syndrome. (Ex. 91-11, -12).

We find that Dr. Achterman's opinion is insufficient to establish compensability of claimant's left upper extremity complex. Although Dr. Achterman's opinion includes "magic words," such as "the major contributing cause," it is conclusory, without significant explanation. He did not explain why claimant's work was the major contributing cause of her left upper extremity condition when she also had symptoms with regular household activities. Moreover, he did not explain why claimant's symptoms increased when she was off work, nor did he address the fact that her hours as a massage therapist had been greatly reduced in the last few years, but her symptoms were more "intense." In sum, we do not find Dr. Achterman's opinion persuasive because he did not explain why claimant's work exposure contributed more to the claimed condition than all other causes combined. *See Dietz*, 130 Or App at 401.

The ALJ also relied on Dr. McKinstry's opinion in finding the claim compensable. For the following reasons, we agree with SAIF that Dr. McKinstry's opinion is not sufficient to establish compensability.

Dr. McKinstry first examined claimant on April 2, 1999, more than three years after her symptoms began. (Ex. 91A). He diagnosed "[n]eck, back and chest pain," which was severe, progressive and debilitating. (Ex. 91A-2). He recommended further rheumatological screening. (*Id.*) On June 29, 1999, Dr. McKinstry diagnosed "[c]hronic upper back, neck and chest pain; overuse syndrome from years of heavy massage." (Ex. 97-1). He noted that inflammatory processes had been ruled out by rheumatology. (*Id.*)

In a "check-the-box" letter from claimants attorney, Dr. McKinstry agreed that "overuse syndrome" was the appropriate diagnosis for claimant. (Ex. 99-2). He also agreed that claimants work activity as a massage therapist was the major cause of her "overuse syndrome" or "symptom complex." (*Id.*)

Because there is no evidence whether Dr. McKinstry had reviewed claimant's other medical records, we are not persuaded that his opinion on causation was based on adequate and complete information. Moreover, we find Dr. McKinstry's "check-the-box" opinion unpersuasive because it is lacking in explanation and analysis. *See, e.g., Marta I. Gomez*, 46 Van Natta 1654 (1994) (Board gives the least weight to conclusory, poorly analyzed opinions, such as unexplained, conclusory "check-the-box" reports).

The remaining medical opinions on causation are not sufficient to establish compensability of claimant's left upper extremity complex. Dr. Mayhall opined that only claimant's lateral epicondylitis condition was related to her work. (Ex. 91-11). He did not believe claimant's left upper extremity symptom complex was caused by her work for employer. (Ex. 91-13). Dr. Ploss found that the etiology of claimant's chronic neck and chest wall pain, as well as the "[c]hronic infra and parascapular muscle strain/spasm[,]" was uncertain. (Ex. 98-9). As we discussed earlier, Dr. Smith reported that claimant had somatization personality characteristics. (Ex. 98-13). He agreed that claimant's generalized upper extremity complaints were likely the result of the underlying somatization condition, rather than her work exposure. (Ex. 100).

In sum, we conclude that claimant has failed to sustain her burden of proving compensability of her left upper extremity complex.[1]

---

[1] In light of our disposition, we need not address SAIF's argument that claimant's "left upper extremity symptom complex" is not a "condition" as required by the statutes.

ORDER

The ALJ's order dated September 2, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside SAIF's denial of claimant's "left upper extremity symptom complex" is reversed. SAIF's denial of that condition is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich dissenting.

Because I disagree with the majority's analysis of the medical evidence, I respectfully dissent. Instead, I agree with the ALJ's conclusion that claimant's left upper extremity complex is compensable.

When the medical opinions of Drs. Achterman and McKinstry are read together, they are sufficient to sustain claimant's burden of proving compensability. I would apply the long-standing presumption favoring the treating doctor's opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983). I agree with the ALJ that claimant's testimony is credible and is corroborated by the chart notes of various physicians regarding her upper extremity symptoms. In particular, Dr. Achterman treated claimant on numerous occasions and has determined that claimant's upper extremity problem is related to her work activities. Dr. Achterman's opinion is persuasive because it is well-reasoned and based on complete information.

Furthermore, I agree with the ALJ that the contrary medical opinions are not sufficient to overcome the opinions of claimant's treating physicians. Although Dr. Mayhall did not believe claimant's "upper extremity left symptom complex" condition was work-related, he acknowledged that her lateral epicondylitis was caused by her work activities. (Ex. 91-11, -12, -13). Dr. Mayhall explained that the biomechanics of claimant's massage work involved gripping and twisting and pressure applied with the arms. (Ex. 91-11). Dr. Mayhall did not explain why claimant's work activities were not causing her other upper extremity symptoms. Similarly, I agree with the ALJ that neither Dr. Moneta nor Dr. Cline explained why claimant's pain in her arm and shoulder was not work-related.

Claimant has the burden of proving, by a preponderance of the evidence, that her claim is compensable. In this case, the preponderance of evidence establishes that claimant's work activities were the major contributing cause of her left upper extremity symptom complex. In this case, the majority has disregarded that measurement and applied a more stringent burden of proof. I believe the ALJ correctly determined that claimant had established compensability of her left upper extremity complex and I would affirm the ALJ's order.

In the Matter of the Compensation of
CARRIE L. ELLER, Claimant
WCB Case No. 99-05499
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that found that claimant was not entitled to an attorney fee under ORS 656.386(1) or 656.382(1). On review, the issue is attorney fees.

We adopt and affirm the ALJ's order. *See LaToy E. Hamilton*, 51 Van Natta 724 (1999) (the carrier's response to the claimant's request under ORS 656.262(6)(d) that acceptance encompassed requested condition complied with the processing requirements of ORS 656.262(6)(d) and 656.386(1)(b)).

ORDER

The ALJ's November 11, 1999 order is affirmed.

In the Matter of the Compensation of
TRUDY M. SPINO, Claimant
WCB Case No. 99-05314
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

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

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

We do not find that claimant has failed to comply with her doctor's advise about medication.

We do not find that the "progression" of Dr. Silver's causation opinion detracts from his conclusions. Nonetheless, we agree with the ALJ that Dr. Silver's opinion is insufficient to carry claimant's burden of proof, based on the following reasoning.

Drs. Farris and Wilson, examining physicians, identified several nonwork related predisposing factors that probably contribute to claimant's CTS. These contributors include decreased circulation due to age, age-related female hormonal changes, long time estrogen supplementation, fluid retention, hypothyroidism, and cigarette smoking. The examiners explained that these factors involve or cause decreased circulation that contributes to claimant's CTS. Noting that hypothyroidism is an autoimmune condition thought to compromise microcirculation to nerves, Dr. Farris also opined that claimant's thyroid condition contributes to her CTS, because her thyroid hormone replacement treatment does not affect the activity of the underlying autoimmune condition. In addition, Dr. Farris cited claimant's age-related decreased physical capacities, deconditioning, lack of exercise, and her .89 wrist ratio as CTS contributors. (Exs. 10, 13, 14).

Dr. Silver, treating physician, acknowledged that "predisposing factors" contribute to claimant's CTS. (Ex. 12-3). He discounted some of the cited factors, reasoning that claimant is "on adequate thyroid replacement," her mother's CTS could have been due to job activity; and attributing claimant's CTS to her postmenopausal status would be unfair. (*Id.*). Considering the degree of claimant's CTS disability and the repetitive motion required by her work, Dr. Silver concluded that claimant's work was responsible for her condition. (*Id.; see also* Exs. 15, 17).

But Dr. Silver did not respond to the examiners' reasoning regarding the mechanism of claimant's disease (including decreased circulation) and he did not discount or otherwise explain away most nonwork causes the examiners identified. Moreover, Dr. Silver's ultimate opinion is that claimant would not have CTS if she did not engage in repetitive motions involving her hands and wrists. (Ex. 17). Under these circumstances, we agree with the ALJ that Dr. Silver's opinion is inadequately explained and insufficient to carry claimant's burden of proof. *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); *see also McGarrah v. SAIF*, 296 Or 145 (1983) (to prove major causation, the claimant must establish that employment conditions, when compared to non-employment conditions, were the "major contributing cause" of the disease).

ORDER

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

Board Chair Bock specially concurring.

I agree with the result in this case because Dr. Silver's opinion supporting the claim is inadequately reasoned and insufficient to carry claimant's burden of proof under ORS 656.802(2)(a). In addition, I write separately to emphasize that we evaluate claims involving contributory preexisting conditions on a case-by-case basis, depending on the medical evidence. *See Cassandra J. Hansen*, 50 Van Natta 174, 175 (1998) (Board Chair Bock specially concurring).

In the Matter of the Compensation of
JACK L. KRUGER, Claimant
WCB Case Nos. 99-01692 & 98-06034
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld Liberty Northwest Insurance Company's compensability and responsibility denials, on behalf of Adroit Construction, of his lumbar spondylosis and stenosis condition; and (2) upheld the SAIF Corporation's compensability and responsibility denial, on behalf of McCormack Pacific Company, of the same condition. On review, the issues are compensability and, potentially, responsibility. We affirm.

FINDINGS OF FACT

While working for Liberty's insured on May 1, 1995, claimant was injured when he fell from a truck into a dumpster. (Exs. 1, 3). On September 6, 1995, he sought treatment from Dr. Morris, who reported that claimant had noticed severe left shoulder discomfort, moderate neck pain and right hip discomfort at the time of the May 1995 incident. (Ex. 3). At the time of the appointment, claimant had left shoulder, neck and right hip pain. (*Id.*) Dr. Morris noted that claimant's low back was "normal to inspection." (*Id.*) He diagnosed a "C-spine strain," a "right SI joint" sprain, as well as "left shoulder sprain versus rotator cuff tear versus unrecognized humeral head fracture[.]" (Ex. 3). The "827" form from Dr. Morris referred to "C spine strain, left shoulder sprain, (R) SI joint strain, fall." (Ex. 4). On October 9, 1995, Liberty accepted a nondisabling claim for "spine, left shoulder and joint strain." (Ex. 5).

In May 1996, Dr. Morrison reported that claimant had pain in his neck, left elbow and left hand. (Ex. 11). He diagnosed left shoulder impingement and degenerative changes, cervical spine. (Exs. 6, 11). Dr. Morrison signed a "Notice of Claim for Aggravation" on May 22, 1996. (Ex. 8). On June 25, 1996, Liberty accepted a nondisabling aggravation claim for "spine, left shoulder and joint strain," which was later changed to a disabling claim. (Exs. 10, 12). Claimant was diagnosed with a rotator cuff tear and Dr. Morrison performed left shoulder surgery on August 16, 1996. (Ex. 13).

On March 20, 1997, Dr. Morrison reported that claimant had problems with his right lower extremity and had been having problems with the right hip and low back since his injury. (Ex. 26). He suspected claimant had degenerative changes in his back. (*Id.*) On April 30, 1997, claimant complained to Dr. Morrison of ongoing back and knee problems. (Ex. 31).

A Determination Order issued April 1, 1997, awarding 27 percent unscheduled permanent disability for claimant's left shoulder condition. (Exs. 27, 28). Claimant requested reconsideration. (Ex. 34). A June 5, 1997 Order on Reconsideration increased claimant's unscheduled permanent disability for the left shoulder condition to 32 percent. (Ex. 37). The Order on Reconsideration noted that the accepted conditions were "cervical strain, left shoulder strain, right hip strain" and indicated that the cervical and right hip strains had "resolved." (Ex. 37-1, -2). A January 5, 1998 Opinion and Order increased claimant's unscheduled permanent disability to 46 percent, which included impairment for his left shoulder and cervical spine. (Ex. 43-2, -3). Claimant was also awarded 3 percent scheduled disability for loss of use or function of his left arm. (*Id.*)

Claimant began working for SAIF's insured in August 1997. (Tr. 9). On November 24, 1997, claimant sought treatment for low back pain from Dr. Diller. (Ex. 41). Claimant told Dr. Diller he began having low back problems with his industrial injury in 1995 and had been having intermittent problems since that time. (Ex. 41-1, Tr. 14). Claimant said he woke up the previous week with more serious back pain and now had right leg pain. (*Id.*) He did not have any incidents while working for SAIF's insured that caused the low back pain. (Tr. 14, 15). Dr. Diller diagnosed sciatica. (Ex. 41-2).

Dr. Morrison examined claimant on December 22, 1997 and reported that his low back x-rays showed extensive degenerative changes, with marked disk space narrowing at L4-5 and L5-S1. (Ex. 42). A CT scan showed multiple changes in the lumbar spine with foraminal stenosis and mild central stenosis. (Exs. 44, 45).

On March 4, 1998, Dr. Morrison signed a "Notice of Claim for Aggravation" form. (Ex. 46). Dr. Henderson examined claimant on March 19, 1998 and diagnosed spinal stenosis, degenerative disk disease and sciatica. (Ex. 47).

Liberty, on behalf of Adroit Construction, denied compensability of claimant's aggravation claim on June 29, 1998. (Ex. 49). Liberty denied responsibility on November 3, 1998. (Ex. 51).

On December 29, 1998, claimant's attorney filed a claim with SAIF. (Ex. 53). SAIF denied compensability and responsiblity for claimant's low back condition. (Ex. 54).

On March 22, 1999, Dr. Woodward examined claimant on behalf of SAIF. (Ex. 55).

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Henderson's opinion and concluded that claimant's preexisting low back condition was the major contributing cause of his current need for treatment. The ALJ rejected claimant's argument that, regardless of medical causation, Liberty had accepted "spine" and was therefore precluded from denying the cause of the symptoms, *i.e.*, the underlying spondylosis and stenosis. The ALJ found that the term "spine" was inherently ambiguous and the contemporaneous record was of no assistance. Citing ORS 656.262(6)(c), the ALJ concluded that it was permissible for Liberty to deny claimant's current condition.

Relying on *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), claimant argues that Liberty accepted his "spine" and it is now precluded from denying present treatment of any conditions of claimant's "spine." On the other hand, claimant acknowledges that, unlike *Piwowar*, Liberty did not accept a symptom of an underlying disease.

The scope of acceptance is a factual determination. *SAIF v. Tull*, 113 Or App 449 (1992). Liberty accepted "spine, left shoulder and joint strain." (Ex. 5). Liberty contends that its acceptance is in the conjunctive, rather than the disjunctive. In other words, Liberty argues that the acceptance should be interpreted as "spine [strain], left shoulder [strain] and joint strain."

In previous cases, we have reviewed contemporaneous medical records to determine what condition was accepted by the carrier. *See, e.g., Verna M. Bolin*, 51 Van Natta 1949 (1999); *Fred L. Dobbs*, 50 Van Natta 2293 (1998). After the May 1995 injury, claimant first sought medical treatment in September 1995 from Dr. Morris, who reported that claimant had noticed severe left shoulder discomfort, moderate neck pain and right hip discomfort at the time of the May 1995 incident. (Ex. 3). On September 6, 1995, claimant had left shoulder, neck and right hip pain. (*Id.*) Dr. Morris noted that claimant's low back was "normal to inspection." (*Id.*) Dr. Morris diagnosed a "C-spine strain," a "right SI joint" sprain, as well as "left shoulder sprain versus rotator cuff tear versus unrecognized humeral head fracture[.]" (Ex. 3). Dr. Morris requested x-rays of claimant's cervical spine, left shoulder, right hip and SI joints. (Exs. 2, 3). The "827" form from Dr. Morris referred to "C spine strain, left shoulder sprain, (R) SI joint strain, fall." (Ex. 4). In light of the medical reports from Dr. Morris, we find that Liberty's acceptance should be interpreted as a cervical spine strain, left shoulder strain and joint strain.

The next question is whether the rule of *Piwowar* applies to this case. The critical issue is whether Liberty's acceptance was an acceptance of symptoms of claimant's degenerative low back condition(s) or an acceptance of a separate condition. *See Granner v. Fairview Center*, 147 Or App 406, 411 (1997) (question of fact for the Board was whether the carrier's acceptance of the right patella dislocation was an acceptance of a symptom of the claimant's preexisting knock knee condition or an acceptance of a separate condition).

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. The carrier was precluded from denying the underlying condition.

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 at 410.

Unlike *Piwowar*, Liberty accepted specific conditions, not merely symptoms. Claimant acknowledges that Liberty did not accept a symptom of an underlying disease. Because the insurer did not accept a claim for symptoms, we conclude that 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).

We proceed to analyze the merits of claimant's current low back condition. Dr. Morrison signed a "Notice of Claim for Aggravation" form in March 4, 1998. (Ex. 46). Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Id.*

We begin our analysis with a determination of whether claimant's current low back condition is a compensable condition. Liberty has accepted a cervical spine strain, left shoulder strain and joint strain. On the other hand, Dr. Henderson examined claimant on March 19, 1998 and diagnosed spinal stenosis, degenerative disk disease and sciatica. (Ex. 47). Because claimant's spinal stenosis, degenerative disk disease and sciatica are not accepted conditions, claimant must first establish compensability of those conditions.

As we noted, Dr. Henderson has diagnosed claimant's current low back condition as spinal stenosis, degenerative disk disease and sciatica. (Ex. 47-3). He felt that claimant's May 1995 injury might have made him symptomatic, but he believed that the major underlying cause of his symptoms was related to degenerative arthritis and spinal stenosis. (Ex. 50).

In a deposition, Dr. Henderson agreed that claimant's stenosis preexisted the 1995 injury and combined with the injury to cause his need for treatment. (Ex. 56-12). He believed the major cause of claimant's current symptoms was the underlying degenerative arthritis. (Ex. 56-9, -12, -13).

On March 22, 1999, Dr. Woodward examined claimant on behalf of SAIF. (Ex. 55). He diagnosed lumbar spondylosis and lumbar spinal stenosis, which he felt had been present for "several years." (Ex. 55-8). Dr. Woodward said the lumbar stenosis was a combination of developmental and degenerative stenosis. (*Id.*) The etiology of the degenerative portion of claimant's stenosis was related to his age and not his employment activities. (*Id.*)

The only other opinion on causation is from Dr. Morrison. His opinion is not persuasive, however, because he had an inaccurate history that claimant had injured his back at work in November 1997. (Ex. 48).

Based on the opinions of Drs. Henderson and Woodward, we find that claimant's May 1995 injury combined with his preexisting degenerative back conditions to cause his disability and/or need for treatment. Therefore, ORS 656.005(7)(a)(B) applies to this case. There are no medical opinions that establish that claimant's work injury is the major contributing cause of the need for treatment or disability for his current low back condition. Consequently, we conclude that claimant has failed to establish compensability of his current low back condition.

ORDER

The ALJ's order dated October 7, 1999 is affirmed.

In the Matter of the Compensation of
LYNN L. MURRAY, Claimant
WCB Case No. 99-06215
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Gilroy Law Firm, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of claimant's medical services claim for her current left shoulder condition. On review, the issues are claim preclusion and compensability.

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

Claimant contends that her current left shoulder impingement syndrome is not the same as the condition which was subject to a February 1999 Disputed Claim Settlement (DCS). (Ex. 1). Consequently, she asserts that her claim is not barred by that DCS. For the reasons expressed by the ALJ, as well as those expressed below, we disagree with claimant's contentions.

We interpret the terms of the DCS by applying standard rules of contract construction. *Taylor v. Cabax Saw Mill*, 142 Or App 121, 124 (1996); *Walter E. Judish*, 51 Van Natta 189, 191 (1999). Generally, that review consists of two steps. First, we determine whether the terms of the agreement are ambiguous. If so, we proceed to a determination of the "objectively reasonable construction of the terms" in light of the parties' intentions and other extrinsic evidence. *Taylor v. Cabax Saw Mill*, 142 Or App at 125.

Here, we find that the February 9, 1999 DCS is unambiguous. The agreement expressly refers to a left shoulder impingement syndrome. (Ex. 1-3). Therefore, contrary to claimant's contention, we need not proceed to the second step of the inquiry by analyzing the intent of the parties.

In *Jeffrey N. Davila*, 50 Van Natta 1687 (1998), the claimant suffered a low back injury in August of 1996. A carrier denied the claim for a lumbar strain. The claimant then entered into a DCS for his denied lumbar strain condition, which was approved by an ALJ. Subsequent to the claimant's signing the DCS, but before the ALJ's approval, an MRI and x-rays revealed the presence of low back degenerative disc disease, disc herniations and a disc bulge. Following the ALJ's approval, the claimant filed a claim for lumbar spondylosis, herniated discs at L4-5 and L5-S1 and a bulging disc at L3-4 as related to the August 1996 injury. The carrier denied the claim, contending that the newly claimed conditions were raised or raisable at the time the parties entered into the DCS. We rejected the carrier's argument, holding that the claimant was not barred from bringing the new claims, because the new conditions were not known to the parties at the time they entered into the DCS. 50 Van Natta at 1689. *See also Nancy L. Pendergast-Long*, 48 Van Natta 2334, 2335, *on recon* 48 Van Natta 2517 (1996)(L5-S1 disc derangement condition was not diagnosed at the time of the DCS, therefore the claimant's later claim for that condition was not barred).

Here, by contrast, the parties were aware of the existence of claimant's left shoulder impingement syndrome at the time they entered into the February 9, 1999 DCS. (Ex. 1-3). The fact that the parties referred to the condition, by interlineation, as a "left shoulder *Type II acromion* impingement syndrome" only served to further specify the condition. (Ex. 1-3). It did not, as claimant contends, render claimant's Type II acromion a "preexisting condition" subject to consideration as merely one factor in claimant's current left shoulder condition. *See Raymond Meredith*, 42 Van Natta 816 (1990).

Moreover, claimant did not enter into a DCS of her "Type II acromion" condition only. Rather, the DCS particularly refers to the left shoulder impingement syndrome, the condition for which she currently seeks benefits. Viewed another way, as the ALJ reasoned, the Type II acromion condition was the cause of, or at least predisposed claimant to developing, the left shoulder impingement syndrome which was the subject of the DCS. *(See* Ex. 8-2).

Because we agree with the ALJ that claimant is barred from pursuing this claim by the earlier DCS, we need not address claimant's arguments directed to the merits of the compensability issue.

ORDER

The ALJ's order dated December 3, 1999 is affirmed.

April 6, 2000 Cite as 52 Van Natta 631 (2000)

In the Matter of the Compensation of
LARRY S. ARTMAN, Claimant
WCB Case No. 99-03834, 98-03404 & 98-04315
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Julie Masters (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the SAIF Corporation's compensability and responsibility denials, on behalf of the City of Coos Bay, of his disc herniations at C5-6 and C6-7; and (2) upheld GAB Robins North America, Inc.'s compensability and responsibility denials, on behalf of OMI, Inc., of the same condition. On review, the issues are compensability and, potentially, responsibility.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich dissenting.

The majority adopts and affirms the ALJ's order that concluded that claimant did not meet his burden of proving compensability. Because I disagree with the majority's (and ALJ's) analysis of the medical opinions, I respectfully dissent. I agree with claimant that Dr. Bernstein's reports, when read as a whole and in the context of the medical record, are sufficient to establish that his December 2, 1997 injury was the major contributing cause of his disc herniations at C5-6 and C6-7.

It is first necessary to briefly recount the factual and procedural background of this case. Claimant began working for the employer in 1989. His duties included cleaning, maintaining and repairing sewer lines and storm drains. (Tr. 11, 12). On June 21, 1996, claimant injured his right shoulder and right trapezius at work. (Ex. 3, Tr. 13-14). SAIF accepted a disabling right trapezius strain. (Ex. 11). Claimant returned to regular work without any problems. (Tr. 15-16). A November 27, 1996 Notice of Closure did not award any permanent disability. (Ex. 20).

On or about December 2, 1997, claimant lifted a very heavy manhole cover and felt a twinge where his shoulder met his neck on the right. (Tr. 17-19). Over the course of the day, he developed severe pain in his right neck and shoulder. (Tr. 20). He sought treatment from Dr. Laudenschlager. (Exs. 26, 29). A December 24, 1997 MRI showed disc protrusions at C5-6 and C6-7 that mildly contacted the spinal cord. (Ex. 38). GAB Robins North America, Inc., on behalf of OMI, Inc., accepted a disabling cervical strain. (Ex. 47).

Claimant continued to have symptoms in his neck and right arm and Dr. Bert recommended surgery. (Ex. 50). On June 11, 1998, Dr. Bert performed an anterior cervical discectomy and fusion at C5-6 and C6-7. (Ex. 63). He removed a very large free fragment at C6-7. (*Id.*)

Dr. Bernstein was claimant's treating neurologist. He had been treating claimant since August 1994. (Ex. 1). Dr. Bernstein treated claimant again on April 29, 1997 and December 18, 1997. (Exs. 21, 32, 33, 34). Dr. Bernstein concluded that claimant's December 2, 1997 injury was the the major contributing cause of his cervical disc herniations. (Ex. 73).

A medical opinion must be evaluated in the context in which is was rendered in order to determine its sufficiency. *Worldmark the Club v. Travis*, 161 Or App 644 (1999); *SAIF v. Strubel*, 161 Or App 516 (1999). In the present case, I agree with claimant that the preexisting degenerative disc disease findings carry little significance in the context of this case. Dr. Bernstein reported that claimant's degenerative changes were average for persons of his age. (Ex. 76). Dr. Bernstein's comment is consistent with the February 10, 1998 findings of Dr. Farris, who concluded that claimant's preexisting degenerative changes at C5-6 and C6-7 did not play a significant role in the December 2, 1997 injury. (Ex. 46-5).

Dr. Bernstein was in a unique position because he had examined claimant and treated him before, during and after his injuries. He was aware that claimant had been doing heavy work and was asymptomatic until his December 2, 1997 injury. Dr. Bernstein reported that claimant's history was highly consistent with the pathology demonstrated at surgery. (Ex. 76). Moreover, he did not believe it was likely that claimant could have worked with this lesion. (*Id.*)

I agree with claimant that Dr. Bernstein properly evaluated the relative contributions of the preexisting degenerative condition and the work injury. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Dr. Bernstein's reports, when read as a whole and in context with the medical record, provide much more than "precipitating cause" analysis. The majority and the ALJ err by not relying on Dr. Bernstein's opinion and finding this claim compensable.

In the Matter of the Compensation of
JEFFREY L. PROCIW, Claimant
WCB Case No. 98-08108
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

On March 21, 2000, we withdrew our February 24, 2000 order that: (1) set aside the SAIF Corporation's denial of claimant's C5-6 disc herniation; and (2) awarded a $4,500 insurer-paid attorney fee. We took this action in response to SAIF's announcement that the parties had resolved their dispute and would be submitting a settlement for our consideration. The parties have submitted a Stipulation and Disputed Claim Settlement Agreement" to resolve all issues raised or raisable, including those pending before the Hearings Division in WCB Case No. 99-08818. That portion of the settlement that pertains to issues pending before the Hearings Division has received ALJ approval.

Pursuant to the settlement, the parties agree that SAIF's denial, as supplemented in the agreement, shall remain in full force and effect." The settlement further provides that claimant withdraws his hearing request, which "shall be dismissed with prejudice."

We approve that portion of the parties settlement that pertains to issues pending before the Board, 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
LORENZO K. KIMBALL, Claimant
WCB Case No. 99-06601
ORDER ON RECONSIDERATION
Parker, Bush & Lane, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Claimant requests reconsideration of the attorney fee section of our March 15, 2000 order. Specifically, claimant contends that he is also entitled to an attorney fee under ORS 656.382(2) for services at hearing.

The insurer objects to an assessment of attorney fees pursuant to ORS 656.382(2). The insurer argues that claimant did not prevail against the insurer's request for a hearing. Rather, the insurer reasons that claimant obtained an increase in the compensation awarded by the ALJ as a result of his request for Board review. The insurer contends that there is no statute or rule that authorizes the Board to assess a fee under these circumstances.

In *Patricia L. McVay*, 48 Van Natta 317 (1996), we addressed the issue of whether an insurer-paid attorney fee under ORS 656.382(2) is appropriate for services at both hearing and on review, where, as here, an ALJ, in response to an insurer's hearing request, reduced the amount awarded by an Order on Reconsideration and, on Board review of a claimant's appeal, we reinstated the Order on Reconsideration award. In *McVay*, we concluded that the claimant was entitled to an insurer-paid attorney fee award under ORS 656.382(2), but only for services at the hearings level. We reasoned that, although the insurer was initially successful in its quest for a reduction of permanent disability awards granted by an Order on Reconsideration, it was ultimately unsuccessful by virtue of our order, and, since our order replaced that of the ALJ, it necessarily followed that the claimant was entitled to an insurer-paid fee for her counsel's services at the hearings level. Moreover, because claimant's attorney was already receiving a fee for efforts on claimant's request for Board review of the ALJ's order payable from the "increased" compensation created by our modification of the ALJ's order under ORS 656.386(2) and OAR 438-015-0055(1) (as is the case here as well), it followed that the claimant's counsel was not entitled to an insurer-paid attorney fee for such efforts on Board review.

Based on *McVay*, we find that claimant's entitlement to an insurer-paid attorney fee award is limited to his counsel's services at the hearings level. After consideration of the factors in OAR 438-015-0010(4), we find that a reasonable attorney fee award for claimant's counsel's services at hearing in defense of the Order on Reconsideration's permanent disability award is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented herein, we republish our March 15, 2000 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
MARK A. VICHAS, Claimant
Own Motion No. 00-0066M
OWN MOTION ORDER
Richard O. Nesting, Claimant Attorney

On February 15, 2000, claimant submitted a request for own motion benefits relating to his 1982 low back claim. Claimant's aggravation rights expired on July 28, 1988. Claimant contends that, as of the date of his request, the self-insured employer had not paid any temporary disability compensation or medical benefits. Therefore, claimant contends that he is entitled to a penalty and/or an attorney fee for unreasonable claim processing. On February 24, 2000, the employer submitted its recommendation to reopen claimant's 1982 claim for the payment of temporary disability 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 claimant is actually hospitalized or undergoes outpatient surgery. *Id.*

Claimant underwent surgery on November 18, 1999. Therefore, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning November 18, 1999, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055. We now turn to the penalty/attorney fee issue.

Claimant seeks penalties and attorney fees for the employer's allegedly unreasonable delay in processing his own motion claim for temporary disability compensation. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of up to 25 percent of the amounts "then due." The employer's refusal to pay compensation is not unreasonable if it has legitimate doubt about its liability. *Castle & Cook, Inc. v. Porras*, 103 Or App 65 (1990).

OAR 438-012-0030(1) provides that a carrier is required to submit its own motion recommendation within 90 days of receipt of an own motion claim for temporary disability compensation. A carrier is deemed to have notice of an own motion claim upon receipt of any document that reasonable notifies the carrier that claimant's compensable injury requires surgery or hospitalization. *See* OAR 438-012-0020(3)(b).

By chart note dated July 22, 1999, Dr. Takacs reported that Dr. Trieble was recommending surgery. The employer received Dr. Takacs' chart note on August 27, 1999. We conclude that Dr. Takacs' July 22, 1999 chart note reasonably notified the employer that claimant's compensable condition had worsened and required surgery. The employer did not submit its recommendation to the Board until February 24, 2000, well beyond the 90-day period following claim filing. Under these circumstances, we find the employer's failure to process claimant's Own Motion claim to be unreasonable.[1]

However, a penalty may not be assessed under ORS 656.262(11)(a) unless there is an unpaid amount of compensation "then due" upon which to base the penalty. *Wacker Siltronic Corporation v. Satcher*, 91 Or App 654, 658 (1988). At the time claimant requested temporary disability compensation, his claim was closed and could only be reopened under our own motion jurisdiction. When a claim is under own motion jurisdiction, no compensation is due claimant until we issue an order reopening the claim. Thus, a penalty cannot be assessed under ORS 656.262(11)(a). *See Thomas L. Abel*, 44 Van Natta 1039, *on recon* 44 Van Natta 1189 (1992); *Fredrick D. Oxford*, 42 Van Natta 476 (1990).

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[1] In reaching this conclusion, we acknowledge the employer's assertion that it had raised compensability issues, *i.e.*, its May 7, 1999 denial, as well as questioning the reasonableness and necessity of the surgery. However, OAR 438-012-0030(1) requires a carrier to submit an Own Motion Recommendation regardless of whether a compensability denial has issued. In fact, the Own Motion Recommendation Form contains a space to indicate if there are pending denials on the claim. Had the employer timely submitted its recommendation, the Board would have likely then deferred action pending the outcome of the compensability litigation. *See* OAR 438-012-0050(1)(b).

On the other hand, where, as here, we find that an employer has unreasonably resisted the payment of compensation, we may assess an attorney fee even in the absence of amounts of compensation "then due." *See* ORS 656.382(1); *Martinez v. Dallas Nursing Home*, 114 Or App 453 (1992); *Janet F. Berhorst*, 51 Van Natta 464 (1999); *Robert E. Cornett*, 45 Van Natta 1567 (1993). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services regarding claimant's request for own motion benefits is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (based on the record and claimant's submission), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

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

IT IS SO ORDERED.

April 7, 2000 Cite as 52 Van Natta 635 (2000)

In the Matter of the Compensation of
ANTHONY W. ABSHIRE, Claimant
WCB Case No. 99-01443
ORDER ON RECONSIDERATION
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our February 11, 2000 order that found that he was not entitled to an award for loss of shoulder strength. Specifically, claimant relies on OAR 436-035-0330(19) and OAR 436-035-0007(19)(b) to establish his loss of strength. We abated our February 11, 2000 in order to consider claimant's motion. Having received and considered the insurer's response to the motion, we proceed with our reconsideration.

In our previous order, we relied on the physical capacity evaluation (PCE) findings to determine claimant's loss of strength. The PCE found that claimant's left shoulder strength was rated as 4/5 flexion, 5-/5 abduction, 4-/5 internal rotation and 5-/5 external rotation. (Ex. 30-2).

OAR 436-035-0330(17) (WCD Admin. Order No. 98-055) provides, in part:

> "Injuries to a unilateral specific named peripheral nerve with resultant loss of strength in the shoulder or back shall be determined based upon a preponderance of medical opinion that reports loss of strength pursuant to OAR 436-035-0007(19) and establishes which specific named peripheral nerve is involved."

Claimant relies on OAR 436-035-0330(19), which provides:

> "Valid loss of strength to an unscheduled body part or area, substantiated by clinical findings shall be valued pursuant to section (17) of this rule as if the nerve supplying (innervating) the weakened muscle was impaired."

Claimant asserts that his loss of strength should be treated "as if" the nerve were damaged. He also relies on OAR 436-035-0007(19), which provides that the peripheral nerve or spinal nerve root that supplies (innervates) certain muscles may be identified by referencing current anatomy texts or the *AMA Guides to the Evaluation of Permanent Impairment*, 3rd Ed. (Revised), 1990 or 4th Ed., 1993.

The insurer contends that the record contains no information from which to conclude that claimant has strength loss attributable to either a nerve injury or a specific impaired muscle in the shoulder. The insurer argues there is no evidence in the record to suggest that claimant's PCE findings were attributable to muscle impairment, let alone a specific, identifiable muscle. For the following reasons, we agree with the insurer.

In *SAIF v. Calder*, 157 Or App 224, 227 (1998), the court said that the Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge. The issue in *Calder* was whether, in the Board's interpretation of the medical reports, it could reasonably find that the coracobrachial ligament was involved and that the claimant had suffered loss of strength in the right arm. The court found that it was appropriate for the Board to refer to the medical dictionary to determine what the coracobrachial ligament was. However, the court explained:

> "[T]he Board's opinion went beyond the dictionary definition and also beyond the reasonable inferences that could be drawn from the medical evidence. While it is true that the dictionary identifies the coracobrachial ligament as a ligament of the arm involved in flexion, Vigeland's operative report gave no indication that the coracobrachial ligament had been affected by the injury or the surgery. Scheinberg's report made no reference to loss of arm strength or to the coracobrachial ligament. The Board's finding of loss of arm strength is dependent on its own conclusion that, because the coracobrachial ligament was mentioned in Vigeland's report, it must have been involved in the loss of shoulder flexion noted in Scheinberg's report." *Id.* at 227-28.

The court concluded that the medical evidence did not support the finding that the claimant had experienced a loss of shoulder strength.

In the present case, we agree with the insurer that the record contains no information from which to conclude that claimant has strength loss attributable to either a nerve injury or a specific impaired muscle in the shoulder. The PCE evaluator provided no information regarding the source of claimant's loss of shoulder strength. Because the medical evidence is insufficient, we are unable to determine the appropriate peripheral nerve or spinal nerve root that supplies (innervates) certain muscles even by referring to the resources identified in OAR 436-035-0007(19)(b). Under these circumstances, we adhere to our previous conclusion that claimant is not entitled to an award for loss of shoulder strength.

Accordingly, on reconsideration, as supplemented herein, we republish our February 11, 2000 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
GERALD R. BALCOM, Deceased, Claimant
WCB Case No. 95-09867
ORDER ON REMAND
Robert E. Nelson, Claimant Attorney
Julene M. Quinn (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Balcom*, 162 Or App 325 (1999). The court has concluded that claimant (who died while the SAIF Corporation's appeal of our prior order, *Gerald Balcom*, 49 Van Natta 659 (1997), was pending judicial review) was not survived by anyone entitled to pursue his hearing request under ORS 656.218 and ORS 656.204. Consequently, the court has remanded with instructions to vacate our order and dismiss claimant's hearing request.

Consistent with the court's directive, we vacate our May 27, 1997 order and the Administrative Law Judge's October 28, 1996 order. Claimant's hearing request is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
TONI L. JOHNSON, Claimant
Own Motion No. 00-0068M
OWN MOTION ORDER ON RECONSIDERATION
Coughlin, Leuenberger & Moon, Claimant Attorneys
AIG Claims, Insurance Carrier

On March 22, 2000, we withdrew our March 17, 2000 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 she was in the work force at the time of her current disability. On 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.*

On October 28, 1999, Dr. Bills, claimant's attending physician, recommended that claimant undergo arthroscopic surgery for her compensable condition. On January 12, 2000, the insurer-arranged medical examiners (IME) concurred with Dr. Bills' surgical recommendation. Accordingly, we conclude that claimant's compensable injury has worsened requiring surgery.

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

On reconsideration, claimant submitted a March 15, 2000 affidavit stating that: (1) she worked as a cashier from April 1999 through June 1999 and from August 1999 through November 1999; (2) she quit working as cashier in early November 1999 because her doctor advised that continual standing was "detrimental" to her compensable condition"[1]; and (3) she continues to seek work and has submitted application for employment with several employers. In support of her contentions, claimant submitted copies of various letters of rejection from potential employers. Based on claimant's unrebutted statements and submissions, we conclude that she has established that she was willing to work and was making a reasonable effort to find work at the time of her current worsening.

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

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

IT IS SO ORDERED.

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[1] The IME doctors also concluded that claimant should not return to work as a cashier and should seek a job where she could primarily sit down and limit her walking and standing during work hours. In a March 8, 2000 medical report, Dr. Bills reached the same conclusion. He opined that claimant could not stand the time periods required to do the work as a cashier.

In the Matter of the Compensation of
CLIFFORD L. KAESEMEYER, Claimant
WCB Case No. 99-01741
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's partial denial of claimant's injury claim for current low back and right hip conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated October 21, 1999 is affirmed.

Board Member Phillips Polich dissenting.

Claimant fell about 15 feet from a ladder at work in June 1997. The insurer accepted his injury claim for a low back strain and left wrist and ankle sprains. The claim was closed in October 1997 and claimant returned to work despite ongoing back and right hip pain.

In mid 1998, claimant sought treatment and filed an aggravation claim, which the insurer denied. The insurer also denied claimant's current spinal stenosis, disc prolapse, degenerative disc disease at L2-3, L3-4, and L4-5, and right hip degenerative arthritis conditions.

Dr. Travers provides the most well-reasoned expert evidence. He explained that claimant's work injury was the major contributing cause of claimant's current low back and right hip conditions because the injury was sufficient to worsen claimant's preexisting degenerative conditions rapidly and significantly. Dr. Travers opined that the accepted "lumbar strain" was only a minor component of the total injury sustained. He explained that the injury caused trauma to multiple lumbar discs; that trauma weakened "the fibers of the annulus fibrosus at all levels[;]" and subsequent narrowing of the discs caused neuroforaminal impingement. (Ex. 29). Considering the severity of the injury and the nature of claimant's conditions, Dr. Travers further reasoned that the fall at work (not normal aging or minor injuries) was the primary cause of claimant's current low back and right hip conditions. (*Id*). Thus, Dr. Travers examined the factors contributing to claimant's current problems and explained how and why claimant's work injury was the primary contributor. His opinion is the most consistent with claimant's history of only minor problems before the work injury and ongoing serious problems since the injury.

The remaining medical evidence attributes claimant's current conditions to preexisting degenerative disease. But these conclusions are not consistent with the severity of claimant's 15 foot fall at work or the fact that he was asymptomatic before the injury. Under these circumstances, I would rely on Dr. Travers and find claimant's conditions compensable, based on his well-reasoned opinion. *See Somers v. SAIF*, 77 Or App 259 (1986).

Finally, I would note that claimant bears the burden of proving his claim by a preponderance of the evidence and he has carried that burden, based on Dr. Travers' opinion. The majority's opinion to the contrary effectively and impermissibly increases claimant's burden. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
MARK A. LANTZ, Claimant
WCB Case Nos. 99-04948 & 99-01696
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld Liberty Northwest Insurance Corporation's denial (on behalf of Master Fire Control) of claimant's occupational disease claim for his cervical condition; and (2) found that claimant's injury claim for his cervical condition was untimely filed. On review, the issues are compensability and, potentially, responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the following correction. Claimant first sought treatment for a cervical problem on September 25, 1998, rather than on September 25, 1995.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the ALJ erred in failing to find his claim compensable under the last injurious exposure rule. Claimant argues that his cervical condition is an occupational disease that is the result of his repetitive work activities for Master, Liberty's insured. We disagree.

The record, including claimant's testimony, establishes that claimant sustained an injury while working for Basic, SAFECO's insured, in February 1998. Claimant testified that, in February 1998, he remembered "a significant event that was a popping in my neck...". (Tr. 12). The incident occurred while claimant was pulling on a pipe wrench. Claimant felt some neck pain which eventually progressed to include arm numbness. (Tr. 18). Prior to the February 1998 incident, claimant had never felt a similar pop in his neck. (Tr. 21). Claimant did not seek medical treatment for his symptoms, however, until September 1998, while he was employed with Master. (Tr. 14).

The persuasive expert medical opinions also establish that claimant experienced an injury, rather than an occupational disease. Dr. Rohrer, neurosurgeon, treated claimant after a referral from claimant's treating doctor, Dr. Lorish. Dr. Rohrer also performed claimant's discectomies and fusions at C5-6 and C6-7. Dr. Rohrer reported that claimant's cervical disc condition originated in February 1998. (Ex. 22). According to Dr. Rosenbaum, based on claimant's report of a specific incident in February 1998, it was most likely that claimant's disc herniation originated at that time and eventually resulted in his need for surgery. Dr. Rosenbaum did not believe that claimant's subsequent work activity was a major cause of claimant's need for surgery. (Ex. 21). Finally, while Drs. Zivin and Gripekoven believed that it would be speculative to state that the herniation occurred in February 1998, they acknowledged that claimant may have had an annular ligamentous tear at that time. (Ex. 20C-6). The doctors also noted that claimant had underlying degenerative disc disease and even a trivial event could have resulted in a herniation under the "most trivial of circumstances." (Ex. 20C-5).

Accordingly, after reviewing claimant's testimony and the expert medical opinions, we do not find a persuasive expert opinion that establishes that claimant's condition is the result of his repetitive work activities, rather than an injury with Basic.[1] *Valtinson v. SAIF*, 56 Or App 184 (1982).

Consequently, even if claimant could establish a timely "injury" with SAFECO's insured, in order to shift compensability/responsibility, he must prove a pathological worsening of his cervical condition. However, the persuasive medical evidence fails to establish such a worsening. Alternatively, we conclude that, even if claimant did establish an "injury" with Master, he would not prevail under ORS 656.308(1), as his work at Master is not the major contributing cause of his disability or need for treatment for the combined condition.

[1] Claimant has not challenged that portion of the ALJ's order that found that his injury claim against Basic, SAFECO's insured, was untimely filed.

Therefore, we agree with the ALJ that claimant has not met his burden of proof with respect to the issue of compensability, and we affirm the ALJ's order.

ORDER

The ALJ's order dated September 30, 1999 is affirmed.

In the Matter of the Compensation of
LARRY L. LITTLE, Claimant
WCB Case Nos. 99-05373 & 99-01897
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its compensability and responsibility denial of claimant's current low back condition; and (2) upheld the insurer's denial of responsibility for the same condition. On review, the issues are compensability and responsibility.[1]

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

We would reach the same result if we analyzed this case under *Conner v. B & S Logging*, 153 Or App 354 (1998), and ORS 656.005(7)(a)(A), instead of *Sisters of Providence v. Ridenour*, 162 Or App 467 (1999), and *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984), based on Dr. Nash's persuasive opinion that claimant's 1998 injury was the major contributing cause of claimant's current need for treatment for his low back. *See, e.g., Dennis D. Hall*, 51 Van Natta 1537 (1999).

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

ORDER

The ALJ's order dated December 7, 1999 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the SAIF Corporation.

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[1] Claimant asks us to affirm the ALJ's order. Alternatively, claimant argues that the insurer, rather than SAIF, should be responsible for claimant's low back condition. We do not reach claimant's alternative argument, because we agree with the ALJ that SAIF is responsible.

In the Matter of the Compensation of
DALE A. PETERSON, Claimant
WCB Case No. 99-05829
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's partial denial of claimant's current L5-S1 condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated December 15, 1999 is affirmed.

Board Member Phillips Polich dissenting.

Claimant injured his low back at work in California about ten years ago and he had surgery at L5-S1 for that injury. After recovering from the surgery, claimant returned to work. He had only occasional back aches and no treatment for his back until May 26, 1998. That day, claimant fell on a hard surface at work, landing on his buttocks, tailbone, and back. He experienced immediate back pain, which increased thereafter. An MRI revealed chronic degenerative disc disease at L5-S1, disc slippage, epidural scarring, and foraminal stenosis at that level.

Dr. Kitchel performed surgery on claimant for his L5-S1 degenerative disc disease on February 18, 1999. Dr. Kitchel considered claimant's preexisting contributory factors (the prior L5-S1 herniation, surgery, related scarring, and age-related degeneration) and opined that claimant's 1998 work injury caused his previously asymptomatic condition to become symptomatic. In reaching this conclusion, Dr. Kitchel noted that claimant had recovered well from his prior surgery and performed fairly heavy work for years without back problems. He also stated that claimant's 1998 injury was a rather traumatic incident and claimant's discogram (concordant for an L5-S1 disc lesion) was consistent with damage to the disc sustained in the 1998 fall. Thus, considering claimant's findings and his clinical course, Dr. Kitchel concluded that the 1998 fall at work was the major contributing cause of claimant's recent need for medical treatment.

I would rely on Dr. Kitchel, because he was claimant's treating surgeon and his opinion is well-reasoned. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
KEVIN E. THOMPSON, Claimant
WCB Case No. 99-05300
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that upheld the SAIF Corporation's denial of his injury claim for a C5-6 disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated November 30, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority adopts and affirms the ALJ's order, which concluded that claimant did not sustain his burden of proving compensability of his C5-6 disc condition. Because I disagree with the majority's (and ALJ's) analysis of the medical evidence, I respectfully dissent.

To begin, it is important to focus on the seriousness of claimant's November 30, 1998 injury. Claimant, a truck driver, was driving his route when one of the tires blew out. He drove onto the shoulder of the road, but the shoulder was soft and collapsed under his truck. The truck and trailer tipped over the right side, causing the cab to split open. Claimant was bruised and shaken up and had headaches and severe pain in the neck and back. He also felt stabbing pain in the chest when breathing, and numbness and tingling in both arms.

Claimant was initially diagnosed with a concussion and cervical and lumbar strains. (Exs. 3, 5). SAIF accepted the claim for concussion, lumbar strain, cervical strain, and left 3rd and 4th rib fractures. (Exs. 10, 23).

Claimant continued to have ongoing headaches, neck pain and chest pain. (Exs. 13, 15). In February 1999, he sought emergency room treatment for chest and back pain, and worsening numbness/weakness in both arms and hands down to the thumbs, index fingers, and middle fingers. (Exs. 17, 19). Dr. Preston initially diagnosed a C5-6 herniated disc with right upper extremity radiculopathy. (Ex. 22). He subsequently revised his diagnosis to discogenic pain syndrome at C5-6 and C6-7. (Ex. 42-2).

Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, there are no persuasive reasons not to defer to the opinion of Dr. Preston, claimant's attending physician. Dr. Preston acknowledged there was radiographic evidence of preexisting degenerative disc disease, but he noted that claimant had been asymptomatic until after the work injury. (Ex. 42-2). Claimant had no prior history of neck or arm pain. (*Id.*) Dr. Preston concluded that claimant's current pain was a direct result of his work-related injury. (*Id.*)

In a later report, Dr. Preston said that claimant's work injury was the major cause of his current cervical complaints. (Ex. 42B). He explained that claimant had significant discal injuries at C5-6 and C6-7, which were responsible for his current pain and were caused by the work injury. (*Id.*) Dr. Preston's opinion is persuasive because it is well-reasoned and based on an accurate history. Dr. Preston's opinion on causation is supported by Dr. Wesely, who agreed with Dr. Preston and noted that claimant had neck pain after his work injury, but had no previous neck pain. (Ex. 45).

The contrary medical opinions fail to explain why claimant had no neck pain before the work injury, but had significant cervical symptoms after the injury. The conclusory, "check-the-box" opinions of Drs. McKillop, Bell and Reimer that claimant's preexisting degenerative disc disease was the major cause of his discogenic pain are simply not persuasive, particularly after considering the severity of claimant's November 30, 1998 accident.

Claimant has the burden of proving, by a preponderance of the evidence, that his claim is compensable. In this case, the preponderance of evidence establishes that claimant's November 30, 1998 work injury was the major contributing cause of his C5-6 disc condition. Here, however, the majority has disregarded that measurement and applied a more stringent burden of proof. The majority errs by not finding this claim compensable.

In the Matter of the Compensation of
CHARLOTTE L. VALDIVIA, Claimant
Own Motion No. 00-0018M
OWN MOTION ORDER
Swanson, Thomas & Coon, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable bilateral foot condition. Claimant's aggravation rights expired on April 15, 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.*

A November 4, 1999 operative report documents that claimant underwent hardware removal in her right great toe. On this record, we conclude that claimant's compensable injury worsened requiring surgery on November 4, 1999, which is the time of disability.[1]

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 fails to meet any of the criteria set forth in *Dawkins*. Claimant contends that, although she was not working at the time of her current worsening, she was willing to work and was seeking work within her limitations. Claimant submitted a January 27, 2000 affidavit in support of her contentions. We review the history of the claim along with the additional documentation in an effort to fully address both parties' contentions.

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[1] The "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction (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)), is the date she enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996). The relevant time period for which claimant must establish she was in the work force is the time prior to her November 4, 1999 hospitalization when her condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

On December 10, 1997, we issued an Own Motion Order authorizing reopening of claimant's bilateral foot claim for the provision of temporary disability compensation. This reopening was based on an August 1996 surgery for claimant's right foot. On September 17, 1999, SAIF issued a Notice of Closure which closed her claim with an award of temporary disability compensation from August 7, 1996 through September 8, 1999. SAIF declared claimant medically stationary as of September 8, 1999. That closure was not appealed.

On January 6, 2000, SAIF submitted its Own Motion Recommendation form which recommended denying reopening because claimant failed to establish that she was in the work force at the time of the current worsening. With its recommendation, SAIF submitted a November 4, 1999 operative report demonstrating that claimant underwent surgery on her right foot.

In her January 2000 affidavit, claimant contends that the 1997 reopening was for a worsening to her *right* foot. She explains that when her claim was closed in September 1999, her doctor had indicated to her that she was going to require surgery to her *left* foot and that such surgery was eminent. Accordingly, she did not seek work from September 9 through December 2, 1999 expecting to undergo surgery "any day now." When authorization for the requested surgery on her *left* foot was not forthcoming, claimant outlines an extensive job search beginning December 9, 1999. Finally, claimant attests that she has been willing to work since her release in September 1999 and would have sought work but she "thought the treatment for [her] compensable injury (the upcoming surgery) made a job search futile." Based on claimant's affidavit, we find that she is willing to seek employment.

However, in order to prove that she is a member of the work force, claimant must also satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Based on the following, we find that claimant failed to satisfy those factors.

As noted above, the relevant time period to determine whether claimant was in the work force is at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). On this record, claimant's condition worsened requiring surgery on November 4, 1999 on her *right* foot, which is the date of disability. In her affidavit, claimant admits that she did not seek work for the period between September 9 and December 2, 1999, because *she* thought it was futile.

Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole, especially considering persuasive medical evidence regarding claimant's ability to work and/or seek work. *Jackson R. Scrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where record lacked persuasive medical evidence establishing that the claimant was unable to work and/or seek work due to the compensable injury). In short, the question is whether the work injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

Here, claimant does not offer a medical opinion that would support her "futility" contentions, nor does the record demonstrate that it would have been futile for her to work or seek work at the time of the current worsening. There is no medical evidence that demonstrates that surgery had been recommended for her *left* foot nor, more importantly, that it would have been futile for her to seek work while waiting for an "upcoming" surgery. Accordingly, claimant has not established that she was a member of the work force at the time of the current disability.

Accordingly, claimant's request for temporary disability compensation is denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY L. DAVIS, Claimant
Own Motion No. 00-0054M
INTERIM OWN MOTION ORDER CONSENTING TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

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 1986 injury claim with the SAIF Corporation expired on July 16, 1987. 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 1986 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
FRANCES M. MEAD, Claimant
WCB Case No. 98-03153
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employers denial of claimant's occupational disease for a bilateral foot and toe condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was required to wear steel-toed boots while working for the employer. Because the boots were uncomfortable, claimant placed pads in her boots. In March 1997, claimant sought treatment for pain in her left toenails. Eventually, claimant was diagnosed with foot fungus and her left great toenail was permanently removed.

The ALJ concluded that claimant did not prove that work activities were the major contributing cause of her foot fungus condition. Claimant challenges that order, alleging that the medical evidence carries her burden of proof.

The record contains two medical opinions. First, examining podiatrist Dr. Rothstein found that the major contributing cause of claimant's fungus condition was the occlusive environment caused by her use of pads in the boots; that is, Dr. Rothstein thought that claimant created a warm, damp area where the fungus was allowed to grow. (Exs. 7-5, 9-3, 13-18). Dr. Rothstein also explained that claimant's exposure to the fungus could have been anywhere and was less likely to have been at work because she wore boots. (Ex. 13-28).

During a deposition, claimants treating podiatrist, Dr. McClanahan, first indicated that claimants ill-fitting boots contributed to her condition and that the boots started the chain of events leading to the need for medical treatment. (Ex. 12-16, 12-21). After discussing all the possible contributors to claimant's foot condition, however, Dr. McClanahan agreed that he could not provide an opinion concerning causation without speculating. (*Id.* at 38, 40, 44). In particular, Dr. McClanahan stated that he could not state, without speculating, what caused claimants foot fungus. (*Id.* at 38).

In evaluating medical opinion evidence, we defer to the treating physician absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find no reason not to defer to Dr. McClanahan's opinion in light of his familiarty with claimant's condition and the well-reasoned nature of his opinion. Thus, we find Dr. McClanahan's opinion persuasive.

We find Dr. McClanahan's opinion, however, insufficient to satisfy claimants burden of showing that employment conditions were the major contributing cause of her foot fungus condition. First, because Dr. McClanahan could not provide an opinion without speculating, we find that he did not provide an opinion based on medical reasonableness. Furthermore, although Dr. McClanahan related claimant's boots and use of occlusive materials to the fungus condition, he did not indicate that such factors were the major contributing cause.[1] Finally, even assuming that Dr. Rothstein's opinion is equally persuasive and supports causation, we conclude that, at best, the medical opinion evidence is in equipoise. Consequently, we agree with the ALJ that claimant did not carry her burden of proof. *See* ORS 656.802(2).

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[1] Claimant argues that Dr. McClanahan's opinion nevertheless satisfies her burden of proof because, at the end of the deposition, he agreed that the largest factors in causing claimants condition were her ill-fitting boots and the occlusive devises. (Ex. 12-48). We do not agree that Dr. McClanahan's indication that such factors were the largest means that they were the major contributing cause of claimant's condition, especially in light of his repeated statements and agreement that he could not provide such an opinion without speculating.

ORDER

The ALJ's September 30, 1999 order is affirmed.

April 10, 2000 Cite as 52 Van Natta 647 (2000)

In the Matter of the Compensation of
FIDEL H. PEREZ, Claimant
WCB Case No. 99-03654
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that set aside its denials of claimant's injury claim for cervical and lumbar conditions. On review, the issue is compensability.

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

The ALJ set aside SAIF's denials of claimant's cervical, lumbar, and right shoulder strain conditions, as well as its denial of claimant's right scapular winging condition. The ALJ relied on the opinion of claimant's treating physician Dr. Chandler. On review, SAIF contends that claimant had preexisting degenerative conditions which contributed to his neck and back strain conditions, and that claimant failed to meet his burden of proving that his January 19, 1999 injury was the major contributing cause of his disability or need for treament of these conditions. *See* ORS 656.005(7)(a)(B). For the following reasons, we disagree with SAIF's contentions.

Because of the presence of claimant's preexisting degenerative conditions in his cervical and lumbar spine, this case presents a complex medical question, resolution of which depends on expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967).

Here, all medical opinions are in agreement that claimant's injury combined with his preexisting degenerative disk disease to cause his disability and need for treatment for his cervical and lumbar strain conditions. (Exs. 12A, 16). Claimant's treating physician, Dr. Chandler, diagnosed "Cervical spondylosis, with superimposed strain, lumbar spondylosis with superimposed strain, shoulder strain with impingement, knee strain." [citations to diagnosis codes omitted] (Ex. 12A-1). Drs. Stanford and Watson, who performed an examination at the request of SAIF, similarly diagnosed "preexisting mild degenerative spondylosis, cervical and lumbar." (Ex. 12-6).

Therefore, claimant must prove that his January 19, 1999 on-the-job injury was the major contributing cause of his disability and need for treatment for his cervical and lumbar strain conditions. ORS 656.005(7)(a)(B). We will defer to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Claimant's treating physician Dr. Chandler agreed that claimant's work injury was the major contributing cause of his disability and need for treatment for his cervical and lumbar strain conditions. (Ex. 16-2). Dr. Chandler's concurrence opinion, as well as his earlier chart note, demonstrates that he was aware of and considered the effects of claimant's preexisting cervical and lumbar spondylosis. (Exs. 12A-1, 16-2).

In contrast, Drs. Stanford and Watson uncovered no objective findings of any condition, with the exception of claimant's scapular winging condition. (Ex. 12-6). However, in his deposition, Dr. Watson agreed that claimant's on-the-job injury had initially combined with the effects of his preexisting degenerative conditions to cause symptoms in his cervical and lumbar spine. (Ex. 19-29). With that acknowledgment in mind, we do not find persuasive reasons not to defer to the opinion of Dr. Chandler. Accordingly, we agree with the ALJ that claimant met his burden of proving the compensability of his cervical and lumbar strain conditions on a major contributing cause basis.

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 $752, 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 his counsel's uncontested statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 8, 1999 is affirmed. For services on review, claimant's attorney is awarded $752, payable by SAIF.

In the Matter of the Compensation of
EDWARD T. ROTHAUGE, Claimant
Own Motion No. 66-0410M
OWN MOTION ORDER ON RECONSIDERATION
John C. DeWenter, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our March 15, 2000 Own Motion Order Referring for Fact Finding Hearing. In that order, we concluded that the record before us was inadequate to determine whether we should authorize payment of requested medical services regarding claimant's November 21, 1950 low back injury condition. We also stated that, in order to establish that his current need for medical treatment is compensably related to his 1950 work injury, claimant must demonstrate that the need for treatment bears a material relationship to the compensable work injury. *Beck v. James River Corp.*, 124 Or App 484, 487 (1993).

On reconsideration, SAIF asserts that claimant has multiple degenerative spinal conditions that are consequential or combined conditions and that it is those conditions for which claimant is currently seeking treatment. Furthermore, SAIF contends that, if its assertions are true, then the legal causal relationship standard required is major contributing cause, not material contributing cause. Based on these arguments, SAIF requests that we issue a revised order, deleting the discussion of *Beck* and revising our instructions to the Administrative Law Judge (ALJ) assigned to perform the fact finding hearing.

After considering SAIF's arguments, we proceed with our reconsideration.

We are referring this claim for a fact finding hearing because the record before us is inadequate to decide the issue of whether we should authorize payment under ORS 656.278(1)(b) of the requested medical services regarding claimant's pre-1966 low back injury condition. By the same token, the record before us is inadequate to resolve the factual contentions (which are the basis for SAIF's "standard of proof" argument) SAIF makes in its request for reconsideration.

At the fact finding hearing, however, the parties may present their arguments and any supporting evidence regarding the appropriate standard of proof that claimant must meet to establish entitlement to medical services regarding his 1950 back injury claim under the facts of this case.

Accordingly, we withdraw our March 15, 2000 order. On reconsideration, as supplemented herein, we republish our March 15, 2000 Own Motion Order Referring for Fact Finding Hearing.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARTHUR A. CONNER, Claimant
WCB Case No. 98-08640
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Reinisch, Mackenzie, et al, Defense Attorneys

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denial of his injury claim for a left knee condition. On review, the issue is compensability. We affirm.[1]

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that the ALJ erred by determining that his work injury did not "arise out of" his employment. We need not address that particular argument on review, because even if we assume that claimant is correct, we agree with the employer that the medical evidence is not sufficient to establish that claimant's work incident was the major contributing cause of his need for treatment or disability of his left knee condition.

Dr. Zimmerman, claimant's attending physician, agreed that the September 21, 1998 injury combined with a preexisting condition to cause disability and the need for treatment. (Ex. 32-1). An April 16, 1999 MRI of claimant's left knee showed a complex tear and degenerative change in all of the medial meniscus except for the anterior horn, a tear in the deep fibers of the medial collateral ligament and degenerative changes in the articular cartilage of the medial compartment. (Ex. 31). Based on Dr. Zimmerman's opinion, we find that claimant's injury combined with a preexisting condition to cause or prolong his disability or need for treatment. Therefore, claimant must establish that the September 21, 1998 work incident was the major contributing cause of his disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B).

Dr. Zimmerman provided a "check-the-box" opinion agreeing with claimant's attorney's statement that the September 21, 1998 injury was the major contributing cause (51 percent or more) of claimant's torn left medial meniscus. (Ex. 31). We find this opinion unpersuasive because it is lacking in explanation and analysis. *See Marta I. Gomez*, 46 Van Natta 1654 (1994) (Board will give little, if any weight, to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports).

Moreover, although Dr. Zimmerman acknowledged that claimant had a preexisting condition that combined with the injury, there is no evidence that he evaluated the relative contribution of the preexisting condition in determining causation. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (ORS 656.005(7)(a)(B) requires an assessment of the major contributing cause, which involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause). Although work activities that precipitate a claimant's injury or disease may be the major contributing cause of the condition, that is not always the case. *Id.* The medical expert must take into account all contributing factors in order to determine their relative weight. *SAIF v. Strubel*, 161 Or App 516, 521 (1999).

We acknowledge that a medical opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App at 521; *Worldmark the Club v. Travis*, 161 Or App 644 (1999). Here, however, there is no context within which to evaluate Dr. Zimmerman's opinion. Dr. Zimmerman did not discuss the nature of claimant's degenerative left knee condition in his reports or chart notes. We find nothing in the context of Dr. Zimmerman's reports to support the conclusion that he properly evaluated the relative contribution of claimant's degenerative left knee condition, particularly in light of the MRI report showing that claimant had "degenerative

[1] We note that neither party challenges that portion of the ALJ's order that denied the employer's motion to dismiss claimant's request for hearing. We adopt and affirm that portion of the ALJ's order.

change in all of medial meniscus except for the anterior horn," as well as degenerative changes in the articular cartilage of the medial compartment. (Ex. 31). *See Hugh J. O'Donnell*, 51 Van Natta 1394 (1999) (context of medical opinion did not cure the conclusory nature of the opinion). We conclude that the medical evidence is not sufficient to establish that claimant's work incident was the major contributing cause of his need for treatment or disability of his left knee condition.

Finally, we address the dissent's assertion that the only issue at hearing was "course and scope." Although the employer denied the claim on the basis that the injury was not caused by, and did not arise out of, claimants employment (Ex. 25), there is no evidence that the only issue at hearing was course and scope. At hearing, claimant's attorney said that the issue in dispute was "compensability" of the left knee injury. (Tr. 1). In the Opinion and Order, the ALJ referred to the medical causation issue, noting that Dr. Zimmerman's responses to questions regarding medical causation had no persuasive value because his opinion failed to analyze the risk factors as discussed by the ALJ.

In *Mary K. Phillips*, 50 Van Natta 519 (1998), we held that a denial stating that an injury did not occur in the "course and scope" of employment included the defense of medical causation. We reasoned that the course and scope denial mimicked the language in ORS 656.005(7)(a) by stating that the claimant's condition did not arise out of or in the course and scope of employment. Because of the similarity in language, we construed the denial as asserting that the claimant did not sustain a "compensable injury" or an "occupational disease." We relied on *Tektronix, Inc. v. Nazari*, 117 Or App 409, 411 (1992), *mod* 120 Or App 590 (1993), in which the court said that the "definition of 'compensable injury [in ORS 656.005(7)(a)], in particular the 'arising out of' language, encompasses the concept of medical causation[.]" *See also Vernon L. Minor*, 52 Van Natta 320 (2000) (the carrier's "course and scope" denial encompassed the issue of medical causation). We reach the same conclusion in this case.[2]

ORDER

The ALJ's order dated October 28, 1999 is affirmed.

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[2] In any event, we note that the employer specifically raised the issue of medical causation in its brief and claimant did not object in his reply brief. The dissent is addressing an issue not raised by claimant. Because claimant did not raise an issue about the scope of the employer's denial at hearing or on review, we will not address it. 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); *Sandra M. Goodson*, 50 Van Natta 1116 (1998).

Board Member Phillips Polich dissenting.

The majority determines that it is not necessary to address the course and scope issue in this case because claimant has not sustained his burden of proving medical causation. Because the majority erroneously addresses the issue of medical causation and misinterprets the medical evidence, I respectfully dissent.

In *Tattoo v. Barrett Business Services*, 118 Or App 348, 351 (1993), the court held that a carrier is bound by the express language of its denial. The court reasoned that, to hold to the contrary, would allow an employer to change what it had expressly said in a denial to the detriment of all parties who have relied on the language. *Id.* at 352.

Here, the employer denied the claim on the basis that claimant's left knee injury "was not caused by your employment, nor did it arise out of your employment." (Ex. 25). There is no evidence that the employer amended the denial at hearing to include the issue of medical causation. Moreover, the ALJ framed the issue as "claimant's appeal from an October 7, 1998 denial that his left knee condition arose out of his employment on or about September 21, 1998." (Opinion and Order at 1). The majority errs by addressing medical causation because the only issue at hearing was course and scope.

In any event, even if it is appropriate to address the issue of medical causation, the majority errs by misinterpreting Dr. Zimmerman's opinion. As the treating physician, Dr. Zimmerman's opinion on causation is entitled to deference. *See Weiland v. SAIF*, 64 Or App 810 (1983). Furthermore, there are no contrary medical opinions. I would find claimant's left knee injury claim compensable, based on Dr. Zimmerman's opinion.

Finally, the ALJ erred by concluding that claimant's injury did not "arise out of" his employment. Although the employer relies on *Johnson v. Beaver Coaches, Inc.*, 147 Or App 234 (1997), to argue that claimant failed to establish a causal connection between the injury and the work activity, the employer's reliance on that case is misplaced.

In *Robert L. Dawson*, 50 Van Natta 2110 (1998), *aff'd mem, Jackson Co. S-D # 5 v. Dawson*, 160 Or App 700 (1999), we explained:

> "Subsequent to the *Johnson [v. Beaver Coaches, Inc.,]* decision, the Oregon Supreme Court advised us that Oregon has 'rejected the largely obsolete "peculiar-risk" and "increased-risk" considerations in assessing whether a worker's injury was linked to a risk associated with employment.' *Redman Industries v. Lang*, 326 Or at 36. In addition, the Court reminded us that 'worker's compensation is a no-fault system that compensates a worker for injuries that arise out of and occur in the course of the worker's employment' and held that a claimant who injures herself while 'skip-stepping' around a corner in the workplace has sustained an injury that arises out of employment, even in the absence of some particular hazard arising from the employer's premises. *See Wilson v. State Farm Ins.*, 326 Or 413 (1998); *David L. Starkey*, 50 Van Natta 906 (1998) (Board Chair Bock concurring)."

In *Dawson*, the claimant, a bus driver, injured his ankle as he was returning to his bus after receiving an employer-arranged flu shot on the employer's premises. We concluded that, based on the totality of circumstances, the claimant's injury arose out of employment.

In *Wilson v. State Farm Ins.*, 326 Or 413 (1998), the claimant was injured when she was walking from her employer's office to her work area and "skip-stepped" around a corner. On Board review, we found no risk connected to the claimant's employment, noting that skipping was not the usual means for the claimant to go to her office. The Supreme Court rejected the Board's underlying premise, *i.e.*, that injuries are not compensable if the worker's method of carrying out a work-related activity was not a usual method of doing so. The court concluded that the claimant had satisfied the "arising out of" prong of the work-connection test by showing a causal link between her injury and her work.

Here, claimant injured his left knee as he was descending a flight of stairs on the employer's premises. His leg turned and he grabbed the railing. (Tr. 3, 9, 12). Based on these circumstances, I believe that claimant's injury "arose out of" his employment. There is no dispute that claimant was injured "in the course of" his employment.

In sum, claimant has the burden of proving compensability by a preponderance of the evidence. In this case, the preponderance of evidence establishes that claimant was injured in the course and scope of his employment and that he has established medical causation. The majority, however, has disregarded that measurement and applied a more stringent burden of proof. The majority errs by not finding this claim compensable.

April 10, 2000 Cite as 52 Van Natta 651 (2000)

In the Matter of the Compensation of
EDWIN B. SPURLING, Claimant
WCB Case No. 99-06294
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its partial denial of claimant's current bilateral hearing loss condition. Claimant cross-requests review, seeking sanctions, penalties, and increased attorney fees. On review, the issues are compensability, sanctions, penalties, and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation to address the penalty, sanctions and attorney fee issues.

Claimant requests sanctions under ORS 656.382(3) and ORS 656.390. We deny claimant's requests.

ORS 656.382(3) provides:

> "If upon reaching a decision on *a request for hearing initiated by an employer* it is *found by the [ALJ]* that the employer initiated the hearing for the purpose of delay or other vexatious reason or without reasonable ground, *the [ALJ] may order* the employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances." (Emphasis added).

Claimant is not entitled to a penalty under ORS 656.382(3) for two reasons: First, claimant requested the hearing, and second, the statute provides that only an ALJ may order such a penalty.

ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see also Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996).

The employer has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the argument on review did not ultimately prevail, we cannot say it is "frivolous." *Jack B. Hooper*, 49 Van Natta 669 (1997); *Donald M. Criss*, 48 Van Natta 1569 (1996). Accordingly, we deny claimant's request for sanctions.

Claimant has also requested "additional attorney fees" under ORS 656.386(1). If claimant is requesting an additional fee for services at Board level under ORS 656.386(1), claimant is not entitled to such a fee. Claimant did not initiate the appeal of the ALJ's order. Moreover, he finally prevailed over the employer's denial at the hearing level and has already been awarded an appropriate fee under ORS 656.386(1).

If claimant is requesting an increased fee for services at hearing, we find that the ALJ's explanation supporting the award of a carrier-paid $3,500 attorney fee satisfies the requirements presented in OAR 438-015-0010(4) and *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).

We next turn to claimant's request for additional attorney fees under ORS 656.385(2) and a penalty under ORS 656.385(4).[1] We deny the requests, because neither the Hearings Division nor the Board may award penalties or attorney fees in regard to matters arising under the review jurisdiction of the Director. ORS 656.385(5);[2] *see also Glen A. Bergeron*, 51 Van Natta 900 (1999).

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[1] ORS 656.385(2) provides:

> "If an insurer or self-insured employer refuses to pay compensation due under ORS 656.245, 656.260, 656.327 or 656.340 *pursuant to a final contested case order of the director*, order of the court or otherwise unreasonably resists the payment of such compensation, the insurer or self-insured employer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee * * * *." (Emphasis added).

ORS 656.385(4) provides:

> "If upon reaching a final contested case decision where such contested case was initiated by an insurer or self-insured employer it is *found by the director* that the insurer or self-insured employer initiated the contested case hearing for the purpose of delay or other vexatious reason or without reasonable ground, *the director may order* the insurer or self-insured employer to pay to the claimant such penalty not exceeding $750 and not less than $100 as may be reasonable in the circumstances." (Emphasis added).

[2] ORS 656.385(5) provides in relevant part:

> "Notwithstanding any other provision in ORS 656.382 or 656.386, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the director. Penalties and attorney fees awarded pursuant to this section by the director or the courts shall be paid for by the employer or insurer in addition to compensation found to be due to the claimant.

Finally, claimant's attorney is entitled to an assessed fee for services on review for successfully defending against the employer's request for review on 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 compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.[3]

ORDER

The ALJ's order dated June 30, 1999 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,000, to be paid by the employer.

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[3] Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee, penalty, or sanction 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).

In the Matter of the Compensation of
SCOTT P. CROWE, Claimant
WCB Case No. 99-07378
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to award temporary disability; and (2) did not assess penalties or attorney fees for allegedly unreasonable discovery violations. Submitting additional claim processing documents that he received from the carrier after the hearing, claimant moves for remand to consolidate this matter with another hearing that is presently pending between the parties. On review, the issues are remand, temporary disability, penalties and attorney fees.

We deny the motion for remand and 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). 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).

In this case, the ALJ declined to award claimant temporary partial or total disability because the record did not establish that claimant lost any earning capacity or wages while on modified duty and because no physician had authorized temporary total disability. The additional documents claimant has submitted are presented in the form of a new medical conditon/aggravation claim. Claimant does not cite to, and we do not find, an authorization from his attending physician for temporary disability. In addition, the records submitted do not indicate that claimant's current condition is related to the accepted left shoulder injury. Accordingly, we conclude that the submitted records are not likely to affect the outcome of case; *i.e.*, they would not result in a temporary disability award. Therefore, we deny claimant's request for remand on this basis.

The ALJ also declined claimant's request for an attorney fee under ORS 656.382(1) for an alleged discovery violation. As previously discussed, the submitted documents are not likely to affect the conclusion regarding claimant's entitlement to temporary disability. In light of such a conclusion, there likewise would be no compensation due on which to base a penalty, nor could there be unreasonable resistance to the payment of compensation when no temporary disability was due at the time of the discovery violation.[1] *See Aetna Casualty Co. v. Jackson*, 108 Or App 253, 257 (1991) (no unreasonable resistance to the payment of compensation where all compensation had been paid at the time of the discovery violation). Thus, the submitted records are not likely to affect the outcome of the "discovery" issue. We, therefore, decline to remand on this basis as well.

ORDER

The ALJ's order dated November 15, 1999 is affirmed.

[1] We note that claimant may have the basis for asserting entitlement to penalties and attorney fees for any allegedly unreasonable claim processing issue or discovery violation arising from the pending hearing. In other words, our decision today pertains to the issues arising in this particular case and would have no effect on issues raised in that pending case.

In the Matter of the Compensation of
TARA R. DUNN, Claimant
WCB Case No. 98-08369
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

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 left shoulder and thoracic condition. With its appellant's brief, the insurer has submitted additional evidence and requests that the matter be remanded for admission of that evidence. On review, the issues are remand and compensability. We deny the motion to remand and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The insurer has submitted a December 23, 1999 medical report from Dr. Schilperoort, M. D. and requests that this matter be remanded to the ALJ for admission of the report.

We may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). 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. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Although Dr. Schilperoort's December 23, 1999 report was not "available" at the time of April 22, 1999 hearing, we are not persuaded that the information in the report was unobtainable with the exercise of due diligence at the time of the hearing. *See Lura F. Carter*, 51 Van Natta 1226, 1229 (1999). Moreover, further evidence with regard to claimant's history would be cumulative as the record contains claimant's testimony as well as several medical reports, (including an insurer-arranged examination performed by Drs. Farris and Bald) which record claimant's history. Under these circumstances, we decline to remand this matter for the admission of Dr. Schilperoort's report.

Compensability

We adopt the conclusions and reasoning set forth in the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the 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 November 12, 1999 is affirmed. For services on review, claimant's counsel is awarded $1,200, as a reasonable assessed attorney fee, payable by the insurer.

In the Matter of the Compensation of
ANTONIO R. GARCIA, Claimant
WCB Case No. 99-07397
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) declined to modify the rate of claimant's temporary total disability (TTD) benefits; and (2) declined to assess penalties for the statutory claim processing agent's allegedly unreasonable claims processing. On review, the issues are rate of TTD and penalties.

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

Claimant suffered a compensable injury on May 3, 1999, while working for a noncomplying employer (NCE). Claimant alleges that his rate of TTD should be increased to reflect an average weekly wage of $311.88. Claimant has the burden of proving entitlement to additional temporary disability. ORS 656.266; *Lino Villa-Acosta*, 51 Van Natta 211, 212 (1999). For the following reasons, we agree with the ALJ that claimant failed to carry his burden of proving entitlement to an increased TTD rate.

Generally, the TTD rate is calculated pursuant to OAR 436-060-0025(5)(a)(A). That rule provides, in pertinent part:

> "Insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks."

As the ALJ observed, claimant was paid "under the table," in cash. (Tr. 22). Therefore, there were no cancelled checks, bank records or other reliable indicators of claimant's hours and wages. At hearing, both claimant and the NCE provided calendars allegedly depicting claimant's hours of work and rate of pay for some or all of the relevant time period (52 weeks prior to the May 3, 1999 date of injury). (Exs. 14, 16, 17).

Claimant testified that he kept track of his work hours for the NCE by writing them down each night on his personal calendar. (Tr. 12-14, 17-18, 22-24). However, claimant's records run only from January 1999 through May 1999. (Ex. 14). Thus, even if we were to find claimant's calendar, as opposed to the NCE's calendar, to be an accurate representation of his hours worked between January and May 1999, such a finding would not result in an increased TTD rate. In other words, like the ALJ, we are unable to extrapolate those work hours to the months from May 1998 through December 1998 (to complete the 52-week period prior to claimant's injury). OAR 436-060-0025(5)(a)(A).

Claimant also contends that OAR 436-060-0025(5)(a)(B)(ii), instead of OAR 436-060-0025(5)(a)(A), applies to his claim. That rule provides:

> "Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due to a change of hours worked, change of job duties, or for other reasons with or without a pay increase or decrease, insurers shall average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A)."

We are not convinced that this issue was raised at hearing. Nevertheless, even if it was raised, OAR 436-060-0025(5)(a)(B)(ii) is not applicable. We find no evidence of a "change in the wage earning agreement" either by way of a "change in [claimant's] hours worked" or a "change of job duties" in any of the relevant weeks of employment. *See Eula M. Zarling*, 50 Van Natta 296 (1998). Claimant cites to none.

Finally, claimant contends that, even if OAR 436-060-0025(5)(a)(A) applies, there are "extended gaps" in claimant's employment with the NCE (specifically in August 1998) which we should exclude from any computation of a TTD rate under OAR 436-060-0025(5)(a)(A). We decline to do so for the same reason that we are unwilling to extrapolate from claimant's incomplete work calendar to complete the 52 weeks referenced by the rule. Furthermore, even if we were to use the employer's calendar, we do not consider claimant's missing approximately two weeks in August of 1998 (when compared to a 52-week period) to constitute an "extended gap" in his employment. *See, e.g., SAIF v. Fitzsimmons*, 159 Or App 464 (1999) ("extended gap" found where the claimant missed 15 weeks out of 52 due to a "seasonal layoff"); *Jeffrey S. Mecham*, 51 Van Natta 638 (1999) ("extended gap" found where the claimant missed 14 weeks out of the 52 weeks prior to injury); *Bradley R. Kubik*, 50 Van Natta 989 (1998) (three weeks out of eight total weeks of employment, equal to 36 percent, was considered an "extended gap.")

Therefore, we are not persuaded that claimant's TTD rate should be increased. Finally, inasmuch as we have affirmed the ALJ's decision not to award additional TTD, there are no "amounts then due" upon which to base a penalty. ORS 656.262(11)(a); *Lura F. Carter*, 51 Van Natta 2038 (1999).

ORDER

The ALJ's order dated December 9, 1999 is affirmed.

April 10, 2000 Cite as 52 Van Natta 656 (2000)

In the Matter of the Compensation of
BRIAN K. LUTZ, Claimant
Own Motion No. 94-0392M
OWN MOTION ORDER OF ABATEMENT
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our March 10, 2000 Own Motion Order, that affirmed the carrier's August 5, 1999 Notice of Closure. Claimant further requests an "additional 30 days" in which to submit evidence on his behalf. In light of such circumstances, the following briefing schedule shall be established.

Claimant shall have 30 days from the date of this order to file his opening brief. The insurer shall have 30 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 the insurer'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
WILSON O. SANTAMARIA, Claimant
WCB Case No. 99-03288
ORDER ON REVIEW
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Menashe's order that dismissed his request for hearing. With his request for review, claimant submits copies of several medical documents and a copy of an 827 form. We treat such a submission as a motion to remand to the ALJ for the taking of additional evidence. On review, the issues are remand and the propriety of the ALJ's dismissal. We deny the motion to remand and affirm.

FINDINGS OF FACT

On August 31, 1997, claimant sustained a compensable injury to his left eye. The self-insured employer initially accepted this claim for a disabling contusion/abrasion of the left eye with nondisplaced fracture of the inferior orbital rim and closed the claim by Notice of Closure on December 22, 1998. On January 14, 1999, the employer issued an amended Updated Notice of Acceptance at Closure that accepted the additional condition of a blunt trauma to the left globe. That same date, the employer issued an amended Notice of Closure closing the claim.

Claimant requested reconsideration of these closures, requesting appointment of a medical arbiter panel. After claimant's examination by the appointed medical arbiter panel, the Director issued Orders on Reconsideration on March 25 and March 29, 1999. The March 29, 1999 Order on Reconsideration expressly addressed only the newly accepted condition, *i.e.*, the blunt trauma to the left globe. That order affirmed the January 14, 1999 Notice of Closure in all respects, including finding that: (1) the closure was not premature; and (2) claimant was not entitled to any scheduled or unscheduled permanent partial disability benefits related to the blunt trauma to the left globe.

On April 21, 1999, claimant's attorney requested a hearing on the March 29, 1999 Order on Reconsideration, raising issues of premature closure, scheduled and unscheduled permanent disability, penalties, and attorney fees. Submitted with the hearing request were the first two pages of a retainer agreement; neither page was signed by claimant. A hearing was scheduled for July 26, 1999.

Subsequently, claimant's attorney: (1) limited the issue to claimant's entitlement to scheduled permanent disability for his left eye injury claim; and (2) agreed to have the matter decided on the exhibits and the submission of written closing arguments.

Meanwhile, the hearing process was delayed while the parties attempted to negotiate a settlement. By letter dated October 1, 1999, claimant's attorney notified the employer's attorney that claimant did not want to go forward with the settlement. The ALJ was notified and, because the parties wished to submit the matter on the record, the briefing schedule was reset, with claimant's opening brief due on October 25, 1999. Claimant's attorney did not submit an opening brief. On November 8, 1999, the employer submitted its closing arguments. On November 23, 1999, the ALJ closed the record.

By letter dated November 30, 1999, claimant's attorney stated that he represented claimant in connection with his workers' compensation claim and withdrew the hearing request. On December 3, 1999, the ALJ issued an Order of Dismissal that dismissed claimant's hearing request.

On December 27, 1999, claimant requested review of the ALJ's order, stating that he was requesting review of the ALJ's decision and a new hearing.[1] Claimant submitted several documents with his request for review, including: (1) a December 23, 1999 827 form signed by Dr. Burress, M.D.;

[1] We note that claimant requests a copy of the transcript mentioned in the Board's letter acknowledging his request for review. The letter claimant apparently refers to is a form letter that notes a transcript of the hearing proceedings will be ordered and provides that the briefing schedule will be sent with the transcript. Nonetheless, a transcript is only generated if a hearing is held. Here, no hearing was held. Therefore, no transcript was made and none is available to provide to the parties.

(2) medical reports from Dr. Burress dated September 10, 1999, October 19, 1999, and December 23, 1999; (3) October 7, 1999 notes from Dr. Burress referring claimant to Dr. Wong for evaluation and treatment of left eyelid scarring and to Dr. Cobasko for evaluation and treatment of persistent headaches and dizziness; and (4) a September 24, 1997 medical report from Dr. Della, M.D.

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

With his request for review, claimant submitted to the Board copies of several documents, as enumerated above. We treat this submission as a request for remand for the admission of additional evidence.

The Board may remand a case for the receipt of additional evidence if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). 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).

Here, because the ALJ dismissed claimant's hearing request, the sole issue before us is whether claimant's hearing request should have been dismissed. None of the documents submitted by claimant relate to that issue.[2] Thus, claimant's submissions are not likely to affect the outcome of the case. Accordingly, we find that the record was not improperly, incompletely, or otherwise insufficiently developed to decide the issue before us, and therefore decline to remand this matter to the ALJ.

Propriety of the ALJ's Dismissal

As stated above, 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.

Claimant has the burden of proving that the dismissal order was not appropriate. *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); *Donald J. Murray*, 50 Van Natta 1132 (1998). Although claimant disagrees with his then-attorney's actions in withdrawing the hearing request, he makes no argument as to why the dismissal order was not 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).

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[2] In fact, in his briefs, claimant appears to raise an issue not previously raised by his then-attorney. The issue before the ALJ was limited to claimant's entitlement to permanent partial disability for his left eye injury condition. On review, in addition to arguing that he is entitled to permanent partial disability, claimant argues that his condition has worsened and appears to attempt to raise the issue of aggravation. If claimant wishes to pursue an aggravation claim, that is a separate matter from the issue previously before the ALJ and the issue currently before us.

Inasmuch as claimant is presently unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

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

Here, only the first two pages of the retainer agreement are in the Hearings record, and neither page is signed by claimant. Nevertheless, claimant does not contend that he was not represented by his then-attorney at the time in question. *Cf. Silverio Frias, Sr.*, 49 Van Natta 1514 (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). Indeed, in his brief on review, claimant acknowledges that his then-attorney represented him at the time in question, although claimant has since received a letter from his then-attorney stating that he no longer represents claimant. In addition, claimant does not contend that his then-attorney did not withdraw his hearing request.

Under these circumstances, we find no reason to alter the dismissal order. *William A. Martin*, 46 Van Natta 1704 (1994); *Mike D. Sullivan*, 45 Van Natta 900 (1993); *Eul G. Moody*, 45 Van Natta 835 (1993).

ORDER

The ALJ's order dated December 3, 1999 is affirmed.

In the Matter of the Compensation of
DONALD B. NORRIS, Claimant
WCB Case No. 99-04673
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its denial of claimant's claim for a low back condition; and (2) assessed a penalty for an allegedly untimely denial. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review concerning the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 OR 159 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated December 3, 1999 is affirmed. For services on review, claimant's counsel is awarded $1,200, as a reasonable assessed attorney fee, payable by the insurer.

In the Matter of the Compensation of
PAULA K. TRANMER, Claimant
WCB Case No. 99-06946
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration that awarded claimant 20 percent (64 degrees) unscheduled permanent disability for her cervical and left shoulder injury. On review, the issue is extent of unscheduled permanent disability.

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

The ALJ affirmed the reconsideration order's award of unscheduled permanent disability. In so doing, she found that Dr. Carpenter, the medical arbiter whose impairment findings were used to determine the permanent disability award, provided the most thorough, complete and well-reasoned evaluation of impairment due to the injury.

On review, the employer contends that the ALJ incorrectly evaluated the medical evidence and should have relied, instead, on the medical report of examining physicians, Drs. Marble and Rich, with whom Dr. Densmore, the attending physician at claim closure, concurred. The Marble/Rich panel concluded that claimant had no permanent impairment due to the compensable injury. Having reviewed this record, we reject the employer's contention and conclude that the ALJ properly assessed the medical evidence.

When a carrier objects to an Order on Reconsideration and seeks reduction of a permanent disability award, it has the burden to show that the standards were incorrectly applied in the reconsideration proceeding. *See* ORS 656.283(7); *Roberto Rodriguez*, 46 Van Natta 1722 (1994) (citing *Harris v. SAIF*, 292 Or 683 (1982)). Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. *Orfan A. Babury*, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, we do not find that a preponderance of evidence establishes a different level of impairment from that determined by the medical arbiter because we do not find the Marble/Rich report well-reasoned. As the ALJ noted, Drs. Marble and Rich did not diagnose a cervical condition even though the employer specifically accepted a cervical strain and such a condition was diagnosed on numerous occasions. (Exs. 5, 14, 19, 22, 24, 33, 53, 59). The employer argues that the Marble/Rich panel was not disputing the law of the case, but rather was merely stating that there was no cervical impairment. We disagree.

The panel commented that "we do not believe there is any *history* to support a cervical strain diagnosis." (Ex. 59-6, emphasis added). We conclude that their use of the word "history" indicates more than the belief that claimant has no cervical impairment. Rather, we interpret this as a reflection of their opinion that claimant never sustained a cervical strain in the first instance. Such a belief is contrary to both the medical evidence and the employer's acceptance of a cervical strain. Accordingly, we agree with the ALJ's determination that the Marble/Rich report was not well reasoned. Moreover, we find Dr. Densmore's unexplained concurrence with this report to be somewhat at odds with his refusal to concur with the prior report of another examining physician, Dr. Fuller, who reached conclusions similar to those of Drs. Rich and Marble. (Ex. 52).

Therefore, we do not find the medical evidence from the attending physician, or the Marble/Rich report with which he concurred, constitutes a preponderance of evidence establishing a different level of impairment from that determined by the medical arbiter, Dr. Carpenter. Thus, we affirm.

Because we have not reduced or disallowed claimant's compensation, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 November 30, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

April 11, 2000 Cite as 52 Van Natta 661 (2000)

In the Matter of the Compensation of
CHRISTINE M. VISTICA, Claimant
WCB Case No. C000730
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gatti, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On March 28, 2000, 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 approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $9,375 and the total due claimant's attorney is $3,125. This would equal a total consideration of $12,500. However, the total consideration recited on the second page (No. 12) of the CDA is "$16,500" instead of $12,500. Finally, the agreement states in No. 13 that claimants attorney shall receive an attorney fee of $3,125, which is consistent with the first page and which would be the appropriate attorney fee if the total consideration is $12,500.

Therefore, upon review of the document as a whole, we are persuaded that the reference on the second page of the CDA to a total consideration of $16,500 is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $12,500, with $3,125 payable as an attorney fee.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $3,125, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
TERI L. HEFFLEY, Claimant
Own Motion No. 98-0335M
OWN MOTION ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Business Insurance Company (BICO) requests that we "clarify" our March 13, 2000 Own Motion Order, in which we declined to reopen claimant's 1985 claim for the payment of temporary disability benefits because the current condition and ensuing medical treatment for which claimant requested own motion relief, "remains in denied status, and is the responsibility of a subsequent insurer."

BICO objects that portion of the order which found that claimant's current condition, ulnar neuropathy, was the responsibility of "a subsequent insurer," *i.e.* BICO. BICO points out that in our March 13, 2000 Order on Review, we affirmed that portion of Administrative Law Judge (ALJ) Stephen Brown's May 6, 1999 order which found that claimant's ulnar neuropathy was not compensable. Thus, BICO argues that the ulnar neuropathy condition for which claimant requested own motion relief is not a compensable condition and responsibility of a non-compensable condition cannot be assigned to any party. Having reviewed the record, on reconsideration, we withdraw our prior Own Motion Order and replace it with the following order.

The CIGNA Insurance Company (CIGNA) initially submitted a request for temporary disability compensation for claimant's compensable right elbow condition. Claimant's aggravation rights on that claim expired on January 29, 1992.

On March 16, 1998, CIGNA denied the compensability of and responsibility for claimant's current post-traumatic right ulnar nerve neuropathy condition. Claimant requested a hearing. (WCB Case No. 98-03022). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated May 6, 1999, Administrative Law Judge (ALJ) Stephen Brown upheld CIGNA's March 16, 1998 denial, and found a subsequent insurer responsible for claimant's current lateral epicondylitis condition. Claimant requested and the subsequent insurer cross-requested Board review of ALJ Brown's order, and in an order issued on March 13, 2000, the Board affirmed ALJ Brown'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 right ulnar nerve neuropathy 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
TERESA BROOKE, Claimant
WCB Case No. 98-08782
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Meyers 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 bilateral carpal tunnel syndrome and left anterior scalene syndrome 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 exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's work activity as a clinical consultant and regional sales manager was the major contributing cause of her bilateral carpal tunnel and left anterior scalene conditions. In setting aside the insurer's denial of these conditions, the ALJ relied on the opinion of claimant's treating physician, orthopedic surgeon Dr. Puziss.

The insurer contends that claimant did not meet her burden of proving the compensability of her carpal tunnel syndrome and anterior scalene conditions. The insurer does not contend, and the evidence does not establish, that claimant has a "preexisting condition" with regard to either of these conditions that would implicate the provisions of ORS 656.802(2)(b). Therefore, claimant must prove that her work activities were the major contributing cause of her conditions. ORS 656.802(2)(a). We agree with the ALJ that claimant met this burden, but only with regard to her bilateral carpal tunnel condition.

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 (1983). Dr. Puziss, claimant's treating physician and surgeon, reasoned that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. (Ex. 22c). Dr. Puziss also concurred with the assessment and opinion of Dr. Morrisey, a PhD ergonomist, who performed an evaluation of claimant's use of her hands at work and concluded that claimant's work was the major cause of her conditions. (Exs. 26, 27).

The insurer contends that Dr. Puziss changed his opinion from that which he had earlier expressed; *i.e.* that he could not attribute claimant's condition to her work. (Ex. 4). An unexplained change of opinion renders that opinion unpersuasive. *Kelso v. City of Salem*, 87 Or App 630, 634 (1987). However, here, Dr. Puziss reconsidered his initial opinion in light of additional information about claimant's driving and keyboarding activities at work. (Ex. 13). We therefore find that Dr. Puziss adequately explained his change in opinion. *Kelso v. City of Salem*, 87 Or App at 634.

Dr. Puziss, moreover, relied on complete and accurate information regarding claimant's work activities. (Exs. 13, 27). His opinion is therefore persuasive. *Miller v. Granite Construction*, 28 Or App 473 (1977). In contrast, Dr. Peterson, a neurologist who performed an examination at the request of the insurer, was never provided with an adequate job description, as she had requested. (Ex. 19). Dr. Peterson stated that her ultimate opinion on major contributing cause of claimant's carpal tunnel syndrome depended on receipt of this information. (Exs. 19, 25b-7). We therefore find Dr. Peterson's opinion not to be sufficiently persuasive to overcome the deference we generally accord to Dr. Puziss as claimant's treating physician and surgeon.

The ALJ did not consistently distinguish between claimant's bilateral carpal tunnel and left anterior scalene conditions. On *de novo* review, we find that the evidence does not support the compensability of claimant's anterior scalene condition. In her deposition, Dr. Peterson stated that

claimant's anterior scalene condition "conceivably" was related to her work activity, with the understanding that claimant drove "eight to ten hours a day." (Ex. 25b-10). Although she eventually responded affirmatively to a question from claimant's counsel as to whether she believed it was medically probable that the anterior scalene condition was work-related, it is not clear from Dr. Peterson's testimony that she ever reached an opinion based on reasonable medical probability. (Ex. 25b-9, 10). *Gormley v. SAIF*, 52 Or App 1055 (1981); *James W. Henry*, 51 Van Natta 1822 (1999). Moreover, Dr. Peterson based her opinion on an incorrect assumption regarding the extent of claimant's driving. Claimant's testimony at hearing was that she drove up to eight to ten hours per day, but only three to four days per week. (Tr. 10).

In addition, although he generally concurred with Dr. Peterson's report that had diagnosed the anterior scalene condition, Dr. Puziss never diagnosed this condition. (Exs. 17, 22c). Even assuming claimant suffered from an anterior scalene condition, Dr. Puziss could not explain the cause of the condition. (Ex. 22c-3). He speculated that the condition may be due to poor conditioning. (*Id*). Because we do not find Dr. Peterson's opinion persuasive, and Dr. Puziss could not state an opinion as to the cause of the anterior scalene condition, we find that claimant has not sustained her burden of proof with regard to the compensability of this condition. Accordingly, we reverse the ALJ's order in regard to the compensability of the anterior scalene condition.

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

ORDER

The ALJ's order dated December 17, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the insurer's denial of claimant's anterior scalene condition is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
L. C. DURETTE, Claimant
WCB Case No. 99-04382
ORDER OF ABATEMENT
Popick & Merkel, Claimant Attorneys
Neil W. Jones, Defense Attorney

On March 15, 2000, we issued an Order on Review that reversed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's claim for a right shoulder injury. Asserting that the ALJ was in the best position to make a credibility finding in this case, claimant seeks reconsideration of our decision and affirmance of the ALJ's order. Alternatively, claimant contends that this matter should be remanded to the ALJ to make findings concerning the disputed issues of fact regarding a shoulder injury at claimant's home.

In order to further consider claimant's contentions, we withdraw our March 15, 2000 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 take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL C. JENSEN, Claimant
WCB Case No. 98-02785
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of claimant's low back injury claim. On review, the issue is compensability.[1] 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," except for the second paragraph, with the following supplementation.

On July 15, 1998, the employer denied claimant's 1998 low back strain injury claim, stating that "the major contributing cause of [claimant's] complaint's are [sic] unrelated to [his] work activities." (Ex. 22). Claimant requested a hearing contesting the denial. At the hearing, the ALJ stated that the issues were as raised by the denial (and penalties) and the parties agreed. (Tr. 4-5). The ALJ also noted that the denial "relates to an injury that occurred in December of 1996." (Tr. 5). Arguably, the denial's caption reference to the 1996 injury limited its scope. However, because the body of the denial referred to claimant's "work activities" generally, without mentioning the 1996 injury, we are not persuaded that the compensability issue was limited at hearing to the compensability of claimant's 1998 low back strain *as a consequence of the 1996 injury.*

Nonetheless, we agree with the ALJ that the result is the same if the claim is evaluated as a "separate" injury, because the standard of proof is still "major contributing cause."

Claimant's bilateral arm conditions preexisted the 1998 back strain and combined with his lifting activities at work to cause his back injury. (Tr. 9, 11, 13; *see* Exs. 17, 18, 29-7). Therefore, we agree with the ALJ that ORS 656.005(7)(a)(B) applies to the "new injury" claim and claimant must prove that his work activities contributed more to his strain (or disability or need for treatment for the strain) than did all other factors combined. *See, e.g., McGarrah v. SAIF,* 296 Or 145, 146 (1983). In other words, persuasive medical evidence must evaluate the relative contribution of the causes and explain why the work injury (in 1996 and/or 1998) contributed more to the back strain than all other factors (including claimant's noncompensable ulnar neuropathy) combined. *See Dietz v. Ramuda,* 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because there is no such medical evidence in this case, we agree with the ALJ that claimant's back injury claim must fail.

ORDER

The ALJ's order dated November 8, 1999 is affirmed.

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[1] Claimant asks us to take administrative notice of another Opinion and Order. We need not decide whether the order would be properly subject to notice because, even if it was considered, it would not affect the result in this case. *See John G. Randolph,* 48 Van Natta 162, 164 (1996).

In the Matter of the Compensation of
FRANCISCO J. MARTINEZ, Claimant
WCB Case No. 99-08537
ORDER ON REVIEW
Adams, Day, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that assessed a penalty for allegedly unreasonable delay in payment of compensation. On review, the issue is penalties. We vacate the ALJ's order and dismiss claimant's request for hearing.

FINDINGS OF FACT

Following what claimant asserts was an unreasonable delay in the payment of compensation on his compensable claim, on October 26, 1999, claimant requested a hearing on the issues of temporary total disability and sought a penalty and attorney fees. The parties stipulated that, prior to the hearing, SAIF paid the benefits and that the amount was correct. At the time of hearing the sole issue was entitlement to penalties and attorney fees for allegedly untimely payment of the temporary disability benefits.

CONCLUSIONS OF LAW AND OPINION

As the ALJ's order states, the only issue at hearing was whether the employer had unreasonably delayed payment of compensation, thus entitling claimant to a penalty and attorney fee. Claimant contended that the employer was required to pay temporary disability benefits when the employer knew that claimant was absent from work due to surgery for the compensable injury. SAIF responded that it timely paid compensation on November 10, 1999, upon receipt of the time cards on November 9, 1999. The ALJ disagreed with SAIF's position and assessed a penalty for untimely payment of the time loss benefits under ORS 656.262(11).

ORS 656.262(11)(a) provides, in part, that "[n]otwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection." Thus, where the sole issue is a penalty under ORS 656.262(11), the director has exclusive jurisdiction over that issue. *See Corona v. Pacific Resource Recycling*, 125 Or App 47 (1993) (the Director has exclusive jurisdiction where the sole issue is the entitlement to a penalty); *Robert Geddes*, 47 Van Natta 2388 (1995) (same).

Here, because claimant's hearing request raised temporary disability, in conjunction with penalties and attorney fees, the Hearings Division was initially authorized to address those matters. *See, Marsha E. Westenberg*, 49 Van Natta 2178 (1997) (Hearings Division and Board retain jurisdiction where the claimant raises entitlement to temporary disability as well as penalties). However, when the temporary disability issue was withdrawn as an issue prior to the hearing, the ALJ lost authority to resolve the remaining penalties/attorney fee issue. *See Donald Holcomb*, 50 Van Natta 874 (1998); *Robert Geddes*, 47 Van Natta at 2390. Under such circumstances, the ALJ's order must be vacated and claimant's hearing request dismissed.[1]

ORDER

The ALJ's order dated December 2, 1999 is vacated. Claimant's request for hearing is dismissed.

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[1] Even though the issue was not raised by a party, because the penalty issue is jurisdictional and we are without jurisdiction to hear the appeal, we must dismiss it. *E.g., Hill v. Oland*, 52 Or App 791, 794 (1981).

In the Matter of the Compensation of
ROBERT W. McQUEEN II, Claimant
WCB Case No. 98-08439
ORDER ON RECONSIDERATION
David C. Force, Claimant Attorney
VavRosky, MacColl, et al, Defense Attorneys
Starr & Vinson, Attorneys

Claimant requests reconsideration of our March 23, 2000 Order on Review. Specifically, claimant contends that he is entitled to an increased attorney fee for services on review. The insurer has also requested reconsideration of our Order on Review, and again contends that the Administrative Law Judge's (ALJ's) order should be reversed.

After considering the insurer's arguments with respect to the merits of this case, we adhere to our decision to affirm the ALJ's order. We add the following supplementation regarding claimant's request for an increased attorney fee.

Our order affirmed an Administrative Law Judge (ALJ's) order that: (1) set aside the insurer's denial, on the merits, of claimant's ulnar neuropathy condition; (2) set aside a portion of the denial, pertaining to left ulnar nerve and ulnar groove strain conditions on the ground that no claim had been made; and (3) found that claimant's left elbow epicondylitis claim had been prematurely closed. The ALJ awarded an attorney fee of $4,300 for prevailing over the "ulnar neuropathy" denial. The ALJ also awarded an "out-of-compensation" attorney fee based on his finding of premature closure. On review, we awarded claimant an attorney fee of $1,500, pursuant to ORS 656.382(2).

In support of his request for reconsideration, claimant contends that he is also entitled to an attorney fee pursuant to ORS 656.386(1) for his counsel's services on review, as he "finally prevailed before the Board in overcoming the insurer's denial of his compensable ulnar neuropathy claim within the meaning of ORS 656.386(1)(a)." We disagree.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. *Forney v. Western States Plywood*, 297 Or 628 (1984). ORS 656.386(1)(a) provides, in pertinent part:

> "In all cases involving denied claims where a claimant finally prevails against the denial in an appeal to the Court of Appeals or petition for review to the Supreme Court, the court shall allow a reasonable attorney fee to the claimant's attorney. In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee."

The statute makes it clear that a fee under this section is appropriate in cases where claimant has appealed and prevailed. Here, claimant prevailed *at hearing* before the ALJ (as opposed to prevailing at the Board level), and was awarded attorney fees by the ALJ for finally prevailing over the denial of claimant's ulnar neuropathy condition. On Board review, however, claimant was not appealing, but was *defending* against the insurer's request for review. Consequently, our award was made pursuant to ORS 656.382(2) which provides for a fee when the insurer initiates the appeal and the Board finds that the compensation awarded by the ALJ's order to claimant should not be disallowed or reduced. Accordingly, claimant's request for an attorney fee pursuant to ORS 656.386(1) must be denied.

On reconsideration, claimant also contends that our fee on review was based solely on the premature closure issue and no fee was awarded for his counsel's services regarding the issue of compensability. We note, however, that our order provides that the award was being determined, in part, by the complexity of the "issues." Order on Review, pg. 1. Consequently, our attorney fee award on review acknowledges the fact that claimant did prevail on more than one issue.

Claimant finally contends that the amount of the attorney fee is insufficient, considering the 16 hours he has spent providing services on Board review. Specifically, he asserts that the attorney fee award "under both statutes" should be $2,800.

As previously noted, claimant is not entitled to an additional attorney fee under ORS 656.386 beond the $4,300 fee previously granted by the ALJ's order. Furthermore, we are not authorized to increase the ALJ's "out-of-compensation" attorney fee regarding the premature closure issue.

Additionally, on review, claimant devoted services to the issue of the denial of ulnar nerve and ulnar groove strain. The ALJ set aside the denial on the ground that no claim had been made for such conditions. We acknowledge that the insurer argued, on review, that a claim had been made and the ALJ's order should be reversed. Although claimant's counsel responded to the issue and devoted time to that issue, there is no attorney fee available for services regarding the "moot" denial because the ALJ did not "award" any compensation for those conditions. Consequently, there is no basis for an attorney fee award pursuant to ORS 656.382(2) for that issue.

Finally, claimant's counsel contends that he has devoted 16 hours toward services on review in this matter. A statement of services has not been submitted in this case and, as noted, portions of claimant's brief pertain to matters for which an attorney fee is not available. We reach our conclusion, considering claimant's counsel's notation of hours and the issue on review, with regard to the time devoted to this matter. Moreover, time devoted to the case is but one factor we consider in determining a reasonable attorney fee. Additionally, a reasonable attorney fee is not based solely on a strict mathematic calculation. *See Cheryl Mohrbacher*, 50 Van Natta 1826 (1998); *Danny G. Luehrs*, 45 Van Natta 889, 890 (1993). OAR 438-015-0010(4) instead requires consideration of numerous other factors besides time devoted to the case, such as the complexity of the issues, the value of the interest involved, skill of the attorneys, the nature of the proceedings, the benefits secured, and risk that an attorney's effort may go uncompensated. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999).

Consequently, after again considering the aforementioned factors and claimant's request on reconsideration, we continue to conclude that $1,500 is a reasonable fee for claimant's counsel's services on review, to be paid by the insurer.

Accordingly, our March 23, 2000 order is withdrawn. On reconsideration, as supplemented herein, we republish our March 23, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHELLE L. SHANNON, Claimant
WCB Case No. 99-06106
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer 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.

Relying on the opinion of the attending physician, Dr. Kaesche, the ALJ set aside the insurer's denial of claimant's bilateral carpal tunnel condition, finding that work activities as a dental hygienist were the major contributing cause of the disputed condition. On review, the insurer contends that Dr. Kaesche's opinion is flawed because he incorrectly assumed that carpal tunnel symptoms that first appeared in connection with claimant's pregnancy were "transient" and because he did not receive a sufficiently detailed description of claimant's work activities. For the following reasons, we find the insurer's contentions unpersuasive and affirm the ALJ's compensability determination.

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). Here, we do not find persuasive reasons to depart from our practice of giving greater weight to the attending physician's opinion.

Claimant, who is right hand dominant, developed primarily left sided symptoms in March 1999, consisting of numbness and tingling. She eventually sought treatment from Dr. Farley on May 5, 1999, who then referred claimant to Dr. Kaesche. Dr. Kaesche first examined claimant on May 21, 1999 for complaints of numbness in the hands. (Ex. 23).

The history portion of Dr. Kaesche's chart note states that claimant developed some "dysesthesias" in both hands while pregnant. Dr. Kaesche then wrote: "She has delivered many months ago. These have not improved at all. She has tried splints and Advil and has not gotten any improvement. She saw Dr. Farley and is referred for an evaluation." Later, after attributing claimant's carpal tunnel condition in major part to her employment duties, Dr. Kaesche opined that claimant had only "mild transient symptoms" consistent with carpal tunnel during her pregnancy in 1998. (Ex. 37-1).

The insurer contends that Dr. Kaesche's description of claimant's pregnancy-related carpal tunnel symptoms as "transient" is incorrect in light of the history contained in the May 1999 chart note. The insurer asserts that this chart note establishes that carpal tunnel symptoms persisted after the pregnancy and supports the conclusion of the examining physician, Dr. Button, and a physician who reviewed medical records, Dr. Bell, that the pregnancy was the major contributing cause of the carpal tunnel condition.

Having reviewed the May 1999 chart note, we find that, while it could be interpreted in the manner which the insurer suggests, it is also ambiguous because it is unclear to what the word "these" refers to. Moreover, the reference to splints and Advil probably refers to Dr. Farley's May 5, 1999 chart note which states that claimant's left hand was put in a splint and that she was given anti-inflammatories. (Ex. 19). Accordingly, the lack improvement noted in Dr. Kaesche's May 21, 1999 chart note could refer to the period between Dr. Farley's May 5, 1999 examination and Dr. Kaesche's later in May. Thus, we do not find that Dr. Kaesche's chart note necessarily establishes continuous carpal tunnel symptoms after their first appearance during claimant's pregnancy. In fact, the record contains evidence that supports a contrary conclusion.

On December 3, 1998, Dr. Farley performed a 6-week post-partum check at which time claimant was reported to be "feeling fine." (Ex. 14). No carpal tunnel complaints were reported. In addition, on February 3, 1999, claimant was reported to be in "good health." (Ex. 18). Again, no carpal tunnel symptoms were reported. Finally, no carpal tunnel symptoms were mentioned during an office visit with a registered nurse on March 3, 1999 for reported positional vertigo. (Ex. 19).

In summary, our review of the medical records does not persuade us that Dr. Kaesche's belief that claimant experienced only transient symptoms associated with her pregnancy was incorrect. Thus, we now proceed with an evaluation of the insurer's contention that Dr. Kaesche did not have a sufficient understanding of the nature of the physical activities involved in claimant's work as a dental hygienist.

On August 18, 1999, claimant asked Dr. Kaesche whether her carpal tunnel condition was work related. Dr. Kaesche advised that claimant would have to provide a "precise and detailed history" about the use of her hands. (Ex. 33). In October 1999, Dr. Kaesche agreed that claimant's work activities were the major factor in her carpal tunnel condition. (Ex. 37). There is, however, no specific confirmation in the October 1999 report that claimant provided the detailed description of her duties Dr. Kaesche requested. Because of this, the insurer asserts that Dr. Kaesche's opinion is not persuasive for lack of a complete history. We disagree with this argument.

Dr. Kaesche's October 1999 report indicates that his opinion was based on, among other things, his knowledge of the work of a dental hygienist. Dr. Kaesche explained that claimant's work required constant use of the hands to manipulate dental instruments and that claimant was required to flex, extend and rotate her wrist in awkward positions while applying significant force to accurately manipulate the dental instruments. (Ex. 37-2). Dr. Kaesche further explained that claimant was required to use both hands to manipulate dental instruments as well as the soft tissues of her patients' mouths. (Ex. 37-3). According to Dr. Kaesche, claimant had to constantly use both hands in awkward positions while exerting controlled force over an extended period. *Id.*

Claimant's credible testimony is consistent with Dr. Kaesche's history. Claimant testified that she manipulated dental instruments with both hands and that she used both hands equally. (Tr. 14). Moreover, claimant testified that she used her left hand to manipulate soft tissue and applied constant pressure as she worked inside a patients' mouth. (Tr. 16). Claimant furthered described significant activity involving the left as well as the dominant right hand. (Trs. 16-19).

The insurer points to the testimony of Arterberry, the employer's hygiene coordinator, who agreed with claimant's description of her hand use, but disagreed with claimant's statement that she used both hands equally. Arterberry testified that the "right hand would work more than the left hand." (Tr. 28). Arterberry, however, conceded that she was not a dental hygienist and had not "walked in [claimant's] shoes before." (Ex. 27). In light of this, and the fact that Arterberry agreed with claimant's description of her job duties, we conclude that claimant's testimony regarding the nature of her duties was credible and accurate. Moreover, we conclude that Dr. Kaesche's understanding of claimant's duties is also consistent with that testimony.

Accordingly, we conclude that Dr. Kaesche had a sufficiently complete and accurate understanding of claimant's employment duties. We further agree with the ALJ that Dr. Kaesche's opinion is well-reasoned and persuasive and, thus, satisfies claimant's burden of proving a compensable occupational disease. *See Somers v. SAIF*, 77 Or App 259, 263 (1986) (more weight given to those opinions that are well-reasoned and based on complete information).

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

ORDER

The ALJ's order dated November 16, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
MAVIS SMITH, Claimant
WCB Case No. 99-08711
ORDER DENYING MOTION TO DISMISS
Lundeen, et al, Defense Attorneys

Claimant, *pro se*, has requested Board review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of claimant's left hand and wrist injury claim. Contending that it has not received timely notice of claimant's appeal, the insurer has moved the Board for an order dismissing claimant's request for review. We deny the motion.

FINDINGS OF FACT

On March 2, 2000, the ALJ issued his order. The order recited that copies had been mailed to claimant, the employer, the insurer, and its attorney.

On March 21, 2000, the Board received claimant's March 15, 2000 request for review of the ALJ's order.

On March 27, 2000, the Board mailed a computer-generated letter to the parties and the insurer's attorney acknowledging receipt of claimant's request for review. The insurer received this acknowledgment on March 28, 2000.

CONCLUSIONS OF LAW AND OPINION

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

The failure to timely file and serve all parties[1] with a request for Board review requires dismissal. *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992). However, a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1985); *id.*

Here, on March 21, 2000, the Board received claimant's request for review of the ALJ's March 2, 2000 order. Because March 21, 2000 was within 30 days of the ALJ's order, the request was timely filed. ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(a).

Moreover, the record does not indicate whether claimant provided a copy of her request for review to the insurer. Nonetheless, the insurer received the Board's March 27, 2000 acknowledgment of claimant's request for review on March 28, 2000. Because that date is within the 30-day statutory appeal period from the ALJ's March 2, 2000 order, the insurer received timely actual notice of the request for review. *See Allasandra W. O'Reilly*, 40 Van Natta 1180 (1988). Consequently, we are authorized to consider claimant's request for Board review.

Accordingly, we deny the motion to dismiss. Enclosed with claimant's and the insurer's copies of this order are copies of the hearing transcript. In addition, the following briefing schedule has been implemented. Claimant's appellant's brief (her written argument explaining why she disagrees with the ALJ's decision) must be filed within 21 days from the date of this order. (Claimant is reminded to send a copy of her 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's reply brief (her written reply to the arguments contained in the insurer's brief) must be filed 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.

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[1] "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).

In the Matter of the Compensation of
GENEVIEVE K. BRIDGES, Claimant
Own Motion No. 99-0072M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Martin L. Alvey, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's October 29, 1999 Notice of Closure which closed her claim with an award of temporary disability compensation from April 5, 1999 through October 21, 1999. SAIF declared claimant medically stationary as of October 21, 1999. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 29, 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 November 8, 1999 letter, we requested SAIF to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials.[1] SAIF submitted its response on November 12, 1999 (as supplemented on December 2, 1999), however, no further response has been received from claimant. Therefore, we will proceed with our review.

On October 21, 1999, claimant underwent a "closing" examination by her treating physician, Dr. Grewe. In his chart note following that examination, Dr. Grewe opined that "from a neurological standpoint [claimant] is felt to be medically stationary." He also reported that there was marked tenderness and pain with claimant's right shoulder range of motion and recommended evaluation by a shoulder specialist to rule out the possibility of an intrinsic shoulder pathology. Furthermore, he noted that claimant requested more physical therapy to help her learn how to "work overhead and with pushing and pulling work." Dr. Grewe explained that claimant had been through extensive physical therapy in the past and that although a current regime of physical therapy may not offer further improvement, he opined that it could be tried as an "attempt at palliative care." In closing, Dr. Grewe once again reiterated that from a neurological standpoint claimant was medically stationary, but recommended that she undergo a right shoulder evaluation prior to closing her claim. No further follow-up appointments were scheduled.

Claimant contends that she was not medically stationary when SAIF closed her claim because with her physical therapy treatment, she continues to materially improve. In support of her contention, she points out that her grip strength has improved "by 10 [pounds]." She noted that her physical therapist indicated that with the next twelve visits not only will her strength improve but she may be able to return to work at the same occupation she held prior to her surgeries. Claimant submitted a November 9, 1999 physical therapy report wherein the physical therapist noted that claimant: (1) did have an intrinsic right shoulder problem unrelated to her cervical spine condition; and (2) shown signs of objective improvement when comparing grip strength and shoulder flexion ROM to her physical capacity evaluation of September 2, 1999.

However, claimant's claim was accepted for a cervical strain and C5-6 spondylosis with nerve root compression. The record does not indicate that a right shoulder condition has been accepted by SAIF. Therefore, unless SAIF has accepted a right shoulder condition, claimant must establish that she was not medically stationary at closure with respect to her accepted cervical condition. *Rogers v. Tri-Met*, 75 Or App 470 (1985). All of claimant's "material" improvement has been to the strengthening and increased range of motion to her *right shoulder*. Although Dr. Grewe recommended evaluation of her right shoulder condition, he did not relate the possible right shoulder condition to her compensable claim and found her medically stationary from a neurological standpoint with respect to her accepted cervical condition. He further noted that the physical therapy requested by claimant could be considered palliative treatment. In using the term "palliative," it follows that the need for physical therapy would not necessarily establish that claimant was not medically stationary. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984).

Claimant's physical therapist also noted a right shoulder problem but specifically stated that it was unrelated to her cervical spine condition. He also noted that her improvement was in her grip strength and shoulder flexion. No reference was made to a material improvement of her compensable cervical condition.

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 SAIF's closure was proper.

Accordingly, we affirm SAIF's October 29, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] At claimant's request, she was granted an extension of time in which to file her responsive documents. To be considered, her response was due on or before March 23, 2000. Inasmuch as the time to respond as elapsed, the Board has proceeded with its review.

In the Matter of the Compensation of
GREGORY P. HUBLITZ, Claimant
WCB Case No. 99-04481
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that increased claimant's scheduled permanent disability for the loss of use or function of the left foot (ankle) from 59 percent (79.65 degrees), as awarded by an Order on Reconsideration, to 64 percent (96.4 degrees). Claimant cross-requests review of that portion of the ALJ's order that declined to award additional scheduled permanent disability for a chronic condition. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and briefly summarize the pertinent facts as follows.

In January 1997, claimant sustained a comminuted fracture of the os calcis of the left foot and underwent surgical open reduction and internal fixation, with a left iliac crest bone graft and a skin graft to the left heel. Shortly thereafter he developed post-operative osteomyelitis involving the left calcaneus. He underwent several more operations, including debridement of bone, fusion of the subtalar joint, and fusion of the calcaneocuboid joint. SAIF accepted a left calcaneus fracture and neutrophilic osteomyelitis.

In October 1998, Ms. Bottomly, O.T.R., performed a physical capacities evaluation that was concurred in by Dr. Woll, claimant's attending surgeon.

A January 15, 1999 Notice of Closure awarded claimant 34 percent scheduled permanent disability for his left ankle, based on range of motion impairment. Claimant requested reconsideration.

In April 1999, Dr. Gallagher, orthopedist, performed an arbiter's examination.

A May 7, 1999 Order on Reconsideration increased claimant's scheduled permanent disability to 59 percent for the left foot (ankle), based on the arbiter's findings of decreased range of motion. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant asserted that, based on the medical arbiter's report, he was entitled to additional scheduled permanent disability for loss of plantar sensation in his left foot and for an inability to repetitively use his left foot/ankle. The ALJ awarded claimant 5 percent for partial loss of sensation under OAR 436-035-0200, but declined to award an additional amount for an inability to repetitively use his left foot/ankle.

On review, SAIF argues that the ALJ erred in awarding claimant 5 percent for loss of sensation in the left foot because there were no "objective findings" in that regard.[1] Specifically, SAIF argues that the medical arbiter's statement that the slight decrease in light touch was due to the multiple surgeries that claimant had is a subjective finding that is not reproducible, measurable or observable, as required by ORS 656.005(19). We disagree.

ORS 656.283(7) requires that "any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings." *See also* ORS 656.726(3)(f)(B) ("Impairment is established by a preponderance of medical evidence based upon objective findings"); OAR 436-035-0010 ("all disability ratings * * * shall be established on the basis of medical evidence that

[1] The parties agree that, if the ALJ's award is sustained on review, it should be combined and not added to the 59 percent scheduled permanent disability awarded by the Order on Reconsideration. We have done so in our final calculation of claimant's scheduled permanent disability.

is supported by objective findings"). ORS 656.005(19) defines objective findings as "verifiable indications of injury or disease." The statute further provides that "'objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." The requirements of "reproducible, measurable or observable" are expressed in the disjunctive, rather than the conjunctive. Thus, meeting any one of these requirements is sufficient to support a finding of "objective findings." *Tony D. Houck*, 48 Van Natta 2443 (1996), *aff'd mem Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997).

In this case, with regard to claimant's sensation, the medical arbiter reported as follows:

> "Sensation is slightly decreased to light touch on the dorsolateral and plantar lateral aspect of the left foot as a result of the multiple operations and scarring throughout the lateral side of the foot and ankle. Two-point discrimination is normal in the area of slight hypesthesia.
>
> "* * * * *
>
> "All findings are valid and are related to the accepted condition of left calcaneal fracture, neutrophilic osteomyelitis." (Ex. 46-2, -3).

The arbiter explained that claimant's hypesthesia was the result of multiple surgeries in the area where claimant experiences a lack of sensation. The loss of sensation reported by claimant is verified by the arbiter's physical observation of that portion of claimant's foot. We find that such findings meet the requirements of ORS 656.005(19) because they are verifiable indications of injury or disease which are observable. *See Donald L. Grant*, 49 Van Natta 250 (1997) (findings of an antalgic gait and pain centered over the plantar medial heel are verifiable indications of injury which are observable).[2]

Finally, SAIF contends that the arbiter's report is inconsistent because the two point discrimination test results were "normal." We conclude that such a finding of "normalcy" does not defeat claimant's award for partial loss of plantar sensation in the foot, as the two point discrimination method is used only to establish a value for loss of sensation in fingers and hands, not to establish loss of plantar sensation in the foot. *Compare* OAR 436-035-0110(1)(a) (requiring the use of the two point discrimination test found in the AMA Guides, 3rd Ed. Rev., 1990, to rate loss of palmar sensation in the hand, fingers or thumb) with OAR 436-035-0200(1) (rating loss of plantar sensation in the foot as partial or total, without reference to the use of any test.) The extent of impairment is determined by the standards. Here, claimant has established by objective findings a partial loss of plantar sensation in his left foot. Accordingly, he is entitled to an additional 5 percent scheduled permanent disability award. OAR 436-035-0200(1).

We next turn to claimant's contention that he should receive an additional value of 5 percent for a chronic condition that significantly limits the repetitive use of his left lower leg.

The ALJ concluded that claimant is not entitled to a permanent disability award for a chronic condition significantly limiting repetitive use of his left lower leg, based on a finding that claimant's limitations in walking on uneven surfaces, crouching and climbing stairs were merely "the consequences

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[2] We distinguish our conclusion in this case from that in *John G. Gesner*, 49 Van Natta 2147 (1997). In *Gesner*, the medical arbiter reported normal sensory testing to pinwheel, remarking that the claimant had a slight feeling of somewhat decreased sensation over the entire plantar surface of the left foot compared to the right. But, unlike in this case, the arbiter indicated: "No obvious sensory abnormality was observed."

Because the record in *Gesner* did not indicate whether the claimant reported feeling a loss of sensation on more than one occasion (or whether the medical arbiter repeated the pinwheel testing a number of times during his examination), we were not persuaded that that finding was "reproducible." Moreover, considering the arbiter's comment that no obvious sensory abnormality was observed, we found that the claimant's subjective response regarding decreased sensation was neither reproducable, measurable or observable.

Here, in contrast, the arbiter observed an obvious sensory abnormality that he attributed to the multiple surgeries involving the plantar surface of claimant's foot.

of a sizable PPD award based upon impairment and not qualifying as a 'true' chronic condition," particularly as the arbiter did not use "magic words" that might have entitled claimant to a chronic condition award. We agree that claimant has not established his entitlement to an additional award for a chronic condition, but for the following reasons.

Pursuant to the standards, a claimant is entitled to a 5 percent scheduled chronic condition impairment value if a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the *repetitive use* of his left lower leg (below knee/foot/ankle). OAR 436-035-0010(5)(a). (Emphasis added.)

In determining impairment under the standards, we may rely on the findings of the attending physician at the time of closure, and the subsequent findings of the medical arbiter. ORS 656.245(2)(b)(B), 656.268(7)(a) and 656.268(7)(b); OAR 436-035-0007(12) and (13). Where the findings of the arbiter and the treating physician differ, we defer to the medical arbiter unless a preponderance of the evidence establishes a different level of impairment. OAR 436-035-0007(13).

Dr. Woll, claimant's attending surgeon, concurred in an October 26, 1998 Physical Capacities Examination (PCE). (Exs. 39, 40). Based on the job modifications noted in the PCE, the medical arbiter reported that claimant is:

> "[T]o avoid unprotected heights. He may climb a ladder but he is not to work while standing on the rung of a ladder. He is unable to crouch deeply but can kneel. He is able to climb stairs at a slow pace. He is able to lift in the medium physical demand range unless it is off the floor where he would fall into the light medium physical demand range. He is able to carry objects up to the light medium physical demand range, he has no restrictions to sitting, standing, or walking as long as the surface is even and as long as he is wearing a boot with good support. He is to limit his time on uneven ground to no more than 60 minute intervals and no more than 4 hours of his normal 9 hour day is to be on uneven ground. [Claimant's] work modification will be permanent." (Ex. 46-2).

Consistent with the PCE, the medical arbiter permanently limited claimant's walking on uneven ground to no more than 60 minutes at a time and to no more than four hours in a workday. He also permanently restricted claimant from standing on the rungs of a ladder to work and from crouching, due to his accepted condition.

Although claimant has permanent restrictions on the amount of time he can walk on uneven ground, and is permanently restricted from standing on a ladder or crouching, the medical arbiter did not state that claimant was significantly restricted from the repetitive use of his left lower leg, ankle or foot. Moreover, the PCE (with which Dr. Woll concurred) indicated in addition to the above restrictions only that claimant would move more slowly on uneven ground or on stairs. (Ex. 39-3). Based on the medical evidence, we conclude that claimant has not established, by a preponderance of the medical evidence, that he has a chronic and permanent medical condition which significantly limits repetitive use of his left ankle or foot.

Finally, we combine the impairment values for the left foot for a total value of 61 percent scheduled permanent disability. OAR 436-035-0007(18); OAR 436-035-0130(2). The ALJ's award is reduced accordingly.

ORDER

The ALJ's order dated November 17, 1999 is modified. In lieu of the ALJ's award and in addition to the Order on Reconsideration's award of 59 percent (79.65 degrees) scheduled permanent disability award for the left foot, claimant is awarded an additional 2 percent (2.7 degrees) scheduled permanent disability, for a total award of 61 percent (82.35 degrees). Claimant's "out-of-compensation" attorney fee shall be modified accordingly.

In the Matter of the Compensation of
CHERYL A. LAMB, Claimant
WCB Case No. 98-08100
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Meyers, Biehl and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's occupational disease claim for left lateral epicondylitis and left thoracic strain; (2) calculated the rate of claimant's interim compensation at $535.51; and (3) assessed penalties for allegedly unreasonable claim processing. On review, the issues are compensability, rate of interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant, age 42 at hearing, began working for the employer as a log truck driver on March 16, 1998. She drove a 1980 Peterbilt tractor that had a 20-inch steering wheel and power steering. The driving was primarily off paved roads, which caused bouncing and jarring, and required backing the vehicle and turning many corners. Claimant used her left arm to steer and her right arm to operate the gearshift. The chain-driven window was hard to open and close, requiring the use of both arms. Claimant's duties included securing the logs to the trailer with wrappers and securing the wrappers with binders. After throwing the wrappers over the logs, she used her left arm to pull the wrappers down to hook the binder to the wrapper. She then used both arms to secure the binders.

Claimant worked from eight to 12 hours a day, five days a week. She was paid 30 percent of the charge for each load of logs picked up and delivered. (Ex. A). She completed from one to five loads per day. (*Id.*)

Sometime in July 1998, claimant developed pain in her left elbow and arm, extending to her left shoulder and left wrist, with some left finger numbness. On August 27, 1998, she sought treatment from Dr. Flaming, who took her off work. Nerve conduction studies of September 8, 1998 were negative for nerve problems. Dr. Flaming diagnosed left lateral epicondylitis and left thoracic strain.

The employer had knowledge of the claim on September 14, 1998. (Tr. 58, 109, 110).

On September 23, 1998, claimant's attorney mailed a notice of representation letter to the insurer. (Ex. 9). On the same date, claimant's attorney mailed a form 801 signed by claimant to claimant's employer by certified mail. The letter was returned on October 5, 1998 as unclaimed. (Exs. 12, 12A).

On October 8, 1998, claimant's condition was evaluated by Dr. Hoda, who diagnosed left lateral epicondylitis and injected her left elbow. (Ex. 15).

On October 9, 1998, claimant requested a hearing on the insurer's failure to process the claim, entitlement to temporary disability, rate of temporary disability, and penalties and attorney fees. Also on the same date, claimant's attorney sent the form 801 signed by claimant to the insurer's claim processor. (Ex. 16).

On October 16, 1998, claimant was released to modified work. (Exs. 20, 21, 24).

On October 29, 1998, the insurer's claim processor received copies of prescriptions and a light duty work release dated October 26, 1998. (Ex. 25). On November 5, 1998, the claim processor received copies of an off-work slip dated September 14, 1998 and a modified work release dated October 23, 1998. (Ex. 26). On November 30, 1998, the claim processor paid interim compensation for the period from September 14, 1998 through October 16, 1998. (Ex. 11).

On November 13, 1998, claimant was restricted from driving a log truck, and, on November 30, 1998, she began work for a different employer as a waitress.

On December 4, 1998, claimant amended her request for hearing to include a *de facto* denial of her claim.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's occupational disease claim for her left arm condition was compensable. The ALJ also concluded that claimant was entitled to interim compensation from August 27, 1998 to September 13, 1998 and from October 16, 1998 to December 7, 1998, the date she filed a request for hearing for a *de facto* denial. Applying OAR 436-060-0025(5)(a)(A), the ALJ calculated the rate of temporary disability at $535.51. Finally, the ALJ assessed penalties on amounts due as of the date of her Opinion and Order for an untimely denial. The ALJ also concluded that claimant was entitled to penalties for the insurer's untimely payment of interim compensation and for failure to pay interim compensation at the correct rate, but assessed no penalties because a maximum penalty had already been assessed for the untimely denial.

On review, the insurer contends, first, that claimant's claim is not compensable. Second, the insurer contends that the ALJ's interim compensation rate calculation is incorrect. Third, the insurer contends that it should not be required to pay any penalty based on the ALJ's interim rate calculation because its own rate calculation was not unreasonable.

Compensability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation to address the insurer's argument on review.

The insurer argues that claimant's credibility is undermined by her failure to tell her doctors that her 1980 Peterbilt truck had power steering. On *de novo* review, we agree with the ALJ that both Dr. Flaming and Dr. Hoda opined that the major contributing cause of claimant's left arm condition was her work activities for this employer. Claimant reported to each doctor that it was very hard for her to turn the steering wheel. Even though Dr. Flaming assumed that the steering was "manual," there is nothing in his analysis to indicate that his opinion would be different had he known that the truck had power steering. Dr. Flaming also attributed claimant's condition to wrapping or tying down the logs, as she experienced pain when pulling on the cable chain brace.

Dr. Hoda thought that claimant's driving activities were the major contributing cause of her condition, as the steering was hard for her. Moreover, he thought that the mechanism of injury (repetitive hard turning of the steering wheel) was consistent with her diagnosed left lateral epicondylitis.

There is nothing in the record to indicate that any of the causative factors (repetitive use of a large steering wheel with claimant's left arm to steer on rough roads, frequent backing of the log truck and tightening the wrappers over the logs) did not exist on the job and were not a part of claimant's job duties. Thus, based on the persuasive opinions of claimant's treating physicians, we conclude that claimant has proved both medical and legal causation.

Rate of Interim Compensation

We adopt and affirm the ALJ's opinion on this issue, with the following comment.

Assuming without deciding that claimant was paid by piece work (she was paid a percentage of the charge per load delivered), claimant was nevertheless employed with varying wages. The ALJ accordingly properly applied OAR 436-060-0025(5)(a)(A) to calculate her wage rate. Moreover, the ALJ properly calculated the average weekly earnings based on the actual weeks of employment with the employer during the previous 52 weeks (from March 19, 1998 through August 26, 1998, less 1 week from May 16 through 25 and two weeks from June 20 through July 5) for a total of 21 weeks. *Ken T. Dyer*, 49 Van Natta 2086 (1997) (the plain meaning of "actual weeks of employment" refers only to those

weeks when the claimant was actually employed; that is, earning remuneration for services performed for the employer).[1]

Here, claimant was actually employed 21 weeks by the employer during the 52-week period prior to her injury. During this period, she was paid a total of $11,245.80. Therefore, we agree with the ALJ's conclusion that claimant's temporary disability rate should be calculated on the basis of an average weekly wage of $535.51 ($11, 245.80 divided by 21 weeks).

Penalties

The ALJ found that penalties were warranted for the insurer's failure to timely pay interim compensation from September 14, 1998 through October 16, 1998 and for its unreasonable failure to pay interim compensation at the correct rate. However, the ALJ concluded that claimant was not entitled to a penalty in addition to the penalty already assessed for the insurer's untimely denial.[2] On review, the insurer contends that it should not be required to pay a penalty equal to 25 percent of all compensation "then due" as of the date of the July 7, 1999 Opinion and Order because the insurer's action in calculating claimant's wage rate was not unreasonable.

We need not address the insurer's contention because, assuming without deciding that the insurer's action in calculating claimant's wage rate was not unreasonable, we nevertheless agree with the ALJ that claimant was not entitled to penalties because a maximum penalty of 25 percent of all amounts then due had already been assessed for the insurer's untimely denial. *See Kim L. Haragan*, 42 Van Natta 311 (1990) (there is no authority to assess penalties totaling more than 25 percent of the compensation then due).

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Claimant's attorney submitted an affidavit in support of a $4,500 attorney fee, indicating that he devoted 12 hours to the case on appeal. He requests a fee based upon 12 hours devoted to the appeal at $150 per hour, with additional consideration of the complexity of the case, the value of the case, his experience as an attorney, the benefit secured for claimant, and the risk that he would go uncompensated.

The insurer objects to claimant's attorney's fee request on the basis that it is excessive and asks us to review the amount of the fee awarded in similar cases in which claimant is respondent.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of *this*[3] 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 on review were compensability of claimant's occupational disease claim for a left arm and back condition, rate of interim compensation, and penalties. Claimant's attorney devoted 12 hours to the case on appeal. Claimant's attorney submitted a 13-page brief, of which one and one-half pages were devoted to the penalty issue. We find that the compensability and interim compensation rate issues were of average complexity, considering the range of cases generally submitted to this forum.

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[1] Moreover, we find that the gap period of three weeks out of twenty-four weeks of total employment, *i.e.*, 12.5 percent, constitute an "extended gap" under the rule. *See, e.g., Jeffrey S. Mecham*, 51 Van Natta 638 (1999); *Pedro Frias*, 50 Van Natta 643 (1998); *Brian M. Fitzsimmons*, 50 Van Natta 433 (1998).

[2] We note that neither party has contested that portion of the ALJ's order that assessed a penalty for the insurer's untimely denial. Therefore, we do not address the merits of that issue.

[3] When we evaluate a case in order to assess a reasonable attorney fee, we evaluate each case *on its own merits* by applying the factors set forth in OAR 438-015-0010(4). *E.g., Shannon L. Matthews*, 48 Van Natta 2406 (1996).

The value of the claim and the benefits secured are average. Claimant's attorney is highly experienced and the parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented.[4] Finally, considering the insurer's challenge to the medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After consideration of the aforementioned factors and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability and interim compensation rate issues is $2,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and considering claimant's counsel's statement of services, as well as the insurer's objection), the complexity of the issues, the value of the interests involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The ALJ's order dated July 7, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $2,000, payable by the insurer.

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[4] Claimant's attorney contends that the insurer's appeal of the penalty issue was frivolous. (Claimant's attorney's affidavit at 2). We need not address this contention because 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).

Board Member Meyers specially concurring.

Under applicable case law, *e.g.*, *SAIF Corp. v. Fitzsimmons*, 159 Or App 464 (1999); *Ken T. Dyer*, 49 Van Natta 2086 (1997); and the rule, we first look to whether claimant had been employed 52 weeks prior to the injury. If so, we determine what "extended gaps" might exist. If less than 52 weeks, we count the actual weeks of employment during that period. Because I am compelled to follow these holdings by the doctrine of *stare decisis*, I submit this special concurrence in joining the majority decision.

Here, claimant did not work for the employer for the full 52 weeks prior to the injury. Therefore, the "extended gaps" analysis need not be done. (If it were, I would agree with Board Member Moller's dissent in *Jeffrey S. Mecham*, 51 Van Natta 638 (1999), in that all absences should not be added together to simulate one "gap," but rather each absence analyzed individually relative to the whole.)

"Employment" has been held to mean weeks during which actual wages were payable. This I find troublesome. Because the nature of the methods of compensation for piecework, etc., contemplate irregular, inconsistent wages, it logically follows that some days or weeks will not be paid. A worker might also choose to take some time off for vacation or an extended holiday, thus voluntarily foregoing wages for those days. To then exclude those same days from the calculation of a claimant's average weekly wage creates a simulated 52-week work schedule.

This manner of calculation achieves outcomes contrary to reasonable system goals by creating artificially high TTD rates and resulting costs, along with encouraging a negative financial enticement for a worker who could quite conceivably earn more on time loss than through wages. It is also unrealistic for most employment settings, in that a worker would be simulated to work each and every week of the year.

If I had the proverbial clean slate, I would exclude from the calculation only those weeks during which claimant would have worked, but for reasons outside the worker's control (non-functioning equipment or "no hauling," as in this case, for example). But without an explanation of the reason for absence, such days off should be retained as part of the average wage calculation, resulting in a more realistic picture of the worker's financial pre-injury status.

In the Matter of the Compensation of
LARRY L. LEDIN, Claimant
WCB Case No. 93-0486M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Hollander & Lebenbaum, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests review of the SAIF Corporation's March 30, 1999 Own Motion Notice of Closure that closed his claim with an award of temporary disability compensation from August 23, 1993 through October 2, 1993. SAIF declared claimant medically stationary as of November 4, 1993. Claimant makes no arguments on the merits of the closure. Instead, claimant requests that the Board set aside the closure and remand his right knee condition claim to SAIF for processing under ORS 656.262(7)(c).[1] We affirm SAIF's March 30, 1999 Own Motion Notice of Closure.

FINDINGS OF FACT[2]

On July 26, 1976, claimant sustained a compensable injury while working for the SAIF's insured. These injuries included extensive facial lacerations secondary to a power saw incident. (Ex. A). SAIF accepted the claim for facial laceration and hyperextension of the neck. (Ex. 35A). In 1978, claimant filed a claim for a cervical condition, which SAIF accepted.

In 1988, claimant's claim was reopened for further neck surgery. At that time, claimant's aggravation rights had expired and his claim was in Own Motion status. As a result of that surgery, claimant developed neuropathy in his right leg.

In 1993, claimant filed a claim for a right torn meniscus. (Ex. 35A). This right knee condition was found compensable by an August 21, 1995 Opinion and Order that we adopted and affirmed on March 28, 1996. On the same date, pursuant to ORS 656.278(1)(a), we issued another order reopening his claim. (Ex. 39). We ordered SAIF to pay temporary disability benefits, beginning August 23, 1993, the date of surgery, and to close the claim under the Board's Own Motion rules when claimant's condition became medically stationary. (Ex. 39-1-2).

SAIF appealed our Order on Review, and the Court of Appeals reversed and remanded. *SAIF v. Ledin*, 149 Or App 94 (1997). On January 23, 1998, we remanded the matter to the Hearings Division for further proceedings. *Larry L. Ledin*, 50 Van Natta 115 (1998). By Opinion and Order on Remand issued on December 1, 1998, as amended on December 17, 1998, an ALJ again found claimant's right knee condition compensable. SAIF requested Board review. On March 24, 1999, we affirmed the compensability decision. *Larry L. Ledin*, 51 Van Natta 471 (1999). That order was not appealed and became final by operation of law.

Dr. Berselli, treating orthopedist, performed the August 1993 arthroscopic repair of claimant's right meniscus condition and provided treatment following that surgery. (Exs. 30, 42). In his November 4, 1993 chart note, Dr. Berselli noted that claimant had obtained excellent response from the surgical treatment, was asymptomatic, the right knee was normal, and released him from care. (Ex. 35).

On March 30, 1999, SAIF issued an Own Motion Notice of Closure that closed the claim that had been reopened pursuant to our March 1996 Own Motion Order. Claimant requested review of that closure, both before the Hearings Division and before the Board in its Own Motion jurisdiction.

On June 28, 1999, we postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

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[1] Claimant also filed a request for hearing with the Hearings Division and requested the same relief before that forum. By order dated September 27, 1999, Administrative Law Judge (ALJ) Mills' dismissed claimant's hearing request for lack of jurisdiction. On today's date, we issued a separate order in our "regular" jurisdiction, directing SAIF to reopen claimant's right torn meniscus condition claim pursuant to ORS 656.262(7)(c). WCB Case No. 99-03403.

[2] Some of these findings, and the referenced exhibit numbers, are taken from the record in WCB Case No. 99-03403, the separate case decided in our "regular" jurisdiction on today's date.

CONCLUSIONS OF LAW AND OPINION

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, 477 (1988). 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).[3] In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, there is no dispute that claimant's aggravation rights have expired on his initial injury claim. Moreover, because claimant's condition required surgery, we had the authority to reopen claimant's claim pursuant to ORS 656.278(1)(a) when we issued the March 28, 1996 Own Motion Order. Consequently, we had subject matter jurisdiction when we issued the March 28, 1996 Own Motion Order authorizing the reopening of the claim and directing SAIF to close the claim under our Own Motion rules when claimant's condition became medically stationary. Thus, our March 28, 1996 Own Motion Order was validly issued under ORS 656.278.[4] Accordingly, we now have subject matter jurisdiction to review SAIF's subsequent closure of that claim.[5] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 30, 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).

The only medical evidence regarding claimant's medical stationary status is presented by chart notes from Dr. Berselli, who performed claimant's right knee surgery and provided follow up care. (Exs. 30, 34, 35, 42). These chart notes indicate that, after undergoing right knee surgery on August 23, 1993, claimant was released to return to his regular job on October 3, 1993, with instructions to return for reexamination after being back to work for a month. (Ex. 34). On November 4, 1993, claimant returned to Dr. Berselli, who noted that claimant had obtained excellent response from the surgical treatment, was asymptomatic, his right knee was normal, and released him from care. (Ex. 35).

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[3] 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[.]"

[4] We note that the March 26, 1996 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await for a future case.

[5] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108 (2000).

On this record, we find that claimant was medically stationary as of November 4, 1993. Nothing in the record indicates that claimant's medically stationary status changed from that date until his claim was closed on March 30, 1999. Therefore, we find that claimant's right knee condition was medically stationary at closure.

According, we affirm SAIF's March 30, 1999 Notice of Closure in its entirety.[6]

IT IS SO ORDERED.

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[6] By Order on Review, issued this date, we directed SAIF to reopen claimant's claim pursuant to ORS 656.262(7)(c). However, claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Inasmuch as we have herein affirmed SAIF's Own Motion Notice of Closure, temporary disability benefits paid pursuant to the closure order will need to be considered in determining claimant's temporary disability benefits, if any, that are eventually payable as a result of our Order on Review.

In the Matter of the Compensation of
LARRY L. LEDIN, Claimant
WCB Case No. 99-03403
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that dismissed his hearing request for lack of jurisdiction. On review, the issues are jurisdiction and claim processing. We reverse the ALJ's order, reinstate claimant's hearing request and direct the SAIF Corporation to reopen claimant's claim pursuant to ORS 656.262(7)(c).

FINDINGS OF FACT

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

On July 26, 1976, claimant sustained a compensable injury while working for SAIF's insured. These injuries included extensive facial lacerations secondary to a power saw incident. (Ex. A). SAIF accepted the claim for facial laceration and hyperextension of the neck. (Ex. 35A). In 1978, claimant filed a claim for a cervical condition, which SAIF accepted.

In 1988, the claim was reopened for further neck surgery. At that time, claimant's aggravation rights had expired and his claim was in Own Motion status. As a result of that surgery, claimant developed neuropathy in his right leg.

In 1993, claimant filed a claim for a torn right meniscus. (Ex. 35A). This right knee condition was found compensable by an August 21, 1995 Opinion and Order that we adopted and affirmed on March 28, 1996. On the same date, pursuant to ORS 656.278(1)(a), we issued another order reopening the claim. (Ex. 39). We ordered SAIF to pay temporary disability benefits beginning August 23, 1993, the date of surgery, and to close the claim under the Board's Own Motion rules when claimant's condition became medically stationary. (Ex. 39-1-2).

SAIF appealed our Order on Review, and the Court of Appeals reversed and remanded. *SAIF v. Ledin*, 149 Or App 94 (1997). On January 23, 1998, we remanded the matter to the Hearings Division for further proceedings. *Larry L. Ledin*, 50 Van Natta 115 (1998). By Opinion and Order on Remand issued on December 1, 1998, as amended on December 17, 1998, an ALJ again found claimant's right knee condition compensable. SAIF requested Board review. On March 24, 1999, we affirmed the compensability decision. *Larry L. Ledin*, 51 Van Natta 471 (1999). That order was not appealed and became final by operation of law.

On March 30, 1999, SAIF issued an Own Motion Notice of Closure that closed the claim that had been reopened pursuant to our March 1996 Own Motion Order. Claimant requested review of that closure, both before the Hearings Division and before the Board in its Own Motion jurisdiction.

On June 28, 1999, we postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant contested SAIF's March 30, 1999 Own Motion Notice of Closure, contending that his right knee condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. Relying on *SAIF v. Reddekopp*, 137 Or App 102 (1995), and *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988), the ALJ held that, because our March 28, 1996 Own Motion Order was not appealed, our determination of Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction.

We agree with the ALJ that the Hearings Division lacks jurisdiction over claimant's hearing request insofar as it pertains to the Board's March 28, 1996 Own Motion Order. Nevertheless, insofar as claimant's request pertains to SAIF's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider the matter. *See* ORS 656.283(7); *Craig J. Prince*, 52 Van Natta 108 (2000).

The ALJ correctly held that he did not have jurisdiction to review the Own Motion closure of claimant's claim. That is a matter within our Own Motion jurisdiction under ORS 656.278(1). Nonetheless, claimant also contends that the Board's March 28, 1996 Own Motion Order authorizing time loss for his right knee surgery does not eliminate his right to have his right torn meniscus condition processed under ORS 656.262(7)(c). Based on the following reasoning, we agree.

ORS 656.262(7)(c) provides, in relevant part, that "[i]f a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."[1] ORS 656.262(7)(c) is fully retroactive and applies to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See* HB 2971, 69th Leg., Reg. Session, section 2 (July 25, 1997); *Mario R. Castaneda*, 49 Van Natta 2135 (1997).

The court examined ORS 656.262(7)(c) in *Fleetwood Homes of Oregon v. Vanwechel*, 164 Or App 637 (1999), where it affirmed our order requiring a claim to be reopened under ORS 656.262(7)(c) following acceptance of additional medical conditions. The court held that the "plain language of ORS 656.262(7)(c) is clear[,]" noting that the statute "states that once a claim is closed, if a new condition is accepted, then the insurer or self-insured employer must reopen the claim to process the newly accepted condition." *Id.* at 641.

In *John R. Graham*, 51 Van Natta 1740 (1999), 51 Van Natta 1746 (1999), after the claimant's aggravation rights had expired on his original claim, he requested that the carrier accept new medical conditions as part of his claim. The carrier expanded its acceptance to include the new medical conditions, but it took no action on the claimant's request that those new conditions be rated and closed under ORS 656.268. Litigation followed and ultimately resulted in two Board orders, one in our Own Motion jurisdiction and another in our "regular" jurisdiction.

In our Own Motion Order, we set aside the carrier's Own Motion Notice of Closure whereby it attempted to "close" the claim under ORS 656.278 without an award of any benefits. 51 Van Natta 1747. We reasoned that the carrier's "closure" was a nullity because claimant's claim never qualified for reopening under our own motion jurisdiction, since he did not require surgery or hospitalization. *Id.*

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[1] The entire text of ORS 656.262(7)(c) provides:

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

In our "regular" jurisdiction order,[2] we determined that the legislature intended 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, whether or not aggravation rights had expired on the original claim.[3] 51 Van Natta at 1744. Accordingly, we remanded the new medical conditions to the carrier for reopening under ORS 656.262(7)(c) and processing to closure under ORS 656.268. *Id.*

Subsequent to *Graham*, in *Craig J. Prince*, 52 Van Natta at 110-111, a case decided in our Own Motion jurisdiction, we held that, although it may be appropriate for the claimant's claim to be processed pursuant to ORS 656.262(7)(c), we did not have authority in our Own Motion capacity under ORS 656.278 to direct a carrier to process a claim under ORS 656.262(7)(c). We made that decision in *Prince* even though the claimant's compensable condition otherwise qualified for reopening for Own Motion relief, *i.e.*, his aggravation rights had expired and the compensable condition required surgery. Nonetheless, we found that the issue of whether the claim should be processed under ORS 656.262(7)(c) was a "matter concerning a claim" for which the claimant could request a hearing under ORS 656.283.

In summary, the above line of cases has determined that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268. In addition, this entitlement extends to claims for medical conditions that are made after aggravation rights have expired on the original claim. Such a claim processing issue is, however, a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283.

That brings us to the circumstances of the present case. Here, claimant's right knee condition was initially found compensable pursuant to the ALJ's August 1995 order. We affirmed that decision in March 1996. Consistent with that compensability determination, we also issued an Own Motion Order reopening the claim and directing the payment of temporary disability benefits under ORS 656.278 until claimant's right knee condition was medically stationary (at which time SAIF was ordered to close the claim under our Own Motion rules). Thereafter, litigation continued before the court, Board, and Hearings Division regarding compensability of the right knee meniscus tear condition. This condition was not finally determined compensable until the appeal rights ran on our March 24, 1999 order. *Larry L. Ledin*, 51 Van Natta at 471.

In the mean time, effective July 25, 1997, the legislature enacted ORS 656.262(7)(c). In addition, the legislature explicitly provided that ORS 656.262(7)(c) was fully retroactive. *See* HB 2971, 69th Leg., Reg. Session, section 2 (July 25, 1997).

Thus, the compensability of the right knee condition remained in litigation at the time of the enactment of ORS 656.262(7)(c). Because this new condition was found compensable after claim closure (and that finding became final after the 1997 legislative enactment), SAIF is obligated to reopen the claim for processing of the right knee condition in accordance with ORS 656.262(7)(c).

The court's reasoning in *Liberty Northwest Insurance Corp. v. Koitzsch*, 155 Or App 494 (1998), supports this resolution. In *Koitzsch*, the issue was whether the statutory provision enacted in 1995 that increased the permanent partial disability (PPD) rate applied retroactively to a claim where a claimant's PPD award (granted prior to the effective date of the 1995 amendment) had not become final until after

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[2] Contrary to SAIF's argument on review, we explicitly examined the legislative history of ORS 656.262(7)(c) in *Graham*. 51 Van Natta at 1743-44. Moreover, after that examination, we determined that "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." *Id.* at 1744. In any event, as discussed above, the court has held that the language of ORS 656.262(7)(c) is unambiguous and requires that a carrier reopen the claim to process a newly accepted condition. *See Vanwechel*, 164 Or App at 641.

[3] Consistent with *Susan K. Clift*, 51 Van Natta 646 (1999), this determination did not grant the claimant separate "aggravation rights" extending from the "new medical condition."

the effective date of the amendment.[4] The court reasoned that, because the carrier's appeal of a Board order regarding the claimant's PPD award and an attorney fee award had remained in litigation at the time the retroactive change in the PPD rate was effective, the claimant was entitled to payment of the PPD award at the retroactively increased rate. In reaching this decision, the court rejected the carrier's argument that, because it had contested only the Board's attorney fee award, the PPD award was "final" and not subject to application of the increased PPD rate. The court held that "an issue or 'matter' does not become 'final,' within the meaning of section 66(5)(a) of chapter 332, until the Board order dealing with the matter or the appellate review of the order becomes final." 155 Or App at 503.

Here, as previously noted, the compensability of claimant's right knee condition remained in litigation at the time of the enactment of ORS 656.262(7)(c). Consequently, consistent with the *Koitzsch* rationale, claimant is entitled to the processing of his claim under ORS 656.262(7)(c) because his right knee condition constitutes a condition that was found compensable after claim closure. This conclusion is based on the following findings.

Following claimant's 1976 injury, SAIF accepted the claim for facial laceration and hyperextension of the neck. (Ex. 35A). Subsequently, in 1978, SAIF accepted claimant's cervical condition. Claimant's claim was last closed by a June 11, 1979 Determination Order. (Exs. 1H, 1I). In 1993, claimant filed a claim for a right knee meniscus tear condition, which has been ultimately found compensable. *Larry L. Ledin*, 51 Van Natta at 471. That compensability determination became final in 1999 after the enactment of ORS 656.262(7)(c). Under these circumstances, SAIF is obligated to reopen the claim under ORS 656.262(7)(c) for the processing of claimant's right knee meniscus tear condition.

Finally, we interpret claimant's hearing request as seeking an order directing SAIF to process his new condition claim, *i.e.*, the right meniscus tear condition, under ORS 656.262(7)(c). Based on the above, we grant that request and direct SAIF to reopen the right knee meniscus tear condition under ORS 656.262(7)(c) for processing to closure under ORS 656.268.[5]

ORDER

The ALJ's order dated September 27, 1999 is reversed in part and affirmed in part. Claimant's hearing request is reinstated. The claim is remanded to SAIF for reopening under ORS 656.262(7)(c) and the processing of claimant's right knee meniscus tear condition to closure under ORS 656.268. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $1,050. That portion of the ALJ's order that held that the Hearings Division lacked jurisdiction to review SAIF's Own Motion Notice of Closure is affirmed.

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[4] The court focused on the following provisions enacted by the 1995 legislature regarding retroactive application of changes in the workers' compensation law:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act." Or Laws, ch. 332, section 66(1).

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act." Or Laws, ch. 332, section 66(5)(a).

[5] As discussed in our Own Motion Order Reviewing Carrier Closure, issued this date, claimant is not entitled to duplicate compensation. Therefore, when the right knee meniscus tear condition claim is closed under ORS 656.268, the parties will need to consider the effect of the temporary disability award granted by SAIF's March 30, 1999 Own Motion Notice of Closure.

Board Member Haynes concurring.

I agree with the conclusions and the reasoning expressed in the majority opinion. However, I believe that the consequence of the decision was not one that was contemplated by the Legislature when it enacted ORS 656.262(7)(c).

It is clear from the language of ORS 656.262(7)(c), and the limited legislative history concerning that provision, that there was an intent to allow for a rating of permanent disability for a condition(s) that had not been accepted at the time of the original claim closure. What is not as clear is whether the legislature intended to extend the application of ORS 656.262(7)(c) to those claimants whose aggravation

rights have expired. Had the legislature intended such a result, I would have expected to see more discussion and debate regarding the financial impact on employers as well as the claims processing issues that would arise.

Oregon's workers' compensation financial foundation (loss development, retrospective premium calculations, surety bond requirements, etc.) has been based on the understanding that when an injured worker's aggravation rights have expired, the only benefits available are medical services and temporary disability benefits awarded under ORS 656.278. Moreover, temporary disability benefits that are authorized by the Board under ORS 656.278 are reimbursable from the Reopened Claim Program pursuant to ORS 656.625. As a result of ORS 656.272(c) and our decision in *John R. Graham* a carrier may now be responsible for further temporary disability benefits, as ORS 656.278 requires surgery/hospitalization to qualify for temporary disability benefits whereas ORS 656.262 does not, and possible permanent disability benefits, up to and including permanent total disability. These benefits were not contemplated in calculating the ultimate financial impact in such situations as the present case, and it is not difficult to imagine what such financial impact will be on insurers and self-insured employers in the future.

Significant problems could also arise from a claims processing point of view.[1] One possibility would be that carriers may have to essentially establish parallel claim files for the same worker's injury. One file for the original accepted condition and one for the condition found compensable after claim closure, thus providing for a means of capturing claims costs accurately under both ORS 656.278 and ORS 656.262. This type of scenario would likely raise overhead and personnel costs in order to adequately process both conditions. Ultimately, these costs will be passed on to the employer in the form of increased workers' compensation premiums.

As noted at the outset, I do not disagree with the majority's legal interpretation of ORS 656.262(7)(c). However, for the reasons expressed above, I believe that the legislature should review ORS 656.262(7)(c) and address whether the provision was intended to apply to those claims where an injured worker's aggravation rights have expired.

[1] I assume these claims will be processed under the administrative rules governing initial claims. Having said that, it should be noted that no administrative rules specifically addressing the processing of concurrent claims under ORS 656.278 and ORS 656.262 presently exist.

In the Matter of the Compensation of
RICHARD KNIERIEM, Claimant
WCB Case No. 99-05147
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's consequential depressive disorder. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change. We change the first paragraph on page 7 to read:

> Although Ms. Rhine did not expressly state that claimant's work injury was the "major contributing cause" of his depressive disorder, 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). Based on Ms. Rhine's reports, we conclude that claimant's compensable low back injury was the major contributing cause of his depressive disorder.

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 $2,250, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 29, 1999 is affirmed. For services on review, claimant's attorney is awarded $2,250, payable by the self-insured employer.

April 14, 2000 Cite as 52 Van Natta 687 (2000)

In the Matter of the Compensation of
DARALYNN NEVETT, Claimant
WCB Case No. 99-07228
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hoguet'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.

The ALJ set aside SAIF's denial, concluding that the opinion of the attending physician, Dr. Clyde Farris, proved that claimant, in fact, had bilateral carpal tunnel syndrome and that employment conditions were the major contributing cause of this condition. In making these determinations, the ALJ rejected SAIF's argument that there were no "objective findings" of carpal tunnel syndrome. The ALJ found that the medical record contained medical evidence of reproducible, positive "Tinel's" and "Phalen's" tests and that such constituted "objective findings" as a "matter of law" under *Tony D. Houck*, 48 Van Natta 2443 (1996), *aff'd mem Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997).

On review, asserting that the issue of objective findings must be decided based on the record in this case, SAIF contends that the ALJ incorrectly held that *Houck* stands for the proposition that positive Tinel's and Phalen's tests are "objective findings" as a "matter of law" in all cases.

In *Houck*, we examined whether a claimant's subjective responses to physician testing constituted "objective findings" under ORS 656.005(19). Based on both the language of ORS 656.005(19) and the legislative history, we concluded that, although a physician's mere adoption of a worker's complaint of pain does not constitute an objective finding, a physician's interpretation of a worker's verifiable subjective response to clinical testing can be an objective finding, provided it was "reproducible, measurable or observable." 48 Van Natta at 2448-49. We also observed that the requirements of "reproducible, measurable or observable" are expressed in the disjunctive, rather than the conjunctive. Thus, meeting any one of these requirements is sufficient to support a finding of "objective findings."

Because the claimant in *Houck* responded positively to clinical tests used in diagnosing his bilateral carpal tunnel syndrome and left epicondylitis conditions (including Tinel's and Phalen's tests and clinical testing involving resisted extension and flexion of the wrist), we concluded that the claimant's positive responses constituted verifiable subjective responses to pain that were "reproducible" and came within the definition of "objective findings." *Id.* at 2449. We specifically noted that the Phalen's and Tinel's test results were "reproducible" because the claimant had positive results on a series of tests, conducted at various times in different examinations. *Id.* at 2444, n.4.

We agree with SAIF's assertion that the issue of whether "objective findings" support a claim for injury or occupational disease is one that must be decided on the record developed in each individual case. However, as was true in *Houck*, the Tinel's and Phalen's tests in this case were reproducible because claimant demonstrated positive results in examinations conducted at various times. (Exs. 5, 7, 10, 12-1, 20). Moreover, Dr. Clyde Farris stated that positive Tinel's and Phalen's tests are strong indications that a carpal tunnel condition is present. (Ex. 31).

Accordingly, we conclude that like *Houck*, the positive Tinel's and Phalen's tests in this case also constitute "objective findings" in support of the claim for carpal tunnel syndrome. Accordingly, we affirm the ALJ's determination that the occupational disease claim is compensable.[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 SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 6, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by SAIF.

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[1] SAIF also contends that Dr. Clyde Farris' opinion vacillated about whether claimant has carpal tunnel syndrome. Having reviewed this record *de novo*, we are persuaded that Dr. Clyde Farris' opinion establishes that claimant had a carpal tunnel condition, despite the fact that nerve conduction studies were normal and an examining physician, Dr. Cathleen Farris, concluded that her examination was "highly suggestive" of the absence of any medical condition. (Exs. 13, 14, 20, 23, 32).

In the Matter of the Compensation of
KERRY NGUYEN, Claimant
WCB Case No. 99-06526
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed claimant's temporary disability award granted by a Determination Order (and affirmed by an Order on Reconsideration). On review, the issue is temporary disability. We modify in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW

The ALJ affirmed a Determination Order's award of temporary disability from June 24, 1998 through January 15, 1999. Specifically, the ALJ rejected the insurer's challenge to that portion of the temporary disability award from August 19, 1998 to January 15, 1999. In doing so, the ALJ determined that claimant had not voluntarily withdrawn from the work force and, relying on OAR 436-060-0020(6), found that the Department had "reasonably inferred" from contemporaneous medical records that claimant was unable to perform his regular work during the period in dispute.

On review, the insurer contends that claimant voluntarily withdrew from the work force when he returned to high school and further that the ALJ improperly relied on OAR 436-060-0020(6) to infer authorization of temporary disability from the medical records because neither party raised application of that rule as an issue and because the ALJ was without authority to apply the rule.

Turning first to the withdrawal issue, the insurer cites OAR 436-060-0020(4)(b), which provides that a worker has withdrawn from the workforce when, "a worker who was a full time student for at least six months in the 52 weeks prior to the injury elects to return to school full time." However, as noted by the ALJ, the evidence in the record does not establish that claimant was a full time student prior to his compensable injury. Since the record does not contain evidence sufficient to satisfy the requirements of the rule, we find that claimant did not withdraw from the work force.

We next address the insurer's argument that, even if claimant is found to have been in the work force, reliance on OAR 436-060-0020(6) to infer authorization of temporary disability was improper in this case. For the following reasons, we find the insurer's contention persuasive.

OAR 436-060-0020(6), which concerns authorization of temporary disability, provides:

> "The insurer or self-insured employer shall verify and document temporary disability authorization from the attending physician within five days of the insurer's notice or knowledge of the worker's disability or claim. Authorization from the attending physician may be oral or written. *The insurer, or the Department at time of claim closure or reconsideration, may infer authorization* from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician pursuant to ORS 656.262(4)(f)." (emphasis supplied)

As indicated by the highlighted portion, this rule states that an insurer or the Department "may infer" authorization of temporary disability from medical records such as surgery reports or hospitalization records. Here, the ALJ found that the Department reasonably inferred from contemporaneous medical records that claimant was disabled from August 18, 1998 to January 15, 1999. Thus, the ALJ determined that the documentary record constituted medical authorization from the attending physician for temporary disability.

We disagree with that reasoning because we find that there is no indication that the Department, either in the May 17, 1999 Determination Order or in the August 12, 1999 reconsideration order, relied on the rule. The Determination Order is silent about how temporary disability was determined (Ex. 34) and the reconsideration order expressly referred to a different rule, OAR 436-030-0036(1).[1] (Ex. 38-2). Therefore, because the Department's affirmation of the Determination Order's temporary disability award was based on OAR 436-030-0036(1), with no reference to OAR 436-060-0020(6), we disagree with the ALJ's conclusion that the Department relied on OAR 436-060-0020(6) in making its award of temporary disability. In other words, the Department did not make an "infer[ence]" as described in OAR 436-060-0020(6).

In addition, to the extent that the ALJ relied on OAR 436-060-0020(6) to affirm the temporary disability award, the ALJ was prohibited from doing so by the express terms of the rule. The rule specifically provides that only the insurer or the Department may infer authorization and that such authority is discretionary. As noted above, the record does not establish that the Department ever exercised that discretion. For these reasons, we conclude that the ALJ's reliance on the aforementioned rule was improper.[2]

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[1] That rule provides:

> "Temporary disability shall be determined pursuant to ORS Chapter 656, OAR 436-060 and this rule, less time worked. Beginning and ending dates of authorized temporary disability shall be noted on the Determination Order or Notice of Closure, as well as the statements 'Less time worked' and 'Temporary disability was determined in accordance with the law'."

[2] Although we need not address this issue, we note that OAR 436-060-0020(6) is arguably inconsistent with ORS 656.262(4)(g), which provides that temporary disability is not payable "after the worker's attending physician ceases to authorize temporary disability or for any period not authorized by the attending physician." In other words, the rule's provision that authorization of temporary disability may be inferred from medical records may be inconsistent with the statute's requirement that an *attending physician* authorize temporary disability. However, because we conclude that, even assuming the rule is valid, it has no applicability to this case, we leave resolution of this issue for another case.

We now evaluate the temporary disability issue without regard to OAR 436-060-0020(6). In doing so, we find that claimant's original treating physician, Dr. Pribnow, authorized temporary disability through August 18, 1998. (Ex. 16). On July 30, 1998, Dr. Neary became claimant's new attending physician. (Ex. 17). Dr. Neary did not authorize any temporary disability after August 18, 1998 until he issued his January 15, 1999 Report of Disability. (Ex. 31). In that report, Dr. Neary retroactively authorized temporary disability from June 24, 1998 through January 15, 1999.

Therefore, the record contains no contemporaneous temporary disability authorization from an attending physician after August 18, 1998, until Dr. Neary's retroactive authorization on January 15, 1999. Because ORS 656.262(4)(g) limits the effect of a retroactive authorization of temporary disability to no more than 14 days prior to its issuance, claimant has not established entitlement to temporary disability benefits after August 18, 1998, except for the period from January 1, 1999 through January 15, 1999. *See Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999) (limitations in ORS 656.262(4)(g) apply to both procedural and substantive entitlement to temporary disability); *See also James L. Mack*, 51 Van Natta 1681 (1999).

In conclusion, we disagree with the ALJ's determination that the August 12, 1999 reconsideration order correctly affirmed the award of temporary disability in the May 17, 1999 Determination Order. Thus, we modify that portion of the reconsideration order that affirmed the award of temporary disability from June 24, 1998 through January 15, 1999. In lieu of that portion of the order, we modify the award of temporary disability in the Determination Order to instead award temporary disability from June 24, 1998 through August 18, 1998 and from January 1, 1999 through January 15, 1999. Because the insurer's request for hearing has ultimately resulted in a reduction of claimant's compensation, we also reverse the ALJ's award of an assessed fee under ORS 656.382(2).

ORDER

The ALJ's order dated November 24, 1999 is modified in part and reversed in part. In lieu of the temporary disability award granted by the May 17, 1999 Determination Order, as affirmed by the August 12, 1999 Order on Reconsideration, claimant is awarded temporary disability from June 24, 1998 through August 18, 1998 and from January 1, 1999 through January 15, 1999.[3] The ALJ's $1,000 attorney fee award is reversed.

[3] Because we have reduced claimant's compensation as a result of the insurer's request for hearing, we do not award an attorney fee for claimant's counsel's services on review.

In the Matter of the Compensation of
IRIS K. SCOTT, Claimant
WCB Case No. 97-10026
ORDER ON REMAND
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Deschutes County v. Scott*, 164 Or App 6 (1999). The court has reversed our prior order, *Iris K. Scott*, 50 Van Natta 2271 (1998), that had affirmed an Administrative Law Judge's order that had vacated an Order on Reconsideration that had reduced claimant's scheduled permanent disability awards for the right and left forearm to 9 percent (13.5 degrees). In addition, the court has remanded for reconsideration.

On April 7, 1999, we approved the parties' Claim Disposition Agreement (CDA) in which claimant fully released her rights to "non-medical service" benefits (including temporary, permanent, and permanent total disability) related to her May 1995 claim.

Based on our approval of the parties' CDA (including the aforementioned provisions), the issues pending in this case have been rendered moot. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY L. PARKS, Claimant
WCB Case Nos. 98-05646, 98-01771, 97-08944 & 97-08440
ORDER ON RECONSIDERATION
Parker, Bush & Lane, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Zimmerman & Nielsen, Defense Attorneys
Reinisch, Mackenzie, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our March 24, 2000 order that declined to award an attorney fee. In our order, we affirmed the Administrative Law Judge's (ALJ's) order that set aside USA Waste Company's (USA's) responsibility denial of claimant's current neck condition. Specifically, claimant contends that he is entitled to an attorney fee under ORS 656.386(1).

USA objects to claimant's request for additional attorney fees on review. USA argues that the only issue on review was responsibility and the only issue addressed by claimant in his brief was responsibility. USA contends that any fee on review is constrained by the $1,000 limitation in ORS 656.308(2)(d).

The issues at hearing were compensability and responsibility of claimant's current neck condition. The ALJ awarded claimant's attorney an assessed attorney fee of $5,000. The ALJ did not state which portion of the award was made under ORS 656.386(1) and which part was awarded under ORS 656.308(2)(d) for services concerning the responsibility issue. We must consider claimant's attorney fee for services at hearing with regard to compensability and responsibility.

After applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case, we agree with the ALJ that $5,000 is a reasonable and appropriate attorney fee for services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record), the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We find no evidence in the record that claimant requested an extraordinary attorney fee at hearing. Because claimant neither asserts nor do we find "extraordinary circumstances" warranting an attorney fee in excess of the statutory maximum $1,000 attorney fee, we apportion $1,000 of this $5,000 attorney fee award to claimant's counsel for active and meaningful participation at the hearings level in finally prevailing over USA's responsibility denial. ORS 656.308(2)(d); *see Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997).

Although USA argues that the only issue on review was responsibility, both compensability and responsibility were decided by the ALJ. 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* 119 Or App 447 (1993). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by USA. *See* ORS 656.382(2).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $50. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that the only issue on review was responsibility and claimant's counsel's services on review were devoted to the responsibility issue.

Accordingly, we withdraw our March 24, 2000 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our March 24, 2000 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
GARY SIRES, Claimant
WCB Case No. 99-06088
ORDER ON REVIEW
Raymond Bradley, 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) Hoguet's order that: (1) found that the SAIF Corporation's termination of temporary total disability benefits was proper; and (2) declined to assess a penalty and related attorney fee for the employer's unreasonable claims processing. On review, the issues are temporary disability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant compensably injured his right foot on February 4, 1999, while working as a drywall finisher in Redmond, Washington for the employer, whose business office was located in Newberg, Oregon. Claimant was treated with open reduction, internal fixation surgery. SAIF accepted a Jones fracture, right foot.

On June 7, 1999, Dr. Berselli continued claimant's right leg brace and took claimant off work. (Exs. 33, 35). On the same date, the employer called Dr. Berselli's office informing him of modified work for claimant beginning June 8, 1999. (Ex. 34). Dr. Berselli orally agreed that claimant would be able to perform the job. (*Id.*) On June 8, 1999, claimant called Dr. Berselli to inform him that he was not able to return to work because he was unable to drive 50 miles to work with his injured foot. (Ex. 36).

On June 10, 1999, Dr. Berselli agreed that claimant was unable to drive a car while wearing his cast brace. But Dr. Berselli thought that claimant could perform the modified work. (Exs. 38, 39).

On June 19, 1999, Dr. Berselli formally approved a modified job for a Job Site Watchman at a job site in Longview, Washington, beginning June 7, 1999. (Ex. 40).

Although claimant had difficulty getting from his home in Gresham, Oregon to the Longview location (riding with someone else with a different work schedule and taking public transportation in the absence of other transportation solutions), he worked from June 18, 1999 until June 24, 1999, when he returned to Dr. Berselli complaining of severe right ankle pain from walking long distances to catch a bus to get to work. Dr. Berselli found exquisite tenderness over the anterolateral joint line and moderate effusion of the ankle. He diagnosed a sprained ankle that occurred at the time of the industrial injury. Dr. Berselli took claimant off work for two weeks because he was unable to walk to the bus because of the sprained ankle. (Exs. 43, 43A). Claimant did not return to the modified job.

On June 18, 1999, SAIF ceased paying temporary total disability and began paying temporary partial disability benefits. SAIF did not reinstate temporary total disability benefits after claimant failed to return to work.

On June 28, 1999, SAIF informed Dr. Berselli that there was portal-to-portal transportation available to take claimant to work. (Ex. 44). On July 8, 1999, Dr. Berselli stated that claimant could continue working, if a bus picked him up at his door and took him directly to his place of work. (Exs. 45, 47A).

On July 16, 1999, claimant returned to Dr. Berselli. An MRI revealed an occult trabecular injury and possible evolving avascular necrosis. Dr. Berselli recommended claimant continue on modified duty. (Ex. 47).

On August 4, 1999, claimant was informed that the applied-for portal-to-portal transportation was not available to him. (Ex. 48E).

Claimant has not been found medically stationary.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's temporary total disability benefits had been properly terminated by SAIF in accordance with ORS 656.325(5)(a)[1] and OAR 436-060-0030(5)[2], and that claimant's transportation difficulties are not considered to be work-related restrictions under *Rhonda P. Stockwell*, 46 Van Natta 446 (1994), *Robert E. Dixon*, 48 Van Natta 46 (1996) and their progeny. On review, claimant contends that his doctor took him off work for reasons related to his work. Claimant also contends that his doctor's release to modified work was contingent on his having portal-to-portal transportation. Finally, claimant contends that his case differs in material ways from the cases the ALJ found to be analogous, because it was impossible, not merely inconvenient, for claimant to get to work.

As a preliminary matter, we note that the issue is not termination of temporary total disability benefits, but reinstatement of temporary total disability benefits. SAIF has continued to pay claimant temporary partial disability benefits since claimant accepted the medically approved offer of modified work. Therefore, this case is governed by OAR 436-060-0030(8) (rather than OAR 436-060-0030(5)).

ORS 436-060-0030(8) provides:

> "Temporary partial disability shall be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited to, termination of temporary employment, layoff or plant closure. A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim shall be included in this section. *For the purpose of this rule, when a worker who has been doing modified work quits the job* or the employer terminates the worker for violation of work rules or other disciplinary reasons *it is not a withdrawal of a job offer by the employer, but shall be considered the same as the worker refusing wage earning employment pursuant to ORS 656.325(5)(a).* This section does not apply to those situations described in sections (5), (6) & (7) of this rule." (Emphasis supplied.)

The rule specifically states that, as here, when a worker who has been doing modified work quits the job, it is not considered to be a withdrawal of the offer of employment by the employer. Rather, under the rule, it is deemed to be the same as the worker refusing wage earning employment pursuant to ORS 656.325(5)(a).

Here, claimant's modified job continued to exist. Moreover, there is no evidence that it was withdrawn by the employer. Claimant simply quit the job to which his physician had released him because he was unable to obtain suitable transportation.

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[1] ORS 656.325(5)(a) provides:

"Notwithstanding ORS 656.268[,] [a]n insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the workers' attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that that injured worker is capable of performing the employment offered."

[2] OAR 436-060-0030(5) provides:

"An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the worker had begun the employment when an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:

"(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;

"(b) The attending physician agrees the employment appears to be within the worker's capabilities; and

"(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."

As discussed by the ALJ, we have previously held that a limitation on driving or the need for transportation to the job location is not a work-related restriction because it does not pertain to matters directly affecting a claimant's performance of the modified job *while on the work site*. *Robert E. Dixon*, 48 Van Natta 46 (1996). That is the principle adhered to by the ALJ in this case, and we see no need to alter it because claimant found out after reporting to work that it was impossible for him to get there. Because a medical limitation on driving or the need to obtain transportation to the job location is not considered to be a work-related restriction, *Robert E. Dixon* and progeny, it does not matter whether it was impossible or merely inconvenient to get to work. In other words, neither Dr. Berselli's restriction from driving nor his taking claimant off work merely because he should not be using public transportation directly affects claimant's performance of the modified job while on the Longview work site.

Consequently, because claimant quit his modified job because he was unable to get to work that he agreed he is willing and able to perform, *i.e.*, refused wage earning employment under the rule, he is not entitled to reinstatement of temporary total disability benefits. ORS 656.325(5)(a).

ORDER

The ALJ's order dated June 18, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant is not entitled to a reinstatement of his temporary total disability benefits. I reason as follows.

OAR 436-060-0030(5)(c) provides:

> "An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation as if the worker had begun the employment when an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:
>
> "(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;
>
> "(b) The attending physician agrees the employment appears to be within the worker's capabilities; and
>
> "(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and *place*; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities." (Emphasis added).

A valid offer of employment under the rule is defined to include the place of work. Thus, although the physician has only to determine whether the job is within the worker's capabilities, such a determination tacitly must include claimant's ability or inability to get to the work site, provided that such an inability is due to the compensable injury.

Here, an Oregon employer is offering modified work to the injured worker in the State of Washington. When Dr. Berselli took claimant off work on June 7, 1999, claimant had been prescribed and was wearing a right leg brace as a result of internal fixation surgery for his compensable right foot injury. Even though Dr. Berselli agreed that claimant was capable of performing a modified job as a Site Watchman at a job site in Longview, Washington, he also stated that claimant was unable to drive a car because of the cast brace. Claimant nevertheless did his best to get to work by riding with someone else. This person had a different work schedule from claimant, so the ride did not work out. Claimant next turned to public transit. The only way he could get from Portland, Oregon to Longview, Washington was by train. Claimant took the public bus from his home in Gresham to downtown Portland, which required him to walk some distance to the railroad station in order to get a train to Longview.

Claimant worked from June 18 to June 24, 1999. He then returned to Dr. Berselli, seeking treatment for severe right ankle pain that resulted from walking long distances on his injured foot to catch the bus and from the bus to the train station. Dr. Berselli found tenderness over the anterolateral joint line and ankle effusion. Dr. Berselli attributed this worsened condition to a sprained ankle that had occurred when claimant injured his foot. Dr. Berselli then took claimant off work for two weeks *and authorized time loss as a result of the worsened sprained ankle* that was due to his compensable injury. Once SAIF received evidence that claimant, who had an open and accepted claim, could not work for reasons due to the compensable injury, it should have reinstated temporary total disability payments.

Apparently recognizing that claimant could not get to the workplace by using public transportation, SAIF's next communication to Dr. Berselli was a June 28, 1999 letter informing the doctor that Tri-met had a lift program that would arrange to have claimant transported from his home to his modified job. (Ex. 44). Based on this understanding, Dr. Berselli was asked to re-approve the modified job offer. *Id.* Dr. Berselli approved the modified job, but *only under the condition that the bus pick up claimant at his door and take him directly to his place of work.* (Ex. 45).

Claimant's right ankle condition continued to worsen. An MRI revealed an occult trabecular injury and possible evolving avascular necrosis. On July 16, 1999, Dr. Berselli again took claimant off work from July 8, 1999 *until door to door bus service was provided.* (Ex. 47A). On August 4, 1999, claimant was informed that he did not qualify for the Tri-Met LIFT Program. (Ex. 48E). But there is no evidence that this information was provided to Dr. Berselli, who continued to approve the modified job.

Under these circumstances, I would find that claimant's doctor took him off work for reasons related to his work injury. Moreover, the doctor's release to modified work was contingent on SAIF's assurance that claimant would not have to walk on his compensably injured ankle in order to get to the job in Washington. Therefore, I would find that none of the requirements for terminating temporary total disability benefits under ORS 656.325(5)(a) have been satisfied. Claimant made heroic efforts to return to work, *and in fact worked* until his condition worsened and he was again taken off work. His physician said that claimant could not get to work *because of his injury.* I do not find any evidence that claimant refused wage earning employment. He did not return to the job in Washington because his physician *took him off work.* Moreover, claimant's physician's release to the modified job was contingent on SAIF's assurance that portal-to-portal transportation would be provided. Given this contingency, I would not infer that the physician would have approved the job offer absent SAIF's assurance that transportation would be provided.

Thus, I would find that this assurance is part of the notice of the specific duties to be performed by the injured worker under ORS 656.325(5)(a). Dr. Berselli's agreement that the injured worker is capable of performing the employment offered *provided that transportation would be provided* is a specific condition of that employment offer. Accordingly, I would conclude that SAIF had no authority to cease temporary total disability payments because, in effect, its job offer was defective. In sum, I would find that SAIF was required to reinstate temporary total disability payments when claimant was taken off work by his attending physician, and that SAIF had no authority to terminate such payments thereafter.

I would also like to reiterate the point I made above, that this is an Oregon employer offering modified work *in Washington.* No evidence was presented regarding whether this employer had other suitable work for this claimant. Access to such evidence is difficult if not impossible for claimant to ascertain, and the employer has an obligation to show that no other suitable work was available to claimant. Without such evidence, what is there to prevent employers from creating light duty work in locations inaccessible to injured workers, in order to avoid their obligation to provide compensation in contravention of the stated objective of Oregon's Workers' Compensation Law: "To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers *and fair, adequate and reasonable income benefits to injured workers and their dependents.*" ORS 656.012(2)(c).

In the Matter of the Compensation of
JAMES D. ROUTON, Claimant
WCB Case No. 98-06603
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Cole, Cary, et al, Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that upheld the self-insured employer's denial of his L5-S1 disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the third full paragraph on page 6, we delete the sixth sentence. In the fifth paragraph on page 7, we change the second sentence to read: "He later conducted a records review on November 11, 1998, concluding that the major contributing cause of claimant's condition was his degenerative disc disease compounded by psychological factors. (Ex. 88-3)." We delete the findings of ultimate fact.

On review, we write to address claimant's argument that Dr. Karasek's opinion is "balanced and reflective" and establishes that his work injury was the major contributing cause of his internal disc disruption.

Even if we assume, without deciding, that claimant has an internal disc disruption, we find that Dr. Karasek's opinion is insufficient to establish that it is related, in major part, to the work injury. Dr. Karasek agreed that the description of an internal disc disruption would apply, as well, to the progression of degenerative disc disease. (Ex. 91-29). He testified that the annular disruption or fissures can be part of degenerative disc disease. (Ex. 91-35). In his April 6, 1998 report, he acknowledged that claimant's "underlying degenerative condition also plays a significant role." (Ex. 84A). Dr. Karasek explained that discography "does not date the injury and does not allow us to solve the riddle of which is more important, the trauma or the underlying degenerative condition." (*Id.*) On *de novo* review, we agree with the ALJ that Dr. Karasek's opinion is not sufficient to establish compensability.

ORDER

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

In the Matter of the Compensation of
BRUCE W. TIMBY, Claimant
WCB Case No. 99-04392
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that declined to grant permanent total disability. On review, the issue is permanent total disability.

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

In declining to award claimant permanent total disability, the ALJ reasoned that claimant conceded that he was not totally disabled based on the medical evidence alone. The ALJ further concluded that claimant had not carried his burden of proving that he was permanently and totally disabled under the "odd-lot doctrine." The "odd-lot doctrine" provides that a claimant may prove entitlement to permanent total disability through a combination of medical and non-medical factors. *See Welch v. Bannister Pipeline*, 70 Or App 699 (1984).

The ALJ relied on the opinion of vocational expert Roy Katzen, who identified several jobs within claimant's physical and vocational skill level. (Ex. 110; Tr. 41, 42). The ALJ found Katzen's opinion more persuasive than that of Robert Male, PhD, who prepared a written report on behalf of claimant. (Ex. 112). We agree with the ALJ that Katzen's opinion is more persuasive. In particular, we note that Male's opinion did not consider claimant's transferable clerical skills. In reaching this conclusion, Male reasoned that claimant gained these skills more than 25 years ago. (Ex. 112-2). Like the ALJ, we find that claimant gained and used clerical skills as recently as June 1992, when he worked as a gas meter prover for the employer. (Ex. 112-2).[1]

Next, claimant relies on *Wilson v. Weyerhaeuser*, 30 Or App 403 (1977) to establish that, if he is unable to return to work for his employer at injury, he is entitled to permanent total disability. We disagree. In *Wilson*, the claimant had an eighth-grade education and had worked in only heavy labor jobs all of his life. 30 Or App at 405. Here, in contrast, claimant has completed high school and has at least some skills which are transferable to light duty and sedentary jobs. (Ex. 110-9). Moreover, the claimant in *Wilson* proved not only that he could not return to work for his employer at injury, but also that his job search with several other employers had been unsuccessful. *Id.*

Finally, even if a claimant can establish that a work search would be futile, he must nevertheless prove that, but for the compensable injury, he is willing to work. ORS 656.206(3); *SAIF v. Stephens*, 308 Or 41 (1989); *Harry L. Lyda*, 52 Van Natta 21 (2000); *Joan K. Rassum*, 51 Van Natta 1511 (1999). Here, the record does not persuasively establish that claimant is willing to work or has made reasonable efforts to obtain work. Absent such proof, we decline to find claimant permanently and totally disabled. *See Champion International v. Sinclair*, 106 Or App 423 (1991).

In conclusion, based on the reasoning set forth above, as well as that expressed by the ALJ, we affirm the ALJ's decision that declined to grant claimant permanent total disability benefits.

ORDER

The ALJ's order dated November 15, 1999 is affirmed.

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[1] In finding that claimant retains some transferable clerical skills, we emphasize that we do not necessarily find that claimant is highly skilled in the field of computers based on his ownership of a home computer and use of electronic mail. We merely find unpersuasive Male's conclusion that claimant has *no* transferable clerical skills, based on his relatively recent work as a meter prover.

In the Matter of the Compensation of
CHRISTINE M. WESTMAN, Claimant
WCB Case No. 99-04027
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that set aside an Order on Reconsideration on the ground that it was premature. On review, the issue is premature closure.

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

On review, the insurer contends that the ALJ improperly addressed the issue of premature closure. The insurer argues that the only issues raised before the ALJ were the medically stationary date and extent of permanent disability. We disagree.

The May 7, 1999 Order on Reconsideration provides that one of the issues raised by claimant was "premature closure." (Ex. 21-2). Claimant subsequently requested a hearing on the Order on Reconsideration and again listed "premature closure" as an issue. In claimant's written arguments, submitted in lieu of a hearing, claimant framed the issues as "premature claim closure and extent of permanent unscheduled disability...". Claimant's Opening Argument, pg. 1. Consequently, we conclude that the issue of premature closure was properly decided by the ALJ.

The insurer alternatively contends that claimant did not specifically argue that the issue of premature closure was based on a procedurally improper closure pursuant to ORS 656.268(4)(a). Therefore, the insurer argues that it was not proper for the ALJ to decide the case on that basis.

In *Martha E. Leyva*, 49 Van Natta 1177 (1997), the claimant raised the issue of premature closure at hearing and then argued on review that claim closure was not proper because the carrier failed to "strictly comply" with an administrative rule. We held that, even if the claimant had not specifically raised an argument of "strict compliance" at hearing, we could consider such an argument on the basis of a "new legal theory" on review. We noted that a new legal theory could be considered for the first time on review and we found there was no argument that the insurer was prejudiced by the claimant's alleged failure to specifically raise a "strict compliance" argument at hearing.[1]

Similarly, we conclude that the issue of premature closure was before the ALJ in this case, and there has been no showing of prejudice by the insurer with respect to the ALJ's consideration of the propriety of the closure. Therefore, the ALJ's order is affirmed.

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 find that a reasonable fee for claimant's counsel's services on review is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the 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 21, 1999, as reconsidered by the January 18, 2000 order, is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

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[1] Here, the insurer has contended that it was prejudiced by the ALJ's consideration of the propriety of the closure itself. However, it has not shown how it has been prejudiced in this regard. Moreover, because the record in this case is limited to the reconsideration record, we find no prejudice to the insurer by the ALJ's consideration of such a theory. *Leyva*, 49 Van Natta 1180, n.4.

In the Matter of the Compensation of
JOEL H. ULLEDAHL, Claimant
WCB Case No. 99-04625
ORDER ON REVIEW
Phillip H. Garrow & Janet H. Breyer, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral shoulder condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the first paragraph of the ALJ's "Conclusions of Law and Opinion, with the following supplementation.

As a preliminary matter, we note that the parties agree that the record should contain a *signed* version of claimant's attorney's July 27, 1999 concurrence letter to Dr. Sulkowsky, rather than the unsigned version of the letter marked as Exhibit 22. Accordingly, based on the parties' agreement, we treat the signed version of the letter (one copy marked "extraneous," outside the exhibit packet and another submitted by claimant, attached to his "Motion to Supplement the Record", signed and annotated by Dr. Sulkowsky) as admitted and we consider it on review.[1] (*See also* Tr. 2).

Claimant works for the employer as an equipment operator on its road construction crew. He spends most of his work time driving equipment, but he also does some manual labor, including "cold patching," which involves shoveling asphalt from the back of truck into holes in the road.

The ALJ found the medical evidence insufficient to establish that claimant's work activities were the major contributing cause of his bilateral shoulder impingement syndrome condition. We agree, based on the following reasoning.

Claimant contends that his shoulder configurations, Type II acromions, are not preexisting conditions within the meaning of ORS 656.005(24)[2] because they are "normal" for about 40 percent of the population. (*See* Ex. 24-2). However, the medical experts agree that claimant's Type II acromions predispose him to shoulder impingement. They also agree that claimant's bilateral condition is due in part to his shoulder configuration. Thus, because claimant's preexisting anatomy predisposed him to his impingement disease and contributed to it, claimant's Type II acromions are preexisting conditions under the statute.[3] *See Cresencia Green*, 50 Van Natta 47 (1998) (where persuasive medical evidence indicated that the claimant's shoulder anatomy amounted to a predisposition that contributed to her impingement condition, it qualified as a "preexisting condition" under ORS 656.005(24)).

Claimant argues that his work activities for the employer involved repetitive shoulder use and these activities, not his Type II acromions, caused his condition. Claimant relies on the opinion of Dr. Sulkowsky, treating physician.

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[1] *See e.g., Tom Fredrickson*, 45 Van Natta 211 (1993) (Board considered a document on review that had not been admitted at hearing, where the parties intended that it be admitted (though it was not , due to an apparent oversight) and there was no objection to considering it on review).

[2] Under ORS 656.005(24), "'Preexisting condition' means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273."

[3] Nonetheless, we need not determine whether claimant's work activities caused a worsening of his preexisting condition, because we find the medical evidence insufficient to establish that those activities were the major contributing cause of his bilateral condition. *See* ORS 656.802(2)(a) & (b).

Dr. Sulkowsky was initially under the impression that claimant "does *a lot* of shoveling, overhead work." (Ex. 13, emphasis added). He acknowledged that "a lot" of claimant's condition is "anatomical," due to his "fairly tight subacromial arc." Dr. Sulkowsky also noted that a person "who did things down at his side all the time" would probably not have problems, but claimant developed degenerative changes in his acromioclavicular joints and supraspinatus tendon because he did "heavy strenuous work with repetitive overhead, push/pull, etc." (*Id*). Dr. Sulkowsky agreed with the examining physicians that claimant's congenital anatomic type contributed to his shoulder problems, stating "it is more of an attritional-type and chronic injury in part, because of the 'initial design of his shoulders' and the type of work he is doing." (Ex. 21-2). He also opined that, if repetitive overhead activity such as shoveling only amounted to "'5 % of his job,' then obviously this should not be that much of a disability[.]" (*Id*).

Claimant's attorney sent Dr. Sulkowsky a letter describing claimant's condition and asked the doctor to sign it if he agreed, *inter alia*, that claimant's shoveling and other work of a similar nature (with his arms at chest level or higher) was most likely the major contributing cause of his shoulder impingement, "whether he does these activities 5 percent of the time or 95 percent of the time." (Ex. 22). Dr. Sulkowsky signed the letter and wrote "with letter of clarification I dictated on 8/4/99 enclosed." (*Id*). In his clarification letter, Dr. Sulkowsky stated that he agreed with the majority of claimant's counsel's letter, but he had "a few additions." (Ex. 23). Specifically, Dr. Sulkowsky opined that repetitive use of arms at shoulders at the mid chest level does cause "wear or impinging wear" on the rotator cuff tendons,

> "not in everyone, but [] in somebody who has a type II or type III acromion or a very tight subacromial arc such as [claimant]. This does not happen 'in everyone.' The attritional wear is not necessarily something that you can say is 1%, 3%, 10% 20%; it is just that if you do pinch the bursa and have a tight arc and the bursa becomes swollen[,] then you are going to pinch it more because now hydrologically you cannot compress a liquid and it becomes a chronic, painful problem. The wear and tear portion goes along with this. * * * I do feel that [claimant] has the type II acromion and is much more susceptible to a wear type disorder because of his anatomical makeup." (*Id*).

Thus, Dr. Sulkowsky reiterated that *both* claimant's predisposing anatomy and his "overhead" activities contributed to his condition. In our view, he did not ascribe to claimant's counsel's contention that such activities caused the condition "whether he does [them] 5 percent of the time or 95 percent of the time." *See SAIF v. Strubel*, 161 Or App 516 (1999) (physician's opinion evaluated in context). Instead, the doctor declined to assign a contribution percentage (between 1 and 20 percent) to "attritional wear."[4]

Under these circumstances, we cannot say that Dr. Sulkowsky's opinion supports a conclusion that chest level or overhead work activities contributed more to claimant's shoulder condition than did his anatomical predisposition. *See McGarrah v. SAIF*, 296 Or 145, 166 (1983) ("major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined). Consequently, we conclude that claimant has not carried his burden of proof under ORS 656.802(2)(a).

ORDER

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

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[4] We also note that the record does not indicate that claimant did "a lot" of chest high or overhead work activities. Rather, claimant spent most of his work time driving, with his arms below chest level. (*See* Ex. 16-1; Tr. 26-27, 33).

Board Member Phillips Polich concurring.

I write separately to emphasize that we evaluate claims involving potentially contributory preexisting conditions on a case-by-case basis, depending on the medical evidence. *See Trudy M. Spino*, 52 Van Natta 626 (2000) (Board Chair Bock specially concurring) (citing *Cassandra J. Hansen*, 50 Van Natta 174, 175 (1998). We do not rely on a "laundry list" of predispositions or preexisting conditions that automatically weigh against an otherwise compensable claim. *See Debbie S. Thomas*, 52 Van Natta 7 (2000); *see also Glen E. Wilbur*, 50 Van Natta 1059 (1998).

In this case, I agree with the lead opinion that the medical evidence establishes that claimant's preexisting Type II acromions contribute to his bilateral shoulder condition. And, because the medical evidence does not establish that claimant's work exposure was the major contributing cause of the claimed conditions, I also agree that the claim must fail.

In the Matter of the Compensation of
RICHARD L. JONES, Claimant
WCB Case No. 98-02826
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of his claim for left-sided deep vein thrombosis. On review, the issue is compensability.

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

On Board review, claimant argues that Dr. DeLoughery's opinion is less persuasive regarding the cause of claimant's left-sided deep vein thrombosis than that of Dr. Morford because Dr. DeLoughery, who is board certified in hematology, as well as internal medicine and medical oncology, relied upon claimant's medical records to obtain claimant's history rather than examining and interviewing claimant in person. We reject this argument. This case involves expert analysis rather than external observation; thus, we are not persuaded that Dr. DeLoughery's opinion is less persuasive because he did not personally examine claimant. *See Allie v. SAIF*, 79 Or App 284, 287 (1986).

Dr. DeLoughery had the same history possessed by Dr. Morford, but drew different conclusions than did Dr. Morford. As the associate director of transfusion medicine at Oregon Health Sciences University, the director of the hematology section, and the medical director of the anti-coagulation clinic, we agree with the ALJ that Dr. DeLoughery's expertise in the area of blood diseases, such as claimant's, is greater than that of Dr. Morford, who is a resident in family medicine. Dr. Morford opined that the left-sided deep vein thrombosis was caused by immobilization due to claimant's left ankle sprain. In Dr. DeLoughery's opinion, the immobilization was insufficient to cause claimant's thrombosis. Dr. DeLoughery also relied upon the fact that claimant subsequently developed venous thrombosis in the uninjured right leg. Dr. DeLoughery opined that this was strong evidence of an underlying "hypercoagulable state" or underlying propensity to form blood clots. Dr. Morford did not address Dr. DeLoughery's opinion regarding the significance of the venous thrombosis of the right leg.

Claimant argues that Dr. DeLoughery's opinion is unpersuasive because he did not review claimant's prior medical records regarding claimant's prior injuries, gun shot wounds to the abdomen and temple and a fractured skull from a blow to the head with a metal pipe. Dr. DeLoughery opined that incidence of deep venous thrombosis with both head and abdomen trauma is substantial and that the treatment records should be reviewed to insure that claimant had not suffered a deep venous thrombosis previously.

We are not persuaded by this argument because claimant has the burden of proof, ORS 656.266, and there is no evidence that Dr. Morford reviewed these prior records of head and abdominal trauma, even though she testified that once a person has had venous thrombosis that person is more likely to develop it in the future. Under such circumstances, we find that the failure to review the prior medical records detracts from the persuasiveness of Dr. Morford's opinion, especially given her lesser expertise in this area. For the reasons stated herein and in the ALJ's order, we find that claimant has failed to establish compensability of the left-sided deep vein thrombosis condition.

ORDER

The ALJ's order dated October 7, 1999 is affirmed.

In the Matter of the Compensation of
WILLIAM G. THERRIAULT, Claimant
WCB Case No. 99-03585
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its denial of claimant's injury claim for a right hip condition; and (2) awarded a $4,500 attorney fee under ORS 656.386(1) for claimant's attorney's services in setting aside the denial. On review, the issues are compensability and attorney fees.

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

This is an injury claim involving a preexisting necrosis condition. In setting aside SAIF's denial, the ALJ found that claimant's August 6, 1998 injury was the major contributing cause of his disability and need for treatment for his combined right hip condition. ORS 656.005(7)(a)(B). The ALJ relied on the opinion of claimant's treating physician, orthopedic surgeon Dr. Grossenbacher. On review, SAIF contends that the opinion of Dr. Fuller is more persuasive. For the reasons expressed by the ALJ, as well as those expressed below, we disagree with SAIF's contentions.

Generally, we will defer to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Marshall v. Boise Cascade Corp.*, 82 Or App 130, 134 (1986). Here, we find specific reasons not to rely on Dr. Fuller, who performed an evaluation at the request of SAIF. Medical opinions that rely on incomplete or inaccurate information are less persuasive and entitled to little weight. *Miller v. Granite Construction*, 28 Or App 473 (1977). Dr. Fuller concluded that claimant's preexisting avascular necrosis condition was the major contributing cause of his right hip condition. (Ex. 6-6). Dr. Fuller's opinion depended in large part on the incorrect assumption that claimant had a history of coronary artery disease, and had undergone coronary artery bypass surgery. (Ex. 11-3; Tr. 18). In contrast to Dr. Fuller, Dr. Grossenbacher and vascular surgeon Dr. Serres relied on an accurate history of no coronary artery problems. (Exs. A, 1, 4, 10-2).

Next, SAIF contends that Dr. Grossenbacher based his opinion on the unsupported theory that claimant suffered a "microcollapse" of the femoral head in his right hip. However, we find that Dr. Grossenbacher's opinion that claimant had suffered a microcollapse which was the cause of his disability and need for treatment was adequately explained and consistent with claimant's history of symptoms. (Exs. 10-2, 12-1, p. 4). In this regard, Dr. Grossenbacher persuasively rebutted Dr. Fuller's statement that claimant would not have been able to walk with a microcollapsed femoral head, by stating that claimant would have been able to (and did) walk, albeit with a great deal of pain. (Ex. 12-2, p. 7).

Finally, SAIF argues that Dr. Grossenbacher engaged in an impermissible "precipitating cause" analysis. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). We disagree. It is clear from Dr. Grossenbacher's opinion that, from the time of his initial examination of claimant, he took into account the effect of claimant's preexisting avascular necrosis condition. (Exs. 4-1, 7-1, 12). Dr. Grossenbacher stated that the August 1998 work injury was the major contributing cause of claimant's disability and need for treatment for his combined right hip condition, in comparison to the necrosis condition. (Ex. 12-1). Like the ALJ, we find Dr. Grossenbacher's opinion well-reasoned and persuasive.

Finding no persuasive reasons to do otherwise, we rely on Dr. Grossenbacher's opinion to determine that claimant's August 1998 work injury was the major contributing cause of his need for treatment or disability for his combined right hip 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 438-015-010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,400, payable by SAIF.[1] In reaching this conclusion, we have particularly considered the time devoted to the

[1] Claimant is not entitled to an attorney fee for services on review devoted to the attorney fee issue. *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986).

issue (as represented by claimant's respondent's brief, request for attorney fee on Board review, and SAIF's response to claimant's requested fee on review), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 22, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,400, payable by SAIF.

In the Matter of the Compensation of
DONALD WATKINS, Claimant
WCB Case No. 99-04550
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration awarding no scheduled permanent disability for his bilateral elbow injury. On review, the issue is extent of scheduled permanent disability.

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

The ALJ declined to award scheduled permanent disability for claimant's bilateral elbow condition, finding that claimant failed to prove that he sustained permanent impairment as a result of the compensable injury. On review, claimant contends that the opinion of his attending physician, Dr. Ferguson, establishes that he is entitled to a bilateral "chronic condition" award based on significant limitations on repetitive use of his elbows. We disagree.

OAR 436-035-0010(5) provides, in part:

"A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following four body parts:

"* * * * *

"(c) Forearm (below elbow/hand/wrist); and/or

"(d) Arm (elbow and above)."

Dr. Ferguson indicated on several occasions that claimant does not have permanent impairment due to the compensable injury. (Exs. 47, 61, 62-85, 65-2). Dr. Ferguson, however, has opined that claimant requires permanent limitations because his bilateral elbow condition flares up when he returns to his regular work involving repetitive use of his elbows. Dr. Ferguson has also stated that he believes that claimant has a chronic medical condition that significantly limits repetitive use of his arms. (Ex. 65-2). Claimant contends that this evidence establishes that he has permanent impairment due to the compensable injury and that he qualifies for a bilateral "chronic condition" award.

However, limiting repetitive use to prevent reinjury or an increase in symptoms does not establish chronic condition impairment. *See, e.g., Rena L. Rose*, 49 Van Natta 2007 (1997) (holding that a restriction on repetitive use to prevent reinjury or an increase in symptoms does not constitute persuasive evidence of a chronic condition impairment); *see also David A. Kamp*, 46 Van Natta 389, 390 (1994); *Rae L. Holzapfel*, 45 Van Natta 1748 (1993) *aff'd mem Holzapfel v. M. Duane Rawlins, Inc.*, 127 Or App 208 (1994). Moreover, even if we assumed that the limitations imposed by Dr. Ferguson were not designed to prevent reinjury or an increase in symptoms, we would still conclude that claimant is not entitled to a bilateral "chronic condition" award.

Dr. Ferguson testified in his deposition that claimant should not perform powerful gripping and pinching activities. (Ex. 62-86). Dr. Ferguson also testified, however, that this limitation was not due to residuals of his compensable injury, but rather this was due to idiopathic reasons. (Ex. 62-76, 77, 86, 87). Although Dr. Ferguson agreed in a "post-deposition" concurrence report that the alleged chronic medical condition was the result of his "industrial exposure," (Ex. 65-2), Dr. Ferguson's retreat from his earlier opinion is not sufficiently explained and is inconsistent with his prior opinion.[1] As such, it should be given little weight. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

Accordingly, we find that claimant has not proved he is entitled to an award of scheduled permanent disability. Thus, we affirm.

ORDER

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

[1] Dr. Ferguson agreed in his concurrence letter that he had "speculated" that claimant may have had an underlying genetic or other predisposition toward the development of his overuse syndrome, but that he did not have a medical diagnosis, laboratory data or other medical data to support this "supposition." Dr. Ferguson, however, expressed no such reservations in his deposition testimony that attributed the need for work limitations to factors personal to claimant. Considering Dr. Ferguson's opinion as a whole, we do not find that it establishes that the recommended limitations on repetitive use are due to the compensable injury.

In the Matter of the Compensation of
PAULA T. SMITH, Claimant
WCB Case No. 99-00322
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) upheld the SAIF Corporation's denial of a chest injury claim; and (2) declined to assess penalties for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

In 1993 claimant had breast augmentation surgery in which saline implants were implanted in both breasts. On December 17, 1998, as claimant was entering the rest room in the course of her employment as a janitor at the Eugene airport, a ticketed customer suddenly exited a stall ramming claimant's left chest into a wall. Claimant noted an immediate onset of pain and, within 45 minutes, her left breast implant had deflated.

On December 22, 1998, claimant was examined by Dr. Cutler, who had performed the original augmentation surgery. Dr. Cutler noted that claimant was experiencing discomfort in the upper part of the left breast and a "complete deflation of the implant." (Ex. 1). Reporting that there was "no residual fluid evident in the left breast implant" and that there was a "pronounced asymmetry" between the left and right breasts, Dr. Cutler recommended a capsulectomy replacement of the left breast implant. (Exs. 1, 4). Dr. Cutler also indicated that he did not believe there was any chance that the damaged breast implant, if unrepaired, could pose any health risk. (Ex. 6-1). He also responded that the breast implant did not aid in the performance of any natural function. (Ex. 6-2).

In response to claimant's injury claim, SAIF issued a denial of her chest injury. Claimant requested a hearing.

Applying ORS 656.005(7)(a)[1] and OAR 436-010-0230(10),[2] the ALJ determined that claimant failed to prove a compensable injury claim. Specifically, the ALJ found that claimant's breast implant failed to meet the definition of a "prosthetic appliance" in OAR 436-010-0230(10) in that the record did not establish that it was either an artificial substitute for a missing body part or a device that aided the performance of a natural function. We disagree with the ALJ's reasoning and find that claimant has established a compensable injury.

There is no dispute that claimant was in the course and scope of her employment when she was accidentally struck with such force by a customer exiting from a rest room stall that claimant's left breast implant was ruptured. In addition, there is no dispute that the work incident was the major contributing cause of the deflated breast implant. But there is also no dispute that the incident did not result in disability. Instead, the issue is whether claimant sustained an injury as a result of the work incident that required medical services and whether any such injury is established by medical evidence supported by objective findings.[3] ORS 656.005(7)(a). Based on the following reasoning, we find that claimant satisfied both requirements.

ORS 656.005(7)(a) provides two bases for compensable injuries. A "compensable injury" may be an "accidental injury" to a claimant's person, or it may be an "accidental injury to prosthetic appliances." Where the requirements to prove a compensable injury involving an "accidental injury" to a claimant's person have been met, there is no need to inquire further as to whether the injury might qualify as an "accidental injury to prosthetic appliances." Because that is the case here, we need not address the reasoning expressed by the ALJ in upholding SAIF's denial.

Within days of the work accident, claimant sought medical treatment from Dr. Cutler. Claimant sought medical treatment both because of the pain she experienced due to the work accident and to determine what could be done about the damage to her chest. (Exs. 1, 4). Following an examination, Dr. Cutler reported that the left breast implant was "completely flat" with "no residual fluid evident in the left breast implant." (Ex. 4). Dr. Cutler further found that claimant's chest exhibited "pronounced asymmetry," with the left breast and right breast no longer matching. (Exs. 1, 4).

Based on claimant's visit to Dr. Cutler, we find that the work injury required medical services. ORS 656.005(7)(a). In addition, Dr. Cutler's findings during his examination establish an injury by medical evidence supported by objective findings. *Id.* Specifically, the findings of a "completely flat" left breast implant, "no residual fluid evident in the left breast implant," and the "pronounced asymmetry" of claimant's breasts, all of which were caused by the work injury, constitute objective findings in support of medical evidence in that these findings are observable, measurable, and verifiable indications of injury. ORS 656.005(19). Thus, the work injury that resulted in these findings constitutes a compensable injury. Therefore, we set aside SAIF's denial.

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[1] ORS 656.005(7)(a) provides, in relevant part:

"A 'compensable injury' is an accidental injury, *or* accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; * * * if it is established by medical evidence supported by objective findings[.]" [Emphasis added].

[2] OAR 436-010-0230(10) provides:

"The cost of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury, is a compensable medical expense, including when the worker received no physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part *or* any device by which performance of a natural function is aided, including but not limited to hearing aids and eye glasses." (Emphasis added).

[3] "Objective findings" is defined as follows:

"'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." ORS 656.005(19).

Penalty

Claimant seeks a penalty for SAIF's allegedly unreasonable denial. SAIF argues that Dr. Cutler's medical reports, together with the legal question as to whether claimant's breast implant qualified as a "prosthetic appliance" under ORS 656.005(7)(a) and OAR 436-010-0230(10) raised legitimate doubt as to its liability regarding claimant's breast implant deflation. We agree with SAIF.

A penalty may be assessed when a carrier "unreasonably delays or refuses to pay compensation." ORS 656.262(11). The standard for determining unreasonable resistance to payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about 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 light of all the information available to the carrier at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Here, before issuing its denial, SAIF had received a chart note and a letter from Dr. Cutler indicating that the work incident resulted in a deflated left breast implant. (Exs. 1, 4). In addition, Dr. Cutler stated that it could be argued that this condition was "purely a cosmetic matter," although, in his opinion, it should be covered as a work injury. (Ex. 4-1). Moreover, because a breast implant was involved and the definition of "prosthetic appliances," OAR 436-010-0230(10), could reasonably be read to exclude a breast implant under the circumstances in this case, SAIF had reason to doubt its responsibility for this injury.

Under these circumstances, we find that SAIF's denial was not unreasonable and, therefore, decline to assess a penalty.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $4,500 payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record 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 10, 1999 is reversed in part and affirmed in part. That part of the order that upheld the SAIF Corporation's January 5, 1999 denial is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded a fee of $4,500, payable directly to claimant's attorney by SAIF. The remainder of the order is affirmed.

Board Member Phillips Polich specially concurring.

I agree with the majority regarding the merits of this claim, including the decision regarding the penalty issue. Nevertheless, I feel that the circumstances of this case present a separate basis supporting compensability of this injury claim. I write to address that separate basis.

Here, SAIF denied claimant's injury claim, contending that the work incident was "not compensable under ORS 656.005(7)(a) and [OAR] 436-010-0230(10)." Thus, SAIF's denial was based on its contention that the deflated left breast implant did not constitute a "prosthetic appliance" as defined under OAR 436-010-0230(10).

As the majority finds, claimant sustained a the deflated breast implant as a direct result of her work activity. Moreover, the deflated implant itself clearly represents "objective findings," in that it is a physical finding that is measurable and observable. Thus, I would find a second basis for resolving the compensability issue, *i.e.*, whether the breast implant qualifies as a prosthetic appliance under ORS 656.005(7)(a), an accidental injury to which would constitute a compensable injury. Based on the following, I find that it does.

As quoted above, ORS 656.005(7)(a) includes within the definition of a "compensable injury" an "accidental injury to prosthetic appliances," provided that the injury to prosthetic appliances meets certain other requirements.[1] ORS 656.005(7)(a) does not, however, define "prosthetic appliances." Therefore, it must be determined what the legislature intended by the term "prosthetic appliances."

In determining legislative intent, I look first to the text and context of the statute. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). Because the focus is on the meaning of specific statutory terms, I follow the methodology set forth in *Springfield Education Assn. v. School Dist.*, 290 Or 217, 221-30 (1980), which held that there are three classes of statutory terms, each of which conveys a different responsibility for the agency promulgating the rules under the statute and for the administrative/judicial body reviewing the agency's rule making: (1) terms of precise meaning, whether of common or technical parlance, requiring only fact-finding by the agency and administrative/judicial review for substantial evidence; (2) inexact terms which require agency interpretation and administrative/judicial review for consistency with legislative policy; and (3) terms of delegation which require legislative policy determination by the agency and administrative/judicial review of whether that policy is within the delegation.

I conclude that, as used in ORS 656.005(7)(a), the term "prosthetic appliances" is a statutory term within the second class described in *Springfield*. That is, it is a statutory term that embodies a complete expression of legislative meaning, even though its exact meaning is not obvious. *See Tee v. Albertsons, Inc.*, 314 Or 633, 637-38 (1992) (reaching same conclusion regarding term "gainful occupation" in ORS 656.206(1)(a)). An inexact term gives the agency interpretive but not legislative responsibility. *See Springfield Education Assn. v. School Dist.*, 290 Or at 233. In determining whether the agency's interpretation is consistent with legislative policy, I must discern and apply the legislature's intent. The best indication of legislative intent is the words of the statute themselves. *State ex rel Juv. Dept. v. Ashley*, 312 Or 169, 174 (1991). Words of common usage should be given their "plain, natural and ordinary meaning." *PGE* 317 at 611. Finally, an administrative agency may not, by its rules, amend, alter, enlarge, or limit the terms of the statute. *Cook v. Workers' Compensation Department*, 306 Or 134, 138 (1988).

The medical definition of "prosthetic" is "serving as a substitute; pertaining to the use or application of prostheses." *Dorland's Illustrated Medical Dictionary*, 28th Ed. (1994), page 1367. "Prostheses" is the plural of "prosthesis," which is defined as "an artificial substitute for a missing body part, such as an arm or leg, eye or tooth, used for functional or cosmetic reasons, or both." *Id.* Finally, although the general definition of "appliance" focuses on its use in dentistry, the term "prosthetic appliance" is defined as "a device affixed to or implanted in the body, designed to take the place, or perform the function, of a missing body part, such as an artificial arm or leg, or a complete or partial denture." *Id.* at 110. These definitions, taken as a whole, demonstrate that a prosthesis or prosthetic appliance can be used for functional or cosmetic reasons, or both.

In its definition of "prosthetic appliance," the Director's rule does not include any use regarding "cosmetic reasons." Instead, it defines a prosthetic appliance, in part, in terms of a device that aids functional performance. *See* OAR 436-010-0230(10) (defining a prosthetic appliance as "an artificial substitute for a missing body part or any device by which performance of a natural function is aided"). ORS 656.005(7)(a) provides no indication that a "prosthetic appliance" includes *only* devices that aid in performance of a natural function. By excluding cosmetic reasons in the definition of prosthetic appliances, the Director's rule limits the terms of ORS 656.005(7)(a).

In addition, by requiring consideration of the reason for a prosthetic appliance, the Director's rule places the concept of fault into the equation. Under the Director's rule, a "prosthesis" that does not replace a missing body part qualifies as a "prosthetic appliance" *only* if it aids in the performance of a "natural function." ORS 436-010-0230(10). Thus, a prosthesis that performs any other function, such as augmentation or cosmetic function, would not qualify as a "prosthetic appliance" under the rule. Such a requirement requires judgment of the value of the prosthesis, even to the extent of inserting the concept of fault, that is, if the reason for a prosthesis is anything other than to aid in the performance of a "natural function," it is not worthy of replacement if damaged or destroyed while in the course and scope of employment. In other words, if the reason for the prosthesis does not meet a specific value judgment, it is the worker's own fault for choosing to have the prosthesis in the first place. Under such

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[1] Those "other requirements" include arising out of and in the course of employment, requiring medical services, and being established by medical evidence supported by objective findings. As addressed by the majority, all of those "other requirements" have been met.

circumstances, under the Director's rule, replacement of such a prosthesis damaged in the course and scope of employment would not be covered under Workers' Compensation law. Such a restrictive definition places fault in the Oregon Workers' Compensation system, which is supposed to be a "no-fault" system. *See Andrews v. Tektronix, Inc.*, 323 Or 154 (1996) (the Oregon Workers' Compensation system is a "no-fault" system).

Therefore, for all of the reasons discussed above, I find that the Director's rule is not consistent with the legislative intent.

In addition, I find that the breast implant constitutes a "prosthetic appliance" under ORS 656.005(7)(a) in that it is a device implanted into the body that serves a cosmetic use. (Ex. 4). Thus, the work injury to claimant's breast implant is a compensable injury.

As for the penalty issue, at the time of the denial, there was no case precedent considering whether a breast implant constitutes a "prosthetic appliance" under ORS 656.005(7)(a) and OAR 436-010-0230(10). Moreover, as discussed above, in defining "prosthetic appliances," OAR 436-010-0230(10) included only devices that aided in the "performance of a natural function," omitting devices used for "cosmetic reasons." Given the language of OAR 436-010-0230(10) and the lack of case precedent interpreting that language, I agree that SAIF had legitimate doubt as to its liability for claimant's injury claim. *See Maria R. Porras*, 42 Van Natta 2625 (1990) (penalty and attorney fee not appropriate when the carrier's reliance on a former rule was reasonable).

In the Matter of the Compensation of
JOHN P. ADKINS, Claimant
WCB Case No. 99-0121M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cole, Cary, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's November 19, 1999 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary disability benefits from April 21, 1999 through October 28, 1999, less time worked. The insurer declared claimant medically stationary as of October 28, 1999. Claimant contends that the "own motion closure" was inappropriate and requests that we set aside that closure and remand the claim to the insurer for rating of permanent disability benefits and appropriate closure. We affirm the insurer's November 19, 1999 "Notice of Closure Board's Own Motion Claim."

FINDINGS OF FACT

On November 30, 1989, claimant compensably injured his right shoulder. The insurer accepted the claim for a right shoulder strain and a C5-6 disc herniation. Claimant's aggravation rights expired on November 30, 1994.

On January 14, 1999, Dr. Butters, claimant's attending physician, requested authorization for an arthroscopic right subacromial decompression. On January 20, 1999, claimant requested that his 1989 injury claim be reopened.

On March 29, 1999, the insurer submitted a "Carrier's Own Motion Recommendation" form that recommended reopening claimant's claim for own motion relief. That recommendation indicated that: (1) the accepted conditions were "right shoulder strain [and] C5-6 disc herniation;" and (2) the current condition was "possible right shoulder rotator cuff tear."

On April 1, 1999, the Board 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. When claimant's condition became medically stationary, the insurer was ordered to close the claim under the Board's own motion rules.

On April 21, 1999, claimant underwent the proposed right shoulder surgery, performed by Dr. Butters. On October 28, 1999, Dr. Butters examined claimant for a closing evaluation and declared him medically stationary.

On November 19, 1999, the insurer closed claimant's claim by Notice of Closure that awarded temporary disability benefits from April 21, 1999 through October 28, 1999, less time worked, and declared claimant medically stationary as of October 28, 1999. Claimant requested Board review of that Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Citing *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), claimant requests that the Board, in its own motion authority, review the insurer's November 19, 1999 closure. Claimant argues that the "own motion closure is inappropriate because the condition under treatment is the subject of an accepted claim for a new medical condition," contending that, on July 21, 1999, the insurer issued a "modified notice of acceptance" that accepted "the new medical condition of right partial rotator cuff tear."[1] Claimant requests that we set aside the insurer's closure and remand the claim to the insurer for "rating of permanent disability and appropriate closure." We interpret claimant's request as a request to order the insurer to process the claim pursuant to ORS 656.262(7)(c)[2] and 656.268. Claimant makes no argument regarding the merits of the closure.

Based on the following reasoning, we find that we have subject matter jurisdiction in our own motion capacity to review the November 19, 1999 closure. In addition, although we have no authority in our own motion capacity to order the insurer to process the claim pursuant to ORS 656.262(7)(c) and 656.268, we treat claimant's request that his claim be processed under ORS 656.262(7)(c) and 656.268 as a request for hearing before the Hearings Division on a "matter concerning a claim" pursuant to ORS 656.283.

In *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we recently issued orders in our own motion capacity and our "regular" capacity involving issues similar to those presented in the current case. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our own motion authority under ORS 656.278. There, as here, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

The Administrative Law Judge (ALJ) held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant requested Board review.

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the own motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was

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[1] We note that claimant did not submit a copy of this modified acceptance in support of his contention. Furthermore, there is no copy of that acceptance in the Own Motion record. Nonetheless, for the purpose of reviewing the November 19, 1999 Own Motion Notice of Closure, it is not necessary for us to determine whether the insurer issued a modified acceptance for a "right partial rotator cuff tear."

[2] ORS 656.262(7)(c), as amended in 1997, 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." This amendment applies retroactively to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See Mario R. Castaneda*, 49 Van Natta 2135 (1997).

obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our own motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a)[3] and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685.

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the April 1, 1999 Own Motion Order[4] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review the insurer's subsequent closure of that claim.[5] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the November 19, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect or his temporary disability compensation was incorrectly calculated. Instead, claimant's argument is solely procedurally-based, *i.e.*, claimant essentially argues that review of the carrier's Own Motion Notice of Closure should be under ORS 656.268 rather than the Board's own motion jurisdiction. Because we have rejected that argument and claimant raises no substantive arguments, we affirm the insurer's November 19, 1999 Own Motion Notice of Closure in its entirety.

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[3] 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[.]"

[4] We note that the April 1, 1999 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await a future case.

[5] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108, 111 (2000).

Finally, we turn to claimant's request that we order the insurer to process the claim pursuant to ORS 656.262(7)(c) and 656.268. As we have previously explained, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111.

In other words, in our own motion jurisdiction, we do not have authority to grant claimant's request to order the insurer to process the claim pursuant to ORS 656.262(7)(c) and 656.268. Claimant's relief, if any, regarding his request for additional benefits for the right partial rotator cuff tear condition lies with the Hearings Division, not the Board in our own motion jurisdiction.

In light of our decisions in *Ledin* and *Prince*, we treat claimant's request that his claim be processed under ORS 656.262(7)(c) and 656.268 as a request for hearing on a "matter concerning a claim" pursuant to ORS 656.283. Consequently, we have referred the matter to the Hearings Division.[6] WCB Case No. 00-02886.

Accordingly, the insurer's November 19, 1999 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

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[6] As we discussed in *Ledin*, a claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Thus, consistent with the *Ledin* rationale, inasmuch as we have herein affirmed the insurer's Own Motion Notice of Closure, temporary disability benefits paid pursuant to that closure order will need to be taken into consideration should the proceeding before the Hearings Division eventually result in a reopening of his claim under ORS 656.262 and closure pursuant to ORS 656.268.

In the Matter of the Compensation of
HECTOR M. BELTRAN, Claimant
WCB Case No. 99-03538
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that increased claimant's unscheduled permanent disability award for his low back injury from zero, as awarded by an Order on Reconsideration, to 2 percent (6.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant entitled to an award of 2 percent unscheduled permanent disability. In making this finding, the ALJ first concluded that the impairment findings of the medical arbiter, Dr. Hermans, should be used in determining claimant's unscheduled permanent disability. Relying on the range of motion findings in Dr. Hermans' report, the ALJ found that claimant was entitled to an impairment value of 8 percent. The ALJ then rejected claimant's argument that he was entitled to disability based on social/vocational factors.

Instead, the ALJ concluded that, under ORS 656.726(3)(f)(D)(ii), claimant had been released to available regular work, but that he had failed to return to work because of an intervening motor vehicle accident (MVA) and, therefore, was limited to an award of permanent disability based on permanent

impairment alone.[1] Finally, the ALJ apportioned the 8 percent impairment award under OAR 436-035-0007(2)(a) based on Dr. Hermans' finding that only 25 percent of claimant's low back impairment was related to the compensable injury and 75 percent was related to the intervening MVA. Citing *Lloyd S. Abraham*, 50 Van Natta 659 (1998), the ALJ determined that claimant was entitled to 2 percent disability.

On review, claimant contends that ORS 656.726(3)(f)(D)(ii) does not apply and that, therefore, the ALJ should have considered age, education and adaptability factors in determining his unscheduled permanent disability. Moreover, claimant argues that the ALJ should not have apportioned his permanent disability, asserting that *Abraham* was wrongly decided and that the apportionment rule, OAR 436-035-0007(2), is invalid.[2] For the following reasons, we agree with claimant that his permanent disability should not be based on impairment alone. We agree, however, with the ALJ that apportionment of claimant's permanent disability award is appropriate.

It is first necessary to refine the issue regarding consideration of social/vocational factors. It is clear that subsections (i) and (iii) of ORS 656.726(3)(f)(D) do not apply in this case because claimant never returned to regular janitorial work and claimant's employment was never terminated for cause unrelated to the injury. Thus, unless the requirements of subsection (ii) are satisfied, claimant is entitled to consideration of age, education and adaptability factors pursuant to ORS 656.726(3)(f)(A). Subsection (ii) requires a release by the attending physician to regular work, availability of the job, and, finally, the worker's failure or refusal to return to the regular work. Here, the record establishes that claimant was released to regular work and that claimant failed to return to work because of the intervening MVA. (Exs. 8, 12). The issue then is whether claimant's regular janitorial work was available.

The ALJ referred to two statements in the record regarding the availability of regular work issue. Although the ALJ considered them contradictory, we do not find them to be so. The first statement is from claimant's attending physician, Dr. Gray, who reported in a June 15, 1998 chart note that claimant had a low back strain and was released to light duty, but that, after few days, could have gone back to his regular job except that he had an MVA that involved the upper back and shoulders. (Ex. 12). The second statement is contained in Dr. Hermans' arbiter's report, where it is reported that claimant was doing janitorial work at the time of injury but that he did not return to that work due to the lack of availability of such work. (Ex. 32-1).

Having reviewed this evidence, we conclude that Dr. Gray's chart note does not address the availability of claimant's regular work. Instead, it addressed claimant's physical capacity, *i.e.* that claimant was physically capable of returning to regular work but for the intervening MVA. The only direct evidence in the record addressing job availability is contained in Dr. Hermans' report. Dr. Hermans' unrebutted history is that claimant's regular work was not available. *Id.*

Accordingly, we conclude that claimant's regular work was not available at the time he was released to regular work. Therefore, because availability of regular work is a required element of 656.726(3)(f)(D)(ii), that subsection is not satisfied. We, thus, find that claimant is entitled to consideration of age, education and adaptability factors in determining his unscheduled permanent disability. We now proceed with that permanent disability determination.

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[1] ORS 656.726(3)(f)(D) provides:

"Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if:

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury."

[2] OAR 436-035-0007(2) provides that:

"Where a worker has a superimposed condition, only disability due to the compensable condition shall be rated as long as the compensable condition is medically stationary and remains the major contributing cause of the overall condition. Then, apportionment is appropriate."

The claim closure in this case occurred on November 25, 1998. Thus, we apply the standards (Admin Order 97-065, effective 1/15/98) in effect at the time of closure. ORS 656.283(7); ORS 656.726(3)(f)(A).

OAR 436-035-0280 describes the steps in assembling the factors relating to unscheduled permanent disability. That rule provides that, after the basic value for impairment is determined using OAR 436-035-0320 through 436-035-0450 (step 1), the appropriate value for the age factor is determined using OAR 436-035-0290 (step 2). The appropriate value for the education factor is then determined using OAR 436-035-0300 (step 3). Age and education values are then added together (step 4). The appropriate value for the adaptability factor is then determined using OAR 436-035-0310 (step 5). Next, the sum of the age and education values is multiplied by the adaptability value (step 6). This product is then added to the impairment value and the resulting value is rounded off pursuant to OAR 436-035-0007(15) (step 7). This represents the percentage of unscheduled permanent disability to be awarded.

We now assemble the appropriate factors relating to claimant's unscheduled permanent disability in accordance with OAR 436-035-0280. Turning first to the impairment value (step 1), no party contests the ALJ's finding that the impairment value for lost range of motion (without apportionment) is 8. As previously noted, however, Dr. Hermans' attributed only 25 percent of claimant's impairment to the compensable injury. The ALJ apportioned claimant's permanent impairment due to the compensable injury pursuant to OAR 436-035-0007(2) and *Lloyd S. Abraham*. The issue then becomes whether and to what extent the 8 percent impairment value should be apportioned.

Claimant argues that apportionment is only appropriate under ORS 656.214(5) where there is a preexisting condition that has caused or contributed to the disability. Claimant asserts that the administrative rule is inconsistent with the statute when it allows apportionment in cases such as this where there has been a superimposed injury occurring after the compensable injury. Claimant requests that we overrule *Abraham* and find the administrative rule invalid.

Citing ORS 656.214(5) and OAR 436-035-0005(16), we noted in *Abraham* that, in order to be entitled to unscheduled permanent disability, the claimant must show "permanent loss of earning capacity due to the compensable injury." We further noted that unrelated impairment findings are excluded and not given a value under OAR 436-035-0007(2). We also observed that, under OAR 436-035-0007(2)(a), when a worker has a "superimposed condition," and the compensable injury is the major contributing cause of the "overall condition," impairment is apportioned and that only that portion of impairment findings "due to the compensable condition" receives a value.

Because a physician in *Abraham* indicated that she could only "hazard a guess" and "considered it impossible" to determine what portion of the claimant's impairment was due to the compensable condition, we found a lack of persuasive evidence concerning what portion, if any, of claimant's impairment should be given a value. In other words, the physician's report did not provide a preponderance of evidence regarding the claimant's impairment "due to the compensable condition." Consequently, we agreed with the carrier that the claimant was not entitled to unscheduled permanent disability.

After considering claimant's contentions, we decline his invitation to disavow *Abraham*. That case and the administrative rule are consistent with ORS 656.214(5), which provides that the criteria for rating unscheduled permanent disability shall be "permanent loss of earning capacity *due to the compensable injury*." (emphasis supplied).

Pursuant to OAR 436-035-0007(2)(a), claimant is entitled to 25 percent of the 8 percent impairment value. This equals 2 percent impairment. In accordance with OAR 436-035-0280, we next turn to the age and education values (steps 2-4).

Claimant was 19 years old at the time of reconsideration. Pursuant to OAR 436-035-0290(2), no value is given for the age factor (step 2). Claimant completed only the 10th grade and does not have high school diploma or GED certificate. A value of 1 is given for formal education. OAR 436-035-0300(2)(b). The Specific Vocational Preparation (SVP) value is based on claimant's janitorial work. DOT 382.664-010. This has an SVP of 3 and a value of 3. OAR 436-035-0300(3). Therefore, the education value is 4 (step 3). The sum of age and education is 4 (step 4). This sum is multiplied by the adaptability value (steps 5 and 6). Claimant was released to regular work. Based on this evidence, we are persuaded that claimant's residual functional capacity (RFC) is the same as his base functional capacity (BFC), and, therefore, claimant would be entitled to an adaptability value of 1. *See* OAR 436-035-0270(4)(a). However, OAR 434-035-0007(2)(b) provides that:

"In claims for the hip, shoulder, spine, pelvis or abdomen, where a worker's adaptability factor (residual functional capacity) is affected by the compensable condition, the physician shall describe any loss of residual functional capacity due only to the compensable condition and only that portion shall receive a value."

Dr. Hermans stated that his allocation of 25 percent impairment to the compensable injury also applied to residual functional capacity. (Ex. 32-4). Thus, 25 percent of claimant's adaptability value of 1 is attributable to the compensable injury. Therefore, we multiply this value (.25) times the sum of age and education (4). This equals 1. When added to 2 percent impairment (step 7), claimant's total disability due to the compensable injury is 3 percent. Claimant's unscheduled award is modified accordingly.

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 2 percent unscheduled permanent disability granted by the ALJ's order and the 3 percent unscheduled permanent disability granted by our order). However, the total "out-of-compensation" attorney fee granted by this order and the ALJ's order shall not exceed $3,800. ORS 656.386(2); OAR 438-015-0055.

ORDER

The ALJ's order dated October 22, 1999 is modified. In addition to the ALJ's award of 2 percent (6.4 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees), for a total of 3 percent (9.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order (1 percent unscheduled permanent disability difference between the ALJ's order and this order), payable directly to claimant's counsel. The total "out-of-compensation" attorney fee granted by this order and the ALJ's order shall not exceed $3,800.

In the Matter of the Compensation of
SYNNDRAH R. SPILLERS, Claimant
WCB Case No. 99-05069
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of claimant's right forearm (wrist), whereas an Order on Reconsideration had awarded 11 percent (16.5 degrees). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order. *See Kenneth W. Emerson*, 51 Van Natta 654, 655 (1999) (where no medical evidence describes disputed impairment as consistent with the compensable injury, *SAIF v. Danboise*, 147 Or App 550 (1997), does not apply); *Robert A. Moon*, 51 Van Natta 242, 244 n. 3 (1999) (medical evidence is necessary to establish that impairment is consistent with, or a direct medical sequelae of, the accepted condition).

ORDER

The ALJ's order dated November 18, 1999 is affirmed.

In the Matter of the Compensation of
THOMAS D. CAWARD, Claimant
Own Motion No. 99-0454M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's February 4, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from July 25, 1999 through December 29, 1999. SAIF declared claimant medically stationary as of December 29, 1999. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the February 4, 2000 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 March 9, 2000 letter, we requested SAIF submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. SAIF submitted its response on March 17, 2000, however, no further response has been received from claimant. Therefore, we will proceed with our review.

In a January 19, 2000 letter to SAIF, Dr. Bowman, claimant's attending physician, stated that were claimant working, he would be released to work. He also indicated that x-rays indicated claimant had full range of motion and was not in pain. Dr. Bowman further stated that "[claimant] would be declared medically stationary as of 12/29/99." This opinion is unrebutted.

In his request for review of SAIF's closure, claimant states that he is not medically stationary because his doctor has prescribed physical therapy that needs to be completed before a prosthetic will be made. He offers no medical documentation to support his contention. However, even if we were to consider claimant's assertion that he requires further physical therapy, this does not support the conclusion that he was not medically stationary when his claim was closed. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation, at claim closure, that further medical treatment would "materially improve" claimant's compensable condition. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Based on Dr. Bowman's unrebutted medical opinion, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's February 4, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
VENITA A. GALLAGHER, Claimant
WCB Case Nos. 99-02177 & 98-07248
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the insurer's denial of her cervical/thoracic degenerative disc disease and C4-5 disc pathology. The insurer cross-requests review of those portions of the ALJ's order that: (1) set aside its denial of claimant's current cervical/thoracic strain and right upper extremity conditions; (2) found that claimant had perfected a claim for aggravation; (3) awarded interim compensation from July 10, 1998 through March 30, 1999; and (4) assessed a penalty for the insurer's allegedly unreasonable failure to pay interim compensation. In its respondent's brief, the insurer asserts that the ALJ should have upheld its *de facto* denial of claimant's aggravation claim, and upheld its oral denial of claimant's C6-7 condition. On review, the issues are compensability, aggravation, interim compensation and penalties. We modify in part, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second paragraph on page 2 of the Opinion and Order, we delete the last sentence. In the third paragraph on page 2 of the Opinion and Order, we delete the last sentence. We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability - September 11, 1998 Denial

We adopt and affirm the ALJ's order regarding compensability of claimant's cervical/thoracic degenerative disc disease and C4-5 disc pathology with the following change. In the last paragraph on page 4 of the Opinion and Order that continues on page 5, we change the seventh sentence to read: "The preponderance of evidence establishes that claimant's cervical degenerative disc disease and C4-5 disc pathology is unrelated to her work injuries."

Compensability - Current Right Upper Extremity and Cervical/Thoracic Condition

Claimant's accepted conditions are a right arm strain, cervico-thoracic strain and right epicondylitis. (Exs. 34, 40, 42, 46, 56). The ALJ set aside the insurer's denial of claimant's current condition of a cervical/thoracic strain and right upper extremity problems. The ALJ found no medical opinion that claimant's right upper extremity problems were not due to the accepted condition of a right arm strain and right epicondylitis. The ALJ found there was no combined condition of the right arm that could make a current condition denial applicable. Consequently, the ALJ set aside the insurer's denial of claimant's right upper extremity problems. In addition, the ALJ found that the insurer's current condition denial of claimant's cervical/thoracic strain was not appropriate. The ALJ reasoned there was no persuasive evidence of a combined condition and, therefore, all of claimant's symptomatology and need for treatment was related solely to her accepted cervical/thoracic strain.

The insurer argues that claimant failed to establish compensability of her current cervical/thoracic and upper extremity conditions. The insurer contends that it accepted a combined condition and then denied that condition as required by ORS 656.262(7)(b). According to the insurer, it has established that claimant's current condition is due solely to factors that preexisted her accepted injuries or are independent of those injuries.

On the other hand, claimant contends that the insurer failed to prove there was a "combined condition." She argues that the insurer's denial of her mid-back and right arm conditions was procedurally and substantively improper and must be set aside.

We briefly recount the factual and procedural background of this case. On May 10, 1996, the insurer accepted a disabling thoracic strain resulting from claimant's February 1996 claim. (Exs. 2, 12). A July 30, 1996 Notice of Closure awarded temporary disability, but did not award any permanent disability. (Ex. 19).

Claimant signed a new "801" form on November 16, 1997 that referred to "tendonitis from repetitive use" and "back strain from lifting." (Ex. 30). The insurer initially accepted a nondisabling right arm strain with regard to the November 1997 claim. (Ex. 34). On February 26, 1998, claimant's attorney requested that the insurer amend its acceptance to include tennis elbow, tendinitis and cervical strain. (Ex. 34A). On March 30, 1998, the insurer modified the acceptance to include a nondisabling cervico-thoracic strain. (Ex. 40). The claim was later changed to disabling. (Ex. 42). On May 15, 1998, the acceptance was modified to include right epicondylitis. (Ex. 46).

On June 23, 1998, claimant's attorney requested that the insurer amend the acceptance to include a cervical disc herniation at C4-5. (Ex. 51A). On July 24, 1998, Dr. Long signed a "Notice of Claim for Aggravation." (Ex. 53).

On September 11, 1998, the insurer issued an "Updated Notice of Acceptance at Closure" that referred to the accepted conditions as right arm strain, right epicondylitis, and "cervico-thoracic strains combined with pre-existing degenerative disc disease at C4-5." (Ex. 56). On the same day, the insurer issued a Notice of Closure awarding temporary disability, but no permanent disability. (Ex. 57).

Also on September 11, 1998, the insurer issued a denial, which stated, in part:

> "Your right arm strain and right epicondylitis have resolved without permanent impairment and are medically stationary. Further, you have been diagnosed as having degenerative disc disease with a possible surgical lesion at C4-5. This degenerative disc disease and disc pathology is pre-existing and combined with your cervical and thoracic strains at work. Your compensable cervical/thoracic strain is not the major contributing cause of your ongoing need for medical treatment and disability. The major contributing cause of your current condition is no longer compensable. Therefore, without waiving further questions of compensability, we hereby issue this current condition denial of the cervical/thoracic degenerative disc disease and C4-5 disc pathology, as well as a current condition denial of the right upper extremity problems as it does not appear that the accepted injuries of 11/8/97 are the major contributing cause of your current condition and ongoing need for medical care and treatment and disability." (Ex. 55).

The ALJ indicated that the parties had agreed that the September 11, 1998 denial included a denial that claimant's cervical/thoracic degenerative disc disease, C4-5 disc pathology and right upper extremity problems were related to the February 1996 accepted condition. The parties stipulated that the September 11, 1998 denial also included a denial of claimant's aggravation claim regarding the 1996 injury. (Tr. 2-4).

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, the insurer's "Updated Notice of Acceptance at Closure" referred to the accepted conditions as right arm strain, right epicondylitis, and "cervico-thoracic strains combined with pre-existing degenerative disc disease at C4-5." (Ex. 56). 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). *See Gerry L. Schreiner*, 51 Van Natta 1998 (1999); *Billie L. Lore*, 51 Van Natta 1957 (1999).

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."

Claimant argues that the evidence the insurer relies on to support its current condition denial affirmatively disproves any change in her condition since the dates of the acceptances.

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 Gerry L. Schreiner*, 51 Van Natta at 1998 (the claimant's compensable injury was no longer the major contributing cause of the current combined cervical condition). Unlike *Noble*, we find that the medical evidence in this case establishes that claimant's compensable injuries are no longer the major contributing cause of her current condition.

The insurer accepted a right arm strain, cervico-thoracic strain and right epicondylitis. (Exs. 34, 40, 42, 46, 56). Dr. Long, claimant's current attending physician, diagnosed a cervical disc injury at C4-5 with myelopathy, bilateral lower extremity numbness, secondary to the C4-5 disc injury, abnormal painful discs at C3-4, C4-5, C5-6 and C6-7, and right upper extremity pain, radicular, associated with a C6-7 disc lesion. (Exs. 78, 81). Dr. Slack concurred with Dr. Long's findings and conclusions. (Ex. 69). Neither Dr. Long nor Dr. Slack indicated that claimant continues to suffer from a right arm strain, cervico-thoracic strain or right epicondylitis.

Drs. Berkeley and Misko also believed that claimant's current symptoms were due to a cervical disc problem. Dr. Berkeley diagnosed cervical spondylosis at C4-5 with stenosis, "giving rise to the patient's neck and shoulder-arm pain syndrome[.]" (Ex. 44-3). Dr. Misko diagnosed a disc protrusion with spinal cord and nerve root compression at C4-5 and C6-7, for which he performed cervical surgery on July 20, 1999. (Ex. 79). For the reasons discussed by the ALJ, we are not persuaded by Dr. Long's opinion that claimant's cervical/thoracic degenerative disc disease and C4-5 disc pathology is compensable.

The preponderance of medical evidence establishes that claimant's accepted right arm strain, cervico-thoracic strain and right epicondylitis had resolved and were medically stationary. Dr. Takacs was claimant's attending physician from January 1997 until May 1997. (Exs. 23, 63). Dr. Takacs treated claimant for thoracic pain and reported that, by May 22, 1997, claimant's pain was limited to T8-10, and she was medically stationary at that time. (Exs. 28, 63). (Ex. 63). Throughout the time Dr. Takacs treated claimant, she had no complaints of neck, arm (including tendonitis) or leg symptoms. (Ex. 74-1). Dr. Takacs said that claimant's work injury did not involve any neck or arm symptoms. (Ex. 63-2). She reported that the right arm and epicondylitis component of claimant's initial claim had resolved before Dr. Takacs treated her. (Ex. 74-1). Dr. Takacs did not believe anything other than claimant's thoracic strain and associated discomfort were related to her work injury. (Exs. 74-2).

Dr. Tesar examined claimant in March 1998 on behalf of the insurer. (Ex. 37). He felt that claimant's lateral epicondylitis of the right elbow was medically stationary without any permanent impairment. (Ex. 37-6).

Drs. Fuller and Radecki examined claimant in May 1998 on behalf of the insurer. (Ex. 48). They reported that claimant's right tennis elbow, cervical strain and cervical/thoracic conditions were medically stationary. (Ex. 48-9, -13). They did not believe claimant needed further treatment for her right arm strain or lateral epicondylitis. (Ex. 48-13). They found no impairment related to the industrial condition. (Ex. 58). After reviewing additional records, Dr. Fuller's impression was age-related degenerative disc disease at C3-4, C4-5, C5-6 and C6-7, with no evidence of a work-related injury to the cervical spine. (Ex. 70-3).

In August 1998, Dr. Calhoun examined claimant on behalf of the insurer. (Ex. 54). He felt claimant's cervicothoracic condition was medically stationary. (Ex. 54-7).

In sum, Drs. Long, Slack, Berkeley and Misko have attributed claimant's current symptoms to a cervical disc condition, which we have determined is not compensable. Dr. Takacs, claimant's previous attending physician, said that claimant's right arm and epicondylitis had resolved before she began treating claimant. (Ex. 74-1). Dr. Takacs felt that claimant's thoracic condition was medically stationary in May 1997. (Exs. 63). Dr. Takacs' opinion is supported by Dr. Tesar, who said that claimant's lateral

epicondylitis was medically stationary (Ex. 37-6), and Drs. Fuller and Radecki, who reported that claimant's right tennis elbow, cervical strain and cervical/thoracic conditions were medically stationary (Ex. 48-9, -13), and Dr. Calhoun, who also said that claimant's cervicothoracic condition was medically stationary. (Ex. 54-7).

Based on the foregoing medical reports, we conclude that claimant's compensable injury is not the major contributing cause of her current cervical/thoracic or right upper extremity symptoms. *See* ORS 656.262(6)(c). Consequently, we reverse the portion of the ALJ's order that set aside the insurer's denials of claimant's current cervical/thoracic strain and right upper extremity condition.

Perfection of Aggravation Claim/Interim Compensation

The ALJ found that Dr. Long's chart note that accompanied the aggravation claim form met the requirements of ORS 656.273(3) and triggered the insurer's responsibility to pay interim compensation. The ALJ concluded that claimant was entitled to interim compensation from July 10, 1998 to March 30, 1999.

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).

The insurer argues that claimant failed to perfect a claim for aggravation. The insurer contends that Dr. Long's reports did not meet the statutory requirements. Furthermore, the insurer asserts that claimant is not entitled to interim compensation because she failed to perfect her claim for aggravation.

On July 24, 1998, Dr. Long signed a "Notice of Claim for Aggravation." (Ex. 53). The form indicated that time loss was authorized from April 11, 1998 through September 24, 1998. (*Id.*) The insurer does not dispute that Dr. Long's July 24, 1998 chart note accompanied the aggravation claim form. Dr. Long became claimant's attending physician in March 1998. (Ex. 36). In the July 24, 1998 chart note, Dr. Long reported that claimant had neck, mid-back and right upper and lower extremity pain, as well as paresthesias in the left lower extremity. (Ex. 52-1). He indicated that claimant's total cervical motion was 76 percent of normal. (*Id.*) Dr. Long diagnosed:

> "Work injury 2/9/96 with,
>
> "a) clinical and imaging evidence of cervical disc injury, C45, central and right paramedian, with myelopathy.
>
> "b) bilateral posterior leg numbness, probably secondary to a).
>
> "c) right arm pain, probably secondary to a), without frank cervical radiculopathy." (Ex. 52-2).

Dr. Long questioned whether a C4-5 discectomy and fusion would relieve all of claimant's symptoms because it was not clear if the cervical pain was originating from lower levels. (*Id.*) For that reason, Dr. Long recommended cervical discography. (*Id.*)

ORS 656.273(3) provides:

> "A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative. The claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury."

We conclude that Dr. Long's July 24, 1998 chart note was sufficient to establish "by written medical evidence supported by objective findings" that claimant had suffered a worsened condition

attributable to the 1996 compensable injury. On July 24, 1998, Dr. Long indicated that claimant had neck, mid-back and right upper and lower extremity pain, as well as paresthesias in the left lower extremity. (Ex. 52-1). He indicated that claimant had reduced cervical range of motion and said that claimant might need a C4-5 discectomy and fusion. (Ex. 52-1, -2). Dr. Long's diagnosis specifically referred to claimant's "[w]ork injury 2/9/96 with" a cervical disc injury, bilateral leg numbness and right arm pain. (Ex. 52-2). In addition, Dr. Long authorized time loss from April 11, 1998 through September 24, 1998. (Ex. 53). We agree with the ALJ that Dr. Long's aggravation claim form and chart note triggered the insurer's duty to pay interim compensation.

"Interim compensation" is paid upon receipt of notice of a claim until the claim is accepted or denied, whereas temporary disability is paid after acceptance of the claim. *See Jones v. Emanuel Hospital*, 280 Or 147 (1977); *Labor Ready, Inc. v. Mann*, 158 Or App 666, 669-70, *mod* 160 Or App 576 (1999). ORS 656.262(4)(a) provides that the "first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." To trigger the worker's entitlement to interim compensation, the attending physician's authorization must relate the claimant's inability to work to a job-related injury or occupational disease. *Gustavo B. Barajas*, 51 Van Natta 613, *on recon* 51 Van Natta 732 (1999), *aff'd mem Nike, Inc. v. Barajas*, 166 Or App 237 (2000).

On July 24, 1998, Dr. Long submitted an aggravation claim form accompanied by his chart note of the same date. (Exs. 52, 53). Dr. Long advised the insurer that claimant was restricted from regular/modified work from July 24, 1998 through September 1, 1998. (Ex. 52-2). Dr. Long had previously authorized time loss beginning April 11, 1998. (Exs. 41-3, 53). Based on our review of the record, we are persuaded the insurer had notice of claimant's aggravation claim when it received the July 24, 1998 claim form and chart note.

Claimant asserts that her aggravation claim was neither accepted nor denied before the March 30, 1999 hearing. On the other hand, the insurer contends that it issued a denial sufficient to terminate entitlement to interim compensation. According to the insurer, both the aggravation claim form that claimant submitted and the accompanying chart note referenced the claim number for the November 8, 1997 claim. (Exs. 52, 53). The insurer reasons that its September 11, 1998 current condition denial referenced the same claim number (Ex. 55), and, as the parties stipulated at hearing, the denial covered both dates of injury. Therefore, the insurer argues that the denial effectively included claimant's aggravation claim.

The insurer's September 11, 1998 denial refers to claim number "787 CE 67890" and the "date of loss" as "11/8/97." (Ex. 55). The language in the denial makes no reference whatsoever to claimant's aggravation claim or to her February 1996 claim. In contrast, the aggravation form and Dr. Long's July 24, 1998 chart note referred to the date of injury as February 9, 1996 and the claim number as "787CEO67890M787." (Exs. 52, 53). In addition, Dr. Long's diagnosis specifically referred to claimant's February 9, 1996 work injury. (Ex. 52-2). We do not agree with the insurer that the claim number in the September 11, 1998 denial is the same as the claim number referred to by Dr. Long. Moreover, even if we assume that the claim number in the September 11, 1998 denial is the same number, but is merely incomplete, the insurer's denial clearly referred to the November 1997 injury, *not* the February 1996 injury. Under these circumstances, we are not persuaded that the insurer's September 11, 1998 denial included a denial of the aggravation claim.

We agree with claimant that the insurer did not deny the aggravation claim until March 30, 1999, the date of the hearing. (Tr. 2, 3). We find that the insurer's duty to begin payment of interim compensation was triggered when it received the July 24, 1998 aggravation claim and Dr. Long's July 24, 1998 chart note.

In *Labor Ready, Inc. v. Mann*, 158 Or App at 670, the court held that the employer's receipt of the claimant's attorney's September 26, 1996 letter triggered its obligation to pay interim compensation pending acceptance or denial of the claim. The court reversed and remanded for an award of interim compensation due from the date the employer received the September 26, 1996 letter. 160 Or App at 578.

We reach a similar conclusion in this case. Although we have determined that claimant's claim is not compensable, she is still entitled to interim compensation. The insurer's duty to begin payment

of interim compensation was triggered when it received the July 24, 1998 aggravation claim and Dr. Long's July 24, 1998 chart note. In other words, because those documents provided medical verification of an inability to work resulting from a *prima facie* compensable worsening under ORS 656.273(1), the insurer was required to begin the payment of interim compensation within 14 days from its receipt of the documents. *See* ORS 656.273(6).[1] Thus, claimant is entitled to an award of interim compensation due from the date the insurer received the July 24, 1998 documents until March 30, 1999. *See Gene T. Lapraim*, 41 Van Natta 956 (1989) (carrier is obliged to pay interim compensation for noncompensable claims from date carrier received notice of disability). We modify the ALJ's order accordingly.

Penalties

The ALJ assessed a penalty for the insurer's unreasonable resistance to the payment of interim compensation from July 10, 1998 to March 30, 1999.

The insurer argues that, because it was not obligated to process the July 24, 1998 claim, it did not act unreasonably.

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). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the information available to the carrier at the time it denied benefits. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Although we have determined that claimant perfected her aggravation claim and the insurer is obligated to pay interim compensation benefits, we do not consider the insurer's failure to have begun paying such benefits to have been unreasonable. We find that the insurer had a legitimate doubt as to whether claimant had perfected the aggravation claim, as well as a legitimate doubt regarding its liability to provide interim compensation on its receipt of the aggravation claim form and the July 24, 1998 chart note. Under these circumstances, we conclude that claimant is not entitled to a penalty.

July 24, 1998 Aggravation Claim

After the ALJ issued the September 7, 1999 order, the insurer requested reconsideration, requesting that the ALJ clarify the disposition of claimant's July 24, 1998 aggravation claim. The insurer asserted that the ALJ made no findings as to whether claimant had sustained her burden of proof regarding her aggravation claim.

On reconsideration, the ALJ responded that "a contrary finding was made and discussed[.]" Order on Reconsideration at 2. On review, the insurer contends that the ALJ erred by not expressly finding that claimant had failed to establish a compensable claim for aggravation.

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. *See SAIF v. Walker*, 330 Or 102 (2000). Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Id.*

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[1] ORS 656.273(6) provides:

"A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first installment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a compensable worsening under subsection (1) of this section."

Claimant's aggravation claim is apparently related to her February 1996 claim. The insurer accepted a thoracic strain resulting from claimant's February 1996 claim. (Ex. 12). A July 30, 1996 Notice of Closure awarded temporary disability, but did not award any permanent disability. (Ex. 19). As we discussed above, Drs. Long, Slack, Berkeley and Misko have attributed claimant's current symptoms to a cervical condition. (Exs. 44-3, 69, 78, 79, 81). Dr. Long diagnosed a cervical disc injury at C4-5 with myelopathy, bilateral lower extremity numbness, secondary to the C4-5 disc injury, abnormal painful discs at C3-4, C4-5, C5-6 and C6-7, and right upper extremity pain, radicular, associated with a C6-7 disc lesion. (Ex. 81). We have determined that the preponderance of medical evidence indicates that claimant's accepted condition is medically stationary. (Exs. 28, 48, 54, 63, 74).

We find that claimant's current cervical condition is not the same as the accepted condition from the 1996 injury. Therefore, claimant must first establish that her current cervical condition is compensable. As we discussed earlier, we agree with the ALJ that claimant has not sustained her burden of proving that her cervical/thoracic degenerative disc disease and C4-5 disc pathology is compensable. Consequently, we uphold the insurer's *de facto* denial of claimant's aggravation claim.

Oral Denial of C6-7 Condition

On reconsideration, the insurer requested that the ALJ amend the Opinion and Order to include a finding that a claim for a C6-7 condition was made at hearing, was denied and was not appealed. The ALJ reasoned that ORS 656.262 required written notice of a claim for a new medical condition, as well as a written denial, but neither had occurred with regard to claimant's C6-7 disc condition. Moreover, the ALJ said that the parties had not stipulated to litigate compensability of the C6-7 condition. The ALJ concluded that the insurer's oral denial of claimant's C6-7 condition had no legal effect.

On review, the insurer argues that the ALJ should have upheld its denial of claimant's C6-7 disc condition. We disagree.

At hearing, claimant's attorney stated that claimant was not making a claim for a C6-7 disc condition at that time. (Tr. 36-39). The ALJ said that, because claimant was not raising the C6-7 condition, there was nothing to rule on regarding that condition. (Tr. 39).

We find no evidence that claimant has made a "new medical condition" claim for a C6-7 disc condition. ORS 656.262(7)(a) sets forth very specific requirements for making a new medical condition claim. A claimant is obligated to "clearly request formal written acceptance" of the claimed new medical conditions. Because claimant did not request formal written acceptance of the C6-7 disc condition, we agree with the ALJ that the insurer's oral denial of the C6-7 disc condition had no legal effect. *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).

ORDER

The ALJ's order September 7, 1999, as reconsidered October 21, 1999, is reversed in part, affirmed in part and modified in part. That portion of the ALJ's order that set aside the insurer's denial of claimant's current cervical/thoracic strain and right upper extremity conditions is reversed. The insurer's denial of those conditions is reinstated and upheld. The ALJ's $3,000 attorney fee award is also reversed. The portion of the ALJ's order that awarded interim compensation from July 10, 1998 through March 30, 1999 is modified. Claimant is awarded interim compensation beginning the date the insurer received the July 24, 1998 documents until March 30, 1999. Claimant's "out-of-compensation" attorney fee is adjusted accordingly. The ALJ's penalty assessment is reversed. The insurer's *de facto* denial of claimant's aggravation claim is upheld. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
DAVE A. HUMPHREY, Claimant
WCB Case No. 99-0332M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's October 6, 1999 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary disability benefits from November 5, 1997 through January 18, 1998. SAIF declared claimant medically stationary as of February 2, 1998. Claimant requests that we abate this closure and remand the claim to SAIF for processing as a "new medical condition." We affirm SAIF's October 6, 1999 "Notice of Closure Board's Own Motion Claim."

FINDINGS OF FACT

During all of the time in question, claimant has worked for the same employer. On October 20, 1987, claimant compensably injured his low back. SAIF accepted the claim for a disabling dorsal-lumbar strain. Claimant's aggravation rights expired on September 20, 1993, five years from the date the claim was first closed.

By July 1988, Liberty Northwest Insurance Corporation (Liberty) had taken over workers' compensation coverage for the employer. On July 12, 1988, claimant experienced severe left leg pain when he stepped out of his truck at work. On October 5, 1988, Liberty accepted a gastrocnemius muscle tear condition.

Subsequently, claimant experienced ongoing back pain and intermittent left leg radicular pain. Ultimately, he was diagnosed with a L5-S1 disc herniation. On November 5, 1997, Dr. Gallo, treating surgeon, performed a left L5-S1 discectomy. Dr. Gallo provided medical care following the surgery and declared claimant's condition medically stationary on February 2, 1998.

Litigation proceeded regarding compensability of and responsibility for the L5-S1 disc herniation condition. By Opinion and Order dated February 2, 1999, the L5-S1 disc herniation condition was found compensable and SAIF was found responsible for that condition. Following SAIF's request for review, we affirmed the Opinion and Order. *Dave A. Humphrey*, 51 Van Natta 1003 (1999). Our order was not appealed and became final by operation of law.

On September 2, 1999, SAIF submitted a "Carrier's Own Motion Recommendation" form that recommended reopening claimant's claim for own motion relief. That recommendation indicated that: (1) the accepted condition was dorsal-lumbar strain; and (2) the current condition was "disk herniation L5-S1."

On September 24, 1999, the Board issued an Own Motion Order that authorized the reopening of claimant's claim to provide temporary disability compensation beginning November 5, 1997, the date claimant was hospitalized for surgery. When claimant's condition became medically stationary, SAIF was ordered to close the claim under the Board's own motion rules.

On October 6, 1999, SAIF closed claimant's claim by Notice of Closure that awarded temporary disability benefits from November 5, 1997 through January 18, 1998, and declared claimant medically stationary as of February 2, 1998. Claimant requested Board review of that Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Claimant requests that we abate SAIF's Own Motion Notice of Closure and remand the claim to SAIF for processing pursuant to *Johansen v. SAIF*, 158 Or App 672 (1999). Claimant argues that, as a consequence of the litigation determining that SAIF is responsible for the L5-S1 disc herniation condition, SAIF is required to process that condition as a "new medical condition, pay time loss, permanent disability, etc." We interpret claimant's request as a request to order SAIF to process the claim pursuant to ORS 656.262(7)(c)[1] and 656.268. Claimant makes no argument regarding the merits of the closure.

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[1] ORS 656.262(7)(c), as amended in 1997, 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." This amendment applies retroactively to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See Mario R. Castaneda*, 49 Van Natta 2135 (1997).

Based on the following reasoning, we find that we have subject matter jurisdiction in our own motion capacity to review the October 6, 1999 closure. In addition, although we have no authority in our own motion capacity to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268, we treat claimant's request that his claim be processed under ORS 656.262(7)(c) and 656.268 as a request for hearing before the Hearings Division on a "matter concerning a claim" pursuant to ORS 656.283.

In *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we recently issued orders in our own motion capacity and our "regular" capacity involving issues similar to those presented in the current case. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our own motion authority under ORS 656.278. There, as here, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

The Administrative Law Judge (ALJ) held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant requested Board review.

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the own motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our own motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a)[2] and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685.

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the

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[2] ORS 656.278(1)(a) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

September 24, 1999 Own Motion Order[3] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review SAIF's subsequent closure of that claim.[4] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 6, 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).

Here, claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect or his temporary disability compensation was incorrectly calculated. Instead, claimant's argument is solely procedurally-based, *i.e.*, claimant essentially argues that review of SAIF's Own Motion Notice of Closure should be under ORS 656.268 rather than the Board's own motion jurisdiction. Because we have rejected that argument and claimant raises no substantive arguments, we affirm SAIF's October 6, 1999 Own Motion Notice of Closure in its entirety.

Finally, we turn to claimant's request that we order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. As we have previously explained, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111.

In other words, in our own motion jurisdiction, we do not have authority to grant claimant's request to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. Claimant's relief, if any, regarding his request for additional benefits for the L5-S1 disc herniation condition lies with the Hearings Division, not the Board in our own motion jurisdiction.

In light of our decisions in *Ledin* and *Prince*, we treat claimant's request that his claim be processed under ORS 656.262(7)(c) and 656.268 as a request for hearing on a "matter concerning a claim" pursuant to ORS 656.283. Consequently, we have referred the matter to the Hearings Division.[5] WCB Case No. 00-02887.

Accordingly, SAIF's October 6, 1999 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

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[3] We note that the September 24, 1999 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await a future case.

[4] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108, 111 (2000).

[5] As we discussed in *Ledin*, a claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Thus, consistent with the *Ledin* rationale, inasmuch as we have herein affirmed SAIF's Own Motion Notice of Closure, temporary disability benefits paid pursuant to that closure order will need to be taken into consideration should the proceeding before the Hearings Division eventually result in a reopening of his claim under ORS 656.262 and closure pursuant to ORS 656.268.

In the Matter of the Compensation of
PAMELA A. MARTIN, Claimant
Own Motion No. 00-0127M
OWN MOTION ORDER

The self-insured employer has voluntarily reopened the claim pursuant to ORS 656.278 for claimant's compensable left knee condition. Claimant's aggravation rights expired on January 21, 1999. The employer asks the Board to authorize the reopening of the claim. However, the employer does not state it's position regarding claimant's workforce status. Upon review of the record, we find it sufficiently developed to reach a conclusion regarding claimant's workforce status at the time of her disability and issue the following order.

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

On March 28, 2000, claimant underwent a total knee replacement. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

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

With its recommendation form, the employer submitted medical reports from Dr. Heusch, 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 August 3, 1999 medical report, Dr. Heusch noted that claimant "has been employed for the past 37 years * * * where she does inspections." In a March 21, 2000 note, Dr. Heusch noted that claimant was to undergo surgery on March 28, 2000 and was advised not to work on March 27, 2000. Dr. Heusch further noted that claimant would be unable to return to work until "approximately" July 1, 2000.

Additionally, the employer submitted a copy of an insurer-arranged medical examination (IME). Dr. Jones, the IME physician, noted that claimant has worked for the last 36 years for the same company. He opined that claimant would probably be able to return to her regular duty work activities after her recovery from the proposed surgery. Dr. Jones further noted that claimant "finds her sense of well-being from work. [Claimant] enjoys her work." Finally, Dr. Jones opined that claimant was a "dedicated worker who wishes to go back to work after a total knee replacement." Dr. Heusch concurred with Dr. Jones' IME report in its entirety.

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 March 28, 2000, 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
KATHLEEN A. MEDLEY, Claimant
WCB Case No. 99-04561
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denial of her occupational disease claim for bilateral arm and shoulder conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.[1] We agree with the ALJ that claimant has failed to establish that her work activities were the major contributing cause of her bilateral arm and shoulder conditions. We write only to address claimant's argument that we should give greater weight to the opinion of her treating physician, Dr. Poulson.

We agree with the ALJ that it appears that Dr. Poulson had an inaccurate understanding of claimant's work activities. Dr. Poulson reported that claimants job involved repetitive motions involving the upper extremities, handling a keyboard and doing it under pressure. (Ex. 15). The ALJ noted, however, that claimants testimony indicated that her job was actually quite stationary. The movement required of her shoulders was minimal and her hands remained essentially stationary. Because Dr. Poulson's opinion appears to be 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).

Furthermore, even if we assume that Dr. Poulson had an accurate history, we find that his opinion on causation is not sufficient to establish that claimant's work activities were the major contributing cause of her bilateral arm and shoulder conditions. *See* ORS 656.802(2)(a).

Dr. Poulson first examined claimant on May 26, 1999. (Ex. 9). He reported that claimant had pain in both shoulders that radiated up into the cervical spine area and also had symptoms consistent with a cervical spine problem. (Ex. 9-1). He recommended a right shoulder MRI, which was negative. (Ex. 10). On July 20, 1999, Dr. Poulson reported that a cervical MRI showed rather advanced degenerative changes at the C5-6 and C6-7 levels with protrusion into the canal with compression of the cord which is probably causing her pain. (Exs. 13, 18A-47, -48). He recommended that claimant see a neurosurgeon for further evaluation. (Exs. 13, 18A-40).

On August 26, 1999, Dr. Poulson reported that claimant had a typical job that brings on this kind of problem which is repetitive motions involving the upper extremities, handling a keyboard and doing it under pressure. (Ex. 15). He agreed that the injury of 1/25/99 was the major contributing cause of claimants "present problems." (Ex. 16).

In a deposition, Dr. Poulson explained that his diagnosis was degenerative cervical spine and a shoulder strain. (Ex. 18A-55). He testified that claimants biggest problem seemed to be the cervical spine problem and she was also having pain in both shoulders. (Ex. 18A-41). He agreed that claimants degenerative condition was advanced enough that she could require surgery, which was why he recommended that she see a neurosurgeon. (Ex. 18A-50). Dr. Poulson explained that claimants cervical spine problem was separate from her shoulder problem, but he had not determined what percentage of claimants symptoms were coming from the cervical spine as opposed to the scapular area. (Ex. 18A-41, -57, -58). He was unable to separate how much of claimants shoulder complaints were related to the cervical pathology and how much was related to the shoulder strain. (Ex. 18A-58). Dr. Poulson agreed that cervical problems can radiate into the shoulders. (*Id.*)

In his August 26, 1999 report, Dr. Poulson said that the injury of 1/25/99 was the major contributing cause of claimant's "present problems." (Ex. 16). In the deposition, he made it clear that claimant had a degenerative cervical problem *and* a shoulder strain. Dr. Poulson agreed that claimant's

[1] We modify the ALJ's order to note that Exhibit 18A was admitted in evidence.

cervical problem was *not* related in major part to her work. (Ex. 18A-57). In light of Dr. Poulson's testimony that he was unable to determine which of claimant's symptoms were related to the "advanced" degenerative cervical condition and which symptoms were related to the shoulder strain, we are not persuaded that claimant's work activities were the major contributing cause of her shoulder strain. We conclude that Dr. Poulson's opinion is not persuasive because it is not well-reasoned and lacks adequate explanation.

ORDER

The ALJ's order dated December 3, 1999, as reconsidered December 15, 1999, is affirmed.

April 20, 2000 Cite as 52 Van Natta 728 (2000)

In the Matter of the Compensation of
BRENT L. MARLATT, Claimant
WCB Case Nos. 99-03277 & 99-03163
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of his claim for a low back injury. On review, the issue is compensability.

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

The ALJ found Dr. Gallego's opinion unpersuasive on the grounds that he had an incorrect history and that his opinion was conclusory and did not address claimant's preexisting conditions. Claimant argues that Dr. Gallegos eventually had a correct history. We disagree. The record does not contain any statement from Dr. Gallegos that establishes that he realized that he had recorded an incorrect history and that after considering the correct history he still maintained his opinion that claimant's actual work activities were sufficient to cause the injury.

Claimant also argues that the ALJ erred in relying on the opinion of Dr. Schilperoort because Dr. Schilperoort opined that there was only a possibility that claimant had a preexisting condition. We disagree. Dr. Schilperoort opined without qualification that claimant had preexisting kyphoscoliosis and leg length discrepancy that was "possibly currently symptomatic" at the time of the March 18, 1999 examination. (Ex. 13). Claimant's back and left leg pain had completely resolved by the time the April 14, 1999 claim denial was issued. Dr. Schilperoort opined that claimant's discomfort was caused by the preexisting conditions and not a work-related injury. Although Dr. Schilperoort was not sure that the preexisting conditions were still symptomatic at the time of his examination, he expressed his opinion regarding the cause of claimant's back and leg problem in terms of a probability, not a possibility.

ORDER

The ALJ's order dated October 25, 1999 is affirmed.

In the Matter of the Compensation of
LINDA N. SHINALL, Claimant
WCB Case No. 99-05512
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's occupational disease claim for a left foot 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 found that claimant proved compensability of her left foot condition, diagnosed as left plantar fasciitis. The insurer challenges that order, contending that the medical evidence is not sufficiently persuasive to carry claimant's burden of proof.

Claimant works as a security officer. During an eight-hour period, claimant conducts two inside patrols, each of which take between 45 minutes to one hour. Additionally, claimant conducts at least one outside patrol, which takes about 30 minutes. During the remaining five to six hours, claimant sits and answers the telephone.

In March 1999, claimant saw Dr. Hoang with complaints of left foot pain. In April 1999, Dr. Hoang referred claimant to Dr. Stevens, orthopedic surgeon. Claimant returned to Dr. Hoang for follow-up treatment. (Ex. 3-2).

The record contains several opinions concerning the cause of claimant's left foot condition. Examining orthopedic surgeon, Dr. Strum, explained that he considered the "main etiologic factors" to be claimant's age and obesity, both of which had been shown "to have a definitive cause-and-effect relationship with developing plantar fasciitis." (Ex. 3-5). Dr. Strum also stated that "simple walking," by itself, was not an etiologic factor. (*Id.*)

According to Dr. Strum, to the extent that claimant's walking had contributed to her symptoms, that factor had combined with her age and obesity; Dr. Strum, however, considered age and obesity to be the major contributing cause of claimant's left foot condition. (*Id.*)

Dr. Stevens reviewed Dr. Strum's report and concurred with "the findings." (Ex. 5).

Dr. Hoang reported that claimant's "constant walking, stretching, stress and pressure on her feet are contributing factors to the fasciitis problem." (Ex. 8-1). Dr. Hoang also noted "some difference of opinion" with Dr. Strum's evaluation in that he thought that claimant's "age and obesity are contributing factors * * * but it is the type of work and the constant stress of her foot due to the walking which is the major cause of her plantar fasciitis." (*Id.* at 2).

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to defer to Dr. Hoang's opinion.

Dr. Hoang does not explain why the "constant walking" was a greater factor than claimants age and obesity. That is, although agreeing that age and obesity contributed to her condition, Dr. Hoang provides no reasoning for his conclusion that walking was the major contributing cause.

In sum, we find that Dr. Hoang's opinion is not well-reasoned. Furthermore, Dr. Strum and Dr. Stevens came to contrary conclusions. Thus, at best, we find the medical opinions in equipoise. Consequently, we conclude that claimant did not carry her burden of proving that work activities were the major contributing cause of her left foot plantar fasciitis condition.

ORDER

The ALJ's order dated November 10, 1999, as corrected November 12, 1999, is reversed. The insurers denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

In the Matter of the Compensation of
PAUL E. SMITH, Claimant
WCB Case No. 99-0130M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Bottini, Bottini & Oswald, Claimant Attorneys
Crawford & Co., Insurance Carrier

Claimant requests review of the insurer's October 7, 1999 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary total disability compensation from January 13, 1999 through March 4, 1999. The insurer declared claimant medically stationary as of September 27, 1999. Claimant requests that the Board, in its own motion authority, review the insurer's closure "to include a determination of temporary disability and permanent disability with respect to the newly accepted L4-5 disc herniation condition." In addition, with his request for review of the insurer's closure, claimant submitted a request for hearing before the Hearings Division, requesting the same relief before that forum.[1] We affirm the insurer's October 7, 1999 "Notice of Closure Board's Own Motion Claim."

FINDINGS OF FACT

On August 11, 1987, claimant compensably injured his low back. The insurer accepted the claim for "L5-S1 and L4-5 bulge." The claim was first closed by Determination Order on January 9, 1989. Subsequently, claimant's claim was reopened twice for compensable aggravation claims, with the last aggravation claim being closed on March 26, 1992. Claimant's aggravation rights expired on January 9, 1994, five years from the first claim closure.

On December 23, 1998, claimant requested that his claim be reopened. On January 13, 1999, claimant underwent "re-exploration with laminectomy, foraminotomy, and diskectomy, right L4-5" performed by Dr. Brett, treating neurosurgeon.

On April 2, 1999, the insurer issued a denial of compensability of the L4-5 disc herniation condition. Claimant requested a hearing on that denial. WCB Case No. 99-02940. Also on April 2, 1999, the insurer submitted a Carrier's Own Motion Recommendation, recommending that claimant's claim not be reopened based on its contentions that the current condition was not causally related to the accepted condition, the insurer was not responsible for the current condition, and the surgery was not reasonable and necessary. On April 23, 1999, the Board postponed action on the own motion matter pending resolution of the litigation on the related compensability issue.

On August 2, 1999, the parties entered into a Stipulation and Order that resolved, *inter alia*, the compensability issue, with the insurer agreeing that it would "rescind the April 2, 1999 denial[,] * * * accept claimant's L4-5 disc herniation including appropriate benefits for the January 13, 1999 surgery, and * * * process claimant's Own Motion claim referenced as No. 99-0130M according to law."

On August 12, 1999, the Board issued an Own Motion Order that authorized the reopening of claimant's claim to provide temporary disability compensation beginning January 13, 1999, the date claimant was hospitalized for surgery. When claimant's condition became medically stationary, the insurer was ordered to close the claim under the Board's own motion rules.

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[1] Specifically, claimant raises the following issues in his request for hearing: (1) premature closure; (2) substantive entitlement to temporary total disability (TTD) and temporary partial disability (TTD); (3) scheduled and unscheduled permanent partial disability; "10-7-99 Notice of Closure, Board's Own Motion Claim;" and (4) attorney fees. Claimant's hearing request has been assigned WCB Case No. 00-02377. That hearing is scheduled before Administrative Law Judge (ALJ) Marshall on June 1, 2000.

On August 16, 1999, the insurer issued a Notice of Claim Acceptance that accepted a disabling L4-5 disc herniation condition as part of the August 11, 1987 injury claim.

On March 4, 1999, claimant returned to Dr. Brett, who released him to light work effective that date. Claimant was to return for a closing examination in June 1999; he did not return for that examination.

On March 29, 1999, claimant underwent an insurer-arranged medical examination performed by Dr. Smith, neurosurgeon. Dr. Smith found claimant medically stationary as of that date and noted that he was working in bank sales, which involved no lifting.

Claimant next saw Dr. Brett on September 27, 1999. Dr. Brett found claimant "medically stationary with a mild permanent partial disability in that he should not lift or carry more than 50 lbs."

On October 7, 1999, the insurer closed claimant's claim by Notice of Closure that awarded TTD benefits from January 13, 1999 through March 4, 1999, and declared claimant medically stationary as of September 27, 1999. Claimant requested Board review of that Notice of Closure. He also requested a hearing with the Hearing Division regarding that Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Citing *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), claimant requests that the Board, in its own motion authority, review the insurer's October 7, 1999 closure "to include a determination of temporary disability and permanent disability with respect to the newly accepted L4-5 disc herniation condition." We interpret claimant's request as a request to order the insurer to process the claim pursuant to ORS 656.262(7)(c)[2] and 656.268. In addition, with his request for review of the insurer's closure, claimant submitted a request for hearing before the Hearings Division, requesting the same relief before that forum. WCB Case No. 00-02377. Claimant makes no argument regarding the merits of the closure; however, on his hearing request he checks, *inter alia*, the issues of "[p]remature closure" and "[s]ubstantive TTD/TPD," although he does not indicate the period for which he seeks TTD/TPD.

Based on the following reasoning, we find that we have subject matter jurisdiction in our own motion capacity to review the October 7, 1999 closure. In addition, although we have no authority in our own motion capacity to order the insurer to process the claim pursuant to ORS 656.262(7)(c) and 656.268, we note that claimant has made a request for that relief before another forum that has such authority, *i.e.*, the Hearings Division.

In *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we recently issued orders in our own motion capacity and our "regular" capacity involving issues similar to those presented in the current case. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our own motion authority under ORS 656.278. There, as here, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

The Administrative Law Judge (ALJ) held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant requested Board review.

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[2] ORS 656.262(7)(c), as amended in 1997, 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." This amendment applies retroactively to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See Mario R. Castaneda*, 49 Van Natta 2135 (1997).

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the own motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our own motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a)[3] and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685.

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the August 12, 1999 Own Motion Order[4] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review the insurer's subsequent closure of that claim.[5] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 7, 1999 Notice of Closure, considering claimant's

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[3] 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[.]"

[4] We note that the August 12, 1999 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await a future case.

[5] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108, 111 (2000).

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).

Here, although raising the issues of premature closure and entitlement to temporary disability benefits, claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect or his temporary disability compensation was incorrectly calculated. Instead, claimant's argument is solely procedurally based, *i.e.*, claimant essentially argues that review of the carrier's Own Motion Notice of Closure should be under ORS 656.268 rather than the Board's own motion jurisdiction. Because we have rejected that argument and claimant raises no substantive arguments, we affirm the insurer's October 7, 1999 Own Motion Notice of Closure in its entirety.[6]

Finally, we turn to claimant's request that we order the insurer to process the claim pursuant to ORS 656.262(7)(c) and 656.268. As we have previously explained, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111.

In other words, in our own motion jurisdiction, we do not have authority to grant claimant's request to order the insurer to process the claim pursuant to ORS 656.262(7)(c) and 656.268. Claimant's relief, if any, regarding his request for additional benefits for the L4-5 disc herniation condition lies with the Hearings Division, not the Board in our own motion jurisdiction. As previously noted, claimant is currently pursuing that relief through his pending hearing request in WCB Case No. 00-02377.[7]

Accordingly, the insurer's October 7, 1999 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

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[6] Claimant requests that we review the insurer's closure in our own motion authority "to include a determination of * * * permanent disability with respect to the newly accepted L4-5 disc herniation condition." 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 in our own motion capacity.

[7] As we discussed in *Ledin*, a claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Thus, consistent with the *Ledin* rationale, inasmuch as we have herein affirmed the insurer's Own Motion Notice of Closure, temporary disability benefits paid pursuant to that closure order will need to be taken into consideration should the proceeding pending before the Hearings Division eventually result in a reopening of his claim under ORS 656.262 and closure pursuant to ORS 656.268.

In the Matter of the Compensation of
BILLY W. WASHINGTON, Claimant
WCB Case No. 96-0512M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Swanson, Thomas & Coon, Claimant Attorneys
EBI Ins. Co., Insurance Carrier

Claimant requests review of the March 31, 1999 Own Motion Notice of Closure issued by EBI Companies on behalf of Connecticut Indemnity Company (EBI) that closed claimant's claim with an award of temporary disability compensation from August 27, 1996 through October 6, 1997. EBI declared claimant medically stationary as of October 6, 1997. Claimant makes no arguments on the merits of the closure. Instead, he requests that the Board set aside the closure and remand his left knee condition claim to EBI for processing under ORS 656.262(7)(c).[1] We affirm EBI's March 31, 1999 Own Motion Notice of Closure.

FINDINGS OF FACT

On February 9, 1979, claimant compensably injured his left knee while working for the SAIF Corporation's insured. This injury resulted in a partial medial meniscectomy in February 1981, performed by Dr. Baum, claimant's treating orthopedist.

On September 13, 1984, claimant sustained a compensable left knee injury while working for EBI's insured. EBI accepted the injury claim and first closed the claim by Determination Order on April 16, 1985. Claimant's aggravation rights expired five years later, on April 16, 1990.

As a result of the 1984 injury with EBI's insured, claimant underwent three additional surgeries performed by Dr. Baum, with the last one occurring in March 1990. EBI reclosed the claim for the final time by an October 17, 1990 Determination Order.

On September 10, 1992, claimant sustained a compensable acute strain of the left knee, which was accepted as a longshore claim by a subsequent insurer. On November 6, 1992, EBI issued a current condition denial, indicating that it was not accepting responsibility for this injury and need for treatment. That denial became final by operation of law.

On July 31, 1995, Dr. Baum diagnosed tri-compartmental degeneration in the left knee with the medial compartment the dominant area of degeneration. After a referral for a second opinion regarding a total knee replacement, conservative treatment was attempted.

On July 2, 1996, claimant felt a pop in his left knee when he attempted to lift a 55 gallon drum while working for West Coast Paper. On August 27, 1996, Dr. Baum performed a left total knee arthroplasty for claimant's tri-compartmental degenerative arthritis.

On October 29, 1996, EBI denied compensability of and responsibility for claimant's current left knee condition. That same date, EBI submitted a Carrier's Own Motion Recommendation that recommended against reopening claimant's claim for Own Motion relief based on its contention that the current condition was not causally related to the accepted condition and it was not responsible for the current condition. Claimant requested a hearing on EBI's October 29, 1996 denial.

On November 8, 1996, the Board postponed action on the Own Motion matter pending resolution of the litigation regarding compensability of and responsibility for claimant's current left knee condition.

On October 31, 1997, an Opinion and Order issued that, in part: (1) found EBI responsible for claimant's current left knee condition and need for treatment; (2) set aside EBI's October 29, 1996 denial of claimant's current left knee condition; and (3) remanded the claim to EBI for processing in accordance with the workers' compensation laws. EBI requested review.

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[1] Claimant has also filed a request for hearing with the Hearings Division and requested the same relief before that forum, raising the issue of entitlement to unscheduled permanent disability benefits regarding the 1984 left knee injury claim, among other issues. Pursuant to that request, a hearing has been scheduled for June 8, 2000. WCB Case No. 00-01969.

On June 5, 1998, the Board adopted and affirmed the October 31, 1997 Opinion and Order. That same date, the Board issued an Own Motion Order that: (1) authorized reopening claimant's 1984 left knee injury claim to provide temporary disability compensation beginning August 27, 1996, the date he was hospitalized for surgery; and (2) ordered EBI to close the claim under the Board's Own Motion rules when he became medically stationary. These orders were not appealed and became final by operation of law.

In July 1998, claimant requested enforcement of the June 5, 1998 Own Motion Order. Later that month, the parties' entered into a Stipulation that resolved the enforcement dispute, including EBI's payment of $17,203.58 in temporary disability compensation, as well as penalties and out-of-compensation attorney fees. As a result of this agreement, the enforcement matter was dismissed by an August 17, 1998 Own Motion Order of Dismissal.

On March 31, 1999, EBI issued an Own Motion Notice of Closure that closed the 1984 injury claim that had been reopened pursuant to our June 5, 1998 Own Motion Order. This Notice of Closure awarded temporary total disability compensation from August 27, 1996 through October 8, 1996 and temporary partial disability compensation from October 9, 1996 through October 6, 1997. This temporary disability compensation totaled $17,203.58. EBI declared claimant medically stationary as of October 6, 1997.

Claimant requested Board review of EBI's March 31, 1999 Own Motion claim closure. Subsequently, claimant requested a hearing before the Hearings Division and raised, *inter alia*, the issue of entitlement to unscheduled permanent disability benefits. WCB Case No. 00-01969.

CONCLUSIONS OF LAW AND OPINION

Claimant requests review of EBI's March 31, 1999 closure, contending that that closure should be "overturned." Claimant makes no argument regarding the merits of the closure; instead, he requests that we order EBI to process the claim pursuant to ORS 656.268.

Based on the following reasoning, we find that we have subject matter jurisdiction to review the March 31, 1999 closure and decline to "overturn" it. In addition, although we have no authority in our own motion capacity to grant claimant's request to order EBI to process the claim pursuant to ORS 656.268, we note that claimant has made a request for that relief before another forum that has such authority, *i.e.*, the Hearings Division.

In *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we recently issued orders in our own motion capacity and our "regular" capacity involving issues similar to those presented in the current case. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our own motion authority under ORS 656.278. There, as here, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

The Administrative Law Judge (ALJ) held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant requested Board review.

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the own motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our own motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a)[2] and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685.

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Moreover, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the June 5, 1998 Own Motion Order[3] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review EBI's subsequent closure of that claim.[4] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 31, 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).

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[2] ORS 656.278(1)(a) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

[3] We note that the June 5, 1998 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await for a future case.

[4] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108 (2000).

Here, claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect or his temporary disability compensation was incorrectly calculated. In addition, in July 1998, the parties entered into a Stipulation in which they agreed to EBI's payment of temporary disability compensation in the amount of $17,203.58, the amount of "time-loss compensation paid" listed in the Own Motion Notice of Closure. Under such circumstances, we affirm EBI's March 31, 1999 Own Motion Notice of Closure in its entirety.

Finally, we turn to claimant's request that we order EBI to process the claim pursuant to ORS 656.262(7)(c). As we have previously explained, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111.

In other words, in our own motion jurisdiction, we do not have authority to grant claimant's request to order EBI to process the claim pursuant to ORS 656.262(7)(c). Claimant's relief, if any, regarding his request for unscheduled permanent disability benefits for the 1984 left knee condition lies with the Hearings Division, not the Board in our Own Motion jurisdiction.

Here, claimant has requested relief before the Hearings Division. Specifically, on March 14, 2000, claimant requested a hearing with the Hearings Division, raising, *inter alia*, the issue of entitlement to unscheduled permanent disability benefits regarding the 1984 left knee injury claim. Therefore, although we are without authority in our own motion capacity to direct a carrier to process a claim under ORS 656.262(7)(c), claimant is currently pursuing that remedy before the forum that has such authority.[5]

Accordingly, EBI's March 31, 1999 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

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[5] As we discussed in *Ledin*, a claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Thus, consistent with the *Ledin* rationale, inasmuch as we have herein affirmed EBI's Own Motion Notice of Closure, temporary disability benefits paid pursuant to that closure order will need to be taken into consideration should the proceeding before the Hearings Division eventually result in a reopening of his claim under ORS 656.262 and closure pursuant to ORS 656.268.

In the Matter of the Compensation of
LORNA D. WILLIAMS, Claimant
WCB Case No. 99-05773
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that affirmed an Order on Reconsideration that awarded claimant 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of the left hand. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the order of the ALJ, with the following supplementation.[1]

On review, the insurer contends that the medical arbiter violated Workers' Compensation Division rules and directives by reviewing medical records beyond those provided by the Appellate Review Unit. In support of this contention, the insurer requests that we take official notice of the Medical Arbiter Resource, which is a guide published by the Workers' Compensation Division and provided to physicians who perform medical arbiter examinations. Claimant opposes admittance of such evidence on the ground that the document was not in the reconsideration record and was not submitted at hearing.

We conclude that it is not necessary to determine whether administrative notice is proper in this case. Specifically, we conclude that even if we considered the portion of the guide relied on by the insurer, it would not change the result in this case. Although the guide provides that arbiters should review only the medical records provided by the Appellate Review Unit, in this case, as the ALJ noted, there is no evidence that the arbiter relied on prior records (which involved other body parts) in rating claimant's accepted condition.[2]

Claimant 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 $1,300, to be paid 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 December 3, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,300, to be paid by the insurer.

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[1] We note that the Department has submitted an "Intervenor's" brief on review. Pursuant to ORS 656.726(3)(h), we have considered the Department's brief. *See Larry A. Thorpe*, 48 Van Natta 2608 (1996). However, because the insurer has not continued to contest consideration of the medical arbiter's report on the basis it previously pursued at the hearing level, it is unnecessary for us to further address this contention (or the Department's position regarding this contention).

[2] We acknowledge that the arbiter referenced "extra-record" notes. Nevertheless, the arbiter's report does not indicate that these notes were the basis for his findings. To the contrary, the findings were based solely on the arbiter's exam and testing. (Ex. 22).

In the Matter of the Compensation of
PAUL E. CLARK, Claimant
WCB Case No. 99-02738
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's denial of his left hand injury claim. On review, the issue is whether the injury occurred in the course and scope of employment.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated November 8, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms without opinion the ALJ's determination that claimant's left hand injury did not occur in the course and scope of his employment. Because I would reach a different conclusion on these facts, I respectfully dissent.

The facts of this case are not in dispute. Claimant was employed as a foreman for the employer that was installing a fire control sprinkler system at a high school. This work would occasionally require power tools for cutting wood, but the employer did not provide all the necessary equipment. This necessitated employees such as claimant to borrow tools at the job site. Here, claimant and coworkers obtained permission from the high school janitor to use the saws belonging to the school.

On December 23, 1998, claimant was in the high school wood shop installing the sprinkler system. Claimant had been using a saw in the wood shop that night in order to cut pieces of wood to make headers. (Tr. 56). Claimant had just finished cutting some wood, when he broke for lunch. (Tr. 56, 61). In order to do the sprinkler installation properly, claimant and his crew needed to make and use wood headers. (Tr. 58).

After claimant had finished lunch, and after his unpaid half-hour lunch break was over, claimant walked over to another saw, which had a "dado" blade in it, to experiment with that machine. (Tr. 57, 64-5). A "dado" blade is a kind of saw blade typically used in cabinet making and is designed to cut channels of various widths in wood. Claimant was going to make a slight groove in the wood he had cut before lunch that he was going to use in the sprinkler installation. (Tr. 57). However, claimant did not need to cut the groove in order to install the header. He simply wanted to try out the "dado" blade because he had a project with cabinets at home for which use of that blade might be helpful. (Tr. 57, 65). Claimant had used that same saw with a different blade on prior occasions at the job site to cut headers. (Tr. 68).

In making the test cut, claimant sustained a severe left hand injury for which he sought medical treatment. The employer denied the claim as not having occurred in the course and scope of employment. The ALJ upheld the employer's denial. In doing so, the ALJ distinguished *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996), in which the court affirmed our determination that the claimant's injury occurred in the course and scope of employment, even though he was engaged in a personal project that did not benefit the employer. Unlike the ALJ, I find this case sufficiently similar to *Arnold* so that I would conclude that claimant's injury in this case is also compensable.

In *Arnold*, the claimant became ill after spray painting a helmet that he had taken to work. Spray painting was a personal project, but the employer in *Arnold* had a practice of allowing employees to engage in personal projects during their employment and to use the employer's equipment. As previously noted, the court affirmed our order finding that claimant's injury occurred in the course and scope of employment.

Specifically, we determined that the claimant's activities in sanding, priming and painting his own motorcycle helmet did not benefit employer and that the claimant had failed to obtain the employer's permission to work on his helmet with the employer's equipment. Nevertheless, we also found that the employer had acquiesced in the claimant's use of the employer's equipment to sand and prime the helmet and that the use of the employer's equipment for personal projects was typically allowed with permission during regular work hours. We further found that the claimant's exposure to various irritating gases was an ordinary risk of his work with sanding and priming equipment and that some exposure to paint spray from the painting booth also was a risk associated with his work. We also determined, however, that the same could not be said of the claimant's own use of the painting equipment, which was not an ordinary part of his job. We finally noted that the claimant's activities took place on the employer's premises and were paid for by the employer.

We then concluded that, considering all the above factors, without any one factor being dispositive, the claimant's activities in sanding and priming his helmet did arise out of his employment. We noted in particular that, although the claimant's work on his helmet was a personal mission, the employer acquiesced in its employees' activities on personal projects, at least to the extent that those activities were part of the employee's regular duties.

Obviously no case will contain exactly the same facts as *Arnold*. Therefore, there will inevitably be some differences between that case and this one. Nevertheless, I find this case sufficiently similar to *Arnold* so as to support a finding that this injury arose out of and in the course of claimant's employment.

As was true in *Arnold*, claimant here was injured while engaged in a personal project. That fact did not defeat compensability in *Arnold* and should not do so here. In fact, the deviation from claimant's employment in this case was much less significant than that in *Arnold*. Claimant here made only a brief and narrow departure from his work to make an experimental cut using the "dado" blade. This was a much less extensive personal project than the spray painting project in *Arnold* that the court found did not preclude a finding of compensability.[1]

Moreover, that the claimant's personal project in *Arnold* did not benefit the employer did not preclude a finding that the claim was compensable. The fact that the employer did not benefit from claimant's use of the "dado" blade should also not prevent claimant here from receiving benefits. Although claimant's use of the "dado" blade was for personal reasons, his use of the saw itself was work-related because he used it to make headers necessary for installation of the sprinkler system. In addition, like the claimant in *Arnold*, claimant here was on company time because he had finished his unpaid lunch break. (Tr. 57). Granted, unlike the claimant in *Arnold*, claimant in this case was not injured on the employer's premises. Claimant was, however, injured on the job site. I find no significant distinction between the two situations.

There are other similarities between this case and *Arnold*. In *Arnold*, the employer acquiesced in employees doing personal projects on the job. Here, the fact that the employer inadequately equipped its employees created the necessity that its employees use equipment at the high school. The employer either knew or should have known that its employees would use saws belonging to the high school to complete their work. This amounts to employer acquiescence in claimant's use of the saw that resulted in his injury. I acknowledge that the particular blade claimant was using to groove the header was not essential in his job duties. However, the departure from work activities was so minor as to be insignificant. In short, I find that, as was true in *Arnold*, there was employer acquiescence in this case.

Accordingly, I would conclude that, considering the totality of circumstances, claimant has proved that his injury arose out of and in the course of employment. Therefore, I would reverse the ALJ's order and find the claim compensable. Because, the majority has reached a contrary conclusion, I dissent.

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[1] As the court noted in *Kammerer v. United Parcel Service*, 136 Or App 200, 205 (1995) (citing Larson, 1A Workmen's Compensation Law section 23.00.), generally, if an employee's conduct does not amount to a substantial deviation from the course of employment, an injury suffered on the job is compensable.

In the Matter of the Compensation of
REBECCA A. MUNSON, Claimant
WCB Case No. 99-04393
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of that portion of the Administrative Law Judge (ALJ) Crumme's order that declined to direct the insurer to reopen the claim after setting aside the insurer's post-closure denial of a myofascial pain syndrome condition. On review, the issue is claim processing. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a cervical strain. In May 1998, the claim closed. In April 1999, claimant asked the insurer to modify its acceptance to include, among other conditions, a myofascial pain syndrome condition. The insurer then issued a denial of that condition.

The ALJ set aside that denial on the basis that the myofascial pain syndrome is simply a more specific classification of the cervical strain condition that insurer already accepted. The ALJ, however, refused to direct the insurer to reopen the claim for processing of the condition under ORS 656.262(7)(c). In this regard, the ALJ reasoned that the statute did not apply because the condition was already encompassed by the insurers previous acceptance.

Citing *Fleetwood Homes of Oregon v. Vanwechel*, 164 Or App 637 (1999) (a decision issued subsequent to the ALJ's order), claimant asserts that the insurer is required to reopen the claim because the myofascial pain syndrome condition was found compensable after claim closure. Alternatively, claimant contends that she proved a compensable aggravation of her cervical strain.

In *Vanwechel*, the court addressed whether ORS 656.262(7)(c)[1] required the carrier to reopen the claimant's claim because, after claim closure, it amended its acceptance to include two new conditions. On appeal, the carrier in part argued that it was not required to reopen the claim because the new conditions had already been processed.

In interpreting the statute the court found that the text unambiguously required reopening of the claim. In particular, the court reasoned that, because the carrier accepted new conditions after claim closure, it was required to reopen the initial claim and process those conditions. 164 Or App at 639.

We find that the holding in *Vanwechel* applies here. Whether or not the myofascial pain syndrome condition is considered as encompassed by the initial acceptance, it is a new condition that was not included in the initial acceptance.[2] By setting aside the insurer's denial, the ALJ effectively ordered the insurer to accept the myofascial pain syndrome condition. Thus, because the insurer was ordered to accept the myofascial pain syndrome condition after claim closure, we conclude that it is required to reopen the claim pursuant to ORS 656.262(7)(c).

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[1] ORS 656.262(7)(c), in pertinent part, 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. * * * 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] In finding that the myofascial pain syndrome condition did not come under ORS 656.262(7)(c) because it was encompassed by the initial acceptance, we understand the ALJ as concluding that the statute did not apply because the new condition had already been processed with the cervical strain condition. As noted above, the carrier in *Vanwechel* made a similar argument on appeal that was rejected by the court.

In light of this conclusion, we need not address claimant's alternative argument concerning a compensable aggravation. Finally, claimant is entitled to an out-of-compensation attorney fee of 25 percent of any increased temporary disability compensation created by this order, not to exceed $1,050, payable directly to claimant's counsel.[3] *See* ORS 656.386(2).

ORDER

The ALJ's order dated October 1, 1999, as corrected October 5, 1999, and reconsidered November 29, 1999, is reversed in part and affirmed in part. That portion of the order declining to order reopening of the claim is reversed. The insurer is directed to reopen the claim for further processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded an attorney fee of 25 percent of any increased temporary disability compensation created by this order, not to exceed $1,050, payable directly to claimant's counsel.

[3] Pursuant to claimant's retainer agreement, any "out-of-compensation" attorney fee payable from temporary disability granted by an ALJ or Board order shall be "25% of the compensation up to $1,050."

In the Matter of the Compensation of
DALE F. DEAN, Claimant
WCB Case No. 99-01247
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The self-insured employer requested review of that portion of Administrative Law Judge (ALJ) Marshall's order that set aside its partial denial of an L4-5 annular tear 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

On July 17, 1998, while working for the employer as a truck driver, claimant injured his low back while attempting to unhook a trailer with a jack. The employer accepted the injury as a disabling lumbosacral strain. Claimant asserts that he also sustained an annular tear at L4-5 as a direct result of the July 17, 1998 work injury.

Relying on the medical opinions of Dr. Walker, treating D.O., and Dr. Didelius, consulting M.D.,[1] the ALJ found that claimant established compensability of the L4-5 annular tear injury claim. Accordingly, the ALJ set aside the employer's partial denial of that condition. After our *de novo* review of the record, we find that the persuasive medical evidence does not support compensability of the L4-5 annular tear condition.

In order to establish compensability of the claimed L4-5 annular tear condition as a direct result of the July 17, 1998 work injury, claimant has the burden of proving that the work incident was a material contributing cause of that condition. ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

[1] On this record, Dr. Didelius' area of medical expertise is not clear. Claimant testified that Dr. Walker referred him to Dr. Didelius for treatment. (Tr. 20). The only medical evidence in the record from Dr. Didelius is a May 4, 1999 chart note, which appears to be an initial examination, and in which Dr. Didelius states that claimant's medical status is stable, without need for further treatment, intervention or diagnostic studies. (Ex. 68-3). That chart note does not indicate Dr. Didelius' area of medical expertise.

Claimant did not experience immediate pain following the July 17, 1998 work injury in which he lifted the con gear while attempting to unhook a trailer with a jack. But he felt like he had lifted too much weight. Following completion of his work shift, claimant went home and slept. He woke up with mid-back soreness and right lower extremity symptoms. The next day, claimant's soreness increased. On July 20, 1998, he sought medical treatment from Dr. Pfeiffer, chiropractor. MRIs taken on July 27, 1999, and September 18, 1998, showed a left paracentral high intensity zone annular tear without significant impingement or disc herniation. (Exs. 8A, 26A). Claimant had right lower extremity symptoms.

Given the delay in the onset of symptoms and the location of symptoms in the right leg versus the location of the left paracentral L4-5 annular tear, the issue of whether the claimed L4-5 annular tear condition is causally related to the July 17, 1998 work incident presents a complex medical question that must be resolved by expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993). In evaluating medical opinions, absent persuasive reasons to the contrary, we generally defer to the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, we find that the dispute involves expert analysis rather than expert external observations, and therefore, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284, 287 (1986); *Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979). 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).

The medical evidence supporting compensability is provided by Drs. Walker and Didelius. (Exs. 68, 69). Dr. Didelius stated that, because claimant "never had any prior symptoms or problems of his spine prior to the injury in question, it would seem reasonable to attribute at least the annular tear of the disc at L4-5 to the industrial accident." (Ex. 68-2). He also stated that "[t]he fact that [claimant's] pain was not immediately intense would be most compatible with the annular tear or disc injury being the primary injury from the industrial accident." (*Id.*). Based on these statements, Dr. Didelius concluded that, although claimant might have sustained a minor T11 fracture,[2] "on a more probably than not basis the more likely injury and the more certain injury would be that annular tear at the L4-5 level." (Ex. 68-3).

Regarding compensability of the L4-5 annular tear and whether a slight annular tear on the left side is inconsistent with claimant's right leg symptoms, Dr. Walker stated that "annular tears are well renowned for inconsistent and confusing symptoms. This is because the tear, while going through the healing process, sheds proteins, which irritate the nerve roots and sometimes are not selective towards left or right side." (Ex. 69-1).

In contrast are the opinions of Dr. Fuller, examining orthopedist, Dr. Radecki, examining physiatrist, and Dr. Geist, an orthopedist who was subsequently deposed by the parties.[3] (Exs. 56, 63, 64, 71). Drs. Fuller and Radecki reviewed the MRI films and Dr. Geist reviewed the MRI reports. (Exs. 56-6, 71-10). Thus, these physicians were aware of the defect in the left paracentral region of L4-5.

On February 10, 1999, Drs. Fuller and Radecki examined claimant, with Dr. Fuller dictating the medical report. They noted that the radiologist read the defect shown in the MRIs as an annular tear, but wondered if it was not a venous defect, considering that claimant had similar congenital anomaly, Schmorl's nodes, etc., elsewhere throughout his spine. (Ex. 56-8). Nevertheless, even considering that this defect was an annular tear, Drs. Fuller and Radecki opined that it was not caused by the work

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[2] The ALJ upheld the employer's partial denial of claimant's T11 fracture claim. Claimant did not challenge that portion of the ALJ's decision.

[3] Dr. Farris, neurologist, also examined claimant on behalf of the employer. (Exs. 30, 62). Although Dr. Farris reviewed the MRI reports, she did not render an opinion as to the cause of the annular tear. Finally, Dr. Palmer, M.D., examined claimant on referral from the employer and provided some treatment. (Exs. 7, 8A, 9). Following the initial MRI, Dr. Palmer listed his "impression" as "lumbar annular tear at L-4, 5 with a right L-4, 5 radiculopathy." (Ex. 9-2). However, he later listed his "impression" as claimant "has had a lumbar strain which is resolved." (Ex. 45-8-9). Claimant contends that this represents an unexplained change of opinion, presumably rendering Dr. Palmer's opinion unpersuasive. Nonetheless, even if we disregard Dr. Palmer's opinion, we find that claimant has failed to establish compensability of the annular tear condition.

injury based on two factors: (1) if the work injury caused an annular tear, the pain would have been immediate and claimant's symptoms were not immediate; and (2) the location of the suspected annular tear was not consistent with the location of claimant's symptoms in his right leg. As to the latter point, Drs. Fuller and Radecki explained:

> "When there is a definite hole in the annulus, it leaks enzymatic fluid which irritates the *adjacent* nerve root, thus causing the symptoms of sciatica without any of the physical or electrical signs. Thus, it is possible for [claimant] to have an annular tear irritating the *right* L5 or L4 nerve roots, but this type of scenario is not reflected by his present *left* sided MRI finding." (Ex. 56-8, emphasis added).

Dr. Geist reached the same conclusion, *i.e.*, that the work injury did not cause an acute annular tear, based on the same factors, *i.e.*, lack of immediate acute symptoms and location of the annular tear on the left versus the location of leg symptoms on the right. (Exs. 63-5-6, 64-1-2, 71-18-24). Dr. Geist repeatedly opined that annular tears are very painful when they occur. He also explained that, if claimant had slight but not acute symptoms at the time of the work injury, that would be more indicative of a strain than an annular tear because, with an annular tear, he would expect acute pain at the time of the accident. (Ex. 71-23). He also disagreed that symptoms on the right could be attributed to an annular tear on the left within a reasonable medical probability. (Ex. 71-24).

We conclude that there are persuasive reasons to defer to the opinions of Drs. Fuller, Radecki, and Geist, rather than the opinions of Drs. Walker and Didelius. *See Taylor v. SAIF*, 75 Or App 583 (1985). First, Fuller and Geist are orthopedic surgeons with special training and experience in diagnosing musculoskeletal conditions. While we recognize that Drs. Walker and Didelius are competent to offer an opinion with regard to an orthopedic problem, in this case we give greater weight to the opinion of physicians specializing in orthopedics. *See Thomas v. Liberty Mutual Ins. Corp.*, 73 Or App 128 (1985); *Abbott v. SAIF*, 45 Or App 657 (1980); *Ellen L. Hamel*, 40 Van Natta 1226 (1988). Moreover, the preponderance of the evidence establishes that an acute annular tear injury causes immediate pain, which did not occur here. Dr. Walker's opinion does not address this factor, and Dr. Didelius stated the opposite, *i.e.*, lack of immediate intense pain was compatible with the annular tear injury being the primary injury from the work accident.

In addition, the preponderance of the evidence establishes that, when there is a hole in the annulus, it leaks enzymatic fluid that irritates the *adjacent* nerve root, which was not reflected by claimant's left-sided MRI finding and his right leg symptoms.[4] Dr. Didelius did not address this factor and Dr. Walker stated, without explanation, that the leakage from the annulus tear "sometimes" is not selective toward the left or right side. To the extent that it represents a possibility rather than a reasonable medical probability, Dr. Walker's opinion is not persuasive. *See 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).

On this record, claimant failed to establish compensability of the L4-5 annular tear injury claim. Accordingly, we uphold the employer's denial of that condition.

ORDER

The ALJ's order dated August 30, 1999 is affirmed in part and reversed in part. That portion of the order that set aside the employer's partial denial of the L4-5 annular tear injury claim is reversed. The employer's partial denial of claimant's L4-5 annular tear injury claim is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

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[4] Claimant contends that a medical dictionary definition of "paracentral" as meaning "next to and close to or along side the center" supports a finding that the left paracentral L4-5 annular tear caused his right-sided leg symptoms and, thus, supports compensability of the annular tear claim. The record establishes that the medical experts were aware of the location of the L4-5 annular tear through review of either the MRI films or the MRI reports. We do not have the medical expertise to interpret the MRI films and/or reports, with or without the help of a medical dictionary. Instead, we must rely on the medical experts' opinions.

In the Matter of the Compensation of
DONNA J. HALL, Claimant
WCB Case No. 99-01485
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of her left knee condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. We do not adopt the ultimate findings of fact. On page 2, we replace the fifth paragraph with the following:

> Based on claimant's continued left knee symptoms and the results of a left knee MRI, Dr. Webb recommended surgery. (Ex. 32). On February 9, 1999, he performed left knee surgery, which consisted of a diagnostic left knee arthroscopy, joint debridement and [e]xcision arthrofibrosis with excision of the medial synovial shelf, left knee. (Ex. 37-1). Dr. Webb's post-operative diagnoses were: left knee arthrofibrosis, hypertrophied medial synovial shelf, and grade 1 to 2 chondromalacia medial tibial plateau. (*Id.*)

The ALJ found that Dr. Webb's history of a twisting injury on October 22, 1998 was not supported by the record and, therefore, his opinion on causation was not persuasive. In addition, the ALJ was not persuaded by Dr. Webb's opinion in light of the opinions of Drs. Weinman and Farris that the primary cause of claimant's symptoms was underlying and preexisting developmental factors.

On review, claimant argues that the ALJ erred in concluding there was no history of a specific twisting injury upon which Dr. Webb's opinion is based. According to claimant, an overwhelming preponderance of evidence supports the history given to Dr. Webb. Claimant contends that we should defer to the opinion of her treating physician, Dr. Webb.

For the following reasons, even if we assume that Dr. Webb had an accurate history regarding claimant's work injury, we conclude that his opinion is not sufficient to establish that claimant's work injury was the major contributing cause of her need for treatment or disability for her left knee condition.

The persuasive medical evidence establishes that claimant has preexisting left knee conditions that combined with her work injury to cause her disability and/or need for treatment. After performing claimant's left knee surgery, Dr. Webb diagnosed left knee arthrofibrosis, hypertrophied medial synovial shelf, and grade 1 to 2 chondromalacia medial tibial plateau. (Ex. 37-1). Dr. Webb reported that the ligamentum mucosum was fibrotic. (*Id.*) He excised the ligamentum mucosum and the medial synovial shelf. (Ex. 37-2).

Dr. Farris reviewed Dr. Webb's surgical report and said that claimant's pathologic synovial plica and the fibrotic ligamentum mucosum preexisted her October 1998 injury. (Ex. 40-7). Dr. Weinman agreed that those conditions preexisted the injury. (Ex. 41-11). Dr. Farris explained that a pathologic synovial plica was the result of developmental factors and was not related to trauma or repetitive microtrauma. (Ex. 40-8). He believed that claimant's work caused the preexisting synovial plica to irritate her knees and cause symptoms. (Ex. 40-9). We interpret Dr. Farris' opinion to mean that claimant's preexisting knee condition combined with her work injury to cause or prolong her disability or need for treatment. Therefore, under ORS 656.005(7)(a)(B), claimant must prove that the October 1998 work injury was the major contributing cause of the disability and/or need for treatment of the combined condition.

In light of the multiple possible causes of claimant's left knee condition, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (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). 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).

A determination of the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Even if we assume, without deciding, that Dr. Webb had an accurate history regarding claimants work injury, we find that his conclusory opinion is not sufficient to establish that claimants work injury was the major contributing cause of her left knee condition.

Dr. Webb first examined claimant on November 19, 1998 and diagnosed left knee chondromalacia patella and patellofemoral syndrome with synovitis. (Ex. 24). When claimant's symptoms did not improve, he recommended an MRI and later recommended a diagnostic arthroscopy. (Ex. 29). After the February 9, 1999 surgery, Dr. Webb diagnosed left knee arthrofibrosis, hypertrophied medial synovial shelf, and grade 1 to 2 chondromalacia medial tibial plateau. (Ex. 37-1). Dr. Webb's report on causation consists of a concurrence letter from claimant's attorney, in which he agreed with the following:

> "You felt that based on the history reflected in your chart note of November 19, 1998 and your operative findings, that her work injury was the major cause of her need for surgery. The surgery was necessary to remove arthrofibrosis which was caused to some degree by the injury of October 1998 and certainly made symptomatic by the injury." (Ex. 41A).

In contrast, Drs. Farris and Weinman did not believe claimant's injury was the major contributing cause of her disability or need for treatment. Dr. Farris concluded that claimant's preexisting pathologic synovial plica was the major contributing cause of her left knee condition. (Ex. 40-9). In a deposition, he said that claimant's primary problem has been a pathologic synovial plica, which was a congenital problem and was not the result of injury or overuse. (Ex. 42-10). Based on Dr. Webb's surgical report, Dr. Farris concluded that claimant's synovial plica was the cause of her knee symptoms, rather than a strain injury. (Ex. 42-19). Dr. Farris explained that claimant's synovial plica was big enough to irritate her knee and the repetitive irritation caused scarring in the knee. (Ex. 42-25).

Dr. Weinman agreed with Dr. Farris' conclusion that claimant's pathologic synovial plica and the fibrotic ligmentum mucosum preexisted her October 1998 injury. (Ex. 41-11). Likewise, Dr. Weinman believed that claimant's preexisting synovial plica was the major contributing cause of her left knee condition. (Ex. 41-12, -13).

Drs. Farris and Weinman provided well-reasoned and complete medical reports that considered the relative contribution of different causes of claimant's left knee condition. On the other hand, Dr. Webb did not discuss the contribution of claimant's preexisting synovial plica, as required under *Dietz*, 130 Or App at 402-03.

Furthermore, Dr. Webb's opinion is not persuasive because it lacks adequate explanation. Although Dr. Webb agreed that claimant's surgery was necessary to remove arthrofibrosis, he said the arthrofibrosis "was caused to some degree by the injury of October 1998[.]" (Ex. 41A). He does not explain why, if the arthrofibrosis was caused to "some degree" by the injury, the injury then became the "major cause" of her need for surgery. In addition, Dr. Webb's comment that the arthrofibrosis was "certainly made symptomatic by the injury" implies a "but for" or "precipitating cause" analysis. *Dietz*, 130 Or App at 401. We conclude that Dr. Webb's opinion is not sufficient to satisfy claimant's burden of proof.

ORDER

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

In the Matter of the Compensation of
VICKI L. HAVLIK, Claimant
WCB Case No. 98-00608
SECOND ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Sedgwick James of Oregon, Inc., Insurance Carrier

Claimant has requested reconsideration of our March 30, 2000 Order on Remand. Specifically, claimant contends that, in addition to the $4,725 attorney fee awarded by the Court of Appeals, his counsel is entitled to $10,500 for services at hearing and on Board review. Having considered claimant's request and her counsel's statement of services,[1] we proceed with our reconsideration.[2]

Where a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); *Deana F. Marshal*, 51 Van Natta 415, 417, n.2 (1999). Although statutory authority to award an attorney fee for services rendered at the hearings, Board, and court levels rests with this forum (because claimant did not finally prevail until the issuance of the Order on Remand), the court already granted claimant a $4,725 fee.

Neither party challenges the statutory basis for the court's attorney fee award for services on judicial appeal. In any event, after considering the factors set forth in OAR 438-015-0010(4), we would find that the court's $4,725 award represents a reasonable fee for claimant's counsel's services performed before that forum. *Id.*

We next turn to a determination of a reasonable fee for claimant's counsel's services at hearing and on Board review for finally prevailing over the employer's denial of claimant's mental disorder claim. Claimant requests $10,500, for 49.5 hours of attorney time at the hearings and Board levels. We accept claimant's counsel's unrebutted statement of services.

The hearing took a full day and involved ten witnesses, five of whom were presented by claimant. The record included 32 exhibits. The case involved legal issues centering around application of the phrase "generally inherent in every working situation" in ORS 656.802(3)(b). It also involved factual issues regarding the cause of claimant's mental disorder. These issues were more complex than those normally presented to this forum for resolution. Claimant's counsel submitted a 12 page appellant's brief on Board review.

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

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on Board review is $10,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's appellate arguments to the Board, and claimant's counsel's unrebutted statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated.[3] This award is in addition to the $4,725 awarded for services performed before the court, resulting in a total award for services rendered before all prior forums of $15,225, to be paid by the employer.

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[1] The self-insured employer has not objected to claimant's fee request.

[2] We acknowledge that claimant has filed a petition for judicial review of our March 30, 2000 Order on Remand. Because this order is being issued within 30 days of our March 30, 2000 order, we retain 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).

[3] We do not apply a contingency factor or "multiplier" in a strict mathematical sense. *See June E. Bronson*, 51 Van Natta 928, 931 n 5 (1999).

Accordingly, our March 30, 2000 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our March 30, 2000 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
TIMOTHY W. TRUJILLO, Claimant
WCB Case No. 99-00534
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) declined to remand to the Department for another medical arbiter's examination; and (2) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's pulmonary condition. On review, the issues are remand and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed a January 6, 1999 Order on Reconsideration that awarded claimant no unscheduled permanent disability for his compensable pulmonary condition.[1] In doing so, the ALJ rejected claimant's request that the claim be remanded to the Department because he had been deprived of a "complete" medical arbiter's examination.[2] The ALJ reasoned that he was without authority to remand to the Department for another arbiter's report and, further, that an additional report would not be admissible under the current statutory scheme.

On review, claimant contends that the claim should be remanded to the ALJ with an order that further evidence from the medical arbiter be obtained regarding his pulmonary function. The insurer argues that the ALJ properly held that there is no authority to grant claimant the relief he requests. For the following reasons, we decline claimant's request for remand.

In *Melody R. Ward*, 52 Van Natta 241 (2000) (a decision that issued after the ALJ's order), we held that, where neither a medical arbiter nor the Director requested a supplemental or "clarifying" medical arbiter's report, an ALJ was not authorized to remand a claim to the Director to obtain a "clarifying" report from a medical arbiter. In this case, neither the arbiter nor the Department represented that the arbiter's report was "incomplete." (Exs. 36, 37). Therefore, pursuant to *Ward*, neither the Board nor the ALJ are authorized to remand to the Director to obtain additional information from the medical arbiter. Moreover, as we noted in *Ward*, such "post-reconsideration" medical evidence would not be admissible under ORS 656.268(7)(g). Accordingly, we deny claimant's request for a remand to the ALJ so that further medical evidence may be obtained from the medical arbiter. We, therefore, proceed to an evaluation of the permanent disability issue based on the reconsideration record.

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[1] The ALJ also determined that the claim had not been prematurely closed by an August 17, 1998 Determination Order. Claimant does not challenge that portion of the ALJ's order on review.

[2] Claimant had argued that the medical arbiter had failed to measure his pulmonary function three consecutive times spaced one week apart as required by OAR 436-035-0385(4).

The medical arbiter, Dr. Johnson, opined that claimant's pulmonary function had deteriorated and that his condition was no longer medically stationary. (Ex. 36-7). When the medical arbiter opines that a claimant's compensable condition is no longer medically stationary and has worsened, it is not appropriate to rely on the arbiter's report in rating permanent disability. *See Randy S. Lay*, 51 Van Natta 649 (1999); *Georgina F. Luby*, 49 Van Natta 1828 (1997); *Phyllis G. Nease*, 49 Van Natta 195, *on recon* 49 Van Natta 301, *on recon* 49 Van Natta 494 (1997) (rejecting impairment findings of medical arbiter who believed that the claimant was not medically stationary and was in need of further medical treatment). In accordance with those decisions, we do not use Dr. Johnson's arbiter's report to determine claimant's permanent disability.

Instead, we look to medical evidence from claimant's attending physician at the time of closure, Dr. Fennell, or impairment findings with which he concurred. *See Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). In that regard, Dr. Fennell concurred with the report of an examining physician, Dr. Vitums, who opined that, while claimant might have mild exercise induced asthma, he could not determine what percentage was present before claimant's injury and whether the ashma condition was exacerbated by the industrial injury. (Exs. 29, 30). Claimant does not contend, and we do not find, that this evidence establishes that claimant has permanent impairment due to the compensable condition. Thus, we affirm the Order on Reconsideration that affirmed the August 17, 1998 Determination Order awarding no permanent disability for claimant's pulmonary condition.

ORDER

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

April 26, 2000 Cite as 52 Van Natta 749 (2000)

In the Matter of the Compensation of
STEVEN N. GRABENHORST, Claimant
WCB Case No. 99-06346
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of his occupational disease claim for a cervical condition. On review, the issue is compensability.

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

Dr. Rosenbaum indicated that he could not determine how much degenerative disease was present in claimant' cervical spine prior to September 1989, the date claimant began working for the employer. (Ex. 9). However, Dr. Rosenbaum opined that degenerative disease clearly preexisted the onset of claimant's symptoms in April 1999. (*Id.*). Dr. Rosenbaum's conclusion is supported by the fact that claimant frequently sought chiropractic treatment for cervical symptoms, prior to April 1999. (Ex. A). Because claimant's degenerative condition preexisted the commencement of claimant's treatment for the cervical disc herniation, we agree with the ALJ's conclusion that claimant did not carry his burden of proof under ORS 656.802(2)(b). *See Cessnun v. SAIF*, 161 Or App 367 (1999).

ORDER

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

In the Matter of the Compensation of
JOHN D. USINGER, Claimant
WCB Case No. 99-0119M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Steven M. Schoenfeld, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's January 28, 2000 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary disability benefits from December 31, 1998 through January 3, 2000. The insurer declared claimant medically stationary as of January 3, 2000. Claimant contends that the insurer prematurely closed his compensable cervical injury claim and requests that the Board, in its own motion jurisdiction, set aside the insurer's closure on that basis. In addition, claimant has requested a hearing before the Hearings Division, raising, *inter alia*, the issue of "[f]ailure to reopen [the] case as per *John* [*R.*] *Graham*[, 51 Van Natta 1740, 51 Van Natta 1746 (1999)]." Claimant's hearing request has been assigned WCB Case No. 00-00968. That hearing is scheduled for May 1, 2000. We set aside the insurer's January 28, 2000 Own Motion Notice of Closure as premature and remand the claim to the insurer.

FINDINGS OF FACT

On September 10, 1991, claimant compensably injured his neck. The insurer accepted the claim as a "nondisabling cervical strain" on December 9, 1991. Claimant's aggravation rights expired on September 10, 1996.

On November 12, 1998, claimant requested that the insurer reopen his claim. At that time, claimant's current cervical condition included a C6-7 disc herniation. On December 10, 1998, Dr. Brown, claimant's attending physician, referred him to Dr. Grewe, orthopedist. On December 31, 1998, Dr. Grewe performed cervical surgery, including C6-7 discectomy and fusion. Dr. Brown provided some follow-up care, last seeing claimant on February 26, 1999. Dr. Grewe also provided follow-up care, last seeing claimant on June 8, 1999.

On March 29, 1999, the insurer submitted a Carrier's Own Motion Recommendation, recommending that claimant's claim not be reopened based on its contentions that the current condition was not causally related to the accepted condition and it was not responsible for the current condition. On April 16, 1999, the insurer issued a partial denial, denying claimant's current cervical condition on the grounds that it was not related to the September 1991 work injury. Claimant requested a hearing on that denial.

On June 23, 1999, we postponed action on the own motion matter pending resolution of the litigation on the related compensability issue.

On November 11, 1999, the parties entered into a Stipulation and Order that resolved, *inter alia*, the compensability issue, with the insurer agreeing that it "rescinds its denial, agrees to accept claimant's aggravation claim, including his C6-7 disc herniation, and to pay compensation according to law." Claimant's hearing request was dismissed with prejudice.

On November 24, 1999, we issued an Own Motion Order that authorized the reopening of claimant's 1991 injury claim for the payment of temporary disability benefits beginning December 31, 1998, the date he underwent surgery. The insurer was ordered to close the claim under the Board's own motion rules when claimant's condition became medically stationary.

On January 3, 2000, claimant underwent an insurer-arranged examination (IME) performed by Drs. Williams, neurosurgeon, and Schilperoort, orthopedist, who stated that the accepted C6-7 disc herniation condition was medically stationary.

On January 14, 2000, claimant returned to Dr. Grewe, who prescribed physical therapy and advised claimant to try an aggressive reconditioning program during and following the physical therapy. Noting that claimant's ultimate limits were yet to be determined, Dr. Grewe concluded that claimant had potential to return to strenuous work depending upon his final outcome. In the meantime, Dr. Grewe released claimant to light duty work. Dr. Grewe reported that claimant had a follow-up appointment in about two months and "[i]t is presumed he will be medically stationary at that time."

On January 28, 2000, the insurer issued a "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary total disability benefits from December 31, 1998 through June 7, 1999, and temporary partial disability benefits from June 8, 1999 through January 3, 2000. The insurer declared claimant medically stationary as of January 3, 2000.

On March 10, 2000, Dr. Brown sent a letter to the insurer indicating that he had reviewed the January 3, 2000 IME report and agreed with its medically stationary finding.

On February 1, 2000, claimant requested a hearing with the Hearing Division raising, *inter alia*, the issue of "[f]ailure to reopen [the] case as per *John* [*R.*] *Graham.*" WCB Case No. 00-00968.

On February 14, 2000, claimant requested Board review of the insurer's January 28, 2000 Own Motion Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Citing *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), and *Craig J. Prince*, 52 Van Natta 108 (2000), claimant contends that the Board in its own motion capacity has authority to review the insurer's January 28, 2000 Own Motion Notice of Closure. The insurer responds that "this dispute is properly one for the Hearings Division," and requests that we refer the matter to the Hearings Division.[1] We agree with claimant.

Based on the following reasoning, we find that we have subject matter jurisdiction in our own motion capacity to review the January 28, 2000 closure. In addition, although we have no authority in our own motion capacity to order the insurer to process the claim pursuant to ORS 656.262(7)(c)[2] and 656.268, we note that claimant requested such relief before another forum that has such authority, *i.e.*, the Hearings Division.

In *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we recently issued orders in our own motion capacity and our "regular" capacity involving issues similar to those presented in the current case. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our own motion authority under ORS 656.278. There, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

The ALJ held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant requested Board review.

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the own motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

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[1] Subsequent to the insurer's statement of its position, claimant requested a hearing before the Hearings Division, as noted above. WCB Case No. 00-00968.

[2] ORS 656.262(7)(c), as amended in 1997, 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." This amendment applies retroactively to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See Mario R. Castaneda*, 49 Van Natta 2135 (1997).

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our own motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a)[3] and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685.

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the November 24, 1999 Own Motion Order[4] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review the insurer's subsequent closure of that claim. Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the January 28, 2000 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).

Here, three medical opinions address claimant's medically stationary status. On January 3, 2000, Drs. Williams, neurosurgeon, and Schilperoort, orthopedist, examined claimant on behalf of the insurer and stated that the accepted C6-7 disc herniation condition was medically stationary. On March 10, 2000, Dr. Brown, attending physician, reviewed the report of Drs. Williams and Schilperoort and found it "reasonable that [claimant] would be medically stationary as of this date one year after his surgery." Dr. Brown also stated that he "would not expect significant additional healing over one year after this type of surgical procedure."

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[3] 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[.]"

[4] We note that the November 24, 1999 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await for a future case.

Finally, Dr. Grewe, treating surgeon, saw claimant on January 14, 2000, having last seen him on June 8, 1999. Dr. Grewe noted that, when last seen, claimant's x-rays suggested he was establishing a solid fusion. At that time, claimant had been given a prescription to start physical therapy and return to light duty work if available. Claimant reported that he was unable to pursue the previously prescribed physical therapy or attend a follow-up appointment in September 1999 because his workers' compensation claim had not been accepted and he could not afford further medical care. After his claim was accepted, he returned for follow-up.

After examining claimant, Dr. Grewe prescribed physical therapy and advised claimant to try an aggressive reconditioning program during and following the physical therapy. Noting that claimant's ultimate limits were yet to be determined, Dr. Grewe reported that claimant had potential to return to strenuous work depending upon his final outcome. In the meantime, Dr. Grewe released claimant to light duty work. Dr. Grewe noted that claimant had a follow-up appointment in about two months and "[i]t is presumed he will be medically stationary at that time."

The insurer argues that Dr. Brown's opinion is most persuasive, noting that Dr. Brown, not Dr. Grewe, is claimant's attending physician. But a medical opinion regarding medical stationary status need not be rendered by the attending physician to be persuasive. In fact, here, the insurer itself relied on a medical opinion from IME physicians to find claimant medically stationary and close the claim. Apparently, it was not until that closure was challenged that the insurer sought Dr. Brown's opinion.

On the other hand, we generally give greater weight to the treating doctor's opinion, unless there are persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, two treating physicians provide opinions regarding claimant's medically stationary status: Dr. Brown and Dr. Grewe.

Dr. Brown referred claimant to Dr. Grewe for surgery. Although Dr. Brown provided some follow-up care after surgery, the record shows that he last saw claimant on February 26, 1999. There is no indication that Dr. Brown examined claimant prior to rendering his medically stationary opinion, which appears to be based solely on his review of the IME report. In addition, Dr. Brown's statement that it was "reasonable that [claimant] would be medically stationary as of this date one year after his surgery" relies on a general assumption rather than claimant's specific condition. Moreover, it is unclear whether Dr. Brown was aware that claimant had been unable to complete the physical therapy program prescribed in July 1999. In this regard, there is no indication that Dr. Brown reviewed Dr. Grewe's January 14, 2000 chart note.

On the other hand, Dr. Grewe examined claimant prior to rendering his medically stationary opinion. In addition, he noted that claimant was unable to undergo the physical therapy treatment prescribed in June 1999, and again prescribed physical therapy and reconditioning. He found that claimant had the potential to return to strenuous work depending upon his final outcome. Finally, as the physician who performed claimant's cervical surgery, Dr. Grewe is in a good position to determine when the cervical condition has become medically stationary. For all of these reasons, we find Dr. Grewe's opinion most persuasive. Therefore, based on Dr. Grewe's opinion, we find that claimant has met his burden of proving that he was not medically stationary at claim closure.

Accordingly, we set aside the insurer's January 28, 2000 Own Motion Notice of Closure as premature. The insurer is ordered to recommence the payment of temporary disability compensation in this claim, beginning the date the insurer previously terminated those benefits.[5] When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

Claimant's attorney is allowed an out-of-compensation fee in the amount of 25 percent of the increased temporary disability compensation, if any, awarded under this order, not to exceed $1,500. *See* OAR 438-015-0010(4); 438-015-0080.

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[5] We note that, by letter dated January 25, 2000, claimant requested that we enforce our November 24, 1999 Own Motion Order, contending that the insurer had improperly terminated his procedural temporary total disability benefits. Subsequently, on January 28, 2000, the insurer closed the Own Motion claim, rendering claimant's prior enforcement request moot.

Finally, we emphasize that our current order only deals with claimant's own motion claim. As noted above, we do not have authority in our own motion jurisdiction to order the insurer to process the claim pursuant to ORS 656.262(7)(c) and 656.268. Claimant's relief, if any, regarding his request for additional benefits (outside of the additional temporary disability benefits payable as a result of this own motion order) for the C6-7 disc herniation condition lies with the Hearings Division, not the Board in our own motion jurisdiction. *See Prince*, 52 Van Natta at 111. As previously noted, claimant is currently pursuing that relief through his pending hearing request in WCB Case No. 00-00968.[6]

IT IS SO ORDERED.

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[6] As we discussed in *Ledin*, a claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Thus, consistent with the *Ledin* rationale, inasmuch as we have herein set aside the insurer's Own Motion Notice of Closure, temporary disability benefits paid under claimant's own motion claim will need to be taken into consideration should the proceeding pending before the Hearings Division eventually result in a reopening of his claim under ORS 656.262 and closure pursuant to ORS 656.268.

April 26, 2000 Cite as 52 Van Natta 754 (2000)

In the Matter of the Compensation of
LOY W. WILLIAMS, Claimant
WCB Case No. 99-07972
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

FINDINGS OF FACT

On October 5, 1999, claimant signed a retainer agreement employing his former attorney to represent him in connection with his workers' compensation claim. The retainer agreement provided that claimant retained his former attorney to "represent me concerning my Workers' Compensation claim and any other claims that may arise from it."

On October 8, 1999, claimant, through his former attorney, requested a hearing challenging the insurer's denial of his claim and raising the issues of compensability and attorney fees. A hearing was scheduled for January 10, 2000. By handwritten note dated January 10, 2000, claimant's former attorney withdrew the hearing request. On January 11, 2000, the ALJ dismissed claimant's hearing request.

By letter dated January 20, 2000, claimant sent a letter to his former attorney terminating his former attorney's services. By another letter dated January 20, 2000 and received by the Board on January 25, 2000, claimant requested review of the ALJ's dismissal order. In that request, claimant contended that, on the date of the hearing, he had "accepted the decision" of a representative of the insurer that he had "no case against their client." By letter of February 8, 2000, claimant's former attorney filed a Resignation of Attorney form with the ALJ and the Board, providing copies to claimant and the insurer.

CONCLUSIONS OF LAW AND OPINION

Claimant has the burden of proving that the dismissal order was not appropriate. *Donald J. Murray*, 50 Van Natta 1132 (1998). 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. *Wilson O. Santamaria*, 52 Van Natta 657 (2000); *Robert S. Ceballos*, 49 Van Natta 617 (1997); *Gilberto Garcia-Ortega*, 48 Van Natta 2201 (1996).

Here, claimant does not contend that his former attorney did not in fact withdraw his request for hearing.[1] *Wilson O. Santamaria*, 52 Van Natta 657. Furthermore, the record indicates that claimant terminated his legal representation with his former attorney after issuance of the ALJ's dismissal order. Therefore, we find no reason to alter the dismissal order. *See Richard J. Rocha*, 49 Van Natta 1411 (1997); *William A. Martin*, 46 Van Natta 1704 (1994).

ORDER

The ALJ's order dated January 11, 2000 is affirmed.

[1] It appears that claimant disputes actions taken by his attorney on his behalf. We lack authority to address such issues. *See Gerald C. Alm*, 52 Van Natta 456 n2 (2000).

April 27, 2000 Cite as 52 Van Natta 755 (2000)

In the Matter of the Compensation of
JAMIE J. BOLDWAY, Claimant
WCB Case No. 98-07321
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers, Bock and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that awarded a $12,000 attorney fee under ORS 656.386(1) for claimant's counsel's services in setting aside its denials of claimant's low back and spondylolisthesis conditions. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact as supplemented below.

On March 23, 1999, the parties proceeded to hearing on the issues of SAIF's aggravation and compensability denials for claimant's spondylolisthesis and low back conditions. The hearing lasted all day. The parties called eight witnesses, seven on behalf of claimant. The transcript of the hearing consisted of 129 pages. The exhibits submitted totaled 73, 19 of which were originally submitted by claimant's attorney. However, claimant's attorney generated none of the exhibits. Four physician depositions were conducted, three requested by claimant and one requested by SAIF.

After the hearing, claimant's counsel submitted a statement of services to the ALJ. Claimant's counsel detailed the time spent on the claim by himself and his legal assistant. The total time spent by claimant's counsel was 38.12 hours.[1] His legal assistant spent an additional 8.7 hours on claimant's case.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded an attorney fee of $12,000 for claimant's attorney's services at hearing. In arriving at this figure, the ALJ reasoned that claimant's attorney spent almost 44 hours of time. The ALJ also noted that claimant's counsel was skilled and experienced, having practiced workers' compensation law predominantly since 1986. Moreover, the ALJ noted that claimant's counsel estimated his office overhead costs at between $15,000 and $25,000 per month. Finally, the ALJ increased the attorney fee to account for the fact that "claimants lose 51.8 percent of partial denial cases." (*O&O* at 12).

[1] The ALJ's Finding of Fact No. 10 is therefore modified to read: "Claimant's counsel devoted 38.12 hours to representing claimant in this matter; his assistant provided an additional 8.7 hours."

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-010(4). Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. *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).

SAIF contends that the attorney fee awarded by the ALJ was unreasonable in light of several factors. First, SAIF contends that time attributed to claimant's counsel's legal assistant cannot be considered in setting a reasonable attorney fee. OAR 438-015-0010(4)(a).

In *Candace L. Spears*, 47 Van Natta 2393, 2394 n1 (1995), we stated that legal assistant time could be considered only if it represented hours devoted to "research and investigation" which were subject to supervision by an attorney. (*Id.*) Here, we cannot discern from claimant's counsel's statement of services which, if any, time spent by the legal assistant amounted to research or investigation subject to supervision by an attorney. The tasks attributed to the legal assistant in the statement of services are predominantly, if not all, secretarial in nature. Because such secretarial services are not "research and investigation," we decline to consider the time spent by claimant's counsel's legal assistant (approximately 8.7 hours) in assessing a reasonable attorney fee. Instead, we consider only the 38.12 hours spent by claimant's counsel.

Turning to the remaining factors, we agree with the ALJ that claimant's counsel is skilled and experienced, as reflected in the qualifications noted in his November 5, 1999 letter. Moreover, based on compensability disputes typically litigated before the Hearings Division, this case was of above-average complexity in terms of the medical evidence. There were four depositions, one of which was requested by SAIF. One of the depositions was in Grants Pass, requiring claimant's counsel to travel from Medford. *See Marilyn E. Keener*, 49 Van Natta 110, 113 (1997) (attorney's time preparing for, traveling to, and attending depositions considered in assessing a reasonable attorney fee). At the hearing, which took an entire day and was recorded on a 129-page transcript, there were 73 exhibits, 19 of which were submitted, but not generated, by counsel for claimant.

Finally, considering the conflicting medical opinions, there was a significant risk that claimant's counsel's efforts might have gone uncompensated.[2] *See* OAR 438-015-0010(4)(g). In reaching this conclusion, we do not, however, take administrative notice of any statistics regarding the frequency with which claimants prevail over partial denials, as referenced by the ALJ. (*O&O* at 12). On this record, it is not clear from which source the ALJ derived this information. In any event, even if the ALJ had referenced statistics from the Department of Consumer and Business Services (the Director), we have held that the Director's "official records" do not represent agency decisions or orders, and as such, are not subject to administrative notice. *See Mark Grossetete*, 50 Van Natta 2235 n2 (1998); *Carrie Newton*, 50 Van Natta 1750, 1753 n1 (1998).

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[2] SAIF contends that consideration of claimant's attorney's "overhead" costs is not permissible in arriving at a reasonable attorney fee. After hearing, claimant's attorney submitted a letter to the ALJ in which he estimated that the cost of maintaining a "fully-staffed workers' compensation department" is "somewhere between $15,000 and $25,000." The ALJ considered this estimate of overhead expenses in setting the amount of the attorney fee. (*O&O* at 12).

As noted by SAIF, a claimant's attorney's office overhead costs is not expressly recited as a factor enumerated in the administrative rule. In *Michael A. Dipolito*, 45 Van Natta 1776 (1993), we suggested that a claimant's attorney's office overhead is not a directly relevant consideration in setting a reasonable attorney fee. ("Claimant's attorney offers no proof of the amount of time he spent on this matter, and aside from representations concerning his office overhead, does not address the factors set forth in OAR 438-15-010(4).")

Nonetheless, to the extent that such costs represent the expenses attributable to a claimant's attorney in pursuing denied claims and the risk that an attorney might go uncompensated for such services, such consideration is encompassed within the Board's attorney fee rules. However, as we have emphasized on several occasions, our consideration of the general contingency factor under OAR 438-015-0010(4)(g) is not by a strict mathematical factor. *Cheryl Mohrbacher*, 50 Van Natta 1826 (1998).

Based upon application of each of the previously enumerated rule-based factors and considering the parties' arguments, we conclude that $9,000 is a reasonable attorney fee for services at the hearings level in this case. In reaching this determination, we have primarily considered factors such as the time devoted to the case by claimant's attorney (as represented by the record, as well as claimant's counsel's statement of services and SAIF's objections), the value of the interest involved, the complexity of the issues, the nature of the proceedings (a full day hearing with four depositions), the skill and standing of claimant's counsel, and the risk that claimant's counsel might go uncompensated. Accordingly, we modify the ALJ's attorney fee award.[3]

ORDER

The ALJ's November 10, 1999 order is modified in part and affirmed in part. In lieu of the ALJ's $12,000 attorney fee award, claimant's counsel is awarded an attorney fee of $9,000 for services at hearing, payable by SAIF. The remainder of the ALJ's order is affirmed.

[3] Claimant's counsel is not entitled to an attorney fee for services on review regarding the attorney fee issue. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

Board Member Phillips Polich dissenting.

Because I believe that the ALJ's award of $12,000 was an entirely reasonable attorney fee in this case, I respectfully dissent.

After the hearing in this case, claimant's attorney submitted a statement regarding his requested attorney fee accompanied by a detailed statement of services. To avoid mischaracterization of the submission, I am including a complete copy of claimant's attorney's statement:

> Dear Judge Brown,
>
> Consider this letter compliance with your request that I submit some kind of statement regarding my work in this matter. This was, obviously, an incredibly complex case in light of the legal issues which were, to a great degree, separable from the medical issues. Both avenues had to be explored, the interplay of these two avenues, and the technical nature of such obviously makes this a highly complex case.
>
> This case involved four (4) depositions, one of Dr. Porter in Medford, Dr. Moline in Grants Pass, Dr. Kho in Grants Pass, and Dr. Weinman in Medford. These depositions, as reflected by the time indicated therein, were significantly time consuming and required a great deal of preparation. We had a hearing which lasted somewhere in the range of four hours which involved numerous witnesses, subpoenas, etc. * * *[1]
>
> In the award of a fee, you must remember that this is a contingency system which relates directly to the question of whether an attorney's efforts will be rewarded or not. As a contingency practice we do not keep strict time records, but the time has been reconstructed from our notes and discussions with my legal assistant.
>
> The value of the interest involved, should the claimant prevail, is indeed significant insofar as it involves the compensability of a current condition which includes a lumbar fusion and potential benefits from such a condition. The surgical notes of Dr. Potter reflect the significance of this surgery.
>
> I have been doing workers' compensation work since around 1986 when I began work for SAIF Corporation as a staff attorney and I worked for them for several years. Approximately 70 percent of my practice is workers' compensation related where I practice before the Workers' Compensation Hearings Division, Workers' Compensation Board and Appellate Courts. The other 30 percent of my practice involves the practice of Social Security Disability matters and includes legal/medical analyses relating to disability. I have practiced before the Hearings Division, WCB, and Court of Appeals and work on briefs to the Oregon Supreme Court. I am licensed in the Federal District Court of Oregon and the 9th Circuit Court of Appeals.

[1] Claimant's attorney's letter has been edited slightly to protect client confidentiality.

> In assessing attorney fees in the context of a contingency system like this is the reality that it is more difficult to obtain benefits for injured workers without a highly skilled and effective staff. I think it is a fair estimate that the cost of maintaining a workers' compensation department that is fully staffed in order to be able to serve the injured workers of southern Oregon at hearings, and appeals, is somewhere between $15,000 and $25,000 a month. Again, this is an estimate but I think it is a fair one given the number of fine staff we have had to hire along with the associated overhead of such. To argue that overhead is not relevant would be to ignore the contingency structure of the statutory fees here. The risk that the claimant could go uncompensated is certainly increased as a result of Senate Bill 1197 and Senate Bill 369. It appears that claimant's [*sic*] lose approximately 51.8 percent of partial denial cases. That being the case, the claimant's risk of going uncompensated is significant. The increased contingency nature of the practice due to legislative changes should result in higher attorneys' fees. (App. A).
>
> Finally, you need not be hypertechnical in assessing a fee as SAIF often contends. You merely need to comply with the general framework method by the Oregon Court of Appeals. *Smith [sic] v. Bacon*, 160 Or App 596 (1999). We feel an attorney fee in the $12,000 range would be appropriate in this case.

In response to claimant's attorney's request, ALJ Brown issued the following order on the issue of attorney fees:

> Claimant's attorney is entitled to an assessed fee for services at hearing. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, I find that a reasonable fee for claimant's attorney's services at hearing is $12,000, payable by SAIF Corporation. In reaching this conclusion, I have particularly considered the time devoted to the case, the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated. In particular, I note from Mr. Stevens' affidavit that it takes between $15,000 and $25,000 per month to keep his office open. Claimants lose 51.8 percent of partial denial cases. He spent almost 44 hours on this case. The hearing was abnormally long - almost a full day including final argument. Four depositions were taken, and seven lay witnesses testified. He has practiced workers' compensation law since 1986, and has demonstrated a high degree of skill in this and past cases that he has presented to me.
>
> Since he has only about 50 percent chance of prevailing representing injured workers, he must bring in approximately $20,000 for every 80 hours of work (he does not get paid for one-half of the work he does per month). That comes out to $250 per hour. Looking at it another way, if he were getting paid by the hour, he would have to bill out about 160 hours per month at $125 per hour to meet his overhead. One hundred twenty-five dollars is a reasonable amount to pay defense counsel; Mr. Stevens' skill and expertise is at least on a par with Mr. Ulsted's.
>
> Forty-four hours at $250 per hour is $11,000. Multiplying wages by hours is simplistic. The other factors - the risk of going uncompensated, the complexity of the issues involved, the value of the interest involved (claimant had a fusion); the skill of the attorneys, the nature of the proceedings, the benefit secured for Ms. Boldway, merit a high hourly rate. Claimant asserts a fee in the neighborhood of $12,000 is reasonable. I agree.

I believe that claimant's attorney and the ALJ did an admirable job of justifying the fee awarded in this case. I would not have disturbed the ALJ's award.

Specifically in regard to the issue of legal assistant time, I believe the majority has mischaracterized our precedent. Although legal assistant time may not be considered directly on the issue of the *attorney's* time spent on the case, legal assistant time *is* a relevant consideration in the total award of an attorney fee. In *Elloy Cuellar*, 48 Van Natta 814 (1996), we considered the claimant's counsel's statement of services which included "2.5 hours of legal assistant time" in awarding an assessed fee of $2,300. In *Candace L. Spears*, 47 Van Natta 2393 (1995), we stated that "to the extent that reference to 'paralegal' time represents hours of research and investigation subject to supervision

of an attorney, such efforts have been considered in evaluating a reasonable attorney fee. Of course, in light of the indirect involvement of the attorney, such services are accorded less significance than efforts directly expended by the attorney." 47 Van Natta at 2394 n1. I do not believe the majority's opinion adequately accounts for claimant's attorney's legal assistant time as a relevant *overall* factor in assessing an attorney fee in this case.

Moreover, we must remember that the Board precedent on attorney fees cited by the majority was all decided prior to *Schoch v. Leupold & Stevens*, 162 Or App 242 (1999), which requires the Board to undertake an analysis of *all* of the factors in the administrative rule and reach a reasoned conclusion on the amount of an assessed fee therefrom.

Calculation of a reasonable attorney fee is not done by strict mathematical factors. *Cheryl Mohrbacher*, 50 Van Natta 1826 (1998). Overall, claimant's attorney did an excellent job of accounting for his time spent on this case and justifying his requested fee under the factors contemplated by the administrative rule. Claimant's attorney is an experienced and skilled practitioner who faced a significant risk of going uncompensated in this complex medical case. Given the information provided to him, the ALJ's attorney fee award was reasonable. I would therefore have affirmed the ALJ's attorney fee award on this record. For these reasons, I respectfully dissent.

April 27, 2000 Cite as 52 Van Natta 759 (2000)

In the Matter of the Compensation of
LOUIS L. HARON, Claimant
Own Motion No. 66-0195M
OWN MOTION ORDER
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

On April 12, 2000, the SAIF Corporation submitted claimant's request for medical benefits relating to his compensable April 13, 1960 condition. SAIF recommends reopening of this claim under our own motion for the provision of medical services in the form of medications and office visits for claimant's compensable condition.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

We find that the requested medical services are reasonable and necessary and causally related to the compensable injury. Accordingly, the claim is reopened to provide the requested medical services.[1] *See* OAR 438-012-0037.

The claim shall remain reopened to provide the requested medical services. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] On April 12, 2000, SAIF issued a Notice of Closure which closed claimant's claim with an award of temporary disability compensation from January 8, 1990 through April 4, 2000. SAIF declared claimant medically stationary as of April 4, 2000. Inasmuch as temporary disability compensation has been terminated effective claimant's medically stationary date (to date, the closure has not been appealed nor set aside), the current reopening is for the provision of medical services only.

In the Matter of the Compensation of
SHERRY A. LOUGHER, Claimant
WCB Case No. 99-06817
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's left ankle injury claim. On review, the issue is 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 to address SAIF's arguments on review.

Claimant, an employee of the State Judicial Department, injured her left ankle when she slipped and fell on the stairs in the vestibule of the Multnomah County Courthouse while on her way out of the building during her paid morning coffee break. On review, SAIF argues that the employer did not exercise sufficient control over the stairs in the vestibule of the building and that claimant was not in the course of employment while on her break.

The Supreme Court has established a unitary test to determine whether an injury is compensable, which considers both whether the injury arose out of claimant's employment and whether it occurred in the course of it. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). Neither factor is dispositive. *Id.* Although the relationship may be measured in different factual situations by the application of one test or another, the ultimate inquiry is the same: is the relationship between the injury and the employment sufficient that the injury should be compensable? *Rogers v. State Acc. Ins. Fund*, 289 Or 633 (1980); *Torrko v. SAIF*, 147 Or App 678 (1997) (Board improperly focused only on the fact that the claimant was injured by an instrumentality over which the employer had control; instead, Board should have considered whether the totality of the events that gave rise to the claimant's injury was causally related to his employment (citation omitted)).

Here, the ALJ applied the unitary test in his analysis of whether the totality of the events that gave rise to the claimant's injury was causally related to her employment. As discussed by the ALJ, claimant was on a paid break; it was common for claimant and other workers to leave the building and their leaving was acquiesced in by the employer; the increase in morale and productivity as a result of the break benefitted the employer; the employer had some control over the steps where claimant fell; and claimant slipped on the worn-out non-skid strips that had been installed upon request of the employer. Under application of the unitary test, we agree with the ALJ that the totality of the events that gave rise to claimant's injury were causally related to her employment.[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 $1,500, payable by SAIF. In reaching this

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[1] SAIF cites to *Garnette D. Cone*, 51 Van Natta 848 (1999), in support of its argument that the employer did not exercise control over the area where claimant was injured. In *Cone*, a State Judicial employee fell when she slipped outside the employee entrance to the Washington County Justice Services Building while returning from her lunch break. The Board found no persuasive evidence that the State Judicial Department had any legal or contractual right to require that the county maintain the grounds outside the building adjacent to the employee entrance, even though complaints by judicial department employees were generally taken care of. In the absence of such evidence, the Board concluded that claimant had not satisfied the "in the course of" element of the work-connection test.

Here, in contrast, the injury occurred inside the courthouse rather than outside the building. Moreover, the evidence establishes that the employer had sufficient control over the premises to have routine maintenance performed and non-skid strips installed on the stairs where claimant slipped. This control, in addition to the other factors evaluated in this case, establishes the causal relationship between the injury and claimant's employment.

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 21, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DENNIS A. SHELDRICK, Claimant
Own Motion No. 00-0079M
OWN MOTION ORDER DENYING RECONSIDERATION

Claimant requests reconsideration of our March 10, 2000 Own Motion Order on Reconsideration, which authorized an approved fee for his attorney's services culminating in our March 6, 2000 Own Motion Order.[1]

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and *former* ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666; *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

Here, claimant's request for reconsideration was received on April 17, 2000, more than 30 days after the issuance of our March 10, 2000 Own Motion Order on Reconsideration. Claimant asserts that he was unable to timely file his request for reconsideration because he had to leave town due to his mother's illness. In support of his contention, claimant submitted a copy of his airline boarding pass demonstrating he flew out of town on April 8, 2000.

We have previously found that a claimant's preoccupation with other concerns during the time allotted to request reconsideration, review or appeal a denial, does not prevent him from the relatively simple task of filing a request for reconsideration. At best, we have found that the other concerns may have distracted a claimant from filing. Based on this reasoning, we have concluded that the claimant's lack of diligence does not constitute good cause. *James Minter*, 48 Van Natta 979 (1996); *William B. Potts*, 41 Van Natta 223 (1989). Consequently, we deny claimant's request for reconsideration.[2]

IT IS SO ORDERED.

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[1] Our March 6, 2000 Own Motion Order authorized the reopening of claimant's claim for the provision of temporary disability compensation beginning the date he is hospitalized for surgery. ORS 656.278.

[2] Following his request for reconsideration, claimant submitted a copy of a letter sent to his attorney of record declaring his "revocation" of their retainer agreement and announcing his retention of a new attorney. Notwithstanding this "post-order" revocation, had we reconsidered our prior decision, we would not alter our attorney fee award. In reaching this conclusion, we note that any attorney fee dispute between claimant and his former attorney is a matter between them, not this forum.

In the Matter of the Compensation of
RALPH A. SCHULTZ, Claimant
Own Motion No. 00-0136M
OWN MOTION ORDER

The self-insured employer has submitted a request for temporary disability compensation for claimant's compensable right wrist and shoulder conditions. Claimant's aggravation rights expired on August 20, 1998. The employer recommends that we authorize the payment of temporary disability compensation However, the employer does not state it's position regarding claimant's workforce status. Upon review of the record, we find it sufficiently developed to reach a conclusion regarding claimant's workforce status at the time of his disability and issue the following order.

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

On June 14, 1999, claimant underwent a right carpal tunnel release. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

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

With its recommendation form, the employer submitted medical reports from Dr. Hayes, 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 March 1, 1999 chart note, Dr. Hayes noted that claimant was a "63 [year old] truck driver." He noted that claimant had pain in his wrist and shoulder when he was "writing out a load ticket" and "throwing wrappers across the loads." In the June 14, 1999 History and Physical Report, Dr. Hayes again noted that claimant was currently a truck driver.

Additionally, the employer submitted a copy of an insurer-arranged medical examination (IME). Drs. Scheinberg and Denekas, the IME physicians, noted that claimant has worked since 1956 for the same company. They noted that claimant was off work following the June 1999 surgery until two weeks prior to their October 1999 IME examination. They further noted that claimant had "resumed full work" as a truck driver, working nine hours a day, five days a week.

Thus, we conclude that claimant was in the work force at the time of his 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 June 14, 1999, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT W. SMITH, Claimant
WCB Case No. 99-04007
ORDER ON REVIEW (REMANDING)
Martin L. Alvey, Claimant Attorney
Hitt, 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 self-insured employer's denials of his current left shoulder condition and thoracic outlet syndrome. Claimant also requests remand for the submission of additional medical evidence. On review, the issues are remand and compensability. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph on page 2, we change the date in the eighth sentence to "November 19, 1998." In the first full paragraph on page 3, we change the first sentence to read: "Dr. Irvine did not agree with Dr. Woodward's findings and conclusions and he continued to diagnose thoracic outlet syndrome." In the third full paragraph on page 3, we clarify that the findings in that paragraph were the opinion of Dr. Farris. We do not adopt the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought to establish compensability of his thoracic outlet syndrome and current left shoulder condition. The ALJ concluded that the more persuasive expert medical opinion was that there was a psychological basis for claimants pain behavior. The ALJ was not persuaded by the opinion of claimant's attending physician, Dr. Irvine, in part, because there were no objective findings to substantiate claimant's thoracic outlet syndrome. The ALJ commented that Dr. Irvine might be correct that claimant suffers from thoracic outlet syndrome, "but there wasn't much to go on in this record." (Opinion & Order at 6). The ALJ noted that Dr. Irvine said that he would know if claimant had thoracic outlet syndrome if he responded well to surgery.

On review, claimant requests remand for consideration of new medical evidence regarding his surgery. He contends that the newly discovered evidence concerns disability, was not obtainable at the time of hearing and is reasonably likely to affect the outcome of the case. According to claimant, the newly discovered evidence establishes definitively that he had thoracic outlet syndrome and that surgery for removal of his cervical rib has resulted in a near complete resolution of his symptoms.

Claimant submits a December 9, 1999 surgical report from Dr. Hill, who performed a left first rib resection. Dr. Hills diagnosis was left thoracic outlet syndrome. Claimant submits a December 10, 1999 discharge summary from Dr. Hill, as well as a December 20, 1999 chart note that noted claimant had no complaints and said that everything feels better. Claimant also submits a January 7, 2000 chart note from Dr. Irvine, who reported that claimant was making excellent progress after his surgery. Dr. Irvine indicated claimant's symptoms were almost completely resolved. Claimant also submits documents indicating that Dr. Irvine released claimant for regular duty work without restrictions on January 7, 2000.

The employer opposes claimants motion for remand. In particular, the employer argues that the additional evidence submitted by claimant would not reasonably be likely to affect the outcome of the case. The employer contends that, at most, the new evidence indicates claimant is no longer reporting pain in his shoulder and neck. The employer argues that, in light of the ALJs adoption of Dr. Farris diagnosis of pain behavior, little credence should be given to claimants reports that surgery has alleviated his symptoms.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *See Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1983) (Board has no authority to consider newly discovered evidence). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason

exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, we conclude that a compelling reason has been shown for remanding the case. First, the evidence regarding claimant's surgery for a left first rib resection concerns his disability. The new evidence concerning claimant's surgery was not available or obtainable by the time the record closed on November 1, 1999. The Opinion and Order issued on November 18, 1999 and claimant's surgery was on December 9, 1999.

Moreover, we agree with claimant that the new evidence is reasonably likely to affect the outcome of the case. The ALJ was not persuaded by Dr. Irvines opinion that claimant had thoracic outlet syndrome. Dr. Irvine explained that thoracic outlet syndrome is a rare condition and he testified that he would know if claimant had thoracic outlet syndrome if he responded well to surgery. (Ex. 46-9, -26, -28). The ALJ relied instead on Dr. Farris reasoning for rejecting the thoracic outlet diagnosis. Dr. Farris diagnosed a probable somatoform personality disorder and indicated that claimants condition was psychosocial in nature rather than due to a medical condition. (Ex. 40-6). However, we note that Dr. Farris also said that "individuals who do have true first rib caused thoracic outlet syndrome" do improve with surgery. (Ex. 44-2). The ALJ concluded that the more persuasive expert medical opinion was that there was a psychological basis for claimants pain behavior. Because the ALJ rejected claimants diagnosis of thoracic outlet syndrome, he concluded that the claim was not compensable. The ALJ did not discuss the details of whether or not claimant's thoracic outlet syndrome was work-related.

After reviewing the proffered evidence regarding the results of claimant's left first rib resection surgery, we agree with claimant that the new evidence regarding causation of his thoracic outlet syndrome 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); *Linda J. Williams*, 51 Van Natta 1528 (1999) (case remanded for post-hearing surgical reports). We base our conclusion on the fact that there was no confirmed diagnosis of thoracic outlet syndrome before the hearing and that the existence (or non-existence) of such appeared to be significant to the physicians offering opinions in this case.

Therefore, we conclude that the case should be remanded to the ALJ for further development of the record. Accordingly, the ALJ's order is vacated and this matter is remanded to ALJ Otto to reopen the record for the admission of additional evidence from the parties regarding the post-hearing surgery and the resultant findings. The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order resolving this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
L. C. DURETTE, Claimant
WCB Case No. 99-04382
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Safeco Legal, Defense Attorney

On April 12, 2000, we issued an Order of Abatement. We took this action in order to address claimant's request for reconsideration of our March 15, 2000 Order on Review. Subsequent to our abatement order, we received claimant's announcement that she was withdrawing her reconsideration motion.

Accordingly, consistent with claimant's announcement, we republish our March 15, 2000, Order on Review in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THELMA L. UNDERHILL, Claimant
Own Motion No. 00-0096M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable right arm/shoulder condition. Claimant's aggravation rights expired on August 15, 1985. 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.*

On January 18, 2000, Dr. Kretzler, claimant's attending physician, recommended surgical debridement of the calcific deposit in her lateral deltoid. On this record, we conclude that claimant's compensable injury worsened requiring surgery.[1]

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

SAIF contends that claimant has not worked since October 1999 when she left her prior employment due to a dispute with her employer (and not as a result of her compensable condition). Thus, SAIF contends that claimant was not in the work force at the time of the current worsening.

In response, claimant submitted copies of her 1998 and 1999 W-2 tax forms. Claimant's submission of her 1998 and 1999 W-2 tax forms demonstrates that she worked in sometime in 1998 and 1999. However, claimant's condition worsened in January of 2000. In order to be considered in the work force at the time of her current disability, claimant must show she was in the workforce prior to her January 2000 worsening. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

Additionally, with her W-2 forms, claimant submitted an unsworn statement detailing her current employment situation. In that statement, claimant does not dispute SAIF's assertion that she has not worked since October 1999. Rather, claimant contends that Dr. Kretzler recommended that if, by January 2000 she showed no signs of improvement, then both he and claimant "would talk about surgery." As a result, claimant asserts that she "put off" seeking employment "until after the surgery * * * I didn't feel that starting a new job, then having to take time off would look good to a new employer." We interpret claimant's statement to mean that, although she is willing to work, she has not worked or sought work because she has been anticipating undergoing surgery.

However, in order to prove that she is a member of the work force, claimant must satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Based on the following, we find that claimant failed to satisfy those factors.

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[1] 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 she enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996). The relevant time period for which claimant must establish she was in the work force is the time prior to January 18, 2000 when her condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

As noted above, the relevant time period to determine whether claimant was in the work force is at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). On this record, claimant's condition worsened requiring surgery on January 18, 2000, which is the date of disability. In her statement, claimant admits that she did not seek work because *she* thought it was futile inasmuch as she was expecting to undergo surgery and it would not look good to a new employer.

Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole, especially considering persuasive medical evidence regarding claimant's ability to work and/or seek work. *Jackson R. Scrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where record lacked persuasive medical evidence establishing that the claimant was unable to work and/or seek work due to the compensable injury). In short, the question is whether the work injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

Here, claimant does not offer a medical opinion that would support her "futility" contentions, nor does the record demonstrate that it would have been futile for her to work or seek work at the time of the current worsening. There is no medical evidence that demonstrates that would have been futile for her to seek work while waiting for an "upcoming" surgery. Accordingly, claimant has not established that she was a member of the work force at the time of the current disability.

Accordingly, claimant's request for temporary disability compensation is denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
SAN N. LANG, Claimant
WCB Case No. C000847
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
David B. Wagner, Claimant Attorney
Travelers Ins., Insurance Carrier

Reviewed by Board Member Biehl and Haynes.

On April 11, 2000, 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 approve the proposed disposition.

Here, the first page of the proposed agreement provides a date of injury of June 6, 1970. However, our records indicate that June 6, 1970 is the date of claimants birth and that the date of claimants injury is March 12, 1999. We also note that the cover letter accompanying the agreement provides that the date of injury is March 12, 1999. Therefore, we consider the correct date of injury to be March 12, 1999.

We conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $1,000, payable to claimant's attorney, 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
TERI L. CAOUETTE, Claimant
WCB Case No. 99-00623
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Meyers, Bock and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that found that she had failed to perfect an aggravation claim regarding her accepted low back condition. On review, the issue is jurisdiction and, potentially, aggravation.

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

The ALJ found that claimant had failed to perfect an aggravation claim, finding that the Department's aggravation Form 2837 dated February 3, 1998 (but not submitted to the insurer until April 26, 1999) was not "accompanied by" an attending physician's report establishing by written medical evidence supported by objective findings that claimant had suffered a worsened condition attributable to the compensable injury. *See* ORS 656.273(3). On review, claimant contends that she had perfected an aggravation claim by April 28, 1999, which the insurer failed to process. We disagree.

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).

Here, the Director's aggravation claim form was filled out on February 3, 1998 and was intended to be submitted to the insurer later that month. (Exs. 61A, 62A). The ALJ found, and we agree, that the record does not establish that the form was sent to the insurer until claimant submitted it to a prior ALJ on April 26, 1999 (with a copy to the insurer's counsel) as part of the exhibit submissions for an April 28, 1999 hearing regarding the insurer's failure to process the aggravation claim. An attending physician's report dated April 28, 1999, which satisfies the requirements of ORS 656.273(3), was also submitted by claimant as an exhibit on the 28th.[1] (Ex. 73).

Having reviewed this record, it is apparent that the completed February 1998 Director's aggravation claim form was over 14 months old before it was submitted to the insurer in April 1999. Moreover, the April 28, 1999 attending physician's report was not submitted to the insurer's counsel until two days after the February 1998 aggravation claim form. Neither the aggravation claim form nor the attending physician's report were directly submitted to the insurer for processing, but rather the alleged "perfection" of the aggravation claim occurred in a piecemeal manner as a result of the exhibit submission process.

Under these circumstances, we do not find that the Director's aggravation claim form was "accompanied by" a medical report establishing a worsened condition attributable to the compensable injury. Accordingly, we agree with the ALJ that claimant failed to perfect an aggravation claim in April 1999. Therefore, we affirm.

ORDER

The ALJ's order dated November 8, 1999 is affirmed.

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[1] A copy of this exhibit was sent to the insurer's counsel.

Board Chair Bock concurring.

I concur with the majority's conclusion that claimant failed to perfect an aggravation claim in April 1999. I write separately to emphasize that workers' compensation in Oregon is an administrative system that depends on the orderly filing and processing of claims. It appears to me that the legislature's point in requiring a completed aggravation form with accompanying attending physician's medical report was to eliminate any ambiguity about whether an aggravation claim was being asserted and to facilitate orderly processing of aggravation claims.

In this case, allowing piecemeal perfection of an aggravation claim through the exhibit-exchange process would, in my opinion, run counter to that purpose. In other words, sanctioning "perfections" such as what allegedly occurred in this case would make orderly claim processing difficult in that increased monitoring of the claim would be required to determine whether an "accompanying" medical report has been matched with the Director's aggravation form, thus "perfecting" the aggravation claim. I can conceive of instances where weeks and perhaps months pass before the accompanying attending physician's report is matched to the aggravation form, creating considerable uncertainty in the interim about whether an aggravation claim will ever be perfected.

Because what is asserted in this case is not the kind of perfection conducive to an orderly administrative process, I agree with the majority's decision to affirm the ALJ's order.

Board Member Biehl dissenting.

The majority concludes that claimant failed to perfect an aggravation claim by April 28, 1999. While the manner in which this aggravation claim was perfected may have been unusual, it was perfected nonetheless by that date. Accordingly, I must dissent.

The 1995 amendments to ORS 656.273(3) require a form for filing an aggravation claim in order to prevent assertion of a "de facto" denial of an aggravation claim of which the carrier had not been adequately informed. In this case, the insurer was clearly informed of the aggravation claim in April 1999 when it was presented with an aggravation claim form, as well as the accompanying attending physician's medical report supported by objective findings and establishing the worsened condition due to the compensable injury.

I acknowledge that the accompanying attending physician's report was not physically attached to the aggravation claim form and was submitted to the insurer two days after the claim form. However, ORS 656.273(3) does not necessarily require that the aggravation form and accompanying report be physically attached or arrive at precisely the same time. Under the circumstances of this case, a two-day gap in submission of the accompanying medical report should not defeat perfection of the aggravation claim.

Granted, the perfection of the aggravation claim was highly unusual in that it occurred as part of the exhibit-exchange process. I also do not advocate the Hearings Division as a venue for the filing of aggravation claims. Nevertheless, the perfection did occur in this case. Therefore, I would find that the insurer should have processed the aggravation claim in April 1999. Because the majority concludes otherwise, I respectfully dissent.

In the Matter of the Compensation of
CAMILO AYALA-RAMIREZ, Claimant
WCB Case No. 99-07923
ORDER ON REVIEW
Lavis & Dibartolomeo, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that affirmed the Order on Reconsideration award of 19 percent (60.8 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 13, 2000 is affirmed.[1]

[1] Claimant has not submitted a respondent's brief. Therefore, we do not award an attorney fee under ORS 656.382(2), even though claimant's compensation has not been disallowed or reduced. *Robert B. Chambers*, 48 Van Natta 1113, 1114 (1996); *Shirley M. Brown*, 40 Van Natta 879 (1988).

In the Matter of the Compensation of
LESTER L. KORSMO, Claimant
Own Motion No. 66-0389M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On April 26, 2000, the SAIF Corporation submitted claimant's request for medical benefits relating to his compensable February 23, 1965 condition. SAIF recommends reopening of this claim under our own motion for the provision of a medical services in the form of prescriptions for claimant's compensable condition. In addition, SAIF recommends that the claim remain open until medical services are no longer required.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

We find that the requested medical services are reasonable and necessary and causally related to the compensable injury. Accordingly, the claim is reopened to provide the requested medical services. *See* OAR 438-012-0037.

This order shall supplement our July 24, 1995 order that previously reopened claimant's 1965 claim for the payment of compensable medical services. The claim shall remain reopened to provide the requested medical services. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
SANDRA R. CARMAN, Claimant
WCB Case No. 98-05278
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the insurer's denial of her injury claim for a left knee condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of claimant's left knee condition that she alleged was related to on-the-job incidents of injury in October 1996 and November 1997. Claimant did not file a workers' compensation claim until April 1998, when she experienced a flare-up of left knee pain in March 1998 after an incident at home when she squatted down and felt her left knee pop and give out. Claimant eventually underwent left knee surgery in late July 1998. Although finding claimant to be a credible witness, and that the alleged injuries in October 1996 and November 1997 did occur, the ALJ, nevertheless, concluded that the opinion of claimant's orthopedic surgeon, Dr. Galt, was not sufficient to satisfy her burden of proving that her left knee condition was compensable.

On review, claimant contends that Dr. Galt's opinion satisfied her burden of proving that the alleged October 1996 injury was the major contributing cause of claimant's left knee condition in April 1998. Thus, claimant asserts that the ALJ incorrectly upheld the insurer's denial. We disagree.

In evaluating the medical evidence concerning causation, we rely on those opinions that 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 orthopedic surgeon, Dr. Galt, we find persuasive reasons not to defer to his opinion.[1]

Dr. Galt initially opined that the March 1998 incident at home had not caused a significant injury, but had most likely aggravated her previous injuries that occurred at work. (Ex. 16). Claimant's counsel later requested Dr. Galt to determine the major contributing cause of her knee condition. Without explanation, Dr. Galt identified the incident "when she lost her balance and twisted her knee." (Ex. 19-2). This presumably meant the October 1996 injury. After the insurer obtained an opinion on the causation issue from Dr. Baker, who reviewed the relevant medical records, claimant's attorney requested a response to the Baker report. In his response, Dr. Galt defended his diagnoses and the treatment he had rendered, but he offered no reasoning on the causation issue except to indicate that he adhered to his previous conclusion. (Ex. 21-2).

Having reviewed the medical evidence from Dr. Galt in its entirety, we find that it lacks sufficient reasoning to support a conclusion that the October 1996 or November 1997 injury is the major or a material contributing cause of claimant's left knee condition. Thus, we do not find Dr. Galt's conclusory opinion persuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (rejecting conclusory medical opinion).

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[1] It is apparent from the ALJ's order that he was uncertain about the precise level of proof. (Opinion and Order page 7). The ALJ, however, applied a major contributing cause standard based on the parties' arguments. We need not decide the exact standard of proof (material or major contributing cause) because we conclude that the medical evidence does not satisfy claimant's burden of proof under either standard.

In contrast, Dr. Baker performed a thorough review of the relevant medical records and produced an extensive analysis of the causation issue. Dr. Baker concluded that claimant's current knee condition is related only incidentally to her work injuries and the off-the-job incident in March 1988. According to Dr. Baker, the major contributing cause of the current knee condition is congenital extensor mechanism malalignment and lateral patellar compression syndrome. (Ex. 20-5).

Dr. Baker's conclusion that claimant's current left knee condition is not related to the October 1996 and November 1997 incidents is supported by the opinion of another attending physician, Dr. Helman, who treated claimant's condition prior to Dr. Galt. Dr. Helman opined that, if the March 1998 incident occurred off-the-job, claimant's need for treatment and disability would not be due to claimant's employment. (Ex. 18). Because it is undisputed that the March 1998 incident occurred off-the-job, Dr. Helman's opinion does not support compensability of claimant's left knee claim.

Accordingly, we conclude, based on our *de novo* review of the medical record, that claimant failed to sustain her burden of proving that her left knee condition is compensable.[2] Therefore, we affirm the ALJ's decision to uphold the insurer's denial.

ORDER

The ALJ's order dated November 3, 1999 is affirmed.

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[2] We recognize that the ALJ found claimant to be a credible witness based on demeanor and that the 1996 and 1997 injuries did occur. However, the medical causation issue is complex, given the several potential causes of claimant's left knee condition. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993). Thus, expert medical evidence is required to establish medical causation. Having reviewed this record, we are not persuaded that a preponderance of the expert medical evidence satisfies claimant's burden of proof.

In the Matter of the Compensation of
JON L. PIERSON, Claimant
WCB Case No. C000880
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Scott M. McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On April 13, 2000, 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 approve the proposed disposition.

Here, the first and second page of the proposed agreement provides a date of injury of August 28, 1960. However, our records indicate that August 28, 1960 is the date of claimant's birth and that the date of claimant's injury is January 20, 1999. Therefore, we consider the correct date of injury to be January 20, 1999.

We conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $3,500, payable to claimant's attorney, 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
FILBERT M. FIMBRES, Claimant
WCB Case No. 98-07427
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) determined that SAIF's acceptance of foraminal stenosis at L5-S1 included degenerative disc disease at the same level; and (2) set aside SAIF's denial to the extent that it denied degenerative disc disease at L5-S1. In its reply brief, SAIF moves to strike those portions of claimant's brief that refer to the scope of acceptance issue because it was not raised before the ALJ. SAIF alternatively moves for remand to the ALJ. On review, the issues are motion to strike, motion to remand, and scope of acceptance. We deny the motions and reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" in his original Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a low back injury on November 15, 1996. SAIF accepted a lumbosacral strain. An MRI scan later revealed degenerative disc disease, including disc bulges at L3-4, L4-5 and L5-S1 and foraminal stenosis at L5-S1. SAIF modified its acceptance to include the foraminal stenosis at L5-S1. On July 21, 1998, SAIF denied claimant's disability and need for treatment after July 6, 1998 because the compensable injury was no longer the major contributing cause of a "combined" low back condition and need for treatment and disability. Claimant requested a hearing.

At hearing, claimant argued that SAIF's acceptance of foraminal stenosis was necessarily an acceptance of the degenerative disease that allegedly caused the stenosis. The ALJ initially found that SAIF's acceptance of foraminal stenosis at L5-S1 did not encompass the underlying degenerative disc disease. The ALJ reasoned that SAIF accepted a specific condition, foraminal stenosis, that was separate from the overall degenerative condition affecting claimant's lumbar spine.

Claimant requested reconsideration, asserting that SAIF's acceptance of the foraminal stenosis condition necessarily included the underlying degenerative condition. The ALJ, citing *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), agreed. The ALJ reasoned that the *Piwowar* principle that acceptance of symptoms is acceptance of the underlying cause of those symptoms should apply in this case. That is, the ALJ held that acceptance of a condition necessarily must include the underlying cause of the condition. Determining that the medical evidence established that the underlying degenerative disease at L5-S1 caused the foraminal stenosis, the ALJ held on reconsideration that claimant's degenerative disease at L5-S1 was included in SAIF's acceptance of the foraminal stenosis condition.

On review, SAIF contends that the ALJ's original order was correct and that, because it accepted a specific condition, not symptoms of an underlying degenerative condition, its acceptance of foraminal stenosis did not include the degenerative disc disease at L5-S1.[1] For the following reasons, we agree with SAIF's contentions.

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. 305 Or at 497. The Supreme Court concluded that, because the carrier had accepted a

[1] In its reply brief, SAIF argues that the scope of acceptance issue was not properly raised at hearing and that we should not consider it on review. Alternatively, SAIF requests that the case be remanded to the ALJ. From our review, it appears that the scope of acceptance issue was raised before the ALJ. Thus, we find that the ALJ properly addressed the issue. Therefore, we decline to grant SAIF's motions to strike and remand.

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. The carrier was precluded from denying the underlying condition.

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. As the Court of Appeals has indicated, acceptance of a particular condition does not necessarily include the cause of that condition. *See Granner v. Fairview Center*, 147 Or App 406, 410 (1997) (question of fact for the Board was whether the carrier's acceptance of the right patella dislocation was an acceptance of a symptom of the claimant's preexisting knock knee condition or an acceptance of a separate condition).

Unlike *Piwowar*, SAIF in this case accepted a specific condition (foraminal stenosis), not merely symptoms. In this regard, we conclude that the medical evidence establishes that foraminal stenosis is a separate condition and not a symptom of the underlying degenerative condition. For instance, Dr. Grant noted that the foraminal stenosis was one of several abnormalities separate from the underlying degenerative disease. (Ex. 1E-1). Dr. Henderson opined that 25 percent of claimant's reduced range of motion was due to the accepted conditions of foraminal stenosis and lumbosacral strain and 75 percent due to the degenerative disease. (Ex. 6). This report indicates that the foraminal stenosis condition is a condition separate from the underlying degenerative condition. In addition, examining physicians, Dr. Farris and Bald, separately diagnosed foraminal stenosis and degenerative disc disease. (Ex. 15-6). Finally, no physician on this record opined that foraminal stenosis is a symptom of the degenerative condition at L5-S1.[2]

Because SAIF did not accept a claim for symptoms, we conclude that the rule of *Piwowar* does not apply. *See Jack L. Kruger*, 52 Van Natta 627 (2000);[3] *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). Accordingly, we reverse that portion of the ALJ's order determining that the underlying degenerative disc disease condition at L5-S1 was included in SAIF's acceptance of foraminal stenosis.[4]

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[2] As previously noted, the ALJ stated that the *Piwowar* principle should be extended to acceptance of conditions; *i.e.*, that acceptance of the condition should include the process that caused the condition. Indeed, claimant points to medical evidence he interprets as establishing that the underlying degenerative condition caused the foraminal stenosis. (Exs. 1b, 1d, 1I, 1J, 14). Like the ALJ, claimant argues that, under these circumstances, SAIF's acceptance of the foraminal stenosis necessarily included the underlying condition that allegedly caused the stenosis condition. We disagree. Even if we assumed that the medical evidence established that the degenerative condition caused the foraminal stenosis (something no physician has expressly stated in this record), the *Granner* court has rejected the argument that acceptance of a particular condition necessarily includes the cause of that condition. *Granner v. Fairview Center*, 147 Or App at 410. Therefore, the question here is whether acceptance of claimant's foraminal stenosis is acceptance of a symptom of the preexisting degenerative disc disease condition or an acceptance of a separate condition. As the *Granner* court noted, that is a question of fact for the Board to answer. Having reviewed this record, we conclude that acceptance of foraminal stenosis was acceptance of a condition separate from the underlying degenerative condition.

[3] In *Kruger*, we also held that, unlike *Piwowar*, the carrier had accepted specific conditions, not merely symptoms. Because the carrier did not accept a claim for symptoms, we concluded that the rule of *Piwowar* did not apply.

[4] We also uphold SAIF's July 21, 1998 denial of claimant's "combined" condition at L5-S1 on the merits. In this regard, we note that Dr. Henderson opined that claimant's preexisting degenerative disc disease is 75 percent responsible for the disability and need for treatment of the "combined condition." (Ex. 11). Examining physicians, Drs. Bald and Farris, concluded that claimant's preexisting degenerative disc disease is the major contributing cause of the disability of the combined condition. (Ex. 15-8). This evidence is unrebutted. Accordingly, we conclude that claimant's preexisting degenerative disc disease is the major contributing cause of the need for treatment and disability of the "combined condition," consisting of the compensable injury (resulting in a lumbar strain and foraminal stenosis at L5-S1) and the preexisting degenerative disc disease.

ORDER

The ALJ's order dated April 8, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside SAIF's denial of L5-S1 degenerative disease is reversed. SAIF's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
KAREN L. GILL, Claimant
WCB Case No. 99-02766
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of her current head, neck, right eye, right shoulder, elbows, wrists, hands, low back and seizure conditions. In her request for review, claimant asserts that she sustained injuries because of "work in 1992." Claimant's request for review also includes a copy of the ALJ's Opinion and Order with her remarks written in the margins. We treat her submission as a motion for remand. On review, the issues are compensability and remand.

We adopt and affirm the ALJ's order with the following change and supplementation. In the last full paragraph beginning on page 3 and continuing on page 4, we change the word "probable" in the fourth sentence to "possible."

Claimant's request for a review includes a copy of the ALJ's Opinion and Order with her remarks written in the margins. To the extent claimant is attempting to introduce additional evidence we treat claimant's references as a motion to remand.

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. *See Judy A. Britton*, 37 Van Natta 1262 (1985). However, we may only remand 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).

Claimant's remarks written in the margins of the copy of the ALJ's Opinion and Order include additional evidence not submitted at the hearing. Although such evidence apparently pre-dates the hearing, claimant has not shown why such evidence was not obtainable, with due diligence, before the hearing.[1] 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.

In her request for review, claimant asserts that she sustained multiple injuries because of "work in 1992," which we have interpreted as two perforated disks, two spurs in her neck, two ruptured disks and two spurs in her tailbone. The insurer contends that those conditions were not among those claimant initially sought to have included in the Notice of Acceptance and, therefore, those conditions are raised for the first time on review. Alternatively, the insurer argues that there is no medical evidence to support compensability of such conditions.

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[1] We note that claimant did not appear at the hearing, although the ALJ indicated that he had considered a letter submitted by claimant in support of her claim.

There is no indication in the record that claimant previously raised compensability of the aforementioned conditions and the ALJ did not address that issue. The claim litigated at the hearing concerned the causal relationship between the 1991 injury claimant sustained while working for the employer and her current head, neck, right eye, right shoulder, elbows, wrists, hands, low back and seizure conditions. The issue in dispute did not pertain to a 1992 injury. The record indicates that claimant was terminated from her employment with the at-injury employer in 1991. (Exs. 8-2, 54-3). We decline to address this issue because it was raised for the first time on review.[2] *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

ORDER

The ALJ's order dated December 7, 1999 is affirmed.

[2] In her request for review, claimant also refers to alleged problems she had with a physician regarding an independent medical examination. This is a matter that must be raised before a different forum, not the Workers' Compensation Board.

April 28, 2000 Cite as 52 Van Natta 775 (2000)

In the Matter of the Compensation of
DALE L. ILG, Claimant
WCB Case No. 99-04012
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability.[1] We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has a 17 year history of low back problems, including multiple injuries and 4 surgeries. In December 1982, claimant suffered an acute lumbar strain at work and missed about 6 months of work. He had ongoing low back symptoms after he returned to work and an increase in symptoms in April 1984. In October 1984, claimant had surgery, a bilateral posterolateral fusion at L4-5. He was off work for about a year after this surgery.

Claimant re-injured his low back in October 1986 and in September 1987. After the 1987 injury, his condition was diagnosed as recurrent lumbosacral strain superimposed on grade 1 spondylolisthesis L4-5 with a spondylolysis at L4-5; his fusion was also incomplete on one side. Claimant's low back pain persisted. Dr. Waldram became claimant's attending physician and he performed a laminectomy at L4-5 and L5-S1, bilateral with operative fusion L4-S1, using Steffe plates, on March 29, 1988. Claimant returned to work as a truck driver 3 months later.

Claimant suffered worsened low back pain in November 1990. Dr. Waldram performed a fusion at L4-5 and L5-S1, with Wiltse type fixation and insertion of a spinal stimulator, in January 1992. The stimulator was removed in September 1992.

[1] The insurer moves to strike claimant's "sur-reply" brief. We need not address the insurer's motion because we have not considered the disputed arguments. *See* OAR 438-011-0020(1) & (2).

Dr. Waldram performed a closing exam in November 1992, noting that "a pseudo-arthrosis" had caused the need for surgery. He restricted claimant to lifting 20-25 pounds, rarely 35 pounds, but no more.

Claimant sought treatment for progressively worsened low back pain in April 1993. Dr. Waldram took him off work for 2 weeks.

Claimant re-injured his low back in December 1996 and April 1997. June 1997 films revealed motion at L4-5 and a broken rod at the superior end, and findings suggestive of a small disc fragment or herniation at L3-4. (Exs. 18-21). Dr. Waldram performed a solid fusion from L4 to S1 on November 12, 1997. He removed the fixation device implanted in 1992 and fragments of the electric stimulator also implanted in 1992. Dr. Waldram released claimant to light duty work on January 7, 1998.

Claimant returned to truck driving and sought treatment for persistent right leg symptoms in March 1998. Dr. Waldram advised claimant against truck driving and iron work.

On January 6, 1999, claimant injured his low back again, when he grabbed the end of a heavy piece of channel iron at work. He experienced the immediate onset of intense low back pain.

Dr. Waldram reviewed claimant's records and films and opined that claimant had "a lot of collapse of the vertebral bodies" since June 1997. (Ex. 32A). He diagnosed status post fusion with acute back strain and possible acute radicular irritation. A myelogram and CT scan revealed an "anterior extradural defect" at L3-4. (Exs. 33-34). Dr. Waldram also noted that the L3-4 facet joints above the fusion were deteriorating. (Ex. 34A)

Claimant filed a claim for the January 6, 1999 injury, which the insurer denied.

The ALJ found the claim compensable, based on Dr. Waldram's reasoning, which the ALJ found persuasive. The ALJ relied on Dr. Waldram's advantage as claimant's longtime treating physician, noting that he performed claimant's 1988, 1992, and 1997 fusion surgeries. The ALJ also noted Dr. Waldram's observation that a comparison of claimant's 1997 and 1999 films revealed a pathological worsening: Claimant's L3-4 disc was small and equivocal in 1997 and it was large in 1999. The ALJ further noted that Dr. Waldram attributed claimant's current symptomatology to his new pathology; claimant's prior right leg symptoms had resolved (before the 1999 injury); and claimant had been able to perform his regular work without symptoms (causing disability or requiring medical treatment) -- until the 1999 injury. Therefore, based on Dr. Waldram's opinion, the ALJ concluded that claimant carried his burden under ORS 656.005(7)(a)(B).

We agree that claimant is subject to the "major contributing cause" standard of proof under the statute, because his preexisting low back condition combined with the 1999 injury to cause his need for treatment or disability for his current condition. Because Dr. Waldram provides the only medical opinion supporting the claim, the question is whether that opinion is sufficient to carry claimant's burden. We conclude that it is not, based on the following reasoning.

We acknowledge that Dr. Waldram was in a particularly good position to evaluate and compare claimant's condition before and after the 1999 incident, because of his long-term status as claimant's attending physician. However, the doctor's advantageous position is not a substitute for causal analysis, particularly in a medically complicated case like this.

Dr. Waldram noted that claimant's 1998 symptoms resolved before the 1999 injury and he was able to perform physically intensive work until he had severe lumbar pain with that injury. On this basis, Dr. Waldram initially concluded that the work injury "must have fundamentally changed [claimant's] lumbar spine and herniated disc." (Ex. 40). He opined that claimant's L3-4 disc was "previously very small, and certainly, with an episode of injury he had, and [sic] acute onset of symptoms, it seems to me more probable that his symptoms are related to the more recent injury, rather than to his old work injury." (Ex. 41). We find the former reasoning unpersuasive because it is based solely on temporal reasoning. We find the latter opinion similarly unpersuasive, because it addresses claimant's symptoms only, it does not explain away or otherwise discount the contribution of claimant's undisputed preexisting condition, and claimant had several (not just one) prior work injuries.

Later, Dr. Waldram concurred with an opinion letter indicating that claimant's preexisting L3-4 disc herniation was small and not clinically significant. He disagreed with the examining physician's opinion that "most of the damage was done" before the 1999 injury, considering the "large extradural defect" discovered after the injury. (Ex. 43). Therefore, based on claimant's history (including his treatment since 1988, his ability to work before the injury, and the mechanism of the injury) and his diagnostic films (comparing the disc in 1997 to the disc in 1999), Dr. Waldram concluded that the 1999 injury was the major contributing cause of claimant's current disability and need for treatment for his L3-4 disc. (*Id.*; *see* Ex. 44).

A close examination of Dr. Waldram's reasoning reveals that his conclusion is essentially based on the fact that claimant's L3-4 disc was symptomatically and pathologically worse in early 1999 than it had been when previously filmed in 1997. But claimant's films and symptoms do not necessarily mean the 1999 injury *caused* his combined 1999 disc condition (or disability and need for treatment therefore).

A medical opinion must consider *and evaluate* the relative contributions of compensable and noncompensable causes in order to be persuasive. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Although the work activities that precipitate a claimant's injury or disease may be the major contributing cause of the condition, that is not always the case. *Id.*

Here, it is undisputed that claimant's noncompensable preexisting L3-4 disc condition contributes to his current L3-4 condition. And Dr. Waldram's only response to the examiner's opinion that further disc material could extrude from claimant's previously torn annulus "with relative ease," was to state that claimant was working without problems until the 1999 injury. (*See* Exs. 37-2, 43). Although such facts establish the temporal relationship between the injury and claimant's symptoms, they do not, in our view, persuasively explain why or how the injury contributes more to claimant's current condition than all other causes combined. *See McGarrah v. SAIF*, 296 Or 145, 146 (1983).

Under these circumstances, we find Dr. Waldram's opinion unpersuasive because it is inadequately reasoned. *See Vicki F. Brown*, 51 Van Natta 1961 (1999) (treating doctor's opinion inadequately explained and unpersuasive because it was based on the temporal relationship between the claimant's work and her symptoms, without explaining why work contributed more than undisputed preexisting condition). Accordingly, in the absence of persuasive evidence supporting the claim, we uphold the insurer's denial.

ORDER

The ALJ's order dated December 14, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
MICHAEL E. LOPEZ, Claimant
WCB Case No. 99-05856
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
VavRosky, 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 increased claimant's unscheduled permanent disability award for a cervical condition from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to 16 percent (51.2 degrees). On review, the issue is unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ increased claimant's unscheduled permanent disability award for his cervical strain condition to 16 percent. In doing so, the ALJ relied on the impairment findings and opinion of the medical arbiter, Dr. Berselli. (Ex. 50). On review, the employer contends that we should rely instead on the findings of examining physician Dr. Rosenbaum, with which claimant's attending physicians concurred. (Exs. 40, 41, 42). On that basis, the employer argues that the Order on Reconsideration award of 14 percent unscheduled permanent disability should be reinstated.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). When rating impairment, only the opinions of the attending physician and the medical arbiter, if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). Where a medical arbiter is used, as in this case, we do not automatically rely on the medical arbiter's opinion in evaluating impairment, but rather, rely on the most thorough, complete, and well-reasoned evaluation of impairment due to the injury. *See David L. Glenn*, 49 Van Natta 1251 (1997); *Carlos S. Cobian*, 45 Van Natta 1582 (1993).

The employer contends that the opinion of Dr. Rosenbaum is the most thorough and well-reasoned, and therefore more persuasive. Dr. Rosenbaum performed an evaluation at the request of the employer on May 5, 1998. (Ex. 40). Dr. Rosenbaum found that claimant had permanent impairment, but stated that only 50 percent of the impairment was secondary to the compensable injury, whereas 50 percent was related to claimant's preexisting degenerative condition. (Ex. 40-5).

Here, the medical arbiter's findings were made almost a year after those of Dr. Rosenbaum, and one and a half months before the Order on Reconsideration. (Exs. 40, 50, 51). However, impairment findings that are later in time and closer to the date of the reconsideration order are not always more persuasive. *Charlene L. Vinci*, 47 Van Natta 1919 (1995). That factor alone is not decisive, if the preponderance of medical evidence argues in favor of a different level of impairment. *David J. Rowe*, 47 Van Natta 1295, 1297 (1995). We agree with the employer that Dr. Rosenbaum's report is more thorough and well-reasoned than Dr. Berselli's relatively sparse arbiter examination report. Unlike the ALJ, therefore, we decline to rely on the impairment findings of the medical arbiter, Dr. Berselli.

Moreover, Dr. Berselli incorrectly understood claimant's accepted condition to be "cervical spondylosis," as opposed to "cervical strain." (Exs. 15, 50-2). We have previously held that where the medical arbiter expressly relates a claimant's impairment to causes other than the compensable injury, the arbiter's opinion is not persuasive evidence of injury-related impairment. *See Manuel G. Garcia*, 48 Van Natta 1139, 1140 (1996); *Julie A. Widby*, 46 Van Natta 1065 (1994). For that reason as well, we find Dr. Rosenbaum's impairment findings, as concurred in by claimant's treating physician, to be more persuasive than those of the medical arbiter Dr. Berselli.

Based on the aforementioned attending physician - ratified findings, we conclude that claimant is not entitled to an unscheduled permanent disability award beyond the 14 percent granted by the Order on Reconsideration. Consequently, the ALJ's order that had increased claimant's award to 16 percent is reversed and the Order on Reconsideration award is reinstated.

In the Matter of the Compensation of
ELIZABETH MARKUSON, Claimant
WCB Case No. 99-05117
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW

The ALJ set aside the insurer's current condition denial based on *Croman Corporation v. Serrano*, 163 Or App 136 (1999). We affirm the ALJ's order, but on a different basis.

Claimant suffered a compensable cervical strain condition as related to her July 25, 1996 injury. Through litigation, the insurer accepted the cervical strain condition on June 3, 1999. (Exs. 48, 49). Also on June 3, 1999, the insurer closed claimant's claim via a Notice of Closure awarding no permanent disability. (Ex. 50). On June 10, 1999, the insurer issued a denial of claimant's current cervical strain condition. Asserting that the strain had combined with a preexisting condition, the insurer contended that the injury was no longer the major contributing cause of the need for treatment or disability for the combined condition. (Ex. 52). However, the parties agree that claimant has not sought treatment for that condition since September 1996. Claimant is also not currently requesting medical services for the cervical strain condition.

Absent a current claim for benefits, a denial of a previously accepted claim is a prospective denial, and therefore improper. *Evanite Fiber Corp. v. Striplin*, 99 Or App 353 (1989). This is true even of "post-closure" denials. *Striplin*, 99 Or App at 357. Here, the insurer acknowledges that claimant has not sought medical services for her compensable cervical strain condition since September 1996. (App. Br. at 3). Because the insurer's "current condition" denial was not issued in response to any current claim for benefits, we find that it was aimed improperly at denying future responsibility for the claim. 99 Or App at 357.

In *Jose D. Rodriguez*, 49 Van Natta 703 (1997), the claimant had an accepted left wrist sprain condition. Later medical evidence indicated that the left wrist sprain had combined with a preexisting left wrist fracture and arthritis conditions. On June 26, 1996, the employer denied the claimant's current left wrist condition. However, the claimant had not sought medical treatment for his left wrist condition since October 24, 1995. Although the claimant's treating physician speculated that the claimant might need wrist surgery in the future, there was no current request for surgery, nor were any medical services being provided for the left wrist condition at the time of the denial. We held that the employer's denial was procedurally improper as a prospective denial of benefits. 49 Van Natta at 704.

In *Green Thumb v. Basl*, 106 Or App 98 (1991), the court held that a denial may not be prospective in nature if it denies a current need for treatment as opposed to future benefits. However, in *Basl*, although there were no unpaid medical bills, the claimant was receiving chiropractic treatment for her low back condition at the time that the employer issued its denial. *Green Thumb v. Basl*, 106 Or App at 100. There was therefore a current need for medical services which, as a procedural matter, the employer properly denied. The court distinguished *Striplin* on that basis. 106 Or App at 101.

Here, there has been no ongoing treatment, nor any request for medical services related to claimant's cervical strain condition, since September 1996. *A fortiori*, based on *Striplin* and *Rodriguez*, the insurer's June 10, 1999 "current condition" denial was an improper prospective denial of claimant's cervical strain condition. In lieu of the ALJ's reasoning, for the reasons expressed above, we therefore concur with the ultimate decision of the ALJ to set aside the insurer's denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, 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 December 16, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the insurer.

May 2, 2000 Cite as 52 Van Natta 782 (2000)

In the Matter of the Compensation of
SHERRYL A. BRONG, Claimant
WCB Case No. 99-01868
ORDER OF ABATEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our April 3, 2000 order that reversed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's occupational disease claim for a cervical condition. The employer contends that we erred in evaluating the medical evidence.

In order to further consider this matter, we withdraw our April 3, 2000 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days of the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
TOMMY A. FORSYTHE, Claimant
WCB Case No. 99-06610
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of his 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.

Claimant argues that Dr. Button's opinion on causation "indirectly" stated that his work activity was the major contributing cause of his left carpal tunnel syndrome (CTS). Claimant contends that, when Dr. Button's opinion is "adjusted to correct his misperceptions of fact," it carries his burden of proving medical probability. (Claimant's opening brief at 13).

We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). Here, however, even if we disregard the references in Dr. Button's report to a videotape that was not admitted in evidence, we find that his report is not sufficient to establish that claimant's work activities were the major contributing cause of his left CTS.

Dr. Button reported that claimant's work was a "materially contributing cause of the onset of symptoms" and the work exposure at the employer "has contributed to some degree" relative to his present left CTS. (Ex. 7-6). Dr. Button concluded, however, that "[i]t is very difficult to ascertain as to whether that brief, distant work exposure was the major contributing cause of the onset of the condition, perpetuation of symptoms, and now need for surgical left carpal tunnel release." (*Id.*) In addition, Dr. Button did not believe claimant had given him an accurate history of his activities. (*Id.*) We agree with the ALJ that Dr. Button's report is not sufficient to establish that claimant's work activities were the major contributing cause of his left CTS. *See* ORS 656.802(2)(a).

Claimant questions the accuracy of Dr. Button's understanding of the mechanics of his work, as well as his understanding of the amount of claimant's work exposure. To the extent that Dr. Button had an inaccurate history, 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). Although claimant urges us to "adjust" Dr. Button's opinion to correct his "misperceptions" of fact, our findings must be based on medical evidence in the record and the reasonable inferences that can be drawn from the medical evidence. *See SAIF v. Calder*, 157 Or App 224 (1998). We do not agree with claimant that changing the facts upon which Dr. Button based his opinion is a reasonable inference. We agree with the ALJ that claimant has failed to sustain his burden of proving compensability.

ORDER

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

In the Matter of the Compensation of
JAMES P. LAVIN, JR., Claimant
WCB Case Nos. 99-08348, 99-06593 & 99-06592
ORDER ON REVIEW
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant, *pro se*, requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of claimant's claim for a right foot/ankle injury. With his request for review, claimant has attached several documents. We treat this submission as a motion for remand. In its brief on review, the employer requests sanctions against claimant for claimant's alleged failure to provide "pre hearing" discovery. On review, the issues are remand, compensability, and sanctions. We deny the motions and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Conclusion," except for the last sentence of the second full paragraph on page 4.

In addition, we offer the following supplementation regarding the parties' motions.

Claimant has included several documents with his request for review. Some, but not all, of these documents duplicate exhibits admitted at hearing. (*See* Exs. 14-1-5, 18-1-2, 19-2, 22-2, 23). In addition, claimant submits a typewritten "Interview Summary" dated June 14, 1999, apparently annotated by claimant; a November 18, 1999 operative report describing surgery performed on claimant's left shoulder; a physician's authorization for return to modified work dated December 20, 1999; a cover letter from the Department of Veterans Affairs dated December 15, 1999, referencing enclosure of medical information dated June 7, 1999 and thereafter; a June 7, 1999 urgent care clinic report and blood test results; July 21, 1999 medical reports discussing claimant's right shoulder and left ankle conditions; a September 21, 1999 chart note; incomplete December 9, 1999 progress notes; a "Work Status Notification" and chart note dated June 7, 1999, and chart notes dated June 11 and June 15, 1999.

Our review is limited to the record developed at hearing. ORS 656.295(5). Therefore, we treat claimant's post-hearing submissions (*i.e.*, those not already admitted) as a motion for remand to the ALJ for further development of the hearings record. *Judy A. Britton*, 37 Van Natta 1262 (1985). We consider the post-hearing submission only for the purpose of determining whether remand is appropriate.

We may remand to the ALJ only if 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)[1]; *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

There is no showing in this case that these documents were unobtainable with due diligence at the time of the hearing. In any case, we find that none of the submitted materials would be reasonably likely to affect the outcome of the case. Under these circumstances, we find no compelling basis for remanding and we conclude that the case has not been improperly, incompletely, or otherwise

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[1] A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. *Id.*

insufficiently developed without the additional evidence. Consequently, remand is not appropriate and claimant's motion is denied.[2] *See Ana M. Martinez*, 51 Van Natta 800 (1999).

In its brief, the employer asks us to impose sanctions against claimant for his alleged failure to provide appropriate discovery.

The Board's authority to impose sanctions arises out of ORS 656.390(1). The statute provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board "may impose an appropriate sanction upon the attorney who filed the request for review." Thus, by its terms, ORS 656.390(1) only provides for sanctions against an *attorney* who files a frivolous request for review. Here, claimant is unrepresented and there is no evidence that he is an attorney. Therefore, ORS 656.390(1) does not apply and the employer's motion for sanctions is denied. *See Neal Falls*, 49 Van Natta 465, 466 (1997).

ORDER

The ALJ's order dated December 9, 1999 is affirmed.

[2] The Workers' Compensation Board is an agency of the State of Oregon and an adjudicative body. It addresses issues presented to it from disputing parties. Because of that role, the Board cannot extend advice to the parties. Nonetheless, the Board notes that claimant is unrepresented. Under such circumstances, if he has further questions, claimant may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. The Ombudsman may be contacted, free of charge, at 1-800-927-1271, or written to at Department of Consumer and Business Services, Workers' Compensation Ombudsman, 350 Winter St. NE, Salem, OR 97310.

May 3, 2000 Cite as 52 Van Natta 785 (2000)

In the Matter of the Compensation of
DENICE K. DRUSHELLA, Claimant
WCB Case Nos. 99-03676 & 98-03957
ORDER OF ABATEMENT
Welch, Bruun & Green, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On April 3, 2000, we issued an Order on Review that reversed an Administrative Law Judge's (ALJ's) order that had set aside the SAIF Corporation's denial of claimant's "left upper extremity symptom complex." *Denice K. Drushella*, 52 Van Natta 621 (2000). Contending that our decision contains legal and factual errors, claimant seeks reconsideration of the order.

In order to consider claimant's arguments, we withdraw our April 3, 2000 order. SAIF 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 take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY T. BLANCHARD, Claimant
WCB Case No. 98-09313
ORDER ON REVIEW
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mills' order that found that claimant was not entitled to temporary disability. The self-insured employer contends that the Board is without jurisdiction because filing of the request for review was procedurally defective. On review, the issues are jurisdiction and temporary disability. We affirm.

FINDINGS OF FACT

Claimant has an accepted claim for bilateral carpal tunnel syndrome. (Exs. 33, 35). In June 1998, the employer issued a Notice of Closure awarding only temporary disability. An Order on Reconsideration rescinded the Notice of Closure after finding that the claim was prematurely closed. (Ex. 40-2). An ALJ affirmed the Order on Reconsideration. (Ex. 42).

Claimant requested a hearing alleging entitlement to temporary disability as of June 4, 1998.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, because claimant did not attend the hearing and testify, claimant was relying only on hearsay statements contained in the documentary record, which the ALJ found was insufficient to carry claimants burden of proof.

On review, the employer first asserts that claimant did not provide timely copies of his request for review. According to the employer, this procedural defect prevents the Board from having jurisdiction of the matter. However, the record establishes that a Board computer-generated letter acknowledging the request for review was mailed to the employer and its attorney on January 14, 2000, the 28th day after the ALJ's December 17, 1999 order. Under such circumstances, we conclude that it is more probable than not that the employer received actual notice of claimant's appeal within the statutory time period. *See Grover Johnson*, 41 Van Natta 88 (1989).

Turning to the merits of claimant's appeal, we agree with the ALJ that claimant did not prove entitlement to temporary disability and we adopt the reasoning in the order.[1] Furthermore, we find no authorization from the attending physician for temporary disability, as required by ORS 656.262(4)(g).

ORDER

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

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[1] Claimant did not submit a brief on review. In requesting review, claimant stated that he was entitled to some type of permanent partial disability[.] It is at claim closure that the determination is made regarding permanent disability. Because the claim currently is open and the hearing concerned only temporary disability, we do not decide any entitlement to permanent disability.

In the Matter of the Compensation of
CARL L. CHARLES, Claimant
WCB Case No. 99-01918
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that affirmed an Order on Reconsideration finding that claimant's neck injury claim was prematurely closed. On review, the issue is premature claim closure. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for cervical dorsal strain, C5-6 disc herniation, surgery and fusion. An August 3, 1998 Determination Order found claimant medically stationary February 18, 1998 and closed the claim. On October 26, 1998, an Order on Reconsideration rescinded the Determination Order, finding that the claim was prematurely closed.

The ALJ agreed with this conclusion, reasoning that the more persuasive medical opinions showed that claimant was not medically stationary as of claim closure. The employer contends that the persuasive medical evidence shows that there was no actual expectation of improvement and, thus, claimant was medically stationary.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Whether or not claimant is medically stationary is primarily a medical question. *Harmon v. SAIF*, 54 Or App 121 (1985). Claimant's condition and the prospect of any material improvement are evaluated as of the date of closure, without consideration of subsequent changes in his condition. *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985).

Here, claimant's previous treating physician, Dr. Gallo, found claimant's neck condition medically stationary on June 2, 1997. (Ex. 10-2). Although the employer issued a Notice of Closure based on that declaration, an Order on Reconsideration rescinded the Notice of Closure and ordered that the claim remain open. (Ex. 13).

Claimant then designated Dr. Simmons as his attending physician. (Ex. 13A). On February 18, 1998, claimant was evaluated by examining physicians, Drs. Morton, Lammers, Dordevich, and Labs. Their report found claimant "medically stationary in regard to the accepted cervical/dorsal condition." (Ex. 18-29).

When asked whether he concurred "with the findings of the report," Dr. Simmons checked both "yes" and "no," adding that he didn't honestly know. (Ex. 19). Dr. Gallo concurred with the report. (Ex. 20).

A Determination Order issued on August 3, 1998, finding claimant medically stationary on February 18, 1998. (Ex. 23). On August 13, 1998, Dr. Simmons wrote to the claims processor that, when asked whether he concurred with the panels report, he marked "yes and no * * *, meaning I could not answer them or there are yes and no components[.]" (Ex. 24).

On September 11, 1998, Dr. Simmons wrote to claimants attorney, further explaining that he "could not say just yes or no, because I was not present during the examination when the findings were made." (Ex. 26-1). Dr. Simmons added that he "certainly did not feel that [claimant's] neck condition had reached a medically stationary status as of February 18, 1998 or by the date of my response, April 6, 1998." (*Id.*) Finally, Dr. Simmons indicated that he did agree with the panel's recommendation that claimant undergo physical therapy since it "holds a reasonable expectation for improved ranges of motion of the cervical spine[.]" (*Id.* at 2).

We find Dr. Simmons' opinion most persuasive concerning claimant's medically stationary status. Dr. Simmons is the treating physician and was the most familiar with claimant's condition at the time of claim closure, in contrast to the examining panel, which saw claimant only one time, and Dr. Gallo, who had not treated claimant since November 1997. Although Dr. Simmons first indicated at least some agreement with the panel's report, he later explained why he provided such a response and also discussed why he did not consider claimant medically stationary at the time of the panel's examination or when he provided his response. Finally, Dr. Simmons stated that he expected material improvement in claimant's condition with a course of physical therapy.

Thus, based on Dr. Simmons' opinion that claimant was not medically stationary, we conclude that claimant showed that the claim was prematurely closed.

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 claimant's appellate brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's December 17, 1999 order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
LARRY L. LITTLE, Claimant
WCB Case Nos. 99-05373 & 99-01897
ORDER ON RECONSIDERATION
Kryger, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Julie Masters (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our April 7, 2000 order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside its compensability and responsibility denial of claimant's current low back condition; and (2) upheld Wausau's denial of responsibility for the same condition. SAIF argues that we erred in characterizing its denial as a "current condition" denial and in evaluating the medical evidence.

We withdraw our April 7, 2000 order for reconsideration. After reviewing SAIF's motion and our prior order, we adhere to and republish our April 7, 2000 order.[1] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We acknowledge SAIF's contention that we mischaracterized its denial as a "current condition" denial. However, the medical evidence uniformly indicates that claimant has but one low back condition, despite her several diagnoses. There is no evidence that claimant's current low back diagnoses are medically separable. Consequently, we continue to agree with the ALJ that SAIF in fact denied claimant's current low back condition. (Opinion and Order p. 10). We also continue to agree with the ALJ that Dr. Nash' opinion persuasively establishes that claimant's injury during SAIF's coverage was the major contributing cause of his current disability and need for treatment for her low back. (*See* Exs. 51-3, 63, 64-2, 67-11-13, 67-17-18, 67-20-22, 67-28-29).

In the Matter of the Compensation of
JOSEPH L. CILIONE, Claimant
WCB Case No. 97-08921
ORDER REPUBLISHING ORDER ON REVIEW

It has come to our attention that a copy of the Board's September 22, 1998 Order on Review, as corrected September 28, 1998, was not mailed to the noncomplying employer. Inasmuch the prior order has not become final, we address the employer's contentions regarding the compensability of claimant's injury claim.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8).[1] Copies of the Board order shall be sent by mail to the Director and to the parties. ORS 656.295(7). The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. *Berliner v. Weyerhaeuser Company*, 92 Or App 264, 266-67 (1988).

When an order has been mailed to a party at an address other than that previously provided to the forum, the order has not been properly mailed and it is not final. *Mary J. Gates*, 42 Van Natta 1813 (1990); *see Ernest L. Vaughn*, 40 Van Natta 1574 (1988).

Here, in response to claimant's request for review, the Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial, on behalf of the alleged noncomplying employer, of claimant's claim for deep vein thrombosis of the left calf was reversed. SAIF's denial was set aside and the claim was remanded to the claim processor for further processing in accordance with law.

The Board's September 22 and September 28, 1998 orders provided that copies were sent to claimant, the statutory claim processing agent (Johnston & Culberson), the Department of Justice, DCBS, and the employer. Our orders also provided that the employer's copies were sent to 5280 Wicket Ct, Klamath Falls, OR 97603.

The employer represents that his address is (and has been, at all time relevant to this matter) 19855 Hwy 97 South, Klamath Falls, OR 97603. The employer's representations are unrebutted. Moreover, the ALJ's order was mailed to the latter address and the record otherwise confirms that the employer did not notify the Board that his address had changed.

Under these circumstances, we find that the employer's copies of our orders were mailed to an incorrect address. Because the Board's September 22, 1998 and September 28, 1998 orders were not properly mailed, the orders are not final and we retain jurisdiction to republish the Board's decision and to consider the employer's objections to claimant's injury claim. *Berliner*, 92 Or App at 266-67; *Mary J. Gates*, 42 Van Natta 1813.

Turning to the merits of claimant's request for review of the ALJ's order and after considering the employer's objections, we adhere to and republish our September 22, 1998 order, as corrected September 28, 1998, that determined that claimant's injury claim was compensable. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. *International Paper Co. v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656, 659 (1986).

In the Matter of the Compensation of
TREVOR A. CONTRERAS, Claimant
WCB Case No. 99-06343
ORDER ON REVIEW
Margaret F. Weddell, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal order.

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

Page 2 of the ALJ's order is modified to read "It is *undisputed* that claimant and his attorney received the hearing notices which scheduled the hearing for November 9, 1999."

Claimant and his attorney had notice of a hearing scheduled for November 9, 1999 at 9:00 A.M. at the Board's Portland office. At the scheduled time, claimant and his attorney both failed to appear for the hearing. Shortly thereafter, the attorney for the insurer placed a call to claimant's attorney's office but there was no answer. The insurer then moved for an order of dismissal. In response to the motion, the ALJ issued a Show Cause Order directing claimant to respond within 15 days.

The day of the scheduled hearing (November 9, 1999), claimant and his attorney appeared at the Portland Hearings Division at 1:30 P.M. By letter to the ALJ dated that same day, claimant's attorney explained that he had inadvertently miscalendared the hearing for 1:30 P.M.

After reviewing claimant's response, the ALJ found no extraordinary circumstances justifying a postponement or continuance of the hearing. Therefore, the ALJ dismissed claimant's request for hearing on the basis that it had been abandoned under OAR 438-006-0071.

OAR 438-006-0071 provides:

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

On review, claimant contends that his failure to appear at his scheduled hearing was not "unjustified," given the misinformation as to the hearing time provided by his attorney. We disagree. In *Kara Holmsten*, 50 Van Natta 194, 196 (1998), we affirmed the ALJ's dismissal of the claimant's hearing request where the claimant's attorney had mistakenly believed that his legal assistant had postponed a scheduled hearing. *See also Barbara Vieke*, 50 Van Natta 1447 (1998) (calendaring error attributed to legal assistant did not excuse attorney's negligence in filing late request for hearing where attorney was aware of denial).

This case is analogous to *Holmsten* and *Vieke*. Moreover, in this case, claimant's attorney himself takes responsibility for the calendaring error. Claimant's attorney does not therefore attribute the error to a member of his staff who does not have ultimate responsibility for claimant's claim. *See Ogden Aviation v. Lay*, 142 Or App 469 (1996) (the claimant had "good cause" for filing a request for hearing beyond 60 days under ORS 656.319(1)(b) due to error by legal secretary in failing to place denial on attorney's desk).[1]

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[1] Similarly, in cases involving untimely briefs to the Board, we have held that a calendaring error does not constitute an "extraordinary circumstance beyond the control of the moving party," and therefore does not justify a motion to waive the Board's briefing rules. *See* OAR 438-011-0030; *Antonina Gnatiuk*, 50 Van Natta 976 (1998); *Lester E. Saunders*, 46 Van Natta 1153, 1154 (1994).

In arguing that his failure to appear was not "unjustified," claimant urges us to adopt the standard for setting aside a judgment in civil cases found in ORCP 71B(1). ORCP 71B(1) provides:

> "On motion and upon such terms as are just, the court may relieve a party or such party's legal representative from a judgment for the following reasons: (a) mistake, inadvertence, surprise or excusable neglect. . ."

We decline to adopt such a standard, given the fact that the Board has a specific administrative rule regarding dismissal. (OAR 438-006-0071). *Compare Hempel v. SAIF*, 100 Or App 68, 70 (1990); *Ivan R. McDaniel*, 51 Van Natta 967 (1999) (the Board considered ORCP 71B in interpreting "good cause" for failing to request a hearing within 60 days under ORS 656.319(1)(b)).

Moreover, in cases such as *Vieke* and *Ogden Aviation v. Lay*, ORS 656.319(1)(b) has been interpreted in a manner that would not excuse claimant's attorney's calendaring error. Therefore, even if we were to adopt the standard from ORCP 71B(1) in this case, claimant would still not have shown the "extraordinary circumstances" necessary to avoid dismissal.

Accordingly, for the reasons expressed above as well as those expressed by the ALJ, we affirm the ALJ's order dismissing claimant's request for hearing.[2]

ORDER

The ALJ's order dated December 13, 1999 is affirmed.

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[2] With its respondent's brief, the insurer submits a copy of a billing from Dr. Porter, who was scheduled to appear at the November 9, 1999 hearing. We decline to consider this exhibit as it is not relevant to our analysis.

In the Matter of the Compensation of
LARRY D. HUFF, Claimant
WCB Case No. 99-07085
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's occupational disease claim for substance exposure. On review, the issue is compensability.

We adopt and affirm the ALJ's order. *See Geoffrey R. Lewis*, 50 Van Natta 1352 (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 $1,200, 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 January 5, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the insurer.

In the Matter of the Compensation of
JOSEPHINE A. GROFF, Claimant
WCB Case No. 99-06786
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's occupational disease claim for a right wrist condition. On review, the issue is compensability.

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

The employer contends that claimant did not meet her burden of proving the compensability of either an injury or occupational disease involving her right wrist. The employer, first of all, cites to several alleged inconsistencies in claimant's history of her injuries on July 25, 1999 and July 26, 1999. The employer argues that claimant is therefore not credible. We disagree.

Although in the medical record claimant alternatively referred to both a ham slicing injury on July 25, 1999 and an incident while lifting a chicken on July 26, 1999, we find that both of these incidents did in fact occur. In this regard, we note that claimant's co-worker, Terri Ball, testified that claimant had told her that her wrist was "burning" after slicing deli ham on July 25, 1999, and that claimant had told her she had hurt her wrist again while lifting chicken the next day. (Tr. 31).

Although Ms. Ball admitted she had been fired by the employer for "misappropriation," we do not find that this admission necessarily impeached her testimony in regard to claimant's injuries. The information with which Ms. Ball was impeached was on a collateral matter. *See Westmoreland v. Iowa Beef Processors*, 70 Or App 642 (1984), *rev den* 298 Or 597 (1985); *Frank Sica*, 50 Van Natta 2092 (1998). Moreover, although Ms. Ball is claimant's long-time friend and therefore may arguably be biased to render favorable testimony on her behalf, there are several other references to the ham slicing and chicken lifting incidents in the medical record which also corroborate claimant's history. (*See* Exs. 5, 8, 10, 11A).

The employer next contends that the medical evidence from claimant's treating physician Dr. Hansen is not sufficient to meet claimant's burden of proof. Dr. Hansen concluded that claimant's work activity in July 1999 was the major contributing cause of her disability and need for treatment for her right wrist tendonitis condition. (Exs. 16A, 16B). Dr. Hansen's opinion was unrebutted. Therefore, we need not examine its relative persuasiveness compared to the opinions of other physicians. However, we still must examine Dr. Hansen's opinion to confirm that it satisfies claimant's burden of proof. *McIntyre v. Standard Utility Contractors, Inc.*, 135 Or App 298, 302 (1995).

The employer argues that Dr. Hansen did not have enough specifics of claimant's work activity to reach an opinion based on reasonable medical probability. Dr. Hansen initially agreed with the employer that, "To issue a medical opinion based on reasonable medical probability as to the cause of Ms. Groff's condition associated with a reported injury of July 25, 1999, you would need to know the specifics of her job activities at [the employer] and her off-the-job activities." (Ex. 17-4).

However, Dr. Hansen was later provided with this specific information as reflected in his November 17, 1999 letter. Dr. Hansen confirmed his signature to this opinion letter on December 7, 1999, as requested by the ALJ. (Ex. 16B-1; Tr. 57). In this letter, Dr. Hansen accurately described both the ham slicing and chicken lifting incidents, as well as reciting that claimant "had been working doing a lot of cleaning, scrubbing, repetitive lifting along with using the Hobart Meat Slicer in the deli." (*Id.*) We are therefore satisfied that Dr. Hansen relied on an accurate and specific work history before rendering his final opinion in this matter.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 24, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the employer.

In the Matter of the Compensation of
RICHARD M. MADEN, Claimant
Own Motion No. 00-0143M
OWN MOTION ORDER
Welch, Bruun & Green, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable L4-5 disc herniation. Claimant's aggravation rights on that claim expired on August 5, 1990.

SAIF recommended that claimant's claim be reopened. SAIF agrees that the lumbar fusion with internal fixation and bone graft at L4-5 is compensably related to claimant's 1982 work injury, and does not oppose reopening the claim for that portion of the surgery. But it contends that the surgery at L5-S1 is not causally related to his compensable condition. SAIF has denied that the compensability of claimant's L5-S1 facet arthritis as it relates to his 1982 work injury on which claimant has timely requested a hearing with the Hearings Division. (WCB Case No. 00-01709).

Claimant's 1982 claim was first closed on August 5, 1985, and his aggravation rights expired on August 5, 1990. ORS 656.273(4)(a). Thus, when claimant's condition worsened requiring surgery on January 27, 2000, claimant's claim was under our own motion jurisdiction. Inasmuch as we have exclusive own motion jurisdiction over the claimant's 1982 claim, we turn to whether the claimant is entitled to temporary disability benefits as set forth in ORS 656.278.

The Board's Own Motion authority is provided under ORS 656.278. Except for claims for injuries which occurred prior to January 1, 1966, ORS 656.278(1) limits the Board's authority to those cases where 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.

Our own motion jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. The Board, in its Own Motion authority, does not have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries excepted). Rather, jurisdiction over these disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 and 656.704(3)(b) or with the Director under ORS 656.245, 656.260 or 656.327 and 656.704(3)(b). *See Gary L. Martin*, 48 Van Natta 1802 (1996).

On January 27, 2000, Dr. Burkhart, claimant's attending physician, recommended that claimant undergo a lumbar fusion at two levels, L4-5 and L5-S1, with internal fixation and bone graft. SAIF disputes the compensability of that portion of the surgery regarding the L5-S1 facet arthritis, as it relates to claimant's compensable 1982 injury. As noted above, this "compensability" dispute is not within our jurisdiction to decide and has been properly set before the Hearings Division under ORS 656.283(1).

However, the parties agree, and the medical evidence supports, that a portion of the recommended surgical procedure (*i.e.* fusion at L4-5) is a compensable component of his 1982 work injury. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. *Howard L. Browne*, 49 Van Natta 485 (1997) (claimant's multilevel back surgery included treatment for both compensable and noncompensable conditions; however, that portion of the surgery that related to his compensable L4-5 injury satisfied the "surgery" requirement under ORS 656.278(1)(a)).

Accordingly, we authorize the reopening of claimant's 1982 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery at L4-5. When claimant's condition related to the surgery at L4-5 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 $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
CYNTHIA K. STRODE, Claimant
WCB Case No. 99-05689
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that awarded claimant 19 percent (60.8 degrees) unscheduled permanent disability for her upper and lower back condition, whereas an Order on Reconsideration awarded claimant no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt his Ultimate Finding of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the arbiter's examination of claimant was persuasive and consequently, he adopted the arbiter's range of motion findings. On review, the insurer contends that the arbiter's findings should not be accepted, due to comments he made regarding restrictions and symptoms attributable to claimant's pregnancy. We agree with the insurer for the following reasons.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. *Orfan A. Babury*, 48 Van Natta 1687 (1996). The "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). Rather than automatically relying on a medical arbiter's opinion in evaluating a worker's impairment, we will rely on the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, claimant's treating doctor, Dr. Glassman, agreed with Dr. Neumann who examined claimant on behalf of the insurer. On July 28, 1998, Dr. Neumann examined claimant and reported that, because of functional behavior patterns, claimant demonstrated few valid objective findings of impairment. (Ex. 12). On July 30, 1998, Dr. Glassman concurred with Dr. Neumann's report. (Ex. 14). Dr. Glassman specifically agreed that claimant was medically stationary with no ratable permanent impairment. (Ex. 13-1). Finally, Dr. Glassman's August 1998 chartnote provides that claimant's symptoms did not correlate with objective findings. Dr. Glassman released claimant to work and noted her impairment as "None." (Ex. 15).

The medical arbiter, Dr. Filarski, examined claimant on June 9, 1999. At the time of the examination, claimant was seven months pregnant. Dr. Filarski reported that claimant's "working diagnosis" was "myofascial sensitivity with subjective symptoms outweighing objective findings." Dr. Filarski also found that claimant had lost range of motion in the cervical, thoracic and lumbar areas, but noted that "[r]epeat objective testing might be appropriate following the completion of pregnancy and a period of conditioning." Dr. Filarski further reported that claimant's examination was "somewhat limited because of pregnancy", and claimant was "asked to participate in all examination maneuvers to within her pregnancy capacity and her symptom limits." Finally, Dr. Filarski concluded that claimant "did perform well but in a restricted fashion because of her pregnancy status." (Ex. 24-4).

In light of Dr. Filarski's statements regarding claimant's pregnancy limitations during the exam, we are unable to find that claimant's loss of range of motion findings are due to the compensable injury. Moreover, Dr. Filarski also noted subjective symptoms outweighing objective findings. (Ex. 24-4). Alternatively, even if the arbiter's report could be construed to provide findings due to the compensable injury, we would not find it persuasive because of Dr. Filarski's failure to explain why such findings are due to the injury, rather than claimant's pregnancy.

Accordingly, we conclude that a preponderance of the medical opinion establishes a different level of impairment than the findings provided by the arbiter. Because claimant's treating doctor has found no permanent impairment and we find no reason to reject his opinion, we conclude that claimant is not entitled to an award of permanent disability for her upper and lower back condition. Therefore, the ALJ's order is reversed.

ORDER

The ALJ's order dated January 10, 2000, as amended by the January 11, 2000 order, is reversed. The July 14, 1999 Order on Reconsideration is affirmed in its entirety. The ALJ's "out-of-compensation" attorney fee award is reversed.

Board Member Biehl dissenting.

I agree with the ALJ's conclusion that claimant has established an entitlement to an award of permanent disability for her loss of range of motion. I also agree with the ALJ that the arbiter's report is the most persuasive opinion in the record with regard to claimant's impairment.

Although the majority has rejected the arbiter's report based on comments pertaining to claimant's pregnancy restrictions, I believe that the report, when considered in its entirety, establishes that claimant's loss of range of motion is actually due to the compensable injury. There is no evidence that Dr. Filarski failed to comply with the Department's instructions to measure claimant's impairment and to describe any objective findings resulting from the accepted condition. (Exs. 23C-2, 24). Moreover, Dr. Filarski specifically noted that no findings on the examination were considered invalid. (Ex. 24-5).

Under the circumstances, I conclude that Dr. Filarski's findings should not be rejected merely because he was attempting to provide a complete examination by noting claimant's pregnancy status. Without a clear statement that her findings were not due to the compensable injury, or that the findings were invalid, I conclude that the arbiter's report should be construed to support an award of permanent disability. I therefore respectfully dissent from the majority's decision in this case.

In the Matter of the Compensation of
VICKY L. WOODARD, Claimant
WCB Case No. 99-06153
ORDER ON REVIEW (REMANDING)
Hilda Galaviz, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Johnson's order affirming an Order on Reconsideration that rescinded a Notice of Closure as prematurely issued. Claimant cross-requests review of that portion of the ALJ's order that awarded an attorney fee of $1,300. On review, the issues are premature closure, (potentially) extent of permanent disability and attorney fees. We reverse and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

On July 3, 1998, claimant was compensably injured when she slipped and fell while carrying empty boxes to a stock room. (Ex. 1). The insurer accepted disabling bilateral ankle sprains. (Ex. 4). An April 20, 1999 Notice of Closure indicated claimant was medically stationary on March 10, 1999. (Ex. 21). Claimant was not awarded any permanent disability. (*Id.*) A July 19, 1999 Order on Reconsideration rescinded the Notice of Closure, finding that the claim was prematurely closed. (Ex. 26). The Appellate Reviewer relied on Dr. Sedgewick's opinion and found that claimant had materially improved with additional medical treatment and time. (Ex. 26-2).

The ALJ found that Dr. Sedgewick's opinion addressed claimant's condition at the time of closure. The ALJ determined that Dr. Sedgewick had administered "curative" medical treatment and such treatment had actually improved claimant's condition. Based on Dr. Sedgewick's opinion, the ALJ concluded that claimant was not medically stationary as of the date of closure.

On review, the insurer argues, among other things, that Dr. Sedgewick's opinion was not relevant because he was not treating claimant for an accepted condition. For the following reasons, we agree with the insurer.

An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Whether the carrier has prematurely closed the claim depends on whether claimant was medically stationary at the time of the Notice of Closure, without consideration of subsequent changes in her condition.[1] *See Scheuning v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987); *Alvarez v. GAB Business Services*, 72 Or App 524, 527 (1985).

In *James L. Mack*, 50 Van Natta 338 (1998), we concluded that a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure. In reaching this conclusion, we relied on the legislature's 1997 adoption of ORS 656.262(7)(c), which provides, in part, that "[i]f a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

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[1] Claimant argues that, because the insurer requested a hearing, it has the burden of proving that claimant was medically stationary at the time of closure. Claimant generally bears the burden of proving that his or her compensable condition was not medically stationary at claim closure. *See Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981); *but see Kurt C. Miller*, 41 Van Natta 1899 (1989) (because the carrier argued that the claimant was medically stationary prior to the date set forth in the Determination Order, it had the burden of proof). In the present case, we need not decide whether claimant's contention regarding the burden of proof is correct because the result in this case would be the same no matter which party has the burden of proof.

At the time of the April 20, 1999 claim closure, the insurer had accepted disabling bilateral ankle sprains. (Exs. 4, 20). Dr. Sedgewick first examined claimant on April 28, 1999, several months after the July 3, 1998 injury. (Ex. 22). Claimant complained primarily of left ankle pain. (*Id.*) He gave claimant an injection within the joint, explaining: "If her pain goes away, it speaks toward an intra-articular pathology. If it is cartilaginous damage, this will not show up on MRI or bone scan per se." (*Id.*) Dr. Sedgewick became claimant's attending physician on April 28, 1999. (Ex. 23).

On May 20, 1999, Dr. Sedgewick reported that claimant had noted benefit from the cortisone injection for a week and a half. (Ex. 24). She continued to have complaints of instability and pain, although they had improved after the injection. (Ex. 24). He diagnosed left ankle arthralgia. (*Id.*) Dr. Sedgewick commented: "[a]t this time she is improved with cortisone injection, which suggests that the problem is more intra-articular versus extra-articular or instability issues." (*Id.*)

On June 3, 1999, Dr. Sedgewick reported that claimant's right ankle had become symptomatic. (Ex. 25). He noted that she had been treated with a cortisone injection in the left and had improved range of motion. (*Id.*) Dr. Sedgewick gave claimant another injection in the ankle in the hope it would alleviate her symptoms. (*Id.*) He commented that he was "going to send out an arthritis panel and sed rate to make sure that we are not necessarily dealing with an inflammatory process and not related to her Workers' Comp. injury." (*Id.*)

Although claimant's accepted condition was bilateral ankle sprains, Dr. Sedgewick diagnosed left ankle arthralgia and he indicated that claimant's problem was "intra-articular." (Ex. 24). "Arthralgia" is defined as "pain in a joint." Dorland's *Illustrated Medical Dictionary* 140 (28th ed. 1994). "Intra-articular" means "within a joint." *Id.* at 853. On the other hand, 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." *Id.* at 1566. Thus, the dictionary definitions indicate that a "sprain" refers to a joint injury involving ligament damage, whereas Dr. Sedgewick's diagnosis of left ankle arthralgia refers to pain within the joint itself. Dr. Sedgewick did not indicate he was treating bilateral ankle sprains. Moreover, in his June 3, 1999 report, Dr. Sedgewick indicated further testing was necessary to determine whether claimant's symptoms were related to some type of inflammatory process rather than the work injury. (Ex. 25).

Claimant argues that Dr. Davidson's June 25, 1999 report indicates that he agreed that Dr. Sedgewick was treating the same condition Dr. Davidson had been treating. We disagree. On June 25, 1999, Dr. Davidson wrote to the Department and said that if Dr. Duff's report had been available to him at the time of claimant's March 12, 1999 examination, he would have deemed claimant to be medically stationary at that time. (Ex. 25A). Dr. Duff had examined claimant on March 10, 1999 and found she was medically stationary and could return to her regular work without restrictions. (Ex. 16-4, -5). Dr. Duff said there was no specific diagnosis of either ankle and the objective physical findings were normal. (Ex. 16-4). In the June 25, 1999 report, Dr. Davidson reiterated that he concurred with Dr. Duff's report. (*Id.*) Dr. Davidson noted that claimant was currently being treated by Dr. Sedgewick and explained:

> "In review of [claimant's] notes, after seeing Dr. Sedgewick, [claimant] has received relief from intra-articular injections and Dr. Sedgewick may feel that there is, in fact, something that can be dealt with and I will let him comment on his opinion." (*Id.*)

Contrary to claimant's argument, we find no evidence in the record that indicates Dr. Davidson felt that Dr. Sedgewick was treating the same condition he had been treating. Dr. Sedgewick did not refer to claimant's ankle problems as sprains and Dr. Davidson did not indicate that he believed Dr. Sedgewick was treating a bilateral ankle sprain condition. To the contrary, Dr. Davidson's comment that Dr. Sedgewick felt there was "something that can be dealt with" indicated that claimant might have another treatable condition. Moreover, in the June 25, 1999 report, Dr. Davidson reiterated that he believed claimant's accepted condition was medically stationary. Based on the medical record, we find that claimant's left ankle arthralgia is not the same as the accepted bilateral ankle sprains.[2]

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[2] Claimant also contends that Dr. Sedgewick's June 3, 1999 chart note reflects that he believes the treatment was rendered for the "sequelae" of the July 3, 1998 work injury. To the extent that claimant is relying on ORS 656.268(16), that statute refers to rating permanent disability, not determining medically stationary status. *Dennis J. Neeley*, 50 Van Natta 2127 (1998). The issue of compensability of claimant's left ankle arthralgia is neither before us at this time, nor is it relevant to the issue of whether claimant's accepted conditions are medically stationary.

A determination of whether a claim has been prematurely closed (because the worker was not medically stationary) must focus only on those conditions that were accepted at the time of claim closure. *See James L. Mack*, 50 Van Natta at 339. Dr. Sedgewick did not indicate he was treating bilateral ankle sprains. Because we find that the medically stationary status of claimant's non-accepted left ankle arthralgia condition is irrelevant to the premature closure determination, we conclude that claimant's reliance on Dr. Sedgewick's reports is misplaced.

We examine the remaining medical opinions to determine if the claim was prematurely closed. At the time of closure, Dr. Davidson was claimant's treating physician. (Ex. 3). Dr. Davidson concurred with the report from Dr. Duff, who found that claimant was medically stationary and could return to her regular work without restrictions. (Exs. 16-4, -5, 19). Dr. Duff reported that there was no specific diagnosis of either ankle and the objective physical findings were "entirely" normal, although he noted there was "clearly" a nonorganic element to claimant's symptoms. (Ex. 16-4). In a June 25, 1999 report to the Department, Dr. Davidson said that if Dr. Duff's report had been available at the time of claimant's March 12, 1999 examination, he would have deemed claimant to be medically stationary at that time. (Ex. 25A).

Dr. Woll examined claimant in January 1999 and reported that she had "[c]hronic pain bilateral hindfeet of unclear etiology." (Ex. 14-2). Dr. Woll recommended an MRI scan and said that "if that is negative, have her treated for chronic pain and advise closure of her claim[.]" (Ex. 14-1). A February 15, 1999 MRI did not identify any significant abnormalities. (Ex. 15). Although Dr. Woll indicated claimant should be treated for "chronic pain" (Exs. 14-1, -3), he did not associate the pain with the work injury, but rather said it was "of unclear etiology." We find that Dr. Woll's opinion does not support the conclusion that the claim was prematurely closed.

Based on the opinions of Drs. Davidson and Duff, we conclude that the medical evidence establishes that claimant's condition was medically stationary at the time of claim closure. Therefore, we find that the April 20, 1999 Notice of Closure was not prematurely issued and reverse the ALJ's decision setting aside the claim closure.[3]

Extent of Permanent Disability

Because the ALJ concluded that claimant was not medically stationary and set aside the Order on Reconsideration, he did not address the issue regarding extent of claimant's permanent disability.

Claimant contends that if the Board finds she was medically stationary at the time of closure, the claim must be remanded to the Appellate Review Unit for completion of the reconsideration proceeding. She asserts that she challenged the Notice of Closure and requested the appointment of a medical arbiter, but that examination never took place because the Department determined that the claim was prematurely closed. Claimant raised this issue at hearing. The insurer does not respond to claimant's argument.

Because the Order on Reconsideration found that the claim had been prematurely closed, the Department did not appoint a medical arbiter. Although we lack the authority to remand this matter to the Department for appointment of a medical arbiter, *see Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993), claimant is statutorily entitled to a medical arbiter report because she timely disagreed with the impairment findings used to rate her disability. *See* ORS 656.268(7)(a). Accordingly, we must fashion a remedy which accommodates both the *Pacheco-Gonzalez* decision and claimant's statutory right to a medical arbiter's report.

Under the circumstances of this case, we conclude 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)(f). *See, e.g., Katherine M. Tofell*, 51 Van Natta 1845 (1998); *Dennis R. Loucks*, 50 Van Natta 1779 (1998). The parties shall be responsible for contacting the Director to make arrangements for the appointment of a

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[3] Based on this conclusion, it follows that the ALJ's attorney fee award (for claimant's defense to the insurer's challenge concerning the premature closure issue) should also be reversed. Under these circumstances, we need not address claimant's cross-request for review regarding the amount of the attorney fee for services at hearing.

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 December 16, 1999 is reversed. The Order on Reconsideration's rescission of the Notice of Closure is reversed. The ALJ's attorney fee award is reversed. This matter is remanded to ALJ Johnson for further proceedings consistent with this order.

May 5, 2000 Cite as 52 Van Natta 799 (2000)

In the Matter of the Compensation of
LEROY J. GROVER, Claimant
WCB Case No. C000930
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Kryger, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

On April 27, 2000, 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 approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is "$32,150" and the total due claimant's attorney is $5,250. This would equal a total consideration of $37,400. However, the total consideration recited on the first page, as well as page 2, number 12 and 18, of the CDA is "$37,500." On page 3, number 13 provides that the amount payable to claimant's attorney is $5,250, which is consistent with the first page. Furthermore, page 4, number 18 states that the consideration to claimant is $32,250.

Thus, the lone reference on the first page of the CDA to a distribution to claimant of $32,150 and a $5,250 attorney fee, equaling a total consideration of $37,400, appears to be a typographical error. In reaching this conclusion, we note that a payment of $32,250 to claimant would be consistent with a total consideration of $37,500 with an attorney fee of $5,250. Accordingly, we interpret the agreement as providing for a total consideration of $37,500, with claimant receiving $32,250, and claimant's counsel an attorney fee of $5,250.

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 $5,250, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY A. WILLIAMS, Claimant
WCB Case No. C000946
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Dierking & Schuster, Claimant Attorneys
Sather, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On April 20, 2000, 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 approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $1,875 and the total due claimant's attorney is $625. This would equal a total consideration of $2,500. However, page two of the document provides a total consideration of *$1,875 out of which* claimant's attorney would receive $625. The reference on page two of the CDA to a total consideration of $1,875, and the provision that the attorney fee would be deducted from that consideration, appear to be typographical errors.[1] Accordingly, we interpret the agreement as providing for a total consideration of $2,500, with $625 payable to claimant's attorney and $1,875 to claimant.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $625, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

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[1] Furthermore, a $625 attorney fee payable from $1,875 in CDA proceeds would exceed the Boards standard attorney fee schedule, whereas such a fee out of $2,500 in proceeds would be within prescribed limits. *See* OAR 438-015-0052(1).

In the Matter of the Compensation of
JOSHUA D. BEAVER, Claimant
WCB Case No. 99-01967
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers, 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 left leg, back and shoulder injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

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

At the time of his injury, claimant was on his way to work at the employer, a casino located on the east side of Highway 101 in Coos Bay. Claimant parked in an employer-designated parking lot on the west side of Highway 101, walked to the signalled crosswalk, activated the walk signal, and, when partly across Highway 101, was hit by a car making a left turn from the casino exit, crossing the northbound lanes and the crosswalk to go south on Highway 101.

The casino caused an increase in traffic at the entrance to the casino and on Highway 101. (Ex. A). Claimant's injury took place on a public highway. The employer has provided two designated parking lots for employees and patrons. One designated parking lot is north of the casino on the same side of Highway 101. The other designated parking lot is on the west side of Highway 101, the side opposite from the casino. The employer is not responsible for the operation or maintenance of the traffic signal and crosswalk at the intersection of Highway 101 and Lewis Street (the entrance to the casino).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the employer created an increased risk of injury at the location where claimant was injured and that claimant's status as an employee exposed him to a greater degree of risk than members of the general public, which were sufficient to establish control for purposes of the "greater hazard" exception to the "coming and going" rule. The ALJ concluded that claimant's injury occurred within the course and scope of employment and was, therefore, compensable.

On review, SAIF argues that claimant has failed to prove that he was injured "in the course of employment" because the employer did not own or maintain the public road on which claimant was injured, nor did the employer create any special hazard. For the reasons set forth below, we agree with SAIF that claimant did not prove that he was injured "in the course of employment."

For an injury to be compensable under the workers' compensation law, it must "aris[e] out of" and occur "in the course of employment." ORS 656.005(7)(a). The "arise out of" prong of the compensability test requires that a causal link exist between the worker's injury and his or her employment. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525-26 (1996); *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). The requirement that the injury occur "in the course of" the employment concerns the time, place, and circumstances of the injury. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366.

The two prongs are two parts of a single "work-connection" inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366. Both prongs of the work-connection test must be satisfied to some degree; neither is dispositive. *Krushwitz*, 323 Or at 531; *Norpac*, 318 Or at 366. The work-connection test may be satisfied if the factors supporting one prong of the statutory test are

minimal while the factors supporting the other prong are many. *Krushwitz*, 323 Or at 531 (citing *Phil A. Livesley Co. v. Russ*, 296 Or 25, 28 (1983)). Both prongs serve as analytical tools for determining whether the causal connection between the injury and the employment is sufficient to warrant compensation. *Andrews v. Tektronix, Inc.*, 323 Or 154, 161-62 (1996).

Ordinarily, under the "going and coming" rule, an injury sustained while a worker is going to or coming from work is not considered to have occurred "in the course of" employment and, therefore, is not compensable. *Krushwitz*, 323 Or at 526 (citing *Cope v. West American Ins. Co.*, 309 Or 232, 237 (1990)); *Norpac*, 318 Or at 366.[1]

However, there are some exceptions to the "going and coming" rule. One is the "greater hazard" exception. Under that exception, injuries sustained "[i]f the employee's employment requires [the employee] to use an entrance or exit to or from * * * work which exposes [the employee] to hazards in a greater degree than the common public" while the worker is going to or coming from work have a sufficient work-connection to be considered to have occurred "in the course of" employment. *Nelson v. Douglas Fir Plywood Co.*, 260 Or 53, 57 (1971).

This exception has been applied only in certain limited circumstances, in which an employee is injured while traveling upon the only means of ingress to or egress from the employer's premises and some "greater hazard" existed upon that route. *See id.* at 57-58 (greater hazard exception applied when employee was injured while traveling upon the only road that led to employer's plant and dangerous, heavy traffic subjected employee to hazards "peculiar and directly attributable to her employment"); *Montgomery v. State Ind. Acc. Com.*, 224 Or 380, 387-89, 393-94 (1960) (greater hazard exception applied when employee was injured while traveling across a public road with heavy traffic that was the only means of entering employer's plant and employer had had traffic light installed and had gained right to operate light, because of the heavy traffic).

Here, claimant was injured while crossing a public highway in a public crosswalk, going from one of the employer-designated parking lots to the casino where he worked. Therefore, the question is whether claimant can establish that his employment required him to use an entrance or exit to or from his work which exposed him to hazards in a greater degree than the common public. If so, he is regarding as being within the course of his employment. *Nelson*, 260 Or at 57.

In *Nelson*, the claimant was required to turn from a public road on to the employer's private road. She was involved in an accident with one of the employer's trucks. The Court found that the claimant was subjected to hazards which were peculiar and directly attributable to her employment. The general public would not be exposed to the same hazards as employees who were required to turn onto the employer's premises, because they would be traveling in a straight direction, not turning off of the road.

Here, the presence of the employer's business resulted in increased traffic volume both on Highway 101 and in entering and exiting the casino. (Ex. A). The employer provided two parking lots to accommodate patrons and employees. The employees were required to park either in the portion of the north parking lot (on the same side of Highway 101 as the casino) farthest from the casino or in the west parking lot across Highway 101 from the casino. When claimant parked in the west parking lot, he had no choice but to cross Highway 101 in order to get to the work premises.

But, unlike in *Nelson*, in this case the general public also parked in the same parking lot. (Tr. 50). The employer provided a shuttle to take patrons and employees to and from the casino and west parking lot on request. Therefore, claimant was not traveling upon the only means of ingress to or egress from his place of employment. Moreover, patrons and employees who chose to walk across the street were alike required to cross Highway 101 in order to get to the casino. Members of the general public, therefore, encountered the same risk as claimant when they walked to the casino using the

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[1] The reason for the "going and coming" rule is that the relationship of employer and worker ordinarily is suspended from the time the worker leaves work to go home until he or she resumes work because, while going to or coming from work, the worker is rendering no service for the employer. *Krushwitz*, 323 Or at 526-27 (citing *Heide v. T.C.I. Incorporated*, 264 Or 535, 540 (1973)).

crosswalk. Because using the crosswalk was not the exclusive means of getting to and from work, and because claimant was exposed to no greater risks than those faced by the general public, he is not subject to the "greater hazard" exception from the going and coming rule.[2]

Consequently, claimant has not established that he was within the course of his employment when he was injured in the crosswalk.

ORDER

The ALJ's order dated July 8, 1999 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed.

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[2] Claimant asserted at hearing that the degree of frequency of crossing from the west parking lot created an increased risk of injury peculiar to employees greater than a typical member of the general public. The ALJ agreed, citing to citing to *Montgomery v. State Ind. Acc. Commission* for authority. We do not agree with the ALJ's analysis.

In *Montgomery*, the claimant was injured when he was struck by a car while crossing a public street as he was leaving work. The employer previously had convinced city authorities to install a traffic control light at the scene of the accident, and the employer controlled the light. The Court concluded that, although the injury occurred after work on a public street, the claimant was in the course of employment because the injury occurred in an area over which the employer exercised some control, all employees were required to cross the public street by foot or automobile because it was the only means of entering the employer's plant, the employment resulted in the employees being exposed to hazards of the public street to a greater degree than the common public, the crossing of the public street was a special risk of claimant's employment, and the public street was in fact an extrusion of the employer's plant.

It was in the context of establishing whether the claimant was exposed to hazards of the public street greater than the general public that the *Montgomery* Court discussed the doctrine announced in *Cudahy Packing Co. of Nebraska v. Parramore*, 263 US 418 (1923). In *Parramore*, an accident that occurred at a railroad crossing adjacent to the employer's plant that all employees had to cross to get to their employment was viewed as having arisen "out of and in the course of employment." The crossing was the only available or practical approach to the place of employment. *Montgomery*, 224 Or 392. The *Montgomery* Court then stated that there is an additional requirement that "use of the public thoroughfare exposes the workman, as in the Parramore case, to the hazards of the road in a degree greater than the general public. In the Parramore case, the extra hazard consisted of the danger of passing daily over the several lines of railroad tracks." *Id.*

Here, the ALJ determined that the extra hazard to claimant consisted not only of the risk of crossing Highway 101 but was increased by doing so twice a day. But there is no evidence that claimant actually parked in the west lot every day and crossed the highway twice a day. Even though claimant testified that he was unaware that he could use the shuttle to get from the west parking lot to work, the designated portion of the north parking lot was available for employee parking, which would take him out of harms way. Therefore, unlike the circumstances in *Parramore* and *Montgomery*, claimant's passage across Highway 101 was not only not the exclusive and required means to get to work, but the frequency with which he crossed the highway was under his own control.

Board Member Phillips Polich dissenting.

I disagree with the majority's analysis and agree with the ALJ that claimant has established that he was in the course and scope of his employment when he was injured. I believe the majority has erred when it concluded that claimant was not subject to a "greater hazard" than the general public. For the following reasons, I respectfully dissent.

Unlike the majority, I would find that *Nelson* is applicable here. In *Nelson*, the court held that if the employee's employment requires him to use an entrance or exit to or from his work which exposes him to hazards in greater degree than the common public, he is regarded as being within the course of his employment. It is immaterial whether the road the employee is required to travel in order to reach the plant is public or private if the employee is exposed to hazards in a greater degree than the common public. *Nelson*, 260 Or at 57.

Here, the only reason that claimant was in the west parking lot was to go to work. Claimant was required to park in the employer's designated parking lot, which necessarily entailed his crossing Highway 101 at the crosswalk, thus encountering a risk from cars that were turning left onto the highway from the casino driveway as well as from cars travelling on the highway itself. Moreover, by

requiring claimant to park in this specific area, claimant was exposed to hazards peculiar to his employment and not experienced by the traveling members of the public, because a patron can choose not to go to the casino, while an employee of the casino cannot make that choice (unless he also chooses to lose his job). The fact that claimant could have parked in the other parking lot is irrelevant to the circumstances of this case.

In addition, the previous business that occupied the casino site had a pedestrian overpass that enabled the employees of that business to cross Highway 101 safely. In July 1995, a traffic impact study was prepared by Access Engineering of Eugene, Oregon, for the casino development. (Tr. 9). As part of the planning process, this pedestrian overpass was to be replaced with a new structure in the future. (Ex. A-6, paragraph 1; A-10, paragraph 3). Prior to replacement of the overpass, Access Engineering stated: "The existing pedestrian sky bridge crossing over the Highway and railroad tracks is available to provide safe pedestrian access." (Ex. A-11). This indicates that there was a known problem in crossing Highway 101, even before the increase in traffic engendered by the casino. This overpass spanning Highway 101 existed from 1969 until it was removed by the development arm of the tribe (CEDCO) in 1996. (Ex. E). As of the date of claimant's injury, the pedestrian overpass had not been replaced.

In addition to the known hazard to employees crossing Highway 101, the casino and associated businesses caused average daily traffic to increase on Highway 101. (Exs. C-2, Table 2; C-3, Table 4).[1] This traffic increase is consistent with expectations during the casino planning phase. Moreover, SAIF acknowledges that traffic at the intersection of Highway 101 at Lewis Street had increased after the casino and additional facilities were in place.[2] (Appellant's Brief at 1).

Clearly, these circumstances (removal of the overpass and increased traffic) establish that the "employer created hazard" to the "going and coming" rule is applicable. Claimant's employment at the casino required him to cross and recross Highway 101 when he drove to work and parked in the west parking lot. This exposure existed each and every time he parked in the west parking lot.

In contrast, the casino provided public parking next to its facility which did not require crossing Highway 101. (Exs. F, G). Because of his ongoing employment at the casino (in contrast to the occasional visits--and even more occasional parking in the more distant west parking lot--by the general public), the hazards to claimant were clearly greater than for the general public. Therefore, claimant's exposure to the risk of injury while crossing Highway 101 was, by the very nature of the employment, greater for him than for the general public.

In sum, claimant was using a parking lot designated by his employer for parking his vehicle and, because of the removal of the formerly safe elevated pedestrian crossing, the location of the signal light, cross walk location, the employer's driveway location, and the requirement that claimant cross Highway 101, he was exposed to hazards in a greater degree than the general public. Therefore, I would find that claimant was in the course and scope of his employment when he was hit in the crosswalk by a vehicle leaving the casino.

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[1] That there were no traffic studies showing an increase in traffic volume on Highway 101 from pre-casino times to the time of the December 1998 accident, or that the estimated traffic increase was less than the actual increase does not contradict the ALJ's finding on this issue. Moreover, as additional facilities were added (bingo and the lounge), traffic further increased. (Ex. C).

[2] SAIF stated: "Although the employer's casino no doubt resulted in more traffic at Highway 101 at Lewis Street than would have been the case without a casino * * * ."

In the Matter of the Compensation of
AUDENCIA MONTEZ, Claimant
WCB Case Nos. 99-06577 & 99-02429
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Sheridan, Bronstein, et al, Defense Attorneys

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the SAIF Corporation's denial of claimant's injury claim. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

Claimant's husband, Mr. Negre, worked seasonally in the employer's orchards. The employer hired Mr. Negre, among others, to pick cherries in June 1999. When claimant and Mr. Negre went to the employer's farm to seek employment for claimant on June 10, 1999, they were told to return the next day to fill out the necessary papers. Claimant, claimant's son, and Mr. Negre returned to the farm the next day.

Mr. and Mrs. Roloff and Ms. Nunez hire almost all the workers employed on the farm. Hiring is based on applicants' proof of identity and completed I-9 and W-4 forms.

Claimant presented her identification to Mr. Roloff and he helped her complete her forms on June 11, 1999.

Claimant's son sought employment at the same time, but he did not have his identification with him that day. Mrs. Roloff and Ms. Nunez instructed claimant (in English and Spanish) to go home, get her son's identification, come back with her son, and watch a safety video.

Claimant did not go home; instead, she and her son went to the orchard and began picking cherries with Mr. Negre. They picked cherries for the employer for 6 or 7 days thereafter.

On June 19, 1998, claimant fell from a ladder and fractured the little finger of her right hand, while picking cherries in the employer's orchard. She filed a claim which SAIF denied.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial of claimant's injury claim, finding that claimant was not a subject worker at the time of her injury. The ALJ reasoned that claimant and her son never completed the employer's hiring process and "the employer was not even aware that claimant and her son were picking cherries." Therefore, the ALJ found the evidence "overwhelming that the claimant and her son were never hired by this employer."

The issue is whether claimant was a "worker" when she was injured. ORS 656.005(30) defines a worker as "any person * * * who engages to furnish services for remuneration, subject to the direction and control of an employer" (with certain exceptions not relevant here). The pivotal question is whether the employer hired claimant.

Claimant contends that she engaged to provide services for the employer for remuneration when Mr. Roloff helped her fill out the required forms and told her to get a ladder and go to work. (*See* Tr. 9, 11, 13, 20; *see also* Tr. 59). She argues that we should focus first on *her* perspective in determining whether she was employed by the employer, citing *Newport Seafood v. Shine*, 71 Or App 119, 124 (1984) (holding that determination of employment relationship focuses first on the "claimant's perspective").

However, the court has since rejected the "claimant's perspective" argument (in another employment relationship case), noting that *Shine* involved application of the "loaned servant" doctrine. *Liberty Northwest Ins. Corp. v. Church*, 106 Or App 477, 480-481, *rev den* 312 Or 16 (1991). Here, as in

Church, claimant was not a loaned servant and *Shine* has no bearing.[1] Accordingly, although claimant clearly believed that she was employed at the time of her injury, that belief does not establish an employment relationship.

Claimant bears the burden of proving the existence of the employment relationship. *See Hix v. State Acc. Ins. Fund*, 34 Or App 819, 825 (1978). In order for an employment relationship to exist, there must be a contract for hire,[2] express or implied, and the employer must have the right to direct and control the employee.[3]

Here, the parties agree that claimant completed her W-4 and I-9 forms, with Mr. Roloff's help, on June 11, 1999. (Tr. 20, 46, 63). Claimant testified that Mr. Roloff then told her to go to work. Mr. Roloff testified that he did not hire her at that time because "she hadn't seen the video." (Tr. 64).

Mr. and Mrs. Roloff and Irene Nunez, the employer's translator, testified that claimant was informed that she must watch a safety video before going to work. (*See* Tr. 47, 60, 81). Mrs. Roloff and Ms. Nunez also stated that they specifically instructed claimant to go home and get her son's identification, then return and watch the video before going to work. (*See id.*).

Thus, the evidence relevant and material to the employment relationship issue is conflicting -- specifically, regarding whether claimant satisfied the employer's requirements and conditions for employment. We cannot say that one parties' version of the events on June 11, 1999 is more persuasive or compelling than the other. Consequently, we find the evidence to be in equipoise. Under these circumstances, we are unable to find that claimant has carried her burden of proving that she engaged to furnish services for the employer and we agree with the ALJ that claimant was not a "worker" at the time of her injury. *See S-W Floor Covering Shop v. National Council on Compensation Insurance*, 318 Or 614, 630 (1994) (one who is not a "worker" is not subject to workers' compensation coverage, and the inquiry ends).

ORDER

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

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[1] Claimant also relies on *Van M. Gibson*, 41 Van Natta 2182 (1989), in support of her argument that there was an implied contract for hire in this case. The relevant portion of that case provides:

> "Here, Mitchell asked claimant to do the work which claimant agreed to do. Claimant expected to be paid for that work, albeit by Diamond. Claimant knew that he was working to further Mitchell's business purposes. These facts are sufficient to establish an implied contract for hire, and we so conclude." 41 Van Natta at 2185.

But *Gibson*, like *Shine*, involved application of the "loaned servant" doctrine and it has no bearing here. Moreover, there was apparently no evidence in *Gibson* suggesting that the claimant failed to follow the employer's instructions before beginning work.

[2] *See Rogers v. State Acc. Ins. Fund*, 289 Or 633, 641-642 (1980) ("The essence of the Workers' Compensation Act is that financial consequences flow from the existence of the employment relationship itself. Liability and compensability are predicated on employment.").

[3] "There are two fundamental elements which must be present if an employer-employe relationship is to be found to exist: (1) a contract for hire between the parties, either express or implied; and (2) a right of control." *Oremus v Ore. Pub. Co.*, 11 Or App 444, 446 (1972), *rev den* (1973); *compare Lamm v Silver Falls Timber Co.*, 133 Or 468, 498-496 (1930) (" Workmen's Compensation legislation rests upon the idea of status, not upon that of implied contract * * * * The [employer's] liability is based, not upon any act or omission of the employer, but upon the existence of the relationship which the employer bears to the employment * * * *") (quoting *Cudahy Co. v. Parramore*, 263 US 418, 423-424 (1923).

Board Chair Bock specially concurring.

If I were writing on a "clean slate," I would be persuaded by claimant's reasonable understanding that she was hired before she was injured. *See, e.g., Newport Seafood v. Shine*, 71 Or App 119 (1984). Claimant did pick cherries for the employer, she was paid for her work, and she was subject to direction and control by the employer. Clearly, her injury arose out of and in the course and scope of her work, *if* she was subject to an employment contract.

Claimant, however, must be a "subject worker" in order to receive "compensation" under the Worker's Compensation Act. ORS 656.027. And she must be a "worker," before she can be a "subject worker." *See S-W Floor Covering Shop v. National Council on Compensation Insurance*, 318 Or 614, 630 (1994) (quoted, *supra*). Thus, the first determination to be made is whether claimant is a "worker" within the meaning of ORS Chapter 656. *See e.g., Martelli v. R.A. Chambers and Associates*, 310 Or 529, 534 (1990).

A worker is any person who engages to furnish services for remuneration, subject to the direction and control of an employer. ORS 656.005(30). Here, the pivotal question is whether claimant was engaged by the employer, *i.e.*, whether there was a contract for hire between the parties. *See Oremus v. Ore. Pub. Co.*, 11 Or App 444, 446 (1972) (quoted at n. 4, *supra*).

Claimant clearly believes that she was employed and authorized to begin working when she began picking cherries in the employer's orchard. The employer equally clearly believes that there was no such contract, because claimant was subject to certain instructions *before* beginning work and she did not comply with those instructions.

I agree with the lead opinion that the record reveals no persuasive reason to find one parties' understanding more compelling than the other. Under these circumstances, there is insufficient evidence of a "meeting of the minds," and therefore no employment contract is proven. As a public matter, I think that claimant *should* have been covered by workers' compensation insurance (because she performed a service for the employer, for remuneration), but I am not free to reach that result, absent an employment contract. Accordingly, because I am constrained by the law and the facts, I agree with the result in this case.

Board Member Phillips Polich dissenting.

The majority finds that claimant was not a subject worker when she was injured, because it finds the evidence in equipoise regarding the existence of an employment contract between claimant and the employer. I disagree, based on the following undisputed facts.

Claimant clearly performed services for the employer for 6 or 7 days before her injury: She picked the employer's cherries and she was paid for her work. Although claimant was paid *via* her husband's check (because she picked cherries under his "picking number"), the employer knew that the 27 boxes of cherries claimant's family picked was not the work of just one person. The employer also knew that claimant was working in its orchard: The employer's foreman not only showed claimant where to pick, but drove the family to the picking location each day. And the employer clearly benefited from claimant's work.

The employer did tell claimant to obtain her son's identification and it may have told her to watch a safety video. But claimant was already hired, because she had completed the necessary paperwork and been told to go to work, and in fact went to work. And her employment was not contingent upon the employer's "post hiring" instructions. Under these circumstances, she was a "worker" under ORS Chapter 656 when injured, not a trespasser or a volunteer.

Accordingly, based on the parties' course of conduct, I would find that there was a contract of employment between claimant and the employer. And the claim should be compensable, because claimant was injured in the course and scope of her employment.

May 8, 2000 Cite as 52 Van Natta 807 (2000)

In the Matter of the Compensation of
CHARLOTTE L. VALDIVIA, Claimant
Own Motion No. 00-0018M
OWN MOTION ORDER OF ABATEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our April 7, 2000 Own Motion Order, that declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she was in the work force at the time of disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD J. WHISENANT, Claimant
WCB Case No. 99-07729
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) awarded temporary total disability (TTD) for the period from October 31, 1998 through November 2, 1998 and temporary partial disability (TPD) for the period from November 3, 1998 through May 4, 1999; (2) assessed a penalty for the employer's allegedly unreasonable failure to pay temporary disability; and (3) awarded 11 percent (14.85 degrees) scheduled permanent partial disability for loss of use or function of claimant's right foot, whereas an Order on Reconsideration had awarded 8 percent (10.8 degrees). On review, the issues are temporary disability, scheduled permanent disability, and penalties. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Temporary Disability and Penalties

The ALJ found that the employer was not authorized to terminate claimant's TTD on October 31, 1998, because claimant's treating doctor did not release him to full duty work on that date. Finding that claimant returned to work on November 3, 1998, the ALJ directed the employer to pay TTD for the period from October 31, 1998 through November 2, 1998 and TPD for the period from November 3, 1998 through May 4, 1999 (when claimant's claim was closed). Further finding that any failure to pay the withheld temporary disability was unreasonable, the ALJ assessed a penalty of 25 percent of any temporary disability that the employer had not paid.

We reverse the ALJ's temporary disability awards because the record contains no contemporaneous time loss authorization for the period beginning October 31, 1998. *See Fred Meyer, Inc. v. Bundy*, 159 Or App 44, 54, *review dismissed*, 329 Or 503 (1999) (limitations in ORS 656.262(4)(g) apply to all temporary disability awards under ORS 656.268); *Douglas R. Hart*, 51 Van Natta 1856 (1999) (no entitlement to temporary disability for any period of time not authorized by the attending physician).

We also reverse the ALJ's penalty assessment, because, as a result of our decision on the temporary disability issue, there is no compensation "then due" on which to base a penalty.

Scheduled Permanent Disability

The ALJ awarded claimant 5 percent scheduled permanent disability for loss of dorsiflexion in claimant's right ankle and lost right toe joint range of motion. The ALJ noted that the medical arbiter "took a history that claimant had previously lacerated the dorsum of his left foot resulting in residual dysesthesia" and therefore declined to compare claimant's lost range of motion with that of his left ankle

and toes. *See* OAR 436-005-0007(23).[1] The ALJ reasoned that claimant's compensable right foot injury caused his diminished right ankle dorsiflexion and lost right toe joint range of motion, and concluded that the "'contralateral joint' includes the foot as well as the ankle." Noting that the employer agreed that claimant was entitled to a 6 percent rating (in addition to the undisputed 5 percent rating for a chronic condition) for lost ankle and foot (toe joint) range of motion, *if* contralateral comparison is not appropriate, the ALJ increased claimant's scheduled permanent disability to a combined total of 11 percent.

On review, the employer argues that the ALJ erred in refusing to apply the contralateral joint comparison under OAR 436-005-0007(23), because there is no documented medical evidence of injury to the contralateral left joints. *See Lopez v. Agripac, Inc.*, 154 Or App 149, 154, *rev den* 327 Or 583 (1998). Specifically, the employer contends that the rule applies because claimant's account of a prior laceration of the dorsum of his left foot does not constitute *medical evidence* of prior injury to left ankle or toe(s). Therefore, the employer argues that the Order on Reconsideration correctly awarded: 3 percent scheduled permanent disability for loss of dorsiflexion of the right ankle (based on a comparison with the left ankle range of motion); 5 percent for loss of repetitive use of the right foot; and nothing for lost right toe joint range of motion (based on a comparison with left toe joint range of motion). We agree with the employer.

As the court explained in *Lopez*, the "account of an injury or disease to the contralateral joint must be established by medical evidence." *Id.* Because there is no such evidence in this case, we conclude that the Order on Reconsideration properly evaluated claimant's scheduled permanent disability, based on comparisons with claimant's contralateral joints.

ORDER

The ALJ's order dated December 15, 1999 is reversed. That portion of the order that awarded temporary disability for the period from October 31, 1999 through May 4, 1999 is reversed. That portion of the order that awarded 11 percent (14.85 degrees) scheduled permanent disability for loss of use or function of claimant's right foot is reversed. In lieu of the ALJ's award, claimant is entitled to 8 percent (10.8 degrees) scheduled permanent disability, as awarded by the Order on Reconsideration. Those portions of the order that awarded a penalty and attorney fees are reversed.

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[1] The rule provides, in pertinent part:

"The 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 or disease or when either joint's range of motion is zero degrees or is ankylosed."

May 9, 2000 Cite as 52 Van Natta 809 (2000)

In the Matter of the Compensation of
VENITA A. GALLAGHER, Claimant
WCB Case Nos. 99-02177 & 98-07248
ORDER OF ABATEMENT
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Claimant requests reconsideration of those portions of our April 20, 2000 order that: (1) found that the insurer had accepted a combined condition; (2) found that claimant was not entitled to a penalty for the insurer's allegedly unreasonable failure to pay interim compensation; and (3) upheld the insurer's denials of claimant's "1996 and 1997 thoracic strains" and her 1997 right arm strain and lateral epicondylitis. Specifically, claimant contends that the insurer did not accept a combined condition with regard to her first on-the-job injury, there is no evidence to support the finding that the insurer's aggravation denial was reasonable, and that we erred in evaluating the medical evidence.

In order to allow sufficient time to consider claimant's motion, we withdraw our April 20, 2000 order. The insurer is granted an opportunity to respond to the motion. To be considered, the response

should be filed within 14 days of the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

May 8, 2000 Cite as 52 Van Natta 810 (2000)

In the Matter of the Compensation of
JUDY A. WIRFS, Claimant
WCB Case No. 99-07447
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that reinstated a June 1, 1999 Notice of Closure that had been rescinded by an August 24, 1999 Order on Reconsideration as premature. On review, the issue is propriety of the administrative claim closure. We reverse.

FINDINGS OF FACT

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

On January 14, 1999, claimant sustained a compensable right shoulder injury that the SAIF Corporation subsequently accepted as disabling right shoulder bursitis. Initially, claimant treated with Dr. Mackey, M.D., but she began treating with Dr. Macha, M.D., on January 29, 1999. Dr. Macha continued Dr. Mackey's restriction to modified work and prescribed further conservative treatment, including physical therapy and prescription medications.

On May 7, 1999, SAIF's claim adjuster sent claimant a letter by certified mail. The letter stated, in relevant part:

> "I have learned that you have not seen your doctor, Thomas J. Macha[,] MD, since April 8, 1999, having been a no-show for [a] May 6, 1999 appointment. Oregon law allows your claim to be closed, without your doctor's approval, if you fail to seek treatment for 30 days, unless you can prove such failure was for reasons beyond your control.
>
> "To prevent closure of your claim, you must seek medical treatment or schedule an appointment, within 14 days of the date of this letter. If you do not seek treatment or fail to advise SAIF that you have scheduled an appointment, your claim will be closed." (Ex. 9).

Claimant did not respond in writing to SAIF's May 7, 1999 letter. On May 10, 1999, however, she telephoned SAIF and stated that: she had moved to Iowa; she had not attended her last doctor appointment; she was having just a bit of right shoulder discomfort; and she would likely not respond further to SAIF's May 7, 1999 letter and let the claim close. (Ex. 10).

On June 1, 1999, SAIF closed the claim with a Notice of Closure that awarded temporary disability benefits but no permanent disability benefits. (Ex. 12). On its Notice of Closure Worksheet, SAIF indicated that claimant had been released to regular work on April 8, 1999. (Ex. 12-4).

Also on June 1, 1999, claimant returned to Dr. Macha for further treatment. (Ex. 13). Her subjective symptoms had increased and she had a positive impingement sign and reduced ranges of motion in her right shoulder. Dr. Macha injected claimant's shoulder, prescribed medication and physical therapy, and released her to modified work.

On June 7, 1999, Dr. Macha completed an aggravation form. (Ex. 14A). On July 1, 1999, claimant returned to Dr. Macha, who noted that she was making slow progress with therapy, prescribed continued conservative treatment and imposed continuing work restrictions. (Ex. 15).

On July 29, 1999, claimant requested reconsideration of the Notice of Closure, raising all potential issues.

On August 24, 1999, the Workers' Compensation Division issued an Order on Reconsideration that rescinded the June 1, 1999 Notice of Closure as premature, finding that claimant was not medically stationary at claim closure. (Ex. 17-2). The Order on Reconsideration stated, in part, that "[w]e find this claim was prematurely closed and order the Notice of Closure dated June 1, 1999 be rescinded pursuant to OAR 436-030-0135(7)."[1] (*Id.*).

On September 21, 1999, SAIF requested a hearing regarding the August 24, 1999 Order on Reconsideration and raised the issue of premature closure. The hearing was held on the record and written arguments were submitted.

CONCLUSIONS OF LAW AND OPINION

Citing *Daquilante-Richards v. Cigna Ins. Cos.*, 149 Or App 682 (1997), the ALJ found that claimant had the burden of proving that her claim was prematurely closed, despite the fact that SAIF requested the hearing to challenge the Order on Reconsideration. Furthermore, the ALJ found that claim closure was not premature because, pursuant to *former* ORS 656.268(1)(b),[2] SAIF was entitled to close claimant's claim on June 1, 1999. Based on the following reasoning, we disagree with both findings.

Here, the claim was closed by an administrative claim closure pursuant to *former* ORS 656.268(1)(b). Where an administrative claim closure is proper under *former* ORS 656.268(1)(b) and the applicable Director's rules applying that statute,[3] the claim is *not* prematurely closed, irrespective of the

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[1] OAR 436-030-0135(7) provides: "When the department finds, upon reconsideration, that the claim was closed prematurely by failing to meet the requirements of OAR 436-030-0015, 436-030-0020, 436-030-0030, 436-030-0034 or 436-030-0035, the department may issue an order rescinding the Notice of Closure or Determination Order." WCD Admin. Order 97-065.

[2] Effective October 23, 1999, subsection (b) of *former* ORS 656.268(1) was renumbered as subsection (c) of that same section without any changes in the text of that subsection. *Former* ORS 656.268(1)(b) provides:

"(1) One purpose of this chapter is to restore the injured worker as soon as possible and near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed if the worker's condition has not become medically stationary unless:

"* * * * *

"(b) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control."

[3] Claimant's claim was closed on June 1, 1999. Therefore, the Director's rules governing that closure are found at WCD Admin. Order No. 97-065, effective January 15, 1998. The rules applying *former* ORS 656.268(1)(b) are found at OAR 436-030-0020(3)(b) and 436-030-0034(1).

OAR 436-030-0020(3)(b) provides, in relevant part:

"(3) The insurer may issue a Notice of Closure on an accepted disabling claim when medical information indicates the worker's condition is not medically stationary and:

"* * * * *

"(b) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules[.]"

OAR 436-030-0034(1) includes the notification requirements and provides, in relevant part:

"(1) A claim may be closed by the insurer or Department when the worker is not medically stationary and the worker has not sought medical care for a period in excess of 30 days, without the instruction or approval of the attending physician, for reasons within the worker's control; and

"(a) The insurer has notified the worker after the close of that 30-day period, by certified letter, that claim closure may result for failure to seek medical treatment for a period of 30 days. The notification letter shall inform the worker of the worker's responsibility to seek medical treatment in a timely manner, and shall inform the worker of the consequences for failing to do so, including claim closure.

"(b) Workers shall be given 14 days from the mailing date to respond to the certified notification letter before any further action is taken by the insurer towards claim closure."

worker's medically stationary status at closure. *See Tat Hueng*, 50 Van Natta 2205 (1998) (Board concluded that a claimant may not negate a valid administrative claim closure pursuant to *former* ORS 656.268(1)(b) with evidence that he or she was not medically stationary).

The August 24, 1999 Order on Reconsideration, although acknowledging facts regarding the administrative claim closure process,[4] nevertheless decided the premature closure issue on the merits, *i.e.*, whether the record established that claimant was medically stationary at claim closure. (Ex. 17-2). In response, SAIF requested a hearing regarding the Order on Reconsideration and raised the issue of premature closure.

In its written arguments at hearing, SAIF argued that, pursuant to *former* ORS 656.268(1) and OAR 436-030-0034(1), claimant's claim was properly closed regardless of her medically stationary status at closure. Thus, SAIF relied on its compliance with the statute and rules to argue that its administrative claim closure should be affirmed.

Generally, the 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. ORS 183.450(2); *Harris v. SAIF Corp.*, 292 Or 683 (1982).

Here, given SAIF's position that its administrative claim closure was proper, the initial burden of proof is upon SAIF to prove that position. If SAIF meets its burden of proof, the inquiry ends under the reasoning in *Hueng, i.e.*, if the administrative claim closure is proper, the medically stationary issue is not reached. In this regard, *Daquilante-Richards v. Cigna Ins. Cos.*, the case relied on by the ALJ to assign the burden of proof to claimant, is distinguishable. *Daquilante-Richards* did not involve an administrative claim closure; instead, it involved a closure made on the merits of the medically stationary issue. Thus, the claimant had the burden of proving that her condition was not medically stationary at the time of closure. 149 Or App at 688.

On review, claimant makes several arguments that SAIF failed to comply with the applicable rules in issuing its administrative claim closure. SAIF responds that claimant cannot raise an issue that was not raised at hearing. As noted above, however, SAIF itself raised the issue of its compliance with the applicable rules at hearing. Thus, claimant's arguments regarding SAIF's compliance do not raise a new issue on review.

It is well-established that notice given by a carrier must be in strict compliance with the applicable rule in order for an administrative closure to be proper. *Paniagua v. Liberty Northwest Ins. Corp.*, 122 Or App 288 (1993); *Annie L. Bounds*, 51 Van Natta 358 (1999); *Martha E. Leyva*, 49 Van Natta 1177 (1997). When a rule specifically and unambiguously requires the carrier to follow a certain procedure, substantial compliance is not sufficient. *SAIF v. Robertson*, 120 Or App 1 (1993); *Fairlawn Care Center v. Douglas*, 108 Or App 698 (1991); *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986).

OAR 436-030-0034(1)(a) provides that a carrier may close a claim when the worker is not medically stationary and when the worker has not sought medical care for a period in excess of 30 days, without approval of the attending physician, for reasons within the worker's control provided that the carrier "has notified the worker *after the close of that 30-day period*, by certified letter, that claim closure may result for failure to seek medical treatment for a period of 30 days." (Emphasis added).

Here, in its May 7, 1999 letter, SAIF noted that claimant had not seen Dr. Macha since April 8, 1999. The close of the 30-day period following the April 8, 1999 examination would be May 8, 1999. SAIF, however, sent its certified letter on May 7, 1999, which is *before* the close of the 30-day period. Therefore, SAIF did not strictly comply with the notice requirements in OAR 436-030-0034(1)(a).

SAIF argues that, even though its notification letter indicated that the last date of treatment was April 8, 1999, the record indicates that there was no treatment between February 12, 1999 and June 1, 1999. In addition, SAIF argues that, if April 8, 1999 was the last date of treatment, the record indicates that claimant knew about the notification letter as of May 10, 1999, more than 30 days after April 8, 1999. In effect, SAIF contends that it substantially complied with the rules. In addition, SAIF contends that claimant was not prejudiced by the timing of the notification letter.

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[4] Specifically, the Order on Reconsideration acknowledged that SAIF had "sent a 14-day certified letter to the worker on May 7, 1999, and the worker by telephone on May 10, 1999 indicated she was out-of-state and would likely ignore the certified letter[.]" (Ex. 17-2).

Nevertheless, as explained above, substantial compliance is not sufficient. Nor is a "lack of prejudice" to claimant the correct standard. Furthermore, SAIF is held to the terms of its notification letter (which represented that claimant was last treated on April 8, 1999), and cannot now represent that, although some statements in its notification letter were incorrect, the record as a whole nevertheless supports an administrative claim closure. As we found in *Hueng*, an administrative claim closure that is properly issued precludes the worker from reaching the merits of whether his or her condition was medically stationary at closure. If a carrier wishes to take advantage of such a significant preclusion, its notification letter must strictly comply with the applicable rule in order for its administrative closure to be proper.

Finally, SAIF argues that OAR 436-030-0034(1)[5] is not applicable because it exceeds the scope of ORS 656.268(1)(b). Respondent's Brief, page 6. However, SAIF did not raise this issue at hearing. To the contrary, at hearing, SAIF argued that it complied with the applicable rule, without contesting the validity of that rule. Where the issue of validity of the Director's rules was not raised at hearing, we decline to consider it on review. Indeed, to allow the case to be decided on a different standard from what was litigated at hearing would be fundamentally unfair. *See Sean W. Miller*, 45 Van Natta 2337 (1993) (Board declined to consider the carrier's challenge to the claimant's claim under ORS 656.005(7)(a)(B) where the defense was raised for the first time on review); *Linda R. Burrow*, 44 Van Natta 71 (1992) (Where hearing was based on denial of causal relationship, Board declined to consider a new "course and scope" defense on review).

Because SAIF failed to strictly comply with OAR 436-030-0034(1), the administrative closure rule, we conclude that SAIF's administrative closure was improper. Accordingly, we affirm the August 24, 1999 Order on Reconsideration that set aside the June 1, 1999 Notice of Closure as premature.[6]

Attorney Fees

Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of any additional temporary disability compensation created by this order, not to exceed $5,000, payable directly to claimant's attorney. ORS 656.386(2); OAR 438-015-0055(1).

In addition, because claimant ultimately prevailed over SAIF's request for hearing regarding the Order on Reconsideration, he is also entitled to an attorney fee under ORS 656.382(2) for his counsel's services at the hearings level. *See Patricia L. McVay*, 48 Van Natta 317 (1996) (carrier-paid attorney fee appropriate for services at hearings level where the carrier requested a hearing on an Order on Reconsideration, the ALJ reduced the permanent disability award granted by the Order on Reconsideration, but the Board ultimately affirmed the Order on Reconsideration); *Lorenzo K. Kimball*, 52 Van Natta 411, *on recon* 52 Van Natta 633 (2000) (same). After consideration of the factors in OAR 438-015-0010(4), we find that a reasonable attorney fee award for claimant's counsel's services at hearing in defense of the Order on Reconsideration's finding of premature closure is $1,200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated January 10, 2000 is reversed. The August 24, 1999 Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of any additional temporary disability compensation created by this order, not to exceed $5,000, payable directly to claimant's attorney. In addition, claimant's attorney is awarded a $1,200 carrier-paid attorney fee for services at the hearings level, payable by SAIF directly to claimant's attorney.

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[5] Although citing OAR 436-030-0135(7), we assume that SAIF is referring to OAR 436-030-0034(1), which provides the procedures required to close a claim when the worker is not medically stationary and has not sought medical treatment for 30 days.

[6] We note that the parties do not argue the merits of claimant's medically stationary status on review. Instead, they rely on various contentions regarding the propriety of SAIF's administrative closure. Under these circumstances, we have confined our review to the propriety of SAIF's administrative closure.

In the Matter of the Compensation of
JAMES D. STEVENS, Claimant
WCB Case No. TP00004
THIRD PARTY DISTRIBUTION ORDER
Barton & Strever, Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant has petitioned the Board for the allowance of an extraordinary attorney fee for services rendered in connection with a third party judgment. Specifically, claimant seeks approval of an attorney fee equal to 36-2/3 percent of the third party judgment. RSK Co. Claims Services, on behalf of Federal Express, as the paying agency, does not oppose the petition. We find that extraordinary circumstances exist to justify the requested fee.

FINDINGS OF FACT

Claimant was compensably injured in October 1997 as a loading dock timber fell towards his feet while he was picking up packages. Claimant dodged the falling timber while holding a heavy box and injured his left shoulder.

On October 20, 1998, Dr. Watanabe diagnosed a partial rotator cuff tear and a superior labral anterior-posterior lesion. Claimant had surgery, but was left with permanent impairment and was unable to return to regular work.

Claimant retained his present attorney on October 20, 1997 to represent him in the third party civil claim. He signed a retainer agreement, agreeing to pay 33-1/3 percent of any settlement prior to 7 days before the commencement of a trial or hearing and 40 percent of the total sum recovered if the case proceeded to trial.

Claimant's counsel made numerous requests for settlement with the third party insurer, with no response. On July 22, 1999, claimant filed a third party cause of action against three corporate defendants. The third party defendants agreed to mediate the case three weeks before the scheduled trial date, but the mediation was unsuccessful.

At the beginning of the trial, claimant's counsel had advanced $14,051.51 in costs to prosecute this action. After a jury trial, judgment was entered for claimant in the amount of $433,369.15. Claimant and his attorney subsequently agreed to an attorney fee of 36-2/3 percent.

CONCLUSIONS OF LAW AND OPINION

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

We have authorized extraordinary attorney fees in previous cases. *See, e.g., Ted Somers*, 51 Van Natta 1223 (1999) (approving an extraordinary attorney fee of 40 percent of the judgment proceeds); *Victoria A. Brokenshire*, 50 Van Natta 1411 (1998) (approving a 45 percent share of a $729,967.76 judgment).

The circumstances of the present case are very similar to previous cases in which we have authorized extraordinary attorney fees. We find that the issues in this case were complex. Defendants denied fault until the morning of trial. To establish liability, however, claimant's law firm had devoted 34 hours to investigation and undertook exhaustive research regarding federal and state loading dock regulations. Numerous witness statements were taken, along with depositions of most witnesses. Written jury instructions were prepared and then modified once defendants admitted liability. Claimant's counsel had also prepared opening statement, closing arguments and jury *voir dire* to litigate the liability issue.

In addition, the medical issues were complex. Claimant's treating surgeon did not want to testify voluntarily and it was necessary for claimant's counsel to hire an orthopedic surgeon to perform an independent medical examination. The issue of claimant's resultant disability were complicated because it was based on subjective, pain-related loss of range of motion.

Moreover, claimant's counsel achieved an extremely favorable result, with a judgment of $433,369.15. Claimant and his attorney had originally agreed to an attorney fee of 40 percent of the total sum recovered if the case proceeded to trial, but they subsequently agreed to an attorney fee of 36-2/3 percent. Finally, RSK Co. Claims Services does not object to claimant's counsel's request of a fee of 36-2/3 percent of the proceeds.

Under these circumstances, we are persuaded that claimant's counsel is entitled to an attorney fee in excess of one-third of the third party judgment. Accordingly, for the reasons expressed herein, we find that this case involves extraordinary circumstances justifying the allowance of an extraordinary attorney fee. Commensurate with the request from claimant's counsel and the agreement between claimant and his counsel, we further hold that the extraordinary attorney fee shall equal 36-2/3 percent of the third party judgment proceeds. Consequently, claimant's counsel is directed to retain the aforementioned extraordinary attorney fee from the third party judgment proceeds.

IT IS SO ORDERED.

May 9, 2000 Cite as 52 Van Natta 815 (2000)

In the Matter of the Compensation of
FRANCES M. MEAD, Claimant
WCB Case No. 98-03153
ORDER OF ABATEMENT
Martin L. Alvey, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our April 10, 2000 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order upholding the self-insured employers denial of claimants occupational disease claim for a bilateral foot and toe condition. In her motion, claimant asserts that our order narrowly focussed on the compensability of claimants *foot fungus condition* when the claim was for a bilateral *toe condition*. According to claimant, the necessity of wearing steel toed boots led to the use of occlusive devices such as pads, which in turn led to the development of a fungal infection, onychomycosis, which in turn required medical services and/or resulted in disability.

In order to consider this matter, we withdraw our April 10, 2000 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY P. HUBLITZ, Claimant
WCB Case No. 99-04481
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our April 14, 2000 Order on Review that reduced the Administrative Law Judge's (ALJ's) award of scheduled permanent disability award for loss of use or function of the left foot from 64 percent (96.4 degrees) to 61 percent (82.35 degrees). Specifically, claimant seeks an attorney fee under ORS 656.382(2) for his counsel's services on Board review.

Claimant begins by requesting a modification of our statement of the issue. Our statement of the issue was based on the dispositional language of the ALJ's order, which stated: "(1) Claimant is hereby awarded an *additional* 5 percent scheduled permanent partial disability award arising out of loss of left foot plantar sensation." (Opinion and Order at 6). The Order on Reconsideration awarded 59 percent scheduled permanent disability for the loss of use or function of the left foot. An *additional* 5 percent scheduled permanent disability for the left foot would result in a total of 64 percent scheduled permanent disability.

On Board review, SAIF requested elimination of the ALJ's award or, alternatively, reduction in the total award by "combining" the ALJ's 5 percent "loss of sensation" valuation with the Order on Reconsideration's 59 percent "overall impairment" valuation. In his respondent's brief, claimant agreed that, if the total valuations were sustained on review, they should be "combined" and not "added" to produce claimant's total scheduled permanent disability award.

After conducting our *de novo* review, we agreed with the ALJ's conclusion that claimant was entitled to a 5 percent value for plantar sensation loss. Nonetheless, after "combining" (rather than "adding") the 5 percent sensation loss value with claimant's other impairment values, we rated claimant's total permanent disability at 61 percent. Consequently, we modified the ALJ's order, by reducing the ALJ's 64 percent award to 61 percent.

ORS 656.382(2) provides that, if a request for review is initiated by an employer or insurer, and the board finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay claimant's attorney a reasonable attorney fee. Here, we agreed with the ALJ's conclusion that claimant was entitled to a 5 percent value for plantar sensation loss. Nonetheless, "combining" rather than "adding" the 5 percent sensation loss value to claimant's other impairment values (59 percent), we rated claimant's total permanent disability at 61 percent. Consequently, we modified the ALJ's 64 percent award to 61 percent. Thus, as discussed above, the compensation awarded by the ALJ's order (64 percent scheduled permanent disability) has been reduced to 61 percent.[1] Therefore, claimant is not entitled to an attorney fee award under ORS 656.382(2).

Accordingly, we withdraw our April 14, 2000 order. On reconsideration, as supplemented herein, we republish our April 14, 2000 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] In addition to noting that the ALJ's 5 percent valuation for a plantar sensory loss was not disturbed on Board review, claimant asserts that he has never disputed that his impairment values should be "combined" rather than "added." We have no quarrel with claimant's assertions. Nevertheless, such matters do not alter the indisputable fact that, as a result of SAIF's request for Board review, the ALJ's 64 percent scheduled permanent disability award has been reduced to 61 percent. Under such circumstances, the statutory predicate for a carrier-paid attorney fee award under ORS 656.382(2) has not been satisfied.

In the Matter of the Compensation of
AARON D. TODD, Claimant
Own Motion No. 99-0423M
OWN MOTION ORDER
Nicholas M. Sencer, Claimant Attorney

The self-insured employer submitted a request for temporary disability compensation for claimant's compensable low back, left shoulder, cervical, left elbow and knee and head conditions. Claimant's aggravation rights expired on January 7, 1998. Claimant requested temporary disability compensation for his current condition. On November 29, 1999, the Board postponed action on the own motion request because litigation on related issues was pending before the Hearings Division. (WCB Case No. 99-08840).

On May 3, 2000, Administrative Law Judge (ALJ) Howell approved a "Stipulation and Order" which resolved the parties' dispute pending before the Hearings Division. Pursuant to that settlement, claimant agreed that the employer's November 18 and 19, 1999 denials would remain in full force and effect. In addition, claimant agreed that his request for hearing "shall be dismissed with prejudice," and that the settlement resolved "all issues raised or raisable."

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).

Here, the employer's November 18 and 19, 1999 denials of claimant's current condition under his 1993 claim, remain in full force and effect. In light of such a stipulation, we are without authority to authorize temporary disability compensation for claimant's current condition, as the employer has not accepted responsibility for that condition under his 1993 claim. Should claimant's circumstances change, and the employer accept responsibility for his current condition under his 1993 claim, claimant may again request own motion relief.

Accordingly, the request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLARD R. ALLEN, Claimant
WCB Case No. 99-00791
ORDER ON REVIEW
Holly J. Somers, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the SAIF Corporation's denial of his claim for multiple injuries sustained in a motor vehicle accident; and (2) declined to assess penalties for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

At hearing, claimant argued that he was entitled to a penalty based on SAIF's allegedly unreasonable refusal to pay compensation. (Tr. 33). *See* ORS 656.262(11)(a). 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). Accordingly, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated December 8, 1999 is affirmed.

In the Matter of the Compensation of
ROGER K. ANDERSON, Claimant
Own Motion No. 99-0385M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable upper dorsal/cervical conditions. Claimant's aggravation rights on that claim expired on April 6, 1993.

On October 20, 1999, SAIF denied the compensability of claimant's current condition. Claimant requested a hearing. (WCB Case No. 99-08627). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated April 20, 2000, Administrative Law Judge (ALJ) Kekauoha upheld SAIF's October 20, 1999 denial. That order was not appealed.[1]

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

Here, the current condition and ensuing medical treatment for which claimant requests own motion relief in his 1987 claim, remain in denied status. As a result, we are not authorized to grant claimant's request for own motion relief. *See Id.*

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

IT IS SO ORDERED.

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[1] On May 3, 2000, SAIF submitted a letter wherein it announces that it will not appeal ALJ Kekauoha's April 20, 2000 Opinion and Order. It also recommended the Board issue an Own Motion Order authorizing the reopening of claimant's claim for the provision of temporary disability compensation regarding his August 1986 claim.

In the Matter of the Compensation of
ROGER K. ANDERSON, Claimant
Own Motion No. 99-0386M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on August 3, 1992. SAIF denied the compensability of claimant's current condition. In addition, SAIF opposed reopening on the grounds that: (1) SAIF was not responsible for claimant's current condition; (2) surgery or hospitalization was not reasonable and necessary for the compensable injury; and (3) claimant was not in the work force at the time of disability. Claimant requested a hearing with the Hearings Division. (WCB Case No. 99-08628).

On December 30, 1999, we consolidated this own motion matter with the pending hearing. If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the accepted injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time her condition worsened.

On April 20, 2000, Administrative Law Judge (ALJ) Kekauoha issued an Opinion and Order which set aside SAIF's denial. In doing so, ALJ Kekauoha found that claimant's spinal stenosis at L4-5 condition was causally related to the August 1986 compensable injury. The ALJ's order has not been appealed.[1]

Furthermore, reporting that the record supported a conclusion that claimant was in the work force at the time his condition worsened and in light of the causal relationship between claimant's compensable injury and his surgery and the aforementioned "work force" record, ALJ Kekauoha recommended that we reopen the claim pursuant to ORS 656.278(1)(a).

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

On April 29, 1999, claimant underwent L4-5 laminectomy with neural decompression and bilateral medial facetectomy with laminectomy and thecal sac decompression at L3-4. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. Furthermore, based on the record and the ALJ's uncontested recommendation, we further find that claimant was in the work force at the time of his disability.

Accordingly, we authorize the reopening of claimant's 1986 injury claim to provide temporary disability compensation beginning April 29, 1999, 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 $1,500, 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] On May 3, 2000, SAIF submitted a letter wherein it announces that it will not appeal ALJ Kekauoha's April 20, 2000 Opinion and Order. It also recommends the Board issue an Own Motion Order authorizing the reopening of claimant's claim for the provision of temporary disability compensation.

In the Matter of the Compensation of
REGINALD G. BARR, Claimant
WCB Case No. 99-07220
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's denial of his claim for spinal cord compression and spinal nerve root compression. On review, the issue is compensability.

We adopt and affirm the order of the ALJ.

ORDER

The ALJ's order dated December 30, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I believe that, in this case, claimant has met his burden of proving that the January 22, 1999 injury is the major contributing cause of claimant's combined condition. For the following reasons, I disagree with the majority's decision to affirm the ALJ.

Dr. Mason, neurosurgeon, provided an opinion regarding causation of claimant's combined condition. Dr. Mason was aware of the problems claimant had prior to the injury and he also had an accurate history of the injury itself. Althouth Dr. Mason indicated that claimant's preexisting spondylosis made him more susceptible to injury, he nevertheless opined that it was the injury that caused the damage to the cervical spinal cord and nerve root. (Ex. 15). Here, Dr. Mason concluded that the treatment he proposed was directed toward the result of the injury, rather than the degenerative condition. Accordingly, Dr. Mason has persuasively explained why the injury was the major cause of claimant's condition and need for treatment.

On the other hand, I find that the opinion provided by Dr. Rosenbaum is neither accurate nor persuasive. Dr. Rosenbaum believed that claimant's need for treatment was due to his preexisting condition. Dr. Rosenbaum based his conclusion on his belief that claimant did not have any signs of radiculopathy following the injury. (Ex. 17). However, Dr. Mason has identified evidence of radiculopathy which followed the injury. (Exs. 18, 28).

Finally, I would also reject the opinion of Dr. Bergquist who related claimant's need for treatment to the preexisting condition. Dr. Bergquist reached his conclusion on the basis of there being no diagnosable conditions supported by objective findings on x-rays. (Ex. 22). However, as claimant argues, "objective findings" are not limited to x-rays. *See* ORS 656.005(19). Dr. Mason has identified objective findings which existed to support his opinion that the January 22, 1999 injury is the major cause of claimant's condition.

Because I believe that claimant's treating doctor, Dr. Mason, has provided the most persuasive opinion on this record, I respectfully disagree with the majority's decision to affirm the ALJ.

In the Matter of the Compensation of
LISA M. FORRISTER, Claimant
Own Motion No. 00-0144M
OWN MOTION ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney

On April 28, 2000, the Board received claimant's attorney's April 27, 2000 letter attaching a copy of an attorney fee retainer agreement. However, with the retainer agreement, claimant's attorney announced that he was waiving his "out of compensation attorney fees in connection with the new own motion reopening order." We interpret claimant's attorney's submission as a request for reconsideration of our April 28, 2000 Own Motion Order.

Our April 28, 2000 order authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. Our order also awarded claimant's attorney an "out-of-compensation" fee, payable by the self-insured employer directly to claimant's attorney. We took this action because the employer had acknowledged, in its own motion recommendation, that claimant was represented and a signed attorney fee retainer agreement had been submitted as part of the record.

However, on reconsideration, claimant's attorney announced that he was not seeking an out-of-compensation attorney fee arising from the reopening of claimant's claim. The employer has not responded to claimant's attorney's announcement.

OAR 438-015-0080 provides that attorney fees in Own Motion cases are to be paid out of the claimant's increased temporary disability compensation, which the claimant's attorney has been instrumental in obtaining for the claimant. In light of claimant's attorney's waiver of said attorney fees, we conclude that it is appropriate to withdraw the "out-of-compensation" attorney fee awarded in this matter.

Accordingly, our April 28, 2000 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our April 28, 2000 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
WES J. SESSUMS, Claimant
Own Motion No. 00-0157M
OWN MOTION ORDER
Liberty Mutual Fire, Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights on that claim expired on March 26, 1997. The insurer 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.

In a March 17, 2000 chart note, Dr. Floyd, claimant's attending physician, recommended that claimant undergo a laminectomy and revision discectomy. Thus, we conclude 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).

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 17, 2000, when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App at 414; *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, the insurer contends that claimant was not in the workforce because he has not demonstrated a loss of income. It argues that, although claimant asserts that he became self-employed in December 1999 and provided documentation evincing that self-employment, because he has made no income from that employment, he is not considered to be in the work force at the time of his current disability.

Self-employment may constitute regular gainful employment, and claimant need not prove a particular loss in wages to be entitled to temporary disability benefits. *Carlos C. Santibanez*, 43 Van Natta 2685 (1991), *citing International Paper Co. v. Hubbard*, 109 Or App 452 (1991). In this case, claimant has submitted various documents in supporting his self-employment as a trainer and breeder of Thoroughbred horses including: (1) January 2000 receipt of payment for a racing license; (2) March 2000 receipt of payment for stall rental and horse-breaking; (3) February 2000 receipts of payment of commissions on sales of claimant's livestock; and (4) January through April 2000 receipts of payment for livestock feed and supplies. Although, as claimant admits, his income is sporadic at this time, given the infancy of his business and his current medical disability, the record shows that he is engaged in regular gainful employment through his self-employment business. The fact that he has lost more income than he has earned makes no difference regarding his *entitlement* to temporary disability benefits.[1] Based on claimant's submissions, we find that he was in the work force at the time of his current worsening which requires surgery.

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[1] It may result that the wage used to calculate claimant's temporary disability pursuant to ORS 656.210 may very well be computed as zero. In any event, that is a matter to be eventually be resolved by the parties once the insurer completes its calculation of claimant's temporary disability rate.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DUGALD L. STEELE, Claimant
WCB Case No. 99-03417
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) declined to award temporary total disability benefits; and (2) declined to assess penalties for the insurer's allegedly unreasonable failure to pay temporary disability benefits pending its appeal of an earlier ALJ's compensability decision. On review, the issues are entitlement to temporary disability benefits and penalties.[1]

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

The ALJ found, based on the prior ALJ's March 22, 1999 order, that the only condition found compensable was claimant's L4-5 disc condition. Finding that claimant's current disability and need for treatment was due to the L3-4 disc condition, which was not mentioned in the "order" section of the prior ALJ's order, the ALJ concluded that claimant had not established entitlement to temporary disability benefits.

After our review, we agree with the ALJ that the "Order" portion of the March 22, 1999 Opinion and Order takes precedence over the body of the order. *See Kenneth D. Salsbury*, 41 Van Natta 565, 568 (1989) (precedence given to order language where order language and body of order were in conflict regarding attorney fee award). Because the "order" section of the prior ALJ's order states only that the denial of the L4-5 disc herniation is set aside and does not mention the L3-4 condition, and given the medical evidence suggesting that claimant's temporary disability results from the L3-4 condition, we agree with the ALJ that the insurer was not unreasonable in failing to pay the benefits.

ORDER

The ALJ's order dated October 13, 1999 is affirmed.

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[1] This matter has been consolidated for review with WCB case No. 98-09583. 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.

In the Matter of the Compensation of
DUGALD L. STEELE, Claimant
WCB Case No. 98-09583
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's claim for a low back condition. On review, the issues are the scope of review and compensability.[1] We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the ALJ's findings of ultimate fact. We briefly summarize the relevant facts.

During the 1970's and 1980's claimant worked as a highway patrol officer in California. He sustained a number of low back injuries. In 1973, he was hit by a car and experienced low back and right buttocks pain that resolved in 3 to 4 days. In 1985 and 1986, claimant was involved in motor vehicle accidents that involved some low back pain.

On August 24, 1992, claimant began working as an automobile adjustor/appraisor for the employer. In November 1995, claimant experienced right-sided low back pain after picking up an object away from work. Studies performed at the time revealed significant degenerative disc disease in claimant's lumbar spine.

On May 22, 1998, claimant was inspecting a car in the course of his job duties. He bent down on one knee and twisted his head, neck and back to look for damage under the car. He felt muscles pull in his low back. Claimant experienced pain that was similar to his previous low back problems, but were in a different area. Whereas the prior symptoms had been concentrated in the buttocks and right side, the pain he experienced on May 22, 1998 was higher and was on both the left and right sides of his low back.

Claimant sought treatment on May 28, 1998 from Dr. Weil, who diagnosed a lumbar strain and degenerative disc disease. Studies revealed degenerative disc disease in the lumbar spine and an L4-5 disc herniation. On July 23, 1998, the insurer accepted claimant's lumbar strain. Claimant's lumbar strain claim was closed by Notice of Closure on September 28, 1998 without an award of permanent disability benefits. Claimant requested reconsideration and Dr. Dupuis was appointed. An Order on Reconsideration affirmed the Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Scope of Review

The insurer takes the position that only the L4-5 disc condition is at issue on Board review and argues that compensability of an L3-4 condition has not been appealed. We disagree. The ALJ's order addresses compensability of claimant's combined low back condition, including both the L4-5 and L3-4 conditions. By virtue of the insurer's appeal, we conclude that compensability of claimant's entire combined low back condition is before us on review.

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[1] This matter has been consolidated for review with WCB case No. 99-03417. 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 "Order" section of the ALJ's order states that the insurer's November 30, 1998 denial of claimant's L4-5 disc herniation is set aside. However, the issues before the ALJ, as reflected by the record, the insurer's denial, and by the "Issues" section of the Opinion and Order, were "compensability of central disk bulge at L4-5, aggravation of any pre-existing disk abnormalities at L4-5, neural foraminal compromise at L3-4, and aggravation of any pre-existing neural foraminal compromise at L3-4. The issue is whether the May 22, 1998, industrial injury is the major contributing cause of claimant's need for treatment for his combined low back condition." (O & O, p. 1). Thus, the parties clearly litigated the compensability of claimant's low back combined condition, including the L4-5 and L3-4 conditions. Moreover, the insurer's denial denies both the L4-5 and L3-4 conditions and the ALJ did not uphold any portion of the insurer's denial. Finally, we note that the ALJ relied on both Drs. Weil and Anderson in setting aside the denial. Thus, we are persuaded that the ALJ found the entire combined low back condition compensable and we address the compensability of the entire combined low back condition in this order.

Compensability of Combined Low Back Condition

The ALJ found claimant's combined low back condition compensably related to the May 22, 1998 injury and set aside the insurer's denial. On Board review, the insurer argues that claimant has not established compensability of his disc herniation at L4-5. The insurer relies on Drs. Wilson, Scheinberg, Rohrer and Dupuis. Claimant argues that he has established compensability of the L4-5 and L3-4 conditions based on the opinions of Drs. Weil and Anderson. The insurer argues that Dr. Weil and Dr. Anderson rendered unpersuasive opinions. For the following reasons, we conclude that claimant has failed to establish compensability.

Multiple physicians address the cause of claimant's low back condition. Dr. Wilson, a neurologist, and Dr. Scheinberg, an orthopedic surgeon, examined claimant on behalf of the insurer. They opined that the May 22, 1998 incident may have caused a lumbar strain, but the degenerative disease at L3-4 and L4-5 with a central disc bulge at L4-5 and lateral neural foraminal compromise at L3-4, right were preexisting and unrelated to the injury. (Ex. 72).

Dr. Wilson later reviewed additional medical records regarding claimant's prior low back problems dating from 1986. After reviewing the additional information, he opined that the May 22, 1998 injury was not the type of injury that should cause degenerative disc disease or a disc herniation. Dr. Wilson could not say that the disc did not herniate at the time of the incident, but indicated that it would have been the "straw that broke the camel's back," and not the major contributing cause of claimant's back condition. (Ex. 108).

Dr. Weil is claimant's treating physician. He did not concur with the opinion of Drs. Wilson and Scheinberg and felt that whether the herniation was preexisting was speculation. Dr. Weil indicated that he had treated claimant in the past and noted that claimant had a longstanding history of back problems which he had endured and functioned with completely. Dr. Weil indicated that the pain claimant described on May 28, 1998 was somewhat different than the pain claimant had experienced before. Dr. Weil noted that the MRI showed a fairly large herniation of disc material centrally at L4-5 that he believed probably resulted from the work injury. Dr. Weil stated that this was distinguished from the problems claimant had in the past.

Dr. Rohrer, a neurosurgeon, treated claimant for his back problems. Dr. Rohrer concurred with the report of Drs. Wilson and Scheinberg. Dr. Rohrer opined that the central disc bulge at L4-5, aggravation of any preexisting disc abnormalities at L4-5, neural foraminal compromise at l3-4 and aggravation of any preexisting neural foraminal compromise at l3-4 preexisted the May 22, 1998 injury. Dr. Rohrer further indicated that claimant's subsequent need for treatment was caused by a combination of the preexisting low back problems and the injury and that the injury was not the major contributing cause of claimant's need for treatment or disability.

Claimant was also examined by Dr. Dupuis, an orthopedist. Dr. Dupuis stated that claimant had a significant low back history and significant evidence of preexisting degenerative disc disease from L3 to the sacrum. He further opined that the May 22, 1998 incident would be considered a very trivial event from a biomechanical standpoint and is not consistent from a medical probability standpoint of causing a lumbar disc herniation. In Dr. Dupuis' opinion, the incident would be consistent at most with a mild lumbar strain. (Ex. 105A).

Dr. Anderson opined that there was no doubt that claimant had a new condition develop as a result of the May 22, 1998 injury. Dr. Anderson opined that claimant developed an L3-4 radiculopathy condition with motor involvement as a result of the compensable injury. Dr. Anderson further opined that claimant's condition was associated with a definite and measurable amount of muscular loss involving the lower extremity.

The only medical opinions in the record that support compensability are those of Drs. Anderson and Weil. After reviewing the medical evidence, we are not persuaded by the opinions of Dr. Anderson or Dr. Weil. In this regard, given claimant's significant preexisting disease, both opinions are conclusory and lacking in explanation or analysis. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (conclusory and unexplained medical opinion rejected). Neither opinion explains how the mechanism of injury, bending and looking underneath a car, caused the disc bulge at L4-5 or the neural foraminal compromise at L3-4, especially given claimant's significant preexisting history of low back problems.

In addition, we find that the preponderance of the persuasive evidence establishes that claimant's condition is not compensable. In this regard, we disagree with the ALJ's conclusion that the opinion of Drs. Wilson and Scheinberg is unpersuasive because it was contrary to the law of the case that claimant had sustained a compensable lumbar strain as a result of the May 22, 1998 injury. To the contrary, Drs. Wilson and Scheinberg opined that the injury could cause a strain, but would not have caused the disc conditions and degenerative disease at L4-5 and L3-4 which the doctors believed preexisted the injury. This opinion is consistent with the law of the case in that the insurer has accepted a lumbar strain as a result of the injury. In addition, the opinion of Drs. Wilson and Scheinberg is supported by both Dr. Rohrer and Dr. Dupuis. Under such circumstances, we conclude that the denial should be upheld.

ORDER

The ALJ's order dated March 22, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

May 11, 2000 Cite as 52 Van Natta 827 (2000)

In the Matter of the Compensation of
JIM M. STEINER, Claimant
Own Motion No. 99-0198M
OWN MOTION ORDER ON RECONSIDERATION
Sheridan, Bronstein, et al, Defense Attorneys

On June 3, 1999, we issued an Own Motion Order that authorized the reopening of claimant's 1988 bilateral carpal tunnel syndrome to provide temporary disability compensation beginning the date claimant was hospitalized for a 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 bilateral carpal tunnel syndrome with a date of injury of 1998. (WCB Case No. 99-05393). On April 5, 2000, Administrative Law Judge (ALJ) Crummé 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's denial under claimant's 1988 claim contained in the Stipulation would be upheld in all respects; and (2) the employer would rescind its denial and issue a separate acceptance on the 1998 bilateral carpal tunnel claim (claim number 83817802663375515).

On April 25, 2000, the employer requested that we withdraw our Own Motion order because claimant's current bilateral carpal tunnel 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). In extraordinary circumstances, however, we may, on our own motion, reconsider a prior order. *Id.*

Under the particular facts of this case we find that extraordinary circumstances exist that justify reconsideration of our prior order. In this regard, the employer has rendered a "post-Own Motion Order" determination for which it has accepted responsibility for claimant's condition as a "new injury" claim (the same condition for which Own Motion relief had been 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 bilateral carpal tunnel syndrome 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 bilateral carpal tunnel syndrome is unrelated to his June 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.

May 11, 2000 Cite as 52 Van Natta 828 (2000)

In the Matter of the Compensation of
ROBERT J. VEGA, Claimant
WCB Case Nos. 99-00670 & 99-00079
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld AIG's denial of his aggravation claim for his current right upper extremity conditions; and (2) upheld Liberty Northwest Insurance Corporation's denial of his occupational disease claim for the same conditions. AIG requests review of that portion of the ALJ's order that found that claimant had established "good cause" to excuse his untimely request for hearing with regard to AIG's denial. On review, the issues are "good cause," compensability, and potentially, responsibility.

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

On review, claimant contends that the "true issue" in this case was responsibility between AIG and Liberty. Although claimant acknowledges that Liberty's denial raised compensability as an issue, and the issue was not waived at hearing, he asserts that "the fact remains that the issue of compensability was never argued by the parties at hearing." Thus, claimant contends that the "ALJ erred in failing to reach the responsibility question." Claimant's Reply Brief, Pg. 3. We disagree.

At hearing, claimant's counsel identified the issues as the appeal of the insurers' denials of aggravation, compensability, and responsibility. Tr. 3. The insurers' attorneys agreed that the issues included timeliness, aggravation, compensability and responsibility. Tr. 4. Accordingly, in light of the fact that the compensability issue was not waived, we conclude that the ALJ did not err in addressing the issue. *See e.g., Nevada J. Williams*, 48 Van Natta 998 (1996) (Board found no error by the ALJ in addressing the merits of a "back-up" denial where the parties agreed to litigate the issue).

Finally, we conclude that it is not necessary to address whether claimant established "good cause" for his untimely hearing request, as we agree with the ALJ that claimant has failed to meet his burden of proof with regard to the issue of compensability.

ORDER

The ALJ's order dated October 28, 1999 is affirmed.

In the Matter of the Compensation of
PATRICK R. BOGGS, Claimant
WCB Case No. 99-04731
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that affirmed an Order on Reconsideration that had affirmed a Notice of Closure that awarded no scheduled permanent disability benefits for a bilateral eye injury. On review, the issue is extent of scheduled permanent disability benefits.

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

At hearing and on review, claimant argues that he is entitled to scheduled permanent disability benefits for loss of visual fields. Claimant must establish that impairment is due to a compensable injury. ORS 656.214(2). Claimant argues that he meets his burden of proof under the reasoning in *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997). Like the ALJ, we disagree with this argument.

The *Danboise* court held that when a treating doctor or medical arbiter makes impairment findings, describes those findings as "consistent with" the compensable injury, and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is "due to" the compensable injury. 147 Or App at 553. But, in *Danboise*, the *medical evidence* described the disputed impairment as "consistent with" the compensable injury. Here, there is no such evidence. In contrast to *Danboise*, here, both the treating doctor and the medical arbiter find that claimant's bilateral eye injury healed without measurable impairment as a result of the work injury. (Exs. 9-3, 9-5, 14, 20-1). Thus, *Danboise* does not apply. *See Kenneth W. Emmerson*, 51 Van Natta 655 (1999) (where no medical evidence established that right finger and thumb impairment was consistent with accepted right hand, wrist, and elbow injuries, *Danboise* was inapplicable).

ORDER

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

In the Matter of the Compensation of
AUDENCIA MONTEZ, Claimant
WCB Case Nos. 99-06577 & 99-02429
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Sheridan, Bronstein, et al, Defense Attorneys

On May 5, 2000, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's injury claim. Asserting that our order contains "two clerical errors," SAIF asks that we "correct these errors." We treat SAIF's request as a motion for reconsideration.

Specifically, SAIF contends that our order incorrectly listed two WCB case numbers, whereas only one case number was before us on review. In order to address SAIF's contention, we have withdrawn our May 5, 2000 order. On reconsideration, as supplemented herein, we republish our prior order.

The WCB case numbers in question arose from two hearing requests filed by claimant. WCB Case No. 99-02429 pertains to claimant's hearing request from Paula Insurance's denial of claimant's injury claim. WCB Case No. 99-06577 refers to claimant's hearing request from SAIF's denial of claimant's injury claim. Those hearing requests were consolidated for hearing, which was held on November 18, 1999 by ALJ Peterson. Parties to that hearing were claimant, Paula Insurance (on behalf of Roloff Brothers, Inc.), and SAIF (on behalf of Roloff Farms, Inc.), as well as their legal representatives.

At the hearing, the parties agreed that the claim against Roloff Brothers / Paula should be dismissed. Nonetheless, although the parties' agreement was mentioned in the ALJ's Opinion and Order, the ALJ did not dismiss claimant's hearing request from Paula's denial by a separate Order of Dismissal. Instead, the ALJ's order upheld Paula's denial, as well as SAIF's denial.

Thereafter, claimant requested Board review of the ALJ's order. Because the ALJ's determinations regarding claimant's claims against both SAIF and Paula were included in one final order, all parties to the hearing remained parties to the proceeding on review. *See Donald L. Melton*, 47 Van Natta 2290 (1995); *Jerry R. Miller*, 44 Van Natta 1444 (1992) (if a party has been dismissed from a proceeding and its dismissal as a party is *not* contained in the appealed ALJ's order but rather is contained in a separate unappealed ALJ's order, that party is not considered a party for purposes of Board review of the appealed ALJ's order).

Under such circumstances, our order properly included Paula Insurance as a party to the proceeding, as well as correctly referred to WCB Case No. 99-02429 (the case that pertained to claimant's hearing request from Paula's denial). Likewise, the inclusion of Paula's attorney, as an entity receiving a copy of our order, was appropriate.[1]

Notwithstanding these observations, we have detected an omission in our May 5, 2000 order. Specifically, our order neglected to list "Roloff Brothers, Inc." (Paula's insured) as a party to be mailed a copy of our order. To correct this oversight, we include Roloff Brothers, Inc. on our list of parties and representatives to receive a copy of our order.

On reconsideration, as supplemented herein, we republish our May 5, 2000 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] SAIF also asserts that we erroneously referred to claimant's attorney as "both claimant and defense attorneys." Our order does not mention the affiliation of any of the attorneys who were listed as receiving copies of our order. Rather, claimant's attorney's firm and its address were listed directly under claimant's name and address. If anything, such a sequential order is consistent with the actual relationship of claimant and her respective counsel. Furthermore, Paula Insurance's counsel and the firm's address are listed directly beneath Paula Insurance and its address, thereby also supporting an accurate impression of Paula's legal representation. In light of such circumstances, we do not consider the aforementioned references to which SAIF objects to have been in error.

Member Phillips Polich dissenting.

For the reasons expressed in my dissenting opinion in the Board's May 5, 2000 order, I continue to find that claimant was a subject worker when she sustained her injury. Consequently, I adhere to my prior conclusion that her claim is compensable and should be remanded to SAIF for processing.

May 12, 2000 Cite as 52 Van Natta 831 (2000)

In the Matter of the Compensation of
DEBBIE J. FERERO, Claimant
WCB Case No. 97-07250
ORDER OF DISMISSAL
Michael A. Bliven, Claimant Attorney
Steven D. Gerttula, Defense Attorney

Mars on Broadway, a noncomplying employer, requested review of Administrative Law Judge (ALJ) Lipton's order that set aside the SAIF Corporation's denial of claimant's left knee condition. The parties have submitted a "Stipulation and Disputed Claim Settlement" (DCS) to resolve all issues raised or raisable between them.

Pursuant to the settlement, the parties agree that "the issued denial as supplemented by the contentions stated in this agreement, shall remain in full force and effect." The DCS also states that the "employer agrees to withdraw their Request for Board Review[.]"[1]

We approve the parties' DCS, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[2] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] We also note that, under the DCS, claimant "agrees to withdraw her civil claim against the employer with no costs to either party." Because our authority is confined to workers' compensation matters under ORS Chapter 656, our approval of the parties' settlement does not extend to any matters in the agreement that pertain to civil litigation.

Furthermore, although the DCS provides that the claim processing agent agrees to pay future medical bills, this proceeding concerns the worker's right to receive compensation and, thus, we have jurisdiction of this claim. *See* ORS 656.704(3).

[2] The DCS was previously signed by an ALJ. Because the settlement, however, pertains to the resolution of a dispute that is pending Board review, the DCS requires Board approval. *See* OAR 438-009-0015(5). Our signatures on this order constitute our approval of the parties' DCS.

In the Matter of the Compensation of
WILMA J. YOUNG, Claimant
WCB Case No. C000963
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed b Board Member Biehl and Haynes.

On April 24, 2000, 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 approve the proposed disposition.

The first page of the proposed CDA provides that the total compensation is $15,000 with claimant receiving $12,500 and claimant's attorney receiving $2,500. However, the "payment" recited on page 2, number 12 of the document is "$12,500" instead of $15,000. On page 3, number 13 of the CDA, the attorney fee (consistent with the first page) is given as $2,500. Thus, the lone reference on page two of the document to a total consideration of $12,500 appears to be an error. Accordingly, we interpret the agreement as providing for a total consideration of $15,000, with $12,500 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
ROSA M. CHAVEZ, Claimant
WCB Case No. 99-02636
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. In her brief, claimant contends that she is entitled to penalties and attorney fees for an allegedly untimely denial. On review, the issues are compensability, penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's reasoning and conclusions on this issue with the following supplementation.

The ALJ found that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. In making this finding, the ALJ relied on the opinion of Dr. Peacock, an attending physician, who attributed claimant's carpal tunnel condition to her employment. The ALJ noted that a chiropractor, Dr. Muller, who treated claimant for a non work-related motor vehicle accident (MVA), had suggested that the carpal tunnel condition was related to the MVA. But the ALJ discounted that opinion because neither Dr. Peacock nor Dr. Button, an examining physician, related the carpal tunnel condition to the MVA.

On review, the insurer contends that Dr. Muller provided a persuasive opinion on the causation issue that should establish that the carpal tunnel condition is not compensable. We disagree.

Dr. Muller noted that claimant had suffered significant injuries to the cervical spine (whiplash syndrome) and pelvic regions as a result of the MVA. Dr. Muller opined that bilateral hand numbness "can be related" to the cervical injury and that the whiplash syndrome, irritated by repetitive arm and hand movement "can" lead to a "double crush syndrome." (Ex. 34-3).

Having reviewed Dr. Muller's opinion, we find that it is based largely on expressions of medical possibility rather than medical probability. Accordingly, we do not find Dr. Muller's tentative opinion persuasive on the causation issue. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).[1]

Penalties and attorney fees

Claimant contends that the insurer unreasonably resisted the payment of compensation when it denied her claim 9 months after it was filed.[2] Thus, claimant asserts that she is entitled to an award of penalties and attorney fees. For the following reasons, we conclude that a penalty under ORS 656.262(11) is appropriate.

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[1] Nor do we find the opinion of another chiropractor (Guerrero), who opined that the MVA caused the carpal tunnel condition, persuasive. (Ex. 7-25). Dr. Guerrero reasoned that claimant's symptoms of carpal tunnel began shortly after the MVA. However, the record indicates that claimant's hand complaints did not begin until January 1998, 8 months after the May 1997 MVA. (Ex. 7-16). Therefore, we conclude that Dr. Guerrero's opinion, based on an alleged temporal relationship, was premised on an inaccurate history and is, thus, unpersuasive. *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).

[2] The ALJ did not address the penalty issue, although the issue was raised at hearing. (Tr. 1).

Claimant filed her claim on April 16, 1998. (Ex. 1). The insurer did not deny the claim until February 5, 1999, more than 90 days after its receipt of the claim. (Ex. 52). The insurer provides no explanation for its delay in denying the claim.

Accordingly, we conclude that the insurer's conduct constituted unreasonably delayed acceptance or denial of the claim. Therefore, we conclude that claimant is entitled to a 25 percent penalty pursuant to ORS 656.262(11) based on compensation due as a result of the ALJ's order (which we have affirmed) as of the date of the denial. *See Constance A. Asbury (Shaffer)*, 48 Van Natta 1018, 1020 (1996). This penalty is to be shared equally by both claimant and her attorney.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $2,650, 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 and her counsel's statement of services), the complexity of the issue, and the value of the interest involved.[3]

ORDER

The ALJ's order dated December 20, 1999 is modified in part and affirmed in part. Claimant is awarded a 25 percent penalty to be based on compensation due as of the date of the denial (as a result of the ALJ's order) and to be shared equally by claimant and her counsel. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $2,650, payable by the insurer.

[3] Claimant's attorney is not entitled to an attorney fee for services concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

In the Matter of the Compensation of
THOMAS D. CAWARD, Claimant
Own Motion No. 99-0454M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

The Board is in receipt of claimant's May 8, 2000 letter requesting reconsideration of our April 20, 2000 Own Motion Order Reviewing Carrier Closure, that affirmed the SAIF Corporation's February 4, 2000 Notice of Closure. Pursuant to OAR 438-012-0016, a copy of any document in an own motion proceeding directed to the Board must be simultaneously mailed to all other parties. As it is unclear whether claimant mailed a copy to SAIF, we enclose a copy of claimant's May 8, 2000 letter. In the future, claimant is requested to send copies of information sent to the Board to all parties or their attorney.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within 14 days of the date of this order. Following SAIF's submission, if claimant wishes to submit additional written material, he may do so. To be considered, claimant's submission must be filed within 14 days from the date of mailing of SAIF's reply. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA J. PEACOCK, Claimant
WCB Case No. 99-01081
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's occupational disease claim for latex allergy and asthma; (2) assessed a penalty for allegedly unreasonable claim processing; and (3) awarded an attorney fee of $9,000 for claimant's counsel's services at hearing. On review, the issues are compensability, claim processing, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, finding that the major contributing cause of claimant's latex allergy and asthma conditions were caused in major part by claimant's work for many years at the employer as a phlebotomist. The ALJ also determined that the insurer's denial was issued untimely and that the insurer failed to provide adequate reasons for the untimeliness. Thus, the ALJ also assessed a 25 percent penalty based on the insurer's failure to deny the claim within 90 days of the claim as required by ORS 656.262(6)(a). Finally, the ALJ awarded an assessed fee of $9,000 for claimant's counsel's services with respect to the compensability issue.

On review, the employer first contests compensability. Second, the employer argues that the ALJ erred in assessing a penalty. Specifically, the employer contends that it did not act unreasonably in waiting from January 26, 1999 until March 23, 1999 to issue the denial, because it had informed claimant that Dr. Dordevich's report would not be completed until the doctor received additional evidence. Finally, the employer disputes the $9,000 attorney fee on the basis that the only evidence in support of the fee was claimant's counsel's estimate that he had spent 40 hours on the case. The employer also objects to the fee because the ALJ did not state whether the ultimate award included an amount for costs and did not explain his reasons that led him to award the fee based on the applicable factors. We address each issue in turn.

Compensability

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

Penalties

A carrier is liable for a penalty when it "unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). Pursuant to ORS 656.262(6)(a), a carrier has 90 days in which to accept or deny a claim after it has notice or knowledge of the claim.

Here, the employer had notice or knowledge of the claim on October 28, 1998. (Ex. 61). Under the statute, the employer had until January 26, 1999 to issue an acceptance or denial. Dr. Dordevich did not examine claimant until January 25, 1999. (Ex. 81A). At that time, Dr. Dordevich opined that claimant's asthma was not attributable to her latex allergy. He also requested additional medical records. *Id.* The employer contends that the reason for the delay was the failure to obtain additional medical information preliminary and necessary to make its decision.[1]

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[1] On January 25, 1999, the employer informed claimant's attorney that it was unable to make a decision regarding the compensability of claimant's claim by the 90th day because Dr. Dordevich had requested additional *testing* and would complete his report when he received the test results. (Ex. 81C). There is no evidence that such additional testing was performed. On March 9, 1999, the employer again informed claimant that, despite several attempts, it did not have a report from Dr. Dordevich. (Ex. 82B).

On March 10, 1999, the employer received Dr. Dordevich's second report, in which he stated that, after reviewing additional medical records, his conclusions, impression and discussion remained the same as those in the January 25, 1999 report. (Exs. 82A, 83).

Here, we agree with the ALJ that the length of the delay (two months) after the employer had sufficient information to issue a timely denial (based on Dr. Dordevich's January 25, 1999 report) was unreasonable, particularly in light of the employer's unexplained delay in having claimant examined by its physician only one day before the 90-day deadline. Moreover, Dr. Dordevich's report, on which the employer's denial is based, was received March 10, 1999, but the denial was not issued until March 23, 1999, 13 days later. The employer offered no explanation for these delays. Under such circumstances, we agree with the ALJ's conclusion that the employer's conduct was unreasonable. Accordingly, we assess a penalty under ORS 656.262(11)(a) based on amounts then due as of the date of the employer's denial. *Jeffrey D. Dennis*, 43 Van Natta 857 (1991).

Attorney Fee - Hearing

The ALJ awarded a $9,000 attorney fee for services for prevailing over the employer's denial of claimant's occupational disease claim for latex allergy and asthma. The ALJ noted that claimant's counsel had expended about 40 hours on the case and had about $1,500 in expenses and requested a fee of $7,500 to $9,000. In establishing a reasonable fee, the ALJ considered claimant's counsel's representation of time spent on the case, the medical complexity of the case, the voluminous medical documentation, the length of the hearing, the deposition, and the amount of medical evidence generated by claimant's counsel in the face of similar substantial medical evidence generated by the employer to defeat the claim. The ALJ also considered the substantial benefit to claimant, the experience of the attorneys, and the risk that claimant's counsel would go uncompensated.

The employer contends that the ALJ's attorney fee award of $9,000 for services at hearing should be reduced, on the basis that the only evidence in support of the fee was claimant's counsel's estimate that he had spent 40 hours on the case. The employer also objects to the fee because the ALJ did not state whether the ultimate award included an amount for costs and did not explain his reasons that led him to award the fee based on the applicable factors under *Schoch v. Leopold & Stevens*, 162 Or App 242 (1999).

Claimant responds that her attorney had devoted "approximately 40 hours and had expended about $1,500 in costs" on the case and that the employer had accepted the 40-hour representation of time spent. Claimant also observed that the case was medically complex, with about 90 exhibits received and a medical record that went back five or six years.[2]

Claimant also stated that her attorney had advised the ALJ how much money had been expended in expert witness fees "not in an attempt to recover any costs, but, rather, to let the fact-finder know the expenses that claimant's attorney's office incurred in prosecuting the claim." (Claimant's Response Brief at 13). This information was provided to demonstrate a higher degree of risk that claimant's attorney would go uncompensated. The employer counters that the greater the expenditure for an expert's opinion, the less the risk that the attorney might go uncompensated.

The risk in a particular case that an attorney's efforts may go uncompensated is one of a number of factors to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4). *See Schoch v. Leupold & Stevens*, 162 Or App at 250 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). In determining a reasonable attorney fee award, we will take into consideration the risk (particularly in light of the medical complexity of the issue, the nature of the proceedings, and the employer's vigorous defense) that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.[3] OAR 438-015-0010(4)(g).

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[2] Claimant's counsel also cited *June E. Bronson*, 51 Van Natta 928 (1999), in support of his claim that this was a complicated case and that the fee requested was justified. Claimant's citation is inapposite. When we evaluate a case in order to assess a reasonable attorney fee, we evaluate each case on its own merits by applying the factors set forth in OAR 438-015-0010(4). *E.g., Shannon L. Mathews*, 48 Van Natta 2406 (1996).

[3] Both counsel acknowledge that *costs* may not be considered in awarding an assessed fee and we do not consider the $1,500 in costs attested to by claimant's attorney. The time involved in the deposition of the expert witness, however, has been considered in awarding an assessed fee. *See Marilyn M. Keener*, 49 Van Natta 110 (1997).

In addition to the risk factor, the remaining factors that we apply to the circumstances of this case to determine the amount of claimant's counsel's attorney fee for services at hearing are: The time devoted to the case; the complexity of the issues involved; the value of the interest involved; the skill of the attorneys; the nature of the proceedings; the benefits secured for the represented party; and the assertion of frivolous issues or defenses. OAR 438-015-0010(4). We now proceed to review the attorney fee for services at hearing *de novo*.

The issues at hearing were the compensability of claimant's latex allergy and asthma conditions and penalties for an allegedly untimely denial. As indicated above, claimant's attorney devoted about 40 hours to the case, which is not disputed by the employer.[4] The record consists of 166 exhibits, of which 14 were provided by claimant. Claimant's attorney also obtained a detailed 20-page medical statement from claimant's treating physician that was favorable to claimant's position. The hearing was held on two days three months apart. The first day of hearing lasted one and one-half hours, the second a little over one and one-half hours. Claimant appeared as the only witness on the second day of the hearing. The transcript for the first day of hearing was 31 pages and for the second day was 22 pages.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of above average complexity regarding the legal and factual issues involved. Given the complexity of claimant's interrelated medical conditions and the numerous attempts to establish a proper diagnosis, the medical issues were of substantially above-average complexity. Moreover, the value of the interest and the benefit secured were significant, in that claimant has obtained temporary disability and other compensation for her latex allergy and asthmatic conditions.

Both attorneys are skilled litigators with substantial experience in workers' compensation law. Both attorneys presented their positions in a thorough and vigorous manner. No frivolous issues or defenses were presented. Finally, given the nature of claimant's diagnoses, the conflict in medical opinions and the employer's vigorous defense, claimant's attorney assumed a significant risk that he might go uncompensated for his services rendered in this case.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that a reasonable fee is $7,500 for claimant's attorney's services at the hearings level regarding the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the voluminous record and the number of hours claimant's counsel expended on the case--with the proviso regarding the time spent on the penalty issue noted above), the particular complexity of the medical and factual components of the issue, the value of the interest involved, the nature of the proceeding (a two-day hearing, as well as a deposition), and the considerable risk that claimant's counsel might go uncompensated. Thus, after our review of the case and our application of these factors, we conclude that a reasonable fee for claimant's counsel's services at hearing regarding the compensability issue is $7,500. The ALJ's $9,000 award is modified accordingly.

Claimant's attorney is also entitled to an assessed fee for services on review for defending against the employer's request for review regarding the compensability issue.[5] 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 assessed attorney fee for claimant's counsel's services on review concerning the compensability issue is $2,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief and fee request), the complexity of the issue, and the value of the interest involved.

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[4] Claimant's counsel did not separate the time spent on the compensability and the penalty issues. The ALJ's and our authority to award an assessed attorney fee under ORS 656.386(1) is for services devoted to the compensability issue only; *i.e.*, overturning the denial. The statute does not provide for a fee for services directed to the penalty issue. Instead, claimant's counsel receives one-half the penalty based on 25 percent of the compensation "then due" as a result of the unreasonable claims processing issue. Because a portion of claimant's counsel's services have been devoted to the penalty issue, we have reduced the ALJ's award which made no such adjustment in granting claimant's counsel the full amount of his request. In taking this action, we note that our award is consistent with the lower end of claimant's counsel's requested attorney fee range ($7,500).

[5] Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee or penalty issues either at hearing or on review. *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 October 4, 1999 is affirmed in part and modified in part. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $7,500, to be paid by the self-insured employer. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded a fee of $2,000, to be paid by the employer.

Member Biehl concurring in part and dissenting in part.

I concur with those portions of the majority's order that find the claim compensable and assess a penalty for unreasonable claim processing. Because I disagree with the majority's decision to reduce the ALJ's attorney fee award, I respectfully submit this dissenting opinion.

In modifying the ALJ's attorney fee award, the majority notes that a portion of claimant's counsel's services were devoted to the penalty issue and, as such, cannot be considered in granting an attorney fee under ORS 656.386(1) for finally prevailing against the employer's compensability denial. I do not disagree with the general proposition espoused in the majority's reasoning. Nonetheless, the majority does not quantify the portion of claimant's counsel's services that have been excluded from their consideration in reducing the ALJ's $9,000 attorney fee award. From my review of the record, the time devoted to the penalty issue by claimant's counsel was minimal. Consequently, I submit that the record does not support the majority's decision to reduce claimant's attorney fee award by 1/6 ($1,500 of the ALJ's $9,000 award).

Finally, even accomodating for claimant's counsel's services directed to the penalty issue, I would find that, in light of the complexity of the medical and legal issues, the protracted nature of the proceedings (two hearings over a three month period, as well as a deposition), the voluminous documentary record (several portions of which were provided by claimant's counsel and pivotal to the ultimate compensability determination), the undisputed skill and experience of the attorneys, and the substantial risk that claimant's counsel might go uncompensated for his services, a $9,000 attorney fee award for services at the hearing level in finally prevailing over the employer's compensability denial is reasonable. Therefore, I would affirm the ALJ's attorney fee award.

In the Matter of the Compensation of
MIKEL T. HOLBROOK, Claimant
WCB Case No. 99-03861
ORDER ON REVIEW
John M. Pitcher, Claimant Attorney
Meyers, Radler, 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 binaural hearing loss. On review, the issue is compensability.

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

Assuming claimant's work activities prior to 1974 were the major cause of his hearing loss at that time, claimant was not disabled nor did he seek treatment in 1974. Claimant did not seek treatment for hearing loss until 1992. (Tr. 16). That date is the "onset" of claimant's occupational disease claim. *See SAIF v. Cessnun*, 161 Or App 367 (1999); *Medford Corp. v. Smith*, 110 Or App 486 (1992). For the reasons set forth in the ALJ's order, we agree that claimant has not established that his work activities were the major contributing cause of his hearing loss condition or a pathological worsening of that condition. ORS 656.802(2)(a) & (b).

ORDER

The ALJ's order dated January 27, 2000 is affirmed.

In the Matter of the Compensation of
ROBERT S. RICHEY, Claimant
Own Motion No. 98-0521M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
McGinty & Belcher, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant initially requested enforcement of our February 11, 1999 Own Motion Order that authorized the payment of temporary disability compensation beginning December 28, 1998, the date claimant was hospitalized for surgery, and ordered the insurer to close the claim under OAR 438-012-0055 when claimant became medically stationary. Specifically, claimant contends that the insurer was not entitled to unilaterally terminate his temporary total disability compensation on February 11, 1999. In addition, claimant requests penalties based on the insurer's allegedly unreasonable claim processing in unilaterally terminating temporary disability compensation. While litigation was pending regarding this enforcement issue, the insurer issued a May 19, 1999 Notice of Closure that closed claimant's claim with an award of temporary total disability compensation from December 28, 1998 through February 11, 1999, and declared claimant medically stationary as of April 29, 1999. Claimant requests review of that claim closure. Thus, the issues before us are claim processing, penalties, and review of carrier closure.

FINDINGS OF FACT[1]

On March 7, 1988, claimant compensably injured his right knee. The insurer ultimately accepted disabling right knee puncture and medial meniscus tear injuries. (Exs. 2, 7). Claimant's aggravation rights expired on May 3, 1993.

On December 28, 1998, claimant underwent arthroscopic surgery performed by Dr. Pollard, attending physician. (Ex. 13). By Own Motion Order dated February 11, 1999, we authorized reopening the claim for payment of temporary total disability compensation beginning December 28, 1998, the date of surgery. In addition, we ordered the insurer to close the claim under OAR 438-012-0055 when claimant became medically stationary.

Dr. Pollard provided follow-up care following the December 1998 surgery. On February 11, 1999, Dr. Pollard examined claimant and noted that claimant presented new complaints of soreness around the patellofemoral joint. (Ex. 17A). On examination, claimant's right knee showed no effusion, all ligaments were stable, and range of motion was full. Dr. Pollard stated that claimant probably had "chondromalacia patella." (*Id.*). He noted that claimant was not yet medically stationary but would be in about a month. He asked claimant to return in a month and expected to close the claim then. (*Id.*). He released claimant to regular work as of February 11, 1999, and verbally advised claimant of that release as of that date. (*Id.*, 17, 18A, 24).

Based on Dr. Pollard's release to regular work, the insurer terminated claimant's temporary disability compensation as of March 15, 1999. (Ex. 22). On April 6, 1999, claimant requested a hearing with the Hearings Division, raising, *inter alia*, the issue of procedural entitlement to temporary disability compensation. WCB Case No. 99-02893. On April 12, 1999, the insurer notified claimant that an overpayment of $2,028.70 resulted from claimant being released to return to work as of February 11, 1999, and his temporary disability compensation payments being paid through March 15, 1999. (*Id.*).

Claimant did not keep his March 19, 1999 appointment with Dr. Pollard. (Ex. 18B). By letter dated March 26, 1999, the insurer notified claimant that, unless it heard from claimant or his physician within two weeks, it would assume he had recovered and his claim would be closed based on failure to seek medical treatment. (Ex. 19).

On April 5, 1999, claimant returned to Dr. Pollard. (Ex. 19A). At that time claimant had medial knee pain possible secondary to overdoing his rehabilitation exercises. Dr. Pollard recommended that claimant "back off" the rehabilitation exercises a little and elected not to close the claim "at [claimant's] request." (*Id.*). He also noted that claimant remained "released for work." (*Id.*).

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[1] Our findings of fact and exhibit citations are derived, in part, from the record developed in the April 26, 1999 fact finding hearing.

On April 26, 1999, a hearing was convened before Administrative Law Judge (ALJ) Johnson regarding the enforcement of our February 11, 1999 Own Motion Order. WCB Case No. 99-02893. Following the hearing, and prior to issuance of an order, ALJ Johnson determined that the Hearings Division did not have jurisdiction over enforcement issues regarding claims under our own motion authority. In light of these circumstances, ALJ Johnson deferred issuance of an order pending our decision regarding claimant's enforcement request of our February 11, 1999 Own Motion Order.

On April 29, 1999, claimant returned to Dr. Pollard for his closing examination. After examining claimant's right knee and taking AP and lateral x-rays, which showed joint spaces were well maintained, Dr. Pollard found that the right knee was medically stationary, without additional permanent impairment as a result of the December 1998 surgery.

On May 19, 1999, the insurer closed claimant's claim with an award of temporary total disability compensation from December 28, 1998 through February 11, 1999, and declared claimant medically stationary as of April 29, 1999. Claimant requested review of that closure.

On July 15, 1999, having found the own motion record inadequate to determine the enforcement issue, we issued an Own Motion Order Referring for Fact Finding Hearing. WCB Case No. 98-0521M. We requested that ALJ Johnson issue a recommendation making findings of fact on whether claimant was entitled to: (1) temporary disability benefits; and (2) penalties for the insurer's allegedly unreasonable refusal to pay compensation. We acknowledged that the prior hearing convened before ALJ Johnson on April 26, 1999 could serve as the evidentiary hearing and requested that ALJ Johnson issue his Own Motion recommendation based on the testimonial and documentary evidence submitted at that hearing.

On August 30, 1999, ALJ Johnson issued: (1) an Opinion and Order in WCB Case No. 99-02893 that dismissed claimant's hearing request regarding enforcement of the February 11, 1999 Own Motion Order; and (2) an Own Motion Recommendation in WCB Case No. 98-0521M.

On September 1, 1999, we implemented a briefing schedule to allow the parties to submit their written positions regarding ALJ Johnson's Own Motion Recommendation. Neither party submitted any argument/position.

CONCLUSIONS OF LAW AND OPINION

In his Own Motion Recommendation, ALJ Johnson recommended that claimant be found entitled to "procedural" temporary disability compensation from February 11, 1999, the date the insurer terminated his benefits, through April 21, 1999, the date ALJ Johnson determined that claimant received *written* notification that he was released to return to regular work. Nevertheless, because the claim had been closed, ALJ Johnson determined that, pursuant to *Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992), claimant was not eligible for payment of these "procedural" temporary disability benefits. Finally, ALJ Johnson recommended that a penalty be assessed pursuant to ORS 656.262(11)(a) for the insurer's unreasonable termination of procedural temporary disability benefits. ALJ Johnson recommended a penalty of 25 percent of the unpaid procedural temporary disability compensation for the period from March 16, 1999 through April 21, 1999.[2]

Based on the following reasoning, we find that the insurer properly terminated claimant's temporary disability benefits on the date he was released to regular work. *See former* ORS 656.268(3)(b).[3] Furthermore, because the termination of temporary disability benefits was not unreasonable, no penalties are due. Finally, we affirm the insurer's Notice of Closure.

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[2] In determining the "amounts then due" upon which to base the penalty, ALJ Johnson noted that the insurer continued to pay time loss benefits through March 15, 1999, although the insurer subsequently contended that time loss benefits paid after claimant's February 11, 1999 release to regular work represented an overpayment. Under these circumstances, ALJ Johnson determined that the "amounts then due" included the unpaid procedural temporary disability compensation for the period from March 16, 1999 through April 21, 1999.

[3] *Former* ORS 656.268(3) was renumbered by the Legislature as ORS 656.268(4) effective October 23, 1999. (Senate Bill 220, Sec. 1(4)). The language remains the same, however.

Claim Processing [Enforcement of our February 11, 1999 Own Motion Order]

OAR 438-012-0035(4)[4] provides the conditions under which a carrier may unilaterally terminate temporary disability compensation on an own motion claim. Under OAR 438-012-0035(4)(c), temporary disability compensation may be terminated when such termination is authorized by the terms of *former* ORS 656.268(3)(a) through (c).[5] Under *former* ORS 656.268(3)(b), a carrier is permitted to terminate temporary disability benefits when the "attending physician advises the worker and documents in writing that the worker is released to return to regular employment." ALJ Johnson relied on *Ronald P. Olson*, 51 Van Natta 354 (1999), to interpret this statute as requiring the attending physician to provide *written* notification to the worker that he or she is released to regular employment before the carrier is permitted to unilaterally terminate temporary disability benefits. We disagree.

In *Olson*, the claimant was released to *modified* work, not regular work. 51 Van Natta at 355. Under those circumstances, *former* ORS 656.268(3)(c) applied to allow termination of temporary disability benefits when the "attending physician advises the worker and documents in writing that the worker is released to return to modified employment, *such employment is offered in writing to the worker* and the worker fails to begin such employment." [Emphasis added]. In *Olson*, the necessary criteria to terminate temporary disability compensation was not met because there was no indication that the claimant was offered modified employment in writing and that he failed to begin such employment. 51 Van Natta at 355. Thus, in *Olson*, the determinative factor was the lack of evidence that the claimant was provided with a *written offer of modified employment*. There was no determination that the worker was required to be provided with a written release to modified employment from his attending physician.

Pursuant to *former* ORS 656.268(3)(b), the attending physician is merely required to "advise" the worker of the regular work release and document the release in writing. The statute does not require written notification of the regular work release to be given to the worker. *See Harley J. Gordineer*, 47 Van Natta 2138 (1995); *compare Trevor E. Shaw*, 46 Van Natta 1821, *on recon* 46 Van Natta 2168 (1994) (interpreting a prior version of ORS 656.268(3)(b) that required the attending physician to give the worker a written release to regular work).

Here, the requirements of *former* ORS 656.268(3)(b) were met. First, Dr. Pollard explicitly stated that he advised claimant he was released to regular work as of February 11, 1999. (Exs. 17A, 24). Moreover, claimant does not dispute that Dr. Pollard notified him he was released to regular work. Second, Dr. Pollard documented this release to regular work in writing in his February 11, 1999 chart note, on an 828 form, and in letters to the insurer. (Exs. 17, 17A, 18B, 24). Having met the requirements of *former* ORS 656.268(3)(b), the insurer was permitted to unilaterally terminate claimant's temporary disability benefits as of February 11, 1999.

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[4] OAR 438-012-0035(4) provides:

"(4) Temporary disability compensation shall be paid until one of the following first occurs:

"(a) The claim is closed pursuant to OAR 438-012-0055;

"(b) A claim disposition agreement is submitted to the Board pursuant to ORS 656.236(1), unless the claim disposition agreement provides for the continued payment of temporary disability compensation; or

"(c) Termination of such benefits is authorized by the terms of ORS 656.268(3)(a) through (c)."

[5] *Former* ORS 656.268(3) provides:

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

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

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

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

Penalties

Having found that the insurer complied with *former* ORS 656.268(3)(b) in terminating claimant's temporary disability benefits as of February 11, 1999, we find that the insurer's claim processing was not unreasonable. Thus, there is no basis for a penalty.

Review of the May 19, 1999 Notice of Closure

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 19, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

The only medical evidence regarding claimant's medically stationary status is provided by Dr. Pollard. On April 29, 1999, Dr. Pollard performed a thorough closing examination that included repeat x-rays. He found claimant medically stationary as of April 29, 1999. Dr. Pollard is claimant's attending physician and treating surgeon. In addition, he provided follow-up care following claimant's surgery. Under these circumstances, Dr. Pollard is in a good position to know when claimant's condition became medically stationary. Finally, there is no contrary opinion. There is also no evidence that claimant's condition changed from the time Dr. Pollard declared him medically stationary on April 29, 1999, until the insurer closed the claim on May 19, 1999, less than three weeks later. Consequently, on this record, we find that claimant's compensable right knee condition was medically stationary on the date his claim was closed.

We also find that the insurer's award of temporary disability compensation was proper. As ordered by our February 11, 1999 Own Motion Order, the insurer began paying temporary total disability on December 28, 1998, the date of claimant's right knee surgery. The insurer awarded temporary total disability compensation from that date through February 11, 1999, the date claimant was released to regular work, as discussed above. For the reasons discussed below, we find that the award of temporary total disability compensation properly ended on February 11, 1999.

Here, the record establishes that claimant was temporarily totally disabled from the date of his surgery until he was released to regular work by Dr. Pollard on February 11, 1999. Moreover, claimant remained released to regular work after that date. Therefore, after February 11, 1999, claimant was not disabled due to the compensable injury. Thus, he was not entitled to temporary disability compensation after that date.

Accordingly, we affirm the insurer's May 19, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
KARA S. GREENHILL, Claimant
WCB Case Nos. 98-07056 & 98-02583
ORDER ON REVIEW
Heiling & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denials of claimant's occupational disease claims for a right wrist ganglion cyst and recurrent ganglion cyst conditions. 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 (1983). This is especially true where, as here, the treating physician is also the treating surgeon and has therefore had the unique opportunity to examine claimant's condition firsthand during surgery. *(See* Ex. 8). *Argonaut Insurance v. Mageske*, 93 Or App 698 (1998).

Here, we agree with the ALJ's decision to defer to the opinion of claimant's treating physician, Dr. Layman. Dr. Layman, who examined claimant repeatedly over several months and performed surgery to excise claimant's ganglion cyst, reasoned that claimant's work activity was the major contributing cause of her right wrist ganglion cyst condition. (Exs. 16, 30). Drs. Nye, Fuller and Button believed that claimant's condition was idiopathic and not work related. (Exs. 22, 24, 28). However, Drs. Fuller and Button performed only records reviews at the request of SAIF. (Exs. 22, 28). Dr. Nye examined claimant only once. (Ex. 11).

The fact that Dr. Layman's opinion is in the minority is not in and of itself a reason to find it less persuasive. Dr. Layman's opinion is well-reasoned and persuasively explains how claimant's work activity irritated the tissues in her right wrist, eventually causing the physiological changes that led to the development of claimant's ganglion cyst condition. (Ex. 30). Dr. Layman's opinion is not therefore based on a mere "temporal relationship" between claimant's work activity and her ganglion cyst condition.

Although Dr. Layman did not review the videotape of claimant's work activity (Ex. 11A), he took an accurate work history directly from claimant. (Ex. 6, 12-2). He correctly understood that claimant "went to work putting cutters for chain saws in slots on a rack[,] activity requiring repetitive wrist and hand activity." (Ex. 12-2). We therefore find that Dr. Layman's opinion is based on complete and accurate information regarding claimant's work activities. *Miller v. Granite Construction*, 28 Or App 473 (1977).

Next, SAIF contends that claimant failed to prove that her ganglion cyst condition "pathologically worsened" as a result of her work activity. ORS 656.802(2)(b). SAIF concedes that the medical evidence demonstrates increased buildup of fluid in claimant's ganglion cyst. However, SAIF argues that without medical evidence that this increased buildup is more than a "symptomatic" worsening, claimant has not sustained her burden of proof on the issue. We disagree with SAIF's contentions.

First, Dr. Layman did not identify a "preexisting condition" in claimant's right wrist. Rather, Dr. Layman stated that claimant's work activities were the major contributing cause of her ganglion cyst *condition*, as opposed to a worsening of any underlying condition. (Ex. 30). ORS 656.802(2)(a). For the same reasons that we defer to Dr. Layman on the issue of causation, we defer to Dr. Layman on the issue of whether claimant has a "preexisting condition" that would implicate ORS 656.802(2)(b).

Moreover, even assuming, *arguendo*, that claimant had a preexisting condition, the medical evidence from Drs. Nye, Button and Layman supports the proposition that this fluid buildup was an objective change coincident with claimant's work activity. (Exs. 11, 24-2, 28, 30). In particular, Dr. Nye stated that "there is no doubt that work activity causes ganglion or synovial fluid to increase in production and ganglions that are already present to expand and become more apparent." (Ex. 24-2,3).

Although none of these physicians expressly stated that claimant's work activity "pathologically worsened" the ganglion cyst condition, "magic words" are not always required. *See Freightliner v. Arnold*, 142 Or App 98 (1996); *McClendon v. Nabisco Brands*, 77 Or App 412 (1986). Under these particular circumstances, even assuming claimant has a preexisting condition, we find that the persuasive medical evidence supports the fact that claimant's work activities as a chrome plate operator caused a pathological worsening of her right wrist ganglion cyst and recurrent ganglion cyst conditions. ORS 656.802(2)(b).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 28, 1999 is affirmed. For services on review, claimant's attorney is awarded $900, payable by SAIF.

In the Matter of the Compensation of
PAUL D. HAMILTON, Claimant
WCB Case No. 99-05803
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that upheld the self-insured employer's denial of his injury claim for a neck condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that he sustained a compensable neck injury on August 24, 1995, which combined with a preexisting condition. Relying on the opinion of his treating neurosurgeon, Dr. Hacker, claimant further argues that he proved that the compensable injury is the major contributing cause of the combined condition, thus satisfying the compensability standard under ORS 656.005(7)(a)(B). The employer responds that claimant did not show that he sustained an injury to his neck at the time of the 1995 fall and, in any case, Dr. Hacker's opinion is not sufficiently persuasive to carry claimant's burden of proof.

Relying on claimant's history, Dr. Hacker reported that claimant suffered a fractured rib injury and a neck injury, after which he experienced chronic pains throughout his neck lasting for over six months for which treatment was not pursued. According to Dr. Hacker, claimant had significant cervical spondylosis throughout the midcervical region from C4-5 through C6-7 that was accelerated by soft tissue injury of the cervical spine in the 1995 fall. (Exs. 60, 61, 62, 68). Dr. Hacker also stated that the major contributing cause of the need for treatment and disability was the work injury. *Id.* Dr. Hacker reasoned that degenerative cervical disc disease is rarely as advanced as in claimant's case absent some injury or other event that results in an acceleration of those changes. Dr. Hacker added that claimant's symptoms were typical of someone who has suffered a soft tissue injury of the cervical spine: "A protracted course of pain, usually without obvious neurologic deficit" and "the neck is often aggrvated by activities which would otherwise be performed without difficulty, such as the additional work (shovelling) which [claimant] describes as 'the last straw'."

The remaining medical opinion is from Drs. Coletti, orthopedist, and Glusman, neurologist. The doctors concluded that the major cause of the degenerative changes in claimant's neck were due to those idiopathic causes that typically cause the development of cervical spondylosis and degenerative change, similar to that occurring in the lumbar spine. They noted that claimant had well-preserved disc spaces and a lack of foraminal narrowing, which was reflected in his lack of radicular symptoms, finding that claimant's spine pain was consistent with degenerative change. They further stated that if a severe injury to the neck, such as a severe neck sprain, accelerated his degenerative change, it might well be considered to have some bearing in the case, if such a severe neck injury had been documented. But Drs. Coletti and Glusman concluded that, based on the medical record and their inability to correlate that record with the history claimant provided, they were unable to evaluate the contribution of the neck injury to claimant's degenerative condition.

Absent persuasive reasons to do otherwise, 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 Dr. Hacker's opinion. First, there is no evidence that Dr. Hacker reviewed the medical record;[1] instead, it appears that he relied solely on claimant's history, which, as discussed by Drs. Coletti and Glusman, is difficult to correlate with the medical record. Moreover, as discussed by the ALJ, Dr. Hacker does not explain how or why he believes that the 1995 injury was the major contributing cause of claimant's initial need for treatment in 1997, particularly in light of claimant's failure to seek treatment for his neck until 18 months after the injury and the fact that he first sought treatment after a severe coughing spell that caused his neck to become severely symptomatic. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (ORS 656.005(7)(a)(B) requires an assessment of the major contributing cause, which involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause). Because Dr. Hacker did not take into account the medical record, we find its persuasiveness diminished. The persuasiveness of Dr. Hacker's opinion is further undermined by the opinion of Drs. Coletti and Glusman, who attributed the major contributing cause of claimant's disability and need for treatment to his preexisting condition.

Consequently, whether or not claimant proved legal causation, we agree with the ALJ that the medical evidence is insufficient to prove medical causation.

ORDER

The ALJ's order dated December 29, 1999, as reconsidered January 2, 2000, is affirmed.

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[1] The medical record establishes that claimant's neck was examined and evaluated at the time of the original injury. (Ex. 2-1). At that time, claimant denied having any neck pain. *Id.* On physical examination, the neck was found to be nontender with full range of motion including flexion and extension and was without evidence of stepoff. *Id.* Claimant's C-spine was cleared clinically as claimant had no pain on palpation or with full range of motion. (Ex. 2-2). In other words, there is no medical evidence that claimant experienced a neck strain as a direct result of the injury. Moreover, the medical record shows that claimant did not seek any treatment for his neck until January 1997, three days after an off-work coughing spell and 18 months after the 1995 injury.

In the Matter of the Compensation of
DARLA HAMPTON, Claimant
WCB Case No. 99-04361
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Mannix, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the self-insured employer's denial of his left forearm, left arm and left shoulder strains and right shoulder strain; and (2) declined to assess penalties for the employer's allegedly unreasonable claim processing. On review, the issues are scope of acceptance, compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had not established that she sustained separate injuries to her left arm, left shoulder, or right shoulder as a result of the September 2, 1998 MVA. The ALJ declined to order the employer to specifically accept those conditions and upheld the employer's April 7, 1999 and November 11, 1999 denials.

On review, claimant contends that the employer should amend its notice of acceptance to include left arm, left shoulder and right shoulder strains pursuant to ORS 656.262(6)(d) and ORS 656.262(7)(a) in order to reasonably apprise the claimant and medical providers of the nature of the compensable conditions. We disagree.

Left arm and shoulder conditions

We adopt and affirm the ALJ's opinion on this issue, with the exception of the last sentence under the left shoulder section, and with the following supplementation.

On March 11, 1999, claimant wrote to the employer requesting that it amend its notice of acceptance to include, *inter alia*, left forearm, left arm and left shoulder strain under ORS 656.262(6)(d). The employer timely responded, stating that it was denying claimant's request because claimant had neither been diagnosed with a condition nor found to have objective findings related to her arm pain, and that there were no objective findings supporting a shoulder strain. In other words, the employer's response to claimant's request for an amended notice of acceptance treated the requested strain conditions as a request for acceptance of "new medical conditions" and denied them.

Right Shoulder Condition

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.

In its November 8, 1999 letter responding to claimant's September 23, 1999 request to amend its notice of acceptance for a right shoulder strain, the employer declined to expand its acceptance on the basis that that condition was already encompassed in the accepted cervical and thoracic strain diagnoses, again treating claimant's request to amend its notice of acceptance as a request for a new medical condition under ORS 656.262(7)(a).

At hearing, the parties framed the right shoulder issue as compensability of the right shoulder strain (Tr. 2, 3), and the ALJ decided the issue as a compensability question. Because the issue at hearing was framed in terms of compensability, we question whether the theory that the condition is reasonably encompassed within the previously accepted strains has any application in this case. In other words, the "reasonably apprises" analysis is premised on the acceptance of a claimed condition, whereas the employer's position is that it is not liable for the claimant's right shoulder strain condition, *i.e.*, that the condition is not compensable.

In any event, because we agree with the ALJ that the disputed condition is not compensable, even if we applied ORS 656.262(7)(a), we would decline to require the employer to amend its acceptance to include the disputed conditions.

Penalties and Attorney Fees

We adopt and affirm the ALJ's opinion regarding penalties. We supplement to address claimant's attorney fee argument.

Claimant contends she is entitled to an attorney fee and penalties[1] under ORS 656.262(7)(c), based on the employer's alleged *de facto* denial of claimant's right shoulder condition. We find no evidence that claimant raised an argument regarding ORS 656.262(7)(c) or related attorney fees under ORS 656.386(b)(B) or (C) at hearing. 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 January 6, 2000 is affirmed.

[1] As noted above, the ALJ addressed the penalty issue in his order. The statute governing assessment of penalties is ORS 656.262(11)(a), not ORS 656.262(7)(c) or the related attorney fee provisions.

In the Matter of the Compensation of
RAUL G. LEON, Claimant
WCB Case No. 99-03940
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's denial of his low back aggravation claim.[1] On review, the issue is aggravation.

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

The ALJ upheld the insurer's aggravation denial, finding that claimant had failed to prove that his compensable condition had "actually worsened." *See* ORS 656.273(1). After the ALJ's order, the Supreme Court in *SAIF v. Walker*, 330 Or 102 (2000), affirmed the Court of Appeals opinion, 145 Or App 294 (1996), that had reversed a Board order setting aside an aggravation denial based on the claimant's symptomatic worsening.

In doing so, the Court determined that the text, context, and applicable case law surrounding the 1995 amendments to ORS 656.273(1) clarified the legislature's intended meaning of that statute, as well as the interplay between that statute and ORS 656.273(8). Accordingly, the Court held that evidence of a symptomatic worsening that exceeds the amount of waxing anticipated by an original permanent disability award -- that is, the degree of worsening addressed in ORS 656.273(8) -- may prove an aggravation claim under ORS 656.273(1) if, but only if, a physician concludes, based on objective findings (which may incorporate the particular symptoms), that the underlying condition itself has

[1] The insurer has enclosed a letter it received from claimant and has asked us to advise whether it should be construed as claimant's "brief." If so, the insurer requests an opportunity to respond. We have reviewed the correspondence and conclude that it does not constitute a "brief." Alternatively, even if considered to be a brief, claimant's submission would not alter our conclusion that claimant's aggravation claim is not compensable. Under such circumstances, we have proceeded with our review.

worsened. Stated differently, the Court reasoned that, if, in a physician's medical opinion, a symptomatic worsening that exceeds the degree anticipated does *not* demonstrate the existence of an actual worsening of the underlying condition, then the worker does not qualify for an aggravation award.

In this case, we find that no physician has concluded based on objective findings that the underlying low back condition has worsened. Accordingly, we agree with the ALJ that claimant failed to prove a compensable aggravation claim.

ORDER

The ALJ's order dated February 9, 2000 is affirmed.

May 16, 2000 Cite as 52 Van Natta 848 (2000)

In the Matter of the Compensation of
ANNA B. MADRIZ, Claimant
WCB Case No. 98-03837
ORDER ON RECONSIDERATION
Hilda Galaviz, Claimant Attorney
Terrall & Terrall, Defense Attorneys

On March 20, 2000, we withdrew our February 18, 2000 Order on Review that upheld the self-insured employer's denial of claimant's right lateral meniscus tear and reversed an Administrative Law Judge's (ALJ's) attorney fee award under ORS 656.386. We took this action to consider the arguments contained in claimant's motion for reconsideration. Having received the employer's response, we proceed with our reconsideration.

On reconsideration, claimant has submitted a copy of a March 10, 2000 order involving a case before the Medical Review Unit of the Workers' Compensation Division. The order held that a causation issue involving a diagnostic medical services claim regarding an accepted medial collateral ligament strain must be resolved by the Board's Hearings Division under ORS 656.704(3). Consequently, claimant asks that we reconsider our decision and remand this matter to the Hearings Division for joinder with the WCD case.

The employer opposes claimant's request for remand and joinder. The employer contends that, because claimant did not raise the remand issue on review, she should not be able to raise it for the first time on reconsideration. The employer also argues that the issue in the pending hearing involving medical services is distinguishable from this case, which involves compensability.

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

First, we are not inclined to address the remand issue because we find that claimant's request is untimely. Specifically, claimant sought deferral before the ALJ to await a decision from the Department. On review, however, claimant did not raise any argument or request for deferral. Rather, claimant asserted that the ALJ's decision finding the claim compensable should be affirmed. Thus, claimant did not raise the "remand/joinder" issue until reconsideration following our decision to reverse the ALJ's order.[1] Under the circumstances, we consider claimant's request to be untimely. *See Fred Meyer, Inc. v. Hofstetter*, 151 Or App 21 (1997); *Annette E. Farnsworth*, 48 Van Natta 508 (1996).

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[1] The fact that the WCD order issued after our initial order does not alter our conclusion that the "remand/joinder" issue could have been raised prior to our decision. In other words, although described as a "deferral" motion prior to the issuance of our initial decision and the WCD order, claimant's "remand/joinder" motion is designed to reach the same objective; *i.e.* deferral of this compensability dispute to await resolution of a diagnostic dispute on an accepted claim for consideration of findings resulting from that proceeding. WCD's decision to refer that "diagnostic" matter to the Hearings Division does not change the fundamental point that claimant could have presented such an argument before the issuance of our initial order.

Alternatively, we conclude that, even if we addressed claimant's request for remand, we would deny such a request. Here, we do not find any compelling reason to remand/consolidate this matter with claimant's case involving a medical services claim for diagnostic services for an accepted medial collateral ligament strain. We have previously held that we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together: *See, e.g., Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd* 139 Or App 512 (1996).

In this matter, however, the case which we have decided involves the compensability of a disputed condition, whereas the other case involves a diagnostic service under an accepted claim. Although claimant contends that the results of that diagnostic test may impact the merits of this compensability dispute, we find such an argument to be speculative. In other words, we are unable to find evidence that would be reasonably likely to affect the outcome of this case.[2] Accordingly, we conclude that claimant's request for remand and consolidation must be denied.

On reconsideration, as supplemented herein, we republish our February 18, 2000 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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[2] Claimant argues that if the diagnostic procedure is authorized, the results may affect that doctor's opinion in this case. Again, we find such an argument to be based on speculation and we do not find persuasive expert medical evidence to support claimant's contention.

May 17, 2000 Cite as 52 Van Natta 849 (2000)

In the Matter of the Compensation of
NOE ACEVEDO, Claimant
WCB Case No. 99-00717
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of his current low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a choker chaser, injured his low back on September 20, 1996 while picking up two chokers. (Ex. 1). He sought medical treatment and was diagnosed with an acute low back strain. (Exs. 2, 3, 4). SAIF accepted a disabling lumbar strain. (Ex. 7). A November 1996 MRI showed degenerative disc disease at L4-5. (Ex. 8). Dr. Hayes, claimant's attending physician, diagnosed degenerative disc disease and mechanical low back pain. (Exs. 9, 11, 12, 14, 17).

Dr. Hayes reported that claimant was medically stationary on March 14, 1997 and was able to perform his regular work. (Ex. 18). An April 29, 1997 Notice of Closure awarded temporary disability, but no permanent disability benefits. (Ex. 21).

Claimant continued to have low back pain. In June 1997, Dr. Hayes recommended a lumbar myelogram, which was within normal limits. (Exs. 24, 25). Dr. Hayes continued to diagnose degenerative disc disease and mechanical low back pain. (Exs. 26, 28, 30). In March 1998, Dr. Hayes recommended physical therapy. (Ex. 32).

On July 1, 1998, Dr. Delgado began treating claimant. (Ex. 35). He diagnosed a chronic lumbosacral strain and sacroilitis and recommended more physical therapy. (Exs. 37, 38, 39, 42).

On December 7, 1998, Dr. McKillop performed a records review on behalf of SAIF. (Ex. 45).

On December 11, 1998, SAIF issued a current condition denial on the ground that claimant's condition was not compensably related to the accepted lumbar strain. (Ex. 46). SAIF said that claimant's current need for treatment was for a degenerative low back condition and it asserted that the September 1996 injury was no longer contributing to claimant's need for treatment. (*Id.*)

On December 8, 1998, Dr. Bray examined claimant and performed an orthopedic evaluation. (Ex. 47).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's preexisting degenerative disc disease combined with the compensable injury and, therefore, claimant had the burden of proving that the combined condition was the major cause of his current need for treatment. The ALJ relied on Dr. McKillop's opinion and upheld SAIF's denial.

Claimant argues that the ALJ erred in relying exclusively on Dr. McKillop's opinion and improperly disregarding the contrary conclusions of Drs. Hayes and Bray. He contends that his September 1996 work injury remains the major contributing cause of his need for treatment.

In light 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). Absent persuasive reasons to do otherwise, we generally give deference to the opinion of a treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. Hayes.

Dr. Hayes began treating claimant in October 1996. (Ex. 5). He diagnosed degenerative disc disease and mechanical low back pain. (Ex. 9). He found that claimant was medically stationary in March 1997 and was able to perform regular work. (Ex. 18).

On April 11, 1997, Dr. Hayes agreed that it was medically probable that claimant's low back degenerative disc disease preexisted the September 1996 injury and combined with that injury. (Ex. 20-1). He also stated that claimant's injury of September 1996 remained the major contributing cause of his need for treatment and commented that claimants disc bulge may have been caused by the September 1996 injury. (*Id.*)

In a September 28, 1998 report subsequent to claim closure, Dr. Hayes indicated he did not agree that claimant had preexisting low back degenerative disc disease. (Ex. 33). In the same report, he agreed that degenerative disc disease was a factor in claimants disability and need for treatment, but he said the percentage was unknown. (*Id.*) Dr. Hayes agreed that the September 1996 injury was the major contributing cause of the combined condition, disability and need for treatment and he noted that claimant had not given a history of preexisting injury. (*Id.*)

For the following reasons, we are not persuaded by Dr. Hayes' opinion. In April 1997, he agreed that claimant's low back degenerative disc disease preexisted the September 1996 injury (Ex. 20-1), but in September 1998, he did not agree that claimant had preexisting low back degenerative disc disease. (Ex. 33). Because Dr. Hayes did not provide any explanation for his apparent change of opinion, it is not persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

Moreover, although Dr. Hayes said in September 1998 that claimant's September 1996 injury was the major contributing cause of his disability and need for treatment, the most recent chart note from Dr. Hayes was from November 1997.[1] Dr. Hayes said the percentage of claimant's degenerative

[1] We note that Dr. Hayes submitted a palliative care request in March 1998, but there is no accompanying chart note in the record. (Ex. 32).

disc disease was "unknown," but he did not explain why he believed that claimant's September 1996 injury continued to be the major contributing cause of his disability and need for treatment. Moreover, Dr. Hayes' comment that claimant's disc bulge may have been caused by the September 1996 injury expresses only a possibility, not a probability of medical causation. (Ex. 20-1). *See Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). We find that Dr. Hayes' opinion is not sufficient to establish that claimant's September 1996 injury remains the major contributing cause of his disability and/or need for treatment.

Claimant also relies on the opinion of Dr. Bray, who examined him on one occasion in December 1998. Claimant argues that the Causation and Apportionment section of Dr. Bray's report provides language sufficient to establish that his work injury is the major contributing cause of his disability and need for treatment.

Dr. Bray diagnosed claimant with a "[m]usculoligamentous sprain, lumbosacral spine, superimposed on degenerative disc disease of the lumbar spine" and an L4-5 disc bulge. (Ex. 47-7). In the Causation and Apportionment section of Dr. Bray's report, he said:

> "[Claimant] had a specific injury of September 20, 1996. The injury resulted in a Moderate/Severe sprain of his lumbar spine and development of a lumbar radiculopathy.
>
> "He was temporarily totally disabled until February 10, 1997, when he was released to modified work, as [sic] which time work of No Lifting Over 10 lbs., Repetitive Bending or Stooping, or Prolonged Sitting would have been appropriate if available. He was reasonably permanent and stationary as of March 14, 1997.
>
> "Apportionment is not indicated." (Ex. 47-8, -9).

Dr. Bray examined claimant on only one occasion and his opinion is not entitled to any deference as an attending physician. We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). A physician's opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516, 521-22 (1999). Here, however, we find that Dr. Bray did not address the issue of causation of claimant's current low back condition. Dr. Bray's report, when read as a whole, is not sufficient to establish compensability.

There are no other medical opinions that support compensability. Dr. McKillop concluded that claimants preexisting degenerative disc disease was the major contributing cause of claimants current disability and need for treatment. (Ex. 45-3). He adhered to that opinion in a deposition. (Ex. 46-28, -29). Based on this record, we find that claimant failed to meet his burden of proving that his September 1996 injury is the major contributing cause of his disability and/or need for treatment of his current low back condition.[2]

ORDER

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

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[2] In light of our disposition, we need not address claimant's request for an attorney fee and SAIF's argument concerning that request.

In the Matter of the Compensation of
ELIZABETH W. HARRISON, Claimant
WCB Case No. 99-03620
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
VavRosky, et al, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's occupational disease claim for right shoulder tendonitis. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant, age 46 at hearing, worked at the employer, a video store, as a purchasing assistant from May 1998 until April 1999. (Tr. 13). Her job duties entailed running weekly and monthly reports, calling stores to check on shipments, and placing special orders. (Tr. 13, 14). On average, she spent one-half to two-thirds of her time performing data entry and producing reports. The rest of her time, she did phone work. (Tr. 14). Claimant's computer duties increased somewhat because of the purchase from another store and the employer's bankruptcy. *Id.*

When off work, claimant and her family spent long hours at home playing video and computer games, and had done so for a number of years. (Ex. 16-8). Claimant would play 2-4 hours a night and 6-7 hours on the weekends. (Ex. 16-9). The computer games claimant played involved use of both a computer keyboard and a mouse, which she used with her right hand. (Tr. 30, 31). Claimant also played games by using a controller held in both hands and operated with both thumbs. (Tr. 32, 33).

In about January or February 1999, claimant experienced occasional aching in her right shoulder, elbow and arm that became constant and extended into her thumb by about the middle of March 1999. (Ex. 16-5; Tr. 15, 16). On March 30, 1999, she sought medical treatment. Dr. Maroney found tenderness around the biceps tendon and forearm, which he diagnosed as tendinitis and referred claimant to occupational medicine. (Ex. 1). Claimant did not return to work; her last day of work was March 26, 1999. Claimant also stopped using her computer and video games at home. (Tr. 36).

On April 8, 1999, claimant returned for further treatment after waking with severe pain radiating down the arm and into the top of the hand with any right arm movement. (Ex. 3). Dr. Ingle diagnosed tendinitis. *Id.*

On May 3, 1999, claimant was seen by Dr. Peacock, occupational physician. (Ex. 9). He noted that claimant's shoulder had been progressively uncomfortable for several weeks. Dr. Peacock diagnosed claimant's condition as rotator cuff tendinitis, but reported this was not the usual work-related injury and that he was hard pressed to say that claimant's condition was work related. *Id.*

On May 17, 1999, x-rays revealed calcific tendinitis and early glenohumeral and acromioclavicular joint degenerative changes. (Ex. 12B).

On May 20, 1999, Dr. Woodward, orthopedic surgeon, evaluated claimant for the insurer. (Ex. 14). Dr. Woodward diagnosed claimant's condition as right shoulder tendinosis, due to age-related degeneration of her rotator cuff. (Ex. 14-6). Dr. Peacock concurred with Dr. Woodward's findings and conclusion. (Ex. 15B).

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. McDonald's opinion and concluded that claimant had established that her right shoulder tendinitis was a compensable occupational disease. On review, the insurer contends that claimant's workload did not increase and that claimant had not established that her work activities were the major contributing cause of her right shoulder condition. We agree.

Claimant contends that her right shoulder pain resulted from an increased work load at the employer at the beginning of 1999. Claimant admitted that toward the end of 1998, her computer work had slowed down because there were no funds to buy videos. (Tr. 23). She also testified that she was required to generate more reports in 1999 because of the employer filing for bankruptcy. (Tr. 25). These were spreadsheet reports for which she used a mouse rather than the keyboard. (Tr. 26). Claimant also testified that she was required to input special orders each week. (Tr. 46).

But claimant's supervisor pointed out that, because the purchasing department had no money to purchase new videos in 1999, claimant's normal workload, producing purchase orders and other reports, had also dropped off in 1999, due to the lack of funds. (Tr. 38, 39). Claimant's supervisor agreed that claimant had to produce some new reports as a result of the bankruptcy, but these were automated spreadsheet reports. The supervisor also testified that, during the bankruptcy period, claimant took several breaks each morning and afternoon. (Tr. 45). Claimant did not dispute the supervisor's testimony about the increased breaks, indicating that she had more time for breaks rather than less. And because of the employer's bankruptcy and lack of funds, it appears that the time claimant spent inputting special orders was minimal, which is more in accord with claimant's testimony that her computer duties increased only "somewhat" in 1999.

Claimant has the burden of proving compensability of her occupational disease claim. ORS 656.266. In order to do so, she must prove that her work activities were the major contributing cause of her right shoulder tendinitis. ORS 656.802(2)(a). "Major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *Dietz v. Ramuda*, 130 Or App 387 (1994), *rev dismissed* 321 Or 416 (1995); *McGarrah v. SAIF*, 296 Or 145, 166 (1983). 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.

Here, Dr. McDonald initially concluded that claimant's shoulder condition was caused in major part by her work activities. (Ex. 16). However, during his deposition, he modified his initial opinion and did not thereafter opine that claimant's work was the major cause of her condition.

Claimant testified that she was required to generate more spreadsheet reports, which entailed increased use of the mouse but not increased keyboarding. (Tr. 26). When Dr. McDonald was advised that claimant's increased work load involved more mouse usage, he testified that this information changed his impression of claimant's job duties and led him to discount the effect of claimant's job, especially in light of her lack of overhead lifting. (Ex. 17-10). He concluded that claimant's work activities would not be the major cause of her condition. (Ex. 17-11). Dr. McDonald also explained that it would be unusual for rotator cuff tendinitis to be caused by keyboarding, and that claimant's calcific tendinitis and degenerative changes in the shoulder joint would be the more likely cause of claimant's condition. *Id.*

Dr. McDonald subsequently agreed that a low placement of claimant's chair at work combined with use of the mouse on her desk at a high placement would be important to consider. Dr. McDonald stated that shoulder injuries could be caused by an incorrect arm angle and that if the claimant carried her arm at not quite shoulder level, it would have an effect. (Ex. 17-13). But claimant did not establish the level she carried her arm or the angle at which she used her mouse at her desk. Moreover, Dr. McDonald did not opine that claimant's use of a computer mouse under either of these circumstances was the major contributing cause of her shoulder condition. Rather, he explained that, if claimant was reaching at or below breast level, there would not be much impact on her shoulder. And he also explained that, if claimant's desk were only a little too high, he would expect her symptoms to start in the ulnar area of her elbow. (Ex. 17-17). Therefore, because claimant did not establish the level at which she was reaching or the height of her desk in relation to her chair, and Dr. McDonald did not opine that claimant's increased mouse use was the major cause of her right shoulder tendinitis, claimant has failed to meet her burden of proof.

The other doctors who treated or examined claimant, Dr. Woodward and Dr. Peacock, agreed that claimant suffered from right shoulder tendinosis, due to age-related degeneration of her rotator cuff. (Ex. 14-6). As Dr. Woodward explained, tendinosis of the shoulder has not been related to keyboarding, and, most importantly, claimant did not show any improvement in her condition despite not working for almost eight weeks, a factor not considered by Dr. McDonald.

In sum, we conclude that claimant has failed to establish that her work activities were the major contributing cause of her right shoulder tendonitis condition. Therefore, we reverse the ALJ's order.

ORDER

The ALJ's order dated November 19, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

The majority finds that claimant failed to prove a compensable occupational disease. Because Dr. McDonald's opinion is well-reasoned and based on an accurate history, I would affirm the ALJ's determination that claimant satisfied her burden of proof.

As discussed by the ALJ, Dr. McDonald attributed claimant's right upper extremity complaints to rotator cuff tendinitis caused in major part by her use of a computer mouse at work. Dr. McDonald's opinion was based on the assumptions that, in using the mouse, claimant extended her right arm above the optimum angle and that her computer mouse use at work increased in early 1999.

The ALJ found that Dr. McDonald's opinion was based on an accurate history of claimant's work activity at the onset of her symptoms. The ALJ further found that claimant's testimony was consistent with the work history she had provided throughout the course of the claim. The ALJ further found that the testimony of claimant's supervisor that claimant's work load decreased was no better than speculative, as he did not base his testimony on his personal knowledge of claimant's work activity during the period in question, but, instead, was based solely on the fact that the employer's routine puchasing activity decreased during this period.

In contrast, the ALJ correctly noted that claimant did not associate the onset of her symptoms with an increase in her routine purchasing activity, but on the increase in her overall computer use in preparing special reports associated with the employer's pending bankruptcy.

The ALJ's assessment of the parties' testimony indicates that she found claimant's testimony to be credible and that claimant provided an accurate history to Dr. McDonald. Because Dr. McDonald's opinion on causation was based on claimant's credible and accurate history, I would defer to his opinion as the treating physician.

Finally, I noted that claimant has the burden of proving, by a preponderance of the evidence, that her claim is compensable. In this case, the *preponderance* of the evidence establishes that claimant's work activities were the major contributing cause of her medical condition. In this case, however, the majority has disregarded that measurement and applied a more stringent burden of proof. The majority errs in not finding this claim compensable. Therefore, I respectfully dissent.

In the Matter of the Compensation of
JEWELL F. RAMIREZ, Claimant
WCB Case No. 99-06550
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Steven T. Maher, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

Relying primarily on the opinion of the attending physician, Dr. Bergquam, the ALJ set aside the insurer's denial, finding that claimant's work activities as a data entry clerk were the major contributing cause of her bilateral carpal tunnel condition.

On review, the insurer contends that the ALJ incorrectly set aside the denial. It asserts that the ALJ's reliance on Dr. Bergquam's opinion was misplaced because Dr. Bergquam never opined that claimant's condition was work related on a bilateral basis and because there is no temporal relationship between claimant's right-sided symptoms and her work exposure. The insurer also contends that, while claimant's symptoms arose on the left side, her work activity was primarily right-handed. Therefore, the insurer argues that claimant's carpal tunnel condition is not work-related, but rather is due to predisposing factors such as diabetes, obesity or family history. For the following reasons, we do not find the insurer's contentions persuasive.

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). Here, we do not find persuasive reasons not to give greater weight to Dr. Bergquam's opinion.

Although Dr. Bergquam opined that work activities were the major contributing cause of claimant's "carpal tunnel," she did not explicitly state that those activities were the major cause of *bilateral* carpal tunnel syndrome. (Ex. 15A). Dr. Bergquam, however, was provided with the report of examining physicians, Drs. Arbeene and Bell, who diagnosed bilateral carpal tunnel syndrome. (Ex. 13-5). In addition, Dr. Bergquam also reviewed the nerve conduction studies performed by Dr. Cassini that revealed bilateral entrapment neuropathy of the median nerve. (Ex. 15). Under these circumstances, we are persuaded that Dr. Bergquam was referring to *bilateral* carpal tunnel when she confirmed that work activities were the major contributing cause of the carpal tunnel condition. (Ex. 15A).

Moreover, contrary to the insurer's assertion that claimant's right-sided symptoms did not arise until after she ceased her employment, claimant reported to an insurance investigator that she experienced bilateral symptoms while she was working. (Ex. 11-8). In addition, claimant credibly testified that her bilateral symptoms arose during her employment and that she was given splints for both hands. (Tr. 10). Finally, claimant reported to the examining physicians that she experienced symptoms in both hands while performing her job duties. (Ex. 13-2). Having reviewed this record in its entirety, we are persuaded that claimant's right-sided symptoms, while not as severe as those on the opposite side, did arise during her employment.

Finally, we are persuaded that claimant's employment involved substantial left-sided work activity. Claimant credibly testified that her work involved repetitive typing and entering work with both hands. (Tr. 9, 15). Claimant's supervisor also testified that a part of claimant's work activities called "keying" also involved repetitive use of the fingers and "hands." (Tr. 31).

Accordingly, we conclude that Dr. Bergquam's opinion was supported by an accurate history of substantial bilateral hand activity in her employment. Therefore, we agree with the ALJ that Dr. Bergquam's opinion is persuasive and establishes the compensability of the bilateral carpal tunnel claim. Thus, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,450, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs and counsel's statement of services), the complexity of the compensability issue, and the value of the interest involved.[1]

ORDER

The ALJ's order dated December 14, 1999 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,450, to be paid by the insurer.

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[1] Claimant's attorney is not entitled to an attorney fee for services concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986). Moreover, we do not compensate claimant's counsel for time spent preparing the affidavit and log in support of the attorney fee request.

In the Matter of the Compensation of
CONNIE L. SCHERER, Claimant
WCB Case No. 99-06720
ORDER ON REVIEW
J. R. Perkins III, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) declined to reinstate claimant's temporary disability; and (2) declined to assess a penalty for the insurer's allegedly unreasonable claim processing.[1] On review, the issues are temporary disability and penalties. We adopt and affirm the ALJ's order with the following supplementation.

Temporary Disability

At the time of her compensable injury, claimants regular work had been as a certified nurses' aide on the day shift. The insurer terminated claimant's temporary total disability (TTD) after she refused to accept modified work folding laundry on the ground that she was taking medication for conditions unrelated to her claim that made her too sleepy to work the graveyard shift. Claimant's attending physician, Dr. Irvine, had opined that claimant was physically capable of folding laundry, but that taking medicine when she finished the night shift would be of detriment to her. (Ex. 13). Dr. Irvine later stated that he did not explicitly instruct claimant to refuse modified work on the graveyard shift, but that he did believe that her medical conditions of migraine headaches and insomnia would have been worsened. (Ex. 25).

Concluding that the attending physician had indicated that folding laundry was within claimant's capabilities as that term is used in OAR 436-060-0030(5)(b)[2], and citing *Brent L. Marlatt*, 50 Van Natta 2369 (1998), the ALJ determined that the insurer properly terminated claimant's TTD when she refused to accept modified work folding laundry. On review, claimant contends that *Marlatt* is distinguishable and that, while Dr. Irvine stated that claimant had the physical capacity of folding laundry, this employment was not within her capabilities under OAR 436-060-0030(5)(b) because of her medication requirements for other medical conditions.

We agree, however, with the ALJ's reasoning with respect to the application of the administrative rule. Moreover, we agree with the ALJ that *Marlatt* is instructive.

In *Marlatt*, the claimant requested to continue working at light duty work during the swing shift and refused to accept a new light duty job. The sole reason for the claimant's refusal was that his child-care arrangements interfered with his ability to work during the "regular shift" because his wife also worked during that shift, which would necessitate obtaining child-care, an option that the claimant found economically unfeasible. When the claimant refused the new light work job, the employer stopped paying his wages, but continued paying him the temporary disability he would have received if he had accepted the new light duty job. The claimant requested a hearing.

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[1] With her appellant's brief, claimant has attached documents not admitted into evidence. However, our review is limited to the record developed before the ALJ. *See* ORS 656.295(5). Therefore, we have not considered claimant's submission on review.

[2] 436-060-0030(5) provides that:

"An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the worker had begun the employment when an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:

"(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;

"(b) The attending physician agrees the employment appears to be within the worker's capabilities; and

"(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."

At hearing, the claimant argued, in part, that, given his child care circumstances, the change of shift in the new light duty job offer was unreasonable, and the employer should have commenced payment of TTD when it no longer offered him a light duty position on the swing shift. Relying on *Glenda Jensen*, 50 Van Natta 346, *on recon* 50 Van Natta 1074 (1998), *aff'd mem Jensen v. Liberty Northwest Insurance Corporation*, 161 Or App 198 (1999), the ALJ rejected the claimant's arguments.

In *Jensen*, the claimant refused a modified job offer approved by her attending physician because the shift offered conflicted with the claimant's child-care arrangements. Specifically, the claimant's husband (due to his work schedule) would not be able to watch their children during some of the offered shift. The claimant asked if she could accept the position at a different shift and was told that it was not possible. Based on the claimant's refusal of the employer's job offer, the insurer terminated TTD.

We found in *Jensen* that the employer had complied with all of the statutory and regulatory requirements for terminating TTD benefits. Specifically, we reasoned that the employer had offered the claimant a modified job that was within her physical capabilities and had been approved by her attending physician, and the claimant had refused the offer. Therefore, we found that the insurer was authorized to terminate TTD benefits pursuant to ORS 656.268(3)(c). While we understood that the claimant had legitimate family needs that outweighed her interest in accepting the available modified employment, we found that her decision represented a personal choice based on considerations that were outside the parameters of the statute and rules authorizing termination of TTD benefits. We concluded that neither the statutes nor rules require an employer to offer modified work at the same work shift as the job at injury.

We applied the *Jensen* reasoning in *Marlatt*. The fact that the claimant in *Marlatt* was working at a modified job and was being paid temporary partial disability benefits when he refused the changed light duty job offer did not change the result. Because the employer in *Marlatt* complied with ORS 656.268(3)(c) and OAR 436-060-0030(5), it was entitled to continue paying temporary partial disability after the claimant refused the changed light duty job offer. We determined that the employer in *Marlatt* was not required to offer modified work at the same work shift as the job at injury, nor was it required to begin paying TTD when the claimant refused the changed modified job offer.

Unlike the claimants in *Jensen* and *Marlatt*, who declined modified work on different work shifts because of child-care considerations, claimant in this case has declined to accept modified work on a different shift for medical reasons. We do not believe that this distinction requires a different result. Both *Marlatt* and *Jensen* are clear. An employer is not required to offer modified work during the same work shift as the job at injury. In accordance with those cases, we conclude that the employer in this case was not required to offer modified work during the same work shift as the job at injury.

Moreover, it is well-settled that a carrier may properly terminate temporary disability when a claimant refuses a modified job for reasons unrelated to the compensable injury. *See Roseburg Forest Products v. Wilson*, 110 Or App 72, 75 (1991). In this case, claimant has declined to accept modified work because of medication requirements for noncompensable medical conditions. Thus, claimants loss of wages is not due to the compensable injury. Therefore, under *Wilson*, she is not entitled to temporary disability, regardless of the legitimacy of her reasons for declining modified work on the graveyard shift.[3]

Penalty

During closing argument, claimant sought a penalty for the employer's allegedly unreasonable claim processing. The insurer asserted that the penalty issue had been waived because the issue had not been raised until closing argument. *See Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995). The ALJ did not directly address the waiver issue, reasoning that, even if the termination of temporary disability had been improper, that conduct would not have been unreasonable under existing case law.

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[3] In her appellant's brief and before the ALJ, claimant argued the applicability of the Americans with Disability Act (ADA). In her reply brief, claimant concedes that this is not the proper forum for an ADA claim. Claimant is correct. *See Tricia C. Wagner*, 51 Van Natta 755 (1999); *Sandra J. Way*, 45 Van Natta 876 (1993), *aff'd on other grounds Way v. Fred Meyer, Inc.*, 126 Or App 343 (1994).

On review, claimant asserts that she did not waive the penalty issue because it was raised in her hearing request and evidence and argument was offered at hearing on the issue. Claimant contends that she is entitled to a penalty under ORS 656.262(11)(a) based on evidence that the initial payment of temporary disability was untimely. (Ex. 15). The insurer again asserts that the penalty issue was waived because it was not raised until closing argument. We agree with the insurer.

In *Clifford D. Cornett*, 51 Van Natta 1430 (1999), the claimant raised a penalty issue in the pleadings. But, when specifically asked by the ALJ at hearing whether there were any issues to be decided in addition to compensability and responsibility, the claimant's counsel expressly stated that compensability and responsibility were the only issues raised. Considering the "totality of circumstances," we concluded that the claimant waived the penalty issue and reversed the ALJ's assessment of a penalty under ORS 656.262(11)(a). We cited *Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 688 (1995), *on remand Connie M. Johnson*, 48 Van Natta 239 (1996) (whether a "waiver" has occurred must be ascertained from the "totality of the circumstances").

Here, claimant did raise the issue of penalties in her hearing request. However, the issue was not addressed in her hearing memorandum. In addition, at the hearing, claimant was specifically asked by the ALJ at the commencement of the proceedings what issues she was raising. Claimant stated Procedural TTD and the final date of TTD. (Tr. 1). Considering the totality of the circumstances, we find that claimant in this case, like the claimant in *Cornett*, waived the penalty issue.[4]

ORDER

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

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[4] Claimant asserts that evidence admitted which establishes that the insurer's initial temporary disability payment was untimely is proof that she intended to litigate the penalty issue. The evidence to which claimant cites (Ex. 15) was submitted by the insurer, however. Moreover, while the exhibit does contain a concession by the insurer that the initial payment of temporary disability was untimely, that exhibit was also relevant to the merits of the temporary disability issue.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's decision that claimant was not entitled to temporary disability when she declined modified employment on the graveyard shift for medical reasons. Because this case is distinguishable from those on which the majority relies, I would find that the insurer improperly terminated temporary disability in this case.

The claimants in *Brent L. Marlatt*, 50 Van Natta 2369 (1998) and *Glenda Jensen*, 50 Van Natta 346, *on recon* 50 Van Natta 1074 (1998), *aff'd mem Jensen v. Liberty Northwest Insurance Corporation*, 161 Or App 198 (1999), declined modified work on a different shift because of a personal choice. Unlike those workers, claimant, here, had no alternative but to decline modified work on the graveyard shift. Refusing modified work because of a medical condition, in contrast to refusing such work because of child-care difficulties, is not the result of a personal choice. I, therefore, conclude that this case requires a different result from *Jensen* and *Marlatt*. For this reason, I respectfully dissent.

In the Matter of the Compensation of
DIANN K. THURSTON, Claimant
WCB Case No. 99-06544
ORDER ON REVIEW
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum'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," except for the last paragraph and the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer making paintbrushes since 1987. For the past two years, she worked as a material handler in the finishing department. In this position, she placed brushes in shipping boxes and assembled and taped the boxes.

Claimant used a manual tape dispenser to tape the filled boxes, then carried and/or stacked the boxes. Filled boxes weigh between 35 and 70 pounds. Claimant carried boxes with her right hand underneath and her left hand on top. Her work was repetitive.

Claimant's right elbow began to hurt when carrying boxes. After about a year of elbow pain, in February 1999, claimant also developed immobilizing right shoulder pain. She sought medical treatment. Electrodiagnostic testing suggested bilateral carpal tunnel syndrome and x-rays revealed right shoulder calcific tendinitis. Dr. Kelly provided conservative treatment.

Claimant filed claims for right shoulder tendinitis and pain at the ulnar nerve of the right elbow, which the insurer denied.

The ALJ found that claimant failed to prove the right elbow claim, because she found no medical evidence supported by objective findings[1] that established the right elbow complaints as an occupational disease.

With regard to the right shoulder claim, the ALJ found that

> "even without a specific opinion on causation from Dr. Kelly, and notwithstanding Dr. Scheinberg's opinion to the contrary, the evidence proves that more likely than not, claimant's shoulder tendinitis was caused by her work activities."

The ALJ reasoned that claimant had no preexisting right shoulder conditions and no off-work activities that could have caused her condition. The ALJ noted that Dr. Kelly accurately described claimant's work and did not question claimant's truthfulness, symptoms, or the nature of her work. The ALJ further noted that Dr. Kelly provided treatment for claimant's symptoms and ordered modified work duties. Considering Dr. Kelly's chart notes as a whole, the ALJ concluded that Dr. Kelly believed that claimant's work caused her tendinitis.[2]

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[1] The ALJ specifically noted negative elbow and ulnar nerve test results. Claimant, *pro se*, does not challenge the ALJ's reasoning or conclusion regarding her elbow claim.

[2] The ALJ also found Dr. Scheinberg's contrary opinion unpersuasive because it was entirely conclusory, reasoning that she was not required to accept even an uncontradicted medical opinion.

Considering claimant's multiple upper extremity symptoms and diagnoses, we find that the causation issue regarding claimant's disputed right shoulder tendinitis is medically complicated. *Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985), *rev den* 300 Or 546 (1986). Under these circumstances, medical causation must be established by expert evidence. *Id.* Because there is no expert evidence indicating that claimant's work was the major cause of her right shoulder condition, we conclude that the claim must fail. *See Rashell A. Terranova*, 51 Van Natta 1496 (1999) (absent medical evidence establishing that the claimant's work activities were the major contributing cause of her condition, medically complex claim failed); *John Kunsman*, 50 Van Natta 2299 (1998), *aff'd mem* 161 Or App 198 (1999) (same).

ORDER

The ALJ's order dated December 7, 1999 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's claim for a right shoulder tendinitis condition is reversed. The denial is reinstated and upheld. The remainder of the order is affirmed.

Board Member Meyers specially concurring.

I agree that claimant's occupational disease claim is not compensable without supporting medical evidence.

I am also mindful that claimant has appeared on Board review without benefit of legal representation and an unrepresented party is not expected to be familiar with Workers' Compensation Law. Under such circumstances, if claimant has further questions, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. The Ombudsman may be contacted, free of charge, at 1-800-927-1271, or written to at Department of Consumer and Business Services, Workers' Compensation Ombudsman, 350 Winter St. NE, Salem, OR 97310.

In the Matter of the Compensation of
NGA H. BURSON, Claimant
WCB Case No. 98-08574
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Spangler's order that reclassified claimant's occupational disease claim from nondisabling to disabling. On review, the issue is claim reclassification. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following exception and correction. We do not adopt the ALJ's ultimate findings of fact. At the time of the hearing, the employer was self-insured. Previously, however, the employer was insured by Hartford. On March 11, 1997, Hartford denied compensability of and responsibility for claimant's occupational disease claim for a left lateral epicondylitis condition.

CONCLUSIONS OF LAW AND OPINION

On January 19, 1996, claimant first sought medical treatment for her left elbow condition. Subsequently, claimant filed a workers' compensation claim against the employer, who was insured by Hartford at that time. On March 11, 1997, Hartford denied compensability of and responsibility for claimant's occupational disease claim for a left lateral epicondylitis condition. Subsequent litigation determined that claimant's occupational disease claim for a left lateral epicondylitis condition was compensable against Hartford, as the insurer for the employer. (Exs. 8, 9).

On September 30, 1998, the employer accepted the claim for left lateral epicondylitis as a nondisabling claim. (Ex. 10). On October 8, 1998, claimant requested that the Department reclassify the claim as disabling. The Department found that it had no authority to review or issue a determination order because claimant's request for reclassification was made more than a year after the date of injury. (Ex. 12). Claimant requested a hearing.

Relying on *Donald R. Dodgin*, 45 Van Natta 1642 (1993), the ALJ found that the employer had accepted claimant's claim more than one year after the date of her injury and, thus, it was through no fault of claimant's that she did not request reclassification of the claim within a year from the date of injury. Accordingly, the ALJ found that claimant's request for reclassification, which was filed eight days after the employer's acceptance of the claim, was timely. The employer requested review.

Subsequent to the ALJ's decision, the court issued *Alcantar-Baca v. Liberty Northwest Insurance Corp.*, 161 Or App 49 (1999), and *Shaw v. Paccar Mining*, 161 Or App 60 (1999). *Alcantar-Baca* applied to an injury claim and *Shaw* applied to an occupational disease claim. Both cases held that the unambiguous language of ORS 656.277(2)[1] requires that "a request for reclassification made more than one year after the date of injury *must* be made 'pursuant to ORS 656.273 as a claim for aggravation.' That language admits to no exceptions -- equitable or otherwise." *Shaw*, 161 Or App at 65 (emphasis in original); *see also Alcantar-Baca*, 161 Or App at 58-9. Both cases also determined that our reasoning in *Dodgin*, which provided for an equitable exception to the one year requirement to request reclassification, was erroneous. *Shaw*, 161 Or App at 65; *Alcantar-Baca*, 161 Or App at 59 fn7. Furthermore, as the court explained, the "date of injury in an occupational disease claim is either the date of disability or the date when medical treatment is first sought." *Shaw*, 161 Or App at 63 fn 1 (quoting *Papen v. Willamina Lumber Co.*, 123 Or App 249, 254, *rev den* 319 Or 81 (1994)).

Thus, here, the "date of injury" for claimant's left elbow occupational disease claim was January 19, 1996, the date claimant first sought treatment for her left elbow condition. Following litigation that found claimant's occupational disease claim compensable, the employer accepted the claim as a nondisabling left lateral epicondylitis condition on September 30, 1998. Shortly thereafter, claimant requested the Director to reclassify the claim as disabling. But because claimant's request for reclassification was made more than a year after the "date of injury," it *must* be made under ORS 656.273 as a claim for aggravation. ORS 656.277(2).

Finally, claimant did not alternatively raise an "aggravation" issue. Rather, at hearing and on review, claimant *solely* raised a challenge to the nondisabling classification. As explained above, because this challenge was raised more than a year after the date of injury, it is too late.[2] *See John B. Shaw, Sr.*, 52 Van Natta at 64; *Robert E. Kelly*, 52 Van Natta 25 (2000). Therefore, claimant is not entitled to have her claim reclassified as disabling.

ORDER

The ALJ's order dated February 26, 1999, as reconsidered on April 6, 1999, is reversed. The ALJ's attorney fee award is also reversed.

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[1] ORS 656.277 provides, in relevant part:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.

"(2) A claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation."

[2] We note that the 1999 legislature has amended ORS 656.277 to address the issue raised by claimant in this case. *Amended* ORS 656.277 provides that a request for reclassification by the worker of an accepted, nondisabling injury that the worker believes was or has become disabling must be made pursuant to ORS 656.273 as a claim for aggravation if the request is made more than one year after the date of acceptance (rather than more than one year after the date of injury). Or Laws 1999, ch 313, Sec. 3(2) (SB 220, Sec. 3). However, the legislature did not express any intention that the amended statute be applied retroactively. Thus, *amended* ORS 656.277 does not apply to claimant's claim. *See John B. Shaw, Sr.*, 52 Van Natta 63, 64 fn4 (2000).

In the Matter of the Compensation of
JOHNNY J. CAROLUS, Claimant
WCB Case No. 99-03345
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Sather, Byerly & Holloway, 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 denials of claimant's current cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the last paragraph on page 2 that continues on page 3, we change the last sentence to read: "Claimant had a successful result from surgery and has been performing a different job in quality assurance since his return to work." We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

There were two primary issues at hearing: claim preclusion and compensability. The ALJ found that claimant's failure to appeal the employer's March 20, 1996 denial of his cervical condition had no preclusive effect on his current occupational disease claim. Based on the opinion of Dr. Ordonez, the ALJ found that claimant's work activities were the major contributing cause of a pathological worsening, disability and need for treatment of his cervical condition.

On review, the employer argues that the doctrine of claim preclusion bars the 1999 claim and, in any event, claimant has failed to prove compensability under ORS 656.802. We need not address the employer's claim preclusion argument because we find that claimant's claim for a cervical condition fails even if it is not precluded.

We briefly recap the history of claimant's cervical symptoms. Claimant has worked for the employer since 1984 performing different jobs. In July 1995, he filed a claim for a right shoulder injury dating back to March 1993. (Ex. 1). Claimant was working in quality assurance and related his problems to testing he had performed on the fifth wheel assembly. (Tr. 6, 7). He had to open the fifth wheel of each vehicle, some of which needed to be pulled quite hard. (*Id.*) A cervical MRI on July 27, 1995 showed extensive anterior spurs at C3 through C7 and posterior interbody spurs at C4-5. (Ex. 3). Dr. Ordonez first examined claimant on August 29, 1995. (Ex. 4). He felt that claimant's symptoms suggested C5 radiculopathy due to stenosis at C4-5 and he discussed the possibility of surgery. (Exs. 4-3, 5). The employer denied the claim on March 20, 1996. (Ex. 10). Claimant did not appeal the denial.

Claimant testified that his pain did not resolve. (Tr. 8). In 1996, he changed jobs and became an electrician. (*Id.*) The pain subsided, although he continued to have numbness in the shoulder. (Tr. 8-9). In December 1998, he returned to the quality assurance department. (Tr. 9-10). His job duties included test driving vehicles, pulling on the fifth wheels and pulling hoods over (weighing up to 170 pounds). (*Id.*) Claimant's condition worsened from just a shoulder and neck problem to include his elbow and hand. (Tr. 11).

On March 8, 1999, claimant again sought treatment from Dr. Ordonez. (Ex. 16). Dr. Ordonez believed that claimant had C5 radiculopathy on the right, most likely caused by a C4-5 disc herniation. (Ex. 16-2). Dr. Ordonez performed cervical surgery on May 5, 1999. (Ex. 29). Claimant's symptoms improved after the surgery. (Tr. 10, Exs. 29A, 33-3).

Claimant relies on the opinion of Dr. Ordonez, his treating physician, to establish compensability of his occupational disease claim. Claimant agrees that his preexisting degenerative cervical condition combined with his work activities. He asserts that he has carried his burden of proof that the work activities were the "major cause of the pathologically, worsened cervical condition." (Claimant's br. at 10).

We agree with the employer that ORS 656.802(2)(b) applies to this case. Dr. Ordonez believed that claimant had a combined condition and that his preexisting degenerative cervical condition was pathologically worsened by his work activities. (Ex. 33-4). Under ORS 656.802(2)(b), claimant must

prove that his employment conditions were the major contributing cause of the combined cervical condition *and* pathological worsening of the disease.

A determination of the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). The fact that work activities may be the precipitating cause of a claimant's disability or need for treatment does not necessarily mean that work was the major contributing cause of the condition. *Id.*

In light of the multiple possible causes of claimant's cervical condition, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 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. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. Ordonez.

Dr. Ordonez first examined claimant on August 29, 1995. (Ex. 4). He said that the July 27, 1995 MRI showed C4-5 stenosis on the right, spondylitic changes at several levels, and disc degeneration at C4-5, C5-6 and C6-7. (Ex. 4-3). He felt that claimant's symptoms were suggestive of C5 radiculopathy due to stenosis at C4-5. (*Id.*) Dr. Ordonez discussed the possibility of surgery with claimant. (Ex. 5).

After reviewing a September 18, 1995 report from Drs. Snodgrass and Duff, Dr. Ordonez agreed with their diagnosis of "degenerative cervical spine disease with multiple level anterior spur formation and one level right posterior spur, C4-5." (Ex. 7-1). Dr. Ordonez did not agree that the major contributing cause of claimant's need for treatment was related to cervical degenerative disc disease. (Ex. 7-2). On October 5, 1995, Dr. Ordonez explained:

> "While [claimant's] underlying spine condition was not caused by his work, the need for treatment is directly related to the injury of March 1, 1995. He had no symptoms prior to that incident and it remains the major contributing cause to his persistent cervical spine and upper extremity symptoms and need for medical treatment." (Ex. 8).

Dr. Ordonez later said that the previous reference should have been to a March 1, 1993 injury, rather than a March 1, 1995 injury. (Ex. 9).

In March 1999, claimant again sought medical treatment for his cervical symptoms and Dr. Ordonez became his attending physician. (Exs. 15, 16). He said the March 12, 1999 MRI showed a new defect at C4-5 on the right, the "old defect at C4-5" and a new defect at the C6-7 region. (Ex. 18). He recommended a repeat MRI and nerve conduction studies. Dr. Ordonez found that the March 19, 1999 MRI showed multiple level defects at C3-4, C4-5, C5-6 and C6-7. (Ex. 24). He performed surgery on May 5, 1999 and his postoperative diagnosis was "C3-4, C4-5, C5-6 and C6-7 nerve root canal narrowing with the worst or most affected level at the C4-5 level, right, and, to a lesser degree, the C5-6 and C6-7 also affected." (Ex. 29).

In a November 22, 1999 report, Dr. Ordonez referred to the September 18, 1995 report from Drs. Snodgrass and Duff and said it indicated claimant's right shoulder and arm problems had resolved at that time. (Ex. 33-3). Dr. Ordonez reasoned that if the September 18, 1995 report was correct, then all of claimant's symptoms and physical and radiological findings had developed since that time. (*Id.*) He explained that claimant had returned to truck driving in October 1998 and experienced a new onset of symptoms. (Ex. 33-4). Dr. Ordonez concluded that claimant's symptoms and need for treatment were a "direct result" of his work activities. (*Id.*) He explained:

> "I believe that [claimant's] current condition, listed in the denial of 4/23/99 as a pre-existing degenerative condition of the cervical spine, and in the 5/5/99 operative report as C3-4, C4-5, C5-6 and C6-7 nerve root canal narrowing with the worst or most affected level at the C4-5 level, right, and to a lesser degree, the C5-6 and C6-7 levels, has suffered a pathological worsening due to the work activities he performed at [the employer] as outlined in the patient's detailed job history. I further believe that the decreased strength in the right upper extremity, decreased right biceps reflex, and decreased sensation along the C5 nerve root on the right represent a pathological worsening of the combined condition beyond what was noted in my records and the IME report from 1995." (*Id.*)

Although Dr. Ordonez believed that claimant's work at the employer had pathologically worsened his cervical condition, his opinion does not establish that the work activities were also the major contributing cause of the combined condition as required by ORS 656.802(2)(b). In his October 5, 1995 report, Dr. Ordonez explained that claimant's "underlying spine condition was not caused by his work," although he felt that claimant's need for treatment at that time was related to the March 1993 injury. (Exs. 8, 9). In his November 22, 1999 report, Dr. Ordonez said that claimant's "symptoms and need for treatment including surgery in May 1999" were a direct result of his work activities (Ex. 33-4), but he did not explain whether the combined cervical condition itself was caused, in major part, by claimant's work activities.

We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). A physician's opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516, 521-22 (1999).

Here, however, we find that Dr. Ordonez's opinion is not sufficient to establish that claimant's employment conditions at the employer were the major contributing cause of the combined cervical condition *and* pathological worsening of his disease. Moreover, Dr. Ordonez's opinion is not persuasive because he did not evaluate and explain the relative contribution of other causes, particularly the preexisting cervical condition. His opinion on causation is confusing in light of his October 5, 1995 report, which said that claimant's "underlying spine condition was not caused by his work[.]" (Ex. 8). The determination of the major contributing cause requires evaluation of the relative contribution of different causes, both work-related and preexisting. *See Dietz*, 130 Or App at 402-03.

None of the other medical opinions support compensability of claimant's current cervical condition. Dr. Woodward concluded that the major contributing cause of claimant's cervical condition was the preexisting degenerative cervical condition. (Ex. 26-8). In a concurrence letter from the employer, Dr. Weller agreed that claimant's primary problems were the prominent anterior osteophytes at C3-4, C4-5, C5-6 and C6-7, which he believed were idiopathic, age-related changes. (Ex. 32-2).

In sum, we conclude that claimant has failed to establish that his employment conditions were the major contributing cause of his combined cervical condition and pathological worsening of the disease. *See* ORS 656.802(2)(b). We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated December 28, 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.

Because I agree with the ALJ's conclusion that claimant has sustained his burden of proving compensability of his current cervical condition, I respectfully dissent.

We must review the expert medical opinion in the context in which it was rendered in order to determine its sufficiency. *Worldmark the Club v. Travis*, 161 Or App 644 (1999); *SAIF v. Strubel*, 161 Or App 516 (1999). 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. *Weiland v. SAIF*, 64 Or App 810 (1983).

After reviewing the record, I agree with the ALJ that Dr. Ordonez is in the best position to render the most persuasive medical opinion on causation. Although Dr. Ordonez did not use the "magic words" of major contributing cause, I agree with the ALJ that his opinion is sufficient to meet that legal standard when his opinion is evaluated in the context of the record as a whole. The majority erred in concluding otherwise.

In the Matter of the Compensation of
APRIL F. ZAMORA, Claimant
WCB Case No. 99-08782
SECOND ORDER OF DISMISSAL
Glen J. Lasken, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

On April 24, 2000, we dismissed claimant's request for Board review. This action was taken in response to claimant's attorney's announcement that the request was being withdrawn. In response to our order, claimant has submitted a letter explaining her disagreement with the Administrative Law Judge's (ALJ's) March 13, 2000 order that upheld the self-insured employer's denial of claimant's left ankle injury claim. We treat claimant's letter as a motion for reconsideration.

FINDINGS OF FACT

On October 26, 1999, claimant signed a retainer agreement employing her attorney of record to represent her in connection with her workers' compensation claim. Claimant's attorney requested a hearing on claimant's behalf and a hearing was held on February 9, 2000.

The ALJ upheld the self-insured employer's denial of claimant's injury claim on March 13, 2000. Claimant's attorney requested Board review on claimant's behalf on March 17, 2000. On April 20, 2000, claimant's attorney withdrew the request for review and we dismissed that request on April 24, 2000.

Since our April 24, 2000 order, claimant has submitted a letter describing events of August and September, 1999. She also explains her disagreement with several of the ALJ's findings and his ultimate conclusion.

CONCLUSIONS OF LAW AND OPINION

The sole issue before us is whether claimant's request for review should have been dismissed.[1] Based on the following reasoning, we find that our prior dismissal order was 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 request is appropriate. *See e.g., Robert S. Ceballos*, 49 Van Natta 617 (1997); *Gilberto Garcia-Ortega*, 48 Van Natta 2201 (1996).

Here, claimant does not challenge her attorney's authority to withdraw her request for review. Nor does she assert that she was not represented by the attorney at the time in question.

Under such circumstances, we find that, through her former attorney, claimant withdrew her request for review. Although claimant may be dissatisfied with her attorney's action, she does not dispute the attorney's authority to act on her behalf, nor does she dispute the fact that we dismissed her request for review in response to the attorney's withdrawal of the request for review. Under these circumstances, we do not alter the dismissal order. *See e.g., Steve L. Paul*, 50 Van Natta 1987 (1998).

Accordingly, we withdraw our April 24, 2000 order. On reconsideration, as supplemented herein, we adhere to and republish our April 24, 2000 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] Claimant has requested information on workers' compensation. If claimant is presently represented, she may obtain such information from her attorney. If claimant is unrepresented at this time, we note that 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.

In the Matter of the Compensation of
GERALD BARROW, Claimant
Own Motion No. 99-0149M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Meyers, Radler, et al, Defense Attorneys

Claimant requests review of the insurer's March 13, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from June 17, 1999 through December 13, 1999. The insurer declared claimant medically stationary as of December 13, 1999. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 13, 2000 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 April 17, 2000 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 April 21, 2000, however, no further response has been received from claimant. Therefore, we will proceed with our review.

On November 17, 1999, claimant underwent an insurer-arranged medical examination (IME). Although the IME physician noted that claimant might benefit from a short course of strengthening exercises, he opined that claimant was nevertheless medically stationary as to his compensable condition. Dr. Bert, claimant's attending physician, concurred with the IME physician as to claimant's medically stationary status on December 13, 1999. These opinions are unrebutted.

In his request for review of the insurer's closure, claimant states that he is not medically stationary because he has not received "all the authorized physical therapy sessions that were greatly assisting [his] condition." He offers no medical documentation to support his contention. However, even if we were to consider claimant's assertion that he requires further physical therapy, this does not support the conclusion that he was not medically stationary when his claim was closed. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation, at claim closure, that further medical treatment would "materially improve" claimant's compensable condition. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Based on the uncontroverted medical evidence, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's March 13, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAURA R. FRANKE, Claimant
WCB Case No. 96-04464
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Steven T. Maher, Defense Attorney

This matter is on remand from the Court of Appeals. *Franke v. Lamb-Weston, Inc.*, 165 Or App 517 (2000). The court has reversed the Board's order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's current cervical condition. Because the court could not discern whether the ALJ and the Board weighed all the medical evidence before discounting the treating doctor's opinion, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following supplementation.

Claimant experienced immediate pain relief with Dr. Slack's May 29, 1996 injections. However, her cervical symptoms were worse that evening, followed by gradual, significant, and lasting relief over the next 8-10 days.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Claimant worked for the employer as a packaging operator. On May 25, 1995, she turned over boxes of frozen potatoes, weighing 20-36 pounds, for 7 1/2 hours at work. Claimant's neck and upper back began hurting while she did this. She reported her symptoms, sought treatment, and filed a claim. The employer accepted a disabling "cervical strain."

Dr. Oltman provided conservative treatment, including physical therapy, but claimant's symptoms did not resolve.

Claimant was off work in June. She returned to work the first week in July and worked thereafter for about 6 weeks. She was taken off work again in September 1995.

MRIs revealed an extradural defect at C6-7 and changes at C5-6, of uncertain significance, but consistent with an inflammatory process. (Exs. 6, 22-5, 23, 26, 30, 31-1). Examining physicians suspected that psychological factors delayed claimant's recovery.

Claimant returned to modified work in January 1996.

The employer denied claimant's current condition on April 30, 1996 and amended its denial on May 2, 1996. Dr. Oltman referred claimant to Dr. Keenan, who recommended injection therapy on May 8, 1996. A Notice of Closure closed claimant's claim on May 14, 1996.

Dr. Slack injected claimant's cervical spine several times with local anesthetics and steroids on May 29, 1996. Claimant experienced immediate pain relief with the injections. She felt worse that evening, then her symptoms resolved gradually over the next 8-10 days. Dr. Oltman released claimant to regular work on August 5, 1996.

The ALJ found claimant subject to the "major contributing cause" standard of proof, based on evidence that psychological factors combined with claimant's May 25, 1995 compensable strain to produce a "combined condition" under ORS 656.005(7)(a)(B). Based on the examining physicians' opinions, the ALJ found that claimant's "current" cervical condition was not supported by objective findings. The ALJ also relied on Dr. Oltman's opinion that immediate pain relief following Dr. Slack's injections would indicate a psychological, not physical problems, whereas gradual relief would indicate a physical condition. However, the ALJ ultimately discounted Dr. Oltman's conclusion that claimant's condition was physical (rather than psychological), reasoning that the doctor incorrectly understood that claimant had gradual (rather than immediate) relief following Dr. Slack's injections. Therefore, the ALJ concluded that claimant failed to prove that her compensable cervical strain was the major contributing cause of her current condition.

The Board adopted and affirmed the ALJ's order on review. Claimant petitioned the court for judicial review of the Board's order.

The court reversed the Board's order, noting that the last page of Dr. Slack's report included claimant's evaluation of her "post injection" condition and her evaluation indicated that her neck *was* symptomatic the evening after the injections, but her symptoms resolved gradually over the next ten days. The court stated:

> "Thus, the last portion of Dr. Slack's report supports Oltman's opinion that claimant's delayed response to the treatment demonstrates that her condition is not psychological. On the other hand, a claim of immediate relief from the steroid injection by claimant, if made, could be inconsistent with Oltman's reasoning and render it suspect." 165 Or App at 524.

The court could not discern whether the ALJ and the Board considered Dr. Oltman's reliance on claimant's reporting to Dr. Slack about her condition after the local anesthetic wore off or whether all the medical evidence was weighed before discounting Dr. Oltman's conclusion. Accordingly, the court remanded for reconsideration of the claim in light of the entire medical record, including the medical reports that pre-date Dr. Slack's treatment. We proceed with our reconsideration.

Dr. Oltman evaluated claimant's cervical condition and treated it for over a year. He believed that claimant's complaints were genuine, stated that she had a "legitimate medical problem," and suspected that she had an ongoing inflammatory process causing her symptoms. (*See* Exs. 22, 23, 85, 97, 98).

The examining physicians, on the other hand, examined claimant only once each. They did not address claimant's response to Dr. Slack's injections or comment on Dr. Oltman's suggestion that claimant's symptoms were due to an inflammatory process. Finding no orthopedic or neurological explanation for claimant's symptoms, the examiners concluded that claimant had no "objective findings" and her continued complaints were due to "nonanatomical" psychological factors. (Exs. 33, 34, 77, 93).

Dr. Slack administered several cervical anesthetic and steroid injections on May 29, 1996. (Ex. 90). He opined that claimant's "current symptomatology is the result of pain generators present at the left C5-, 6 facet joint, as well as the bulging disc at C-5,6 and C-6-7, as manifested by her pain level decreasing to 0 following injections of these cites." (Ex. 90-3).

The evening after the injections, claimant reported "worse" neck symptoms and the "same" arm and shoulder symptoms; three days later, she reported "worse" neck symptoms and "some" arm and shoulder symptoms. Seven days after the injections, she reported "some" neck symptoms and substantially improved shoulder and arm symptoms. Ten days after the injections, claimant reported substantial improvement in all areas. (Ex. 90-4). Her symptoms did not return thereafter.

Dr. Oltman acknowledged that "somatization"[1] or "psychological overlay" contributed to claimant's ongoing cervical problems. (*See* Ex. 98-10-13, -18). However, he explained that claimant's response to Dr. Slack's injections confirmed his belief that her condition was physical (not psychological), because her symptoms improved gradually (after the local anesthetic wore off) over the ten-day period following the treatment.[2] Therefore, Dr. Oltman concluded that claimant's current condition remained injury-related.

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[1] The doctor defined somatization as "a tendency to put a physical symptom onto an emotional situation." (Ex. 98-9).

[2] On reconsideration, we conclude that the Board initially read Dr. Slack's reporting of claimant's *initial* response to the injections too literally and too narrowly. On reconsideration, we rely on Dr. Oltman's explanation that claimant's gradual relief from the steroids (after the anesthetic wore off) indicated that her condition was physical. In other words, although claimant did report "zero" pain immediately, that did not mean that her symptoms were psychological--only that she was experiencing the immediate effects of the anesthetic, rather than the steroids. (*See* Exs. 98-15, 98-22).

The examining physicians did not address the new information provided by claimant's response to Dr. Slack's injections. Thus, the examiners' causation conclusions are not particularly persuasive (because they are not based on a complete history). Under these circumstances, we rely on Dr. Oltman's uncontradicted reasoning, which is consistent with claimant's clinical history. Accordingly, based on Dr. Oltman's opinion, we conclude that claimant has carried her burden of proof.[3]

Accordingly, on reconsideration, the ALJ's order dated December 11, 1997 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law.

IT IS SO ORDERED.

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[3] Claimant's claim is supported by objective findings, including her bulging disc. (*See* Ex. 98-11; *see also* Exs. 19-1, 22-3, 30-1). Claimant's examination findings are observable and verifiable, and therefore objective. *See Geoffrey R. Lewis*, 50 Van Natta 1352 (1998). They support Dr. Oltman's diagnosis and causation opinion. Finally, we would reach this result, whether claimant is subject to a "material" or "major" cause standard of proof under ORS. 656.005(7)(a) or 656.005(7)(a)(B).

In the Matter of the Compensation of
JERRIN L. HICKMAN, Claimant
WCB Case No. 99-06796
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that increased claimant's unscheduled permanent disability award for a lumbar injury from zero, as awarded by an Order on Reconsideration, to 3 percent (9.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The only issue on review is whether claimant is entitled to an impairment rating for the loss of lumbar extension measured by the panel of medical arbiters, consisting of Drs. Williams, neurosurgeon, Woodward, orthopedist, and Bald, orthopedist. (Ex. 38). The ALJ determined that claimant was not entitled to such an impairment rating because, although the medical arbiters stated in the body of their report that all findings were considered valid, they indicated on their worksheet that the straight leg raising (SLR) validity test was not met. (Exs. 38-2, -8). Based on the following reasoning, we find claimant entitled to an impairment rating for the loss of lumbar extension.

Claimant's claim was closed by Notice of Closure dated May 26, 1999. Therefore, as the ALJ found, the disability rating standards in WCD Admin. Order 98-055 (effective July 1, 1998) apply to determine claimant's permanent disability benefits. Claimant bears the burden of establishing the extent of his disability. ORS 656.266.

The Director's rules provide that when a medical arbiter is used on reconsideration, impairment is determined by the medical arbiter, unless a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14). Impairment findings made by a consulting physician may be used only if the attending physician concurs with those findings. OAR 436-035-0007(13). Otherwise, only the attending physician at the time of claim closure may make impairment findings. ORS 656.245(3)(b)(B). For the reasons explained by the ALJ, we rely on the medical arbiters' findings to rate claimant's impairment.

The Director's rules also provide that, except as otherwise required by rule, only the methods described in the *AMA Guides to the Evaluation of Permanent Impairment*, 3rd Edition (Revised), 1990 [*AMA Guides*]. OAR 436-035-0007(7). The Director has prescribed by bulletin the SLR method for testing the validity of lumbar flexion.[1] That method provides that "measurements of true *lumbar flexion* are invalid if the tightest straight leg raising (SLR) angle is not equal to or within 10 degrees of the sum of the lumbar extension and flexion measured at midsacrum." Bulletin No. 239 (rev., July 15, 1998) at 36 (emphasis added).[2] The same bulletin also provides, as a general principle, that "[m]easurements which do not meet the validity criterion shall be noted in the examiner's report." *Id.* at 31. Interpreting that language, we have concluded that the validity determination must be made by the medical examiner performing the range of motion tests, and that any invalid measurements must be identified by that examiner. *Teri S. Callahan*, 49 Van Natta 548, 549 (1997); *Harvey Clark*, 47 Van Natta 136 (1995); *Michael D. Walker*, 46 Van Natta 1914 (1994); *see also Jeana Larson*, 48 Van Natta 1278 (1996) (finding Bulletin No. 242 properly promulgated).

Furthermore, OAR 436-035-0007(28) provides, in part: "Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid."

Here, the medical arbiters' worksheet indicated that the results of the SLR test showed "lumbar flexion" was not valid. (Ex. 38-8). The failed SLR test itself, as performed by the medical arbiters, establishes the invalidity of the *lumbar flexion* measurements.[3] On the other hand, it does not establish, or even comment on, the validity of the *lumbar extension* measurements. In addition, the body of the medical arbiters' report states that their findings are valid. On this record, we find that claimant has established entitlement to impairment rating for his loss of lumbar extension.

Claimant's 10 degrees of retained lumbar extension is valued at 5 percent. OAR 436-035-0360(20). The parties do not dispute the ALJ's award of 1 percent impairment for his loss of right lateral lumbar flexion. OAR 436-035-0360(21). These values are added for total lumbar impairment of 6 percent. OAR 436-035-0360(22).

The parties also do not dispute the ALJ's award of 2 percent cervical impairment. Combining the cervical (2 percent) and lumbar (6 percent) impairment results in a total unscheduled permanent disability award of 8 percent. OAR 436-035-0360(23). We modify the ALJ's order accordingly.

ORDER

The ALJ's order dated December 16, 1999 is modified. In addition to the ALJ's award of 3 percent (9.6 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, for a total award to date of 8 percent (25.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order. However, the total "out-of-compensation" attorney fee awarded by the ALJ's order and this order shall not exceed $3,800.[4]

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[1] The *AMA Guides* describe the SLR test as an "additional 'effort factor' [that] is available to check lumbar spine *flexion*." *Id.* at 96 (emphasis added).

[2] Bulletin No. 239 (rev., July 15, 1998) incorporated and superseded Bulletin No. 242 (issued November 22, 1991 and revised February 1, 1995). The relevant language remained the same, however. For ease of reference, we cite to Bulletin No. 239.

[3] We note that, at 80 degrees, claimant's lumbar flexion measurement would not entitle him to any impairment even if that measurement was valid. *See* OAR 436-035-0360(19).

[4] Pursuant to claimant's retainer agreement, $3,800 is the maximum "out-of-compensation" attorney fee payable for increased permanent disability up to and including Board review.

In the Matter of the Compensation of
FRANCIS L. JARVIS, Claimant
WCB Case No. 99-03501
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's claim for claimant's combined left foot condition. On review, the issue is compensability.

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

The insurer argues that Dr. Jacobsen's history of the mechanism of claimant's injury is incorrect. Specifically, the insurer argues that Dr. Jacobsen incorrectly assumed that claimant twisted the foot and sustained enough trauma to cause swelling of the foot. We do not agree that Dr. Jacobsen's history is materially incorrect. In this regard, Dr. Jacobsen testified that trauma that caused swelling or bruising was sufficient to cause the environment that reactivated the preexisting staph bacteria. (Ex. 56-18 to 56-20). In any case, claimant indicated that the injury occurred when he stepped off the corner of a step carrying paint and that he "evidently twisted my ankle or the bottom of my foot." (Tr. 24). Claimant's wife confirmed that claimant was having problems with the foot that evening and that he told her he had stepped off a step and twisted the foot. (Tr. 11). Under these circumstances, we are persuaded that Dr. Jacobsen's history of the injury was materially correct.

The insurer next argues that Dr. Jacobsen's opinion is not sufficient to establish that the injury was the major contributing cause of the need for treatment of the combined condition. In this regard, the insurer argues that Dr. Jacobsen fails to weigh the contribution from the injury against the preexisting condition (sequestered staph bacteria from a childhood ankle fracture that became infected).

After reading Dr. Jacobsen's deposition testimony, we are persuaded that he believed the major contributing cause of claimant's need for treatment of his left foot combined condition was the work injury that reactivated the dormant bacteria. In this regard, Dr. Jacobsen was aware of the 1938 left ankle fracture and the osteomyelitis that followed the fracture and we are persuaded that he weighed the contribution from this remote injury and infection against the 1999 work injury.

Moreover, Dr. Jacobsen persuasively rebutted the opinions of Drs. Hohf and Schilperoort that claimant's infection was caused not by the injury but by bacteria that entered through lesions caused by athlete's foot, tinea pedis. Dr. Jacobsen persuasively explained that the staph bacteria causing claimant's infection was highly sensitive to penicillin suggesting that it was a strain of bacteria that had been present but dormant since the 1938 fracture and osteomyelitis and had been activated by the work injury. In this regard, Dr. Jacobsen explained that the strains of staph bacteria that existed in 1999 would not have been as susceptible to penicillin as the bacteria claimant had. Thus, Dr. Jacobsen explained that it was more likely that the bacteria was a sequestered bacteria that had been present since the 1938 injury. Based on this record, we agree with the ALJ that Dr. Jacobsen offered the most persuasive opinion regarding causation.

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 January 19, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
JOHN F. WAGNER, Claimant
WCB Case No. 99-07738
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's injury claim for a cervical condition. On review, the issue is compensability.

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

Claimant, a registered nurse, compensably injured his neck on June 9, 1998 when a 365-pound patient suddenly grabbed and pulled him by the neck. (Ex. 3; Tr. 5). Claimant had had a prior cervical fusion at C4-5 in 1975. (Tr. 8). On July 24, 1998, the insurer accepted a cervical strain condition as a non-disabling claim. (Ex. 5). Later testing revealed "diffuse annular disruption with collapse" at the C6-7 disc space. (Ex. 16). The insurer denied claimant's current cervical condition on September 3, 1999. (Ex. 22).

The ALJ set aside the insurer's denial of claimant's C6-7 cervical disc condition based on the opinions of Dr. Karasek and Dr. Bald. Dr. Karasek is a neurologist who examined claimant several times on referral from claimant's treating physician, Dr. Kitchel, and performed facet joint block injections on two occasions. Dr. Karasek also performed a discogram which demonstrated findings at the C6-7 disk space which were concordant with claimant's symptomatology. (Exs. 16, 24). Dr. Karasek reasoned that claimant's on-the-job injury was the major contributing cause of his cervical disc condition. (Ex. 24). Dr. Bald, who performed an examination at the request of the insurer, similarly concluded that claimant's June 9, 1998 injury was the major contributing cause of his disability and need for treatment for his cervical condition, although he acknowledged that a "very good case could be made" for the opposite conclusion. (Ex. 24A).

The insurer contends that the more persuasive medical evidence comes from Drs. Schilperoort and Green, who performed an examination at the request of the insurer. (Ex. 19). These physicians concluded that claimant's multi-level degenerative disk disease was the major cause of claimant's current condition. (Ex. 19-7). Claimant's treating physician, Dr. Kitchel, echoed the opinion and reasoning of these doctors. (Ex. 25).

We rely on medical opinions that are based on complete and accurate information. *Miller v. Granite Construction Co.*, 28 Or App 473 (1977). As the ALJ noted, Drs. Schilperoort and Green did not have the benefit of reviewing the later MRI and discogram studies. (Exs.15, 17, 19). In contrast, Dr. Karasek administered a discogram on August 10, 1999 which demonstrated disruption of the annulus at C6-7. (Ex. 16). Dr. Karasek based his opinion in large part on the findings from that study. (Ex. 24). The insurer argues that there is no evidence that review of these studies would have altered Dr. Schilperoort and Green's opinions. However, any conclusion to that effect on this record would be speculative.

Finally, the insurer argues that we should defer to the opinion of claimant's treating physician, Dr. Kitchel. We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, even assuming for the sake of argument that Dr. Kitchel is the "treating physician," Dr. Karasek has had the more intimate involvement with claimant's treatment for his cervical condition. Dr. Karasek examined claimant several times and performed two facet block injections. (Exs. 12, 16). In contrast, claimant testified that Dr. Kitchel never examined him, but instead merely consulted with him about his symptoms and prescribed pain medication. (Tr. 7). Like the ALJ, we therefore find persuasive reasons not to defer to the opinion of Dr. Kitchel, and instead rely on the opinion of Dr. Karasek for the reasons stated above.

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

ORDER

The ALJ's order dated January 28, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

May 23, 2000 Cite as 52 Van Natta 873 (2000)

In the Matter of the Compensation of
KAREN E. AFFOLTER, Claimant
WCB Case No. 00-0063M
OWN MOTION ORDER
Bischoff, Strooband & Ousey, Claimant Attorneys

The self-insured employer submitted an Own Motion Recommendation form in which it opposed reopening claimant's 1990 bilateral knee injury claim, contending that claimant was not in the work force at the time of disability.[1] Claimant's aggravation rights expired on October 12, 1998. Claimant responded that her claim is not within our Own Motion jurisdiction under ORS 656.278. Instead, claimant contends that her claim is within the Department's jurisdiction for issuance of a Determination Order as a result of her authorized training program (ATP) ending on January 14, 2000. The issues raised are jurisdiction and, if we have jurisdiction in our own motion capacity, whether the claim should be reopened for own motion relief. Based on the following reasoning, we find that: (1) we have jurisdiction in our own motion capacity; and (2) claimant's claim qualifies for reopening pursuant to ORS 656.278(1)(a).

FINDINGS OF FACT

On October 22, 1990, claimant sustained multiple compensable injuries, including bilateral knee injuries. This injury claim was first closed by Determination Order on October 12, 1993, and her aggravation rights expired five years later, on October 12, 1998.

On January 4, 1999, claimant's claim was reopened for an ATP for training as a medical office specialist, a program that required five terms of community college courses. Due to a noncompensable motor vehicle accident, claimant was unable to attend classes during spring term 1999. However, she completed summer term 1999. By fall term, which began September 20, 1999, claimant was experiencing increased back and bilateral knee pain. She received treatment from Dr. Brink, her attending physician, for this pain.

Claimant continued with her course work for the fall term but, by November 1999, her bilateral knee pain had worsened. Dr. Brink referred her to Dr. Cronk, an orthopedic surgeon who had previously performed her arthroscopic knee surgery. On November 24, 1999, Dr. Cronk scheduled claimant for bilateral knee arthroscopic surgery on November 30, 1999.

The employer authorized that surgery. As a result of the surgery, claimant was unable to complete her fall term course work.

In a January 14, 2000 letter to claimant's vocational consultant, Dr. Brink stated that, due to a substantial deterioration in claimant's condition, she would not be able to participate in vocational rehabilitation or a return to work program at that time. That same date, claimant's vocational training was ended because she was physically incapable of participating in her ATP.

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[1] Although the employer indicates that it received a request to reopen claimant's claim on November 24, 1999, it did not submit a copy of that request with its recommendation form. We note that, on November 24, 1999, Dr. Cronk, claimant's treating orthopedist, notified the employer that claimant was scheduled for bilateral knee arthroscopic surgery on November 30, 1999. The employer authorized that surgery. Therefore, we assume that the employer treated Dr. Cronk's November 24, 1999 surgery notification as a request to reopen claimant's claim on claimant's behalf. The employer neglected to check the appropriate box on its recommendation form indicating whether it voluntarily reopened the claim or recommended reopening or denying the claim. On the other hand, although agreeing that it was responsible for the current condition that required surgery, the employer contended that claimant was not in the work force at the time of the current disability, a contention which, if accurate, would defeat a request to reopen a claim under our Own Motion jurisdiction. ORS 656.278(1)(a). Therefore, we find that the employer opposed reopening claimant's claim in own motion.

On February 11, 2000, the employer submitted an Own Motion Recommendation form in which it opposed reopening the claim, contending that claimant was not in the work force at the time of disability. The employer agreed, however, that: (1) claimant's current knee condition is causally related to the accepted condition; (2) the employer is responsible for the current knee condition; and (3) the surgery was reasonable and necessary.

On February 23, 2000, the Department issued a "post-ATP" Determination Order that awarded temporary total disability compensation from January 4, 1999 through January 14, 2000. According to the Workers' Compensation Division records, claimant has requested reconsideration of that "post-ATP" Determination Order.[2]

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

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

Here, claimant compensably injured her knees on October 22, 1990. This injury claim was first closed on October 12, 1993, and claimant's aggravation rights expired five years later, on October 12, 1998. ORS 656.273(4)(a). Thus, when claimant's condition worsened requiring surgery on November 30, 1999, her claim was under our own motion jurisdiction. ORS 656.278(1)(a). In other words, claimant's claim worsened after the expiration of her aggravation rights. Therefore, the claim is subject to our own motion jurisdiction.

Reopening Under ORS 656.278(1)(a)

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. 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 required surgery on November 30, 1999. 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 her current disability. We disagree.

Inasmuch as claimant was actively participating in an ATP at the time of her current disability, she has not removed herself from the work force. We find that claimant's participation in a vocational training program establishes that she was willing to work and was making reasonable efforts to find employment at the time her compensable injury worsened. *See Gilbert R. Brown*, 43 Van Natta 585 (1991). Thus, we find that claimant was in the work force at the time of her current disability and is entitled to temporary disability benefits.

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[2] The findings of fact regarding the February 23, 2000 "post-ATP" Determination Order are based on our review of the Workers' Compensation Division case records. In making these findings, we note that we may take official notice of any fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *Rodney J. Thurman*, 44 Van Natta 1572 (1992). Here, we find that the Workers' Compensation Division case records are an unquestionably accurate source for determining procedural facts regarding the Department's issuance of the "post-ATP" Determination Order and claimant's request for reconsideration of that order. *See, e.g., Susan K. Teeters*, 40 Van Natta 1115 (1988) (Board held it was proper to take official notice of a hearing request where it had only procedural significance).

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning November 30, 1999, the date claimant underwent bilateral knee surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.[3]

In reaching this decision, we acknowledge that claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Inasmuch as we have authorized the reopening of claimant's claim for own motion relief during a period that claimant's claim was reopened for an ATP, temporary disability benefits paid pursuant to the ATP will need to be considered in determining the amount of temporary disability benefits to which claimant is entitled as a result of this order.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, 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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[3] In ordering the employer to close the claim under OAR 438-012-0055 when claimant becomes medically stationary, we acknowledge that prior cases have held that when a claimant's claim was reopened in own motion and the claimant was subsequently involved in an ATP, the claim was to be closed by the Evaluation Section under *former* ORS 656.268(5), now ORS 656.268(9), when the ATP was completed. *See Robert L. Trump*, 39 Van Natta 314 (1987); *Verna Burton-Berg*, 39 Van Natta 665 (1987); *Arnold R. Johnson*, 41 Van Natta 2199 (1989); *Harvey W. Marshall*, 42 Van Natta 517 (1990). However, we find those cases distinguishable.

In those cases, the own motion claims were reopened *before* the claimants were involved in ATPs. Although a carrier may voluntarily reopen a claim for own motion benefits pursuant to ORS 656.278(5), that did not happen here. Instead, the employer reopened the claim for an ATP, not for own motion purposes. Here, our order reopening the own motion claim is issuing *after* the closure of the claim pursuant to ORS 656.268(9), *i.e.*, after the "post-ATP" Determination Order. Therefore, pursuant to ORS 656.278(1)(a), we are authorized in our own motion capacity to award temporary disability benefits as of the date of surgery, even if that date is prior to the "post-ATP" Determination Order. As explained below, however, any "duplicate" temporary disability benefits must be offset. On the other hand, any "post-ATP" Determination Order temporary disability benefits will be payable pursuant to ORS 656.278 (assuming that the Determination Order is not altered on reconsideration or appeal).

May 23, 2000 Cite as 52 Van Natta 875 (2000)

In the Matter of the Compensation of
ALLAN W. FOSTER, Claimant
Own Motion No. 00-0038M
OWN MOTION ORDER
Darris K. Rowell, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The self-insured employer has submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on August 29, 1984. The employer opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; (2) surgery or hospitalization is not reasonable and necessary; and (3) it is unknown whether claimant is in the work force at the time of the current disability.[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.*

Here, the record does not establish that claimant requires surgery or hospitalization. As a result, we are not authorized to grant claimant's request to reopen the claim.

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[1] In its April 20, 2000 Own Motion Recommendation form, the employer leaves the question regarding claimant's work force status blank.

Accordingly, we deny the request for own motion relief. *Id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

May 23, 2000 Cite as 52 Van Natta 876 (2000)

In the Matter of the Compensation of
MARIA T. BRENA, Claimant
WCB Case No. 99-00018
ORDER ON REVIEW
Heiling & Associates, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) reduced claimant's unscheduled permanent disability award for cervical and thoracic conditions from 15 percent (48 degrees), as awarded by an Order on Reconsideration, to zero; (2) reduced claimant's scheduled permanent disability award for loss of use or function of the left arm from 8 percent (15.36 degrees), as awarded by an Order on Reconsideration, to zero; and (3) upheld the insurer's denial of claimant's injury claim for a left elbow epicondylitis condition. On review, the issues are extent of scheduled and unscheduled permanent disability and compensability. We affirm.

FINDINGS OF FACT

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

Page 2 of the ALJ's order is modified to read: "[Dr. Peterson] did not for example have reports from Drs. Jura and *Bald*," as opposed to "Drs. Jura and Milam."

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The ALJ reduced claimant's awards of scheduled and unscheduled permanent disability for her accepted cervical, thoracic, and left wrist conditions to zero based on the preponderance of medical evidence that claimant had no permanent impairment related to those conditions. In doing so, the ALJ disregarded the findings of the medical arbiter, Dr. Peterson. We agree with the ALJ that the more persuasive medical evidence demonstrates that claimant has no permanent impairment due to her accepted conditions.

Evaluation of a worker's disability is as of the date of the issuance of the reconsideration order. ORS 656.283(7). Only the findings of the attending physician, (or findings with which the attending physician has concurred), or of the medical arbiter, if any, may be used. *Koitzsch v. Liberty Northwest Insurance Corp.*, 125 Or App 666, 670 (1994).

Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14); *Orfan A. Babury*, 48 Van Natta 1687 (1996). However, we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Claimant contends that the arbiter's findings were later in time and therefore are a more accurate representation of claimant's true impairment. However, we have previously held that impairment findings that are later in time, and closer to the date of the order on reconsideration, are not always more persuasive, if the preponderance of evidence indicates a different level of impairment. *David J. Rowe*, 47 Van Natta 1295, 1297 (1995).

Here, although claimant's attending physician never made impairment "findings" with which we can compare the arbiter's findings, claimant's attending physician and several other examining physicians consistently found that claimant did not have permanent impairment. (Exs. 10, 15-2, 40, 43). In contrast, the medical arbiter, Dr. Peterson, found that claimant had permanent impairment, but attributed claimant's impairment at least partially to her newly-diagnosed epicondylitis condition, rather than to her accepted conditions. (Ex. 100). In such circumstances, we agree with the ALJ that the arbiter's impairment findings are unpersuasive. *See Manuel G. Garcia*, 48 Van Natta 1139, 1140 (1996).

Compensability

Claimant contends that the ALJ incorrectly applied the major contributing cause standard in regard to the compensability of her left lateral epicondylitis condition. We disagree. Although the ALJ did not directly address the issue, it is implicit in the ALJ's order that he found claimant's need for treatment or disability for a left lateral epicondylitis condition not related in either material or major part to her November 12, 1997 compensable injury.

In any event, for the following reasons, we find that, even if the material contributing cause standard applies, claimant has not met her burden of proving the compensability of her left lateral epicondylitis condition. We generally defer to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Claimant's treating physician, Dr. Treible, stated that claimant's lateral epicondylitis condition was a valid diagnosis, and that it was related to her November 1997 work injury. (Ex. 104).

Here, like the ALJ, we find persuasive reasons not to defer to Dr. Treible's opinion, but instead to defer to the opinions of Drs. Strum and Bergquist, who performed an examination at the request of the insurer. (Ex. 100). Drs. Strum and Bergquist concluded that claimant did not have specific findings of lateral epicondylitis. These physicians then stated that the mechanism of injury described by claimant is not of the type which would cause a chronic lateral epicondylitis condition. (Ex. 100-6). This reasoning by Drs. Strum and Bergquist was not addressed or rebutted by Dr. Treible or any other physician.

Moreover, claimant's lateral epicondylitis condition was not diagnosed until August 7, 1998, almost nine months after her November 12, 1997 injury. (Ex. 46). For this reason as well, Drs. Strum and Bergquist found that the epicondylitis condition was not related to claimant's compensable injury or to her accepted left elbow strain condition. (Ex. 100-7). Although Dr. Treible related claimant's epicondylitis condition to her November 1997 fall, he did not adequately explain the late onset of the condition, as distinguished from claimant's left elbow strain condition. (Exs. 64, 104-2).

In light of such circumstances, we consider Dr. Treible's opinion to be insufficient to establish that claimant's left lateral epicondylitis condition is compensably related to her November 1997 injury. Consequently, we affirm the ALJ's decision to uphold the insurer's denial of that condition.

ORDER

The ALJ's order dated January 18, 2000, as corrected January 24, 2000, is affirmed.

In the Matter of the Compensation of
ALAN T. KUCERA, Claimant
Own Motion No. 98-0498M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's February 3, 2000 Notice of Closure which closed his claim with an award of temporary total disability compensation from December 17, 1998 through December 15, 1999. The insurer declared claimant medically stationary as of December 15, 1999. Claimant contends that "his wrist and elbow [conditions] are not medically stationary." Based on the following reasoning, we affirm the insurer's Notice of Closure.

FINDINGS OF FACT

On September 16, 1987, claimant sustained a compensable injury to his right wrist. The insurer ultimately accepted the claim for a disabling "right wrist arthrodesis resulting from a fracture."[1] Treatment included surgical repair of the fractured right wrist, ultimately including a distal radial ulnar arthroplasty and an arthrodesis of the right wrist. Claimant's claim was first closed on October 5, 1988, and his aggravation rights expired five years later, on October 5, 1993.

On September 2, 1998, claimant saw Dr. Dietrich for right wrist and elbow pain. Dr. Dietrich opined that the wrist pain probably originated from the open joints which were intended to be fused and the elbow pain probably originated from osteochondroses of the insertion of the triceps tendon.

On October 26, 1998, claimant sought treatment with Dr. Horn, who injected his lateral extensor musculature. In a November 4, 1998 medical report, Dr. Dietrich noted that surgery had been recommended.

On December 9, 1998, the Board authorized the reopening of claimant's claim for the payment of temporary disability compensation commencing the date claimant underwent the proposed surgery.

On December 17, 1998, Dr. Horn performed a right wrist fusion, right second and third carpometacarpal fusions and right hemiresection arthroplasty of the distal ulna.

Thereafter, claimant began physical therapy. He continued to have right wrist problems. On March 12, 1999, Dr. Horn performed further surgery in the form of plate removal of the right wrist, extensor tendon tenolysis and a revision of the hemiresection of the distal ulna.

Claimant continued with his physical therapy following his second surgery. On June 22, 1999, Dr. Horn identified two contributions that were preventing claimant from rotating his arm: (1) the pathology at the distal radial ulnar joint; and (2) the degeneration at the capitellar joint. He recommended that any further surgery be delayed for at least a year. On June 23, 1999, the physical therapist reported that claimant's condition had plateaued and arranged a self-help program.

In August 1999, Dr. Dietrich again injected claimant's right elbow in an effort to alleviate his continuing pain complaints. If claimant's elbow pain did not subside, Dr. Dietrich reported that he may need an extensor origin release.

In September 1999, Dr. Horn opined that claimant had regained some wrist mobility and released him to a light duty position with a follow-up in a couple of months. Following the modified duty work release, Dr. Dietrich reported that no "spontaneous improvement" was anticipated.

On December 15, 1999, Dr. Welch, hand specialist and plastic surgeon, examined claimant on behalf of the insurer. Dr. Welch opined that claimant had reached a "fixed and stable state with regarding to the right wrist." He noted that claimant was also being treated for tendonitis of the extensor muscle group in the right forearm, or "tennis elbow," which "apparently . . . has not been accepted at this time."

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[1] We make this finding from the insurer's letter dated March 24, 2000. We note that claimant does not dispute the insurer's statement regarding the accepted condition.

On February 3, 2000, the insurer issued a "Notice of Closure Board's Own Motion Claim" that closed claimant's claim with an award of temporary total disability compensation from December 17, 1998 through December 15, 1999. The insurer declared claimant medically stationary as of December 15, 1999.

On February 14, 2000, Dr. Horn concurred with the Dr. Welch's findings.

On February 17, 2000, claimant requested "reconsideration" of the insurer's February 3, 2000 closure.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that claimant requested "reconsideration" of the insurer's February 3, 2000 "Notice of Closure Board's Own Motion Claim." In addition to contending that the claim was prematurely closed and disagreeing with the medically stationary date and the temporary disability dates, claimant also disagreed with the medical impairment findings, requested appointment of a medical arbiter, and disagreed with the rating of scheduled permanent disability. These last three matters concern the extent of permanent disability benefits, benefits to which claimant is not entitled under the circumstances of this claim.

Because claimant's aggravation rights have expired, his claim is within our own motion jurisdiction. ORS 656.273(4)(a); *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Claimant makes no argument to the contrary. In addition, the Board, in its own motion jurisdiction, has no authority to award permanent disability benefits. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990) (Effective January 1, 1988, the legislature removed the Board's authority to grant additional permanent disability compensation in its own motion capacity). Therefore, under the circumstances of this case, claimant is not entitled to permanent disability benefits.

Claimant has the burden to establish he was not medically stationary on the date of closure. *Scheuning v. J. R. Simplot & Company*, 84 Or App 622, *rev den* 303 Or 590 (1987); *Andrea M. Gildea*, 45 Van Natta 2293 (1993). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Whether or not claimant is medically stationary is primarily a medical question. *Harmon v. SAIF*, 54 Or App 121 (1985). Claimant's condition and the prospect of any material improvement are evaluated as of the date of closure, without consideration of subsequent changes in his condition. *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985).

Furthermore, a determination of whether a claim has been prematurely closed because claimant's compensable condition is not medically stationary must focus only on those conditions that were accepted at the time of the claim closure. *See Timothy R. Sowell*, 52 Van Natta 112 (2000); *Nancy L. Sabin*, 51 Van Natta 2035 (1999); *James L. Mack*, 50 Van Natta 338 (1998).

Claimant contends that, although Dr. Welch opined that claimant's right wrist condition was "fixed and stable," he also noted that claimant continued to be treated for right forearm tendonitis, or "tennis elbow." There is no contention that claimant has sought the acceptance of his forearm tendonitis condition. Moreover, claimant concedes that the insurer has neither accepted nor denied a claim for right forearm tendonitis.[2] Nevertheless, claimant contends that because he "continues to be treated for tendonitis, his condition cannot be stationary." We disagree.

Here, there was only one condition accepted at the time of claim closure, that of the right wrist condition. Thus, the issue of whether the unaccepted right forearm tendonitis condition was medically stationary at the time of claim closure is irrelevant to the determination of whether claimant's own motion claim was prematurely closed. Therefore, we limit our inquiry to the medically stationary status of claimant's accepted right wrist condition.

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[2] Our own motion authority is strictly limited under ORS 656.278 and does not extend to issues of compensability. *See Gary L. Martin*, 48 Van Natta 1802 (1996). Therefore, our review is confined to the question of whether claimant's accepted condition has become medically stationary and, if so, whether the claim was properly closed.

On December 15, 1999, Dr. Welch, examining hand specialist, found that claimant's wrist was "fixed and stable." On February 14, 2000, Dr. Horn, claimant's treating hand surgeon, concurred with Dr. Welch's opinion. These medical opinions regarding claimant's right wrist condition are unrebutted. Based on this unrebutted medical evidence, we find that claimant's compensable condition was medically stationary on the date his claim was closed.

The February 3, 2000 Notice of Closure awarded temporary total disability compensation from December 17, 1998, the date of surgery, through December 15, 1999, the date claimant became medically stationary. Without making any specific argument, claimant contests this temporary disability compensation award. We find that the award is correct.

Where, as here, a claim qualifies for reopening under the Board's own motion jurisdiction, the worker is entitled to temporary disability benefits from the date he or she is actually hospitalized or undergoes outpatient surgery until his or her condition becomes medically stationary. ORS 656.278(1)(a). As noted above, claimant was awarded temporary disability benefits for this period in the February 3, 2000 Notice of Closure. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's February 3, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
EVERETT L. LEACH, Claimant
Own Motion No. 00-0170M
OWN MOTION ORDER
EBI Ins. Co., 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 January 24, 1988. The insurer opposes authorization of temporary disability compensation, contending that claimant is retired and has withdrawn from the work force. Upon review of the record, we find it sufficiently developed to reach a conclusion regarding claimant's workforce status at the time of his disability and issue the following order.

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

On April 3, 2000, Dr. Mohler recommended that claimant undergo an exploration of the right knee, excision of the lateral femoral condyle osteophyte and tibial component liner exchange. Dr. James, claimant's attending physician, concurred with Dr. Mohler's findings and recommendations on April 13, 2000. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

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

With its recommendation form, the insurer submitted medical reports from Dr. James 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 April 13, 2000 medical report, Dr. James opined that claimant's "current work" is not the major contributing cause of his current need for treatment. In the April 25, 2000 medical report, Dr. James noted that claimant's current work activities "include operation of heavy equipment for excavation purposes."

Additionally, the insurer submitted a copy of an April 3, 2000 consultation report from Dr. Mohler. Dr. Mohler noted that claimant was a 64 year old male that "owns a contracting company and spends a great deal of time on his feet doing heavy work." Also in that report, under the caption "Social History," Dr. Mohler noted that claimant "owns his own heavy equipment excavating business and continues to work full time."

Thus, we conclude that claimant was in the work force at the time of his current worsening. *See Beverly J. Coffman*, 51 Van Natta 1736 (1999); *John R. Kennedy*, 50 Van Natta 837 (1998). 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.

May 24, 2000 Cite as 52 Van Natta 881 (2000)

In the Matter of the Compensation of
SHERRYL A. BRONG, Claimant
WCB Case No. 99-01868
ORDER ON RECONSIDERATION
Swanson, Thomas & Coon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On May 2, 2000, we abated our April 3, 2000 Order on Review to consider the self-insured employer's request for reconsideration. In our April 3, 2000 order, we reversed an Administrative Law Judge's (ALJ's) order that upheld the employer's denial of claimant's occupational disease claim for a cervical condition. The employer contends that we erred in evaluating the medical evidence. Claimant has filed a response to the employer's argument.

Having fully considered the parties' arguments, and having reviewed our prior order and the record, we conclude that our prior order adequately explained why Dr. Gritzka's opinion is persuasive and the contrary opinions are not persuasive.

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

Accordingly, we republish our April 3, 2000 order as supplemented and modified herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUSSELL D. FLETCHER, Claimant
WCB Case No. 99-06067
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

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

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the order of the ALJ with the following supplementation. Claimant contends that: (1) the ALJ incorrectly relied on the medical opinions of Drs. Reimer and Fuller as opposed to Dr. Rath, the treating physician; and (2) the ALJ required claimant to prove his case by clear and convincing evidence rather than by a preponderance of evidence.

Claimant pursued this claim on both an injury theory and an occupational disease theory. All the physicians and, to some extent, claimant himself describe the onset of his low back condition as gradual, rather than sudden, in nature. Therefore, we analyze this claim as an occupational disease, rather than an accidental injury. *See Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343 (1984). To prevail on his occupational disease claim, claimant must prove by a preponderance of the evidence that his employment conditions are the major contributing cause of his low back condition. *See* ORS 656.802(2)(a).[1]

When there is a dispute between medical experts, more weight is given to those medical opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

On July 5, 1999, Dr. Rath concurred with the medical report of Drs. Reimer and Fuller, in which they concluded claimant's work activity was not the major contributing cause of claimant's low back condition. Later, he reversed that concurrence, but offered no explanation for changing his previous opinion. An unexplained change of opinion renders a physician's opinion unpersuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

On this record, claimant failed to establish the compensability of his low back condition.

ORDER

The ALJ's order dated February 23, 2000 is affirmed.

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[1] If this was an injury claim, claimant would have to prove that the work incident was a material contributing cause of his need for treatment or disability for his low back condition. *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Even if analyzed under that standard, we would find Dr. Rath's opinion inadequate to persuasively establish the compensability of claimant's low back condition.

In the Matter of the Compensation of
LAVONNE L. HAUSER, Claimant
WCB Case No. 99-08417
ORDER ON REVIEW
Thomas J. Flaherty, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) affirmed an Order on Reconsideration that awarded claimant 38 percent (121.6 degrees) unscheduled permanent disability for a left shoulder condition; and (2) affirmed an Order on Reconsideration's assessment of a penalty under *former* ORS 656.268(4)(g). In her respondent's brief,[1] claimant requests an increase in the unscheduled permanent disability award. On review, the issues are extent of unscheduled permanent disability and penalties. We affirm.

FINDINGS OF FACT

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

Claimant's claim was closed by a July 2, 1999 Notice of Closure that awarded 27 percent unscheduled permanent disability for claimant's left shoulder condition. Claimant requested reconsideration. An October 1, 1999 Order on Reconsideration awarded a total of 38 percent unscheduled permanent disability. The Order on Reconsideration also awarded a penalty pursuant to ORS 656.268(4)(g). The employer requested a hearing. The ALJ affirmed the Order on Reconsideration in its entirety.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability[2]

The first issue in dispute is claimant's adaptability factor. The parties contest claimant's base functional capacity (BFC).

The ALJ concluded that, based on claimant's at-injury job as a stock clerk, which is a heavy strength position, and claimant's job descriptions given to her doctors, her base functional capacity (BFC) was medium/heavy. The employer contends that claimant has not established that her BFC was "heavy." Specifically, the employer argues that claimant failed to demonstrate the physical capacity to successfully perform that work because her claim is based on her assertion that attempting to perform activities associated with stock work resulted in her left shoulder impingement condition. The employer argues that, therefore, because claimant was unable to successfully perform heavy job duties, the ALJ should have relied on claimant's at-injury, light strength job as a sales clerk to ascertain her BFC. We disagree.

Disability is rated as of the date of the issuance of the Order on Reconsideration. ORS 656.283(7); *Lori Kowalewski*, 51 Van Natta 13 (1999). Claimant's claim was closed by a July 2, 1999 Notice of Closure. Therefore the standards provided in WCD Admin. Order 98-055 apply.

BFC means an individual's demonstrated physical capacity *before the injury or disease.* OAR 436-035-0310(3) (WCD Admin Order 98-055) (emphasis added). Claimant's BFC is the highest strength category assigned in the DOT for the most physically demanding job she successfully performed in the five years prior to the date of issuance. OAR 436-035-0310(4)(a). If claimant does not meet the requirements of OAR 436-035-0300(3), her BFC is based on her job at injury. OAR 436-035-0310(4)(c).

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[1] We also acknowledge claimant's April 26, 2000 submission of a second respondent's brief (entitled "Claimant/Respondent's Brief in Response to Employer's Reply Brief"). We have not considered the second brief on review because claimant did not file a cross-request for review and his second brief is not otherwise authorized. *See* OAR 438-011-0020(2).

[2] The ALJ allowed claimant's testimony at hearing and the employer objected. Claimant provided testimony as an offer of proof. The testimony that claimant sought to introduce was not submitted at reconsideration and was not made a part of the reconsideration record. Therefore, we do not consider claimant's testimony on the issue of extent of permanent disability, nor do we address arguments based on that testimony. ORS 656.268(7)(h); ORS 656.283(7); *Koskela v. Willamette Industries*, 159 Or App 229 (1999); *Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996).

Claimant can meet the requirements of OAR 436-035-0300(3) only if she completed employment for a particular job for the maximum period specified in the SVP table in OAR 436-035-0300(4). OAR 436-035-0300(3)(b)(A).

Claimant was employed as a sales clerk in the food and drug department of the employer from September 13, 1989 to January 1999. (Ex. 46-4). She had been performing cashier duties until August 1997, when her job changed to receiving and distributing materials and stocking shelves. (Exs. 6, 23-2).

The employer's job description lists essential job functions as answering all customer questions politely and quickly, escorting customers to the merchandise when necessary, using the telephone and public address system, moving freight from the stockroom to the sales floor using equipment such as a pallet jack or a hand truck, maintaining store merchandise and fixtures in the stockroom, keeping shelves and displays filled with merchandise, keeping merchandise priced, clean and neat, accurately counting and ordering merchandise, teamwork, and operating a terminal/register. Claimant was also required to rework entire aisles of shelves and merchandise as the seasons changed or new merchandise plans were issued. (Ex. 46-11). According to the job description, claimant was required to lift and carry up to 45 pounds for 50 to 100 percent of the work shift, and was required to frequently reach overhead for higher shelf stocking and retrieving. *Id.*

As noted above, beginning in August 1997, claimant's job duties entailed increased moving of incoming boxes of material, opening them and stocking shelves, and, since November 1997, downstacking pallets. (Exs. 6, 23-2). Claimant reported that she was doing a great deal of overhead lifting and occasionally had to lift 60 to 70 pounds. (Exs. 13, 23-2).

There are two DOT codes that could apply to people who sell merchandise and stock product at retail stores: "SALES CLERK (retail trade)," DOT # 290.477-014, which assigns a strength category of "light" and "STOCK CLERK (retail trade)," DOT # 299.367-014, which assigns a strength category of "heavy."[3]

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[3] The DOT description for "SALES CLERK (retail trade)," DOT #290.477-014, which assigns a strength level of "light," provides:

> "Obtains or receives merchandise, totals bill, accepts payment, and makes change for customers in retail store such as tobacco shop, drug store, candy store, or liquor store: Stocks shelves, counters, or tables with merchandise. Sets up advertising displays or arranges merchandise on counters or tables to promote sales. Stamps, marks or tags price on merchandise. Obtains merchandise requested by customer or receives merchandise selected by customer. Answers customer's questions concerning location, price, and use of merchandise. Totals price and tax on merchandise purchased by customer, using paper and pencil, cash register, or calculator, to determine bill. Accepts payment and makes change. Wraps or bags merchandise for customers. Cleans shelves, counters, or tables. Removes and records amount of cash in register at end of shift. May calculate sales discount to determine price. May keep record of sales, prepare inventory of stock, or order merchandise. May be designated according to product sold or type of store."

The DOT description for "STOCK CLERK (retail trade) alternate titles: stock clerk, self-service store," DOT # 299.367-014, which assigns a strength level of "heavy" and an SVP of 4, provides:

> "Inventories, stores, prices, and restocks merchandise displays in retail store: Takes inventory or examines merchandise to identify items to be reordered or replenished. Requisitions merchandise from supplier based on available space, merchandise on hand, customer demand, or advertised specials. Receives, opens and unpacks cartons or crates of merchandise, checking invoice against items received. Stamps, attaches, or changes price tage on merchandise, referring to price list. Stocks storage areas and displays with new or tranferred merchandise. Sets up advertising signs and displays merchandise on shelves, counters, or tables to attract customers and promote sales. Cleans display cases, shelves and aisles. May itemize and total customer merchandise selection at check out counter, using case register, and accept case or charge card for purchases. May pack customer purchases in bags or cartons. May transport packages to specified vehicle for customer. May be designated according to type of merchandise handles as Baked-Goods Stock Clerk (retail trade); Delicatessen-Goods Stock Clerk (retail trade); Discount-Variety-Store Clerk (retail trade); Liquor-Store Stock Clerk (retail trade); Meat Stock Clerk (retail trade); Pharmacy Stock Clerk (retail trade); Meat Stock Clerk (retail trade); Pharmacy Stock Clerk (retail trade); Produce Stock Clerk (retail trade) or type of store worked in as Supermarket Stock Clerk (retail trade)."

DOT # 299.367-014 assigns a strength level of "heavy" and an SVP of "4."

Claimant's pre-injury stock clerk job, SVP 4, has a training period of 3+ months to 6 months. OAR 436-035-0300(4). According to the employer's job description, claimant performed stock clerk duties, at least intermittently, from the time she was hired in September 1989 to January 1999. And according to claimant's unrebutted reports, she performed cashier duties until August 1997, when she was assigned to stock clerk duties. These duties increased in amount and duration in November 1997 until claimant was injured on December 10, 1997. Because stocking duties were a significant element of claimant's work since August 1997, we find that she has worked more than the minimum time period (3+ months) for establishing proficiency. *See Edward F. Ebert*, 47 Van Natta 2170 (1995), *on recon* 48 Van Natta 37 (1996).

In *Ebert*, we concluded that performance of work beyond the minimum time period constitutes a rebuttable presumption of proficiency. In that case, we found no evidence that the claimant was not proficient or unable to perform the work of a finish carpenter. Likewise, in this case, there is no evidence that claimant was not proficient or unable to perform the work of a stock clerk.[4]

Nevertheless, after reviewing the record, we are persuaded that a combination of DOT codes most accurately describes claimant's duties. Claimant's job involved elements of both "stock clerk" (DOT # 299.367-014) and "sales clerk" (DOT #290.477-014). As discussed above, DOT # 299.367-014 assigns a strength category of "heavy" and DOT # 290.477-014 assigns a strength category of "light." Under OAR 436-035-0310(4)(a), when a combination of DOT codes most accurately describes claimant's duties, the highest strength for the combination of codes shall apply. Therefore, we conclude that claimant's job established her strength category as heavy.[5]

Claimant contends in the alternative that the impairment values for claimant's loss of range of motion and strength should be increased. After *de novo* review of the record, we adopt the ALJ's reasoning on this issue.

Finally, we adopt the ALJ's reasoning in assembling the factors relating to unscheduled permanent disability and affirm his conclusion that the total award of unscheduled permanent disability is 38 percent.

Penalty

We adopt and affirm the ALJ's opinion on this issue.[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 the extent issue, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for her counsel's services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

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[4] As noted above, the employer contends that claimant failed to prove proficiency because she did not demonstrate the physical capacity to perform the work, as demonstrated by her injury. There is no evidence that claimant was not proficient in her stocking duties or was unable to perform those duties prior to her injury. Also as noted above, BFC means an individual's demonstrated physical capacity *before the injury or disease*. Accordingly, claimant has demonstrated successful performance of the stock clerk duties before the injury or disease, as required under OAR 436-035-0310(4).

[5] The employer also contends that we should rely on Exhibit 54, a Vocational Evaluation, to establish claimant's BFC as "light." While we consider the record as a whole, including the job duties and physical demands of the relevant job, the fact remains that the most applicable DOT code or combination of DOT codes determines the strength category for that job. *See* OAR 436-035-0005(17); 436-035-0310(4)(a); *Gloria J. Wiley*, 50 Van Natta 781 (1998); *see also Kathyron D. Parsons*, 45 Van Natta 954 (1993) (a claimant's description is relevant to the determination of which DOT most accurately describes her at-injury job; however, it may not be relied upon to determine that no DOT description accurately describes her job, and that, consequently, her strength category must be determined without regard to the DOT).

[6] We note that *former* ORS 656.268(4)(g), authorizing the assessment of a penalty, has been renumbered as ORS 656.268(5)(e) with no change in language.

ORDER

The ALJ's order dated January 31, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
LUSHONA K. ICENHOWER, Claimant
WCB Case No. 98-10087
ORDER ON REVIEW
Black, Chapman, 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) Mongrain's order that denied claimant's request for a penalty for the SAIF Corporation's allegedly unreasonable claims processing on the basis that the Hearings Division lacked jurisdiction over the dispute. On review, the issues are jurisdiction, and potentially, penalties.

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

Claimant suffered an injury while working for SAIF's insured on November 30, 1998. SAIF denied the claim on December 14, 1998. (Ex. 7). Claimant requested a hearing, which was originally set for March 22, 1999. SAIF requested a postponement in order to conduct a deposition. The hearing convened on June 24, 1999, but was continued at SAIF's request, to allow it to arrange for witnesses in response to the penalty issue.

Shortly before the third scheduled hearing date of October 28, 1999, SAIF agreed to rescind its denial, accept the claim, and pay claimant's counsel a carrier-paid attorney fee. On November 18, 1999, the ALJ approved a Stipulation and Order to that effect. The only remaining issue was the issue of penalties for an allegedly unreasonable denial. On November 24, 1999, the ALJ issued an order that denied claimant's request for a penalty on the basis that the Hearings Division lacked jurisdiction over the dispute.

ORS 656.262(11)(a) provides, in relevant part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection."

Claimant contends that the ALJ retained jurisdiction over the penalty issue because the hearing had already commenced regarding the issues of compensability and penalties, notwithstanding the fact that SAIF later agreed to rescind its denial, making the compensability issue moot. We disagree.

In *Ronald A. Stock*, 43 Van Natta 1889 (1991), we held that the claimant's request for hearing was properly dismissed, where, although the claimant also alleged entitlement to an attorney fee under ORS 656.382(1), the only viable issue remaining was entitlement to a penalty under former ORS 656.262(10). Similarly, here, although compensability was originally at issue, SAIF's rescission of its denial removed that issue from consideration by the ALJ. Because the only remaining issue was entitlement to a penalty, the request for hearing should have been dismissed for lack of jurisdiction.[1] ORS 656.262(11)(a). *Accord Raymond J. Dominiak*, 48 Van Natta 108 (1996).

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[1] We therefore modify the ALJ's "order" paragraph to indicate that claimant's request for hearing is *dismissed*, rather than "the claimant's request for a penalty is *denied* for want of jurisdiction to decide that issue." (*O & O* at 3) (Emphasis added).

ORDER

The ALJ's order dated November 29, 1999 is affirmed, as modified herein.

May 24, 2000 Cite as 52 Van Natta 887 (2000)

In the Matter of the Compensation of
ABRAHAM LEMUS, Claimant
WCB Case No. 99-08679
ORDER ON REVIEW
J. R. Perkins III, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed the Order on Reconsideration award of 19 percent (60.80 degrees) unscheduled permanent disability for a back condition. On review, the issue is extent of unscheduled permanent disability.[1] We reverse.

FINDINGS OF FACT

Claimant is an agricultural worker (cherry picker). On June 24, 1998, claimant sustained a compensable back injury when he fell out of a jeep on the way to his employer's orchard. SAIF accepted a thoracic contusion and T11-12 compression fracture. (Exs. 9, 12, 25).

Claimant returned to his regular work sometime before April 20, 1999, and returned to his job at injury on June 24, 1999. (Ex. 17, 22-3). On June 29, 1999, Dr. Scheinberg performed a closing examination at the request of SAIF. (Ex. 22). Dr. Scheinberg found that claimant's condition was medically stationary. (Ex. 22-9). In response to SAIF's questionnaire, Dr. Scheinberg responded that claimant should be released to regular work. (*Id.*) However, Dr. Scheinberg then stated that "I would suggest that [claimant] have a 50-pound lifting restriction on an occasional basis, and a 30-pound lifting restriction on a repetitive basis." Dr. Scheinberg also commented that "I believe [claimant] should also avoid repetitive continuous torquing of the back. Based on the costrochondral junction strain on the left, I feel for at least the next year [claimant] to some degree should avoid repetitive heavy pushing and pulling with his left upper extremity." (Ex. 22-9).

On July 15, 1999, claimant's attending physician, Dr. Ruiz, concurred with Dr. Scheinberg's report. (Ex. 23). On July 15, 1999, SAIF issued a Notice of Closure that awarded claimant 7 percent unscheduled permanent disability for his back condition, based on his mild compression fractures at T11 and T12 and loss of range of motion in his thoracic spine. (Ex. 24).

Claimant requested reconsideration of SAIF's Notice of Closure. (Ex. 28). On October 11, 1999, an Order on Reconsideration increased claimant's unscheduled permanent disability to 19 percent. (Ex. 29). In particular, the Department awarded claimant an adaptability value of 12 percent to account for his age, education, and residual functional capacity of "medium with restrictions," or medium/light. *See* OAR 436-035-0310. (Ex. 29-3).

SAIF requested a hearing. On January 25, 2000, the ALJ issued an order affirming the Order on Reconsideration. SAIF then requested Board review.

CONCLUSIONS OF LAW AND OPINION

The sole issue is whether claimant is entitled to an adaptability rating for his compensable back condition. The parties agree that claimant's impairment rating is 7 percent, as awarded by the Notice of Closure. The ALJ affirmed the Order on Reconsideration award of 19 percent unscheduled permanent disability, assembling claimant's impairment rating with an adaptability factor of 12. In doing so, the

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[1] Claimant has requested that his untimely filed respondent's brief be considered. SAIF has not objected to the request, which was based on a recent personnel matter and change-over. In light of such circumstances, we have reviewed claimant's respondent's brief, as well as SAIF's reply brief. *See* OAR 438-011-0030.

ALJ found that claimant had not returned to his regular work, but instead was restricted from repetitive twisting or "torquing" of his back, and was thus precluded from regular work meeting the Dictionary of Occupational Titles (DOT) definition for "cherry picker." (DOT 403.687-018); OAR 436-035-0005(17)(c); OAR 436-035-0310(3)(l)(C).

On review, SAIF contends that claimant returned to his regular work, and is therefore precluded from receiving anything beyond a rating for impairment. ORS 656.726(3)(f)(D)(i).[2] We agree.

"Regular work" means "the job the claimant was doing at the time of injury or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-035-0005(17)(c). In *Diane C. Leonetti*, 50 Van Natta 2060 (1998), we found that the claimant was not entitled to an adaptability factor because she had been released to, and was performing, her regular work as a surgical prep nurse. We so held despite the fact that medical evidence established that the claimant would need to request assistance on occasion for lifting greater than 25 pounds. 50 Van Natta at 2060.

Similarly, in *James I. Dorman*, 50 Van Natta 1649, *on recon* 50 Van Natta 1773 (1998), *aff'd mem* 164 Or App 175 (1999), we declined to award the claimant an adaptability rating where he had returned to his regular work as a truck driver, despite the fact that his attending physician had limited him to occasional lifting of no more than 20 pounds, and frequent lifting of no more than 10 pounds. We reached such a conclusion even though the claimant had "self-modified" his manner of performing the same job duties he had performed at injury. 50 Van Natta at 1650.

Here, the evidence in the record with regard to claimant's return to work is: (1) a note by his attending physician that claimant "continues at hvy [*sic*] farm labor" (Ex. 17); and (2) examining physician Dr. Scheinberg's note that "[Claimant] returned to work in Oregon for [his employer] on June 24, 1999. He is picking cherries, working at his own speed. He says he is able to rest when he feels pain." (Ex. 22-3).

Importantly, in *Dorman*, we stated that, in determining whether the claimant has returned to regular work, we must compare his particular job duties at the time of injury with the job duties the worker is performing when he or she returns to work. The DOT description of a given job can be relevant to the determination, but only if the DOT definition accurately reflects "the job held at time of injury," or "employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." 50 Van Natta at 1774. Here, even though Dr. Scheinberg's restrictions place claimant outside of the DOT description for "cherry picker," the only evidence in the record is that claimant has in fact returned to his regular cherry picker job.

Although claimant apparently has partially "self-modified" his job at injury, the record persuasively establishes that he has returned to "regular work" as contemplated by OAR 436-035-005(17)(c). There is no evidence that claimant's job duties or responsibilities have been modified in any specific manner. *Compare Vincent C. Drennen*, 48 Van Natta 819, *on recon* 48 Van Natta 969 (1996) (The claimant had not returned to "regular work" because he returned to his job at injury only after asking his treating doctor to release him to regular duty instead of light duty, and avoided repetitive bending, stooping, twisting and heavy lifting). In *Margaret M. Morgan*, 49 Van Natta 1934, 1935 (1997), we distinguished *Drennen*, where, although claimant's work site was "substantially modified," the record did not establish that the claimant's job duties had changed post injury. Here, there is no proof even that claimant's work site has been modified in any way. As in *Morgan*, therefore, we find that this case is distinguishable from *Drennen*.

Accordingly, we find that claimant is limited to a 7 percent unscheduled award for impairment. ORS 656.726(3)(f)(D)(i). Consequently, we reverse the ALJ's order that had affirmed the Order on Reconsideration and instead reinstate SAIF's Notice of Closure.[3]

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[2] ORS 656.726(3)(f)(D)(i) provides: "Notwithstanding any other provisions of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if * * * (i) the worker returns to regular work at the job held at the time of injury."

[3] Because the increased compensation granted by the Order on Reconsideration has been disallowed, it necessarily follows that the ALJ's insurer-paid attorney fee under ORS 656.382(2) should be reversed.

ORDER

The ALJ's order dated January 25, 2000 is reversed. The July 15, 1999 Notice of Closure is reinstated and affirmed. The ALJ's assessed attorney fee is also reversed.

Board Member Phillips Polich specially concurring.

I agree with the result reached by the Board here to limit claimant to a rating for impairment. The statute is clear that if a claimant returns to regular work, he or she is not entitled to an adaptability rating. ORS 656.726(3)(f)(D)(i). Nevertheless, I write separately in an effort to ensure that we do not lose sight of the broad concept of unscheduled permanent disability.

The purpose of an award of unscheduled permanent partial disability is to account for the claimant's permanent loss of earning capacity. ORS 656.214(5); OAR 436-035-005(16). Here, we have evidence that the claimant's earning capacity as a cherry picker has been adversely impacted by his compensable injury. Claimant has evidently returned to his job at injury, but has done so only by "working at his own speed" and by resting his back when necessary. (Ex. 22-3). This modification is not entirely self-imposed. Examining physician Dr. Scheinberg confirms that claimant should avoid "repetitive continuous torquing of the back." (Ex. 22-9).

The only reasonable conclusion from this evidence is that claimant's ability to earn a living as a cherry picker, a very physically demanding occupation, has been diminished. Therefore, I believe the result reached by the Board, although mandated by statute, is contrary to the overall scheme and purpose of unscheduled permanent disability.

May 24, 2000 Cite as 52 Van Natta 889 (2000)

In the Matter of the Compensation of
JUDITH R. MAY, Claimant
WCB Case No. 99-06575
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) affirmed an Order on Reconsideration that awarded no permanent disability based on claimant's hysterectomy and oophorectomy; and (2) denied claimant's motion for remand to the Director for promulgation of a second temporary rule to address claimant's alleged uterine impairment. On review, the issues are remand and extent of unscheduled permanent disability.

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

We do not adopt the portion of the Opinion and Order finding that the surgical plan contemplated removal of claimant's ovaries regardless of the surgical method employed. Instead, we offer the following findings and conclusions.

Claimant's surgeon anticipated performing "possible vaginal hysterectomy, possible abdominal hysterectomy and bilateral salpingo-oophorectomy, also possible vaginal repair." (Ex. 18). Based on this statement, we cannot say that removal of claimant's ovaries (salpingo-oophorectomy) was planned whether the surgery was vaginal or abdominal. Moreover, the attempted vaginal hysterectomy "had to be aborted" and replaced with an abdominal hysterectomy (with removal of the ovaries), apparently because claimant's "multiple fibroids had fanned out too much[.]" (*Id.*). There is no evidence relating claimant's fibroids to her work injury. And we agree with the ALJ that there is no medical evidence indicating that removal of claimant's ovaries was a sequelae of her injury (rather than a consequence of her fibroids and/or the abdominal procedure necessitated by the fibroids). Under these circumstances, we conclude that claimant has not carried her burden of proving injury-related impairment under OAR 436-035-0430(7). *See Synndrah R. Spillers*, 52 Van Natta 714 (2000).

Finally, we agree with the ALJ's denial of claimant's request for remand for the promulgation of a second temporary rule, as well as the ALJ's reasoning regarding claimant's objection to the Director's first temporary rule regarding the removal of claimant's uterus. *See Leodegario M. Gomez-Martinez*, 51 Van Natta 1251, 1252 (1999) (ALJ lacked authority to substitute his judgment for that of the Director regarding the propriety of temporary rules promulgated under the disability standards) (citing *Shubert v. Blue Chips*, 151 Or App, 710, 715 (1997)).

ORDER

The ALJ's order dated February 18, 2000 is affirmed.

May 24, 2000 Cite as 52 Van Natta 890 (2000)

In the Matter of the Compensation of
DAVID H. McKINLEY, Claimant
WCB Case No. 99-02415
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for an L4-5 condition; and (2) upheld the employer's denial of claimant's L2-3 injury and aggravation claim. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

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

On June 6, 1995, claimant, a carpenter, compensably injured his low back lifting a framed wall. (Ex. 1). Dr. Andrews treated claimant conservatively, but his symptoms recurred. (Ex. 15).

A July 3, 1995 MRI revealed a small Schmorl's node and a slight annular bulge at L2-3 and mild stenosis and an annular bulge and protrusion into the right lateral recess at L4-5. (Ex. 17). Dr. Andrews diagnosed sciatica and lumbar strain. (Ex. 18).

On February 26, 1996, after a myelogram and CT scan were performed, Dr. Franks, neurosurgeon, diagnosed a herniated disc at L4-5 with radicular symptoms from the L5 nerve root. (Exs. 30, 31,32). As of March 7, 1996, Dr. Franks was not recommending surgery for the L4-5 condition. (Exs. 32, 33).

On August 1, 1996, after litigation regarding compensability of a June 6, 1995 herniated disc, the employer accepted a nondisabling lumbosacral strain and L4-5 disc bulge. (Exs. 34, 36, 38). Claimant sought reclassification; an August 19, 1996 Determination Order affirmed the nondisabling classification of the claim. (Ex. 37).

On October 14, 1997, claimant sought treatment from Dr. Ordonez, neurosurgeon, for right foot numbness, cramping in the right buttock, lower leg and foot, pain in the right groin and inner thigh area and back pain. Dr. Ordonez diagnosed an L4-5 disc herniation with radicular pain from the L5 nerve root, for which he requested surgery. (Ex. 39). On October 17, 1997, Dr. Ordonez filed an aggravation claim and authorized time loss. (Ex. 40). A subsequent MRI revealed a disk bulge at L2-3, unchanged. (Ex. 41).

On January 6, 1998, Dr. Williams examined claimant for the employer. (Exs. 43, 44).

On February 2, 1998, the employer denied claimant's aggravation claim on the basis that there was insufficient evidence of a pathological worsening of claimant's condition. (Ex. 45). Claimant requested a hearing, which was dismissed on January 28, 1999 because the request had been withdrawn. (Ex. 54B).

On April 23, 1998, Dr. Ordonez performed a semihemilaminectomy for a large L4-5 disc herniation compressing the L5 nerve root. Dr. Ordonez also performed a diskectomy at L2-3 for a lateral disc herniation. (Ex. 47). Within days of the surgery, claimant reported a remarkable improvement in his symptoms.

On November 4, 1998, claimant formally requested that the acceptance be amended to include the L2-3 disc bulge and subsequent herniation; a herniated disc at L4-5; and reclassification of his claim as disabling. (Ex. 53).

On November 13, 1998, Dr. Ordonez filed an aggravation claim, authorizing time loss. (Ex. 54).

On March 3, 1999, the employer denied the November 13, 1998 aggravation claim on the basis that the worsening of claimant's L4-5 disc condition did not arise out of the original injury of June 6, 1995, and denied that the claim had become disabling. The employer also declined to amend the acceptance to include the L2-3 disc bulge and herniation on the basis that that condition did not arise out of and in the course and scope of employment. (Ex. 54c). Claimant requested a hearing on the denial.

CONCLUSIONS OF LAW AND OPINION

Compensability-L4-5 Herniated Disc

Claimant has an accepted claim for a nondisabling lumbosacral strain and L4-5 disc bulge. Claimant requested acceptance of the L4-5 herniated disc. Claimant's L4-5 disc herniation was diagnosed in 1996 and was ordered accepted by an April 17, 1996 litigation order that was affirmed by the Board and not appealed further. (Exs. 34, 38). Thus, claimant's L4-5 herniated disc is compensable as a matter of law.

Aggravation-L4-5 Herniated Disc

The ALJ concluded that claimant failed to prove an aggravation of the L4-5 herniated disc condition. The ALJ reasoned that, because the February 2, 1998 aggravation denial had become final "with prejudice" by operation of law because claimant had failed to timely request a new hearing on the denial, claimant had to prove that his L4-5 condition had worsened since that denial. Claimant contends that, because the prior request for hearing was dismissed without prejudice, claim preclusion does not operate to bar his subsequent aggravation claim. We disagree for the following reasons.

Because the prior ALJ's order regarding the February 2, 1998 aggravation denial did not expressly dismiss the claimant's hearing request with prejudice, the dismissal was without prejudice. *Julie Mayfield*, 42 Van Natta 871 (1990) (an ALJ's order of dismissal is interpreted by the Board as a dismissal "without prejudice" unless the order otherwise specifies). Where an order is dismissed without prejudice, the dismissal order lacks preclusive effect on subsequent litigation. *See Claudia I. Hamilton*, 42 Van Natta 600 (1990); *Glenn L. Woodraska*, 41 Van Natta 1472, 1476 (1989). Thus, the issue raised by claimant's earlier hearing request could be raised again at any time *provided that the time limits set out by ORS 656.319 were satisfied. Ralph B. DePaul*, 44 Van Natta 92 (1992) (the "reservation" of issues raised by a request for hearing amounts to a dismissal of those issues without prejudice; those issues can then be raised again as long as a new hearing is requested within the time limits set forth in ORS 656.319).

However, as noted by the ALJ, in this case the time in which to protest the February 2, 1998 denial had long since passed.[1] Therefore, even though the prior ALJ dismissed claimant's request for hearing without prejudice, when the dismissal order became final, the denial itself became final by operation of law and claim preclusion attached. *Drews v. EBI Companies*, 310 Or 134, 149 (1990).

In *Drews*, the Court stated that, for purposes of issue or claim preclusion:

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[1] The latest date a request for a new hearing on the February 2, 1998 denial could have been made was 180 days after the denial, by August 1, 1998. ORS 656.319. In order to have avoided claim preclusion, claimant could have requested reinstatement of the request for hearing prior to the dismissal order becoming final.

"A claim determination is not final until hearing and judicial review rights are barred or exhausted. The statutory scheme indicates that the finality requisite for claim or issue preclusion, against the worker, occurs only *when a worker fails to timely request a hearing after a claim denial*, a determination order, or a notice of claim closure, ORS 656.319, or by failure to file a timely appeal to the Board, ORS 656.289(3), or the courts. ORS 656.295(8)." (Emphasis added).

Consequently, because the February 2, 1998 aggravation denial has become final, claimant is barred from relitigating that denial.

Nevertheless, although claimant is barred from pursuing the previously denied aggravation claim, he may file a new aggravation claim if his condition has changed and the claim is supported by new facts that could not have been presented earlier. Consequently, we begin our analysis by determining whether claimant's condition has changed since the earlier claim. *E.g., North Clackamas School Dist. v. White*, 305 Or 48, 57 (1988); *see also Kepford v. Weyerhaeuser*, 77 Or App 363, 365, *rev den* 300 Or 722 (1986).

At the time of the February 2, 1998 denial, claimant had filed an October 17, 1997 aggravation claim based on Dr. Ordonez' review of the July 3, 1995 MRI that revealed an L4-5 disc herniation on the right with extension into the nerve root foramen of L4 and compressing the L5 nerve root on the right and causing stenosis of the lumbar canal at L4-5. Dr. Ordonez' impression was L5 and L1 radiculopathy on the right with most findings indicative of L5 nerve root involvement, caused by an L4-5 disc herniation on the right. (Ex. 39). Dr. Ordonez reported that claimant's condition was an aggravation of symptoms caused by the June 1995 work injury and requested surgery. *Id.* Dr. Ordonez' impression was confirmed by an October 24, 1997 MRI.

In April 1998, after the February 2, 1998 denial, Dr. Ordonez performed the requested surgery. He found the expected L4-5 disc herniation directly compressing the L5 nerve root. (Ex. 47). Claimant could have presented that evidence at the time of the January 28, 1999 hearing. Therefore, we agree with the ALJ that claimant's November 4, 1998 aggravation claim was based on the same facts that were asserted in the prior aggravation claim. Because claimant has not shown that his condition has changed and that the claim is supported by new facts that could not have been presented earlier, claimant has failed to prove a compensable worsening of his accepted L4-5 herniated disc condition.

Compensability of L2-3 Disc Condition

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

ORDER

The ALJ's order dated November 30, 1999 is affirmed.

May 24, 2000 Cite as 52 Van Natta 892 (2000)

In the Matter of the Compensation of
MARTHA K. SEELEY, Claimant
WCB Case No. 99-05193
ORDER ON REVIEW
Susan L. Frank, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of claimant's Hepatitis C claim. On review, the issue is compensability.

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

The ALJ concluded that claimant did not prove compensability of her claim for Hepatitis C because the record showed only that work activities caused an increased risk of exposure and not that her condition was in fact related to her work. *E.g., Bronco Cleaners v. Velasquez*, 141 Or App 295, 299 (1996); *Deborah D. Houston*, 50 Van Natta 1547 (1998). On review, although acknowledging that previous

Board cases support the ALJ's reasoning and conclusion, claimant contends that those cases should be overruled. Furthermore, claimant asserts that the last injurious exposure rule does not require actual causation and, thus, under this theory she proved compensability.

We continue to adhere to those cases that support the ALJ's conclusion. As explained by the court in *Bronco Cleaners v. Velasquez*, ORS 656.266 requires some affirmative evidence that the condition is caused by the claimant's work exposure. 141 Or App at 298.

We also disagree with claimant that application of the last injurious exposure rule allows her to carry her burden of proof. As a rule of proof, the last injurious exposure rule allows a claimant to prove the compensability of an injury without having to prove the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the disease. *E.g., Roseburg Forest Products v. Long*, 325 Or 305, 308 (1997). Thus, although claimant is relieved of proving compensability against a particular employer, claimant continues to have the burden of showing that the disease was caused by employment-related exposure.

Because the record does not affirmatively show that claimant's Hepatitis C was caused in major part by employment-related exposure, whether or not we apply the last injurious exposure rule, we conclude that claimant did not prove compensability.

ORDER

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

In the Matter of the Compensation of
BEN E. CONRADSON, Claimant
WCB Case No. 99-06301
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that: (1) affirmed an Order on Reconsideration that classified claimant's low back strain claim as disabling; and (2) awarded claimant's attorney a fee under ORS 656.382(2). On review, the issues are claim classification and attorney fees. We affirm.

FINDINGS OF FACT

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

On January 29, 1998, claimant compensably injured his low back. On January 13, 1999, after litigation, the employer accepted a nondisabling low back strain claim. (Ex. 21B). A February 22, 1999 Determination Order determined that the claim remain classified as nondisabling. (Ex. 23). Claimant requested reconsideration, contending that the claim should be classified as disabling and requesting a medical arbiter examination. (Ex. 23A).

Dr. Berselli performed the arbiter examination on June 14, 1999. (Ex. 24).

A July 16, 1999 Order on Reconsideration reclassified the claim as disabling on the basis that there was a reasonable expectation that the worker would be entitled to an award of permanent disability under the standards once he became medically stationary as required by OAR 436-030-0045(10)(c). (Ex. 25). The employer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Claim Classification

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.

The ALJ affirmed the July 16, 1999 Order on Reconsideration that cited OAR 436-030-0045(10)(c) to support its "disabling" classification. (Ex. 25-2). As pointed out by the employer, that rule is premised on the proposition that the worker's condition is *not* medically stationary. In analyzing the claim's nondisabling/disabling status, the ALJ found that claimant was declared medically stationary on January 18, 1999. Accordingly, we refer instead to OAR 436-030-0045(10)(b), which states that a claim is disabling if the worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability under the standards developed pursuant to ORS 656.726.

Here, claimant became medically stationary on January 18, 1999 (within one year from his January 29, 1998 injury). Furthermore, based on Br. Berselli's persuasive report, claimant will be entitled to an award of permanent disability under the standards. (*See* Ex. 24). *See* ORS 656.005(17) and 656.005(7)(c). Consequently, his claim must be classified as disabling.

Attorney Fees

The ALJ awarded claimant's attorney an assessed fee under ORS 656.382(2). On review, the employer argues that claimant is not entitled to a fee under that provision. In response, claimant argues that the ALJ correctly awarded attorney fees under ORS 656.382(2) for successfully defending a Request for Hearing initiated by the employer. Claimant also notes that the employer admits that the ALJ did not "disallow" or "reduce" compensation.

ORS 656.382(2) provides, in part:

> "If a request for hearing * * * is initiated by an employer * * *, and the [ALJ] * * * finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer * * * shall be required to pay * * * a reasonable attorney fee * * * for legal representation * * * for the claimant at and prior to the hearing * * *."

There are three things that a claimant must prove to establish an entitlement to attorney fees under this statute: first, that the employer initiated a request for a hearing to obtain a disallowance or reduction in the claimant's award of compensation or filed a cross-appeal to do so, *Dotson v. Bohemia*, 80 Or App 233, 236, *rev den* 302 Or 35 (1986); second, that the claimant's attorney performed legal services in defending the compensation award, *Mobley v. SAIF*, 58 Or App 394, 396, (1982); and, third, that the ALJ found on the merits that the claimant's award of compensation should not be disallowed or reduced. *Liberty Northwest Insurance v. McKellips*, 100 Or App 549, 550 (1990); *Agripac, Inc. v. Kitchel*, 73 Or App 132, 135 (1985).

Here, the employer initiated a request for hearing challenging the Order on Reconsideration's reclassification of claimant's claim to disabling. Furthermore, as supported by the record, claimant's counsel provided legal services in contesting the employer's request for hearing.

Finally, the ALJ concluded on the merits that claimant's compensable low back strain condition claim was properly characterized as "disabling" rather than "nondisabling." Consequently, the ALJ affirmed the Order on Reconsideration's "award" of a disabling claim classification. If the ALJ had concluded otherwise, claimant's "disabling" compensation award would have been disallowed because the claim would have been reclassified to "nondisabling," thereby limiting his entitlement to compensation for medical services only and precluding him from obtaining the eventual closure of his claim and a subsequent evaluation of the claim for temporary and/or permanent disability benefits.

Our analysis is consistent with the Court's analysis in *Shoulders v. SAIF*, 300 Or 606 (1986). In that case, the Court held that an ALJ's finding of "compensability" was an award of compensation because compensation (which 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) would naturally follow from a compensability finding. *Shoulders*, 300 Or at 609. Consequently, the Court determined that the claimant was entitled to an attorney fee award under ORS 656.382(2) when the Board affirmed the ALJ's compensability finding regarding two of four separately disputed conditions.

Here, consistent with *Shoulders*, the Order on Reconsideration's "disabling" classification establishes a finding from which compensation will naturally flow. As such, consistent with *Shoulders*, the Order on Reconsideration's decision constitutes an award of compensation and the ALJ's affirmance constitutes a finding that the Order on Reconsideration's award has not been disallowed or reduced.

Accordingly, for the reasons expressed above, claimant's attorney is entitled to an assessed fee for services rendered at the hearing level. ORS 656.382(2). Inasmuch as the amount of the ALJ's attorney fee award has not been challenged, we affirm the ALJ's order.

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

ORDER

The ALJ's order dated February 9, 2000 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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[1] Claimant's counsel is not entitled to an attorney fee for his efforts on review defending the attorney fee issue. *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986).

May 25, 2000 Cite as 52 Van Natta 895 (2000)

In the Matter of the Compensation of
JAMES FRANZ, Claimant
WCB Case No. 99-0195M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Claimant requested reconsideration of our May 21, 1999 Own Motion Order that declined to reopen his claim for the payment of temporary disability compensation because the record did not establish that claimant required surgery or hospitalization. With his request for reconsideration, claimant submitted a medical report wherein surgery had been recommended for his current condition. However, the SAIF Corporation issued a compensability denial of claimant's current condition on which claimant filed a request for hearing with the Hearings Division (WCB Case No. 99-04212). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated December 30, 1999, Administrative Law Judge (ALJ) Black upheld SAIF's May 17, 1999 denial, and found a subsequent self-insured employer responsible. The employer requested Board review of ALJ Black's order, and in an order issued on today's date, the Board affirmed that portion of ALJ Black's order pertaining to the responsibility issue.

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

Here, the current condition and ensuing medical treatment for which claimant requests own motion relief, remains in denied status, and is the responsibility of a subsequent employer. As a result, we are not authorized to grant claimant's request for own motion relief. *See Id.*

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES FRANZ, Claimant
WCB Case Nos. 99-04212 & 99-02048
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) set aside its responsibility denial of claimant's claim for his current C6-7 condition; and (2) upheld the SAIF Corporation's responsibility denial of the same condition. Claimant cross-requests review, seeking an increased fee for his counsel's services at hearing, in addition to a fee for services on review. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt and affirm the ALJ's order with respect to the issue of responsibility.

Attorney Fees / Hearing

On review, claimant seeks an increased fee beyond the $2,500 attorney fee awarded at hearing by the ALJ pursuant to ORS 656.307. Turning to the factors under OAR 438-015-0010(4), our review of the record reveals the following. Claimant's counsel did not submit a statement of services. Nevertheless, the employer has not opposed claimant's request for an increased fee. We further find that the hearing in this matter lasted approximately one half hour (transcript of 16 pages). No depositions were taken. Additionally, the medical evidence was of average complexity when compared to claims normally presented to this forum for resolution. Finally, the record included approximately 27 exhibits (with claimant's counsel obtaining one litigation report).

With respect to the value of the interest involved and the benefit secured, we find that, although this was a responsibility case, claimant's SAIF claim was in Own Motion status. Consequently, because claimant was required to establish a "new injury" against the self-insured employer in order to secure additional benefits and new aggravation rights, the interest involved and benefit secured were significant.

Finally, we note that all attorneys involved in this matter are skilled litigators with substantial experience in workers' compensation law. No frivolous issues or defenses were raised. However, due to the nature of the proceeding, we find it unlikely that claimant's counsel would go uncompensated for her services.[1]

Based on our consideration of the factors in OAR 438-015- 0010(4), particularly the aforementioned factors of complexity, value, and benefit, we conclude that $3,500 is a reasonable fee for claimant's counsel's services at hearing. We modify the ALJ's order accordingly.

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[1] There has been no contention by the employer that claimant's counsel did not "actively and meaningfully" participate in the responsibility proceedings. *See* ORS 656.307(5); *Darrel W. Vinson*, 47 Van Natta 356 (1995).

Attorney Fee / Board Level

Claimant's attorney is also entitled to an assessed fee for services on review.[2] ORS 656.382(2).[3] After considering the factors set forth in OAR 438-015-0010(4) and applying them in this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved. We further note that claimant is not entitled to an attorney fee on review for services devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated December 30, 1999 is modified in part and affirmed in part. In lieu of the ALJ's award, claimant's counsel is awarded an assessed attorney fee of $3,500, for services at hearing, payable by the employer. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the employer.

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[2] Claimant's compensation was at risk for a reduction due to the fact that the SAIF claim was in Own Motion status and the ALJ assigned responsibility to the self-insured employer, which had the highest rate of compensation. (Ex. 18). It follows that, had we reversed the ALJ's responsibility finding and found SAIF responsible, claimant's benefits would have been reduced. *See Oliver E. Pritchard*, 50 Van Natta 202 (1998).

[3] Claimant, however, is not entitled to an attorney fee award under ORS 656.307 for his counsel's services on review. *See* ORS 656.307(5); *Lynda C. Prociw*, 46 Van Natta 1875 (1994).

May 25, 2000 Cite as 52 Van Natta 897 (2000)

In the Matter of the Compensation of
ARTHUR E. FREDRICKSON, Claimant
WCB Case No. 99-06104
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the statutory processing agent's denial of claimant's injury claim issued on behalf of the alleged noncomplying employer. On review, the issue is whether claimant's injury arose out of and in the course and scope of his employment. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings," with the following exceptions and supplementation.

We do not adopt the last and third from the last sentences.

We do not find that the unpaved area where claimant fell had no "obstructions."

Instead, we find that claimant credibly testified that he fell on the employer's premises, on March 6, 1999, as follows:

> "I took two steps, I think -- took a step on my right foot and I hooked my toe in something, I think. I mean, I believe I did. Anyway, and I -- my foot kind of turned on its side and I fell headlong." (Tr. 22; *see* Tr. 30, 32-33).

CONCLUSIONS OF LAW AND OPINION

Claimant fell and suffered injuries as he was leaving the employer's car sales lot after work on March 6, 1999.

ORS 656.005(7)(a) provides that a "'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]" There are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "arising out of employment" tests the causal connection between the injury and the employment; and (2) "in the course of employment" concerns the time, place, and circumstances of the injury. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994).

The phrases "arising out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. *Norpac Foods*, 318 Or at 366; *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997). This is called the unitary "work-connection" test. Under that test, both elements must be satisfied to some degree; however, they need not be met to the same degree. *Id.* Neither element is dispositive; rather, we consider all the circumstances to determine if the claimant has satisfied the work-connection test. *Norpac Foods*, 318 Or at 366, 369. When the factors supporting one element are many, the factors supporting the other may be minimal. *Redman Industries, Inc. v. Lang*, 326 Or 32, 35 (1997).

We agree with the ALJ that claimant's injury arose in the course and scope of his employment. *See Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997).[1] Accordingly, we adopt the ALJ's "Conclusions" through the third full paragraph on page 2, with the following supplementation.

The ALJ reasoned that claimant's injury was not "distinctly" associated with his employment and the employment did not put claimant in a position to be injured. Further finding that claimant's fall was not due to an idiopathic condition, the ALJ concluded that it did not arise out of claimant's employment because it was "unexplained." We disagree.

An injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." *Norpac Foods*, 318 Or at 366. A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. *Wilson v. State Farm Ins.* 326 Or 413, 416 (1998); *see Phil A. Livesley Co. v. Russ*, 296 Or 25, 29 (1983).[2] "A causal connection must be linked to a risk connected with the nature of the work or a risk to which the work environment exposed [the] claimant." *Wilson*, 326 Or at 416; *Redman Industries v. Lang*, 326 Or at 36 (citing *Fred Meyer, Inc. v. Hayes*, 325 Or at 601). Although we no longer rely on the *Mellis* factors[3] as an independent and dispositive test of work connection, we may consider those factors that remain helpful under the *Norpac Foods'* analysis. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996); *First Interstate Bank of Oregon v. Clark*, 133 Or App 712, 717 (1995).

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[1] In *Hayes*, the claimant suffered a compensable injury after her work shift ended while going to her car, which was parked in the employer's parking lot. The Supreme Court held:

> "An injury occurs 'in the course of' employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it. 'In the course of' employment also includes a reasonable period of time after work for the worker to leave the employer's premises, including the employer's parking lot." 325 Or at 598.

[2] In *Ruben G. Rothe*, 45 Van Natta 369 (1993), we held that the enactment of ORS 656.266 "effectively overruled" the holding in *Russ*, that an unexplained or idiopathic fall is compensable if it occurs at work while the worker is performing regular duties. Because the statute provides that compensability is not established "merely by disproving other possible explanations of how the injury or disease occurred," we held that the worker must show an affirmative work-related cause of the injury or disease. In this case, we find claimant's reporting sufficient to establish that there was a hazard on the work premises that caused his injuries.

[3] In *Mellis v. McEwen, Hanna, Giswold*, 74 Or App 571, 574, *rev den* 300 Or 249 (1985), the court held that, in determining whether an injury arose out of and in the course of employment, the following seven factors should be considered: (1) whether the employment activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and the employee; (3) whether the activity was an ordinary risk of, and incidental to, employment; (4) whether the employer paid for the activity; (5) whether the activity occurred on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission.

Here, claimant was engaged in an activity within the boundaries of his ultimate work when he was injured. The employer required claimant to park the company car that he drove to work on the employer's lot during business hours, so that it was on display for sale. (Tr. 28-29, 73). The employer also required claimant to move that car off the lot at the end of business hours (before claimant drove the car home), so that security barricades (other parked cars) could be set up at the car lot entrances. (Tr. 29, 35, 73-74). Claimant had parked the company car in the lot and re-parked it later in the adjoining alley, during work hours on March 6, 1999. Just after the employer's 8:00 P.M. closing time that day, claimant walked across the unpaved lot where the car had previously been parked toward the paved alley area where he had recently re-parked it. As he walked, claimant "hooked" his right toes on something near the boundary between the paved alley and the employer's unpaved lot and fell forward onto pavement, breaking an ankle and a finger, and injuring a shoulder.

Claimant's parking maneuvers benefited him and the employer. Claimant had traversed the same route for the same reason on numerous previous occasions and the employer was aware that claimant parked in the alley and walked across the lot after work to retrieve the car. Therefore, claimant's activity was contemplated by the employer and claimant and the employer acquiesced in it. Furthermore, the activity occurred primarily on the employer's premises.[4]

These "time, place, and circumstances" facts suggest that the risk of injury while walking across the employer's sales lot was a risk connected with claimant's employment (just as they support a conclusion that claimant's fall occurred in the course and scope of that employment).

The employer contends that claimant's injury did not arise out of his employment because claimant never identified the cause of his fall. It argues that claimant's report of "hooking his toes on something" was mere conjecture, a supposition based on the fact that he fell. Therefore, the employer urges us to find that claimant's fall was unexplained and unrelated to a work hazard or risk. We are not persuaded by the employer's arguments. *See Wilson v. State Farm Ins.*, 326 Or 413.[5]

First, claimant contemporaneously reported that he fell because he "hooked" his toes on something. (Tr. 68). And his subsequent reporting was consistent with his initial reporting. (Exs. 7, 15c-5; Tr. 22, 30). Thus, claimant *did* recall the circumstances of his fall, although he never knew what specific hazard or impediment "hooked" his toes. In other words, claimant was uncertain about the nature of the obstacle he encountered, but he was not uncertain about how he fell. (*See* Tr. 32-33). *See Jennifer Sharp*, 50 Van Natta 829, 829-30 (1998) (compensable injury due to work hazard where the claimant believed she had slipped on a leaf); *Ronald R. Dart*, 49 Van Natta 1027 (1997) (compensable injury due to slipping on wet floor where the claimant felt his foot slip before he fell, even though no water observed on the floor when help arrived).

Claimant's inability to identify the obstacle that caused him to fall does not necessarily mean that the cause was "idiopathic" or due to a risk personal to claimant. *See Robert L. Dawson*, 50 Van Natta 2110, 2112 (1998), *aff'd mem* 160 Or App 700 (1999) (notwithstanding the fact that the stairs were not broken and no other specific impediment was identified that caused the claimant to turn his ankle, the injury was a risk of employment). In fact, there is no evidence that this fall occurred for a "nonwork" reason. Because we have no reason to doubt or discount claimant's recollection that he fell because he "hooked" his toes on something, we are persuaded that he did encounter an obstacle on the employer's premises that caused him to fall.

Under these circumstances, we conclude that claimant's injury was linked to a work hazard and his risk of injury was therefore associated with his employment, even though the hazard remains unidentified. *See Ruby J. Williams*, 49 Van Natta 1550, 1550-51 (1997) (the claimant's testimony sufficient to establish existence of work hazard). Accordingly, we further conclude that claimant has carried his burden of proving that his March 6, 1999 fall at work is compensable.

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[4] Claimant was on probably not on paid time when he fell. (*See* Ex. 15c-3). *But see Wilson* at 598 ("'In the course of' employment also includes a reasonable period of time after work for the worker to leave the employer's premises, including the employer's parking lot.")

[5] In *Wilson*, the Supreme Court held that a claimant who injured herself while "skip-stepping" around a corner in the workplace sustained an injury that arose out of employment, even without evidence of a particular hazard on the employer's premises. *See David L. Starkey*, 50 Van Natta 906 (1998) (Board Chair Bock Concurring).

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 processing agent on behalf of the alleged noncomplying 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 November 24, 1999 is reversed. The processing agent's denial, on behalf of the alleged noncomplying employer, is set aside and the claim is remanded to the agent for processing according to law. For services at hearing and on review, claimant is awarded a $4,500 attorney fee, to be paid by the agent on behalf of the employer.

In the Matter of the Compensation of
JACK L. HOWELL, Claimant
WCB Case No. 99-06699
ORDER ON REVIEW
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's injury/occupational disease claim for a bilateral foot condition.[1] On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, but not the Findings of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

Applying ORS 656.005(7)(a)(B), the ALJ set aside the employer's denial, finding that claimant had proved that a March 10, 1999 injury in which he slipped off the fuel tank of a truck and landed on his heels was the major contributing cause of the need for treatment of a combined condition, consisting of preexisting plantar fasciitis and the traumatic injury. In so doing, the ALJ relied on the medical opinion of an examining physician, Dr. Gritzka, who opined that the March 10, 1999 incident rendered claimant's previously asymptomatic condition symptomatic and was in that sense the major contributing cause of the need for treatment.

On review, the employer contends that Dr. Gritzka's opinion is not sufficient to satisfy claimant's burden of proof. Therefore, it asserts that the ALJ's decision to set aside its denial should be reversed. We agree.

To satisfy his burden of proof, claimant must prove that his March 10, 1999 work injury was the major contributing cause of the disability or need for medical treatment for the combined condition.[2] ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997). The fact that a work injury is the immediate or precipitating cause of a claimant's disability or need for treatment does not necessarily mean that the injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995).

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[1] Claimant was not represented at hearing or on review.

[2] We agree with the ALJ that ORS 656.005(7)(a)(B) applies because the medical evidence establishes that the March 10, 1999 slip combined with the preexisting bilateral foot condition to cause a need for treatment of the "combined" condition. (Ex. 7-5).

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. 130 Or App at 401-2. 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 that are well reasoned and based on accurate and complete histories. *Somers v. SAIF*, 77 Or App 259 (1986).

After reviewing medical evidence from another examining physician, Dr. Rothstein, and Dr. Gauntt, an attending podiatrist, the ALJ determined that neither opinion assisted claimant in satisfying his burden of proof. The ALJ then turned to Dr. Gritzkas opinion. As previously noted, Dr. Gritzka concluded that the March 10, 1999 injury rendered the preexisting condition symptomatic and thus "in that sense was the major contributing cause of the need for treatment. (Ex. 7-5).

Having reviewed Dr. Gritzka's opinion, we find that the sole reason Dr. Gritzka opined that the March 10, 1999 incident was the major contributing cause of the need for treatment was that it rendered the prexisting conditon symptomatic. Although Dr. Gritzka used the words "major contributing cause," it is clear from his use of the phrase "in that sense" that it was only because the March 1999 incident precipitated the need for treatment that he reached that conclusion. Thus, it is clear that Dr. Gritzka relied solely on a "but for" or precipitating cause analysis. However, the precipitating cause is not necessarily the major contributing cause. *Dietz v. Ramuda*, 130 Or App at 401. Dr. Gritzka offered no other basis for concluding that the March 10, 1999 injury was the major contributing cause of the need for treatment. In fact, Dr. Gritzka stated that the major contributing cause of the underlying fasciitis condition was neither an occupational disease nor an acute injury. (Ex. 7-5).

Under these circumstances, where Dr. Gritzka failed to sufficiently weigh the relative contribution of different causes of claimant's need for treatment of the combined condition, we conclude that his opinion does not establish that claimant's bilateral foot condition is compensable.[3] Thus, we reverse.

ORDER

The ALJ's order dated December 22, 1999 is reversed. The employers denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] Neither Dr. Rothstein's nor Dr. Gauntt's opinion establishes compensability of claimant's bilateral foot condition because the former concluded that there was no work-related injury and that obesity and claimant's foot type were the major contributing factors in the bilateral foot condition. (Ex. 6-4). Dr. Gauntt's opinion is unpersuasive because it consists of an unexplained concurrence with *both* Dr. Rothstein's and Dr. Gritzka's opinion. (Ex. 9).

Board Member Biehl dissenting.

The majority finds Dr. Gritzka's opinion insufficient to satisfy claimant's burden of proof under ORS 656.005(7)(a)(B). Accordingly, it reverses the ALJ's order and reinstates the employer's denial. Because I disagree with the majority's assessment of Dr. Gritzka's opinion, I respectfully dissent.

As the ALJ noted, Dr. Gritzka opined that the March 10, 1999 incident was the major contributing cause of the need for treatment of claimant's foot condition, but was not the major cause of the underlying foot condition. (Ex. 7-5). I agree with the ALJ that Dr. Gritzka's opinion was given in the context that showed a clear awareness of all contributing factors, including the underlying, preexisting condition. Because it is well-reasoned and properly weighed the contribution of all potentially casual factors, Dr. Gritzka's opinion is persuasive and should satisfy claimant's burden of proof.

The majority focuses on Dr. Gritzka's use of the phrase "in that sense" to discount the persuasiveness of his opinion. I disagree with the majority's reasoning. As previously noted, the context of Dr. Gritzka's opinion clearly showed that he was basing his opinion on more than a "but for" or precipitating-cause analysis. Rather, the context demonstrates a careful consideration of the various casual factors, including the preexisting condition. *See SAIF v. Strubel*, 161 Or App 516, 521 (1999) (evaluate the sufficiency of a medical opinion within its context).

On this record, Dr. Gritzka's opinion satisfies claimant's burden of proof. Therefore, I part company with the majority and dissent.

May 25, 2000 Cite as 52 Van Natta 902 (2000)

In the Matter of the Compensation of
CHRISTINE MINTON, Claimant
WCB Case No. C001136
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Black, et al, Claimant Attorneys
Cavanagh, et al, Defense Attorneys

Reviewed by Board Member Haynes and Phillips Polich.

On May 8, 2000, 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 approve the proposed disposition.

The function of a claim disposition agreement is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board received the CDA. *See* ORS 656.236(1). It is not the function of a CDA to accomplish claim processing functions such as that possibly suggested by the following provision in the agreement, [c]arrier withdraws the Notice of Closure dated March 8, 2000. (Pg. 2, no. 7). *See Debbie K. Ziebert*, 44 Van Natta 51 (1992). Considering the prohibition against such claim processing provisions, we interpret the CDA and its consideration to be in lieu of the benefit awarded by the Notice of Closure, as opposed to a withdrawal of that prior closure and award.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $4,641.68, 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
JENNIFER PFEIFFER, Claimant
WCB Case No. 99-05613
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) declined to award an attorney fee under ORS 656.386(1); and (2) declined to assess a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are attorney fees and penalties.

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

The ALJ declined to award claimant an attorney fee pursuant to ORS 656.386(1), finding that there was no "express denial" of claimant's compensation. ORS 656.386(1)(b)(A) provides:

"(b) For purposes of this section, a 'denied claim' is:

"(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

We agree with the ALJ that there is no "express denial" of compensation in the record in response to this initial claim for benefits that would yield entitlement to an attorney fee under ORS 656.386(1)(b)(A). *Lidia A. Quintero*, 51 Van Natta 1221 (1998). Moreover, although there is a "Response to Issues" form in the hearing file, the response denies only that claimant is entitled to an attorney fee, for the reason that "no denial exists." *Compare Kimberly Quality Care v. Bowman*, 148 Or App 292 (1997) (carrier's response to the claimant's hearing request that stated that claimant had not sustained a work-related injury or disease amounted to an express denial).

In addition, because there is no proof of "amounts then due," pursuant to ORS 656.262(11)(a), there is no basis for a penalty. Although claimant introduced several medical bills into the record, these bills either do not show evidence of receipt by the insurer or were not due until after the hearing record closed. We therefore also affirm the ALJ's order on the penalty issue.

ORDER

The ALJ's order dated December 21, 1999 is affirmed.

Board Chair Bock concurring.

I agree with the result reached by the Board in this case, *i.e.* to affirm the ALJ's decision on this record not to award claimant an attorney fee or penalty for the insurer's unreasonable claims processing. I write separately to express concern over the inadequate claims processing demonstrated by this record.

As the dissent notes, such delay in processing claims does violence to a system that has been carefully balanced in its allocation of duties between claimant and employer. The insurer's behavior in this case runs afoul of two of the primary objectives of the workers' compensation statute:

(1) "To provide, regardless of fault, sure, prompt, and complete medical treatment for injured workers and fair adequate and reasonable income benefits to injured workers and their dependents;" and

(2) "To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversarial nature of the compensation proceedings, to the greatest extent practicable." - ORS 656.012(2)(a) and (b).

However, I agree with the ALJ that, in this case, the record does not support the award of an attorney fee or penalty payable by the insurer in the absence of an express denial of compensation or proof of "amounts then due." ORS 656.262(11)(a); ORS 656.386(1)(b)(A). The statute simply does not allow the remedy that the dissent urges us to apply.

Board Member Phillips Polich dissenting.

Because I do not believe an employer or insurer should be able to simply do nothing in response to a claim for compensation for a full six months and escape a penalty of any sort, I respectfully dissent. ORS 656.262 places certain minimal processing duties on employers. In response to the insurance lobby's protests that it needed more time to process claims, employers and/or their insurers have now been granted 90 days within which to accept or deny a claim. ORS 656.262(6)(a).

Despite that allowance of time, the insurer here failed to perform even its minimal processing duties, for more than six months. Although claimant filed her 801 form on March 2, 1999, the insurer did not issue a notice of acceptance until September 13, 1999. (Exs. 10, 17). In the meantime, claimant was forced to request a hearing, on July 14, 1999. The insurer did not file a Response to the Request for Hearing until September 27, 1999, in violation of OAR 438-006-0036 (Within 15 days after receiving a request for hearing and specification of the issues, a party defending against a request for hearing shall file a response to the request).

Moreover, I am not convinced that the provision of ORS 656.262(6)(a) that provides that "pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits" applies to claims that are more than 90 days old. At that time, a claim becomes *de facto* denied. *Barr v. EBI Companies*, 88 Or App 132 (1987). The insurer can no longer hide behind the provisions of a statute that is meant to apply to timely processed claims.

Although I agree with the ALJ that there is no proof of "amounts then due" on which to base a penalty, I would have assessed a nominal attorney fee of $1,800, payable by the insurer, for its unreasonable claims processing. In my view, to do otherwise is to sanction conduct that is disrespectful to the system. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
GORDON D. THORNBURG, Claimant
WCB Case No. 99-03075
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right thumb MCP joint condition. In its brief on review, the employer requests sanctions against claimant's attorney for an allegedly frivolous request for Board review. On review, the issues are compensability and sanctions.

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

ORS 656.390(1) allows the Board to impose an appropriate sanction against an attorney who files a frivolous request for review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); *see Westfall v. Rust International*, 314 Or 553, 559 (1992) (defining "frivolous" under former ORS 656.390).

In this case, we find that claimant's pursuit of the compensability issue was not "frivolous" within the meaning of the statute. In reaching this conclusion, we note that claimant raised colorable arguments regarding compensability of his occupational disease claim that were sufficiently developed

so as to create a reasonable prospect of prevailing on the merits. *Gerard R. Schiller*, 48 Van Natta 854 (1996); *Rhonda L. Hittle*, 47 Van Natta 2124 (1995). Under these circumstances, although we ultimately rejected claimant's compensability arguments, we cannot say that his request for review was "frivolous." Accordingly, the employer's request for sanctions is denied.

ORDER

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

May 25, 2000 Cite as 52 Van Natta 905 (2000)

In the Matter of the Compensation of
GARY W. ROGERS, Claimant
WCB Case No. 99-04707
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney
Starr & Vinson, Attorneys

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

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Johnson's order that set aside its denials of claimant's left elbow injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the first four paragraphs, which we replace with the following.

Claimant worked as a painter. On August 16, 1998, a shelf on which claimant was working collapsed. Claimant fell eight to ten feet, landing on his left side. Claimant was initially treated at a hospital emergency room and diagnosed with a fractured left hip. On September 2, 1998, claimant began physical therapy.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's left elbow condition, diagnosed as left cubital tunnel syndrome or left ulnar neuropathy, was compensable. In coming to this conclusion, the ALJ decided that, based on demeanor, claimant was a credible witness and that claimant hit his elbow during the fall at work and had immediate symptoms that did not abate. Although acknowledging the absence of medical documentation until December 2, 1998, the ALJ found it understandable because claimant was "on medication and he was largely immobilized until he started his physical therapy[.]"

SAIF challenges this conclusion. In particular, SAIF asserts that the inconsistencies between the record and claimant's testimony prevent him from carrying his burden of proof.

As the ALJ noted, claimant did not report any left elbow symptoms until an examination with Dr. Lin on December 2, 1998, despite the numerous examinations before that date with his treating physician, Dr. Straub, and physical therapy sessions. Dr. Lin's report stated that claimant noticed for about four weeks now some tingling in his left hand. (Ex. 16-2).

When claimant testified about the onset and history of his left elbow, he stated that he felt immediate pain in his left elbow at the time of the fall that lasted only a short time. (Tr. 14). Claimant further explained that he was initially sore and then numb with physical therapy. (*Id.* at 20, 41).

Dr. Lin is the only physican whose opinion ostensibly supports causation. Although Dr. Lin did not explicitly state that the fall caused the left elbow condition, he indicated that, "[g]iven [claimant's] multiple other injuries and concerns, I am not sure that reliance on the medical record alone in that

there is an absence or failure to mention some left hand tingling and numbness relative to the severe hip pain and injuries that have plagued [claimant] since the time of his injury should be enough to exclude this particular injury from the Workers Comp claim." (Ex. 28A-1). Dr. Lin also thought that nerve conduction studies "were consistent with a more acute injury." (*Id.* at 2).

Dr. Lin's opinion was rebutted by examining neurologist, Dr. Kho, who found "generalized neuropathy, most likely diabetic in nature." (Ex. 28C-4). According to Dr. Kho, because claimant had evidence of bilateral cubital tunnel entrapment, his condition was not caused by the accident but "related to idiopathic/metabolic/degenerative nature." (*Id.* at 5). Dr. Kho also found it significant that claimant's onset of symptoms was after the accident and that no bruising or tenderness was found when claimant was examined in the emergency room. (*Id.*)

Dr. Denekas, neurologist, performed a record review. Although finding that the accident was consistent with injury to the left ulnar nerve, Dr. Denekas noted that there was no documentation in chartnotes from the emergency room and follow-up with Dr. Straub showing "any contusions, bruising or ulnar nerve symptomatology." (Ex. 25-3). Thus, Dr. Denekas found that, because claimant did not report symptoms until December, "we do not have a strong cause and effect" between the accident and the left elbow condition and it was more likely idiopathic. (*Id.*)

Dr. Denekas submitted another report in which he disagreed with Dr. Lin that the nerve conduction reports supported an acute injury. Instead, Dr. Denekas could not "draw any particular conclusion in terms of causality" and found that the tests only gave information about "the severity of the abnormality rather than the origin." (Ex. 29-3, 29-4).

Here, in evaluating whether claimant carried his burden of proof, we do not necessarily disagree with the ALJ's finding that claimant was credible based on demeanor.[1] But even accepting claimant's testimony that he had symptoms from the date of the accident, his testimony is not consistent with the history that Dr. Lin relied upon in rendering his opinion. Dr. Lin reported (in unwieldy language) that claimant's left elbow condition should not be "excluded" based on the absence of documentation showing that claimant had "some left hand tingling and numbness" since the date of his accident.

We find that this portion of Dr. Lin's report shows that he relied on a history that claimant had numbness as of the date of the accident. Claimant, however, testified that he first had soreness that developed into numbness when he began physical therapy. Thus, we conclude that Dr. Lin did not rely on an accurate history.

Furthermore, Dr. Lin provided very little reasoning, relying only on nerve conduction tests that he thought showed an acute injury. Dr. Denekas, however, explained why the tests did not provide information about causation but were limited to showing the severity of claimant's condition. Consequently, we do not find that Dr. Lin's reliance on the nerve conduction tests is particularly persuasive.

In short, because Dr. Lin's understanding of claimant's history is not consistent with claimant's testimony and his reasoning was limited and persuasively rebutted, we conclude that Dr. Lin's opinion is not sufficiently persuasive to prove that the August 1998 was a material, or the major, contributing cause of claimant's left elbow condition.

ORDER

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

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[1] In this respect, we disagree with the dissent that we are not deferring to the ALJ's credibility finding. Furthermore, simply finding claimant credible does not result in claimant carrying his burden of proof since he also must have persuasive medical evidence showing a sufficient causal relationship between the injury and his left elbow condition. In other words, considering the conflicting medical opinions regarding the cause of claimant's condition, the resolution of this complex compensability issue rests with the probative weight of the medical evidence. *See Uris v. Compensation Dept*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993).

Board Member Phillips Polich dissenting.

I disagree with the majority's conclusion that claimant failed to prove compensability. As the ALJ's order states, this case is based on credibility. After carefully observing claimant's testimony at hearing and weighing the evidence, the ALJ found claimant credible based on demeanor.

I would not disturb that finding. We generally defer to the ALJ's credibility finding simply because that person is present during the worker's testimony, giving he or she a perspective that cannot be achieved by the Board on review. *E.g., Erck v. Brown Oldsmobile,* 311 Or 519, 528 (1991). Because the ALJ here found that claimant truthfully testified that he injured his elbow when he fell on August 16, 1998, I would also accept that testimony. Thus, I agree with the ALJ that claimant proved that he injured his elbow during the falling incident.

Moreover, I disagree with the majority that Dr. Lin's opinion is inconsistent with claimant's testimony. I find it more significant that Dr. Lin relied on a history that claimant injured his elbow on August 16, 1998, than his understanding of the onset of any particular symptoms. In contrast, Dr. Kho and Dr. Denekas both in part found no causal relationship based on the assumption that claimant did not injure his elbow on August 16, 1998. Thus, Dr. Lin is the only physician to provide an opinion consistent with claimants credible testimony.

In sum, claimant credibly testified that he injured his left elbow when he fell on August 16, 1998, and Dr. Lin provided an opinion based on that history that the event was the major contributing cause of claimant's need for treatment. Consequently, like the ALJ, I would conclude that claimant proved compensability.

May 26, 2000 Cite as 52 Van Natta 907 (2000)

In the Matter of the Compensation of
BETTINA M. DIEKMAN, Claimant
WCB Case No. 99-07722
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for a left shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In May 1997, claimant underwent surgery for left shoulder pain. The procedure consisted of left shoulder arthroscopy and "tightening" of the middle glenohumeral ligament. (Ex. 1).

On June 27, 1999, claimant began work for the employer as a cashier. After completing her first shift on the 27th, claimant experienced pain in her left shoulder. Claimant sought medical treatment the next day from Dr. Lindquist, who diagnosed a left shoulder strain. (Ex. 4). Claimant filed a workers' compensation claim for the left shoulder condition.

After receiving treatment from Dr. Schader, claimant eventually came under the care of Dr. Croy in August 1999. Dr. Croy diagnosed left rotator cuff strain/tendinitis. (Ex. 10).

On August 24, Drs. Rich and Marble evaluated claimant's left shoulder condition on behalf of the employer. Based on their review of imaging studies, they opined that claimant had a "type 2" acromion without significant anterior "hooking," but that there were abnormal contours in the glenohumeral ligaments of the left shoulder. (Ex. 11-4). The panel acknowledged the presence of preexisting pathology in the left shoulder and opined that, absent the preexisting pathology, they doubted that claimant would have experienced severe pain in her shoulder after a single day's work. (Ex. 11-5). Dr. Croy concurred with the Rich/Marble report, as did Dr. Schader. (Exs. 12, 14).

On September 22, 1999, the employer denied the left shoulder claim. (Ex. 13). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial. In doing so, the ALJ first determined that the major contributing cause standard of ORS 656.005(7)(a)(B) did not apply because the medical evidence from Dr. Rich did not establish the presence of a "combined condition." Applying a material contributing cause standard instead, the ALJ found that claimant had satisfied his burden of proof.

On review, the employer contends that the ALJ should have applied the major contributing cause standard in ORS 656.005(7)(a)(B) and found that claimant did not satisfy her burden of proof. We agree.

It is claimant's burden to prove by a preponderance of the evidence that she sustained a compensable injury to her left shoulder. ORS 656.266; *Hutchinson v. Weyerhaeuser*, 288 Or 51 (1980). Moreover, if an otherwise compensable injury combined with a preexisting condition, claimant must prove that the otherwise compensable injury is the major contributing cause of the disability or need for treatment of the "combined condition." ORS 656.005(7)(a)(B).

Accordingly, the initial issue is whether the medical evidence establishes the presence of a "combined condition." If so, then the major cause standard applies. If not, then the appropriate standard is material contributing cause. *See Ronnie C. Fair*, 51 Van Natta 1860, 1861 (1999).

Dr. Rich directly addressed the question of whether claimant's work activities on June 27, 1999 combined with a preexisting condition. Dr. Rich agreed that those work activities did combine with a congenital abnormality of the left shoulder acromion. According to Dr. Rich, while the 1997 surgery tightened the middle glenohumeral ligament, the congenital abnormality was still present and did combine with the June 27, 1999 work activities to cause a need for treatment. (Ex. 15). Based on our review of Dr. Rich's opinion, we conclude that this case does concern a "combined condition" within the meaning of the statute. After reviewing a concurrence report from Dr. Croy, we find that his opinion also supports our conclusion.

Dr. Croy was asked if he felt that the "combined effects" of the June 15, 1999 injury and any preexisting condition caused or prolonged claimant's need for treatment and/or disability. If so, then Dr. Croy was asked to confirm that the work injury was the major contributing cause of claimant's need for treatment of the combined effects of her preexisting shoulder problems and those conditions that resulted from employment activities. (Ex. 16-2). Dr. Croy proceeded to answer the major contributing cause inquiry, thus indicating that he felt that there was combined condition.

Therefore, the major contributing cause standard of ORS 656.005(7)(a)(B) is applicable. We now proceed to apply the legal standard of that statute to resolve the compensability issue.

As previously noted, to satisfy her burden of proof under that statute, claimant must prove that the work activities on June 27, 1999 were the major contributing cause of the disability and/or medical treatment for the "combined condition." Because of the multiple possible causes of claimant's left shoulder condition, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993). 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, we find persuasive reasons to do otherwise. Dr. Croy checked the box "yes" when asked whether the work injury of June 27, 1999 was the major contributing cause of the need for treatment of the combined effects of the preexisting shoulder problems and the conditions resulting from the employment activities. Dr. Croy, however, supplied little, if any, reasoning to support that conclusion, merely stating that claimant had a brief strain/overuse injury to her shoulder that caused her to seek treatment. (Ex. 16-1). Moreover, Dr. Croy did not weigh the effect of the preexisting left shoulder

condition identified by Dr. Rich. *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). Because it is not well-reasoned, we do not find Dr. Croy's opinion on the major-cause issue persuasive.

In contrast, Dr. Rich agreed that work activities were only a minor contributing cause to claimant's condition and did not pathologically change her underlying, preexisting condition. According to Dr. Rich, the major contributing cause of the combined condition was the preexisting congenital abnormality. Dr. Rich also agreed that the fact that claimant experienced symptomatology after only one day of work confirmed the existence of the underlying condition and claimant's propensity for left shoulder symptomatology. (Ex. 15-2). Considering Dr. Rich's analysis of the preexisting condition in his initial report, a report with which Dr. Croy agreed, we find that Dr. Rich has sufficiently weighed the competing causes of claimant's current left shoulder condition and, thus, that his opinion is the most persuasive on this record.[1]

Accordingly, we conclude that claimant has not satisfied her burden of proof under ORS 656.005(7)(a)(b). Thus, we reverse.

ORDER

The ALJ's order dated January 28, 2000 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

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[1] Dr. Rich did not specifically address whether claimant's work activities on June 27, 1999 were the major contributing cause of the need for treatment of the "combined condition." We find, however, that this is not a case where there is a difference between the major contributing cause of the need for treatment of claimant's combined condition and the major contributing cause of the combined condition itself. *See Robinson v. SAIF*, 147 Or App 157, 162 (1997).

In the Matter of the Compensation of
SHEILA A. LEFORS, Claimant
WCB Case No. 99-07460
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Scheminske, et al, Defense Attorneys

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that decreased claimant's award of unscheduled permanent disability for a low back injury from 17 percent (54.4 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is unscheduled permanent disability.

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

Claimant contends that the ALJ erred in not awarding an impairment value for claimant's reduced low back range of motion. Where a medical arbiter is used, impairment is determined by the arbiter except where a preponderance of medical opinion, from the attending physician or other physicians with whom the attending physician concurs, establishes a different level of impairment. ORS 656.245(2)(b)(B) and 656.268(7); OAR 436-035-0007(13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).

Here, the ALJ concluded that a preponderance of the medical opinion indicated that claimant's diminished ranges of motion were not due to her compensable low back strain. The ALJ relied on the treating physician's concurrence with Dr. Gripekoven's opinion that "the decreased range of motion of the lumbar spine * * * is related to her preexisting degenerative disc disease." (Ex. 53-10). We further note that the medical arbiter offered no opinion about the causes of claimant's low back impairment.

The objective medical evidence establishes that claimant has preexisting degeneration in her lumbar spine. (Ex. 53-6, -7). The only medical evidence addressing this issue is Dr. Gripekoven's opinion that the reduced lumbar range of motion is attributable to the degenerative condition in her lumbar spine, rather than the compensable lumbar strain. (Ex. 53-9, -10). The remaining medical record, including the arbiter's opinion, does not address the etiology of claimant's reduced range of motion.

Claimant urges us to impute a causal relationship from the fact that the arbiter identified the reduced low back range of motion and did not expressly attribute it to a cause other than the compensable CTS. Medical evidence rating an impairment and describing it as consistent with a compensable injury does support a finding that the impairment is due to the compensable injury when the record discloses no other possible source of impairment. *See SAIF v. Danboise*, 147 Or App 550, 553, *rev den* 325 Or 438 (1997). Here, however, the treating physician concurred with Dr. Gripekoven's identification of other possible sources of impairment, *i.e.*, claimant's degenerative disc disease in the lumbar spine. On this record, we conclude that the preponderance of the evidence does not establish that the reduced lumbar range of motion is due to the compensable lumbar strain.

Finally, we address the employer's argument that the ALJ erred in holding that, as the appealing party, the employer 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 had the burden of proof.

ORDER

The ALJ's order dated January 14, 2000 is affirmed.

Board Member Phillips Polich dissenting.

Because I do not agree with the majority that the medical evidence establishes a different level of impairment from that found by the arbiter, I respectfully dissent.

In its reliance on the treating physician's concurrence with Dr. Gripekoven's opinion that the decreased range of motion in claimant's low back is related to her preexisting disc disease, the majority faults the medical arbiter panel for not offering an opinion regarding the cause of claimant's low back impairment or the etiology of her reduced range of motion.

In its letter to the medical arbiter panel, the ARU specified the accepted conditions as cervical and lumbar strains and a contusion, right hip and right knee. The ARU also specified that chronic subluxation of the right sacroiliac joint was a denied condition. In addition, the ARU provided medical records, noting that they may include information concerning unrelated or preexisting conditions, which the panel was instructed to review for determining "*impairment due to the accepted conditions, including any direct medical sequelae.*" (Emphasis in original). It is in this context that the panel provided its report.

In its report, the panel acknowledged the accepted and denied conditions, reviewed the medical records, and specifically noted that its physical examination was limited to the accepted conditions. (Ex. 59B-3). The panel also noted that it evaluated claimant's denied right sacroiliac condition to some degree, finding tenderness over the right sacroiliac region and right sciatic notch. *Id.* However, other than the sacroiliac tenderness, the panel did not attribute any of its findings (including range of motion) to other than the accepted conditions.

Given the context in which the arbiter panel provided its report, I would find that the panel was asked and sufficiently answered the causation question. There is no legal requirement that medical arbiters explain causation or the etiology of claimant's lost range of motion, particularly in light of the statement that its physical examination was limited to the accepted conditions and did not specifically attribute its findings to any other cause. *See SAIF v. Danboise*, 147 Or App 550 *rev den* 325 Or 438 (1997) (when a treating doctor or the medical arbiter makes impairment findings and describes those findings as consistent with a claimant's compensable injury, such findings may be construed as showing that the impairment is due to the injury); *Vickie L. Wing*, 49 Van Natta 1468 (1997).

Therefore, absent the panel's affirmative statement that claimant's lost range of motion is not related to claimant's injury, the employer has not met its burden of proof. Moreover, in its demand that the arbiter panel explain the cause of claimant's lost range of motion, the majority is inserting a new hurdle into the arbiter examination and reconsideration process where no cross-examination can be done. The statutes and rules require our deference to the medical arbiter. That is claimant's *only* remedy.

May 26, 2000 Cite as 52 Van Natta 911 (2000)

In the Matter of the Compensation of
GILBERT T. LESLIE, Claimant
WCB Case Nos. 99-02922 & 99-01104
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Scheminske, et al, Defense Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order: (1) upheld the self-insured employer's denial of claimant's current low back condition; and (2) found that claimant's 1998 low back injury claim with Traveler's Casualty Insurance Co. (Travelers) was time-barred. On review, the issues are timeliness and compensability.[1] We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following modification.

The last sentence of the third paragraph is replaced with: "Claimant did not know whether his June 1998 low back pain was related to his 1995 strain or his recent work activities." (*See* Tr. 23, 25).

CONCLUSIONS OF LAW AND OPINION

Claimant works as a service technician for the employer. He suffered a compensable low back strain in 1995, while the employer was self-insured. Claimant's 1995 claim was closed in 1996 with no award of permanent disability.

Claimant returned to his regular work, but he continued to have occasional low back pain. (Tr. 18, 29-30). He did not receive treatment for his low back between February 1996 and June 1998.

In late May or early June 1998, claimant experienced the onset of increased low back pain at work, around the time he lifted heavy 5 gallon cans of paint into a vehicle. (Tr. *See* 27-28; *see also* Ex. 22A-1). He treated conservatively and missed no work time.

The employer first knew of the 1998 claim on June 3, 1998. (Exs. 21D, 21E).[2]

The employer denied claimant's 1998 low back condition as unrelated to its accepted 1995 claim. Travelers denied claimant's 1998 "new injury" claim on timeliness and causation grounds. The denial alleged that the claim was filed on August 24, 1999, over a year after the June 3, 1998 injury date. (Ex. 24B-1). Claimant requested a hearing.

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[1] We do not reach the potential responsibility issue, because claimant's current condition does not "involve the same condition" as the 1995 accepted low back strain. (*See infra; see also* Exs. 19-6, 20, 23).

[2] We note that the ALJ's order does not specifically list Exhibits 21D & E as admitted. However, claimant submitted those documents at hearing and the ALJ admitted all documents submitted. (Tr. 5-6). Because no party contends that any submitted documents were excluded or improperly admitted (and Travelers refers to Exhibits 21 D& E in its brief), we conclude that these documents are properly in the record as developed at hearing. *See Rebecca L. Jones*, 49 Van Natta 553, 554, n.2 (1997); *Walter Moore*, 45 Van Natta 2073, 2074; *Nellie M. Ledbetter*, 43 Van Natta 570, 571 (1991) (evidence not admitted at hearing considered on review if there is evidence that the ALJ and the parties intended to admit it and it was implicitly admitted).

The ALJ upheld Travelers' denial of claimant's current low back condition. She reasoned that, although the claim was filed within a year of claimant's June 3, 1998 injury date, the employer did not have notice of the accident within 90 days, as required by ORS 656.265(1). Therefore, the ALJ concluded that the claim with Travelers was time-barred under ORS 656.265(4). We disagree, based on the following reasoning.

Claimant bears the burden to prove by a preponderance of the evidence that the employer received some form of written notice of the claim within one year of the accident.[3] *See James J. Lascari*, 51 Van Natta 965, 966 (1999). We have construed ORS 656.265(1) and (4)(a) as barring an injury claim unless notice of the claim is given within one year of the accident and the employer had knowledge of the injury within 90 days. *Jeffrey E. Henderson*, 50 Van Natta 2340, 2342 (1998).

Here, an employer's representative initiated claim filing, with claimant's assistance, by taking information from claimant that was used to fill out an "801 form." (Ex. 21D; *see* Tr. 23-25). The form indicated that the injury was a strain, affecting claimant's low back area, and the date of injury was June 3, 1998. The form also indicated that claimant's low back had been injured before. It provided that the employer "first knew of the claim" on June 3, 1998. (Ex. 21D). Based on this form, we find that the employer knew of claimant's June 1998 claim on June 3, 1998.

The record also contains a "Travelers Insurance Companies" form that provides: "This will acknowledge receipt of the Employer's First Notice of Injury." (Ex. 21E). This form provides that claimant's June 3, 1998 injury was reported to the employer on June 3, 1998.[4] Based on this form, we find that the employer had knowledge of claimant's injury on June 3, 1998.

We note that both forms include a history consistent with claimant's 1995 injury, not his 1998 injury. However, claimant credibly testified that he participated in filling out the "801 form" and *asked* the employer's representative whether the report should refer to the old injury or the new injury. The person taking the information from claimant told him to "fill it out like it was an old injury." (Tr. 25).

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[3] ORS 656.265, entitled "Notice of accident from worker," provides, in pertinent part:

"(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer, but not later than 90 days after the accident. The employer shall acknowledge forthwith receipt of such notice.

"(2) The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker. A report or statement secured from a worker, or from the doctor of the worker and signed by the worker, concerning an accident which may involve a compensable injury shall be considered notice from the worker and the employer shall forthwith furnish the worker a copy of any such report or statement.

"(3) Notice shall be given to the employer by mail, addressed to the employer at the last-known place of business of the employer, or by personal delivery to the employer or to a foreman or other supervisor of the employer. If for any reason it is not possible to so notify the employer, notice may be given to the Director of the Department of Consumer and Business Services and referred to the insurer or self-insured employer.

"(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

"(a) The employer had knowledge of the injury or death; or

"(b) The worker died within 180 days after the date of the accident.

"(5) The issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death."

[4] It also indicates that the "Date Notice Reported" was November 11, 1999, and that notice (*i.e.*, to the insurer) was received by "TELE." *Id.*

Considering claimant's participation in filling out the "801 form" and his reference to his new injury *at that time*, along with the consistent dates of injury and dates of notice (to the employer) on both forms, we reach the following conclusions: First, the employer had knowledge of claimant's 1998 injury on June 3, 1998; and second, claimant filed a claim for that injury the same day (through the employer's representative, who filled out the "801 form").

We find this case similar to *Allied Systems Co. v. Nelson*, 158 Or App 639, 647-48 (1999), where the employer's "801 form" indicated that it first knew of claimant's claim on December 4, 1995. Based on the employer's notation on the "801 form," the court found that "the Board could reasonably infer that the employer knew in December 1995 that claimant was seeking compensation for an allegedly work related condition and thus had notice of a 'claim.'"

Here, as in *Allied Systems*, we infer notice of the claim from the employer's "801 form." Based on claimant's participation in filling out that form, we further find that the form satisfies the statute's requirement of a written "report or statement secured from [the] worker." *See* ORS 656.265(2). And, based on claimant's testimony and the above-described forms, we further infer that the employer had knowledge of the injury at the same time--on June 3, 1998. *See Argonaut Insurance Co. v. Mock*, 95 Or App 1 (1989); *Henderson*, 50 Van Natta at 2343, n.2 (knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate). Therefore, we conclude that claimant's 1998 claim was timely under ORS 656.265. *See Allied Systems*, 158 Or App at 646 ("So long as the employer had "knowledge of the injury" within the prescribed time, an untimely claim must be processed."). Accordingly, we proceed to the merits.

The medical evidence concerning causation is provided by Dr. Golden, treating physician, Dr. Owen, treating chiropractor, and Dr. McNeill, examining physician. Dr. Owen opined that the major contributing cause of "the low back strain" was the 1995 injury. (Ex. 22A-3). However, he also found claimant's history and the mechanism of the 1998 injury "consistent with the 6/3/98 injury being the major contributing cause of a pathological worsening of [claimant's] preexisting low back strain." (*Id.*). Dr. Owen's causation conclusions are at least potentially inconsistent and therefore not helpful in evaluating causation.

Dr. Golden treated claimant after both injuries. He initially referred to claimant's 1998 condition as an "aggravation of [claimant's] prior lumbar strain." (Ex. 15, *see* Exs. 14, 17). About 10 weeks later, after claimant had 8 or 9 chiropractic treatments, Dr. Golden referred to claimant's persistent low back pain as "possibly an aggravation" of the prior work injury. (Ex. 16).

Dr. McNeill examined claimant on November 23, 1998, noting that claimant's symptoms had essentially resolved. Dr. McNeill reviewed claimant's history, diagnosed a "resolved lumbar strain from a lifting injury in June 1998," and opined that the 1995 and 1998 injuries were "two separate incidences," finding no relationship between them. (Ex. 19).

Dr. Golden reviewed Dr. McNeill's report and concurred with it. (Ex. 20). Claimant's attorney posed several questions to Dr. Golden regarding the cause of claimant's 1998 strain. (Ex. 21A). In response, Dr. Golden explained that he initially related claimant's 1998 condition to his 1995 condition, because he did not have a history of lifting paint cans at the time. (Ex. 23). Considering claimant's history and the new information about claimant's 1998 lifting activities, Dr. Golden opined that the 1998 injury was *not* related to the 1995 injury, and concluded that claimant's 1998 work activities were "the major contributing cause of [claimant's] ongoing pain and need for treatment." (*Id.*; Ex. 24-17). We find Dr. Golden's changed opinion well-explained and his ultimate conclusion well-reasoned and persuasive.[5] Accordingly, based on Dr. Golden's opinion, we conclude that claimant has established that his work activities in late May or early June 1998 were the major contributing cause of his recent low back strain and his current condition is not related to the 1995 strain.

[5] We also note that Dr. Golden's reasoning and conclusions are essentially undisputed. (*See* Ex. 25-10-11); *compare* Ex. 22A-3, discussed *supra*).

Finally, we acknowledge Travelers' contention that the claim should fail for lack of objective findings. *See* ORS 656.005(7)(a). Travelers relies on the fact that Dr. Golden characterized claimant's 1998 examination findings as "subjective" and his examination as "normal," and Dr. McNeill reported his examination as normal, without objective evidence of injury, as of his November 1998 examination. (*See* Exs. 24-9-11, 25-5-6). Travelers also apparently contends that Dr. Owen's findings of decreased and painful lumbar range of motion, lumbosacral muscle spasm, and edema are not persuasive, because the remaining examination reports do not describe objective findings. We disagree, for the following reasons.

First, Dr. McNeill's lack of examination findings does not detract from claimant's prior findings, because claimant's condition had resolved by the time Dr. McNeill examined him. Second, Dr. Golden's *medical* characterization of claimant's findings does not necessarily answer the legal question.[6]

"Objective findings" are defined as:

> "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." ORS 656.005(19).

Here, Dr. Owen reported observable objective findings, based on his examination. (Exs. 13G, 13H, 13 J, 14A-G). And Dr. Golden unequivocally diagnosed claimant's 1998 lumbar strain, based on claimant's history and findings, even though he described those findings as "minimal." (*See* Ex. 23). Moreover, Dr. McNeill agreed that claimant had a 1998 low back strain condition, based on claimant's history and "documentation in the records." (Ex. 25-5-6, 25-10-11). We also note that examination findings by one medical professional may support another doctor's diagnosis and causation conclusion. *See Geoffrey R. Lewis*, 50 Van Natta 1352 (1998). Under these circumstances, we conclude that claimant's 1998 low back strain claim is "established by medical evidence supported by objective findings." Accordingly, we conclude that claimant's 1998 claim is compensable and Travelers is responsible.

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

ORDER

The ALJ's order dated January 5, 2000 is reversed in part and affirmed in part. That portion of the order that upheld Travelers Casualty Insurance Company's denial is reversed. The denial is set aside and the claim is remanded to Travelers for processing according to law. For services at hearing and on review regarding the Travelers' claim, claimant is awarded a $4,500 attorney fee, to be paid by Travelers. The remainder of the order is affirmed.

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[6] We note, for example, that Dr. Golden acknowledged his own examination finding that claimant had tenderness with palpation. (Ex. 24-10). Tenderness with palpation may be an "objective finding" under ORS 656.005(19), when it is reproducible. *See Josepy M. Stransky*, 51 Van Natta 143, 144 (1999); *Marilyn M. Keener*, 49 Van Natta 110, 112 (1997).

In the Matter of the Compensation of
WILLIAM F. DAVIS, JR., Claimant
WCB Case No. 99-07705
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

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

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) directed it to reopen and process claimant's new medical condition claim pursuant to ORS 656.262(7)(c) and 656.268; and (2) awarded an assessed attorney fee pursuant to ORS 656.386(1). On review, the issues are claim processing and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

Claimant was compensably injured on August 2, 1979. SAIF accepted the claim as a nondisabling neck strain. Subsequently, pursuant to a July 1988 stipulated order, SAIF rescinded a prior denial of "chronic upper and lower cervical subluxation, chronic lumbo pelvic and sacroiliac subluxations" and agreed to pay for treatment for claimant's cervical, lumbar, and sacroiliac conditions. (Ex. 3-2).

On April 28, 1998, SAIF denied claimant's C6 and C7 degenerative disease and spinal stenosis conditions. Claimant requested a hearing.

On October 27, 1998, a prior ALJ's order set aside SAIF's April 1998 denial and remanded the claim to SAIF for acceptance and processing according to law. That order became final.

On January 29, 1999, the Board in its own motion authority issued an order that denied claimant's request to reopen the claim, finding that he did not require surgery or hospitalization.

On June 19, 1999, claimant requested SAIF to process through closure his new condition of degenerative disc disease and stenosis at C6-7 pursuant to ORS 656.262 and *Johansen v. SAIF*, 158 Or App 672 (1999). (Ex. 4B). SAIF responded that claimant's claim was in own motion status, all bills had been paid, and no time loss was due because there had been no surgery. (Ex. 4C). On July 6, 1999, claimant repeated his request that SAIF process through closure his new condition of degenerative disc disease and stenosis at C6-7 pursuant to ORS 656.262 and *Johansen*. (Ex. 4B).

When SAIF did not respond, claimant requested a hearing on September 29, 1999.

CONCLUSIONS OF LAW AND OPINION

Claim Processing

We adopt and affirm that portion of the ALJ's order that determined SAIF must reopen the claim under ORS 656.262(7)(c) for processing of the C6 and C7 degenerative disease and spinal stenosis conditions and closure under ORS 656.268. *See Larry L. Ledin*, 52 Van Natta 682 (2000); *John R. Graham*, 51 Van Natta 1740 (1999).

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

Attorney Fees For Services at Hearing

At hearing, claimant argued that SAIF's delay in processing the new medical condition claim was unreasonable. Claimant acknowledged that there were no "amounts due." Consequently, as the ALJ found, penalties could not be assessed under ORS 656.262(11). Claimant, however, argued that he was entitled to an assessed attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable delay in processing the claim. The ALJ rejected claimant's argument. Relying on *Mark A. Klouda*, 51 Van Natta 823 (1999), the ALJ found that, because all compensation had been paid, there was no "unreasonable resistance to payment of compensation" upon which to assess an attorney fee under ORS 656.382(1).

Instead, the ALJ found that claimant was entitled to an assessed attorney fee for his counsel's services at hearing pursuant to ORS 656.386(1).[1] Consequently, after considering the factors set forth in OAR 438-015-0010(4), the ALJ found that a reasonable fee for claimant's counsel's services at hearing was $2,800, payable by SAIF.

On review, SAIF argues that claimant is not entitled to an assessed attorney fee under ORS 656.386(1) because it neither expressly denied any condition nor did it refuse to pay on the grounds that the claim did not give rise to an entitlement to any compensation. SAIF contends that, to the extent that claimant's attorney is entitled to a fee, the fee is payable from claimant's compensation pursuant to ORS 656.386(2).[2] We agree.

Unless specifically authorized by statute, the Board has no authority to award attorney fees, even though an inequity could result. *Stephenson v. Meyer*, 150 Or App 300, 303 (1997); *Forney v. Western States Plywood*, 297 Or 628, 632 (1984). Attorney fees under ORS 656.386(1)(a) are awarded for prevailing over a "denied claim," as that term is defined in ORS 656.386(1)(b). Under the circumstances of this case, claimant must establish that SAIF refused to pay a claim for compensation "on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." ORS 656.386(1)(b)(A). Furthermore, a denied claim cannot be presumed or implied from SAIF's failure to pay compensation for a previously accepted condition in a timely fashion. ORS 656.386(1)(c).

Here, pursuant to a prior ALJ's final order, SAIF's denial of claimant's degenerative disease and spinal stenosis at C6-7 was set aside. (Exs. 3, 4A). Thus, the C6-7 degenerative disease and spinal stenosis condition has been found compensable and accepted, albeit involuntarily, by a litigation order. Additionally, that prior order awarded claimant's attorney an assessed fee for overturning SAIF's express denial. (Exs. 3-5-6).

Claimant argues that SAIF's refusal to process his new medical condition claim constitutes a "denied claim." We disagree.

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[1] ORS 656.386(1) provides, in relevant part:

"(a) * * * In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee.

"(b) For purposes of this section, a 'denied claim' is:

"(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation;

" * * * * *

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

[2] ORS 656.386(2) provides: "In all other cases, attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter."

First, SAIF did not refuse to pay compensation on the express ground that the condition for which compensation is claimed is not compensable. ORS 656.386(1)(b)(A). To the contrary, SAIF agrees that claimant's degenerative disease and spinal stenosis at C6-7 is compensable. Second, SAIF does not contend that the claim for compensation of the C6-7 condition "otherwise does not give rise to an entitlement to any compensation." In this regard, SAIF contends that claimant is entitled to the benefits she qualifies for under the Board's Own Motion jurisdiction. Although SAIF is mistaken in this contention, *i.e.*, we have found that the new medical condition claim shall be reopened under ORS 656.262(7)(c) and processed to closure under ORS 656.268, SAIF did not refuse to pay compensation on the grounds that claimant was not entitled to *any* compensation. Finally, pursuant to ORS 656.386(1)(c), we cannot imply a denied claim from SAIF's failure to timely pay compensation for the accepted C6-7 condition.

Accordingly, for the reasons addressed above, claimant is not entitled to an assessed attorney fee under ORS 656.386. Under these circumstances, claimant is entitled to an "out-of-compensation" attorney fee of 25 percent of any increased temporary disability compensation created by this order, not to exceed $1,050, payable directly to claimant's counsel.[3] *See* ORS 656.386(2). 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 January 14, 2000 is affirmed in part and modified in part. In lieu of the assessed attorney fee award of $2,800 for services at hearing, claimant's attorney is awarded an attorney fee of 25 percent of any increased temporary disability compensation created by the ALJ's order, not to exceed $1,050. 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 A. Volk*. For services on review in defending the claim processing matter, claimant's attorney is awarded an assessed fee of $1,000, payable by SAIF.

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[3] Pursuant to claimant's retainer agreement, the "out-of-compensation" attorney fee payable from temporary disability granted by an ALJ order shall be "25% of any increase in temporary disability up to a maximum of $1,050."

Board Member Phillips Polich concurring in part and dissenting in part.

I concur with the majority regarding the claim processing issue and the award of attorney fees under ORS 656.382(2) for services on review. Nevertheless, because I agree with the ALJ that claimant is entitled to an attorney fee award of $2,800 under ORS 656.386(1) for services at hearing, I respectfully dissent.

ORS 656.386(1) provides for a reasonable attorney fee where the claimant finally prevails over a denied claim at hearing. A "denied claim" is defined, in part, as a claim for compensation which the carrier refuses to pay on the ground that the claim "otherwise does not give rise to an entitlement to any compensation." ORS 656.386(1)(b)(A). I find that, under the facts of this case, claimant is entitled to an attorney fee for services at hearing under this provision.

Here, SAIF concedes that claimant's C6 and C7 degenerative disease and spinal stenosis conditions are compensable. Nevertheless, SAIF argues that claimant's claim is in the Board's Own Motion jurisdiction and, therefore, his entitlement to benefits is limited by statute to those that he qualifies for under ORS 656.278(1)(a). SAIF further argues that, because a prerequisite to qualifying for benefits under ORS 656.278(1)(a) is undergoing surgery or hospitalization for the compensable condition, and claimant does not require either surgery or hospitalization, he is not entitled to benefits under ORS 656.278(1)(a). Thus, contrary to the majority, SAIF refused to pay compensation on the ground that the claim "otherwise does not give rise to an entitlement to any compensation."

In reaching this conclusion, I acknowledge that ORS 656.386(1)(b)(C) provides that "[a] denied claim shall not be presumed or implied from an insurer's * * * failure to pay compensation for a previously accepted injury or condition in timely fashion." As the majority notes, claimant's C6 and C7 degenerative disease and spinal stenosis conditions are accepted conditions. However, in reaching my

conclusion that claimant is entitled to an attorney fee under ORS 656.386(1), I am not "presuming" or "implying" a "denied claim" from SAIF's failure to timely pay compensation for an accepted claim. To the contrary, here, SAIF's specific argument that claimant's claim is in Own Motion jurisdiction and he is not entitled to any compensation for that claim *explicitly* brings the claim within the statutory definition of a "denied claim." In other words, SAIF's explicit position that claimant is not entitled to compensation on this accepted claim constitutes a "denied claim" under ORS 656.386(1)(b)(A).

Therefore, SAIF's actions bring this claim within the definition of a "denied claim" under ORS 656.386(1)(b)(A). Accordingly, having prevailed over that "denied claim" at hearing, claimant is entitled to a reasonable attorney fee pursuant to ORS 656.386(1). Finally, for the reasons explained by the ALJ, I agree that $2,800 is a reasonable fee for claimant's attorney's services at hearing.

In the Matter of the Compensation of
PAMELA J. GENTRY, Claimant
WCB Case No. 99-01975
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denials of claimant's current back condition on the basis that it was procedurally improper. On review, the issue is the propriety of the denials.

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

Although the employer did not accept a combined condition, the language of its denials clearly indicated that the employer was attempting to deny claimant's current condition pursuant to ORS 656.262(7)(b). In other words, the employer was attempting under ORS 656.262(7)(b) to deny a combined condition; yet, it had not accepted a combined condition. Under these particular circumstances, we agree with the ALJ that the denials are prohibited under *Croman Corporation v. Serrano*, 163 Or App 136 (1999). Finally, because the employer's March 5, 1999 denial indicates that "claim closure may result from the issuance of this denial," we also agree with the ALJ that the denial was an invalid attempt to circumvent the claim closure process. (Ex. 121); *Cf. David E. Horton*, 50 Van Natta 514 *on recon* 50 Van Natta 795 (1998), *aff'd mem EBI Companies v. Horton*, 157 Or App 397 (1998).[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 $2,000, 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.

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[1] The employer notes that, at the hearing, it amended its denial without objection to include a contention that claimant's current condition was unrelated to the compensable injury. (Tr. 2). In light of this, the employer contends that its denial was procedurally valid under cases such as *Robert Willenburg*, 51 Van Natta 643 (1999); *Corinne L. Birrer*, 51 Van Natta 163 *on recon* 51 Van Natta 467 (1999); and *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). The employer is correct that a carrier may issue a "preclosure" denial of a current condition when that condition is separate or severable from the accepted condition. Here, however, Dr. Long, the attending physician, has opined that claimant's current low back condition is related to the compensable injury of December 10, 1998. (Ex. 127). Therefore, the medical evidence does not unequivocally indicate that claimant's current condition is unrelated to the accepted injury. Thus, we conclude that the employer's denial was not a valid "pre-closure denial." *See Guillermo Ruvalcaba*, 51 Van Natta 313, 314 (1999) (medical evidence did not "unequivocally indicate" that the claimant's current condition when denied was unrelated to the accepted trapezius strain).

ORDER

The ALJ's order dated October 27, 1999 is affirmed. For services on review, claimant's counsel is awarded $2,000, as a reasonable assessed attorney fee, payable by the self-insured employer.

Board Member Meyers dissenting.

The majority affirms the ALJ's conclusion that the employer's denials were improper "pre-closure" denials under the court's decision in *Croman Corp. v. Serrano.* Because I believe that the employer's denials were procedurally valid, I respectfully dissent.

At the outset, I agree that the employer's denials are not permitted under ORS 656.262(7)(b). That is, the employer has not accepted a "combined condition" and therefore cannot issue a denial under that provision. *Serrano,* 163 Or App at 140. However, ORS 656.262(7)(b) only addresses one situation where a "pre-closure" denial may be properly issued. Both the Board and the Court have found other situations where a "pre-closure" denial may be appropriate.

The prohibition against "pre-closure" denials was created by the court in *Aquillon v. CNA Insurance,* 60 Or App 231 (1982). Subsequently, in *Safstrom v. Reidel, Inc.,* 65 Or App 728 *rev den* 297 Or 124 (1983) and *Roller v. Weyerhaeuser,* 67 Or App 583, *on recon* 68 Or App 743, *rev den* 297 Or 601 (1984), the court explained that such a denial was improper because it was an attempt to terminate future responsibility for a compensable condition before the extent of an injured worker's permanent disability had been determined. In other words, such a denial impermissibly circumvented the claim closure process. *Safstrom,* 65 Or App at 732. Although there remained a general prohibition against "pre-closure" denials, there were certain circumstances in which a "pre-closure" denial was allowed.[1] One such circumstance is where the issuance of the denial does not circumvent the claim closure process.

In *Chaffee v. Nolt,* 94 Or App 83 (1988), the carrier issued a denial three days prior to closing the claimant's claim. The court held that in light of the carrier's immediate claim closure after issuance of the denial, the denial was permissible as it was not intended to shortcut the ordinary process of claim closure. *Chaffee* 94 Or App at 84; *see also Bonnie L. Eberhart,* 45 Van Natta 800 (1993); *Daniel R. Bakke,* 44 Van Natta 831 (1992).

Here, the employer denied claimant's current disability and need for medical treatment on March 2, 1998. Thereafter, an amended denial issued on March 5, 1998. On March 8, 1998, claimant's claim was closed by Notice of Closure. Because the employer promptly closed claimant's after issuance of the denial, I would find that the employer's denials did not circumvent the claim closure process. Moreover, as a practical matter, setting aside the employer's denial as procedurally improper does not have any effect on the claim closure, or any litigation arising from the closure.[2] Since the rationale underlying the prohibition against "pre-closure" denials is to discourage carriers from issuing a denial, as opposed to closing the claim, it makes little sense to set aside the denials in these circumstances where the claim has, in fact, been closed.

Based on the foregoing reasoning, I would find that the employer's denials were procedurally proper and decide this case on its merits.[3] For these reasons, I respectfully dissent.

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[1] "Pre-closure" denials are also procedurally valid where the denial is of a separable condition, or the denial is one of responsibility. *See Johnson v. Spectra Physics,* 303 Or 49 (1987); *Karl G. Rohde,* 41 Van Natta 1837 (1989).

[2] In this regard, I disagree with the Board's reasoning in *David E. Horton.* I do not believe a denial can circumvent the claim closure process when the claim has been closed. Whether the closure was appropriate is an issue that is properly determined in the context of litigating the closure order and not in litigation involving the compensability of a current condition.

[3] Setting aside the employer's denials on procedural grounds also delays resolution of the parties' dispute and will likely result in further litigation. In other words, because the claim is closed, the employer can issue a procedurally proper denial of claimant's current condition which would have to be resolved on the merits.

In the Matter of the Compensation of
GARY NORED, Claimant
WCB Case No. 99-05211
ORDER ON REVIEW (REMANDING)
Scott M. McNutt, Sr., Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) declined to admit Exhibits 10 and 11 into evidence; and (2) set aside its denial of claimant's low back injury claim. On review, the issues are the ALJ's evidentiary ruling and compensability. We vacate and remand.

The ALJ set aside the employer's denial of claimant's low back injury claim, finding that claimant sustained an injury on March 30, 1999 that was the major contributing cause of a herniated disc at L5-S1 and the resultant need for treatment. In so doing, the ALJ found persuasive the opinion of claimant's attending neurosurgeon, Dr. Gallo, who opined that the March 30, 1999 injury was the major factor in claimant's need for treatment of the disc herniation. The ALJ also declined the employer's request to admit into evidence proposed Exhibits 10 and 11, consisting of a September 9, 1999 letter from claimant's attorney to Dr. Gallo and Dr. Gallo's "post-hearing" response dated October 4, 1999. The ALJ reasoned that the disputed exhibits should not be admitted into evidence because the evidence could reasonably have been discovered by the employer with due diligence prior to the September 30, 1999 hearing.

On review, the employer contends that the ALJ incorrectly declined to admit the disputed exhibits into evidence. In addition, the employer argues that Dr. Gallo's opinion is not persuasive and does not prove that the March 1999 incident was the major contributing cause of the L5-S1 disc herniation and need for treatment. For the following reasons, we find the ALJ erred in excluding the disputed exhibits and remand for their admission into the record.

Claimant originally injured his low back in March 1988 and was ultimately diagnosed with an L5-S1 disc herniation for which he underwent a percutaneous discectomy in January 1989. (Ex. E). Claimant recovered from the previous injury within 6 months and was symptom-free until March 30, 1999 when, while repairing a telephone line, he experienced another onset of low back pain after twisting in an awkward position while crawling underneath a building.

Claimant was referred to Dr. Gallo, who diagnosed an L5-S1 disc herniation. (Ex. 4). Dr. Gallo noted that claimant had previously injured his low back, but her initial report of May 1, 1999 refers to the prior surgical level as L4-5 at one point and at L5-S1 at another. (Ex. 4-1). In that report, as well in subsequent reports of June 9, 1999, July 21, 1999 and July 29, 1999, Dr. Gallo attributed the current L5-S1 disc condition in major part to the March 30, 1999 incident. (Exs. 4, 6, 8A, 9).

The hearing was scheduled for September 30, 1999. Unbeknownst to the employer's counsel, claimant's attorney had requested an additional report from Dr. Gallo on September 9, 1999. (Ex. 10). Claimant's counsel had inquired about whether the March 30, 1999 injury had combined with the prior injury and whether Dr. Gallo still believed the March 1999 injury was the major contributing cause of the need for treatment at L5-S1. As previously noted, Dr. Gallo's response was not received by claimant's counsel in time for the hearing on September 30th. Dr. Gallo's October 4, 1999 response was, however, forwarded by claimant's counsel to the employer's counsel on October 5, 1999. In the October 4, 1999 report, Dr. Gallo stated that it was her understanding that the prior injury and discectomy involved the L4-5 level. Because the current low back condition concerned the L5-S1 level, Dr. Gallo could not relate the previous injury and surgery to the current injury. Therefore, Dr. Gallo opined that there was no combination of the prior and current injuries. (Ex. 11).

The ALJ's initial order finding the 1999 low back claim compensable issued on October 7, 1999. The employer requested reconsideration on October 15, 1999 based on the newly discovered evidence. As previously noted, the ALJ declined to admit proposed Exhibits 10 and 11. In addition, the ALJ adhered to his prior order, concluding that admission of the disputed exhibits would not alter his opinion on the compensability issue.

The employer contends that it could not have obtained the disputed exhibits prior to the hearing and that their admission would affect the outcome of the hearing. Therefore, according to the employer, they should have been received into evidence. We agree.

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. Under OAR 438-007-0025, the ALJ may reopen the record and reconsider his or her decision based upon newly-discovered evidence where the motion to reconsider states the nature of the new evidence and explains why it could not have been reasonably discovered and produced at hearing. We review the ALJ's evidentiary ruling for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

Dr. Gallo's original report is unclear about whether she was aware that claimant's original injury in 1988 affected the L5-S1 level. As previously noted, her report contained references to both that level and L4-5. It is now clear from the October 4, 1999 report that Dr. Gallo mistakenly assumed that the 1988 injury involved the L4-5 level. Thus, it appears that Dr. Gallo had an erroneous understanding of claimant's medical history that directly affects the persuasiveness of her opinion on the causation issue.

The issue is whether the employer could reasonably have discovered and produced the new evidence at hearing. We conclude that it could not have done so. The employer had no reason to know that claimant's attorney had requested an additional report from Dr. Gallo in September 1999 and, thus, could not have obtained the response directed to claimant's attorney prior to the hearing. We, therefore, conclude that the disputed exhibits themselves were not obtainable by the employer prior to the hearing.

In addition, we find that the substance of Dr. Gallo's October 4, 1999 report could not reasonably have been discovered. In this regard, we agree with the employer that it had no reason to solicit an additional report from Dr. Gallo in light of the numerous reports noted above that she had previously submitted and that had made it clear that she believed the current L5-S1 disc condition was compensable. Granted, Dr. Gallo's initial report indicated some confusion regarding the level of claimant's prior low back surgery. However, the employer had no reason to believe in light of Dr. Gallo's later reports that she did not know the correct level of claimant's 1989 surgery, especially those reports issued after she reviewed and commented on the report of Dr. Fuller, an examining physician, who specifically referred (correctly) to the prior surgery as having been at L5-S1. (Exs. 6A-4, 8A, 9).

In summary, we conclude that the ALJ erred in declining to admit the disputed exhibits. In addition, because the disputed records should have been admitted, this case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5).

Accordingly, the ALJ's order is vacated and the case is remanded to ALJ Peterson for further proceedings consistent with this order. In other words, the ALJ is directed to admit the disputed exhibits and to consider any other evidentiary matters resulting from our decision. These proceedings shall be conducted in any manner that the ALJ deems will achieve substantial justice. The ALJ, upon receipt of this additional evidence and closure of the evidentiary record, shall reconsider the merits of the issues raised by the parties. The ALJ shall then issue a final, appealable order.

IT IS SO ORDERED.

Board Member Biehl dissenting.

The majority remands this case to the ALJ after finding the employer could not have obtained the substance of Dr. Gallo's October 4, 1999 report with due diligence prior to the hearing. Because I disagree with that conclusion, I respectfully dissent.

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). On the facts of this case, I would not tamper with the ALJ's exercise of that broad discretion.

The majority acknowledges that there was confusion in Dr. Gallo's initial report of May 1, 1999 regarding the correct level of claimant's prior surgery in 1989, but that the employer had no reason to believe in light of later reports that Dr. Gallo did not know the correct level of the prior surgery. I am not persuaded by this reasoning.

Clearly, Dr. Gallo's May 1, 1999 report indicated some confusion as to the proper level of the 1989 surgery, given that the report refers to both the L5-S1 and L4-5 levels. (Ex. 4-1). This confusion should have prompted the employer to clarify Dr. Gallo's history. Moreover, in subsequent reports in which Dr. Gallo opined that claimant's current low back condition is due to the March 30, 1999 injury, Dr. Gallo did not mention the level of the prior surgery. (Exs. 6, 8A, 9). Although Dr. Gallo made it clear that she believed the current low back condition at L5-S1 was related to the March 1988 injury, the issue concerning Dr. Gallo's awareness of the correct level of the 1989 surgery was still viable. The employer still had ample reason to clarify Dr. Gallo's history prior to the hearing.

The majority notes that Dr. Gallo reviewed Dr. Fuller's report, which specifically referred to the prior surgery as having been at L5-S1. The majority finds that, in light of this, the employer reasonably assumed that Dr. Gallo was aware of the proper history. I disagree with the majority that this was sufficient to relieve the employer from clarifying Dr. Gallo's history with due diligence prior to the hearing in light of the obvious ambiguity in Dr. Gallo's initial report.

Accordingly, I would find that the employer did not exercise due diligence in obtaining the substance of Dr. Gallo's October 4, 1999 prior to the hearing. The Supreme Court's decision in *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986) supports my position.

In *Compton*, the claimant filed a claim for occupational hearing loss in April 1983. Dr. Ediger, the audiologist to whom the employer referred the claimant, found a seven decibel loss of hearing. Although he characterized the claimant's hearing change as slight, Ediger in his initial report would not rule out the possibility that work for the employer might have caused the change in hearing. The claimant was then referred to an ear, nose and throat specialist, Dr. Hiatt, for evaluation. Hiatt's otological evaluation found no evidence of ear disease and concluded that the cause of additional hearing loss was "undetermined" and not related to noise exposure at the employer, assuming adequate ear protection. After reading the otological report, Dr. Ediger amended his opinion, stating that he did not consider it likely that the claimant's hearing loss was due to employment.

The Referee (now ALJ) found the claim compensable. The employer requested Board review. The employer also requested a "closing report" from Ediger. For that purpose, Ediger conducted another evaluation after the hearing. After this evaluation, Ediger reported evidence of a further reduction in hearing, albeit slight. The report from this evaluation also stated that, after "reviewing and rethinking" the case in light of newly obtained information that the claimant had gone without hearing protection when he needed to communicate with co-workers, Ediger felt that it would be impossible to say that change in hearing from 1966 to 1984, though relatively slight, could absolutely not have resulted from excessive noise exposure as a result of employment.

When the employer requested Board review of the referee's order, claimant moved for remand pursuant to ORS 656.295(5) because the case was improperly, incompletely or otherwise insufficiently developed or heard by the Referee in the absence of this report. We denied remand for consideration of the new report, concluding that a report explaining the [audiologist's] rethinking of his earlier position was not evidence which could not reasonably have been produced and discovered before the hearing. On the merits, we reversed the Referee because the claimant had not established that his work was the major cause of the slight worsening of his hearing loss.

Before the Court of Appeals, the claimant moved pursuant to ORS 656.298(6) to have the court consider the new report as additional evidence concerning disability that was not obtainable at the time of the hearing. The Court of Appeals denied the motion and affirmed our order. The claimant then appealed to the Supreme Court.

The Court agreed with the long line of Court of Appeals decisions that there is a distinction between unavailable and unobtainable evidence and that evidence not submitted at hearing must be "unobtainable," not merely "unavailable" at hearing, before a remand is appropriate. Noting that Dr. Ediger's report was not requested by the claimant, but was requested by the employer for closing the claim, the Court observed that this was not a case of a claimant disappointed with the Referee's decision who engaged in opinion shopping in the medical community to seek additional benefits.

However, the Court held that an erroneous factual foundation or change of opinion did not create "unobtainable" evidence. The Court stated that all the claimant had to do upon receiving Ediger's first report was to produce the doctor to testify at the hearing and merely ask the doctor to assume the disputed fact of unprotected exposure at work and then ask the doctor if this would change his opinion. In the alternative, the Court noted that the claimant could have supplied this information to the doctor and asked for a revised opinion. Observing that all this information existed long before the hearing and, in that sense, was obtainable, the court held that the evidence may not have been made available at the hearing, but it certainly was "obtainable." Accordingly, the Court affirmed the Court of Appeals, emphasizing that the workers' compensation scheme requires not only promptness but also finality in the decision making process, and that to hold otherwise would allow virtually every case to be reopened when a belated discrepancy in the evidence is called to the attention of the claimant. 301 Or at 648-9.

In this case, it now appears that Dr. Gallo's opinion was based on an erroneous factual foundation. However, the *Compton* Court held that an erroneous factual foundation or change of opinion does not create "unobtainable" evidence. Moreover, as the Court emphasized, the workers' compensation scheme requires not only promptness, but also finality in the decision making process, and that to hold otherwise would allow virtually every case to be reopened when a belated discrepancy in the evidence is called to the attention of a party. Thus, in this case, where the substance of Dr. Gallo's October 4, 1999 report was obtainable prior to the hearing, and where we are only concerned with a belated discrepancy in the evidence, I believe that the majority contravenes the policy of finality in the decision making process the *Compton* Court articulated.

Thus, I would conclude that the ALJ did not abuse his broad grant of discretion in excluding the disputed exhibits. Therefore, I would not remand this case to the ALJ.

May 26, 2000 Cite as 52 Van Natta 923 (2000)

In the Matter of the Compensation of
EDET E. ASANA, Claimant
WCB Case No. 99-04072
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability.

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

Dr. Adams did once indicate that claimant's condition was due to his work exposure. (Ex. 32). However, he also concurred with the examining physicians' opinion that claimant's condition was not work-related, without further explanation. (Ex. 36; *see* Ex. 33). Under these circumstances, we find Dr. Adams' various causation opinions unpersuasive because they are inadequately explained.

ORDER

The ALJ's order dated January 24, 2000 is affirmed.

In the Matter of the Compensation of
RODNEY E. OLSEN, Claimant
WCB Case Nos. 98-07606 & 98-01484
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld Farmers Insurance Company's denial of his occupational disease claim for a right scaphotrapezial arthritic condition; (2) upheld Johnston & Culberson's, Inc.'s (JCI's) denial of his occupational disease claim for right epicondylitis, de Quervain's syndrome, radial tunnel syndrome, and scaphotrapezial arthritis; (3) declined to award interim compensation regarding the "JCI" claim; and (4) declined to assess penalties against JCI for allegedly unreasonable claim processing. On review, the issues are compensability, responsibility, interim compensation and penalties.

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

The ALJ held that claimant failed to prove the compensability of his occupational disease claim for the disputed conditions, finding that claimant's work activities were not the major contributing cause of the need for treatment or disability for the denied conditions. On review, citing *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997), claimant argues that the opinion of his attending physician, Dr. Layman, establishes that his work activity was the major contributing cause of his need for treatment of his right upper extremity conditions and, thus, that his occupational disease claim is compensable under ORS 656.005(7)(a)(B).

We agree with the ALJ's reasoning that Dr. Layman's opinion is not persuasive on the causation issue and, therefore, that claimant has not proved a compensable occupational disease claim. However, we disagree with claimant's and the ALJ's understanding that claimant's burden in this case was to prove that work activities are the major contributing cause of the *need for treatment or disability*.

ORS 656.802(2)(a) and (b) require that employment conditions be the major contributing cause of the disease or, if applicable, the combined condition at issue, not merely the current need for treatment. Additionally, ORS 656.802(2)(c) provides that occupational diseases are subject to the same limitations and exclusions as accidental injuries under ORS 656.005(7).

As we held in *Tammy L. Foster*, 52 Van Natta 178 (2000) (a case decided after the ALJ's order and after briefing was completed), subsection (2)(c) of ORS 656.802 indicates that the legislature intended to place additional limitations on the compensability of occupational diseases and not to expand their compensability. As was true in *Foster*, adoption of claimant's analysis of the statute would have the opposite effect of expanding the compensability of occupational diseases.

Finally, neither ORS 656.005(7)(a)(B) nor the *Nehl* court's decision eliminated the requirement in ORS 656.802(2)(b) that a claimant prove that employment conditions are the major contributing cause of the combined condition or of a pathological worsening of the disease. For these reasons, we again conclude that the statutory requirements for proving a compensable occupational disease are *not* satisfied by establishing that work activities are the major contributing cause of a need for medical treatment. *See Jeffrey L. Dennis*, 52 Van Natta 344 (2000) (following *Foster*).

Accordingly, we find that the medical evidence fails to establish that work activities are the major contributing cause of the disputed medical conditions or of a pathological worsening of any preexisting condition. Therefore, we affirm.

ORDER

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

In the Matter of the Compensation of
VICTOR M. BARDALES, Claimant
WCB Case No. 99-08365
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration that awarded claimant 43 percent (137.6 degrees) unscheduled permanent disability for his right shoulder condition and 23 percent (44.16 degrees) scheduled permanent disability for loss of use or function of his right arm. On review, the issue is extent of scheduled and unscheduled permanent disability.

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

On review, the insurer contends that the ALJ and the Department erred in finding the arbiter's rating of claimant's permanent impairment more persuasive than the range of motion findings provided by claimant's treating doctor. We disagree.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. *Orfan A. Babury*, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *Koitzsch v. Liberty Northwest*, 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, after reviewing the record, we agree with the ALJ that the medical arbiter has provided the most persuasive opinion regarding claimant's impairment. We find that the report of Dr. Niles, the medical arbiter, is much more thorough and detailed than the report of Dr. Puziss. (Exs. 9, 12). Moreover, Dr. Niles' examination was performed closer in time to the date of reconsideration. Consequently, the Department and the ALJ did not err in relying on Dr. Niles' impairment findings.

The insurer also argues that, under the Board's decision in *Anthony W. Abshire*, 52 Van Natta 204, *on recon* 52 Van Natta 635 (2000), Dr. Niles' report is not sufficient to establish an award for loss of shoulder and arm strength. Specifically, the insurer contends that there is no medical opinion that establishes which specific named peripheral nerves are involved in claimant's loss of strength.

We find *Abshire* to be distinguishable. In that case, no medical arbiter exam was conducted. The treating doctor did not refer to any loss of strength in his closing exam. Consequently, the only reference to loss of strength in the record was found in a physical capacity evaluation that was later concurred in by the treating doctor. In *Abshire*, therefore, the only mention of loss of strength was described as "4/5 flexion," "5-/5 abduction," etc. On such a record, we found that the medical evidence was not enough to determine the appropriate peripheral nerve of spinal root that supplied (innervated) certain muscles, even under the current version of the rule which provided that such nerves may be identified by referencing current anatomy texts. OAR 436-035-0007(19)(a) and (b).

Here, however, Dr. Niles has provided a detailed report to support her finding that claimant has loss of strength. Dr. Niles specifically described the affected areas, such as "anterior, lateral and posterior deltoid, biceps," etc. (Ex. 12-5). Relying on Dr. Niles' description and current anatomy texts of the AMA Guides and Gray's Anatomy, the Department identified the nerves supplying each muscle. (Ex. 13-2). Accordingly, we conclude that the medical record in this case was sufficient to comply with the rule, and the Department properly awarded impairment for claimant's loss of strength.

Under the circumstances, we conclude that the Department and the ALJ correctly relied on the arbiter's report in establishing claimant's award of permanent disability. We therefore affirm the ALJ's order.

Claimant is entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors listed 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 $1,725, payable by the insurer. In reaching this conclusion, we have particularly relied on the time devoted to the case (as represented by claimant's respondent's brief and attached "Request for Fee at Board Level"), the complexity of the issue, and the value of the interest involved. We have also considered the insurer's proposed fee of $1,000 for services on review. Nevertheless, considering the fact that the insurer appealed both awards of scheduled and unscheduled permanent disability, and in light of the hours spent by claimant's counsel on services on review, we find that a reasonable fee is $1,725, as requested by claimant.

ORDER

The ALJ's order dated February 23, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,725, to be paid by the insurer.

May 30, 2000 Cite as 52 Van Natta 926 (2000)

In the Matter of the Compensation of
ELEAZAR J. NICHOLAS-JIMENEZ, Claimant
WCB Case No. 99-01015
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's injury claim for an umbilical hernia. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The issue is whether claimant, a laborer, sustained a compensable hernia injury on November 30, 1998, when he allegedly felt movement in his abdomen while he was spreading compost with a pitchfork. The employer denied the hernia claim on January 19, 1999. Claimant requested a hearing.

Applying ORS 656.005(7)(a)(B), the ALJ set aside the denial, finding that claimant's work activity on November 30, 1998 was the major contributing cause of claimant's need for treatment, including eventual surgical repair of the hernia. In making her determination, the ALJ found no persuasive reasons not to defer to the opinion of the attending surgeon, Dr. Wilson. Dr. Wilson opined in a deposition that, while work activities were not the major contributing cause of the umbilical hernia (a preexisting defect was the cause), the work activity on the November 30 made the preexisting hernia defect symptomatic.

On review, the employer contends that Dr. Wilson's opinion does not satisfy claimant's burden of proof. For the following reasons, we agree.

At the outset, the parties agree, and we find, that claimant must prove compensability under ORS 656.005(7)(a)(B) because an otherwise compensable injury combined with a preexisting condition to result in a need for treatment. Accordingly, claimant must prove that his work activity during a discrete period on November 30, 1998 was the major contributing cause of the need for medical treatment for his "combined condition." Because of the multiple potential causes of the umbilical hernia, we find that this case involves a complex issue of medical causation. Thus, we require expert medical evidence to resolve the causation issue. *Uris v. Compensation Department*, 247 Or 420 (1967) (when a causation issue presents a complex medical question, expert medical opinion is required to prove compensability); *see also Barnett v. SAIF*, 122 Or App 279 (1993).

Three doctors rendered opinions addressing the cause of the umbilical hernia: Drs. Wilson, Messer and Braun. Dr. Wilson, the treating surgeon, initially opined that claimant likely had a preexisting defect in the umbilical area that was asymptomatic prior to the November 30, 1998 "event." (Ex. 8-1). According to Dr. Wilson, the November 30th "event" was associated with the onset of symptoms only. Dr. Wilson could not tell whether the preexisting defect or the November 30, 1998 incident was the major cause of the umbilical hernia for which he eventually performed surgery. *Id.*

Shortly after this report, however, Dr. Wilson signed a concurrence letter from claimant's attorney, agreeing that "work activities" more likely than not caused the umbilical hernia and that claimant had no predisposing factors. (Ex. 11).

The employer later deposed Dr. Wilson. During that testimony, Dr. Wilson concluded that the work activities on November 30, 1998 were not the major contributing cause of the umbilical hernia. Rather, a preexisting defect was the cause of the hernia. (Ex. 13-9). Dr. Wilson further testified that the work activities on November 30, 1998 were simply associated with the onset of symptoms. (Ex. 13-10). At no point did Dr. Wilson testify that the November 30, 1998 work activity was the major contributing cause of claimant's need for treatment.

In evaluating the medical evidence concerning causation, we rely on opinions that are well reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally give greater weight to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the following reasons, we find persuasive reasons not to do so in this case.

Having reviewed Dr. Wilson's "pre-deposition" opinions, we find that they are contradictory regarding the presence of a preexisting condition, with Dr. Wilson opining at one point that claimant had a preexisting defect in the umbilical area and at another agreeing that there were no predisposing factors. We also find that these opinions are inconsistent regarding the cause of the umbilical hernia, because Dr. Wilson initially could not determine the major cause of the hernia, but shortly thereafter opined that the work activity caused the umbilical hernia.

In his deposition, when he was given the opportunity to explain his opinion, Dr. Wilson never testified that the alleged injury was the major contributing cause of the need for treatment of the "combined condition," *i.e.*, the umbilical hernia. At most, Dr. Wilson's opinion establishes that the alleged injury caused the preexisting hernia condition to become symptomatic. Because ORS 656.005(7)(a)(B) requires that the otherwise compensable injury be the major contributing cause of the need for treatment, we agree with the employer that Dr. Wilson's opinion does not satisfy claimant's burden of proof under the statute. *See Darrell A. Meyer*, 51 Van Natta 135, 137 (1999) (although a physician indicated that the claimant's work injury caused degenerative disc disease to be symptomatic, his opinion did not establish that the work injury was the major contributing cause of disability or need for treatment of a combined condition).[1]

As previously noted, there are two other relevant medical opinions, those of Dr. Messer and Dr. Braun. However, neither opinion supports compensability. Dr. Messer treated claimant in the emergency room on December 7, 1998. Dr. Messer opined that claimant had a preexisting periumbilical cyst condition, of which the November 30, 1998 incident was not the major contributing cause.[2] Dr. Messer further concluded that the only relationship between this condition and work was that claimant noticed symptoms at work. (Ex. 7-2).

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[1] Claimant cites *Daniel P. Senay*, 49 Van Natta 1966 (1997), as support for the ALJ's decision. We do not find that case requires a different result here. In *Senay*, we found an umbilical hernia condition compensable when the attending physician opined that a lifting incident was the major contributing cause of the hernia, when compared with a congenital defect and the claimant's weight. The treating doctor further explained that it was a protrusion caused by the lifting incident, and not congenital weakness, that caused the onset of symptoms and need for surgery. Unlike the treating doctor in *Senay*, Dr. Wilson in this case did not state that work activity caused claimant's need for treatment, including surgery. Moreover, unlike the attending physician in *Senay*, Dr. Wilson here testified that the work activity in this case did not cause the umbilical hernia.

[2] It appears that Dr. Messer's diagnosis of a cyst may have been erroneous in light of subsequent evidence from Drs. Wilson and Braun that the actual diagnosis was an umbilical hernia. In any event, Dr. Messer's opinion does not prove that the alleged injury was the major contributing caurs of claimant's need for treatment, regardless of the proper diagnosis.

Dr. Braun reviewed medical records on behalf of the employer. He noted that umbilical hernias generally have a congenital basis and that the preexisting congenital condition was the major contributing cause of the need for treatment. (Ex. 12).

In conclusion, based on our *de novo* review of the record, we find that claimant failed to prove the compensability of his umbilical hernia under ORS 656.005(7)(a)(B). Therefore, we reverse the ALJ's decision setting aside the employer's denial.

ORDER

The ALJ's order dated January 26, 2000 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

The majority finds that claimant failed to sustain his burden of proving that his umbilical hernia is compensable under ORS 656.005(7)(a)(B). In so doing, it concludes that Dr. Wilson's opinion is not sufficient to satisfy claimant's burden of proof. Because I agree with the ALJ's analysis and would affirm her determination that the umbilical hernia claim is compensable, I respectfully dissent.

At the outset, I note that the ALJ found claimant's testimony credible that an incident of injury occurred during work hours. Thus, this case turns on whether the medical evidence is sufficient to prove that the work activities on November 30, 1998 are the major contributing cause of claimant's need for treatment for the umbilical hernia. That issue depends on whether Dr. Wilson's opinion is persuasive. The ALJ determined that it was. I agree with that assessment.

As the majority notes, Dr. Wilson gave three opinions on the causation issue. Admittedly, the first two were not as clear as one might hope. Nevertheless, Dr. Wilson's testimony in his deposition makes it clear that claimant's umbilical hernia symptoms stemmed from the November 30, 1998 work activity. I agree with the ALJ that what Dr. Wilson was saying was that the work activity caused the underlying preexisting hernia condition to become symptomatic, but did not cause the condition. Accordingly, although it was not the major cause of the umbilical hernia, the work activity on November 30, 1998 was the major factor in claimant's need for treatment, which is all that is required under ORS 656.005(7)(a)(B). While the majority faults Dr. Wilson for not explicitly stating this, it is well-settled that "magic words" are not necessary to establish causation. *McClendon v. Nabisco Brands*, 77 Or App 412 (1986); *Mary A. Crowley*, 51 Van Natta 1829 (1999). Given the context of Dr. Wilson's opinion, I agree with the ALJ that it is persuasive. *See SAIF v. Strubel*, 161 Or App 516 (1999); *Worldmark the Club v. Travis*, 161 Or App 644 (1999).

Finally, I agree with the ALJ that the contrary opinions of Dr. Messer and Dr. Braun are conclusory and, thus, are not persuasive on the causation issue. As the ALJ properly observed, when there is a disagreement between medical experts, deference is given to the treating physician, unless there are persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). In this case, there are no such reasons. Thus, the ALJ properly deferred to Dr. Wilson, the attending surgeon, who provided the most thorough analysis of the causation issue.

In conclusion, because the persuasive medical evidence from Dr. Wilson establishes that the umbilical hernia condition is compensable, the majority should affirm the ALJ's well-reasoned order. Because it does not, I dissent.

In the Matter of the Compensation of
KAREN SMITH, Claimant
WCB Case No. 99-05405
ORDER ON REVIEW
Adams, Day & Hill, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that: (1) upheld the insurer's denial of claimant's occupational disease claim for a bilateral carpal tunnel (CTS) condition; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to provide timely discovery. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's argument on review regarding the proper legal standard to be applied in this case.

Relying on the opinions of Dr. Nye and Dr. Brown, the ALJ found that claimant failed to prove compensability of her bilateral CTS condition as an occupational disease. The ALJ found attending physician Dr. Van Allen's opinion unpersuasive under *Dietz v. Ramuda*, 130 Or App 387 (1994), *rev dismissed* 321 Or 416 (1995), because he failed to address Dr. Brown's discussion of the etiology of claimant's condition and Dr. Nye's opinion that claimant's CTS was idiopathic. On review, claimant argues that *Dietz* is inapplicable and that we should rely on treating physician Dr. Van Allen's opinion to establish compensability. We do not agree.

Contrary to claimant's position, ORS 656.802(2) requires that claimant's employment activities be the major contributing cause of claimant's CTS condition. Because a determination of major contributing cause requires the assessment of the relative contribution of different causes, *Dietz*, 130 Or App at 399, it is necessary to consider the effect of all possible causes of a condition. 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.

In this case, the proper assessment includes evaluating the contribution to claimant's CTS condition of Dr. Brown's theory regarding claimant's propensity to develop CTS because of her build and Dr. Nye's assessment of the contribution of claimant's work activities to her condition. Accordingly, on *de novo* review, we agree with the ALJ's reasoning and opinion regarding the persuasiveness of Dr. Van Allen's opinion.

ORDER

The ALJ's order dated January 4, 2000 is affirmed.

In the Matter of the Compensation of
VENITA A. GALLAGHER, Claimant
WCB Case Nos. 99-02177 & 98-07248
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Claimant requests reconsideration of those portions of our April 20, 2000 order that: (1) found that the insurer had accepted a combined condition with regard to her February 1996 injury; (2) found that claimant was not entitled to a penalty for the insurer's allegedly unreasonable failure to pay interim compensation; and (3) upheld the insurer's denial of her current cervical/thoracic strain and right upper extremity conditions. On May 9, 2000, we abated our order to consider claimant's motion. Having received and considered the insurer's response to the motion, we proceed with our reconsideration.

Claimant contends that the insurer did not accept a combined condition with regard to her first on-the-job injury, which occurred in February 1996. Citing *Croman Corporation v. Serrano*, 163 Or App 136 (1999), claimant argues that the insurer's September 11, 1998 denial is not a valid combined condition denial with regard to the 1996 injury.

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." After the claim acceptance, the employer contended that the claimant's need for ongoing medical treatment was not related to the accepted injury and issued a preclosure denial under ORS 656.262(7)(b). The court concluded that in order for an employer to have properly issued a preclosure denial under ORS 656.262(6)(c) and ORS 656.262(7)(b), the employer must have accepted a combined condition. 163 Or App at 140. Because the employer had not accepted a combined condition, the court agreed that ORS 656.262(7)(b) did not apply. The court affirmed the Board's decision to set aside the employer's denial as an impermissible preclosure denial of medical treatment for an accepted condition. *Id.* at 141-42. The court noted that if the employer believed that the accepted conditions were resolved and that the claimant was no longer in need of medical treatment for those conditions, it could have closed the claim. *Id.*

Here, unlike *Serrano*, the insurer's September 11, 1998 denial was issued more than two years after the 1996 claim had been closed. On May 10, 1996, the insurer accepted a disabling thoracic strain resulting from claimant's February 1996 claim. (Exs. 2, 12). A July 30, 1996 Notice of Closure awarded temporary disability, but did not award any permanent disability. (Ex. 19). The insurer's September 11, 1998 denial was neither "preclosure" nor impermissible. We disagree with claimant's argument that the September 11, 1998 denial of the February 1996 injury must be set aside "as a matter of law."

Claimant also argues that there is no evidence to support the finding that the insurer's aggravation denial was reasonable, and she contends that we erred in evaluating the medical evidence. After reviewing claimant's additional arguments and the insurer's response, we find that claimant essentially raises the same arguments that we addressed in our order. We have nothing further to add to our prior order.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our April 20, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBORAH C. HEMBREE, Claimant
WCB Case No. 99-01306
ORDER ON REVIEW
Johnson, Cram, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Fitzwater's order that set aside its denial of claimant's occupational disease claim for her right shoulder condition. On review, the issue is compensability.

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

On review, the insurer renews its argument that the opinion of Dr. Straub is not sufficient to meet claimant's burden of proof. Specifically, the insurer disagrees with the ALJ's conclusion that Dr. Straub's opinion should be construed as finding that the major cause of claimant's right shoulder condition (as opposed to the cause of her symptoms) was her repetitive work activity with the employer.

After reviewing Dr. Straub's opinion, we agree with the ALJ that, while Dr. Straub did reference claimant's "symptoms," and the cause of her "symptoms," he also discussed the cause of claimant's "condition." Consequently, Dr. Straub's report, as a whole, establishes that work activities were the major cause of her condition. For example, Dr. Straub concluded that it was his "belief that the patient's impingement syndrome and calcific tendinitis is directly related to her work..." (Ex. 50). When asked whether claimant's work was capable of causing her "condition," Dr. Straub replied that "[r]epetitive use of the arms at or above shoulder level is the history most commonly given in patients who develop and impingement syndrome/calcific tendinitis." (Ex. 55-1). When asked whether there were any other factors that may have caused or contributed to claimant's "condition," other than work or the type of her acromion, Dr. Straub replied, "No." (Ex. 55-2).

Accordingly, we agree with the ALJ that Dr. Straub's persuasive opinion establishes compensability of claimant's right shoulder condition. We therefore affirm the ALJ's order.

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

ORDER

The ALJ's order dated February 11, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
DEBORAH L. REYES, Claimant
WCB Case No. 99-06622
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) declined to admit a medical arbiter report into the record; (2) increased claimant's scheduled permanent disability award for loss of use or function of her left forearm (wrist) from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to 17 percent (25.5 degrees); and (3) increased claimant's scheduled permanent disability award for loss of use or function of her right forearm (wrist) from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to 15 percent (22.5 degrees). On review, the issues are evidence and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant has an accepted bilateral carpal tunnel condition. On November 13, 1998, claimant's treating physician, Dr. Layman, performed a closing examination. (Ex. 26). Dr. Layman noted that claimant had "full range of motion in her wrists and fingers." (Ex. 26-2). He also found that claimant had diminished grip strength, which he rated at 4/5 for each wrist. (*Id.*)

On February 25, 1999, a Work Capacity Evaluation (WCE) was performed. (Ex. 27). At the WCE, claimant's bilateral wrist range of motion was measured and found to be somewhat reduced. (Ex. 27-1). The WCE evaluators also found that claimant retained "5/5" grip strength. (Ex. 27-1). However, on grip strength testing, claimant performed at only the 10th percentile, with full effort. (Ex. 27-3). On April 10, 1999, Dr. Layman concurred with the WCE examination report. (Ex. 28). Both Dr. Layman and the WCE examiners concluded that claimant was permanently limited in the repetitive use of both of her wrists. (Exs. 26-2, 27-1).

The insurer closed the claim by a Notice of Closure dated April 27, 1999 that awarded 6 percent scheduled permanent disability for claimant's right wrist and 9 percent for her left wrist (based on loss of range of motion and an award for a "chronic condition" in each wrist). (Ex. 30).

Claimant requested reconsideration (but did not disagree with the impairment findings at claim closure). The insurer then requested the appointment of a medical arbiter panel. On July 30, 1999, claimant participated in a medical arbiter examination by Drs. Farris, Woodward and Hoff. An Order on Reconsideration reduced claimant's awards from 6 percent and 9 percent to 5 percent for each wrist, preserving only the chronic condition awards. (Ex. 32).

Claimant requested a hearing. On February 7, 2000, the ALJ issued an order that increased claimant's scheduled permanent disability to 17 percent for her left forearm (wrist) and 15 percent for her right forearm (wrist) conditions. The ALJ based this award on loss of range of motion, a chronic condition for each wrist and loss of grip strength of 4/5 bilaterally.

CONCLUSIONS OF LAW AND OPINION

Admissibility of the Medical Arbiter Report

The insurer contends that the ALJ erred in declining to admit Exhibit 31, the medical arbiter examination report.[1] We review an ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

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[1] It is undisputed that the medical arbiter examination was arranged at the request of the insurer, and not at the request of the Department.

We have previously decided this issue adversely to the insurer, as it acknowledges. *Ramiro Pelayo*, 52 Van Natta 363 (2000). In *Pelayo*, we held that, because the insurer had closed the claimant's claim by virtue of a Notice of Closure, it could not then request the appointment of a medical arbiter. We reasoned that, because an insurer cannot request reconsideration of its own Notice of Closure, *former* ORS 656.268(4)(e), it likewise cannot initiate a medical arbiter examination. We affirmed the ALJ's decision to exclude the medical arbiter report. We decline to reconsider our decision in *Pelayo*. We therefore conclude that the ALJ did not abuse her discretion in excluding the medical arbiter report.

Extent of Scheduled Permanent Disability

On the merits, the insurer contends that claimant did not prove entitlement to an award for permanent disability as related to her compensable bilateral carpal tunnel condition. We disagree with the insurer and agree with the ALJ's decision to increase claimant's scheduled permanent disability award for her bilateral wrist condition.

The insurer asserts that claimant has not proven that she is entitled to a 5 percent "chronic condition" value for each wrist. We disagree. Pursuant to OAR 436-035-0010(5), a claimant is entitled to a 5 percent "chronic condition" award when a preponderance of evidence establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of either forearm. *Jose I. Rios*, 52 Van Natta 303 (2000).

The ALJ's conclusion in regard to the chronic condition award is supported by the medical evidence from claimant's treating physician, Dr. Layman, and by the WCE, as concurred in by Dr. Layman. (*See* Exs. 26-2, 27-1). Dr. Layman stated that "[Claimant] likely will do satisfactorily without need for medical or surgical treatment if she is not placed in a position where she is required to do rapid or repetitive wrist or hand motion." (Ex. 26-2). The WCE examiners noted that "[claimant] should avoid jobs that require maximal forceful gripping and pinching; [and] continuous, highly repetitious hand use functions * * *" (Ex. 27-1). These opinions persuasively establish that claimant is significantly limited in the repetitive use of both wrists. *Compare Ronny G. Holland*, 50 Van Natta 2240 (1998) (Medical evidence that the claimant would experience "some" limitation on repetitive use of his foot and ankle was not sufficient to support a chronic condition award). Pursuant to OAR 436-035-0010(5), we find that claimant is entitled to an award of 5 percent, bilaterally.

We similarly agree with the ALJ's evaluation of claimant's permanent impairment for loss of range of motion in each wrist. Following a November 13, 1998 closing examination, claimant's treating physician, Dr. Layman, reported that claimant had "full range of motion in her wrists and fingers." (Ex. 26-2). However, at a February 25, 1999 WCE, claimant's bilateral wrist range of motion was specifically measured and found to be somewhat reduced. (Ex. 27-1). On April 10, 1999, Dr. Layman concurred with the WCE examination report. (Ex. 28).

Evaluation of a worker's impairment is as of the date of the order on reconsideration. ORS 656.283(7); *Marvin D. Holbert*, 51 Van Natta 843 (1999). We have previously held that impairment findings later in time and closer to the date of the order on reconsideration are generally, but not always, more persuasive. *See Joan K. Rossum*, 51 Van Natta 1409 (1999). Here, we agree with the ALJ that Dr. Layman's later impairment "findings," *i.e.* his concurrence with the more specific measurements from the WCE, are the more persuasive evidence of claimant's loss of range of motion. Consequently, claimant is entitled to an impairment value of 1 percent for the right wrist and 4 percent for the left wrist for reduced range of motion. OAR 436-035-0080.

The ALJ also awarded a value for reduced grip strength of 4/5 bilaterally, based on the closing examination of Dr. Layman and specific findings of reduced grip strength in the WCE examination. (Exs. 26-2, 27-3). The insurer argues that the WCE evaluators noted claimant's strength to be "5/5 in both upper and lower extremities," and that claimant is therefore not entitled to an award for loss of grip strength. (Ex. 27-1). We disagree.

During his closing examination, Dr. Layman found claimant to have reduced bilateral grip strength, which he rated at "4/5." (Ex. 26-2). We find the medical evidence from Dr. Layman on this issue to be more persuasive than the WCE, which was internally inconsistent, in the following respect. Although the WCE examiners noted claimant's grip strength to be "5/5," that finding cannot be reconciled with the more specific results of hand function testing by the same examiners, on which claimant performed at "less than 10th" percentile bilaterally. (Ex. 27-3). The WCE examiners findings are further confirmed by their notation that claimant's grip strength tests indicated "consistent maximal voluntary effort." (Ex. 27-3).

Alternatively, we find the WCE's more specific findings of reduced grip strength more persuasive than their general and unexplained "5/5" statement. (Ex. 27-1, 27-3). Accordingly, under either of the aforementioned rationales, we also agree with the ALJ's evaluation of claimant's permanent impairment based on bilateral decreased grip strength. OAR 436-035-0007(19)(a); OAR 436-035-0110(8).

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 $1,837.50, 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 uncontested statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated February 7, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,837.50, payable by the insurer.

In the Matter of the Compensation of
SEBULAH A. HOUCHENS, Claimant
WCB Case Nos. 99-03315 & 99-01292
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The Hartford Insurance Company (Hartford), on behalf of its insured, Mid-State Child Development (Mid-State), requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of responsibility for claimant's bilateral carpal tunnel condition; and (2) upheld the responsibility denial of the same condition issued by Liberty Northwest Insurance Company (Liberty) on behalf of its insured, D&D Bar & Grill (D&D). In its brief, Liberty contests that portion of the ALJ's order that set aside its denial of the compensability of the carpal tunnel condition. On review, the issues are compensability and responsibility.

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

After determining that claimant's bilateral carpal tunnel condition was compensable, the ALJ addressed the responsibility issue. The ALJ determined that claimant first sought treatment in October 1998 while employed by Mid-State and, thus, that Hartford was presumptively responsible for the carpal tunnel condition. Applying *Timm v. Maley*, 125 Or App 396 (1993), the ALJ then determined that Hartford was in fact responsible for the carpal tunnel condition because it failed to shift responsibility back to Liberty's insured, D&D, for whom claimant was employed until May 15, 1998. Specifically, the ALJ held that Hartford failed to prove that it was impossible for conditions at Mid-State to have caused the disease or that the carpal tunnel condition was caused solely by claimant's prior employment for D&D.

On review, Hartford contends that it proved that the prior employment at D&D was the sole cause of the carpal tunnel condition. For the following reasons, we disagree.

Two doctors addressed the issue Hartford raises: Dr. Ireland, an examining physician, and Dr. Thayer, the treating physician. Dr. Ireland was deposed, at which time he initially opined that the "sole cause" of claimant's carpal tunnel condition was her employment for D&D. (Ex. 25-10). Dr. Ireland, however, later agreed that, while claimant's work for Mid-State did not contribute to the carpal tunnel condition as much as her work for D&D, it did contribute "some" to the overall disease process. (Ex. 25-21). Having reviewed Dr. Ireland's testimony, we find his responses to be inconsistent and do not establish that work for D&D, Liberty's insured, was the "sole cause" of the carpal tunnel condition.

We now turn to Dr. Thayer's opinion. Dr. Thayer stated that his history indicated that claimant never symptomatically worsened while working for Hartford's insured, Mid-State. Therefore, Dr. Thayer stated that he agreed with Dr. Ireland that claimant's employment for Liberty's insured was the "sole cause" of claimant sustaining carpal tunnel syndrome "to the magnitude, which required surgery." (Ex. 26).

Like the ALJ we are not inclined to give Dr. Thayer's concurrence with Dr. Ireland's opinion full weight given the inconsistencies in Dr. Ireland's opinion. Moreover, we find Dr. Thayer's opinion to be rather conclusory and, further, that it does not rule out some contribution to claimant's carpal tunnel condition by her employment for Mid-State, considering that Dr. Thayer stated that work for Liberty's insured was the sole cause of the carpal tunnel condition only "to the magnitude" it required surgery. Accordingly, we conclude that Dr. Thayer's opinion also does not establish that claimant's employment for D&D was the "sole cause" of the carpal tunnel condition.[1]

Therefore, we agree with the ALJ's decision to set aside Hartford's denial of responsibility. Thus, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 January 10, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by Liberty.

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[1] Hartford argues, alternatively, that Liberty was presumptively responsible for the carpal tunnel condition because claimant became disabled during employment for D&D prior to seeking medical treatment during employment for Mid-State. Hartford cites claimant's testimony that she was unable to continue her regular work as a "first-in" cook during her employment for D&D and undertook modified work on her own in response to her carpal tunnel symptoms. Acknowledging that there was no medical authorization for claimant's assumption of modified work, Hartford, nevertheless, asserts that claimant's self-modification of her employment duties constitutes "disability" for application of the last injurious exposure rule. Even if Hartford is correct that such a modification of employment could constitute "disability," the medical evidence does not establish that this modification of employment duties was the result of the compensable carpal tunnel condition. Thus, we reject Hartford's argument that Liberty was presumptively responsible for the carpal tunnel condition.

In the Matter of the Compensation of
DONALD J. WHISENANT, Claimant
WCB Case No. 99-07729
ORDER OF ABATEMENT
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our May 8, 2000 order that reversed those portions of an Administrative Law Judge's (ALJ's) order that: (1) awarded temporary total disability (TTD) for the period from October 31, 1998 through November 2, 1998 and temporary partial disability (TPD) for the period from November 3, 1998 through May 4, 1999; (2) assessed a penalty for the self-insured employer's allegedly unreasonable failure to pay temporary disability; and (3) awarded 11 percent (14.85 degrees) scheduled permanent partial disability for loss of use or function of claimant's right foot, whereas an Order on Reconsideration had awarded 8 percent (10.8 degrees).

In order to consider this matter, we withdraw our May 8, 2000 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES W. PETRIE, Claimant
WCB Case Nos. 99-01904 & 99-01126
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
VavRosky, MacColl, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's injury claim for a cervical condition. Claimant cross-requests review of that portion of ALJ Nichols' order that upheld the employer's denial of claimant's injury claim for a low back condition. The employer moves to strike claimant's respondents/cross-appellant's brief. On review, the issues are the procedural motion and compensability. We grant the motion, and reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant's respondents/cross-appellant's brief was due on February 22, 2000, 21 days from the date of mailing of the employer's appellant's brief. OAR 438-011-0020(2). On March 2, 2000, claimant requested permission to untimely file his respondents/cross-appellants brief.[1] In support of the request, claimant's counsel indicated that the employers brief had been received in his office, but had not been "docketed." The employer opposes claimant's request.

A motion for waiver of rules may be allowed if the Board finds extraordinary circumstances beyond the control of the party requesting waiver of a rule or rules justify such an action. OAR 438-011-0030. After considering the parties' positions (including the employer's opposition), we do not consider claimant's counsel's docketing error to constitute an extraordinary circumstance beyond the control of the requesting party.[2] *See Steve Duncan*, 50 Van Natta 987 (1998). Accordingly, we reject claimant's respondents/cross-appellant's brief as untimely. In any event, our consideration of the brief would not change our ultimate disposition of this case.

Cervical Condition

The employer contends that the ALJ incorrectly relied on the opinion of Dr. Smith in setting aside its denial of claimant's cervical condition. The ALJ found Dr. Smith's opinion well reasoned and persuasive that claimant suffered a new injury to his cervical spine as the result of an October 1998 falling incident which combined with claimant's preexisting cervical degenerative disease process. We disagree with the ALJ's assessment of Dr. Smith's opinion.

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[1] For procedural purposes we treat this letter as a request for waiver of the Board's rules under OAR 438-011-0030.

[2] We note that in some circumstances a calendaring error can be the result of extraordinary circumstances that would justify an extension. *See Bonnie Rogers*, 48 Van Natta 1211 (1996) (illness of a carrier attorney's paralegal was considered sufficient reason, over the claimant's objection, to justify an extension). In this claim, however, claimant offers no explanation for the docketing error.

Dr. Smith opined that the falling incident of October 1998 combined with claimant's preexisting degenerative disease process resulting in irritation of the cervical nerve roots at C5-6 and C6-7, or "cervical radiculitis." Therefore, to establish that his cervical radiculitis is compensable, claimant must show that the work incident was the major contributing cause of the disability or need for treatment of this combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101 (1997).

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to his need for treatment and disability for the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). This assessment involves an evaluation of the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995).

Here, we review the record for a persuasive medical opinion that evaluates the relative contribution of different causes of claimant's cervical condition and an explanation of why the falling incident of October 1998 contributed more to claimant's need for treatment or disability for the cervical radiculitis than his preexisting degenerative disc disease. Moreover, the fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Id.; see also Robinson v. SAIF*, 147 Or App 157, 162 (1997); *Elaine M. Baxter*, 51 Van Natta 1898 (1999).

According to Dr. Smith, claimant's C5-6 and C6-7 nerve roots were asymptomatic prior to the October 1998 fall, but in a compromised canal, setting him up for the subsequent radiculitis. (Ex. 78A-4). Apparently, the mechanism of claimant's fall, in which he fell forward and landed on his outstretched arms and hands, caused sufficient motion of either the nerve roots in the compromised canal or the compromised canal around the nerve roots to result in the irritation that Dr. Smith describes as "cervical radiculitis." Dr. Smith concurs that the fall did not accelerate or in any other way alter the natural course of the degenerative process in claimant's cervical spine. We find that Dr. Smith's opinion shows that claimant's fall is the precipitating cause of his need for treatment for the "cervical radiculitis," but not necessarily the major contributing cause of his need for treatment for that condition.

Moreover, although Dr. Smith's opinion explains the interaction of the fall and the preexisting degenerative disease process to produce claimant's "cervical radiculitis," it does not offer any evaluation of the relative contributions of the fall and the preexisting degenerative disease process to produce the need for treatment of or the disability from claimant's "cervical radiculitis" condition. Without such an evaluation, his opinion is merely an unsupported conclusion and, as such, is unpersuasive. *See Elaine M. Baxter*, 51 Van Natta 1898, 1899 (1999).

Consequently, the record does not support a conclusion that the major contributing cause of claimant's need for treatment for "cervical radiculitis" is the October 1998 fall at work.[3] Accordingly, we reverse the ALJs decision to set aside the employers denial of claimants cervical condition.

Low Back Condition

We adopt and affirm the balance of the order of the ALJ with the following supplementation to address claimant's contention that the ALJ incorrectly disregarded Dr. Smith's opinion regarding the October 1998 fall and claimants low back condition.

As he did with his opinion concerning claimant's cervical condition, Dr. Smith offers no explanation weighing the relative contributions of claimant's preexisting low back condition that has bothered claimant from time to time and the musculoligamentous strain Dr. Smith attributes to the October 1998 fall. Without such an explanation, his opinion is merely an unsupported conclusion and as such, is not persuasive. Accordingly, claimant has failed to establish the compensability of his low back condition.

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[3] We note that both Dr. Vu and Dr. Tanabe have expressed agreement with Dr. Smith. However, their opinions contained in Exhibits 80 and 81 respectively are both check the box concurrence letters. Such unexplained reports are themselves generally considered to be conclusory and unpersuasive. *See William F. Gilmore*, 46 Van Natta 999, 1000 (1994). Given their conclusory nature, their concurrence with the opinion of Dr. Smith does not help in making Dr. Smith's opinion persuasive.

ORDER

The ALJ's order dated December 14, 1999 is reversed in part and affirmed in part. That portion of the order that set aside the employer's denial of claimant's cervical condition is reversed. The employer's denial of claimant's cervical condition is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

June 2, 2000 Cite as 52 Van Natta 938 (2000)

In the Matter of the Compensation of
LORI M. THOMAS, Claimant
WCB Case No. 99-07861
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law judge (ALJ) Nichols' order that reduced claimant's unscheduled permanent disability for a low back injury from 27 percent (86.4 degrees), as awarded by Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the order of the ALJ with the following supplementation. Claimant contends that Dr. Dineen's medical arbiter statement that "I have no evidence or knowledge of any unrelated cause of the symptoms" should be interpreted to mean "I have read all the medical reports and do not find them sufficient to overcome the evidence that the cause of claimant's restricted ranges of motion is the compensable injury."

If we assume that claimant is correct about Dr. Dineen's statement, there is still no explanation in the record showing how Dr. Dineen arrived at that opinion. Without such an explanation, the opinion is merely an unsupported conclusion and as such, is unpersuasive. Consequently, the record would not support a conclusion that claimant sustained permanent impairment attributable to her compensable injury.

ORDER

The ALJ's order dated January 24, 2000 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority that the record does not support a conclusion that claimant sustained permanent impairment attributable to her compensable injury. Instead, I would reverse the ALJ's order and reinstate the Order on Reconsideration that awarded claimant 27 percent unscheduled permanent disability for her low back injury.

The only fair reading of the arbiter's report is that he reviewed the entire history contained in the record, which included the reports from Providence Urgency Care Clinic, Dr. Hsu, Dr. Schmidt, Dr. Parshley and Dr. Rosenbaum. Having read those reports, he then concluded that they were not of sufficient weight to change his opinion that claimant's impairment was caused by her compensable injury.

Under the administrative rules, the medical arbiter's findings concerning impairment are deferred to in the absence of a preponderance of medical opinion establishing a different level of impairment. OAR 436-035-0007(14). Because I believe that Dr. Dineen's findings are based upon his thorough examination of claimant as well as his complete review of the medical record, I do not find a preponderance of medical evidence in this record establishing a different level of claimants impairment. Accordingly, I would defer to Dr. Dineen's findings concerning claimant's level of impairment, reverse the ALJ's order, and reinstate the Order on Reconsideration award.

In the Matter of the Compensation of
JAMES P. DILLON, Claimant
WCB Case No. 99-06308
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration decreasing his award of scheduled permanent disability for loss of use or function of the left thumb from 29 percent (13.92 degrees), as awarded by a Notice of Closure, to 9 percent (4.32 degrees). On review, the issue is extent of scheduled permanent disability.

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

Claimant contends that the ALJ should have awarded 5 percent permanent disability for a "chronic condition" of his left hand based on the comment of the medical arbiters that "the accepted condition does limit this worker in the ability to repetitively use the left hand." (Ex. 17-4). Even assuming that a "chronic condition" award could be made for the left hand, we decline to do so in this case.

OAR 436-035-0010 provides, in relevant part:

> "(5) A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is *significantly limited* in the repetitive use of one or more of the following four body parts:
>
> "* * * * *
>
> "(c) Forearm (below elbow/hand/wrist)[.]" (emphasis added).

Although the medical arbiters opined that the accepted condition limited claimant in the ability to repetitively use the left hand, they did not state that claimant was "significantly" limited in his repetitive use. Moreover, the arbiters did not explain why claimant was limited in repetitive use of the left hand. *See Gordon Atkins*, 52 Van Natta 284 (2000) (rejecting medical arbiter's opinion when no explanation provided as to why the claimant was significantly limited in the repetitive use of left elbow). Thus, we do not find that the medical arbiters' report establishes claimant's entitlement to a "chronic condition" award for the left hand.

ORDER

The ALJ's order dated February 14, 2000 is affirmed.

In the Matter of the Compensation of
DENICE K. DRUSHELLA, Claimant
WCB Case Nos. 99-03676 & 98-03957
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our April 3, 2000 order that reversed an Administrative Law Judge's (ALJ's) order that had set aside the SAIF Corporation's denial of claimant's "left upper extremity symptom complex." Claimant contends that we erred in failing to defer to the opinion of her attending physician. On May 3, 2000, we abated our order to consider claimant's motion. Having received and considered SAIF's response to the motion, we proceed with our reconsideration.

To begin, we address claimant's request that the Board, *en banc*, reconsider the prior order. She also requests that the Board entertain oral argument on reconsideration. She contends that the issue for resolution may have a significant impact on the workers' compensation system. For the following reasons, we deny both requests.

Although the Board may sit *en banc* in rendering a decision, it may also sit in panels. *See* ORS 656.718(3). When sitting in panels, a majority of the particular panel may issue the Board's decision. *Id.* Whether a case is reviewed *en banc* is a matter solely within our own discretion. *E.g., Dale F. Cecil*, 51 Van Natta 1010 (1999). In the exercise of our *de novo* review, we select for *en banc* review those cases that raise issues of first impression that would have a widespread impact on the workers' compensation system or cases requiring disavowal of prior Board case law. This "significant case" review standard is applied to all cases before the Board. Thus, before issuing our Order on Review, we considered whether this case warranted *en banc* review and decided it was more appropriate for review by a panel.

Our conclusion is not changed by claimant's arguments. The proper standards for reviewing the persuasiveness of medical evidence are well-established by case law. Furthermore, contrary to claimant's arguments, after reconsideration, we continue to find that we appropriately applied those standards in reviewing the medical evidence in this case. Consequently, although we recognize the importance of this matter to claimant, we do not consider this case to be sufficiently significant to warrant *en banc* reconsideration.

For the same reasons, we deny claimant's request for oral argument.[1] We will not ordinarily entertain oral argument. OAR 438-011-0015(2). We may allow oral argument, however, where the case presents an issue of first impression that could have a significant impact on the workers' compensation system. OAR 438-011-0031(2). The decision to grant such a request is solely within our discretion. OAR 438-011-0031(3). Here, through their briefs on reconsideration, the parties have adequately addressed the issues before the Board and we are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. *See Dale F. Cecil*, 51 Van Natta at 1010. Therefore, we proceed with our reconsideration.

Relying on *Weiland v. SAIF*, 64 Or App 810 (1983), claimant contends that we erred in failing to adhere to the longstanding rule that deference is to be given to the opinion of an attending physician absent persuasive reasons not to do so. Claimant argues that there is no persuasive reason not to defer to the opinion of her attending physician, Dr. Achterman. Claimant also contends that we erred in discounting the opinion of Dr. McKinstry.

After reviewing claimant's motion, we find that claimant essentially raises the same arguments that we addressed in our order. We explained why we found persuasive reasons not to rely on Dr. Achterman's opinion and we also explained why Dr. McKinstry's opinion was not sufficient to establish compensability. We have nothing further to add to our prior order.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our April 3, 2000 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] Furthermore, we note that claimant did not make this request before we issued our Order on Review, when it would have been more appropriate to consider oral argument.

Board Member Phillips Polich concurring in part and dissenting in part.

Although I agree with the majority's decision to deny claimant's request for *en banc* reconsideration and oral argument, I continue to believe that claimant has established the compensability of her left upper extremity complex based on the reasons expressed in my prior dissenting opinion. Consequently, I adhere to my previous conclusion that the ALJ's order should be affirmed.

June 2, 2000 Cite as 52 Van Natta 941 (2000)

In the Matter of the Compensation of
KENNETH W. EMERSON, Claimant
WCB Case No. 99-04247
ORDER ON REVIEW (REMANDING)
Ransom & Gilbertson, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its *de facto* denial of claimant's left elbow epicondylitis condition. Claimant requests review of that portion of ALJ Davis' order that upheld SAIF's *de facto* denial of his right ulnar neuropathy condition. Claimant has also submitted further medical evidence and requests that the matter be remanded for admission of that evidence. SAIF objects to claimant's request. On review, the issues are remand and compensability. We remand.

The ALJ upheld SAIF's denial of claimant's right ulnar neuropathy condition. Claimant has submitted further evidence and requests that the matter be remanded for admission of that evidence. The proffered evidence consists of a March 29, 2000, letter from Dr. Sandefur, claimant's treating physician, in which he discusses his findings from a post-hearing surgery on claimant's right elbow to relieve his ulnar nerve problems.

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

Inasmuch as the proffered evidence relates to claimant's right ulnar neuropathy condition, the evidence concerns disability. Moreover, since the surgery did not take place until after the September 1, 1999 hearing, the evidence submitted by claimant was not obtainable, with due diligence, at the time of the hearing. *See Wanda Kelley*, 47 Van Natta 146 (1995) (evidence derived from a "post-hearing" surgery not obtainable with due diligence).

Claimant contends that his right ulnar nerve problem is either a direct result or a consequential condition of his accepted injury of January 9, 1996. In upholding SAIF's denial of claimant's right ulnar neuropathy condition, the ALJ was not persuaded by Dr. Sandefur's theory that claimant's ulnar nerve was being affected by scar tissue from a previous compensable surgery on the right elbow. In particular, the ALJ declined to rely on the opinion of Dr. Sandefur, at least in part because nerve conduction studies could not confirm a compromise of the claimant's ulnar nerve at the elbow. Because the proffered evidence concerns Dr. Sandefur's recent surgical findings of scar tissue surrounding claimant's right ulnar nerve at the elbow, claimant contends that the evidence is reasonably likely to affect the outcome of the case. If claimant is correct, there exists a compelling reason to remand.

SAIF objects to the motion to remand arguing primarily that the proffered evidence is not new information and further argues that it is not reasonably likely to affect the outcome of the case. We disagree.

While Dr. Sandefur's opinion that claimant's ulnar neuropathy is caused by scar tissue at the elbow is not new, the actual physical finding of scar tissue around the ulnar nerve is new. The proffered evidence fills in gaps in the medical record and tends to vindicate Dr. Sandefur's prior opinion that claimant's ulnar nerve condition is caused by scar tissue. Accordingly, we find a compelling reason to remand. *See Parmer v. Plaid Pantry # 54*, 76 Or App 405 (1985); *Linda J. Williams*, 51 Van Natta 1528, 1529 (1999); *Patricia L. Serpa* 47 Van Natta 2386, 2387 (1995).[1]

The ALJ's order dated January 21, 2000 is vacated and this matter is remanded to ALJ Davis to reopen the record for the admission of additional evidence regarding claimant's recent right elbow surgery and the resulting findings regarding the cause of claimant's right ulnar neuropathy condition. The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.

IT IS SO ORDERED.

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[1] This case is strikingly similar to *Parmer v. Plaid Pantry #54*, 76 Or App 405 (1985). That case involved the compensability of a proposed low back surgery. Medical opinions were offered by various doctors, only one of whom attributed the need for the proposed surgery to the accepted injury. That opinion was premised on the possibility that the accepted injury caused additional scarring at the site of previous surgery and was deemed by the hearings referee to be insufficient to establish compensability.

Subsequent to the hearing and the issuance of the ALJ's order, the claimant underwent the disputed low back surgery, which was performed by the same doctor who gave the earlier opinion supporting compensability. In a letter opinion, the doctor stated that, based on what he discovered during the surgery, he believed the accepted injury caused increased scarring and the need for further medical care.

The court concluded that, inasmuch as the "post-hearing" evidence filled in gaps that were found in the medical record, the claimant should have the opportunity to explore fully the medical opinions following surgery. Thus, the court held that remand to the ALJ for further development of the record was warranted.

In the Matter of the Compensation of
MIKEL T. HOLBROOK, Claimant
WCB Case No. 99-03861
ORDER OF ABATEMENT
John M. Pitcher, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Claimant has requested reconsideration of our May 16, 2000 Order on review that affirmed an ALJ's order that upheld the self-insured employer's denial of his occupational disease claim for binaural hearing loss. Specifically, claimant contends that we erred in upholding the denial. In order to further consider claimant's motion, we withdraw our May 16, 2000 order. The self-insured employer is granted an opportunity to respond to claimant's motion. To be considered, the employer's response must be submitted within fourteen (14) days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANDREA E. HENWOOD, Claimant
WCB Case No. 99-06187
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order, with the exception of his finding that compensability had been conceded by the parties. We supplement as follows.

Claimant has a previously accepted claim for bilateral CTS in California. In July 1998, she began working for SAIF's insured in Oregon. In March 1999, she experienced a recurrence of symptoms in both hands. (Ex. 10-2). In April 1999, Dr. Grant performed nerve conduction studies that demonstrated moderately severe and chronic bilateral carpal tunnel syndrome. The studies were worse than those seen in 1997 in California. (Exs. 10-3, 15-2). Dr. Webb recommended bilateral carpal tunnel release surgery. (Ex. 10-3). On April 23, 1999, claimant filed an occupational disease claim in Oregon. SAIF denied the claim and claimant appealed.

At hearing, the parties stipulated that claimant's current bilateral CTS was due in major part to her work activities in California. (Tr. 4, 5). Claimant's attending physician concluded that her work at the Oregon employer had slightly contributed to her condition. (Ex. 26).

The ALJ cited *Silveira v. Larch Enterprises*, 133 Or App 297 (1995), and *The New Portland Meadows v. Dieringer*, 153 Or App 383, *mod* 157 Or App 619 (1998), *rev den* 328 Or 365 (1999), for the proposition that, for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws. The ALJ found that compensability had been conceded by the parties. The ALJ then applied the last injurious exposure rule to assign responsibility to SAIF's insured, reasoning that presumptive responsibility could not be assigned to an employer over which Oregon has no jurisdiction. *See Dieringer*, 153 Or App 622 (citing *Progress Quarries v. Vaandering*, 80 Or App 160, 165-66 (1986)). Finally, because SAIF did not prove sole causation by the previous California employment, or prove that it was impossible for working conditions at SAIF's insured to have caused the condition, the ALJ found that SAIF was unable to avoid responsibility. *See Id.*

On review, SAIF contends that compensability is at issue and that the ALJ erred in applying the last injurious exposure rule, because claimant has a preexisting condition, *i.e.*, the previously accepted California claim. SAIF argues that, therefore, claimant is making a claim for a worsening of a preexisting disease under ORS 656.802(2)(b) and that that preexisting disease is not compensable.

For purposes of establishing that an occupational disease is work related, claimant may rely on all employments, even those that were not subject to Oregon's workers' compensation laws. *Silveira v. Larch Enterprises*, 133 Or App at 302-303.[1] In occupational disease cases, a disease or condition is a "preexisting" one only if it both contributes or predisposes the workers' compensation 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. ORS 656.005(24); *SAIF v. Cessnun*, 161 Or App 367 (1999). Here, claimant first sought treatment and became disabled in California. There is no evidence that claimant's bilateral CTS preexisted the date she first sought medical treatment in California. Therefore, ORS 656.802(2)(b) is inapplicable in this case.

The parties conceded that the major contributing cause of claimant's recurrent bilateral carpal tunnel condition was her out-of-state exposure, *i.e.*, her work and the surgery that took place in 1997 in California. Dr. Webb, claimant's attending physician, opined that claimant's work activity at the Oregon employer, which included filing and computer data entry, had contributed slightly to her

[1] Moreover, claimant is not required to file a claim with other potentially causative out-of-state employers in order to receive compensation in Oregon. *Silveira*, 133 Or App at 303.

condition and need for carpal tunnel release. There are no contrary medical opinions, nor did Dr. Webb attribute claimant's condition to an off-work activity. Consequently, based on the parties' stipulation and Dr. Webb's reports, we are persuaded that claimant's employment conditions, including her out-of-state employment, were the major contributing cause of her recurrent bilateral carpal tunnel condition. *See* ORS 656.802(2)(a).

Moreover, SAIF's argument that claimant is making a claim for a worsening of a preexisting disease under ORS 656.802(2)(b) is an argument that goes to responsibility, not compensability.[2] SAIF's denial of compensability was based solely on its contention that claimant's CTS was *a preexisting condition brought on by an earlier employment*, which is merely an assertion that another employer is responsible. *See, e.g., Garibay v. Barrett Business Services*, 148 Or App 496, 501 (1997).

SAIF next argues that the ALJ erred by applying the last injurious exposure rule to assign responsibility, because the rule does not apply to cases in which there is a previously accepted claim involving the same condition. Citing *SAIF v. Yokum*, 132 Or App 18 (1994), SAIF argues that responsibility should be assigned under ORS 656.308(1). We disagree.

In *The New Portland Meadows v. Dieringer*, the court held that initial responsibility cannot be assigned to a previous out-of-state employer under the last injurious exposure rule.[3] In *Progress Quarries v. Vaandering*, 80 Or App 160 (1986), the court held that, under the last injurious exposure rule, when it has been shown that the Oregon employment is injurious and a potential cause of the claimant's occupational disease, the claimant is entitled to compensation in Oregon. The court also held that an Oregon employer cannot proffer as a defense a subsequent potentially causal employment not covered by the Oregon Workers' Compensation Act. 80 Or App at 164-66.

Similarly, in this case, the responsibility dispute involves an "out-of-state" employer. Here, it has been shown that the Oregon employment is injurious and a potential cause of claimant's occupational disease, and there is no Oregon jurisdiction over the prior "out-of-state" employer. Consequently, we conclude that, just as SAIF cannot defensively use the last injurious exposure rule, SAIF cannot defensively use ORS 656.308(1) to defeat claimant's entitlement to compensation in Oregon. *See, e.g., John J. Jett*, 46 Van Natta 33 (1994) (an "out-of-state" employer would not appear to be subject to Oregon laws and, thus, ORS 656.308 would not apply in "responsibility" disputes pertaining to an "out-of-state" employer). *See also Miville v. SAIF*, 76 Or App 603, 607 (1985) (Oregon can apply its own rules consistently between Oregon employers); *Leonard C. Hobbs*, 46 Van Natta 171 (1994) (citing *Jett*).[4]

Therefore, because there has been no prior accepted Oregon claim for claimant's bilateral CTS (over which Oregon has jurisdiction), 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).

In *Yokum*, the court explained:

> "On its face, the statute addresses the issue of when a responsible employer can shift responsibility to a subsequent employer. It begins from the premise that there is an employer that is responsible to pay for a particular compensable condition. There is no responsible employer until there is an accepted claim and a determination of responsibility, if there is more than one potentially responsible employer. Thus, for

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[2] Moreover, even if we were to apply ORS 656.802(2)(b) to this case, the medical evidence establishes that claimant's Oregon exposure independently contributed to a pathological worsening, as required under *Hensel Phelps Construction v. Mirich* and *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984) (in order to shift responsibility to a subsequent insurer, the injured worker must suffer a worsening of the condition; a mere increase in symptoms is not sufficient). *See* Exhibit 23-6, in which the nerve conduction studies were worse that those seen in 1997 prior to claimant's carpal tunnel release surgery in California.

[3] The court explained that its decision was in keeping with a policy of making certain that Oregon workers are compensated for injuries. ORS 656.012. The court weighed that concern as greater than the policy concern over the potential for "double recovery," a concern of the insurer in that case. 133 Or App at 297 n.3.

[4] SAIF also relies on *Wootton v. Stadeli Pump & Construction*, 108 Or App 548 (1991). *Wootton* is inapposite, in that the issue there involved an initial compensable injury in Oregon and a subsequent out-of-state increased disability of the same part of the body. In *Wootton* the court required a claimant to establish that recovery was precluded in the other jurisdictions where there was potentially causative employment. But the court specifically rejected that same requirement in the occupational disease context in *Progress Quarries v. Vaandering*, 80 Or App at 166. *See also Silveira*, 133 Or App at 302.

the statute to be triggered, there must be an accepted claim for the condition, for which some employer is responsible. In an initial claim context, no employer is responsible until responsibility is fixed."

Here, because there is no accepted claim over which Oregon has jurisdiction, and Oregon has no authority to fix responsibility on an out-of-state employer under the rationale provided in *Progress Quarries* and *Silveira*, the shifting of responsibility under ORS 656.308(1) does not apply. Accordingly, we agree with the ALJ that the last injurious exposure rule applies in this case to assign responsibility to SAIF's insured.

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

ORDER

The ALJ's order dated November 29, 1999, as amended December 2, 1999, is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the SAIF Corporation.

Board Member Haynes specially concurring.

I agree that this result is mandated by the court's decision in *Dieringer*, however, I write to express my concern about the inequities caused by that decision.

Following the court's decision in *Silveira*, claimants were allowed to rely on out-of-state employment exposure to establish that a condition was work-related by use of the last injurious exposure rule (LIER). If a claimant chose to use out-of-state employment exposure, the employer was then allowed to use LIER defensively to escape liability. *See Charles Scott*, 48 Van Natta 2592 (1996) *aff'd mem* 151 Or App 200 (1997). However, under *Dieringer*, a claimant is still allowed to use LIER to establish compensability, but an employer cannot use LIER defensively.[1]

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[1] In *Silveira*, as in *Vaandering*, the claimant did not have a prior, accepted out-of-state claim for the condition claimed in the Oregon occupational disease claim. After permitting the claimants to rely on LIER as a rule of proof to establish the compensability of their occupational disease claims, the courts determined that the Oregon employer was prohibited from applying the rule of responsibility prong of LIER to attempt to shift responsibility to the out-of-state employer.

In reaching this conclusion, the *Silveira* court acknowledged that in claims involving an initial compensable Oregon injury and a subsequent out-of-state increased disability, it had required claimants to first establish that recovery from the out-of-state jurisdiction is precluded. Nonetheless, relying on *Vaandering*, the *Silveira* court observed that the same requirement had been rejected in the occupational disease context on the grounds that cases involving successive injuries "do not involve the problems of proof and responsibility which produced the disease-oriented last injurious exposure rule, under which issues are whether there is compensability in the first instance and which of the successive employers or carriers is responsible." *Vaandering*, 80 Or App at 166.

Here, consistent with the *Silveira* court's express prohibition, it would be inappropriate to require claimant to first establish that she was precluded from recovering benefits under her out-of-state claim before she could pursue her Oregon claim. Yet, in the event that the appellate courts have an opportunity to revisit this question, I submit that the present case is distinguishable from the occupational disease claims litigated in *Vaandering*, *Silveira*, and *Dieringer*.

Specifically, although all of these cases involve claimants pursuing Oregon occupational disease claims that also include out-of-state employment exposure, only this particular claimant has an *accepted*, compensable "out-of-state" claim. Because this claimant has not only previously pursued benefits from the "out-of-state" jurisdiction but received compensation on her claim, the "problems of proof and responsibility" concerns addressed in *Vaandering* and *Silveira* would not exist. In other words, this claimant's current claim is not unlike those of claimants who have an initial compensable injury followed by increased disability. As explained in *Silveira*, when such cases arise, the courts require the claimants to first establish that an "out-of-state" recovery is precluded before they may pursue their Oregon claim. Consistent with that established policy, I submit that such an approach should be applied in this claim. If followed, claimant would be permitted to pursue her Oregon claim once it was ultimately determined that she was precluded from recovering benefits under her "out-of-state" claim for the same condition.

The inequity of such a decision is clearly illustrated in this case where the parties have stipulated that the major cause of claimant's condition is the California work exposure and subsequent surgeries. Responsibility for claimant's condition should initially rest with the California employer and not be shifted to the Oregon employer unless the Oregon exposure independently contributed to a pathological worsening (under *Hensel Phelps Construction v. Mirich*, 81 Or App 290 (1996)) or was the major cause of the condition (under ORS 656.308).

However, because of *Dieringer*, the Oregon employer in this case has become fully responsible for claimant's bilateral carpal tunnel syndrome despite previous treatment and surgery in California and limited exposure while working for the Oregon employer.

June 2, 2000 Cite as 52 Van Natta 946 (2000)

In the Matter of the Compensation of
MARCELINO RUIZ, Claimant
WCB Case No. 99-06823
ORDER ON REVIEW (REMANDING)
Michael A. Bliven, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that dismissed his request for hearing. In its brief, the self-insured employer contends that claimant's request for review was not timely and, therefore, the Board lacks authority to consider his appeal. On review, the issues are timeliness of claimant's request for review and propriety of the dismissal order. We deny the employer's motion to dismiss, vacate the ALJ's order, and remand.

FINDINGS OF FACT

Claimant's attorney filed a request for hearing on August 30, 1999. A hearing was set for November 23, 1999. On that date, claimant's attorney and the employer's attorney appeared, but claimant failed to appear. No reason was given for claimant's non-appearance. The ALJ granted claimant's attorney's request to leave the record open for two weeks (until December 8, 1999) for claimant to submit an affidavit to establish good cause for his failure to appear on November 23, 1999 and thereafter reconvene the hearing for claimant's testimony or, alternatively, claimant's attorney was to submit written arguments by December 8, 1999.

On December 14, 1999, claimant's attorney advised the ALJ that he was unable to locate claimant and that he could not submit the case on the record and, therefore, was unable to proceed. On December 23, 1999, the ALJ found that claimant had abandoned his request for hearing pursuant to OAR 438-006-0071(1). The ALJ dismissed the matter with prejudice, subject to reinstatement within 30 days if claimant submitted a written request to do so that would set forth a good and sufficient explanation of his failure to appear at the date and time specified in the Notice of Hearing.

On January 24, 2000, the Board received claimant's attorney's "Request for Reinstatement and Board Review." The request included a certificate of service indicating that copies of the request were mailed to the Board and the employer's attorney on January 21, 2000. Claimant's attorney explained that claimant was not present at the hearing because his wife's mother had to have surgery, and claimant had to drive his wife to Texas.

On January 26, 2000, the Board issued an "Acknowledgement of Request for Review," which indicated that claimant's request for review was received on January 24, 2000.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claimant's Request for Review

Relying on *Debby R. Coldiron*, 51 Van Natta 905 (1999), the employer argues that the Board lacks authority to consider claimant's appeal because claimant's request for review was not "filed" until after the ALJ's Order of Dismissal became final.

Under ORS 656.289(3), 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. Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

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

Here, the 30th day after the ALJ's December 23, 1999 order was January 22, 2000, a Saturday. Claimant's request for review was not mailed by registered or certified mail and it was received by the Board on January 24, 2000. Nevertheless, we have previously held that, when the last day of the 30-day appeal period falls on a Saturday or a legal holiday, including Sunday, the appeal period runs until the end of the next day that is not a Saturday or legal holiday. *E.g., Sandy K. Preuss*, 50 Van Natta 1028 (1998) (citing ORS 174.120 and ORCP 10A); *Anita L. Clifton*, 43 Van Natta 1921 (1991). Here, because the 30th day fell on a Saturday and the following day (Sunday) was a legal holiday, *see* ORS 187.010(1)(a), claimant's appeal period ran until the end of Monday, January 24, 2000. Under these circumstances, we conclude that claimant's request for review was timely filed.

Propriety of Dismissal Order

Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-006-0071(2). An ALJ shall dismiss a request for hearing if the party that waives appearance is the party that requested the hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. *Id.* OAR 438-006-0081 provides that a "scheduled hearing shall not be postponed except by order of an ALJ upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." In previous cases, we have held that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. *E.g., Fred T. Hardy*, 50 Van Natta 1076 (1998); *William E. Bent II*, 48 Van Natta 1560 (1996).

Here, the ALJ found that claimant had abandoned his request for hearing pursuant to OAR 438-006-0071(1). The ALJ dismissed the matter with prejudice on December 23, 1999, subject to reinstatement within 30 days if claimant submitted a written request to do so that would set forth a good and sufficient explanation of his failure to appear at the date and time specified in the Notice of Hearing. In response to the ALJ's December 23, 1999 dismissal order, claimant's attorney submitted a "Request for Reinstatement and Board Review." Claimant's attorney explained:

> "Claimant's counsel since the date of the dismissal order was contacted by claimant, through an interpreter. Claimant's counsel was advised claimant was not present at hearing because he had to travel to Texas on an emergent basis because his wife's mother had to have surgery, and claimant had to drive his wife to Texas. In the circumstances of the situation claimant did not have the presence of mind to contact his counsel or the Board to advised of his urgent [sic]. Claimant requests that his hearing be reset and that notice is mailed to him so he can return from Texas to appear for hearing. Claimant is willing to explain at that time all circumstances and give testimony on his good cause for not appearing for hearing."

As we discussed above, we find that claimant's request for review was "filed" within 30 days of the ALJ's order. We interpret claimant's "Request for Reinstatement and Board Review" as a motion for postponement of the scheduled hearing. *See Fred T. Hardy*, 50 Van Natta at 1076. Because the ALJ did not have an opportunity to rule on the motion, this matter must be remanded to the ALJ for

consideration of the motion.[1] *See id.*; *compare Tobin E. Weymiller*, 50 Van Natta 2184, 2185 n.2 (1998) (because the ALJ had considered the claimant's "post-dismissal order" correspondence requesting that the hearing be rescheduled, there was no need to remand to the ALJ).

In determining that remand is appropriate, we emphasize that our decision should not be interpreted as a ruling on the substance of any of claimant's representations or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have previously explained, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified.

Accordingly, the ALJ's December 23, 1999 order is vacated. This matter is remanded to ALJ Peterson to determine whether postponement of claimant's hearing request is justified. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. The ALJ's consideration may include, but is not limited to, claimant's February 2, 2000 letter explaining why he did not appear at hearing. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

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[1] We note that the ALJ's "combined order" ("show cause" and "dismissal") was appropriate here, where claimant did not appear at a scheduled hearing and no communication regarding the non-appearance was received. Nevertheless, the "show cause" period should probably have been reduced to around 15 days to avoid confusion and conflict with the 30-day appeal period. *Teresa Marion*, 50 Van Natta 1165, 1166 n.1 (1998); *Brent Harper*, 50 Van Natta 499, 500 n. 2 (1998).

In the Matter of the Compensation of
FRANCES M. MEAD, Claimant
WCB Case No. 98-03153
ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

On May 9, 2000, we abated our April 10, 2000 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order upholding the self-insured employer's denial of claimant's occupational disease claim for a bilateral foot and toe condition. We took this action to consider claimant's motion for reconsideration. Having received the employer's response, we proceed with our reconsideration.

Claimant asserts that our order narrowly focussed on the compensability of a *foot fungus condition* when the claim was for a bilateral *toe condition*. According to claimant, [t]he focus should be on what created the disability or need for treatment of her overall toe/foot condition. Claimant further contends that medical evidence shows that claimant's steel-toed boots created the disability and need for treatment and, thus, she proved compensability.

The employer responds that, as an occupational disease claim, claimant must show that work activities were the major contributing cause of the *disease* and not merely disability or the need for treatment. *See* ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). The employer also contends that the disease in this case is for a foot and toe fungus and the Board correctly analyzed whether claimant proved compensability of such condition.

We agree with the employer. Contrary to claimant's contentions, we evaluated any contribution from claimant's steel-toed boots and found that the medical evidence did not show that such factor was the major contributing cause of her claimed disease, the foot and toe fungus.

On reconsideration, as supplemented herein, we adhere to and republish our April 10, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 2, 2000 Cite as 52 Van Natta 949 (2000)

In the Matter of the Compensation of
MICHAEL L. TRAPP, Claimant
WCB Case No. 98-10097
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for a low back condition. Claimant cross-requests review of that portion of the ALJ's order that declined to address compensability of his arachnoiditis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the last two paragraphs on page 2.[1]

CONCLUSIONS OF LAW AND OPINION

Low Back Condition

Claimant began working for the employer as a sales representative in February 1994. (Ex. 1). For the first 2-1/2 years, his duties included unloading and transporting 170-pound kegs. (Tr. 8-9). Claimant then switched to delivering and stocking cases of beer, which was heavy, repetitive work. (Tr. 8-10).

In late 1997, claimant began having low back pain. He first sought treatment on December 19, 1997 from Dr. Lisk, who recommended anti-inflammatories. (Ex. F). Claimant's back pain continued between December 1997 and June 1998, and for a time he was able to obtain relief while resting on weekends. (Tr. 11). He sought medical treatment in June 1998 because resting no longer helped him and the pain had become intolerable. (Tr. 11, 13). On June 12, 1998, claimant signed an "801" form that referred to June 12, 1998 as the "date of injury." (Ex. 1). Claimant testified, however, that there was no specific injury incident in June 1998. (Tr. 13).

Dr. Yarusso examined claimant on June 15, 1998 and diagnosed a low back strain. (Ex. 4). He explained that claimant had experienced increasing back pain over the last six months and did not recall an isolated injury. (*Id.*) A lumbar MRI on June 18, 1998 showed a small disc herniation at L5-S1, slightly impinging on the S1 nerve root. (Ex. 8). Claimant was referred to Dr. Tanabe, who diagnosed a central herniated nucleus pulposus at L5-S1, but did not recommend surgery. (Ex. 15). After epidural steroid injections were performed, claimant developed significant problems and was later diagnosed with arachnoiditis.

On December 16, 1998, the employer denied the claim on the ground there was insufficient evidence to indicate that claimant's low back condition was related to his employment. (Ex. 30).

The ALJ found there was insufficient evidence to establish that claimant had degenerative disc disease or any other low back condition/disease before he began working for the employer. The ALJ relied on Dr. Hourihane's opinion to conclude that claimant's work activities were the major contributing cause of his low back condition.

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[1] We modify the ALJ's order to change the reference on page 1 from Exhibits "1-8" to Exhibits "1-38."

Relying on *SAIF v. Cessnun*, 161 Or App 367 (1999), the employer argues that the correct analysis is whether claimant had degenerative disc disease that preexisted the first time he sought medical treatment or lost time due to the low back condition. The employer contends that ORS 656.802(2)(b) applies to this case. The employer also argues that Dr. Hourihane's opinion is not persuasive because he had an inaccurate history of a discrete injury.

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

For the following reasons, we need not decide whether ORS 656.802(2)(b) applies to this case because we find that Dr. Hourihane's opinion is insufficient to establish compensability under either standard.

In light of the multiple possible causes of claimant's low back condition, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 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. *Weiland v. SAIF*, 64 Or App 810 (1983).

The ALJ found that Dr. Hourihane had "mistakenly believed at one point" that claimant had experienced a specific injury in June 1998, but the ALJ concluded that Dr. Hourihane's opinion on causation was not based on that belief alone, noting that he had also discussed the role of claimant's work over time.

The employer contends that Dr. Hourihane's opinion is not persuasive because his opinion on causation was based on his understanding that claimant had sustained a discrete injury at work. Claimant argues that Dr. Hourihane had an accurate history of the gradual development of his back problems. He asserts that Dr. Hourihane's use of the term "injury" did not refer to a specific event, but was used as a generalized term to indicate a physical problem.

We begin by reviewing Dr. Hourihane's reports to determine his understanding of claimant's low back symptoms. Dr. Hourihane first examined claimant on November 9, 1998. (Ex. 22A). He explained that claimant's problem began in January 1998 and he noticed pain in his tailbone every time he sat down. (Ex. 22A-1). Dr. Hourihane noted that claimant had been doing light duty "since his injury in January." (Ex. 22A-2). In a deposition, he testified that the main focus of claimant's initial visit was pain management and to confirm the diagnosis of arachnoiditis. (Ex. 38-5).

On December 22, 1998, Dr. Hourihane explained that claimant had given him a history of mild back pain for some months, which increased significantly with his daily work. (Ex. 30A-1). He strongly suspected that the "initial radicular symptoms were related to his back injury and occupation." (*Id.*)

In a January 6, 1999 report, Dr. Hourihane said that he disagreed with Dr. Fuller's opinion that claimant's back pain was primarily due to preexisting back disease. (Ex. 30B-2). He explained:

> "It is reasonable to conclude, and I would strongly advocate, that the four and one-half years of lifting 170-pound beer kegs had a significant impact into the production of degenerative back disease and the production of his secondary pain. With reasonable medical certainty, I can emphatically state that the presenting back pain was due to a work-related injury; if not wholly, at least in large part." (*Id.*)

On March 26, 1999, Dr. Hourihane wrote to claimant's attorney regarding causation, explaining:

> "[Claimant] has done several years of heavy work. The first three years included lifting full beer kegs in the range of 170 pounds. The latter two years have required lifting several cases of liquids, not infrequently totally [sic] 60-80 pounds each. He developed low back pain secondary to musculoskeletal injury, presumed in major part to this disc herniation. This herniation was in large part (at least greater than 50% and probably much more so) to his heavy work activity. The subsequent treatment of the disc led to his arachnoiditis." (Ex. 36A).

In a post-hearing deposition, the employer's attorney asked Dr. Hourihane about his March 26, 1999 report that had referred to claimant developing low back pain secondary to a "musculoskeletal injury":

> "Q. [By the employer's attorney]: What musculoskeletal injury were you referring to there?
>
> "A. Well, this has been variously called three different things and particularly musculoskeletal injuries it's hard to pinpoint a particular area and say this is the area of pain. I'm referring to the -- all the tissues of the low back.
>
> "Q. So were you referring to a specific injury incident?
>
> "A. Both the *specific injury incident of June* and also to a lesser extent some of his back pain he had mentioned earlier on as far back as January '98.
>
> "Q. Okay. And what is your understanding of the June incident?
>
> "A. That was called an acute back strain. I think that's a reasonable label for it.
>
> "Q. Okay. And what is your understanding of what happened to [claimant] to cause a physician to make that diagnosis? I'm asking your understanding of the factual background that led to the diagnosis.
>
> "A. I don't know specifically. *I know I saw it in one of the other letters in particular that he noticed particular exacerbation while lifting a heavy object* and then I think he worked on that particular day and the following day had great difficulty getting out of bed in particular." (Ex. 38-9, -10; emphasis supplied).

When questioned by claimant's attorney, Dr. Hourihane agreed that his understanding of the history was consistent with claimant's testimony at hearing that for four and one-half years, he had carried beer barrels weighing up to 170 pounds and had repetitively carried cases of beer weighing 50 to 60 pounds. (Ex. 38-13, -14). After Dr. Hourihane had agreed that claimant's work activities during his employment were the major contributing cause of the herniated disc, the following colloquy took place between claimant's attorney and Dr. Hourihane:

> "Q. [By claimant's attorney]: Could you explain the thought process leading you to that conclusion?
>
> "A. The work load involved in this particular man's job is pretty heavy. Pretty severe. Repetitive lifting of even 50, 60 pounds is a lot of weight. He had to -- *he had developed some low-back pain with an acute exacerbation related to some particular physical activity* and the MRI was very supportive with respect to the disk herniation of someone who had been doing a lot of heavy work." (Ex. 38-14, -15; emphasis supplied).

In assessing major contributing cause, we must rely on evidence from medical experts and we cannot attempt to supply our own diagnosis. *SAIF v. Strubel*, 161 Or App 516, 520-21 (1999). Our findings must be based on medical evidence in the record and the reasonable inferences that can be drawn from the medical evidence. *SAIF v. Calder*, 157 Or App 224, 227-28 (1998).

Dr. Hourihane's deposition testimony indicates that he understood that claimant had a "specific injury incident of June" and claimant had "noticed particular exacerbation while lifting a heavy object[.]" (Ex. 38-9, -10). Dr. Hourihane explained that claimant "had developed some low-back pain with an acute exacerbation related to some particular physical activity[.]" (Ex. 38-15). Based on Dr. Hourihane's deposition testimony, we find that he understood that claimant had developed an exacerbation of low back pain during a specific lifting incident.

Dr. Hourihane's understanding that claimant had experienced a specific injury is inconsistent with claimant's testimony and the other medical reports. As we discussed earlier, claimant testified that there was no specific injury incident in June 1998. (Tr. 13). Claimant's back pain began in late 1997. (Tr. 10). Resting his back on the weekends helped in the beginning, but by June 1998, claimant said that resting no longer helped and the pain had become intolerable. (Tr. 11, 13).

We are not persuaded that Dr. Hourihane had an accurate understanding of the onset of claimant's low back symptoms. Consequently, we find that his causation opinion 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). Based on Dr. Hourihane's apparent misunderstanding that claimant had experienced a specific back injury, we are unable to determine whether his statements about the contribution of claimant's work to the back condition were based on the effects of a specific injury or the daily work activities. In other words, we are unable to determine whether Dr. Hourihane weighed the contribution of claimant's work activities alone, excluding the nonexistent specific injury.

None of the remaining medical opinions are sufficient to establish compensability of claimant's low back condition. Dr. Lisk initially indicated he concurred with Dr. Fuller's November 9, 1998 report. (Ex. 25). Dr. Fuller had reported that claimant's preexisting degenerative disc disease was the major contributing cause of his combined condition and need for treatment. (Ex. 22-6). On January 11, 1999, however, Dr. Lisk "rescinded" his concurrence. (Ex. 31). Dr. Lisk said that he had not attended claimant until three weeks after the "injury date of 6/12/98" and he deferred the evaluation of the "acute injury" to claimant's initial primary care physician, Dr. Yarusso. (*Id.*) Because Dr. Lisk relied on an inaccurate history of a specific injury, his opinion is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App at 476. In any event, we note that Dr. Lisk deferred to the opinion of Dr. Yarusso, who concurred with Dr. Fuller's report. (Ex. 29). In addition, Dr. Tanabe, who had treated claimant, concurred with Dr. Fuller's report. (Ex. 28). We conclude that the medical evidence fails to establish compensability of claimant's low back condition under either ORS 656.802(2)(a) or ORS 656.802(2)(b).

Arachnoiditis

Claimant argues that the ALJ erred in failing to address compensability of his arachnoiditis condition. Claimant contends that the arachnoiditis should be evaluated as a consequential condition because it developed as a result of treatment directed to the L5-S1 disc herniation. The employer argues that the ALJ correctly deferred any decision regarding the arachnoiditis condition because that condition is compensable, if at all, only as a consequential condition under ORS 656.005(7)(a)(A).

We agree with the ALJ that there is no evidence that claimant developed arachnoiditis as a direct result of his work activities. Rather, his arachnoiditis is compensable as a consequential condition and only if the underlying low back condition is compensable. Because we have determined that claimant's occupational disease claim for a low back condition is not compensable, we need not address compensability of the arachnoiditis condition.

ORDER

The ALJ's order dated October 25, 1999 is reversed. The self-insured employer's denial of claimant's low back condition is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

Because I agree with the ALJ that claimant's occupational disease claim for a low back condition is compensable, I respectfully dissent.

A medical opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516 (1999); *Worldmark the Club v. Travis*, 161 Or App 644 (1999). Moreover, no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996).

After reviewing the entire record, I believe that Dr. Hourihane's opinion is sufficient to establish compensability of claimant's low back condition. I agree with claimant that Dr. Hourihane had an accurate history of the development of the back problems and Dr. Hourihane's use of the term "injury" did not refer to a specific event, but was used as a generalized term to indicate a physical problem. His reference to an "injury" is an inadvertent use of a legally significant term of art. In rejecting Dr. Hourihane's opinion, the majority is mixing up legal and medical standards. It is clear in reading Dr. Hourihane's entire medical opinion, and even in the excerpts quoted in the majority opinion, that Dr. Hourihane's use of the word "injury" is in the lay context, not the legal. It is not a doctor's role in the workers' compensation system to practice law, but to give their expert medical opinion. Dr. Hourihane gave us his expert medical opinion and the Board's role is to apply the appropriate legal standards.

The ALJ correctly determined that Dr. Hourihane was familiar with claimant's daily work requirements and he specifically associated claimant's degenerative back disease with years of heavy and repetitive lifting. (Exs. 30B-2, 36A). Dr. Hourihane explained that the forces involved in doing claimant's work, day after day, produced the wear and tear that led to the development of his degenerative condition, including arthritis. (Ex 38-15, -16). The ALJ correctly determined that claimant's low back condition is compensable. Because the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
GARY S. DESPOIS, Claimant
WCB Case No. 99-01913
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The alleged noncomplying employer requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the statutory processing agent's acceptance of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following supplementation.

Claimant worked as a meat cutter for about 11 years, ending in 1983. Since then, he performed farm and ranch work, most recently for the employer.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the processing agent's acceptance of claimant's occupational disease claim for right CTS, reasoning that the persuasive medical evidence indicates that claimant's work *for the employer* was the major contributing cause of his condition. We reach the same result, based on the following reasoning.

Claimant relies on the "last injurious exposure rule." Under the "rule of proof," the claim is compensable if claimant's work activities generally (*i.e.*, not just for the employer) were the major contributing cause of his right CTS condition.[1]

The medical evidence establishes that claimant's meat cutting and/or his ranch work caused his condition. (Exs. 14B, 16, 21; *see* Ex. 22-21-22). Therefore, the condition is compensable under the last injurious exposure rule of proof. Because claimant's most recent ranch work for the employer "could have" caused his CTS and he first sought treatment for CTS symptoms during the latter employment (and he was not previously disabled due to CTS),[2] responsibility is assigned with the employer (under the rule of assignment). *See William M. Clunas*, 51 Van Natta 765 (1999). Finally, because there is no evidence that claimant's work for the employer could not cause his CTS or that prior employment was its sole cause, responsibility remains with the employer. *Id.* Accordingly, we agree with the ALJ that the processing agent properly accepted claimant's claim for right CTS on the employer's behalf.

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[1] We need not determine whether claimant's CTS preexisted his work for this employer because this claim is not based on a worsening of a preexisting condition. *See* ORS 656.802(2)(b); *SAIF v. Cessnun*, 161 Or App 367, 373 n. 2 (1999).

[2] (*Compare* Exs. 16-2, 19-1, 22-10 and Exs. 22-21-22, -39, -41-42).

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

ORDER

The ALJ's order dated February 17, 2000 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee to be paid by the processing agent on behalf of the noncomplying employer.

In the Matter of the Compensation of
ELVIRA GONZALES, Claimant
WCB Case Nos. 99-08874 & 99-00404
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that part of Administrative Law Judge (ALJ) Black's order that set aside its partial denial of claimant's claim for a consequential fourth extensor compartment tenosynovitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, correction, supplementation, and summary. We do not adopt: (1) the sixth sentence in the 15th paragraph of the findings of fact; (2) the 17th paragraph of the findings of fact; and (3) the findings of ultimate fact.

On December 10, 1997, while packaging meat claimant sustained a right wrist sprain when she twisted her right hand and wrist while trying to prevent a box of meat weighing ten pounds from falling. At that time, claimant was 21 years old.

Dr. Tsang, treating physician, examined claimant on the day of the work injury, and diagnosed a right wrist sprain. (Ex. 3). He treated claimant eight times over the next several weeks, with treatment modalities including restrictions, a splint, medications, and physical therapy. (Exs. 3, 7, 10, 12, 14, 16, 19, 21). Both Dr. Tsang and the physical therapist noted that claimant embellished her pain/examinations and noted that claimant reported less functional ability than she demonstrated when distracted. (Exs. 1, 7, 14, 16, 21).

On January 15, 1998, Dr. Tsang referred claimant to Dr. Ballard, orthopedist, for a second opinion. The next day, Dr. Ballard examined claimant, found no objective physical findings, and noted signs of pain behavior with nonanatomic sensory findings being reported. (Ex. 18). He diagnosed a right wrist sprain, resolved, and recommended that claimant return to work without restrictions as soon as possible. (Ex. 18-2).

On January 27, 1998, Dr. Tsang found that claimant's right wrist strain had resolved, noting that: "Examination shows no swelling or warmth. No crepitance over the dorsum or radial aspect of [claimant's] wrist. Palpating causes no discomfort now. Range of motion is full. Finkelstein's is negative." (Ex. 21).

On February 6, 1998, claimant began treating with Dr. Crockett, chiropractor, who provided 11 chiropractic treatments over a period of a month. (Exs. 23, 25, 26, 27, 28, 29, 31). On March 6, 1998, he indicated that claimant was not medically stationary. (Ex. 31).

On March 5, 1998, the insurer accepted the claim for a disabling right wrist sprain injury. (Ex. 30).

On March 11, 1998, claimant sought treatment for "right wrist pain" from Dr. Horton, orthopedist. (Ex. 32). Dr. Horton found nonspecific subjective right wrist pain with no objective signs of pathology and declared claimant medically stationary from the previously diagnosed right wrist sprain. (Ex. 32-2).

On April 8, 1998, the insurer closed the claim by Notice of Closure. On July 6, 1998, claimant was examined by Dr. Cady, orthopedist, who served as medical arbiter. (Ex. 35). Claimant reported ongoing wrist pain since the injury that consisted of constant mild pain in the volar aspect of the right wrist, increasing to moderate with use. Dr. Cady noted that physical findings were sparse and there were significant indications in the progress notes that the physicians felt claimant was embellishing her symptoms. (Ex. 35-7). But he also reported mild, noticeable swelling of the dorsum of the right wrist and fingers. He found claimant not medically stationary and recommended that future examiners rule out mild reflex sympathetic dystrophy, although he noted there were no typical skin changes of reflex sympathetic dystrophy. (Ex. 35-7).

Because the insurer did not consent to postponement of the reconsideration process based on Dr. Cady's opinion that claimant was not medically stationary at the time of the medical arbiter's examination, that process continued. On July 17, 1998, an Order on Reconsideration issued finding claimant's condition medically stationary on March 11, 1998. (Ex. 36).

On August 17, 1998, claimant returned to Dr. Horton, who diagnosed nonspecific right wrist pain and subtle stiffness consistent with disuse. (Ex. 37). He advised claimant to aggressively exercise her right wrist and arm.

On September 28, 1998, claimant returned to Dr. Tsang. At that time, she presented with different symptoms, which were "quite pinpoint" whereas her prior presentation had been "quite diffuse." (Ex. 38). Dr. Tsang diagnosed a ganglion cyst on the dorsum of the right wrist and noted that this appeared to be a different disease entity than the prior right wrist sprain injury. (*Id.*). Nevertheless, Dr. Tsang signed an aggravation form. (Ex. 40).

On October 23, and October 30, 1998, claimant was examined by Dr. Stringham, M.D.; however, he referred her to Dr. Leonard, plastic surgeon, without providing her any treatment. (Ex. 44B). Dr. Stringham's chart notes are not in the record.

Dr. Leonard treated claimant two times, on December 14, 1998, and January 11, 1999, and diagnosed right wrist fourth extensor compartment tenosynovitis. (Exs. 41, 42). On both occasions, treatment consisted of steroid injections into the right fourth extensor compartment. On March 25, 1999, Dr. Leonard provided a written response to questions from claimant's attorney. (Ex. 44A). The questions to which Dr. Leonard responded are not in the record. Regarding causation, Dr. Leonard stated:

> "4. I would agree that if indeed [claimant] does have a ganglion cyst currently that it absolutely could be related to the original injury of December 10, 1997. Her injury at that time was definitely soft tissue, as x-rays taken were negative. On my examination she gave evidence of an extensor tenosynovitis and underwent steroid injections on two separate occasions. It is absolutely more likely than not that if she did develop a gaglion cyst in this region, that it is associated with the original injury secondary to ongoing infection.
>
> "5. At the time I had seen [claimant] she denied at [sic] any previous injury to the upper extremities, and as such I do not believe there was any significant preexisting condition which would cause her current problems. This would also reinforce my answer to number four which stated that more likely that [sic] not the original strain injury which occurred on December 10, 1997 is definitely the major contributing cause of her current problems." (Ex. 44A-2).

In his first chart note and his written opinion, Dr. Leonard stated that, on examination, there was no evidence of significant edema or mass effect. (Exs. 41-1, 44A-1). He also stated that there was no evidence of a ganglion cyst when he examined claimant. (Ex. 44A-1). In his second chart note, however, he noted a definite "decrease in the mass effect over the fourth extensor compartment" although there was "still a persistent dime size enlargement," which was where claimant was "most point tender." (Ex. 42).

On February 12, 1999, claimant filed a new medical condition claim and requested acceptance of "right wrist fourth extensor compartment tenosynovitis." (Ex. 42A).

On March 19, 1999, Dr. Button, hand surgeon, examined claimant on behalf of the insurer. (Ex. 43). He found clear features of functional overlay, including reported sensation diminished in a stocking glove, circumferential fashion. (Ex. 43-4). He also noted that, although objectively claimant showed normal extrinsic and intrinsic muscle function, due to lack of voluntary effort claimant's right hand pinch was measured below that required for activities of daily living. (*Id.*). He explained that tenosynovitis is an inflammatory process that has distinct objective findings and usually occurs within a short period of time if it were a post-traumatic inflammatory process. (Exs. 43-5, 47). He opined that claimant did not meet these criteria and the work injury had no direct or indirect relationship with the "working diagnoses" of ganglion cyst and right wrist fourth extensor compartment tenosynovitis.

On March 24, 1999, Dr. Tsang responded to questions from claimant's attorney. (Ex. 44). He restated that claimant's right wrist sprain had resolved as of January 27, 1998, and stated that he had never diagnosed claimant with a right wrist fourth extensor compartment tenosynovitis. He also opined that claimant's ganglion cyst condition was not related to the work injury. Finally, he stated that it was not medically probable that the work injury was the cause of claimant's alleged right wrist fourth extensor compartment tenosynovitis. (Ex. 46-1).

On March 30, 1999, the insurer issued a partial denial that denied claimant's aggravation claim and her new medical condition claims for right wrist ganglion cyst and fourth extensor compartment tenosynovitis conditions. (Ex. 45).

At hearing, claimant withdrew her aggravation claim and her new medical condition claim for the ganglion cyst condition. (Tr. 4-5). The hearing proceeded on the issue of compensability of a new medical condition claim for a right wrist fourth extensor compartment tenosynovitis condition under a consequential condition theory. (*Id.*).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant established that her fourth extensor compartment tenosynovitis condition was compensable as a consequential condition under ORS 656.005(7)(a)(A). The insurer argues that the medical record fails to meet claimant's burden of proof under ORS 656.005(7)(a)(A). We agree with the insurer.

Claimant does not contend that the tenosynovitis condition occurred as a direct result of the work injury. Nor would the medical record support such a contention. Instead, claimant argues that the tenosynovitis condition is compensable under ORS 656.005(7)(a)(A), which provides that no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition. *See Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (holding that, when a condition or need for treatment is caused by the compensable condition, as opposed to the industrial accident, the major contributing cause standard is applied).

Due to the repeated references in the medical record to claimant's pain embellishment and/or functional overlay and the varying medical opinions regarding claimant's current condition, the cause of any tenosynovitis condition presents a complex medical question that must be resolved by expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985).

Four medical experts offer their opinion as to the cause of any tenosynovitis condition. Three opinions are rendered by physicians who treated claimant for various periods of time: Dr. Tsang, occupational medicine, Dr. Leonard, plastic surgeon and Dr. Stringham, occupational medicine. A fourth opinion is rendered by Dr. Button, hand surgeon, who examined claimant on behalf of the insurer.

Dr. Tsang treated claimant at the time of the injury and found that her right wrist sprain resolved by January 27, 1998. Subsequently, at the end of September 1998, claimant returned to Dr. Tsang with distinctly different symptoms, which Dr. Tsang diagnosed as a right ganglion cyst. (Ex. 38).

Dr. Tsang found these two conditions to be separate disease entities, with the work injury not contributing to the ganglion cyst. (Exs. 38, 44). Dr. Tsang explicitly stated that he never diagnosed claimant with a right wrist fourth extensor compartment tenosynovitis condition. (Ex. 44-2). In addition, Dr. Tsang stated that it was not medically probable that the work injury was the cause of claimant's alleged right wrist fourth extensor compartment tenosynovitis condition. (Ex. 46).

Dr. Button examined claimant, reviewed the medical record, and opined that the work injury had no direct or indirect relationship to the "working diagnosis" of extensor tenosynovitis. He explained that tenosynovitis is an inflammatory process that "results in swelling that is visible and palpable as well as oftentimes crepitis with mechanical impingement of the tendons passing within the narrow tendon compartment." (Ex. 47-1). In addition, he explained that, if the tenosynovitis was a post-traumatic inflammatory process, "pathology would usually occur within a short period of time after injury." (Ex. 43-5). He noted that none of those factors were met here, even at the time of Dr. Leonard's examination.

Dr. Leonard saw claimant on two occasions, once in December 1998, and a second time in January 1999. (Exs. 41, 42). He noted that claimant described the December 1997 work injury "as a twisting episode to the right wrist when attempting to lift a 20-pound bag, which acutely was knocked from her. She immediately noted a pain over the dorsum of the right wrist, which was later followed by edema but no ecchymosis of any importance." (Ex. 41-1). Claimant also stated that she never completely healed. (*Id.*). Furthermore, Dr. Leonard explicitly relied on this history in diagnosing claimant with extensor tenosynovitis. In this regard, he stated that claimant "gives a fairly good story as well as exam for a moderate tenosynovitis." (Ex. 41-2).

In his December 1998 examination, Dr. Leonard noted that claimant's right wrist exhibited no mass effect or significant edema, even though claimant said it was swollen. (Ex. 41-1). In addition, claimant reported decreased sensation over all areas in the hand, wrist, and forearm with no discernible pattern. Dr. Leonard found an over exaggerated pain response but noted that it could be due to prolonged pain because the injury occurred a year ago. He diagnosed right wrist fourth extensor compartment tenosynovitis and provided a steroid injection.

In his January 1999 exam, Dr. Leonard noted that claimant appeared improved, although she still complained of significant pain. (Ex. 42). He noted a definite "decrease in the mass effect over the fourth extensor compartment" although there was "still a persistent dime size enlargement," which was where claimant was "most point tender." (Ex. 42). He also provided a second steroid injection to the dorsal right wrist.

Dr. Leonard also responded in writing to claimant's attorney's questions, although those questions are not in the record. (Ex. 44A). In this written response, Dr. Leonard stated that the objective finding of tenosynovitis was claimant's tenderness to palpation over the fourth compartment of the extensor tendon at the dorsal wrist. He reiterated that there was no evidence of significant edema or mass effect. His opinion on causation, as quoted in the findings of fact, is very confusing. In this regard, the item identified as number four solely focuses on the compensability of the ganglion cyst condition, an issue claimant withdrew at hearing. Yet item five refers back to item four and concludes that the original strain injury "is definitely the major contributing cause of [claimant's] current problems." Claimant contends that this statement supports compensability of the tenosynovitis condition, since that is the only condition Dr. Leonard diagnosed.

However, even allowing that this statement refers to compensability of the tenosynovitis condition, it is unexplained and, as such, it has little persuasive force. *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); *Somers v. SAIF*, 77 Or App 259 (1986). This is especially the case because Dr. Leonard does not address Dr. Button's contention that tenosynovitis is an inflammatory condition that, if post-traumatic, usually occurs soon after the traumatic event. Here, any tenosynovitis condition did not arise until a year after the work injury. Moreover, Dr. Leonard did not address the impact of claimant's well documented symptom magnification on his opinion.

In addition to the confusion and inconsistencies presented by Dr. Leonard's opinions, there is no evidence that he reviewed the medical record before rendering his causation opinion. As such, his history of the initial injury and claimant's course of treatment comes solely from claimant's report, which we find inaccurate in several aspects. First, the weight of the box involved in the initial injury

was ten pounds, not twenty. (Exs. 2, 3). Second, the initial injury resulted in no edema or overt swelling. (Exs. 3, 7, 10, 14, 16, 18, 19, 21). Dr. Tsang stated that claimant presented with no significant objective findings and his diagnosis of right wrist sprain was made by her history and her subjective complaints. (Ex. 44-1). Third, the preponderance of the medical evidence establishes that the initial wrist sprain did completely heal.

Regarding this last point, Drs. Tsang, Ballard, and Horton all contemporaneously examined claimant and concluded that the right wrist sprain had resolved. (Exs. 18, 21, 32, 44-1). We note that claimant treated with a chiropractor, Dr. Crockett, during this period who checked a box indicating that her right wrist sprain was not medically stationary. (Ex. 31). We give this opinion little weight, however. First, Dr. Crockett did not explain his opinion. Second, we find that the medical doctors, who include specialists in occupational medicine and orthopedics, have specialized expertise over that of Dr. Crockett, a chiropractor. Therefore, we find it appropriate to defer to the specialized expertise of Drs. Tsang, Ballard, and Horton and conclude that claimant's right wrist sprain resolved. *See Abbott v. SAIF*, 45 Or App 657, 661 (1980).

Because Dr. Leonard relied on an inaccurate history in rendering his causation opinion, we do not find that opinion persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinion based on inaccurate history is unpersuasive).

Finally, we do not find that Dr. Stringham's opinion meets claimant's burden of proof. Dr. Stringham saw claimant twice and reviewed Dr. Leonard's chart notes and Dr. Cady's report (Dr. Cady served as the medical arbiter regarding the initial closure of the claim). (Ex. 44B). It is not clear what history Dr. Stringham obtained from claimant because he referred to his intake history in describing that history and the intake history is not in the record. Dr. Stringham stated, however, that claimant reported that the box involved weighed 20 pounds. (Ex. 44B-2).

Dr. Stringham also noted that his diagnosis was right wrist sprain, not tenosynovitis. However, he stated that he did not question Dr. Leonard's diagnosis of tenosynovitis, although he (Dr. Stringham) thought that the diagnosis of right wrist fourth extensor compartment tenosynovitis was included in his more general diagnosis of right wrist sprain. (Ex. 44B-2). Dr. Stringham stated that the major contributing cause of that diagnosis and claimant's current right wrist symptoms and need for treatment was the work injury. (Ex. 44B-2).

We find that Dr. Stringham's opinion has many of the same problems as Dr. Leonard's opinion. Dr. Stringham did not review the medical record, has an inaccurate/incomplete history, presents a conclusory opinion, and fails to address the impact of claimant's well documented symptom magnification on his opinion. Thus, we find his opinion unpersuasive.

In sum, for all of the reasons discussed above, we find that claimant has failed to prove that the work injury is the major contributing cause of a right wrist fourth extensor compartment tenosynovitis condition.[1] Accordingly, we uphold the insurer's partial denial.

ORDER

The ALJ's order dated December 23, 1999 is reversed. The insurer's March 30, 1999 partial denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed.

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[1] In reaching this conclusion, we note that a specific diagnosis is not required to establish compensability; instead, the issue is whether claimant's condition is work related, whatever the diagnosis. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992); *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988). Nevertheless, here, claimant filed a new medical condition claim specifically requesting acceptance of "right wrist fourth extensor compartment tenosynovitis." (Ex. 42A). Claimant has an accepted claim for a right wrist sprain injury, and that condition is not at issue here.

In the Matter of the Compensation of
GABRIEL S. JENSEN, Claimant
WCB Case No. 99-06408
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Randy Rice, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a herniated L5-S1 disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order, except for the last two sentences of the next-to-last paragraph on page four, with the following supplementation.

Dr. Franks offered the only medical opinions arguably supporting claimant's occupational disease claim. He acknowledged that claimant "probably had pre-existent drying out of the development of bulging discs" before May 1, 1999, and wrote:

> "If [claimant] bent and lifted all day long for four years [at work], and not much negatively happened to him off the job, I myself would have to incriminate that his job was a considerable and possibly major etiological factor in the development of his lumbar disc condition." (Ex. 19-2).

We do not rely on this opinion because claimant did not bend and lift all day at work for four years.

Dr. Franks next opined that external factors rather than degeneration were probably responsible for claimant's herniations because only three of claimant's discs were "abnormal." Although he did not have a full history of claimant's work and off work activities, Dr. Franks believed that "the specific sequestration of herniated disc on the right at L5-S1 that lead him to having surgery seems to have been[,] on the basis of his history conveyed to me[,] secondary to on-the-job incident." (Ex. 22) (Emphasis in original). We do not rely on this opinion because there was no "on-the-job incident."

Dr. Franks next agreed with claimant's counsel's statement that the above-quoted opinion means "that the major cause of the need for treatment for the L5-S1 herniation" was claimant's "work activities." We do not rely on this opinion because it is inadequate to establish an occupational disease. *See Tammy L. Foster*, 52 Van Natta 178 (2000).

Under these circumstances, we agree with the ALJ that Dr. Franks' causation opinion is not persuasive and the claim must fail.

ORDER

The ALJ's order dated January 7, 2000 is affirmed.

In the Matter of the Compensation of
TERESA J. KOLIBABA, Claimant
WCB Case No. 98-00825
ORDER ON REVIEW
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of her low and mid back and left and right wrist conditions. With her appellant's brief, claimant has attached several documents not presented at hearing. We treat these documents as a motion for remand for presentation of additional evidence. In addition, SAIF moves to strike portions of claimant's reply brief that allegedly rely on evidence that is not in the record. On review, the issues are remand, motion to strike, and compensability.

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

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 included the following with her appellant's brief: (1) seventeen pages consisting of an allegedly accurate interview and examination of Dr. Coulter's report regarding claimant, including claimant's analysis of Dr. Coulter's conclusions; (2) copies of Exhibits 14A, 14B, 17A, 20, 28, 29 and 30 from the August 18, 1999 hearing with unidentified annotations on Exhibits 14A and 14B;[1] (2) three pages referred to as a chart comparing doctors' findings; (3) four pages referred to as questions not asked of witnesses at the August 1999 hearing; (4) four pages labeled "Terminology;" and (5) twenty pages that begins with the page "196 Common Musculoskeletal Symptoms."

Remand for admission of this proposed evidence would be inappropriate, because the documents were obtainable at hearing.[2] We also find that the proposed evidence would not affect the outcome of the case and remand to admit it would be inappropriate on this basis as well. Accordingly, because no evidence outside the record has been considered,[3] there is no need to strike portions of claimant's brief and SAIF's motion to strike is denied.[4]

ORDER

The ALJ's order dated January 24, 2000 is affirmed.

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[1] Copies of Exhibits 14A and 14B without annotations and 17A, 20, 28, 29 and 30 from the August 18, 1999 hearing and claimant's then-attorney's closing argument are already included in the record and hearing file.

[2] Claimant was represented by an attorney at hearing. Claimant contends that her legal representation was inadequate. However, the Workers' Compensation Board is not the proper forum for litigating the adequacy of legal representation. *See Neal S. Anderson*, 49 Van Natta 1 (1997); *Lori Church*, 46 Van Natta 1590 (1994); *Diane E. Sullivan*, 43 Van Natta 2791, 2792 (1991); *Charles N. Caywood*, 39 Van Natta 83 (1987).

[3] *Jeanne C. Rusch*, 45 Van Natta 163 (1993).

[4] *See Daniel J. Hidy*, 49 Van Natta 527 (1997).

In the Matter of the Compensation of
BARBARA A. MOHL, Claimant
WCB Case Nos. 98-07027 & 98-02471
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's right ear injury claim. Claimant, *pro se*, cross-requests review of that portion of the ALJ's order that: (1) upheld the insurer's denial of her claims for a low back and right hip injury, thoracic spine injury, and rib cage injury; and (2) upheld the insurer's "de facto" denials of her thoracic spine and rib cage injuries. With her respondent's brief, claimant has submitted evidence 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 for remand. The ALJ's order is reversed in part and affirmed in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the second full paragraph on page 3 of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Remand

With her respondent's brief, claimant has submitted evidence not admitted into the record at the time of hearing. Claimant further requests remand to the ALJ for a "new hearing."

Our review is limited to the record developed at hearing. ORS 656.295(5). 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).

First, we agree with the insurer that, to the extent that the documents provided by claimant on review pertain to the right upper body claim, they are not likely to affect the outcome of this case. Claimant, who was represented at hearing, agreed, through counsel, to preserve that issue for future litigation. With regard to the remainder of the documents submitted, after considering the ALJ's demeanor credibility findings and the expert medical evidence in this case, we do not agree with claimant that the employer's witnesses are "impeached," or that such evidence would change the outcome of the case regarding compensability. Consequently, we deny claimant's motion for remand.

Compensability

The ALJ found that, while there was no medical opinion regarding causation, the right ear/hearing claim was sufficiently uncomplicated and could be decided without expert opinion. We disagree.

In *Barnett v. SAIF*, 122 Or App 279 (1993), the court discussed factors for determining whether expert evidence of causation is required. Those factors 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.

We conclude that the situation is complicated. On April 20, 1998, claimant was treated in an emergency room where she reported ear pain, ringing and loss of hearing. Claimant attributed the cause to another worker slamming the flaps down on claimant's trailer. (Ex. 30). However, claimant also advised the emergency room doctor that she had migraines which tended to "cause ear pain/pressure." (Ex. 31-1).

It is also not clear that claimant's symptoms appeared immediately or that claimant advised a superior about an injury. Although claimant reported to the emergency room that her symptoms started "right away," claimant did not testify at hearing regarding the incident. Additionally, although claimant gave a history of a coworker slamming the flaps down, there was no witness that testified at hearing regarding the occurrence of such an incident. Finally, claimant contended that her injury occurred on April 17, 1998, but she was not seen in the emergency room until April 20, 1998. Moreover, the ALJ specifically found that, based on her demeanor and appearance at hearing, and considering "psychosocial factors discussed in the medical record," claimant was not a reliable historian. Opinion and Order, pg. 4.

As mentioned above, claimant apparently was not free from disability of the kind involved. As noted in the emergency room report, claimant had suffered from migraines that caused ear pain and pressure. (Ex. 31-1).

After considering the aforementioned factors, we conclude that an expert medical opinion regarding causation is required in order to establish compensability of claimant's right ear/hearing claim. Additionally, because the sole evidence in this case regarding a right ear injury is based on claimant's history to the emergency room, but the ALJ has specifically found claimant to be an unreliable historian, we do not find that such evidence is sufficient. Accordingly, because there is no expert opinion in the record that provides a discussion regarding causation or the other factors that might have contributed to claimant's condition, we conclude that claimant has failed to meet her burden of proof. ORS 656.266. We therefore reverse the ALJ's order on this issue.

ORDER

The ALJ's order dated August 25, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the insurer's July 15, 1998 denial of claimant's right ear/hearing claim is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award of $1,500 is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
MICHELLE E. FLEMING, Claimant
WCB Case No. 98-05214
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) Livesley's order that upheld the self-insured employer's denial of claimant's occupational disease claim for headaches, numbness and tingling, coldness, muscle weakness, muscle pain, burning sensations, severe stomach aches, dilated pupils, hyperactive reflexes, heart palpitations, excessive sleep, wired feeling, chronic diarrhea, urinary retention, sore throats, night sweats, swollen glands, ears popping, sensitivity to certain perfumes, inks, gasoline or car exhaust, episodes of confusion, hyperactive touch and pain sensation, nausea and/or dizziness and lines in fingernails. On review, the issue is compensability.

We adopt and affirm the ALJ's order,[1] except for the third from last sentence, with the following supplementation.

Dr. Lasala opined that, if claimant's symptoms "are truly occurring only at work it seems most likely that there is an environmental toxin or irritant." (Ex. 29). We do not find Dr. Lasala's reasoning in this regard persuasive because it is based on nothing more than a temporal relationship between claimant's symptoms and her work. Accordingly, absent persuasive medical evidence that claimant's problems were caused, in major part, by work exposure, we agree with the ALJ that the claim must fail.

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[1] We acknowledge that claimant lacks the benefit of legal counsel. If she has questions about workers' compensation procedures, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. She may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271.

ORDER

The ALJ's order dated January 3, 2000 is affirmed.

June 7, 2000 Cite as 52 Van Natta 963 (2000)

In the Matter of the Compensation of
WAYNE W. BOWERS, Claimant
WCB Case No. 98-08977
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

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

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's injury claim for a lumbar strain, T6-7 herniated disc, cervical strain and coccydynia. On review, the issue is compensability. We reverse in part, modify in part, and affirm in part.[1]

FINDINGS OF FACT

Claimant, a lumber carrier driver, has worked for the employer since September 1975. (Tr. 6). He has sustained multiple work injuries. In 1976, claimant injured his low back when he fell approximately 35 to 40 feet off a log deck. (Exs. 6-1, 177-1, 180, 181-22). Claimant was treated with traction and physical therapy. (Exs. 180, 181-22). In 1978, claimant was hospitalized for one week with a back injury (diagnosed as a disc herniation), but he did not require surgery. (Exs. 6-1, 180, 181-23). In May 1982, he twisted his neck at work and was diagnosed with an acute left thoraco-cervical strain. (Exs. 1, 2).

In January 1984, claimant injured his neck and mid-back. (Exs. 3, 5). Dr. Sutherland diagnosed an acute cervical disc herniation and claimant was hospitalized for cervical traction. (Exs. 6, 7). The January 1984 claim was closed in May 1984 without an award of permanent disability. (Ex. 16). Claimant was injured again in February 1985 and Dr. Sutherland diagnosed a dorsal sprain. (Exs. 17, 18).

In December 1985, claimant twisted his neck at work and had pain in his neck and left arm. (Exs. 21, 22, 23). Dr. Sutherland initially diagnosed cervical disc syndrome. (Ex. 21). Claimant's symptoms continued. A cervical myelogram in June 1986 showed a disc herniation at C6-7 and cervical spondylosis at C5-6. (Ex. 62). In December 1986, Dr. Dunn performed an anterior discectomy with decompression at C5-6 and C6-7 with removal of an extruded fragment at C6-7. (Ex. 86). His postoperative diagnosis was degenerative disc disease at C5-6 and a herniated nucleus pulposus at C6-7. (*Id.*)

In July 1987, Dr. Dunn reported that claimant had some radicular pain in his back and he recommended an MRI. (Ex. 107). A July 1987 lumbar MRI showed dessication of the L5-S1 disc with a mild to moderate bulge, and slight disc bulges at L2-3 and L3-4. (Ex. 108). Dr. Dunn reported increasing thoracic symptoms on July 30, 1987 and recommended an MRI of the thoracic area. (Ex. 111). A dorsal spine MRI on August 6, 1987 was normal. (Ex. 113).

In January 1988, Dr. Dunn reported that claimant was medically stationary and had reduced cervical range of motion. (Ex. 144). A March 8, 1988 Determination Order awarded 30 percent unscheduled permanent disability. (Ex. 150). A July 15, 1988 Opinion and Order awarded an additional 5 percent scheduled disability for loss of use or function of claimant's left arm. (Ex. 159). Claimant testified that he did not receive any medical treatment for back or neck problems between 1988 and 1998 and he was free from back and neck pain during that period. (Tr. 12, 13).

[1] Although the ALJ indicated that "Exhibits 1-225" were admitted, we change the ALJ's order to read: "Exhibits 1-8, 16-18, 21, 23-24, 26-30, 32-34, 40-41, 44, 46-47, 49-51, 53-55, 57, 59-63, 65, 71-72, 75-77, 79-82, 86-88, 90-98, 102-108, 111-117, 121, 124, 127, 129-132, 135-144, 149-150, 158-160, and 162-225 were admitted in evidence."

On July 9, 1998, claimant was injured at work when he was carrying a heavy bench and slipped on an ice cube on the floor. (Tr. 7-8, Ex. 162). Dr. Selinger reported that claimant struck his right elbow and right buttock. (Ex. 164). Claimant had discomfort in his elbow, low back and down his legs. (*Id.*) Dr. Selinger noted that claimant had some previous low back problems, but nothing recently. (*Id.*) A radiology report showed minor disc space narrowing at L2-3 and L5-S1 and mild anterior osteophytes at L2 and L3. (Ex. 165). On July 21, 1998, Dr. Selinger reported that claimant's back pain seemed to be worse and he recommended an MRI. (Ex. 166-1). A July 23, 1998 lumbar MRI showed disc space narrowing and loss of disc signal at L2-3 and L5-S1 and a right posterolateral disc protrusion at L5-S1. (Ex. 168). Claimant continued to have low back pain and was referred for physical therapy. (Ex. 169).

On August 6, 1998, claimant sought treatment from Dr. Henderson, complaining of pain in his mid and low back, buttocks, tailbone, legs and heels. (Ex. 172-1). He diagnosed coccydynia, bilateral sciatica, a small disc herniation at L5-S1 and degenerative disk disease at L2-3 and L5-S1. (Ex. 172-3). Dr. Henderson said that the MRI scan findings were mild compared to claimant's severe complaints. (*Id.*) He did not recommend surgery.

Dr. Kirkpatrick examined claimant on August 14, 1998. Claimant complained of ongoing midline lower back pain going down into the tailbone and radiating down the legs into the heels of both feet. (Ex. 177-1). Dr. Kirkpatrick believed claimant had an L5-S1 disc injury with a small protrusion, but no current radiculopathy. (Ex. 177-3). He felt claimant might have a bruised sacral nerve and he recommended physical therapy and medication. (*Id.*)

On September 10, 1998, Dr. Kirkpatrick reported that claimant's symptoms were getting worse. (Ex. 183). He recommended EMG studies, which were normal. (Exs. 183, 185, 186). He felt a thoracic disc herniation was possible and recommended a thoracic MRI. (Ex. 186). The radiologist reported that a thoracic MRI showed a disc protrusion at T6-7 causing moderate deformity of the cord. (Ex. 188). Dr. Kirkpatrick concluded that the protrusion at T6-7 was not causing any significant cord or nerve impingement. (Ex. 187). He strongly suspected a significant psychophysiological reaction. (*Id.*)

On October 20, 1998, claimant sought treatment from Dr. Dunn, who had performed his cervical surgery in 1986. (Ex. 193). Dr. Dunn explained that claimant's x-rays showed degenerative disc disease at T6-7 and an osteophytic spur at T9-10. (Exs. 193-3, 194). Dr. Dunn diagnosed a T6-7 herniated nucleus pulposus with cord compression, cervical and lumbar muscular strain and probable coccydynia. (Ex. 193-3). He recommended a thoracic decompression of the herniated disc. (*Id.*) Dr. Dunn believed that claimant's diagnoses were related directly to the July 9, 1998 injury. (*Id.*)

On October 27, 1998, Dr. Schilperoort examined claimant on behalf of SAIF. (Ex. 195). He concluded that claimant's preexisting multispine degenerative conditions were the major contributing cause of his current need for treatment. (Ex. 195-9, -10). Drs. Henderson and Kirkpatrick concurred with Dr. Schilperoort's report. (Exs. 208, 209).

A cervical MRI on October 30, 1998 showed post-surgical changes at C5-6 and C6-7, a C4-5 bulge and spondylosis at C3-4. (Ex. 199).

Dr. Zelaya reviewed claimant's thoracic films on November 5, 1998, and concluded that conservative treatment was appropriate. (Ex. 201). He found no evidence of any compression of the spinal cord. (*Id.*)

On November 5, 1998, SAIF denied claimant's low back injury claim on the ground that the injury was not the major cause of his need for treatment and disability. (Ex. 200).

On December 8, 1998, claimant's attorney made a claim under ORS 656.262(7)(a) for a T6-7 herniated nucleus pulposus with cord compression, cervical strain and coccydynia. (Ex. 203). In a January 10, 1999 letter, SAIF responded that it was "denying any injuries to [claimant] arising from an alleged incident on July 9, 1998." (Ex. 207).

On March 5, 1999, Dr. Zelaya recommended a complete myelogram and CT scan. (Ex. 212). The CT scan showed a disc herniation at C4-5, a small herniated disc fragment at T6-7 "which causes extensive cord flattening" and a disc herniation at L5-S1. (Ex. 214). Dr. Zelaya recommended that

claimant be examined by a urologist regarding his bladder and bowel problems. (Ex. 212). Dr. Getty, urologist, examined claimant in May 1999 and said that his urgency appeared to be temporarily related to and consistent with neurogenic origin. (Ex. 218).

On March 26, 1999, Dr. Howieson performed a records review on behalf of SAIF. (Ex. 215).

A lumbosacral MRI was performed in August 1999 at Dr. Dunn's request, which showed moderate disc desiccation and moderate degenerative spondylosis at L5-S1, disc desiccation at L2-3, mild facet arthrosis at L4-5 and mild disc bulges at L1-2, L2-3 and L4-5. (Ex. 221). Dr. Dunn did not believe claimant's lumbar area required surgery. (Ex. 222). In August 1999, he recommended a new thoracic MRI, which showed a disc protrusion at T6-7 that deformed the thecal sac and thoracic cord and was slightly more prominent since the October 1998 study. (Ex. 223). Dr. Dunn continued to recommend thoracic surgery. (Ex. 222).

CONCLUSIONS OF LAW AND OPINION

T6-7 Herniated Disc

The ALJ found no evidence of preexisting thoracic disc degeneration or herniation. The ALJ concluded that claimant had established that his work injury was a material cause of the T6-7 disc herniation.

SAIF argues that the ALJ erred by applying a material cause standard. SAIF contends that the major contributing cause standard of ORS 656.005(7)(a)(B) applies and Dr. Dunn's opinion is not sufficient to establish compensability.

The first question is whether claimant had a preexisting thoracic condition when he was injured on July 9, 1998. *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").

On July 30, 1987, Dr. Dunn reported that claimant was having increasing thoracic symptoms and he recommended an MRI of the thoracic area. (Ex. 111). A dorsal MRI on August 6, 1987 was normal. (Ex. 113).

After claimant's July 1998 injury, a thoracic MRI on October 8, 1998 interpreted by Dr. Hofstetter showed a disc protrusion at T6-7 causing moderate deformity of the cord. (Ex. 188). In October 1998, Dr. Dunn reported that claimant's x-rays showed degenerative disc disease at T6-7 and an osteophytic spur at T9-10. (Exs. 193-3, 194). Dr. Dunn diagnosed a T6-7 herniated nucleus pulposus. (Ex. 193-3). In a concurrence letter from claimant's attorney in January 1999, Dr. Dunn agreed with the following:

> "You told me that the thoracic spine MRI is objective evidence of disk injury; and, based upon the fact that the patient was asymptomatic prior to the work injury, you believe that this represents a pathologic worsening of his preexisting condition. You have not seen the actual films interpreted by Dr. Hofstetter; but Dr. Zelaya has seen them, and you would defer to him concerning whether these films represent a new disk injury. You noted that Dr. Hofstetter did not attempt to 'age' the T6-7 herniation, and added that it would be difficult to do so unless calcification (suggesting age) was shown. In any event, you do believe that a pathological worsening has taken place because of the patient's new (post-injury) symptoms." (Ex. 204-1).

Although Dr. Dunn agreed that claimant had a "preexisting condition," he did not explain what condition was preexisting. Dr. Dunn indicated that he deferred to Dr. Zelaya's opinion with regard to the age of claimant's T6-7 disc condition.

In a concurrence letter from claimant's attorney in January 1999, Dr. Zelaya said he had reviewed claimant's October 1998 thoracic MRI. (Ex. 205). He agreed that it was not possible to precisely identify the age of claimant's T6-7 disc protrusion, but because there was no calcification of the disc, he agreed that the disc protrusion was not several years old. (*Id.*) The issue in this case, however, is whether claimant had a thoracic condition that preexisted the July 9, 1998 injury. Dr. Zelaya's comment that the T6-7 disc protrusion was "not several years old" is not pertinent. Dr. Zelaya did not address whether claimant had a T6-7 disc condition that preexisted the July 9, 1998 injury.

On the other hand, Dr. Schilperoort found that claimant had preexisting multilevel degenerative changes in the thoracic spine. (Ex. 195-6, -7). Dr. Schilperoort explained that the T6-7 disc had a dark appearance on the T2 whited images, which implied that it had significant age. (Ex. 195-7, -8). He concluded that the T6-7 disc was "pre-existent." (Ex. 195-9). He did not believe it was incurred as a result of the July 9, 1998 work injury, less than four months ago. (Ex. 195-8). Dr. Schilperoort concluded that claimant's injury had combined with the preexisting multi-level degenerative changes in his spine. (Ex. 195-9). Drs. Henderson and Kirkpatrick, both of whom had treated claimant, concurred with Dr. Schilperoort's report. (Exs. 208, 209). Similarly, Dr. Howieson believed that the T6-7 disc condition was due to a prior injury and he concluded that claimant's work injury had combined with his preexisting condition. (Ex. 215-4).

We find that Dr. Schilperoort's explanation that claimant's T6-7 disc condition preexisted the July 9, 1998 injury is the most persuasive. His opinion that the preexisting degenerative changes combined with the injury to caused claimant's disability or need for treatment is supported by the opinions of Drs. Henderson and Kirkpatrick (both of whom had treated claimant), as well as Dr. Howieson. Based on those reports, we conclude that ORS 656.005(7)(a)(B) applies and claimant must establish that his July 1998 injury was the major contributing cause of the disability or need for treatment of the combined T6-7 disc condition.

ORS 656.005(7)(a)(B) requires an assessment of the major contributing cause, which involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Because the question of what is the major contributing cause of claimant's disability or need for treatment involves a complex medical opinion, we must rely on expert medical evidence in making that determination. *Uris v. Compensation Department*, 247 Or 420, 424-26 (1967); *Schuler v. Beaverton School District No. 48J*, 164 Or App 320, 325 (1999).

Claimant relies on the opinion of Dr. Dunn to establish compensabilty of the T6-7 disc condition. After the July 9, 1998 incident, Dr. Dunn examined claimant more than three months later, on October 20, 1998. (Ex. 193). He reported that claimant had done well after the 1986 cervical surgery and had been free of pain until July 9, 1998. (Ex. 193-1). He said that claimant's x-rays showed degenerative disc disease at T6-7 and an osteophytic spur at T9-10. (Ex. 193-3, 194). Dr. Dunn diagnosed a T6-7 herniated nucleus pulposus and he recommended a thoracic decompression of the herniated disc. (Ex. 193-3). Dr. Dunn believed that claimant's diagnoses were "related directly" to the July 9, 1998 injury. (*Id.*)

In a concurrence letter from claimant's attorney in January 1999, Dr. Dunn agreed that claimant's T6-7 disc protrusion was caused in major part by the July 9, 1998 accident. (Ex. 204-1). He agreed that the work injury was the cause of the need for surgery. (*Id.*) In addition, Dr. Dunn agreed that "based upon the fact that the patient was asymptomatic prior to the work injury," the T6-7 disc condition represented a pathologic worsening of the "preexisting condition." (*Id.*) He agreed there was a pathological worsening "because of the patient's new (post-injury) symptoms." (*Id.*) Dr. Dunn relied on claimant's history of symptoms after the July 9, 1998 injury, together with the clinical findings and MRI findings to conclude that the T6-7 herniation was the primary cause of claimant's current disability and need for medical treatment. (Ex. 204-2). Dr. Dunn continued to recommend thoracic surgery in August 1999. (Ex. 222).

In a September 30, 1999 report, Dr. Dunn disagreed with Dr. Schilperoort's opinion that there was a lack of objective evidence in the presentation of claimant's "thoracic disc." (Ex. 224). Dr. Dunn explained that the presence of hyperrexia in claimant's lower extremities and the fact that coughing, sneezing and even taking a deep breath produced pain indicated that claimant had a "thoracic disc." (*Id.*) Dr. Dunn continued to believe that claimant's July 9, 1998 work injury was the major contributing cause of the T6-7 disc herniation. (Ex. 225).

When there is a dispute between medical experts, we give more weight to those medical opinions which are both well-reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons not to do so, we generally defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810, 814 (1983).

Here, we find persuasive reasons not to defer to Dr. Dunn's opinion. Dr. Dunn did not examine claimant until October 20, 1998, more than three months after the July 9, 1998 incident. Under these circumstances, we are not persuaded that Dr. Dunn was in a more advantageous position as an attending physician to render an opinion on causation. *See McIntyre v. Standard Utility Contractors*, 135 Or App 298, 302 (1995) (A treating physician's opinion is less persuasive when the physician did not examine the claimant immediately following the injury). (1986). Instead, we find that the dispute concerning the T6-7 disc condition 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).

In a January 1999 report, Dr. Dunn said that he had not reviewed the actual films for the October 1998 MRI and he deferred to Dr. Zelaya's opinion regarding the "age" of the T6-7 disc herniation. (Ex. 204-1). Dr. Zelaya, however, merely agreed that the T6-7 disc protrusion was "not several years old." (Ex. 205). As discussed above, we are more persuaded by the opinion of Dr. Schilperoort, who explained that the T6-7 disc had a dark appearance on the T2 whited images, which implied that it had significant age and was therefore preexisting. (Ex. 195-7, -8, -9).

Dr. Dunn's opinion that claimant's work injury was the major cause of his disability and need for treatment was based on the fact that claimant was asymptomatic before the work injury. (Ex. 204). In his October 1998 report, Dr. Dunn said that claimant's x-rays showed degenerative disc disease at T6-7 and in his January 1999 letter, he agreed that claimant had a "preexisting condition." (Exs. 193-3, 194, 204-1). Although Dr. Dunn believed that claimant's work injury provoked symptoms and precipitated the need for treatment, he did not directly discuss the contribution of the preexisting condition versus the work injury to the need for treatment. We find that Dr. Dunn's explanation is nothing more than the "precipitating cause" analysis that was rejected in *Dietz v. Ramuda*, 130 Or App at 401. We conclude that Dr. Dunn's opinion lacks adequate explanation and is not sufficient to establish compensability of the combined condition.

The only other medical opinion that supports compensability is from Dr. Zelaya. In a concurrence letter from claimant's attorney, Dr. Zelaya agreed that claimant's T6-7 disc protrusion was "not several years old." (Ex. 205). Dr. Zelaya agreed with the following:

> "Based upon the fact that the patient was asymptomatic prior to his work accident of July 9, 1998, together with the fact that he apparently sustained a significant axial load in that accident, it is your belief within a reasonable degree of medical probability that the T6-7 disc protrusion was either caused outright or pathologically worsened by that work incident." (*Id.*)

We are not persuaded by Dr. Zelaya's opinion because it lacks adequate explanation and fails to weigh the contribution from the work injury against the preexisting T6-7 disc condition to determine which was the major contributing cause of claimant's need for treatment of the combined condition. *See Dietz*, 130 Or App at 401-402.

None of the other medical opinions support compensability of the T6-7 disc condition. Dr. Kirkpatrick, who treated claimant on several occasions, found that claimant's T6-7 disc protrusion was "unrelated" to the work injury. (Ex. 211-2). Dr. Schilperoort concluded that claimant's T6-7 disc was preexisting and idiopathic. (Exs. 195-8, -9, -10). Dr. Henderson, who treated claimant on one occasion, agreed with Dr. Schilperoort's report. (Ex. 208, 213-13, -14). Similarly, Dr. Howieson believed that claimant's preexisting conditions were the major contributing cause of his current condition. (Ex. 215-5). We conclude that claimant has failed to establish compensability of the T6-7 disc herniation. Therefore, we reverse that portion of the ALJ's order that set aside SAIF's denial of claimant's T6-7 disc herniation.

Lumbar Strain

Although the ALJ found that claimant had preexisting degeneration at L5-S1, he applied a material contributing cause standard in analyzing the lumbar strain claim. The ALJ relied on Dr. Dunn's opinion to establish compensability.

The record establishes that claimant had a degenerative lumbar condition that preexisted the July 1998 injury. A July 1987 lumbar MRI showed dessication of the L5-S1 disc with a mild to moderate bulge and slight disc bulges at L2-3 and L3-4. (Ex. 108).

After claimant's July 9, 1998 work injury, a radiology report showed minor disc space narrowing at L2-3 and L5-S1 and mild anterior osteophytes at L2 and L3. (Ex. 165). A July 23, 1998 lumbar MRI showed disc space narrowing and loss of disc signal at L2-3 and L5-S1 and a right posterolateral disc protrusion at L5-S1. (Ex. 168).

Dr. Schilperoort diagnosed preexisting multilevel degenerative changes in the lumbar spine and an L5-S1 disc protrusion. (Ex. 195-6). He explained that the L5-S1 disc had a dark appearance on the T2 whited images and did not represent a a recent injury. (Ex. 195-8). Dr. Schilperoort concluded that claimant's work injury combined with his preexisting multilevel degenerative changes to cause his disability and need for treatment. (Ex. 195-9). Drs. Henderson and Kirkpatrick concurred with Dr. Schilperoort's report. (Exs. 208, 209). Dr. Dunn did not comment as to whether claimant's preexisting lumbar conditions had combined with his work injury.

Based on the opinions of Drs. Schilperoort, Henderson and Kirkpatrick, we find that claimant's preexisting degenerative conditions in the lumbar spine combined with his work injury to cause his disability or need for treatment and, therefore, ORS 656.005(7)(a)(B) applies to analyzing the lumbar strain.

Claimant relies on the opinion of Dr. Dunn to establish compensability of his lumbar strain. Dr. Dunn examined claimant on October 20, 1998 and diagnosed, among other things, a lumbar muscular strain. (Ex. 193-3). He said that claimant's diagnosis was related directly to the July 1998 work injury. (*Id.*)

In a concurrence letter from claimant's attorney in January 1999, Dr. Dunn agreed that claimant's lumbar strain was caused in major part by the work injury, "based upon the fact that the patient was previously asymptomatic." (Ex. 204-1). In the same report, however, he agreed that claimant's T6-7 disc herniation was the primary cause of claimant's current disability and need for treatment. (Ex. 204-2).

We find that, at most, Dr. Dunn's opinion establishes that claimant's work injury was the precipitating cause of his lumbar strain. The fact that the work injury may have precipitated claimant's need for treatment does not necessarily mean that the work injury is the major cause. *See Dietz v. Ramuda*, 130 Or App at 401. Because Dr. Dunn did not weigh the contribution of claimant's preexisting lumbar condition against the work injury in determining the need for treatment, we conclude that his opinion is insufficient to establish that claimant's July 1998 injury was the major contributing cause of the lumbar strain.

Although Dr. Henderson testified in a deposition that claimant had probably strained his back in the work injury (Ex. 213-10), he agreed with Dr. Schilperoort that the injury had combined with preexisting degenerative lumbar changes and the preexisting conditions were the major contributing cause of claimant's current need for treatment (Exs. 208, 213). Dr. Henderson's opinion is not sufficient to establish compensability of claimant's lumbar strain.

There are no other medical opinions that support compensability of claimant's lumbar strain. Dr. Kirkpatrick concurred with Dr. Schilperoort's opinion that claimant's preexisting degenerative conditions were the major contributing cause of his current need for treatment. (Exs. 195-9, -10, 209). In sum, we conclude that claimant has failed to establish compensability of a lumbar strain. Accordingly, we reverse that portion of the ALJ's order that set aside SAIF's denial of claimant's lumbar strain.

Cervical Strain

The ALJ relied on the opinions of Drs. Dunn and Schilperoort to conclude that claimant's work injury was a material cause of a cervical strain.

The record establishes that claimant had a degenerative cervical condition that preexisted the July 1998 injury. In December 1986, Dr. Dunn performed an anterior discectomy with decompression at C5-6 and C6-7 and removal of an extruded fragment at C6-7. (Ex. 86). He diagnosed degenerative disc disease at C5-6 and a herniated nucleus pulposus at C6-7. (*Id.*)

After claimant's July 1998 injury, a cervical MRI on October 30, 1998 showed post-surgical changes at C5-6 and C6-7, a C4-5 bulge and spondylosis at C3-4. (Ex. 199). A CT scan of the cervical spine on March 17, 1999 showed a disc herniation at C4-5 and extensive postoperative changes. (Ex. 214-2).

Dr. Howieson reported that claimant had cervical spine abnormalities that would be expected after cervical surgery. (Ex. 215-3). He explained that most of the abnormality in the cervical region was due to the prior surgery and some of the abnormality was due to aging and degeneration. (Ex. 215-4). He believed that claimant's preexisting conditions had combined with his work incident. (*Id.*) There are no contrary medical opinions. Based on Dr. Howieson's opinion, we find that ORS 656.005(7)(a)(B) applies and claimant must establish that his work injury was the major contributing cause of his disability or need for treatment of the cervical strain.

Claimant relies on the opinion of Dr. Dunn to establish compensability of his cervical strain. Dr. Dunn is apparently the only physician who diagnosed a cervical strain. The physicians who examined claimant shortly after the July 9, 1998 injury did not refer to neck pain or a cervical strain. Dr. Dunn examined claimant on October 20, 1998 and diagnosed, among other things, a cervical muscular strain. (Ex. 193-3). He said that claimant's diagnosis was related directly to the July 1998 work injury. (*Id.*)

In a concurrence letter from claimant's attorney in January 1999, Dr. Dunn agreed that claimant's cervical strain was caused in major part by the work injury, "based upon the fact that the patient was previously asymptomatic." (Ex. 204-1). Dr. Dunn's explanation of causation of claimant's cervical strain is the same as his explanation of the lumbar strain, which we found to be insufficient. At most, Dr. Dunn's opinion establishes that claimant's work injury was the precipitating cause, which is insufficient to establish that the work activity was the major contributing cause of his cervical strain. *See Dietz v. Ramuda*, 130 Or App at 401.

None of the other medical opinions support compensability of claimant's cervical strain. Dr. Schilperoort concluded that claimant's preexisting degenerative spinal conditions were the major contributing cause of his current need for treatment. (Ex. 195-9, -10). Drs. Henderson and Kirkpatrick concurred with Dr. Schilperoort's report. (Exs. 208, 209). Similarly, Dr. Howieson said that claimant's preexisting conditions were the major contributing cause of his current condition. (Ex. 215-5). We conclude that claimant's cervical strain is not compensable. Consequently, we reverse that portion of the ALJ's order that set aside SAIF's denial of claimant's cervical strain.

Coccydynia

The ALJ found that claimant's symptoms of coccydynia were apparent from the beginning and the diagnosis was made by the first physician who had seen him. The ALJ concluded that claimant's work injury was a material cause of coccydynia.

SAIF argues that claimant's coccydynia symptoms were not apparent from the beginning of the injury and it asserts that claimant never mentioned that his tailbone hurt when he first sought treatment on July 17, 1998. Moreover, SAIF argues that Dr. Henderson found no objective findings of coccydynia such as bruising or swelling.

"Coccydynia" or "coccygodynia" is defined as "pain in the coccyx and neighboring region[.]" Dorland's *Illustrated Medical Dictionary* 347 (28th ed. 1994). Dr. Henderson agreed that the diagnosis of "coccydynia" means pain in the coccyx or tailbone. (Ex. 213-3).

We find no evidence in the record that claimant had a preexisting condition that contributed or predisposed him to disability or a need for treatment for coccydynia. Therefore, claimant need only prove that the July 1998 injury was a material cause of his coccydynia condition.

Claimant testified that on July 9, 1998 he was carrying a heavy bench when he slipped on an ice cube and "smacked" his tailbone really hard. (Tr. 7-8). Claimant had previously explained that he fell on his "butt" and elbow and had immediate pain in his elbow and buttocks area. (Ex. 181-9, -10, -13). Claimant sought medical treatment on July 17, 1998 from Dr. Selinger, who reported that claimant struck his right elbow and right buttock. (Ex. 164). Dr. Selinger noted tenderness in claimant's back. (Ex. 164, 167). Claimant continued to have back pain and discomfort down his legs. (Ex. 166). On July

29, 1998, the physical therapist reported that claimant was complaining of pain from the low back to the coccyx common through the buttock. (Ex. 170-1). The therapist explained that claimant had tightness throughout the lumbogluteal region. (Ex. 170-2).

Dr. Selinger referred claimant to Dr. Henderson, who examined claimant on August 6, 1998. (Ex. 172). Dr. Henderson reported that claimant had tenderness from L4 to S1, as well as the area of the coccyx. (Ex. 172-2). He diagnosed coccydynia, among other things. (Ex. 172-3). In a later deposition, Dr. Henderson explained that he had diagnosed coccydynia and believed it was caused by claimant's work injury based on his understanding of the injury. (Ex. 213-3, -4). He said that claimant had probably injured his tailbone as a result of the injury. (Ex. 213-10).

On August 14, 1998, Dr. Kirkpatrick reported that claimant complained of lower back pain going down into the tailbone and the rectal area. (Ex. 177-1). He noted that claimant might have a bruised sacral nerve. (Ex. 177-3).

Dr. Schilperoort examined claimant on October 27, 1998 and diagnosed a "[b]uttock contusion, secondary to on-the-job injury, resolved." (Ex. 195-6).

SAIF argues that Dr. Henderson's opinion does not support compensability because he testified in a deposition that he had not seen any bruising concerning claimant's coccydynia. (Ex. 213-10).

ORS 656.005(19) defines the term "objective findings" 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."

Here, Dr. Selinger reported that claimant had struck his right buttock in the fall and he noted tenderness in claimant's back. (Ex. 164, 167). The physical therapist reported that claimant was complaining of pain from the low back to the coccyx and he had tightness throughout the lumbogluteal region. (Ex. 170-1, -2). Dr. Henderson reported that claimant had tenderness from L4 to S1, as well as the area of the coccyx. (Ex. 172-2). Likewise, Dr. Kirkpatrick reported that claimant complained of lower back pain going down into the tailbone. (Ex. 177-1, -3). Based on these medical reports, we find that claimant's pain and tenderness in the coccyx area was reproducible and constitutes a valid objective finding. *See e.g., Joseph M. Stransky*, 51 Van Natta 143, 144 (1999) (reproducible tenderness was sufficient to establish "objective findings").

Dr. Henderson diagnosed claimant with coccydynia, which he believed was caused by the work injury. (Exs. 172, 213-3, -4, -10). Similarly, Dr. Dunn believed that claimant's coccydynia was caused by the work injury. (Ex. 204-1). Based on those medical reports, we agree with the ALJ that claimant's July 9, 1998 injury was a material contributing cause of his coccydynia condition.

Claimant's attorney is entitled to an assessed fee for prevailing over SAIF's coccydynia denial at hearing and for successfully defending on Board review that portion of the ALJ's order that found the coccydynia condition compensable. ORS 656.386(1); ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the coccydynia condition is $2,500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's statements of services,[2] the hearing 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] Claimant's counsel submitted a statement of services at hearing, which indicated he had devoted 42.2 hours to the case, and his hourly fee was $160. His statement of services did not differentiate how much time was devoted to each of claimant's conditions. Likewise, claimant's counsel's statement of services on review reflects a total of 5.6 hours, but did not differentiate how much time on review was devoted to the coccydynia condition.

ORDER

The ALJ's order dated January 14, 1999 is reversed in part, modified in part, and affirmed in part. The portion of the ALJ's order that set aside SAIF's denial of a lumbar strain, T6-7 herniated disc and cervical strain is reversed. SAIF's denial of those conditions is reinstated and upheld. The ALJ's attorney fee award is modified. In lieu of the ALJ's attorney fee award, for services at hearing and on review concerning the coccydynia condition, claimant's attorney is awarded $2,500, payable by the SAIF Corporation. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich dissenting in part and concurring in part.

I agree with that portion of the majority opinion that found claimant's coccydynia condition compensable. I also agree that claimant's lumbar strain and cervical strain are not compensable. For the following reasons, however, I disagree with the majority's conclusion that claimant's T6-7 herniated disc is not compensable.

The major contributing cause standard under ORS 656.005(7)(a)(B) applies to the T6-7 herniated disc claim. Absent persuasive reasons to do otherwise, we generally defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). In this case, there are no persuasive reasons not to defer to Dr. Dunn's opinion.

The majority mistakenly discounts Dr. Dunn's opinion on causation because he did not examine claimant until three months after the July 9, 1998 work incident. In a case involving a herniated disc, a three-month delay prior to referral to a neurosurgeon or orthopedic surgeon is normal. Here, a delay of three months does not significantly detract from the persuasiveness of Dr. Dunn's opinion. To the contrary, Dr. Dunn's opinion is persuasive because he clearly evaluated the relative contribution of different causes of the T6-7 herniated disc in determining the major contributing cause. Thus, Dr. Dunn's opinion on causation satisfies the standard required in *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The majority errs by finding that Dr. Dunn's opinion was based only on a "precipitating cause" analysis.

In sum, Dr. Dunn was familiar with claimant's history and he provided a well-reasoned opinion. He explained in detail why he disagreed with Dr. Schilperoort's conclusions. I would defer to Dr. Dunn's opinion and find the T6-7 herniated disc condition compensable. Alternatively, I would increase claimant's attorney fee award for the coccydynia condition to $3,500.

June 8, 2000 Cite as 52 Van Natta 971 (2000)

In the Matter of the Compensation of
LAURA R. FRANKE, Claimant
WCB Case No. 96-04464
ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorneys
Steven T. Maher, Defense Attorney

Claimant requests reconsideration of our May 19, 2000 Order on Remand. Submitting a statement of services from her counsel, claimant seeks an attorney fee award for her counsel's services at hearing and before the Board.

In order to further consider this matter, we withdraw our May 19, 2000 order. The self-insured employer 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 shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ERIC M. CHALLBURG, Claimant
WCB Case Nos. 98-09534 & 98-09187
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Terrall & Terrall, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Pozzi Windows/Jeld Wen, Inc. requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; (2) upheld Safeway Stores' denial of claimant's claim for the same condition; and (3) awarded an assessed attorney fee of $8,000. In his respondent's brief, claimant contends that he is entitled to penalties for allegedly unreasonable denials. On review, the issues are compensability, responsibility, penalties and attorney fees.

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

On review, claimant argues that he is entitled to penalties assessed against both employers for their allegedly unreasonable denials of compensability. We disagree.

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

Here, at the time it issued its denial, Safeway had received claimant's request to accept or deny his claim for an L5-S1 disc and for an L4-5 disc. (Ex. 36). Safeway had also obtained a chartnote from Dr. Belza, claimant's treating doctor, which reported that claimant's diskogram was "essentially negative..." (Ex. 32). Drs. Bell and Arbeene also stated that there was "no evidence based on clinical symptom complex, examination findings, or radiological studies of any "disc condition" resulting from the injury of January 25, 1998. (Ex. 37-8). Consequently, we conclude that, at the time it issued its denial, Safeway had a legitimate doubt regarding its liability for claimant's low back condition.

Similarly, Pozzi Windows also was aware of Dr. Belza's report at the time it issued its denial. Pozzi had also deposed claimant prior to the denial, and claimant admitted that he had not advised his employer of his prior low back problems. (Ex. 44A). Consequently, we conclude that Pozzi Windows/Jeld-Wen also had a legitimate doubt regarding its liability for claimant's condition. Therefore, we agree with the ALJ that no penalty should be assessed against either employer.

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 $1,200, to be paid by Pozzi Windows/Jeld-Wen. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review regarding the penalty and attorney fee issues. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated October 20, 1999, as amended November 5, 1999, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by Pozzi Windows/Jeld-Wen.

In the Matter of the Compensation of
LEO R. MANLEY, Claimant
WCB Case No. 99-04915
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order affirming an Order on Reconsideration that determined that her claim had not been prematurely closed. On review, the issue is premature claim closure.

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

In finding that the claim had not been prematurely closed, the ALJ held that his sole focus in determining whether the claim had been prematurely closed was on the status of the condition (right third finger laceration) which had been accepted at the time of closure, and not on an unaccepted condition (trigger finger) alleged to be a direct medical sequelae of the accepted condition. Because the accepted condition was medically stationary at the time of claim closure, the ALJ determined that the claim closure was not premature.

On review, claimant asserts that, pursuant to *former* ORS 656.268(16), direct medical sequelae must be rated for permanent disability.[1] Therefore, as a necessary corollary of that requirement, claimant argues that such a condition must be medically stationary. Because, according to the medical arbiter, the unaccepted trigger finger condition is a medical sequelae of the accepted condition and is not medically stationary, claimant argues that the claim was prematurely closed.[2] For the following reasons, we agree with the ALJ's decision to uphold the claim closure.

In *James L. Mack*, 50 Van Natta 338, 339 (1998), we concluded that a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure. In reaching this conclusion, we relied on the legislature's 1997 adoption of ORS 656.262(7)(c), which provides, in part, that "[i]f a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

Moreover, to the extent that claimant is relying on *former* ORS 656.268(16), that statute refers to *rating* permanent disability, not determining medically stationary status. Therefore, even assuming that the trigger finger condition is a direct medical sequelae of the accepted laceration condition, the fact that the trigger finger condition was not accepted at the time of closure precludes our consideration of its

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[1] *Former* ORS 656.268(16) provided:

"Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

The statute was renumbered to ORS 656.268(14) in 1999.

[2] The SAIF Corporation contends that the premature claim closure issue is moot because it has now accepted the trigger finger condition and must reopen the claim for processing under ORS 656.262(7)(c). We agree, however, with claimant that the issue is not moot because his 5-year aggravation period runs from the date of the first valid closure, not from the date of closure of the trigger finger claim. *See Susan K. Clift*, 51 Van Natta 646 (1999) (holding the claimant's new medical condition was subject to her five-year aggravation rights stemming from the first closure of the original claim). Thus, claimant's aggravation rights will be affected by our decision in this case.

medically stationary status. *See Dennis J. Neeley*, 50 Van Natta 2127 (1998);[3] *see also Vicky L. Woodard*, 52 Van Natta 796 (2000) (following *Neeley*).

In conclusion, the status of claimant's trigger finger condition is not relevant to the issue of whether claimant's accepted right third finger laceration condition is medically stationary. Accordingly, because the accepted laceration condition was medically stationary at claim closure, the ALJ properly determined that the claim closure in this case was not premature. Thus, we affirm.[4]

ORDER

The ALJ's order dated November 26, 1999, as reconsidered on February 2, 2000, is affirmed.

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[3] In *Neeley*, the claimant contended that his unaccepted syncopal episodes were a symptom of an undiagnosed condition that may have been a "direct medical sequela" of the accepted concussion condition and should be considered in determining his medically stationary status. In support of this contention, claimant relied on *former* ORS 656.268(16). We rejected the claimant's argument, noting that, by its terms, *former* ORS 656.268(16) referred to rating permanent disability, not determining medically stationary status, which is defined under ORS 656.005(17). 50 Van Natta at 2128. Claimant argues that, while *Neeley* addressed the very issue raised in this case, our holding was *dictum* because the medical evidence in that case indicated that the condition at issue was only possibly a direct medical sequelae of the accepted condition. Claimant also contends that *Neeley* was wrongly decided and should be disavowed. Claimant's arguments notwithstanding, *Neeley* addressed the issue presented here. Upon further consideration of that decision, we decline claimant's invitation to disavow it.

[4] Claimant argues that, if we uphold the claim closure, we should award impairment for loss of range of motion and loss of grip strength demonstrated by the arbiters examination, regardless of the trigger finger condition's medically stationary status. We note that claimant did not argue the merits of the permanent disability issue before the ALJ and did not raise this issue until his reply brief. Under these circumstances, we decline to address this issue. *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). We note, however, that, by virtue of SAIF's "post-closure" acceptance of the trigger finger condition, there will eventually be a determination of temporary and permanent disability for that condition. *See Fleetwood Homes of Oregon v. Vanwechel*, 164 Or App 637 (1999) (carrier required under ORS 656.262(7)(c) to reopen claim for processing of "new medical conditions" accepted "post-closure").

In the Matter of the Compensation of
TERRY R. ALLEE, Claimant
WCB Case No. 98-0454M
OWN MOTION ORDER
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights on his 1989 injury claim expired on September 17, 1995.

On November 5, 1998, SAIF denied the compensably of and responsibility for claimant's current condition. Claimant requested a hearing. (WCB Case No. 98-10048). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated January 18, 2000, Administrative Law Judge (ALJ) Howell upheld SAIF's November 5, 1998 denial. Claimant requested Board review of ALJ Howell's order, and in an order issued on today's date, the Board affirmed ALJ Howell'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.

June 8, 2000 Cite as 52 Van Natta 975 (2000)

In the Matter of the Compensation of
TERRY R. ALLEE, Claimant
WCB Case Nos. 99-04555 & 98-10048
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) upheld St. Paul's compensability and responsibility denial, on behalf of Eagle Crest Partners, of claimant's low back conditions (L4-5 and L5-S1 disc herniations or degeneration); and (2) upheld the SAIF Corporation's compensability and responsibility denial, on behalf of Mastercraft Cleaners, of the same conditions. On review, the issues are compensability and responsibility.

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

Claimant contends that claimant's L4-5 and L5-S1 disc conditions are an accepted part of either the 1985 or the 1989 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).

Claimant filed a claim with St. Paul for a low back injury after pushing a pile of sand at work on September 19, 1985. (Ex. A). Prior to December 18, 1985, when claimant suffered an off-the-job low back injury when he slipped and fell on ice, the contemporaneous medical reports in the record establish that the accepted condition was acute lumbosacral strain. (Exs. Aa, B-2). Thus, we conclude that the L4-5 and L5-S1 disc conditions were not accepted by St. Paul.

Moreover, after the SAIF claim was closed, the parties agreed by stipulation that the claim was accepted for an "acute low back strain." (Ex. 31-1). Accordingly, we agree with the ALJ that the claim is for an omitted condition under ORS 656.262(6)(d), rather than an accepted condition under either of claimant's previous claims.

ORDER

The ALJ's order dated January 18, 2000 is affirmed.

In the Matter of the Compensation of
TERRY R. ALLEE, Claimant
WCB Case No. 99-0215M
OWN MOTION ORDER
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The self-insured employer submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights on his 1985 injury claim expired on February 18, 1992.

On May 26, 1999, the employer denied the responsibility for claimant's current condition. Claimant requested a hearing. (WCB Case No. 99-04555). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated January 18, 2000, Administrative Law Judge (ALJ) Howell upheld the employer's May 26, 1999 denial. Claimant requested Board review of ALJ Howell's order, and in an order issued on today's date, the Board affirmed ALJ Howell'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
DEBRA D. OSLER, Claimant
WCB Case No. 99-07845
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
VavRosky, MacColl, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant cross-requests review of that portion of the order that upheld the employer's denial of her occupational disease claim for bilateral ganglion cysts, mild left-sided tardy ulnar palsy and left-sided scapulohumeral myofascial pain syndrome. On review, the issue is compensability.

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

With regard to the claim for bilateral carpal tunnel syndrome, we agree with the ALJ that claimant carried her burden of proof. Examining physicians Dr. Williams, neurosurgeon, and Dr. Schilperoort, orthopedic surgeon, relied on "risk factors," including claimant weight, age, and sex, in concluding that her work was not the major contributing cause of the condition. Because the physicians generally applied these factors without explaining why these factors were relevant in claimant's particular circumstances, we agree with the ALJ that their opinion concerning the bilateral carpal tunnel syndrome is not persuasive. *E.g. Elizabeth Beairsto*, 47 Van Natta 750, 751 (1995) (where physician discounted 21-year work exposure in favor of CTS statistical "risk factors," his opinion was insufficiently explained).

Furthermore, Dr. Smith provided a well-reasoned opinion based on an accurate history to which claimant's treating physician, Dr. McMillan, concurred. Thus, we find his opinion sufficient to carry claimant's burden of proof. *See* ORS 656.802(2)(a).

We also agree with the ALJ that claimant did not carry her burden of proving compensability of the remaining conditions, including bilateral ganglion cysts, tardy ulnar palsy and myofascial pain syndrome. As the ALJ noted, Dr. Smith provided little reasoning concerning the cause of these conditions. Furthermore, he did not address or rebut the panel's conclusion that the myofascial condition was due to deconditioning and that claimant did not show the painful nodules characteristic of such condition.

Claimant's attorney is entitled to an assessed fee for services on review concerning the carpal tunnel syndrome condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's March 17, 2000 order is affirmed. For services on review regarding the carpal tunnel syndrome condition, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
DEANA M. ASHTON, Claimant
WCB Case No. 99-08274
ORDER ON REVIEW
Blake & Duckler, Claimant Attorneys
David L. Bussman, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the insurer's *de facto* denial of claimant's injury claim for a hernia condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation to address claimant's contention that the ALJ's findings are contrary to all the medical evidence in the record.

If we assume that claimant has a inguinal hernia, a fact that is not clear on this record, the evidence indicates the cause of the inguinal hernia to be either a congenital condition or claimant's January 8, 1998 work activity.[1] Considering the potential causes of claimant's condition, the resolution of this issue is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Dr. Blumberg, who examined claimant at the request of the employer, opined that the work activity, as described and demonstrated by claimant during her examination, would not likely cause an inguinal hernia. Dr. Lehti, who examined claimant on referral from Dr. Thomas,[2] originally concurred with Dr. Blumberg, but later indicated he would defer to Dr. Cushman, claimant's treating physician at the time of the hearing. Dr. Cushman indicated that the inguinal hernia was caused by claimant's work activity because her symptoms started at that time.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find persuasive reasons not to defer to Dr. Cushman's opinion.

In determining that work was the cause of claimant's hernia, Dr. Cushman relied solely on claimant's history of the immediate onset of right groin pain starting at the time of the initial injury. That history is not consistent with the medical record which indicates that claimant's initial complaints were pain in the anterolateral area of her right hip and tenderness in her low back.[3] Moreover, there is no indication that Dr. Cushman had claimant demonstrate her work activity as did Dr. Blumberg, or that he considered whether or not the inguinal hernia could be the result of a congenital condition. Accordingly, we find Dr. Cushmans opinion based upon incomplete information and therefore not persuasive.[4] *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

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[1] Claimant contends there is no medical evidence in the record suggesting her hernia is caused by anything other than work. We disagree. Dr. Blumberg's report indicated that the cause of the inguinal hernia is a congenital condition. (Ex. 20-5).

[2] Claimant was referred to Dr. Thomas by Dr. Mehilic, the original treating physician. The purpose of that referral was to perform an MRI for claimant's hip pain. Dr. Thomas referred claimant to Dr. Lehti when Dr. Thomas suspected claimant may have a hernia.

[3] The medical record does not mention right groin pain until January 20, 1999, twelve days post-injury.

[4] Claimant also relies on the opinion of Dr. Lehti, who defers to Dr. Cushman regarding the cause of claimant's hernia. Dr. Lehti offers no explanation for changing his previous opinion concurring with Dr. Blumberg. Accordingly, we do not rely on Dr. Lehti's opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

On this record, claimant has failed to establish the compensability of her inguinal hernia condition.

ORDER

The ALJ's order dated January 21, 2000 is affirmed.

June 9, 2000 Cite as 52 Van Natta 979 (2000)

In the Matter of the Compensation of
ROBERT J. VEGA, Claimant
WCB Case Nos. 99-00670 & 99-00079
ORDER OF ABATEMENT
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Reinisch, Mackenzie, et al, Defense Attorneys

On May 11, 2000, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld AIG's denial of his aggravation claim for his current right upper extremity conditions; and (2) upheld Liberty Northwest Insurance Corporation's denial of his occupational disease claim for the same conditions. Asserting that we did not "address the substantive merits of the evidence," claimant seeks reconsideration of our decision to "address the merits of the compensability issue."

In order to consider claimant's motion, we withdraw our May 11, 2000 order. The carriers are granted an opportunity to respond. To be considered, those responses 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
HEATHER OXLEY, Claimant
Own Motion No. 00-0177M
OWN MOTION ORDER
Donald P. Roach, Claimant Attorney
Liberty Northwest Ins. Co., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable temporomandibular joint dysfunction. Claimant's aggravation rights expired on February 2, 1998. 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. In support of its contention, the insurer submitted a copy of a May 24, 2000 letter from claimant's attorney wherein he states that claimant is not currently in the work force. It appears from claimant's statement, that she is only seeking medical services at this time.

Accordingly, we conclude that claimant has withdrawn her request for Own Motion relief (in other words, she is not seeking temporary disability benefits). Therefore, we dismiss, without prejudice, the request for own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICK R. BOGGS, Claimant
WCB Case No. 99-04731
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our May 12, 2000 Order on Review that adopted and affirmed an Administrative Law Judge's (ALJ's) order that affirmed an Order on Reconsideration that had affirmed a Notice of Closure that awarded no scheduled permanent disability benefits for a bilateral eye injury. In addition, we supplemented our order and explained why we, like the ALJ, rejected claimant's argument that he met his burden of proving entitlement to scheduled permanent disability benefits for loss of visual fields due to the compensable injury under the reasoning in *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997). On reconsideration, claimant repeats this argument, adding the contention that this case is controlled by our decision in *Karen L. Verschoor*, 52 Van Natta 275 (2000), a case that applied *Danboise*.

After further consideration of claimant's argument, we continue to reject it for the reasons explained in our prior order. In other words, we continue to find that the medical evidence in the present case does *not* meet the elements enumerated in *Danboise* that would meet claimant's burden of proof. Specifically, in *Danboise*, the court held that when a treating doctor or medical arbiter makes impairment findings, describes those findings as "consistent with" the compensable injury, and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is "due to" the compensable injury. 147 Or App at 553.

In *Verschoor*, the medical evidence satisfied the elements listed in *Danboise*. There, the claimant had accepted claims for traumatic median neuropathy, right carpal tunnel syndrome, thoracic outlet syndrome, and reflex sympathetic dystrophy. The medical arbiter measured loss of ranges of motion in the right fingers and, when asked to apportion those findings between the accepted conditions and unrelated causes, he reported that no unrelated causes were found. 52 Van Natta at 277. Under those circumstances, we concluded that, because the impairment findings were consistent with the claimant's compensable injury and neither the medical record nor the arbiter attributed the claimant's impairment to other causes, the arbiter's report supported an award for lost range of motion of the right fingers. *Id.*

Here, in contrast to *Danboise* and *Verschoor*, there is no medical evidence that describes any impairment findings as "consistent with" the compensable injury. To the contrary, here, both the treating doctor and the medical arbiter find that claimant's bilateral eye injury healed without measurable impairment as a result of the work injury. (Exs. 9-3, 9-5, 12, 14, 20-1). Therefore, we continue to conclude that claimant failed to establish any ratable impairment due to the compensable injury. ORS 656.214(2).

Accordingly, we withdraw our May 12, 2000 order. On reconsideration, as supplemented herein, we republish our May 12, 2000 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES E. BREWSTER, Claimant
Own Motion No. 00-0178M
OWN MOTION ORDER
Welch, Bruun, et al, Claimant Attorneys

The self-insured employer has voluntarily reopened claimant's claim pursuant to ORS 656.278 for his compensable left shoulder condition. Claimant's aggravation rights expired on June 7, 1996. The employer asks the Board to authorize the reopening of claimant's claim.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(l)(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 retired at the time of the current disability and therefore not in the work force. In response to the Board's inquiry, claimant's attorney, in a June 6, 2000 letter, asserts that claimant agrees that he is retired and that "the claim should be reopened for medical services only." It appears from claimant's statement, that he is only seeking medical services at this time.

Accordingly, we conclude that claimant has withdrawn his request for Own Motion relief (in other words, he is not seeking temporary disability benefits).

Therefore, we dismiss, without prejudice, the request for own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSA M. CHAVEZ, Claimant
WCB Case No. 99-02636
ORDER ON RECONSIDERATION
Gayle A. Shields, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our May 15, 2000 Order on Review that awarded an assessed fee of $2,650 for claimant's counsel's services on review. The insurer contends that the fee should be reduced to the $1,000 to $1,500 level. We disagree.[1]

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 on review in this case were the compensability of claimant's occupational disease claim for bilateral carpal tunnel syndrome and penalties and attorney fees for an allegedly untimely denial. Claimant's attorney submitted an 11 page respondent's brief that addressed both issues. Approximately one-half page was devoted to the penalty issue.[2] The record contains approximately 70 exhibits, including one brief deposition. The transcript is 40 pages long. The case involved a compensability issue of 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 in that we have affirmed the ALJ's determination that claimant's bilateral carpal tunnel syndrome is compensable. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the insurer's vigorous defense of the claim and the conflicting medical evidence, there was a risk on Board review 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 $2,625 is a reasonable attorney fee for services regarding the compensability issue at the Board level. We have reached this conclusion particularly because of the time devoted to the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.[3]

Accordingly, we withdraw our May 15, 2000 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

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[1] With her respondent's brief, claimant submitted a petition for an assessed fee of $2,650 based on 13.25 hours of time devoted to the brief. The insurer did not file a response to the petition as allowed by OAR 438-015-0029(3). While the insurer is not precluded from challenging our attorney fee award because it timely requested reconsideration of our order, we do not consider its motion for reconsideration insofar as it pertains to specific objections to representations offered in the claimant's counsel's attorney fee request. *See Anthony Foster*, 45 Van Natta 1997 (1993).

[2] Claimant states that she spent less than five minutes on the issue.

[3] In reaching this conclusion, we have not considered the minimal time claimant's counsel devoted to the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986). In addition, claimant's attorney is not entitled to an attorney fee for services on reconsideration concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

In the Matter of the Compensation of
JAMES R. CORUM, Claimant
WCB Case No. 97-10164
ORDER DENYING MOTION TO DISMISS
Roger Wallingford, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

The insurer has requested Board review of Administrative Law Judge (ALJ) Lipton's February 24, 2000 order that set aside its denial of claimant's left wrist, ankle and foot injury claim. Claimant moves to dismiss the request for review on the basis that it was not timely filed. We deny the motion.

FINDINGS OF FACT

On February 24, 2000, the ALJ issued an Opinion and Order setting aside the insurer's denial of claimant's left wrist, ankle and foot injury claim.

On May 3, 2000, the Board received a letter dated May 2, 2000 from the insurer's attorney. The letter included a copy of an unsigned February 28, 2000 request for Board review of the ALJ's February 24, 2000 order. The insurer attached affidavits, including one signed by its attorney's assistant, stating that she had previously delivered the insurer's initial request for review to a United States Post Office on February 28, 2000. The request was intended to be mailed by certified mail. However, the insurer's attorney does not have the receipt of the certified mailing.

On May 11, 2000, the Board received claimant's motion to dismiss the request for review, asserting that the request was not timely filed. On May 16, 2000, the Board received the insurer's response to claimant's motion to dismiss.

CONCLUSIONS OF LAW AND OPINION

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

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date of filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. *Id.; see George D. Smith*, 50 Van Natta 1485 (1998).

Here, the 30th day after the ALJ's February 24, 2000 order was Saturday, March 25, 2000. Therefore, the final day to perfect a timely appeal was Monday, March 27, 2000, the first business day following the expiration of the 30-day period. *See Anita L. Clifton*, 43 Van Natta 1921 (1991).

The insurer's request for review was received by the Board on May 3, 2000, after expiration of the 30-day appeal period. Thus, the insurer's request for review is presumed to be untimely.

The insurer argues that its request for review was timely mailed, based on affidavits by its attorney and the attorney's assistant. The attorney attests that a signed original of the insurer's request for review was placed in an office "out box" for post office delivery on February 28, 2000.[1] The

[1] He also states that claimant's counsel notified his office on April 24, 2000 that the Board had not received the request for review.

attorney's assistant attests that she delivered the request for review to a U.S. Post Office and mailed it by certified mail. She states that she was given a date-stamped receipt for this certified mail, but the receipt has since been misplaced.[2]

Claimant contends that the insurer's request for review should be dismissed because it was not filed with the Board within the statutory 30-day period from the ALJ's order and there is no proof that the request was "filed" by certified mail.

The Board received the insurer's request for review more than thirty days after the ALJ's February 24, 2000 order. Thus, there is a rebuttable presumption that the request was untimely filed. However, the insurer's attorney's assistant attested to mailing the request for review to the Board, with copies to claimant, his attorney, and the insurer, on February 28, 1999, well before the 30-day appeal period ended on March 27, 2000. This information is corroborated to some extent by the insurer's undisputed assertion that claimant's counsel received his copy of the request on or about March 1, 2000.

Under such circumstances, we conclude that the insurer has rebutted the presumption of untimely filing. *See Randolph King*, 51 Van Natta 82 (1999) (presumption of untimely mailing rebutted by an affidavit from the claimant's counsel's legal assistant attesting that she timely mailed the request for hearing to the Board and parties); *Brian L. Schmitt*, 48 Van Natta 295 (1996) (the claimant rebutted the presumption under OAR 438-005-0046(1)(b) by showing that the carrier received a copy of the request before expiration of the appeal period and evidence showing the claimant's counsel's customary procedure of mailing the request to the Board, and a copy to opposing counsel, on the same date).

Accordingly, we deny the motion to dismiss. A copy of the hearings transcript is included with claimant's and the insurer's counsels' copies of this order. The following briefing schedule has also been implemented. The insurer's appellant's brief must be filed within 21 days from the date of this order. Claimant's respondent's brief must be filed within 21 days from the date of mailing of the insurer's brief. The insurer's reply brief must be filed 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.

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[2] Because there is no date-stamped receipt of certified mail, there is no "filing" *via* certified mail. *See* OAR 438-005-0046(1)(b). Therefore, because the request was received more than 30 days after the ALJ's order there is a rebuttable presumption of untimely filing. *Id.*

In the Matter of the Compensation of
CHARLOTTE E. HALL, Claimant
WCB Case No. 99-08158
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

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

We do not find that "[d]essication is generally thought to be a degenerative rather than a traumatic process." (Opinion and Order, p. 3).

We do not find that Dr. Booth planned to inject claimant's disc or discs in October 1998. (*Id*). Instead, we find that Dr. Booth provided anesthetic and steroid injections to claimant's L3-4 and L4-5 epidural spaces and her right sacroiliac joint. (Exs. 51, 53, 54).

We do not adopt the last sentence of the last paragraph on page 3 or the first sentence on page 4. And we do not rely on the fact that the insurer never accepted "discogenic pain" or a disc condition.

However, like the ALJ, we decline to rely on Dr. Ellefsen's causation opinion, based on the following reasoning.

We first note that claimant bears the burden of proving that her 1997 injury is a material cause of her current need for treatment or disabliity for her low back condition. ORS 656.005(7)(a). Considering the passage of time since the injury, we also find that expert evidence is necessary to prove this claim. Dr. Ellefsen provides the only such evidence.

Dr. Ellefsen opined that claimant's September 1997 injury continued to cause her low back disability and need for treatment in January 2000. This opinion was based primarily on claimant's January 20, 1998 MRI, which revealed decreased signal on the T-2 weighted images of her L4-5 and L5-S1 disc spaces.[1] Dr. Ellefsen noted that these findings suggest disc desiccation.[2] Therefore, Dr. Ellefsen opined that his diagnosis of "discogenic pain" is consistent with claimant's MRI. (Ex. 72).

But Dr. Ellefsen did not explain why he believes that claimant's September 1997 work injury caused her January 1998 MRI findings of "desiccation" or her disability and need for treatment for "discogenic pain."[3] Because he did not explain why or how claimant's 1997 injury contributes to her current condition (or disability and/or need for treatment for that condition), we find his causation opinion inadequately explained. Therefore, we agree with the ALJ that the claim fails.

ORDER

The ALJ's order dated February 22, 2000 is affirmed.

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[1] We interpret Dr. Ellefsen's notation "#1" to mean "primarily." (Ex. 72).

[2] Dr. Coulam also read the January 1998 MRI as suggesting disc desiccation. (Ex. 25). Similarly, Dr. Baker read claimant's October 1998 MRI as showing "minimal loss of T2 signal" and stated that indicated "degeneration." (Ex. 50).

[3] We also note that Dr. Ball took x-rays that he interpreted as showing "mild degenerative changes consistent with [claimant's] age and her long-standing obesity." (Ex. 62-2).

In the Matter of the Compensation of
EMMETT L. HERRMANN, Claimant
WCB Case No. 99-06415
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
VavRosky, MacColl, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's current bilateral knee condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. At the time of his February 1997 work-related delivery truck accident, claimant was not restrained by a seat belt. After the trucks brakes failed, claimant strenuously and repeatedly pumped the brakes with his right foot. When the truck finally came to rest, claimant was found hanging by his feet from the steering wheel.

We adopt that portion of the ALJ's "Ultimate Findings of Fact" that found claimant and his wife credible.

CONCLUSIONS OF LAW AND OPINION

Right Knee Condition

We adopt and affirm the order of the ALJ with the following supplementation to address the insurers contention that the ALJ incorrectly relied on the medical opinion of Dr. DiPaola, the attending physician, instead of the medical opinions of Drs. Gripekoven and Mayer.

As previously noted, the February 1997 delivery truck accident occurred when the brakes on the truck failed. The truck went over an embankment and down a hill, where it struck a tree and overturned onto its passenger side. Claimant contends that as a direct result of that accident he suffered a torn medial meniscus of the right knee.

X-rays revealed right knee degenerative arthritis. All the doctors agree that claimant's right knee injury combined with the preexisting degenerative arthritis. Therefore, in order to establish that his torn medial meniscus 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 101 (1997). Because of claimant's preexisting condition and the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his 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 the different causes and explain why the February 1997, injury contributed more to claimant's disability or need for treatment for the torn medial meniscus than his preexisting degenerative arthritis. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Relying on claimant's credible description of the motor vehicle accident as well as on both claimant's and his wife's credible description of claimant's subsequent knee problems, and the medical opinion of Dr. DiPaola (claimant's attending orthopedic surgeon), the ALJ concluded that the claim was compensable. The ALJ found Dr. DiPaola's opinion to be based upon complete information and the most persuasive in discussing all the aspects of claimant's condition, including his lack of any knee symptoms prior to the accident, his symptoms of pain, swelling and locking of the right knee immediately after the accident,[1] the various diagnostic tests, and the clinical findings. We agree with the ALJ.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. DiPaola's opinion.

The insurer contends that Dr. DiPaola's opinion is not persuasive because: (1) it is based primarily upon a temporal analysis; (2) it waivers and states causation in terms of possibilities instead of probabilities[2]; (3) it does not discuss the relative contributions of the different causes for claimant's

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[1] Dr. DiPaola concluded that symptoms of intermittent pain, swelling, and locking of the knee were a classic history for a meniscal tear. Dr. Gripekoven, who examined claimant at the request of the insurer, does not dispute that conclusion.

[2] This contention by the insurer comes from Dr. DiPaola's response to a question about the radiology findings as interpreted by Dr. Mayer, who reviewed the March 1999 MRI films at the request of the insurer. In particular, Dr. DiPaolo stated: "Whether the accident actually caused the meniscal tear is arguable." (Ex. 47-8). Reading Exhibit 47 as a whole and in conjunction with Exhibits 43 and 43A, we find the aforementioned remark was merely an acknowledgment that a split of opinion on causation exists in this claim. We further find that Dr. DiPaolo's use of the word "possible" refers to inferring causation from viewing the MRI study alone (because of the two-year period of time between the accident and the MRI study, a traumatically caused tear will appear degenerative). We do not find these remarks represent a wavering or an inconsistency in his opinion.

combined condition; and (4) it is internally inconsistent.[3] We disagree.

Causation may not be inferred from a temporal relationship alone. *See Allie v. SAIF*, 79 Or App 284 (1986). However, Dr. DiPaola's opinion is not based merely upon the chronology of the onset of claimant's right knee symptoms and the truck accident. His opinion also considers the medical record, as well as the forces and mechanism of the truck accident to cause a meniscal tear.[4] While not expressly enumerating all the forces involved in this roll over truck accident, we find that Dr. DiPaola necessarily considered all the forces involved, including claimant's hard right footed brake pumping, a weight bearing type of activity, to conclude that "the motor vehicle accident would undoubtedly provide sufficient force and provide a mechanism for tearing his meniscus." (Ex. 47-10).

The insurer further contends that the opinions of Drs. Gripkoven and Mayer, taken together, are persuasive evidence that the truck accident is not the major cause of claimant's need for treatment of his right knee condition. Again, we disagree.

Dr. Gripekoven opined that tears of the meniscus usually involve torque and shearing forces with weight bearing. He indicated he could not pinpoint any weight bearing type of mechanism in the truck accident. (Ex. 39-6). We note that his description of the history does not include the hard brake pumping activity that claimant undertook in an effort to stop the vehicle. We therefore conclude that he was unaware that claimant was involved in this weight bearing type of action during the course of the truck accident and, therefore, that Dr. Gripekoven did not consider this action in rendering his opinion. Because his opinion is based upon incomplete information, the opinion is not persuasive.[5] *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998). Accordingly, we do not rely upon it.

Dr. Mayer, a radiologist who evaluated the MRI films, opined that claimant's medial meniscus tear was degenerative in nature rather than traumatic in nature. We do not find his opinion necessarily probative. The MRI films in question were taken in March 1999, two years after the accident. We find persuasive Dr. DiPaolo's uncontested comments that after two years of wear and tear, a traumatically caused meniscal tear would appear degenerative in nature in an MRI study. (Ex. 47-9).

In conclusion, based upon Dr. DiPaolo's well reasoned and persuasive opinion, we find that claimant's work injury was the major contributing cause of his disability and his need for treatment for his combined right knee condition. Consequently, we affirm the ALJ's order that set aside the insurer's denial of that claim.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief, and his counsel's uncontested request), the complexity of the issue, and the value of the interest involved.

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[3] The insurer contends that Dr. DiPaola has stated two opposing opinions when he opines that (1) the right knee "condition" is consistent with the accident; or (2) the accident could have caused the tear. We find the insurer's characterization of Dr. DiPaola's opinion inaccurate and accordingly we disagree with the insurer's contention. On review of Dr. DiPaola's opinion, we find that: (1) Dr. DiPaola has opined that claimant's need for surgery is caused by the accident (Ex. 47-6 & 7); and (2) Dr. DiPaolo opined that the accident would provide sufficient force and a mechanism to tear claimant's meniscus. (Ex. 47-10). We do not find the inconsistencies attributed to Dr. DiPaola by the insurer.

[4] The key medical question in this claim is whether, within a reasonable medical probability, the truck accident as described by claimant caused a meniscal tear. Dr. Gripekoven opined that tears of the meniscus usually involve torque and shearing forces with weight bearing. He could not pinpoint any weight bearing type of mechanism in the truck accident. (Ex. 39-6).

[5] The insurer argues that Dr. Gripkoven's opinion is supported by the concurrence of Dr. Asby, claimant's original treating physician. Like Dr. Gripkoven, Dr. Asby does not appear to be aware of claimant's brake pumping activity at the time of the accident. Therefore, his concurrence is also based upon incomplete information and is not persuasive.

Left Knee Condition

The insurer contends that claimant presented no medical opinion regarding claimant's current left knee condition. Consequently, it seeks reversal of that portion of the ALJ's order that set aside that portion of the insurer's denial of that condition. We agree with the insurer's contention. The evidence was exclusively directed at claimant's right knee and did not address issues of causation of the left knee condition. Under such circumstances, the medical and lay evidence does not establish that claimant's February 1997 work injury caused any current need for treatment or disability for his left knee condition. Accordingly, that portion of the insurer's denial is reinstated and upheld.

ORDER

The ALJ's order dated February 2, 2000 is affirmed in part and reversed in part. That portion of the order that set aside the insurer's denial of claimant's left knee condition is reversed. The insurer's denial of claimant's left knee condition is reinstated and upheld. The remainder of the order is affirmed. For services on review, claimant is awarded a $1,750 attorney fee, payable by the insurer.

In the Matter of the Compensation of
MATTHEW W. JOHNSON, Claimant
Own Motion No. 99-0326M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's February 23, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from September 1, 1999 through February 2, 2000. The employer declared claimant medically stationary as of February 3, 2000.

In his request for review, claimant contends that he has been has not been released to full work and that if he tried to exceed his limitations his ankle would fail. Claimant further contends that his ankle is getting worse by the day. We interpret such a statement as a contention that claimant was not medically stationary at claim closure.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the February 23, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In an April 24, 2000 letter, we requested that the employer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The employer submitted its response on May 5, 2000; however, no further response has been received from claimant. Therefore, we will proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issue raised less often is that, although the claimant agrees that he or she was medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant requested review because his ankle is getting worse by the day. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

Claimant contends that he has continued pain and is required to remain on his modified work program so his ankle will not fall apart again. Claimant relies on these contentions to support his position that he was not medically stationary at the time of claim closure. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" claimant's compensable condition at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996).

The employer submitted a February 3, 2000 chart note from Dr. Holmboe, claimant's attending physician, in support of its contention that claimant was medically stationary at the time it closed his claim. Dr. Holmboe opined that he did not expect any further improvement with the passage of time and that claimant was medically stationary from his last ankle arthroscopy. Dr. Holmboe noted that claimant may require palliative care periodically and advised claimant to return on an as-needed basis. Although recommending occasional steroid injections, Dr. Holmboe neither indicates that claimant's condition is no longer medically stationary nor that this ongoing medical care will materially improve claimant's compensable condition. These opinions are unrebutted.

Based on this uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed.[1] Therefore, we conclude that the employer's closure was proper.[2]

Accordingly, we affirm the employer's February 23, 2000 Notice of Closure in its entirety.[3]

IT IS SO ORDERED.

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[1] In reaching this conclusion, we again emphasize that the need for continuing medical treatment to address fluctuating symptoms does not establish that claimant's condition is not medically stationary. *Maarefi*, 69 Or App at 531.

[2] Should claimant's compensable condition subsequently worsen to the extent that surgery and/or inpatient hospitalization is eventually required, he may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

[3] In his request for review of the employers closure, claimant poses many questions regarding his permanent disability award, his entitlement to further disability and the difficulties he has experienced obtaining workers compensation benefits. It appears from claimant's questions that he is unclear as to his rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. He may call 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 97301

In the Matter of the Compensation of
JEAN M. LANGLEY, Claimant
WCB Case No. 99-03547
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Craig A. Staples, Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's claim for a current upper back and neck myofascial pain condition; and (2) assessed a penalty for its allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

Claimant fell at work on June 16, 1998. She sought medical treatment and returned to work the next day. Dr. Harvard diagnosed contusions of the left knee and left rib cage and noted that claimant denied pain elsewhere.

Dr. King examined claimant on July 12, 1998 and described her as "fully recovered."

The employer accepted nondisabling contusions of the left rib cage and left knee on August 6, 1998.

Claimant next sought treatment on December 12, 1998, complaining of intermittent upper back and neck pain. Dr. Donovan diagnosed myofascial pain of the upper back and neck, noting claimant's poor posture.

Claimant filed a second injury claim form on January 21, 1999, stating that she had jarred her shoulder and neck area when she fell on June 16, 1998.

Dr. Norcom first examined claimant on February 4, 1999. He provided conservative treatment for claimant's neck and upper back problems (described as strains).

On April 1, 1999, the employer denied claimant's current condition. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant credible, based on observing her while she testified. Therefore, the ALJ relied on claimant's testimony that her neck and upper back symptoms began within a few days after her June 1998 fall at work.[1] Further finding that claimant's history regarding the onset of these symptoms "is corroborated by the histories she has given the various doctors in this record," the ALJ relied on Dr. Norcom's opinion and concluded that the work injury caused claimant's current neck and upper back myofascial condition. We reach the opposite result, for the following reasons.

First, although claimant testified that she has had intermittent neck and upper back symptoms since soon after her work injury, her testimony in this regard is not corroborated by the contemporaneous medical record. In fact, the June and July 1998 medical reports indicate that claimant denied pain anywhere other than in the left knee and left rib cage area and she was "not in any type of distress" and "without complaint" by July 12, 1998. (Exs. 3, 6). There is no mention of upper back complaints in the medical record until claimant sought emergency treatment on December 19, 1998, six months after the injury. (Exs. 9, 10). Under these circumstances, we conclude that claimant's

[1] Claimant explained that she did not report her upper back symptoms after her fall because her knee and rib area hurt more and she thought that her upper back and shoulder area problems would go away. (Tr. 8-10). Claimant first reported upper back symptoms to Dr. Donovan in January 1999, stating that they began "following" the June 1998 injury. (Ex. 11; *see also* Exs. 9, 14).

contemporaneous reporting casts doubt on her testimony regarding the onset of her upper back symptoms.[2] *See Carrie L. Deel*, 50 Van Natta 2311 (1998).

Second, Dr. Norcom provides the only medical evidence addressing causation and he was not in a good position to evaluate causation because he first examined claimant over 6 months after the injury. *See McIntyre v. Standard Utility Contractors, Inc.*, 135 Or App 298, 302 (1995) ("A treating physician's opinion [] is less persuasive when the physician did not examine the claimant immediately following the injury.") Moreover, we do not find that Dr. Norcom's conclusions establish that the 1998 injury caused claimant's current condition.

On July 22, 1999, Dr. Norcom opined that claimant's June 1998 injury was the major contributing cause of the "cervical and low back strains" that he had been treating, based on his examination, treatment and the history provided. (Ex. 22). But Dr. Norcom also stated that he had not reviewed claimant's injury-related records and "It is always difficult to determine how much a past injury to one part of the body can affect another part." (*Id*).

Dr. Norcom was deposed on December 8, 1999. By this time, he had reviewed claimant's records and stated that they were helpful. (Ex. 23-6). Based on the June and July 1998 medical reports, Dr. Norcom stated, "It's conceivable that she could have twisted her back, at that time, but it's not reasonable. Because it seems to me that she would have been complaining of those things sooner than she did." (*Id.* at 8-9). He opined that it was not likely that claimant's cervical and upper back "strains" in March 1999 were due to the June 1998 fall, explaining that he previously thought they were (due to the fall), because he lacked "any other good explanation" and claimant had told him that she had these problems "since the time of beginning." (*Id.* at 11-13). Dr. Norcom also stated that, if he had the records before, he would have previously stated that the 1998 injury was *not* the major cause of claimant's current complaints. (*Id.* at 14 & 26).

Claimant's attorney posed a "bottom line question":

> "What I have heard you testify to so far is that based on all of the records that are available, it's possible but unlikely or not terribly probable that this upper back pain and discomfort is a result of the injury." (Ex. 23-28).

Dr. Norcom replied, "That's what I truly believe, right." (*Id*).

Then the attorney asked the doctor to assume that there was no other explanation for claimant's pain and she truthfully reported that it started with the injury. Assuming those circumstances, Dr. Norcom still declined to say that claimant's injury caused her upper back condition, because "people can develop myofascial pain out of the clear blue sky." (*Id*). Therefore, the doctor continued to opine that claimant's current pain was possibly, but not probably, related to the work injury. (*Id.* at 29).

Finally, claimant's counsel asked the doctor to assume that claimant "is telling the truth. . . .[t]hat she experienced this pain, didn't really report it initially, because it didn't seem to be a problem, but that it got progressively worse over time." With those assumptions, the attorney asked the doctor if claimant's injury caused her pain and the doctor replied,

> "If I assumed that, then, yeah, it would --I mean, that's why I kept treating her and kept treating it as an on-the-job injury, because I took her at face value that -- often times, in these cases when it's not clear, you have to kind of follow the patients subjectively." (*Id.* at 30-31).

We evaluate Dr. Norcom's statements in context and conclude that he probably changed his opinion once, not twice. *See SAIF v. Strubel*, 161 Or App 516 (1999). When he started treating claimant in 1999, before he reviewed her records, Dr. Norcom believed that the upper body problems were injury-related. Once he knew that she had not reported or sought treatment for such problems

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[2] We acknowledge claimant's February 1999 history that she strained her upper back and neck when she fell in June 1998, "but this did not become problematic until sometime later." (Ex. 17). This history is consistent with claimant's testimony at hearing and Dr. Norcom explained that pain medication *could* have masked her upper back problems early on (Ex. 23-17). Nonetheless, considering Dr. Norcom's opinion as a whole and in context, we cannot say that it persuasively supports the claim, as explained herein.

previously, he "truly believed" her current condition was probably *not* injury-related. Underlying this conclusion is Dr. Norcom's considered opinion that claimant *would* have reported upper back symptoms sooner than she did, if they were injury-related. Thus, in our view, Dr. Norcom explained his changed opinion and we find his explanation persuasive.

Then, when asked to assume that claimant had upper back symptoms since the injury, Dr. Norcom did say that the injury would be their cause--based on that assumption. But the prior context of the latter statement clearly indicates that the doctor did not accept the assumption (because too much time passed without reported symptoms since the injury). Thus, in our view, Dr. Norcom did not depart from his previously explained belief in considering the hypothetical posed. In other words, we do not find Dr. Norcom's response to the hypothetical necessarily inconsistent with his causation conclusion. *See SAIF v. January*, 166 Or App 620 (2000) (inconsistencies may not exist when circumstances are better understood).

Moreover, assuming (without deciding) that Dr. Norcom changed his opinion a second time when he responded to the hypothetical, we would not find the changed opinion persuasive, because it does not follow from the doctor's prior reasoning: A person can develop myofascial pain "out of the blue" and too much time passed without reported symptoms to relate the current complaints to the injury.[3] Accordingly, finding no persuasive medical evidence supporting claimant's claim for upper body myofascial pain,[4] we uphold the employer's denial. Finally, because there are no amounts due under the claim, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated January 19, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee and penalty awards are reversed.

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[3] In other words, if Dr. Norcom intended to change his opinion in response to the hypothetical, we would be unable to reconcile what the doctor "truly believes" with his later summary conclusion that claimant's 1999 symptoms would be injury-related if she was "telling the truth."

[4] No other physician expressed a causation opinion. (*See* Exs. 10-14, 23-25).

Board Member Phillips Polich dissenting.

The majority rejects the ALJ's finding that claimant's testimony about the onset of her upper back and neck symptoms was credible and it therefore concludes that claimant failed to establish compensability. I disagree, for the following reasons.

First, based on his "close and careful observation of the claimant while she testified," the ALJ explicitly found claimant credible. Accordingly, based on claimant's credible testimony, the ALJ further found that claimant's "symptoms came on exactly as she described." In other words, claimant's upper back and neck symptoms *did* begin soon after her June 1998 work injury.

I would defer to the ALJ's credibility determination, because the ALJ *observed* claimant's testimony and found her credible based on his observation. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991); *see e.g., Bragger v. Oregon Trail Savings*, 275 Or 219, 221 (1976).

I also disagree with the majority's conclusion regarding medical causation, because the only medical evidence that is based on a materially accurate history clearly supports the claim.

When Dr. Norcom "assumed" that claimant was telling the truth about the onset of her neck and upper back symptoms, he stated that the work injury caused those symptoms. Thus, when Dr. Norcom relied on an accurate history (that claimant's neck and upper back pain began soon after her fall at work and worsened progressively thereafter), he concluded that claimant's condition is work related. Dr. Norcom's opinion is uncontradicted.

Under these circumstances, I would rely on claimant's credible testimony and Dr. Norcom's opinion based on that testimony. Accordingly, because I would defer to the ALJ's credibility determination -- and adopt and affirm his order -- I must respectfully dissent.

In the Matter of the Compensation of
EVERETT L. LEACH, Claimant
Own Motion No. 00-0170M
OWN MOTION ORDER ON RECONSIDERATION
EBI Ins. Co., Insurance Carrier

The insurer requests reconsideration of our May 23, 2000 Own Motion Order in which we authorized the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for surgery. Specifically, the insurer contends claimant is not entitled to temporary disability benefits because he was retired and receiving "social security benefits" at the time of his current disability.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery.

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

In our May 23, 2000 order, we found that the record established that claimant was in the work force at the time of his disability. To supplement the record, claimant has submitted copies of account receivable reports dated from January 1999 through June 2000. These reports further demonstrate that he worked for remuneration during that period of time. Therefore, we continue to find that claimant was performing work at the time of disability.[1] Because claimant has established that he worked, he is entitled to temporary disability to replace any lost wages, beginning the date of surgery. *See Robert D. Hyatt*, 48 Van Natta 2202 (1996) (the claimant was entitled to temporary partial disability when, although retired, the claimant established that he continued to work part-time).

On reconsideration, the insurer contends that claimant is retired and receiving Social Security benefits, and thus, not entitled to temporary disability compensation. However, because we have concluded that claimant was working at the time of disability, we are not persuaded that the contention is pertinent to our inquiry.[2] In other words, we do not find the receipt of social security benefits determinative, because claimant has established that he was working at the time of disability, and, thus, entitled to temporary disability benefits. *See Robert D. Hyatt*, 48 Van Natta at 2203.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our May 23, 2000 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] The date of disability, for the purpose of determining whether claimant is in the work force, under the Boards own motion jurisdiction, 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 April 3, 2000 when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

[2] In any event, notwithstanding our current finding, the receipt of social security benefits would not necessarily impact our decision. A claimant's eligibility for social security benefits indicates that he is disabled from work due to one or a number of medical conditions. On the one hand, receipt of social security benefits would establish that a claimant is disabled from work (it would be futile for the claimant to seek work), *see Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); on the other hand, the disability which makes seeking work futile may not be due to a compensable injury. *See Kenneth C. Felton*, 48 Van Natta 725 (1996); *Konnie Sprueill*, 45 Van Natta 541 (1993).

In the Matter of the Compensation of
LADDIE R. TOFELL, Claimant
Own Motion No. 00-0195M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights on that claim expired on December 9, 1998.

SAIF recommended that claimant's claim be reopened. SAIF agrees that the arthroscopic debridement of the right knee medial meniscus is compensably related to claimant's 1992 work injury, and does not oppose reopening the claim for that portion of the surgery. But it contends that the surgical repair or excision of the medial meniscus of the left knee is not causally related to his compensable condition. SAIF has denied that the compensability of claimant's bilateral knee occupational disease claim on which claimant has timely requested a hearing with the Hearings Division. (WCB Case Nos. 00-04270 and 00-04271).

Claimant's 1992 claim was first closed on August 5, 1985, and his aggravation rights expired on December 9, 1993. ORS 656.273(4)(a). Thus, when claimant's condition worsened requiring surgery in March 2000, claimant's claim was under our own motion jurisdiction. Inasmuch as we have exclusive own motion jurisdiction over the claimant's 1992 claim, we turn to whether the claimant is entitled to temporary disability benefits as set forth in ORS 656.278.

The Board's Own Motion authority is provided under ORS 656.278. Except for claims for injuries which occurred prior to January 1, 1966, ORS 656.278(1) limits the Board's authority to those cases where 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.

Our own motion jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. The Board, in its Own Motion authority, does not have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries excepted). Rather, jurisdiction over these disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 and 656.704(3)(b) or with the Director under ORS 656.245, 656.260 or 656.327 and 656.704(3)(b). *See Gary L. Martin*, 48 Van Natta 1802 (1996).

On March 31, 2000, Dr. Balme, claimant's attending physician, recommended that claimant undergo surgical repair or excision of the bilateral knee medial menisci tears. SAIF disputes the compensability of that portion of the surgery regarding claimants left knee medial meniscus tear. As noted above, this "compensability" dispute is not within our jurisdiction to decide and has been properly set before the Hearings Division under ORS 656.283(1).

However, the parties agree, and the medical evidence supports, that a portion of the recommended surgical procedure (*i.e.* arthroscopic debridement of the right knee medial meniscus) is a compensable component of his 1982 work injury. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. *Howard L. Browne*, 49 Van Natta 485 (1997) (claimant's multilevel back surgery included treatment for both compensable and noncompensable conditions; however, that portion of the surgery that related to his compensable L4-5 injury satisfied the "surgery" requirement under ORS 656.278(1)(a)).

Accordingly, we authorize the reopening of claimant's 1982 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery on his right knee. When claimant's condition related to the surgery on his right knee 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
JENNIFER D. TURMAINE, Claimant
WCB Case No. 99-03353
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's injury claim for a low back condition. On review, the issue is compensability.

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

At the time of the hearing, claimant was a 20 year-old warehouse worker. On September 15, 1998, claimant injured her lower back when she bent over and twisted to pick up a case of guns. (Ex. 1; Tr. 6). At that time, claimant felt pain in her low back and buttocks. (Tr. 6, 18). The employer's claims processor accepted a lumbar strain condition. (Exs. 6, 36). Claimant's pain improved, but never entirely subsided. (Tr. 14). On November 18, 1998, claimant bent over to pick up a pen and felt pain in her back and down her left leg. (Ex. 9; Tr. 6).

An MRI taken on December 16, 1998 demonstrated an "acute appearing" central disc bulge at L5-S1. (Ex. 32). A second MRI taken on December 28, 1998 revealed a central disc herniation at L5-S1, abutting both right and left S1 nerve roots. (Ex. 37). Claimant made a claim for this lumbar disc condition as related to her September 15, 1998 work injury, which the employer denied. (Ex. 50).

The ALJ set aside the employer's denial based on the opinions of claimant's treating physicians, Dr. Hacker and Dr. Karasek. Drs. Hacker and Karasek reasoned that claimant tore her annulus (the material surrounding a disc) at L5-S1 during the initial twisting injury on September 15, 1998. The disc was still injured as of November 1998, such that a minor movement such as bending over to pick up a pen was sufficient to herniate claimant's disc at L5-S1. (Exs. 51, 53). Drs. Hacker and Karasek concluded that the major contributing cause of claimant's disability and need for treatment for the L5-S1 disc herniation was the September 15, 1998 injury. (*Id.*)

In contrast, Drs. Schilperoort and Brooks, who performed an examination at the request of the employer, believed that claimant suffered only a lumbar strain associated with the September 15, 1998 injury. (Ex. 49-7). According to these physicians, claimant's L5-S1 disc herniation was caused by an "idiopathic weakness" of the annular ligament. (Ex. 49).

The employer contends that claimant did not meet her burden of proving the compensability of her L5-S1 disc herniation. We disagree.

As a threshold matter, medical opinions must be stated in terms of reasonable medical probability, as opposed to possibilities. Medical opinions based on mere possibilities are neither legally sufficient nor persuasive. *Gormley v. SAIF*, 52 Or App 1055 (1981); *Fred L. Jones*, 52 Van Natta 318 (2000). Here, Dr. Schilperoort conceded that it was "strictly speculation" that claimant had a congenital defect in her lumbar spine. (Ex. 52-39). The defect at L5-S1 is simply a "diagnosis of exclusion," according to Dr. Schilperoort. (Ex. 52-53). This acknowledgment undermines Drs. Schilperoort's opinion that claimant's disc herniation was caused by claimant's "unconfirmed" congenital developmental weakness at the L5-S1 disc space. (Ex. 52-33).[1]

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[1] The employer contends that claimant must prove that her September 1998 injury is the major contributing cause of her disability and need for treatment, because it has combined with the effects of a preexisting degenerative condition. *See* ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998). However, for the major contributing cause standard to apply, there must be proof (to a reasonable degree of medical probability) that a preexisting condition has combined with an otherwise compensable injury to cause claimant's disability and need for treatment. *Beverly Enterprises v. Michl*, 150 Or App 357, 360 (1997). Here, we find that the medical evidence fails to establish the existence of a preexisting condition that has combined with claimant's September 1998 injury. Nevertheless, even assuming the standard is "major contributing cause," we find that claimant has satisfied her burden of proof on this record, for the reasons expressed herein.

Ordinarily, we defer to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). However, when a treating physician does not examine the claimant soon after the injury, we have held that this deference is not warranted. *McIntyre v. Standard Utility Contractors*, 135 Or App 298, 302 (1995). Here, Dr. Hacker did not examine claimant until February 24, 1999, five months after the September 1998 work injury. (Ex. 45). Dr. Hacker then referred claimant to Dr. Karasek. (Ex. 46). Accordingly, we do not give deference to these doctors' opinions for the reason that they are claimant's treating physicians.

However, we rely on medical opinions which are both well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). The employer contends that Dr. Hacker and Dr. Karasek relied on an inaccurate or incomplete history of claimant's symptoms in arriving at their opinions on causation. We disagree. In his examination of February 24, 1999, Dr. Hacker took a correct history that claimant injured her back "lifting a box of shotguns in September and twisting. She was immediately aware of severe back pain at the belt level and lower." (Ex. 46). This history is consistent with claimant's testimony of having pain in both her low back and buttocks after her September 1998 injury. (Tr. 6, 18).

Similarly, Dr. Karasek correctly understood that claimant's low back pain continued from September 1998 through November 1998. (Tr. 14). The fact that a physician characterized claimant's lumbar condition as "resolved" on September 20, 1998 does not necessarily contradict claimant's testimony that she continued to have back pain beyond that date. (Ex. 5).

We agree with the ALJ that the opinion of Drs. Hacker and Karasek as to the interplay of claimant's September and November 1998 injuries in causing her L5-S1 disc condition was better reasoned than the opinion of examining physician Dr. Schilperoort, and therefore persuasive. In this regard, we note that Dr. Schilperoort's opinion depended on the presence of a congenital defect in claimant's lumbar spine. (Ex. 49). The existence of a preexisting congenital defect has not been established by medical evidence based on reasonable medical probability, as we explained above.

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 self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated February 10, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,800, payable by the employer.

In the Matter of the Compensation of
LILLIE M. DAWSON, Claimant
WCB Case No. 99-05558
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition. On review, the issue is compensability.

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

On review, the employer contends that the ALJ erred by relying on the opinion of claimant's treating doctor and her surgeon. The employer argues that the more persuasive medical opinions have been provided by Drs. Radecki and Button. We disagree.

The employer first contends that the opinion of Dr. Meigs is insufficient as there is no support for Dr. Meigs' belief that claimant improved on days when she was not working. The employer also argues that Dr. Meigs' opinion is not persuasive as it is based solely on a temporal theory.

At hearing, claimant credibly testified that, when she worked less, her symptoms improved. (Tr. 15.) Under the circumstances, we do not find that Dr. Meigs had an inaccurate history in this regard. Furthermore, after reviewing Dr. Meigs' opinion in its entirety, we are not convinced that his conclusion was based solely on a temporal analysis. Dr. Meigs considered claimant's stature, weight and age in arriving at his opinion. Dr. Meigs also considered his "history and physical findings" and the nature of claimant's work. Although Dr. Meigs also relied on the fact that claimant improved when she took time off from work, it is not the sole basis for his belief that work was the major cause of her carpal tunnel condition. (Ex. 5a). Therefore, we do not find that his opinion should be discounted for the reasons cited by the employer.

We are not persuaded that the opinion provided by Dr. Radecki is more persuasive than the opinions of claimant's treating doctor and surgeon. Dr. Radecki opined that claimant's symptoms were due to personal factors and he believed that, if she were to lose weight, her carpal tunnel symptoms would improve. (Ex. 4-5). However, in response, Dr. Puziss noted that in his experience, he had never seen anyone lose weight and improve a carpal tunnel syndrome. (Ex. 11-4).

Finally, after reviewing the opinions provided by Drs. Meigs, Buehler and Puziss, we conclude that they had the most accurate and detailed understanding regarding the amount of processing done by claimant, the hours worked, and her history of improvement and worsening. (Exs. 5a, 6a, 9, 11). Accordingly, we agree with the ALJ that claimant has met her burden of proving that work is the major cause of her bilateral carpal tunnel condition.

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 $1,800 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 February 16, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,800, to be paid by the self-insured employer.

In the Matter of the Compensation of
DELL D. DICK, Claimant
WCB Case No. 99-05490
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's T12 and L2 compression fractures. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the fourth paragraph of the findings of fact on page 2, we change the citation after the first sentence to "(Exs. 11, 14)." In the last paragraph on page 2, we change the first sentence to read: "Claimant's March 6, 1999 thoracic spine x-rays showed a wedge deformity of the L1 vertebra and midthoracic levoscoliosis. (Ex. 27)." In the second paragraph on page 3, we change the citation after the last sentence to "(Ex. 21a-3)." In the fifth paragraph on page 3, we change the third sentence to refer to "cases of food."

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on the opinion of Dr. Ballard, as supported by Dr. Davies' opinion, and concluded that claimant had established that the March 18, 1999 injury was the major contributing cause of his T12 and L2 compression fractures.

The insurer argues that the ALJ erred by deciding what Dr. Ballard's opinion would have been had he known about a specific traumatic event. The insurer contends that the opinions of Drs. Ballard and Davies are insufficient to establish that the work incident was the major contributing cause of claimant's T12 and L2 compression fractures.

The parties do not dispute the ALJ's finding that claimant had a preexisting degenerative spinal condition and one or more compression fractures that combined with the work incident to cause his disability or need for treatment. After reviewing the medical evidence, we agree that ORS 656.005(7)(a)(B) applies and, therefore, claimant must establish that the March 18, 1999 work incident was the major contributing cause of his disability or need for treatment.

We briefly review claimant's previous injuries. In August 1970, claimant was working on his pickup truck (not work-related) when the jack gave way and struck him on the back, between the shoulders. (Ex. 3). Claimant was diagnosed with vertebral fractures at L1 and L2. (Ex. 4). X-rays on August 30, 1970 showed a compression fracture at L1 and compression of the superior cortical surface of L2. (Ex. 5). The radiologist said there was a probable 11th rib fracture and questioned whether there was a superior cortical compression fracture of D12. (*Id.*)

In August 1996, claimant fell through a ceiling and landed on some rafters. (Exs. 11, 18). X-rays on August 6, 1996 showed "[c]ompression fracture of a vertebra in the lumbodorsal region, probably T12 or L1. This is not necessarily recent." (Ex. 12). On August 7, 1996, Dr. Davies reported that "X-rays show compression fx of spine. This injury is old!" (Ex. 13). X-rays on September 11, 1996 showed multiple fractured ribs. (Ex. 14).

On March 2, 1999, claimant sought medical treatment for chest and abdominal pain. (Ex. 23). A chest x-ray was taken and compared to the September 11, 1996 x-rays. (Ex. 24). The radiologist reported that "[v]ertebral body height loss is again observed at or superiorly at what I take to be T12, compatible with insufficiency fracture." (*Id.*) X-rays of claimants thoracic spine on March 6, 1999 showed a wedge deformity of the L1 vertebra and midthoracic levoscoliosis. (Ex. 27). The radiologist noted a new T7 vertebral body compression fracture when compared with x-rays from August 6, 1996. (Ex. 29). A whole body scan on March 11, 1999 showed a new compression fracture at T9 with an old healed compression of T7. (Ex. 32). The radiologist noted that [w]ith the degree of osteoporosis shown in the radiographs, I see very little reason to suspect that we are dealing with metastatic disease rather than fractures from osteoporosis. (*Id.*)

The injury at issue in this case occurred on March 18, 1999, when claimant helped unload a large quantity of government commodities from a large van and reload the boxes, bags of flour, etc., onto pickups. Claimant testified that when he lifted one of the heavy boxes, he had a shooting pain down his lower back. (Tr. 9, 10). He had not previously experienced that kind of pain in that location. (Tr. 10-11, 13-14).

In light of the multiple possible causes of claimant's T-12 and L-2 compression fractures, 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). Claimant contends that the opinions of his treating physicians, Drs. Davies and Ballard, establish that the March 18, 1999 injury was the major contributing cause of his T12 and L2 compression fractures.

We first examine Dr. Ballard's reports. Dr. Ballard had previously examined claimant in 1996 after he had fallen through a ceiling and landed on some rafters. (Ex. 11). In November 1996, Dr. Ballard believed claimant had transient osteoporosis or a severe bone contusion. (Ex. 20). After the March 18, 1999 injury, claimant initially sought treatment from Dr. Davies and was referred to Dr. Ballard. On April 22, 1999, Dr. Ballard reported the following history:

> "Since the middle of March he has had increasing pain to his lower back to the point that he has unable to do any type of bending, walking or sitting secondary to back pain. He was working for the school district and was moving a lot of cases of food, but there is not one direct trauma that he can remember." (Ex. 53).

Dr. Ballard diagnosed an old L1 compression fracture and a new L2 compression fracture, as well as spondylosis at L4-5 and L5-S1. (*Id.*)

In October 1999, claimant's attorney wrote to Dr. Ballard and asked if he agreed with Dr. Davies' opinion that claimant's work activities were the major contributing cause of his multiple compression fractures. (Ex. 66). Dr. Ballard did not concur and he explained:

> "Compression fx [fracture] can be caused by trauma which requires significant force. They can also be seen in pts with osteoporosis where the bone is weakened resulting in being more susceptible to fx and compression. Certainly, repetitive lifting can apply [increased] stress to the lower back and over time result in [increased] pain. Without a specific episode of trauma I cannot state that work is the major contributing cause. Certainly, it is a factor but his osteoporosis makes him more susceptible and is more of a factor. We see many patients who do repetitive lifting but do not have compression fx. I cannot state that the work is the major contributing cause. Since there is not one specific traumatic event.
>
> "I have seen him only 2 times. Dr. Davies has seen him many times and maybe has more info than I do. If his history doesnt show any significant falls or trauma then I cant conclusively state that repetitive lifting causes compression fx." (Ex. 66-1, -2).

Dr. Ballard did not agree that claimant's work activities were the major contributing cause of his multiple compression fractures. (Ex. 66). Dr. Ballard's history that claimant did not have a specific incident of trauma on March 18, 1999 is inconsistent with claimant's testimony at hearing. Because we are not persuaded that Dr. Ballard had an accurate understanding of the onset of claimant's low back symptoms, we find that his causation opinion 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).

Nevertheless, claimant argues that, because the existence of a specific traumatic event was established, Dr. Ballard's opinion is sufficient to establish that his injury was the major contributing cause of his compression fractures.

We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). A medical opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516 (1999); *Worldmark the Club v. Travis*, 161 Or App 644 (1999).

When Dr. Ballard's reports are reviewed as a whole, we find that his opinion is not sufficient to establish compensability. In 1996, Dr. Ballard indicated that claimant had osteoporosis. In October 1999, Dr. Ballard said that compression fractures may be seen in patients with osteoporosis where the bone is weakened, which results in being more susceptible to fractures and compression. (Ex. 66-1). He explained:

> "Without a specific episode of trauma I cannot state that work is the major contributing cause. Certainly, it is a factor but his osteoporosis makes him more susceptible and is *more of a factor.*" (Ex. 66-1; emphasis supplied).

In light of Dr. Ballard's comments regarding the significance of claimant's osteoporosis, we are unable to determine on this record what Dr. Ballard's opinion would have been, had he been aware that claimant did indeed have a specific incident of trauma on March 18, 1999. Our findings must be based on medical evidence in the record and the reasonable inferences that can be drawn from the medical evidence. *SAIF v. Calder*, 157 Or App 224, 227-28 (1998). In assessing major contributing cause, we must rely on evidence from medical experts and we cannot attempt to supply our own diagnosis. *SAIF v. Strubel*, 161 Or App at 520-21. In any event, we note that Dr. Ballard did not even diagnose a T12 compression fracture and his opinion provides no support for compensability of that condition. We conclude that Dr. Ballard's opinion is not sufficient to establish compensability of claimant's T12 and L2 compression fractures.

Claimant also relies on the opinion of Dr. Davies to establish compensability and he contends that we should defer to his opinion as a treating physician.

Dr. Davies has been treating claimant at least since 1969. (Ex. 1). Dr. Davies treated claimant for his injury in August 1996, after he fell through a ceiling and landed on some rafters. (Ex. 13). X-rays on August 6, 1996 showed "[c]ompression fracture of a vertebra in the lumbodorsal region, probably T12 or L1. This is not necessarily recent." (Ex. 12). On August 7, 1996, Dr. Davies reported that "X-rays show compression fx of spine. This injury is old!" (Ex. 13).

On March 2, 1999, claimant sought medical treatment for chest and abdominal pain. (Ex. 23). A chest x-ray on that date showed that "[v]ertebral body height loss is again observed at or superiorly at what I take to be T12, compatible with insufficiency fracture." (Ex. 24). On March 8, 1999, Dr. Davies examined claimant and noted that his x-rays had been compared with the August 1996 films. (Ex. 26). Dr. Davies commented: "old compression T12 and L1 osteoporotic?? worse??" (*Id.*)

After the March 18, 1999 work injury, claimant sought emergency room treatment on March 29, 1999 and was examined by Dr. Davies on March 30, 1999. (Exs. 26, 34). Dr. Davies reported that claimant had experienced low back pain that knocked him to his knees. (Ex. 26). On April 5, 1999, Dr. Davies' chart note said: "Newer lumbar spine x-rays - spondylosis, facet arthropathy, and new compression L9??" (Ex. 37; underline in original).

In response to an October 1, 1999 letter from claimant's attorney, Dr. Davies said that claimant's current diagnosis was generalized osteoporosis and "multiple compression fractures -- spine." (Ex. 64A). He answered "yes" when asked if claimant's work activities were the major contributing cause of his diagnoses and need for treatment. (*Id.*) Dr. Davies said that claimant had preexisting osteoporosis. (*Id.*) He noted "without the injury -- he would still be working even with the osteoporosis." (*Id.*)

In a concurrence letter from claimants attorney, Dr. Davies agreed that claimant's "T12 and L2 compression fractures were related (> 51%) to the March 13, 1999 [sic] lifting incident at work." (Ex. 65). Claimants attorney subsequently wrote to Dr. Davies and asked whether, after reviewing Dr. Farris' report, he still believed that claimant's work was the major contributing cause of the L2 compression fracture. (Ex. 68). Dr. Davies explained: "The L2 infraction noted in 1970 was a minimal compression of the cortical plate of L2. This (obviously) stabilized for a period of many years until he had further trauma." (*Id.*)

In light of claimant's preexisting osteoporosis and previous compression fractures, we find that the dispute about causation of the T12 and L2 compression fractures involves expert analysis rather than expert external observations and, therefore, Dr. Davies' 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).

Moreover, we find that Dr. Davies' reports on causation are not persuasive because they are inconsistent and lack adequate explanation. Dr. Davies agreed that claimant's T12 compression fracture was related in major part to the "March 13, 1999 lifting incident at work." (Ex. 65). After claimant's 1996 injury, however, the August 6, 1996 x-rays showed "[c]ompression fracture of a vertebra in the lumbodorsal region, probably T12 or L1." (Ex. 12). On August 7, 1996, Dr. Davies reported that "X-rays show compression fx of spine. This injury is old!" (Ex. 13). In addition, claimant's March 2, 1999 x-rays, taken *before* the March 18, 1999 work incident, showed "[v]ertebral body height loss is again observed at or superiorly at what I take to be T12, compatible with insufficiency fracture." (Ex. 24). Dr. Davies' March 8, 1999 chart note referred to claimant's recent x-rays and said: "old compression T12 and L1 osteoporotic?? worse??" (Ex. 26).

Thus, the medical reports, including those of Dr. Davies, show that claimant had a compression fracture at T12 as early as August 1996. Because Dr. Davies did not discuss or explain the previous medical reports regarding the T12 condition, we find that his opinion that the T12 compression fracture was related, in major part, to the March 1999 work incident is entitled to little weight.

Furthermore, Dr. Davies' comment that "without the injury he would still be working even with the osteoporosis" (Ex. 64A), establishes only that he believed the work activity was the precipitating cause of claimant's T12 and L2 compression fractures. We find that Dr. Davies' explanation is no more than the "precipitating cause" analysis that was rejected in *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995).

In sum, we conclude that the opinion of Dr. Davies is insufficient to establish that claimant's work injury was the major contributing cause of his T12 or L2 compression fractures. None of the remaining medical opinions support compensability. Drs. Bald and Farris examined claimant in June 1999, but they needed additional medical records and recommended further diagnostic tests. (Ex. 58). On October 11, 1999, Dr. Farris reviewed additional records and reported that claimant had a long history of osteoporosis and associated vertebral compression fractures. (Ex. 67-5). She noted that, as early as August 1970, claimant had compression fractures of T12, L1 and L2. (*Id.*) She explained that the recent bone density studies showed that claimant had severe osteopenia/osteoporosis at multiple vertebral levels. (*Id.*) Dr. Farris concluded that claimant's various vertebral compression fractures were not related to trauma. (*Id.*) We conclude that the medical evidence is not sufficient to establish compensability of claimant's T12 or L2 compression fractures.

ORDER

The ALJ's order dated February 10, 2000 is reversed in part and affirmed in part. The insurer's denial of claimant's T12 and L2 compression fractures is reinstated and upheld. The attorney's fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
LEE A. PERKINS, Claimant
WCB Case No. 99-04274
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Schwabe, Williamson, & Wyatt, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's T7-8 disc herniation condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On June 13, 1998, claimant went to the emergency room after experiencing severe chest pains at work. The insurer accepted a T7-8 disc bulge.

The insurer, however, subsequently denied a claim for T7-8 disc herniation. The ALJ set aside the denial after finding that the opinion of the treating surgeon, Dr. Van Pett, was the most persuasive because it was "based on the history which is the law of the case" that claimant had the onset of severe chest pain when he lifted a 50-pound sack of potatoes at work. The ALJ reasoned that such a history was the "law of the case" because the insurer accepted a claim for T7-8 disc bulge and claimant provided such a history on his 801 form.

On review, the insurer argues that the "law of the case" doctrine does not apply in the absence of a binding decision by an appellate body concerning the compensability of the T7-8 disc herniation. The insurer further contends that claimant failed to prove compensability of such condition because Dr. Van Pett's opinion is based on an inaccurate history.

"Law of the case" applies when "a ruling or decision has been once made in a particular case by an appellate court"; the effect "is binding and conclusive both upon the inferior court in any further steps or proceedings in the same litigation and upon the appellate court itself in any subsequent appeal or other proceeding for review." *Blanchard v. Kaiser Foundation Health Plan of the Northwest*, 136 Or App 466, 470, (1995).

For instance, in *Kuhn v. SAIF*, 73 Or App 768, 772 (1985), the court decided, on *de novo* review of an aggravation claim, to disregard a doctor's opinion that the injury resulted from non-work related abnormalities because an ALJ, in a previous proceeding, had determined that the injury was compensable. Thus, the court found that the doctor's opinion conflicted with "the law of the case, which is that permanent disability resulted from her industrial injury." Consistent with *Kuhn*, the Board has rejected physicians' opinions when they are based on finding that a compensable or accepted condition is not work-related. *E.g., Charles R. Wright*, 50 Van Natta 1150, 1151 (1998).

Here, we agree with the insurer that its acceptance of a T7-8 disc bulge does not mean that the "law of the case" includes a history that it was caused when claimant lifted a 50 pound bag of potatoes at work on June 13, 1998. The insurer's Notice of Acceptance refers only to the condition of "thoracic 7-8 buldge [sic]"; there is nothing showing that such acceptance was based on any particular history. Moreover, this proceeding concerns the insurer's denial of a T7-8 *disc herniation;* there is no contention that this condition is the same as the accepted disc bulge.

Consequently, consistent with *Kuhn*, we evaluate the medical opinion in light of the "law of the case," which is that the insurer previously accepted a T7-8 disc bulge.

The record contains numerous opinions concerning claimant's T7-8 disc herniation. On June 13, 1998, claimant sought treatment from the emergency room; those records show that he reported a history of intermittent chest pain during the previous weeks that had become severe and continuous at work. (Ex. 1-3). The records also showed that his onset of pain was while "shuffling papers." (Ex. 2-1). Claimant saw Dr. Zastrow the next day, who recorded that claimant's chest discomfort had begun a month previously when claimant began a workout program. (Ex. 3-1).

In October, claimant had an MRI that showed a bulging disc at T7-8. On referral to Dr. Vajda, claimant indicated that, on June 13, 1998, he lifted a 50 pound bag of potatoes and had the onset of chest and back pain. (Ex. 7-1). Dr. Vajda also noted that claimant was "completely free of symptoms" prior to this event. (*Id.*) Dr. Van Pett recorded essentially the same history. (Ex. 9-1).

After the insurer accepted the disc bulge, examining neurosurgeon, Dr. Thomas Rosenbaum, saw claimant. Based on imaging studies, Dr. Rosenbaum diagnosed a herniated disc at T7-8. (Ex. 45-5). Dr. Rosenbaum considered the abnormality to be degenerative, "not likely capable of causing spinal cord compression and generally asymptomatic." (Ex. 46-1). Thus, Dr. Rosenbaum considered claimant's symptoms to be musculoskeletal in nature and, assuming that they were work-related, constituted only a thoracic strain. (*Id.* at 1-2).

Dr. Van Pett disagreed with Dr. Rosenbaum's opinion, first noting that she relied on a different history. (Ex. 51). Dr. Van Pett also noted that, "at surgery, [claimant] clearly had a disc herniation at the thoracic region." (*Id.*)

After reviewing the surgical reports, Dr. Rosenbaum continued to find no evidence of a herniated disc. Instead, Dr. Rosenbaum thought that a thoracic strain caused claimant's need for treatment and such condition was medically stationary. (Ex. 54-1).

Dr. Richard Rosenbaum, neurologist, then reviewed the records. Dr. Rosenbaum found it possible that the disc herniation caused claimant's chest pain on June 13, 1998, but noted that such abnormalities "are often asymptomatic, and at no point did he have a documented classic neurologic finding of disc herniation." (Ex. 56-6). Furthermore, Dr. Rosenbaum stated that, if based on a history of onset during a lifting incident, then claimant's condition was caused by that event. (*Id.* at 7). Dr. Rosenbaum noted, however, that this history was not consistent with the early medical records; based on a history consistent with those reports, Dr. Rosenbaum did not consider claimant's condition to be work-related. (*Id.*)

Before the acceptance of the thoracic bulge and based only on claimant's statement that he had the onset of severe chest pain while lifting a 50 pound bag of potatoes at work, examining physicians Dr. Denekas and Dr. James had found that the lifting incident was the major contributing cause of claimant's need for treatment. (Ex. 21). After reviewing the early medical records, both physicians found that, based on the history recorded there, the work incident was not the major contributing cause of the herniated disc. (Exs. 57-3, 58-3).

Dr. Van Pett was asked her opinion based on a history that claimant had prior chest pain before June 13, 1998. Dr. Van Pett responded that her opinion remained unchanged. (Ex. 61-1). Dr. Van Pett also stated that claimant did not have a "significant pre-existing condition" and the work injury was the major contributing cause of claimant's need for treatment and surgery. (*Id.*) Dr. Van Pett also explained why the operative report did not specifically mention removal of a herniated disc. (*Id.*)

Finally Dr. Denekas explained during a deposition that claimant's symptoms on June 13, 1998 were consistent with a lifting event and that the onset of pain could have been caused by a herniated disc at T7-8. (Ex. 62-8, 62-16). Dr. Denekas further explained, however, that he changed his previous opinion that the lifting incident was the major contributing cause when based on a history that claimant was performing "paperwork" rather than lifting when he had the onset of chest pain. (*Id.* at 21).

In assessing medical evidence, we generally defer to the treating physician's opinion, absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, because Dr. Van Pett relied on a history that claimant was lifting when he had the onset of chest pain on June 13, 1998, we find persuasive reasons not to defer to her opinion.

In particular, as described above, records from the emergency room and Dr. Zastrow show that claimant had intermittent chest pain some time before June 13, 1998 and, more importantly, was "shuffling papers" when he had the onset of chest pain on June 13, 1998. Claimant did not provide a history of chest pain while lifting potatoes until he saw Dr. Vajda in October 1998. Although Dr. Van Pett stated that her opinion was unchanged assuming prior chest pain, she did not provide an opinion based on a history as provided in the emergency room records; instead, Dr. Van Pett provided an opinion based only on a history of chest pain while lifting at work.

We find this factor significant because the opinions of Dr. James and Dr. Denekas changed after they reviewed the emergency room records. That is, when based on the history assumed by Dr. Van Pett, those physicians also thought that the lifting incident was the major contributing cause of claimant's thoracic condition. After learning of claimant's reports that he had the onset of chest pain while performing paperwork, however, neither physician attributed the disc herniation to work activities.

Thus, we find Dr. Van Pett's opinion insufficient to carry claimant's burden of proof and conclude that claimant failed to prove compensability.

ORDER

The ALJ's February 1, 2000 order is reversed. The insurer's denial of claimant's T7-8 disc herniation condition is reinstated and upheld. The ALJ's attorney fee award also is reversed.

In the Matter of the Compensation of
DONALD L. WEBB, Claimant
WCB Case Nos. 99-07552, 99-06457 & 99-01887
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Reinisch, et al, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its responsibility denial of claimant's right knee tricompartmental degenerative joint disease; (2) upheld EBI Insurance Company's responsibility denial of the same condition; and (3) and upheld Lumbermens Alliance's responsibility denial of the same condition. On review, the issue is responsibility.

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

While working for the employer, claimant sustained three right knee injuries: the first, in 1971, was accepted by SAIF; the second, in 1983, was accepted by EBI; and the last, in 1987, Lumbermens accepted. The three insurers disputed responsibility for claimant's current right knee degenerative joint condition.

The ALJ determined that SAIF was the responsible carrier for this condition based on medical evidence that the 1971 injury was the major contributing cause of the right knee condition. On review, SAIF contends that *James A. Hoyt*, 52 Van Natta 346 (2000), and *Safeco Ins. Co. v. Victoria*, 154 Or App 574 (1998), provide the proper analytical framework. SAIF also asserts that EBI should be held responsible for claimant's right knee condition because it failed to prove that its 1983 injury did not contribute, even slightly, to the tricompartmental degenerative joint disease. *See also Mission Ins. Co. v. Dundon*, 86 Or App 470 (1987). We disagree with SAIF's legal analysis.

The cases on which SAIF relies differ significantly from this one. In *Victoria*, the issue was responsibility in the first instance. There were no accepted injuries in that case. 154 Or App at 576. In *Hoyt*, there was only one accepted injury and the issue was whether the claimant sustained a new injury or an aggravation of the accepted injury. 52 Van Natta at 346-48.

In contrast to *Victoria* and *Hoyt*, the issue here is responsibility for the disputed right knee condition in the context of multiple accepted injuries. Under these circumstances, we apply the rebuttable presumption of *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984), unless the medical evidence establishes that an injury is the major contributing cause of the consequential right knee degenerative condition. *See Conner v. B&S Logging*, 153 Or App 354 (1998); *Thomas L. Hinson*, 51 Van Natta 1942, 1944 (1999); *Terry J. Rasmussen*, 51 Van Natta 1287, *on recon* 51 Van Natta 1397 (1999).[1]

Here, we agree with the ALJ that the medical evidence establishes that the 1971 SAIF injury is the major contributing cause of claimants consequential right knee condition. SAIF is, therefore, responsible for the current right knee degenerative condition under ORS 656.005(7)(a)(A). *See Albert H. Olson*, 51 Van Natta 685, 687 (1999).

ORDER

The ALJ's order dated February 3, 2000 is affirmed.[2]

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[1] SAIF argues that the court's reference to the major contributing cause standard in *Conner* was *dicta*. It contends that this is not the proper standard for determining responsibility in this case. We disagree with SAIF's assertions. Having reviewed *Conner*, we are persuaded that the court's application of the major contributing cause standard of ORS 656.005(7)(a)(A) was necessary in determining the responsibility issue in that case and that the ALJ appropriately applied that standard here. *See Conner*, 153 Or App at 358-59.

[2] The ALJ awarded the maximum attorney fee of $1,000 under that ORS 656.308(2)(d). Because we do not find extraordinary circumstances justifying a greater fee, we do not award an assessed fee for claimants counsels services on review regarding the responsibility issue.

In the Matter of the Compensation of
VICKI L. MANGUM, Claimant
WCB Case No. 99-08729
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The Workers' Compensation Division (Division), on behalf of its assigned claims agent, Johnson and Culberson, Inc. (JCI), requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that directed JCI to accept "authorization of palliative services, processing and payment thereof." On review, the issue is jurisdiction. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We summarize the material facts regarding the palliative care request.

Claimant injured her low back on July 22, 1987 while working for a noncomplying employer. The SAIF Corporation, as the then-statutory processor, accepted the claim for "disc herniation at L5-S1, right side." (Ex. 9). The claim was closed by a May 5, 1994 Notice of Closure.

On April 27, 1999, Dr. Sproat, claimant's attending physician, filed a palliative care request. By May 1999, JCI had become the assigned claims agent. On May 14, 1999, JCI wrote to Dr. Sproat, denying palliative treatment, stating that the current medical treatment did not appear to be related to claimant's injury claim. (Ex. 80).

Thereafter, review before the Division's Medical Review Unit (MRU) was requested. On October 25, 1999, MRU issued a Defer and Transfer Order that deferred the Director's administrative review and transferred the dispute regarding the causal relationship to the Workers' Compensation Board. The order stated:

> "After compensability is resolved, the [ALJ] is requested to submit a copy of this order or settlement document to the director (Medical Review Unit). The director will then resume administrative review."[1] *See* ORS 656.704(3) and (4).

The ALJ concluded that the palliative care requested by Dr. Sproat was materially related to the compensable claim. The ALJ then ordered:

> "Johnston and Culberson's May 14, 1999, letter to Dr. Sprout denying the proposed treatment as not related to the July 22, 1997 [sic], accepted L5-S1 disc herniation, is disapproved and set aside, with claimant's claim remanded to said claims processor to [sic] acceptance, authorization of said palliative services, processing and payment thereof."

CONCLUSIONS OF LAW AND OPINION

JCI does not dispute that portion of the order that set aside the denial of the disputed treatment because the treatment is causally related to the compensable claim. But JCI contends that the ALJ lacked authority to order it to authorize the palliative care, to process it and to pay for it. We agree.

ORS 656.245 governs compensability of palliative care, which consists of two components: (1) it is causally related to the compensable injury; (2) it meets other criteria, *e.g.*, is it necessary to enable

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[1] The Division asks that we take administrative notice of this document to supplement the record. We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," such as a Department order or filing with the Board. *See e.g., Grace B. Simpson*, 43 Van Natta 1276, 1277 (1991). The Director's order is the type of document of which we may take administrative notice. Accordingly, we will consider the Director's October 25, 1999 order.

claimant to continue current employment. In 1999, the legislature amended ORS 656.704(3)(b), which addresses jurisdiction regarding medical service disputes between the Workers' Compensation Board and the Division. ORS 656.704(3)(b) provides in relevant part:

> "The respective authority of the board and the director to resolve medical service disputes, other than disputes arising under ORS 656.260, shall be determined according to the following principles:
>
> "(A) Any dispute that requires a determination of the compensability of the medical condition for which medical services are proposed is a matter concerning a claim.
>
> "(B) Any dispute that requires a determination of whether medical services are excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, or a determination of whether medical services for an accepted condition qualify as compensable medical services among those listed in ORS 656.245(1)(c), is not a matter concerning a claim.
>
> "(C) Any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim.
>
> "(D) The board and the director shall adopt rules to facilitate the fair and orderly determination of disputes that involve matters concerning a claim and additional issues. Such rules shall first require the determination of those issues that are matters concerning a claim."

Consistent with ORS 656.704(3)(b)(D), the Board and Director have adopted rules that provide that the causation question be determined first by the Board and its Hearings Division, before the additional issues. *See* OAR 436-009-0008(2)(b), (d); and 436-010-0008(4), (6).[2] Once causation is resolved, the Director proceeds with review of any remaining medical service dispute.

In sum, under this statutory scheme, the Board has jurisdiction over matters concerning a claim and the Director has jurisdiction over all other medical service disputes. Thus, the Board's jurisdiction is limited to resolution of disputes over the compensability of medical conditions and over whether medical treatment is causally related to the compensable injury. This dispute is to be decided first.

The dispute before the ALJ was over the causal relationship of the disputed palliative care to claimant's accepted injury. Under ORS 656.704(3)(b)(C), that dispute was properly under the jurisdiction of the ALJ. However, the ALJ had no authority over whether the disputed treatment qualified as compensable medical services under ORS 656.245 or whether JCI was required to pay for the requested medical services. Rather, these portions of the dispute were subject to the Director's jurisdiction once causation was resolved. We accordingly vacate that portion of the ALJ's order that stated: "[W]ith claimant's claim remanded to said claims processor to acceptance, authorization of said palliative services, processing and payment thereof."

ORDER

The ALJ's order dated February 10, 2000 is vacated in part and affirmed in part. That portion of the ALJ's order stating: "[W]ith claimant's claim remanded to said claims processor to acceptance, authorization of said palliative services, processing and payment thereof[]" is vacated. The remainder of the order is affirmed.

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[2] *See also* Board's Order of Adoption, WCB Admin. Order 2-1999 (temp.) amending OAR 438-005-0046, in which "filing" with the Board is accomplished by filing a request for administrative review with the Director, provided that the request involves a dispute that requires a determination of either the compensability of the medical condition for which medical services are proposed or whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability. Consistent with these amendments, the Director transferred the causation dispute to the Hearings Division.

In the Matter of the Compensation of
KATHLEEN A. SANETEL, Claimant
WCB Case No. 99-02456
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Paul Louis Roess, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the self insured employer's denial of her occupational disease claim for a bilateral foot condition. On review the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation. Specifically, we address claimant's contention that the ALJ incorrectly discounted Dr. Wisdom's opinion because it was not based upon complete information and therefore, was not persuasive.

Claimant agrees that Dr. Wisdom did not review the December 10, 1998, x-ray of claimant's right foot. Nevertheless, claimant argues that Dr. Wisdom's opinion is based upon complete information because Dr. Wisdom reviewed several other imaging studies of claimant's right foot and did not find evidence of a Taylor's bunionette.[1] We disagree.

It is the December 1998 x-ray from which Drs. Gambee and Gardner, who saw claimant at the request of the employer, diagnosed a Taylor's bunionette in claimant's right foot. Dr. Wisdom is not in a position to discount the interpretations of Drs. Gambee and Gardner if he has not reviewed that x-ray. Accordingly, we agree with the ALJ that Dr. Wisdom's opinion is based upon incomplete information and therefore not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

ORDER

The ALJ's order dated February 18, 2000 is affirmed.

[1] The consensus of medical opinion, including the opinion of Dr. Wisdom on whom claimant relies, is that if claimant has a Taylor's bunionette in her right foot, her right foot condition is genetic in nature and not work related.

In the Matter of the Compensation of
TERRI A. BRIGGS, Claimant
Own Motion No. 94-0730M
OWN MOTION ORDER
Foster A. Glass, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

On December 14, 1994, we authorized reopening of claimant's claim for the payment of temporary disability compensation beginning November 28, 1994, the date claimant underwent surgery. The self-insured employer issued a September 15, 1998 Notice of Closure which closed claimant's claim with an award of temporary disability compensation from November 28, 1994 through April 1, 1998. In a January 12, 1999 Own Motion Order Reviewing Carrier Closure, we set aside the employer's September 15, 1998 Notice of Closure and remanded the claim to the employer for further processing in accordance with law. *Terri A. Briggs-Tripp*, 51 Van Natta 21 (1999). In that order, we also noted that, when appropriate, the claim shall be closed by the employer pursuant to OAR 438-012-0055. The employer requested reconsideration of our January 12, 1999 order and, on March 19, 1999, we adhered to and republished our prior order. *Terri A. Briggs-Tripp*, 51 Van Natta 456 (1999). No further reconsideration or appeal was requested; thus, our prior orders became final by operation of law. Claimant now requests enforcement of our January 12 and March 19, 1999 orders (in addition to penalties and attorney fees), contending that the employer unreasonably failed to pay benefits as directed by those orders.

In response, the employer relies on ORS 656.268(4)(d),[1] which states that temporary disability compensation may be terminated upon the occurrence of "any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4)[.]" The employer contends that it has not paid claimant's temporary disability benefits because it has not received any medical documentation authorizing said benefits. Arguing that our holdings in *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996), *Brian Lutz*, 50 Van Natta 1421 (1998) and *Robert Eubank*, 51 Van Natta 669 (1999) should be disavowed, the employer contends that the Court of Appeals decision in *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, *rev dismissed* 329 Or 503 (1999), is controlling. We disagree with the employer's contentions.

In *Bundy*, the court reversed our decision in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), that held that the 14 day limitation on "retroactive" temporary disability authorization from an attending physician set forth in ORS 656.262(4)(g),[2] was not applicable to "substantive" temporary disability awarded at the time of claim closure. After review the legislative history of ORS 656.262(4), the court concluded that the statute's reference to ORS 656.268 was intended to limit the award of retroactive time loss to 14 days regardless of whether the claim was open or pending closure.

ORS 656.262(4)(g) provides that temporary disability is not due and payable *"pursuant to ORS 656.268* after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician." (Emphasis added). The statute further provides that no temporary disability authorization "*under ORS 656.268* shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance." (Emphasis added). 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.

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[1] During the time in question, the statute was numbered ORS 656.268(3)(d). In 1999, ORS 656.268(3)(d) (1997) was renumbered to ORS 656.268(4)(d). Or Laws 1999, ch 313, section 1. We refer to it by its current number.

[2] During the time in question, the statute was numbered ORS 656.262(4)(f). In 1997, ORS 656.262(4)(f) (1995) was renumbered to ORS 656.262(4)(g). Or Laws 1997, ch 639, section 7. We refer to it by its current number, as did the *Bundy* court. ORS 656.262(4)(g) provides:

> "Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

Here, unlike in *Bundy*, temporary disability compensation has been authorized under *ORS 656.278*,[3] not *ORS 656.268*. As discussed in *Knudson* and its progeny, the issue is whether the employer could lawfully withhold or "terminate" temporary disability compensation pursuant to *ORS 656.278* or our "own motion" rules. Although the employer argues that *Knudson* was wrongly decided, we decline to revisit the case, and rely on it as controlling precedent.[4]

Regarding own motion claims, temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(4)(a) through (c). *See* OAR 438-012-0035(4).

Unlike benefits payable under ORS 656.268, temporary disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or Board authorization. *See* OAR 438-012-0035(1). Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Knudson*, 48 Van Natta at 1710. In *Knudson*, we reasoned that, because an attending physician's time loss authorization is not required for commencement of temporary disability benefits pursuant to ORS 656.278, the lack of such authorization is not a basis for the withholding or "termination" of such benefits. *Id.*

Our January 12, 1999 order, as reconsidered March 19, 1999, set aside the employer's Notice of Closure, which necessarily reinstated the employer's obligation to pay temporary disability benefits as set forth in our December 14, 1994 order that reopened the claim. Claimant's attending physician may not have provided the employer with written time loss authorizations; nonetheless, based on the *Knudson* rationale, such a failure does not constitute grounds to delay or terminate the payment of claimant's temporary disability benefits under OAR 438-012-0035(1). Consequently, claimant is entitled to temporary disability benefits beginning April 1, 1998, the date the employer stopped paying such benefits.

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[3] After aggravation rights have expired on a claim, the Board has exclusive jurisdiction to authorize the reopening and processing of that claim under ORS 656.278 and OAR Chapter 438, Division 012. *See Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). 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[.]"

[4] We note that, in arguing *Knudson* was wrongly decided, the employer contends that the legislature intended the requirement of an attending physician's authorization for time loss and the prohibition of retroactive authorization beyond 14 days to apply to own motion claims as well as "regular" claims. The employer argued that this legislative intent is demonstrated by the text and context of ORS 656.262(4)(g) and 656.268. What the employer failed to consider is that, although ORS 656.262(4)(g) explicitly refers to ORS 656.268, it does *not* refer to ORS 656.278. In addition, ORS 656.278 does not reference either ORS 656.262(4)(g) or 656.268. Furthermore, although ORS 656.278 was amended in 1995 in the same Senate Bill that added *former* ORS 656.262(4)(f), now ORS 656.262(4)(g), the only substantive amendment to ORS 656.278 specified that benefits under ORS 656.278(1) do not include vocational assistance benefits. *See* ORS 656.278(2). No amendment was made to ORS 656.278 that addressed the limitations added by *former* ORS 656.262(4)(f). Thus, contrary to the employer's argument, the text and context of the statutes do not establish that the legislature intended the restrictions provided in ORS 656.262(4)(g) to apply to ORS 656.278. To the contrary, inclusion of a reference to ORS 656.268 in ORS 656.262(4)(g) and the lack of any corresponding reference to ORS 656.278 in that statute supports a finding that the legislature did *not* intend the restrictions provided in ORS 656.262(4)(g) to apply to ORS 656.278. The employer's reliance on legislative history contains the same flaw, *i.e.*, none of the legislative history cited by the employer refers to benefits payable under ORS 656.278. Thus, we do not find the employer's legislative intent argument persuasive.

Claimant requests that we assess penalties against the employer for its failure to pay temporary disability compensation. A carrier is liable for a penalty of up to 25 percent of the amounts then due when it "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). In determining whether a delay or refusal to pay compensation is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

Here, the employer's reliance on ORS 656.268(4)(d), in support of its failure to pay temporary disability benefits, is contrary to existing case law and Board rules. *Jeffrey T. Knudson*, 48 Van Natta at 1709-10; *Robert L. Eubank*, 51 Van Natta at 669-70; *Janet F. Berhorst*, 51 Van Natta 1008, 1009 (1999). The employer's "grounds" (the need for a physician's authorization before paying temporary disability benefits) for its failure to pay temporary disability benefits is neither authorized by Board rule or case precedent. *See Id.*; OAR 438-012-0035(1). Additionally, we do not find the employer's reliance on *Bundy* or its disagreement with our decision in *Knudson* and its progeny, constitute valid grounds for its refusal to recommence temporary disability compensation as awarded in our prior orders. As addressed above, *Bundy* did not involve interpretation of ORS 656.278, the statute under which claimant's claim was ordered reopened. Therefore, *Bundy* provided the employer no reasonable basis to refuse to pay temporary disability benefits on this claim. Thus, we find that the employer's reasons for failing to timely comply with our January 12, 1999 order, as reconsidered on March 19, 1999, did not provide it with a legitimate doubt regarding its liability to pay claimant compensation as granted by our orders.

Therefore, under ORS 656.262(11)(a), we find that the employer's termination of claimant's temporary disability benefits was unreasonable. Consequently, we assess a penalty of 25 percent penalty of the amounts "then due" a result of our order, payable in equal shares to claimant and her attorney. *See Janet F. Berhorst*, 51 Van Natta at 1009; *John R. Woods*, 48 Van Natta 1016 (1996); *Jeffrey D. Dennis*, 43 Van Natta 857 (1991).

Accordingly, the employer is directed to recommence temporary disability compensation beginning April 1, 1998, the date it terminated compensation, until it can lawfully terminate such benefits. The penalty assigned by this order shall be based on the unpaid temporary disability compensation made payable by this order between April 1, 1998, and the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA L. MARTIN, Claimant
WCB Case No. 98-03892
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Bruce Bornholdt (Saif), Defense Attorney
James W. Moller, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's injury claim for a cervical condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation to address SAIF's contentions that: (1) the record does not support a finding that claimant suffered a cervical injury in February of 1997; and (2) the ALJ incorrectly relied on the opinion of Dr. Tiley, claimant's treating physician, as opposed to other medical examiners.

On February 26, 1997, claimant was attempting to open a heavy metal door, in order to enter the employer's premises, when the doorknob came off in her hand. The sudden release of the doorknob caused claimant to fall backward down two concrete stairs, where she came to rest on her left side with her head and shoulder pressed up against a cement wall.

Dr. Tiley opined that, based upon the description of the event, claimant suffered an indirect trauma to the cervical area superimposing a strain on her preexisting degenerative process.[1] (Ex. 56-2). Specifically, Dr. Tiley concluded that the falling incident of February 1997 superimposed a cervical strain on claimant's preexisting cervical spondylosis thereby aggravating the cervical spondylosis causing a cervical radiculopathy.

To establish that her cervical condition is compensable, claimant must show that the work incident was the major contributing cause of the disability or her need for treatment of this combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101 (1993). Because of claimant's preexisting condition and the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Relying on claimant's testimony describing the fall and the medical opinion of Dr. Tiley, the ALJ found that claimant established the compensability of her cervical condition. The ALJ found Dr. Tiley's opinion to be based upon complete information and the most persuasive in discussing all the aspects of claimant's symptoms, her early medical care for the injury, the various diagnostic tests, and the clinical findings. We agree with the ALJ.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find no persuasive reasons not to defer to Dr. Tiley's opinion.[2]

Dr. Tiley opined that the major contributing cause of claimant's need for treatment for cervical condition was the 1997 fall that pathologically worsened claimant's preexisting cervical spondylosis. His opinion is supported by: (1) x-ray studies, as interpreted by both Dr. Tiley and Dr. McKillop, showing

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[1] SAIF does not contend that the event did not occur, as SAIF has previously accepted claimant's left distal humerus fracture that arose out of this same incident. (Ex. 22).

[2] SAIF argues that because this claim involves expert analysis, as opposed to expert observation that Dr. Tiley's opinion is not entitled to any special weight. We find Dr. Tiley's opinion to be the most complete and best reasoned opinion in this medical record. Accordingly, we find it the most persuasive absent any special weight.

a progression of the cervical spondylosis condition since claimant's fall; and (2) a cervical myelogram and a post-myelogram CT scan performed in May 1998, showing root-sleeve impression bilaterally at C6 and on the left side at C7 correlating with claimant's left upper extremity symptoms.[3] His opinion is further bolstered by Dr. McKillop's statement that increased neck and left upper extremity symptoms shortly after the fall would indicate significant pathologic worsening or aggravation of claimant's condition from the fall.[4]

Immediately after the fall, claimant presented with sufficient left upper extremity symptoms that Dr. Foglesong, the initial treating physician, injected claimant's subacromial space with celestone and xylocaine.[5] Dr. Foglesong also referred claimant to Dr. Hiebert for left stellate ganglion blocks, which were administered on a regular basis from February 1997, through April 1997. Considering all these circumstances, we find persuasive Dr. Tiley's reasoning that the treatment claimant received for the erroneously diagnosed reflex sympathetic dystrophy masked her cervical symptoms delaying the ultimate diagnosis of cervical radiculopathy.[6]

In conclusion, based upon Dr. Tiley's well reasoned and persuasive opinion, we find that claimant's work injury was the major contributing cause of her disability and her need for treatment for her combined cervical condition. Consequently, we affirm the ALJ's order that set aside SAIF's denial of that claim. Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,965, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief, and her counsel's uncontested request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 5, 1999 is affirmed. For services on review, claimant's attorney is awarded a $1,965 fee, payable by the SAIF Corporation.

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[3] The actual reports for those studies are not contained in the record. The interpretation of the results of those studies is contained in the August 3, 1998, report of Dr. McKillop, who saw claimant at the request of SAIF. (Ex. 57-2).

[4] SAIF argues that this statement, which supports a portion of Dr. Tiley's opinion, is taken out of context. We disagree. Dr. McKillop stated that if such symptoms were documented early on, then he would say that the fall did cause the aggravation. (Ex. 57-2). We note that Dr. McKillop does not think the medical record establishes that claimant's neck and upper left extremity symptoms started immediately after the fall.

[5] Dr. Foglesong administered his injections on the belief that claimant's left upper extremity symptoms represented reflex sympathetic dystrophy. This belief was in error as the medical record establishes that claimant does not have reflex sympathetic dystrophy.

[6] SAIF points out that Drs. Hubbard, Dordevich, Morton, Jones, and Smith, have been unable to conclude that claimant has a cervical radiculopathy. However, none of these examiners is aware of the findings shown by the May 1998, cervical myelogram and post-myelography CT scan. Because their opinions are based upon incomplete information, the opinions are not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

In the Matter of the Compensation of
MICHAEL A. McGARVEY, Claimant
WCB Case No. 98-07764
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Meyers, Bock and Biehl.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. On May 8, 1998, claimant filed a claim for an injury to his right knee which he alleged occurred as the result of stepping off of a curb and twisting his knee on March 17, 1998. On March 20, 1998, three days after the alleged work incident, Dr. Seier, M.D., treated claimant and reported that he complained of right knee pain for the previous five to six days, with "no clear injury, although [he] stands/walks for 7 hours straight at his job." (Ex. 2-1).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the ALJ did not include Exhibit 26, a May 27, 1999 report from Dr. Gritzka, examining orthopedist on claimant's behalf, among the list of exhibits admitted into the record. Nevertheless, the ALJ summarized that exhibit in the findings of fact and the parties refer to it in their briefs. Therefore, we find that Exhibit 26 was admitted into the record and include it in our review.

Based on the medical evidence, the ALJ found that claimant's work injury combined with his preexisting degenerative meniscus disease to cause disability or need for treatment. Thus, the ALJ found ORS 656.005(7)(a)(B)[1] applicable to claimant's claim. We adopt the ALJ's reasoning and conclusions that claimant's current right knee condition is a "combined condition" within the meaning of ORS 656.005(7)(a)(B). But we disagree with the ALJ's conclusion that claimant met his burden of proof under that statute.

Claimant has the burden of proving compensability of his right medial meniscus tear condition. ORS 656.266. Under ORS 656.005(7)(a)(B), claimant must prove that his work activities were the major contributing cause of his disability or need for medical treatment for his combined condition. *SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309 (1997). Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1997), *rev dismissed* 320 Or 416 (1995). Furthermore, given the combination of the preexisting right knee condition and the work injury, the determination of the major contributing cause is a complex medical question, the resolution of which requires medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420,

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[1] ORS 656.005(7)(a)(B) provides:

"(7)(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

* * * * * *

"(B) If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

424 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993) (when a case involves a medically complex condition, there must be expert medical evidence establishing causation). 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).

There are several inconsistencies in the history claimant provided regarding the alleged work injury.[2] In general, claimant alleges that he injured his right knee on March 17, 1998, when he twisted his knee stepping off a curb at work. However, when claimant first sought medical treatment on March 20, 1998, only three days after the alleged work incident, Dr. Seier, M.D., reported that claimant complained of right knee pain for five to six days, with "no clear injury, although [he] stands/walks for 7 hours straight at his job." (Ex. 2-1). Thus, although claimant argues that he told Dr. Seier that he twisted his leg at work, she expressly stated that there was no injury and that claimant complained of pain for five to six days. In addition, Dr. Seier's report is most contemporaneous with the alleged work incident.

Causation opinions were rendered by four orthopedists: (1) Dr. Gritzka; (2) Dr. Kaesche, claimant's treating surgeon; (3) Dr. Gambee, who examined claimant on behalf of the employer; and (4) Dr. Schilperoort, who performed a record review on behalf of the employer. After reviewing these opinions, we find that, at best, the medical evidence regarding causation is in equipoise.

As addressed above, to determine the major contributing cause of an injury, it is necessary to evaluate the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. The medical opinions discuss five factors as potential contributors to claimant's right medical meniscus tear: age, weight, valgus deformity (knock-kneed), degeneration of the knee, and the injury itself.

Claimant is 50 years old, weighs over 280 pounds, and has preexisting degenerative meniscus disease. The doctors agreed that at claimant's age there would be some evidence of degenerative meniscus disease. In addition, the consensus was that claimant's excess weight put two to three times the normal load on his knees. (Exs. 16-2, 18-31). Moreover, Dr. Gambee measured claimant's valgus deformity at 10 degrees, with over 5 degrees being significant. (Ex. 11-4). On the other hand, Dr. Gritzka stated that the valgus deformity was not sufficient to notice. Regarding the effect of the preexisting degenerative meniscus disease, Drs. Gambee and Schilperoort opined that claimant's preexisting degenerative meniscus disease was the major contributing cause of his medial meniscus tear. Drs. Gritzka and Kaesche disagreed and opined that the work injury was the major contributing cause of the tear.

Both Drs. Gritzka and Kaesche stressed the importance of an accurate history of the mechanism of injury from claimant and based their opinions on claimant's history of being asymptomatic prior to the injury and sustaining a distinct twisting injury to his knee while stepping off a curb at work. (Exs. 14, 17, 23-1, 18-11, 18-17, 18-27-32, 18-40, 18-42-43, 26). Dr. Gritzka opined that the mechanism of injury must be given major consideration and claimant described a substantial mechanism of injury. (Ex. 18-27-28). Based on claimant's description of stepping off the curb and twisting his knee, he concluded that the injury was caused by a combination of torsion under load and compression, forces that would produce a complex meniscal tear in an individual of normal weight. (Exs. 18-29-32).

All the doctors opined that the appearance of the meniscus tear would determine whether the tear was degenerative in nature, *i.e.*, caused in major part by the preexisting degenerative meniscus disease, or traumatic in nature, *i.e.*, caused by the work injury. The doctors also agreed that horizontal and oblique tears of the meniscus represent degenerative tears, whereas vertical tears represent traumatic tears. The doctors disagreed, however, as to whether claimant's meniscus tear was vertical or horizontal.

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[2] Claimant variously reported that he injured his knee stepping off a curb onto a rock or piece of wood (Ex. 1), stepping off of a curb that he did not see because he was writing on a clipboard (Ex. 4), and stepping off a curb getting out of a truck (Ex. 9). Mr. Cunningham, a coworker, testified that claimant told him he was injured by walking up and down curbs, not by stepping off of a curb onto a rock. (Tr. 30-31). Mr. Perius, the employer's loss prevention manager, testified that, on May 8, 1998, claimant told him the repetitiveness of walking up and down curbs had injured his knee, or crawling into the back of a trailer two days earlier might have led to the injury. (Tr. 33). Claimant did not file a workers' compensation claim until May 8, 1998.

Dr. Larson, M.D., performed an MRI that he read as showing a complex tear of the posterior horn of the medial meniscus. (Ex. 6). In addition, Dr. Kaesche took photographs of the interior of claimant's right knee during the January 8, 1999 surgery. Although the doctors base their decisions as to whether claimant's meniscus tear is vertical or horizontal on their review of the MRI and operative photographs, they reach opposite conclusions.

Relying on the MRI findings and the operative photographs, Drs. Gambee and Schilperoort opined that claimant's preexisting degenerative meniscus disease was the major contributing cause of his medical meniscus tear, which they determined was a degenerative tear rather than a traumatic tear. (Exs. 11, 13, 16, 20, 24, 25). Dr. Gambee found that the operative photos showed multiple tears of the meniscus in all directions, compatible only with a degenerative process. (Ex. 24-1). He also found that the meniscus tear itself had "the classic crab meat appearance of a degenerative meniscal tear. This tear is in the horizontal, the vertical, the coronal, and every other possible plane." (*Id.*). He found nothing in the photos to suggest an acute tearing situation. He also found the tears compatible with the MRI. He concluded that the operative photos confirmed his strong opinion that the preexisting degenerative processes in claimant's knee were the primary problem and the major contributing cause of the need for treatment. (Ex. 24-2).

Dr. Schilperoort also opined that the operative photos showed that the medial meniscus tear "demonstrates a highly complex nature with vertical, horizontal and oblique components most typically associated with a degenerative meniscus tear." (Ex. 25-2). He noted that the images on the photographs were degenerative, representative of very long-standing disease process, and showing significant "crab meat" appearance and fimbriation which is characteristic of a degenerative meniscus tear. (Ex. 25-3). He concluded that, taking the record as a whole, "namely, the innocuous mechanism of injury, the MRI scan, and now the intraoperative photos clearly, to this examiner, is indicative of a degenerative meniscus tear." (*Id.*).

Dr. Kaesche noted that he reported in his operative report an "interiorly based flap tear" but, according to the operative photographs, "the tear was vertically orientated." (Ex. 23-1). He also stated that claimant's report of twisting his knee stepping off of a curb was a sufficient mechanism of injury to cause a vertical tear of the medial meniscus. (*Id.*).

Dr. Gritzka found that the operative photographs did not show a "complex tear," which "is a term that describes an essentially macerated meniscus in which the whole meniscus appears as 'crab meat.'" (Ex. 26-2). But he earlier had opined that claimant had a "complex tear" due to the work injury. (Ex. 18-31). In addition, the MRI showed a "complex tear of the posterior horn of the medical meniscus." (Ex. 6). Dr. Gritzka disagreed with Dr. Schilperoort's characterization of the photographs as showing a significant "crab meat" appearance. But Dr. Gritzka noted that the photographs showed "fibrillation [sic] of the intermargin of the meniscus with multiple small strands of meniscal material" and a horizontal tear of the meniscus. (Ex. 26-1). According to Drs. Gambee and Schilperoort, these are indications of degenerative meniscus disease. On the other hand, Dr. Gritzka also noted that one of the photographs "is most consistent with a traumatic or vertical tear." (Ex. 26-2). Furthermore, he disagreed with Dr. Schilperoort's characterization of the mechanism of injury as "innocuous," finding claimant's description of the injury "biomechanically consistent with a medial meniscal tear." (*Id.*).

Generally, deference is given to the treating physician who was able to observe the affected body part during surgery. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988). However, although Dr. Kaesche performed claimant's surgery, he does not relate any surgical observations to his causation opinion. *Compare Mageske*, 93 Or App at 702 (treating surgeon's opinion found persuasive where he was able to observe the claimant's shoulder during surgery and indicated that there was no evidence that the claimant's condition was due to congenital defect); *Givens v. SAIF*, 61 Or App 490, 494 (1983) (treating surgeon's opinion found persuasive where he indicated that he saw no evidence during surgery that the claimant's that the claimant's thoracic outlet syndrome was the result of a congenital defect or a compressed artery). In this regard, Drs. Schilperoort and Gritzka agree that Dr. Kaesche's operative report does not identify any vertical meniscus tear. (Exs. 20-4, 25). Furthermore, regarding the operative photographs, Dr. Kaesche simply stated that the tear was "vertically orientated," without addressing the opinions of Drs. Gambee and Schilperoort, who adamantly state that the photographs showed tears in every plane and displayed the "crab meat" appearance typical of a degenerative meniscus tear.

Thus, the record contains medical opinions from four orthopedists regarding the cause of claimant's medial meniscus tear. After examining the same medical evidence, including the operative photographs, these four orthopedists provide two diametrically opposed opinions regarding causation. Given this, at best, the medical evidence regarding causation is in equipoise.

On the other hand, in rendering their causation opinions, including their discussion of the operative photographs, both Drs. Kaesche and Gritzka specifically rely on claimant's history of a distinct knee twisting incident while stepping off a curb at work. However, as discussed above, claimant's history is inconsistent. Most importantly, when he first sought medical treatment, only three days after the alleged work incident, claimant reported no specific injury and instead reported ongoing knee pain over the previous five to six days. (Ex. 2). We find this contemporaneous report of claimant's symptoms and lack of a specific injury more persuasive than his later histories regarding a curb stepping incident.

Accordingly, on this record, we find that claimant failed to meet his burden of proving compensability of his right medial meniscus tear condition.

ORDER

The ALJ's order dated January 13, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed.

Board Member Biehl dissenting.

I agree with the ALJ's analysis of the record and conclusion that claimant's medial meniscus tear is compensable. In addition, as the ALJ points out, the 801 form indicates that the employer had knowledge of claim on March 18, 1998, the day after the work injury. This corroborates claimant's testimony that he contemporaneously told his supervisor about the work injury. In addition, although not making any explicit credibility finding, by accepting claimant's report of twisting his knee stepping off a curb at work, the ALJ implicitly found claimant credible. I do not find the minor discrepancies in claimant's history relevant. The point is claimant twisted his right knee stepping off of a curb at work. In addition, I do not find the medical evidence is in equipoise. Instead, I agree with the ALJ that Dr. Gritzka's opinion is most persuasive. Therefore, I would adopt and affirm the ALJ's Opinion and Order. Because the majority does otherwise, I respectfully dissent.

In the Matter of the Compensation of
LUANA J. NEWBY, Claimant
WCB Case No. 99-04639
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

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

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

Claimant contends that the ALJ incorrectly discounted the medical opinion of Dr. Platt, a consulting physician, who saw claimant at the request of her then-treating doctor, Dr. Carnevale. Based upon the following, we disagree with claimant's contentions.

Claimant correctly points out that Dr. Platt considered many factors in concluding that the work incident was the major cause of her L5-S1 disc herniation. One of the more important of those factors was that claimant had no radicular symptoms prior to the work incident of February 1999. Yet the medical record contains several notations where claimant complained of radiating leg pain prior to

February 1999. (Ex. B, C, 1-1, 1A-2). Claimant contends that these symptoms resolved in 1995 and were of no clinical significance. (Claimant's Appellant's Brief, p. 6). Assuming claimant's contention is correct[1], Dr. Platt's opinion rests on a history of "no radicular symptoms", not a history of resolved symptoms or symptoms of no clinical significance. (Ex. 15).

Accordingly, we agree with the ALJ that Dr. Platt's opinion is based upon incomplete information and, therefore, not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

ORDER

The ALJ's order dated January 27, 2000 is affirmed.

[1] We note that claimant reported leg pain to her doctors in December 1998 and January 1999. (Ex. 1-1, 1A-2).

In the Matter of the Compensation of
ROLAND A. WALKER, Claimant
WCB Case No. 93-07081
ORDER ON REMAND
Allison Tyler, Claimant Attorney
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. *SAIF v. Walker*, 330 Or 102 (2000). The Supreme Court has affirmed the Court of Appeals opinion, *SAIF v. Walker*, 145 Or App 294 (1996), that reversed our prior order adopting and affirming the Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's low back aggravation claim. Concluding that we erroneously affirmed the ALJ's application of the incorrect legal standard in determining the compensability of claimant's aggravation claim, the Supreme Court has reversed and remanded this case for further proceedings.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the pertinent facts and the procedural background. Claimant, a timber faller, injured his lower back and left leg in 1991. Dr. Buza, his treating physician, diagnosed an L5-S1 herniated disc, for which claimant filed a claim and which SAIF accepted.

In May 1992, Dr. Buza declared claimant medically stationary and released him to regular work, beginning in June 1992, without restriction. Dr. Buza's closing report concluded that claimant's loss of function was minimal, although claimant continued to have some pain in his lower back and left leg. SAIF closed the claim on June 23, 1992 by Notice of Closure, awarding claimant 12 percent unscheduled permanent disability.

Claimant requested reconsideration of the closure notice. In February 1993, a medical arbiter, Dr. Burr, examined claimant. A February 12, 1993 Order on Reconsideration then increased claimant's permanent disability award to 16 percent.

In February 1993, claimant experienced increased pain while working and returned to Dr. Buza for treatment. Claimant underwent an MRI scan, which revealed evidence of scar tissue, but no residual or recurrent disc herniation. In May 1993, Dr. Burr re-examined claimant on SAIF's behalf and concluded that, in addition to the herniated disc, claimant suffered from degenerative disc disease with continued symptomatic low back and left leg discomfort. Later, in response to a letter from claimant's lawyer, Dr. Buza concurred with Dr. Burr's report.

Claimant filed an aggravation claim under ORS 656.273, which SAIF denied in April 1993. SAIF asserted that claimant's underlying condition had not worsened since the last award of compensation. Claimant requested a hearing.

The ALJ noted that, to prevail on his aggravation claim under *former* ORS 656.273(1), "claimant must show that increased symptoms or worsening of the underlying condition resulted in diminished earning capacity." The ALJ concluded that, because the evidence showed that claimant's increased symptoms reflected more than a mere waxing and waning of the symptoms anticipated at the time of the claim closure, claimant had proved his aggravation claim. On June 1, 1995, we adopted and affirmed the ALJ's order.

Effective June 7, 1995, however, the legislature amended ORS 656.273(1). That amendment applied retroactively to claimant's case. On June 29, 1995, SAIF petitioned for judicial review of our order, arguing that claimant had not proved his aggravation claim under the amended version of ORS 656.273(1).[1]

A majority of the Court of Appeals concluded that, under ORS 656.273(1) (1995), there must be direct medical evidence that a condition has worsened. The court held that it was no longer permissible for the Board to infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim. Noting that we had incorrectly determined that an actual worsening of a compensable condition may be proven by a symptomatic worsening, the court held that proof of a pathological worsening was required. *SAIF v. Walker*, 145 Or App at 305. Accordingly, the Court of Appeals reversed our order. Claimant then petitioned for Supreme Court review, which was allowed.

The Supreme Court affirmed the Court of Appeals' opinion. After analyzing the text of ORS 656.273(1) (1995), the Court determined that, to prove an aggravation claim, a worker must present evidence of a worsening of the compensable condition itself, not merely a worsening of the symptoms related to the underlying condition. Consequently, the Court concluded that a worker cannot satisfy the requirements of ORS 656.273(1) (1995) (which requires "an actual worsening of the compensable condition") by presenting evidence of worsened symptoms alone. *SAIF v. Walker*, 330 Or at 110.

The Court next addressed the question of whether and to what degree a factfinder may consider evidence of worsened symptoms when determining whether a worker has presented medical evidence of an actual worsening of the compensable condition. Because the statutory text of ORS 656.273(1) (1995) was not helpful, the Court turned to the statutory context, as well as the applicable case law. *Id.*

In summarizing the relevant statutes, the Court observed that the 1995 legislature amended ORS 656.273(1) after years of case law had held that a worker could establish a "worsened condition" by presenting evidence of a worsening of the underlying condition itself or of its symptoms -- in the latter case, with a factfinder inferring the existence of a worsened condition from evidence of a symptomatic worsening. The Court further noted that the 1995 version of ORS 656.273(1) required something different: Proof, based upon medical evidence supported by objective findings, of a worsening of the underlying condition itself, not merely of its symptoms. Nonetheless, based on ORS 656.005(19), the Court reasoned that "objective findings" may include evidence of worsened symptoms. Finally, under ORS 656.273(8) (which had remained unchanged since its 1990 enactment), the Court commented that the statute -- as did the case law that preceded it -- continues to require that a worker with permanent disability establish that the "worsening" at issue is more than a waxing of symptoms associated with the underlying condition, that is, an increase in symptoms that exceeds the degree anticipated by the earlier award.

When considered together, the Supreme Court determined that the text, context, and applicable case law surrounding the 1995 amendment to ORS 656.273(1) clarified the legislature's intended meaning of that statute, as well as the interplay between that statute and ORS 656.273(8). Accordingly, the Court held that evidence of a symptomatic worsening that exceeds the amount of waxing anticipated

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[1] That statute now provides, in part: "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."

by an original permanent disability award -- that is, the degree of worsening addressed in ORS 656.273(8) -- may prove an aggravation claim under ORS 656.273(1) (1995) if, but only if, a physician concludes, based on objective findings (which may incorporate the particular symptoms), that the underlying condition itself has worsened. Stated differently, the Court reasoned that, if, in a physician's medical opinion, a symptomatic worsening that exceeds the degree anticipated does not demonstrate the existence of an actual worsening of the underlying condition, then the worker does not qualify for an aggravation award. *Id.* at 119.

Turning to the present case, the Court then noted that the ALJ had required claimant to prove either that increased symptoms or a worsened condition had resulted in diminished earning capacity. The Court further noted that the ALJ reviewed the evidence of claimant's worsened symptoms and inferred from that evidence alone that claimant's underlying condition had worsened. In affirming the ALJ's application of that legal standard, the court held that we had erred. Accordingly, the Court reversed and remanded the case for further proceedings, stating that, on remand, we must apply the legal standard set out in its opinion to determine whether claimant had established a worsened condition under ORS 656.273(1).[2] *Id.* at 119.

In accordance with the *Walker* Court's directive, we examine this record to determine if medical evidence--*i.e.*, a physician's expert opinion--establishes that claimant's symptomatic worsening represents an "actual worsening" of the underlying condition. In other words, if a medical expert's opinion that an increase of symptoms signifies an actual worsening of a particular compensable condition, then the actual worsening standard of ORS 656.273 is satisfied. *SAIF v. January*, 166 Or App 620, 624 (2000). *See Lepage v. Rogue Valley Medical Center*, 166 Or App 627, 631 (2000).

There are two relevant medical opinions in this record: those of Dr. Buza, the attending physician and Dr. Burr, the examining physician. Dr. Buza noted on March 8, 1993 that claimant was experiencing increased symptoms. (Ex. 24). Dr. Buza, however, expressly stated that claimant's condition was not worse. *Id.*

On May 25, 1993, Dr. Burr examined claimant and concluded that claimant was experiencing a waxing and waning of symptoms, but that there was a worsening of his underlying condition, which he referred to as "diagnosis number two." Dr. Burr's second diagnosis was degenerative disc disease at L5-S1 with continued symptomatic low back and left leg discomfort. (Ex. 29-4). Dr. Buza concurred with the Burr report and also agreed that the degenerative disc disease was not a result of the compensable injury. (Ex. 30).

Having reviewed the medical evidence from Drs. Buza and Burr, we conclude that, at most, the only underlying condition that has worsened is the degenerative condition at L5-S1, but that the medical evidence does not prove that this is a compensable condition.[3] *See Audrey Keeland*, 50 Van Natta 2041 (1998) (if the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a)); *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). Although claimant experienced a worsening of symptoms after claim closure, the medical evidence does not establish that this symptomatic worsening represents an "actual worsening" of the compensable L5-S1 disc herniation.

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[2] In addition to the question whether claimant sufficiently established the existence of a worsened condition, the Court wrote that its review of the record disclosed a discrepancy as to whether the injury that resulted in claimant's underlying compensable condition was the major contributing cause of claimant's alleged worsened condition. The court ordered us to weigh the facts on remand pertaining to all the elements of an aggravation claim under ORS 656.273(1) (1995) -- including causation -- to determine whether claimant qualified for an aggravation award. *Id.* at 119 n. 6.

[3] As directed by the Court, we also address the causation element of the aggravation claim. Dr. Buza initially stated that the 1991 injury was the major contributing cause of claimant's current symptoms. (Ex. 24). However, as previously noted, Dr. Buza subsequently concurred with Dr. Burr's report that attributed claimant's current condition to degenerative disc disease at L5-S1. (Ex. 30). Moreover, Dr. Buza expressly agreed that claimant's degenerative disc disease was not a result of the original injury. *Id.* Having reviewed the medical evidence from Dr. Buza and Dr. Burr, we find that the original compensable injury in 1991 is neither a material nor the major contributing cause of claimant's degenerative low back condition, which is the basis of claimant's aggravation claim.

Accordingly, we conclude that this record does not establish an "actual worsening" of the compensable condition within the meaning of ORS 656.273(1). Thus, on reconsideration of our June 1, 1995 order, we reverse the ALJ's December 1, 1994 order. SAIF's denial of claimant's aggravation claim is reinstated and upheld. The ALJ's attorney fee award is also reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID L. CONNER, Claimant
Own Motion No. 66-0455M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable October 17, 1960 condition. SAIF recommends the reopening of this claim under our own motion authority to provide surgery and medical services related to that surgery. However, SAIF opposed the authorization of temporary disability compensation on the ground that claimant had withdrawn from the work force.

Inasmuch as claimant sustained a compensable 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 benefits. ORS 656.278(1)(b).

On February 15, 2000, Dr. Waldram, claimants attending physician, recommended that claimant undergo right foot surgery to remove a screw, explore the fusion and remove a spur and a sesamoid in his right foot. We find that the requested medical services are reasonable and necessary for curative treatment of the 1960 compensable injury.

Accordingly, claimant's claim is reopened to provide payment for his surgery and medical services related to that surgery. *See* OAR 438-012-0037(1)(a). This order shall supplement our October 12, 1999 order that previously reopened claimant's 1960 claim for the payment of medical services, specifically for the provision of medical services, in the form of office visits and orthotics, which were found to be reasonable and necessary and causally related to the compensable injury. After provision of the aforementioned medical services, the claim is again closed pursuant to OAR 438-012-0055.

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 contended that claimant has not worked since his surgery in November 1998. Thus, SAIF contended that claimant was not in the work force at the time of the current worsening.

In response, claimant submitted an unsworn statement detailing his current employment situation. In that statement, claimant does not dispute SAIF's assertion that he has not worked since November 1998. Rather, claimant contends that: (1) his business is remodeling and he has not solicited work in that field because he would be unable to perform the work; (2) he looked for work in the education sector in June 1999, but did not qualify because he had not been trained in that field; (3) his temporary disability compensation should be retroactive to June 10, 1999 when his claim was closed because his condition never healed from the 1998 surgery; and (4) he is currently willing to work [i]f the injury to [his] right foot would allow it. Claimant relies on an April 10, 2000 chart note from Dr. Waldram to support his contention that he cannot work in his chosen field of remodeling.

In order to prove that he is a member of the work force, claimant must satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Based on the following, we find that claimant failed to satisfy those factors.

As noted above, the relevant time period to determine whether claimant was in the work force is at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). On this record, claimant's condition worsened requiring surgery on February 15, 2000, which is the date of disability. In his statement, claimant admits that he did not seek work following the June 1999 closure because *he* thought it was futile inasmuch the job limitations placed on him by Dr. Waldram precluded him from working as a remodeler.

Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole, especially considering persuasive medical evidence regarding claimant's ability to work and/or seek work. *Jackson R. Scrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where record lacked persuasive medical evidence establishing that the claimant was unable to work and/or seek work due to the compensable injury).

Here, claimant does not offer a medical opinion that would support his "futility" contentions, nor does the record demonstrate that it would have been futile for him to work or seek work at the time of the current worsening. Although Dr. Waldram does place work restrictions that may prevent claimant from working as a remodeler, there is no medical evidence that demonstrates that it would have been futile for him to seek alternate work within those work limitations. Accordingly, claimant has not established that he was a member of the work force at the time of the current disability.[1]

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

IT IS SO ORDERED.

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[1] In his responses to SAIF's position, claimant raised an objection to its June 1999 closure. Claimant contends that the closure was inappropriate because he requires further surgery and thus, was not medically stationary. However, the propriety of a closure turns on whether claimant was medically stationary at the time of closure, considering claimant's condition at the time of closure and *not subsequent events*. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980). In our September 24, 1999 Own Motion Order Reviewing Carrier Closure, we concluded that the record demonstrated that claimant was medically stationary when his claim was closed on June 22, 1999. Dr. Waldrams February 2000 surgery recommendation is a *subsequent event* and does not address claimant's condition at the time SAIF closed claimant's claim in June 1999.

In the Matter of the Compensation of
JERRY L. DAVIS, Claimant
WCB Case Nos. 99-09432 & 99-08352
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

The employer requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that ordered it to accept claimant's annular fissuring condition as a new medical condition. On review, the issue is compensability.

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

On review, the employer contends that it is not clear whether claimant's burden of proof has been analyzed under the major contributing cause standard, as a consequential condition, or as a direct result of the work injury. After reviewing the medical record, we conclude that claimant can meet his burden of proof under either standard. Specifically, as noted by the ALJ, only Dr. Lewis addressed the causation issue concerning the annular fissuring condition. Dr. Lewis explained how fissuring occurs from trauma and stated that the May 1998 work injury was the major contributing cause of the fissuring that was demonstrated in the discography at levels L5-S1 and L4-5. (Ex. 81-2). Accordingly, we agree with the ALJ that claimant has met his burden of proof and has established compensability of his fissuring condition.

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factor set forth in OAR 438-015-0010(4) and applying them to this case, we conclude that $1,200 is a reasonable assessed attorney fee for claimant's counsel's services on review, 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 February 17, 2000, as amended March 2, 2000 and corrected March 13, 2000, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the employer.

In the Matter of the Compensation of
VIRGINIA L. HVAL, Claimant
WCB Case No. 99-08836
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its partial denial of claimant's bilateral calcific tendonitis and subacromial impingement syndrome conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Facts," except for the "Ultimate Findings of Fact," with the following supplementation.

Claimant's shoulder anatomy (specifically, her identified type II/III left acromion with downward sloping anteriorly) contributes to her tendonitis and impingement conditions.

CONCLUSIONS OF LAW AND OPINION

Claimant began working for the employer in 1975. Between 1981 and 1996, claimant opened and closed a heavy steel door by raising it and lowering it like a window, 10-16 times each day at work. In 1996, she experienced a gradual onset of pain in her right arm and shoulder, then in her left arm and shoulder. She sought medical treatment in January 1997.

Claimant's condition was diagnosed as bilateral shoulder bursitis and rotator cuff tendonitis. The insurer accepted claimant's claim for "bilateral shoulder bursitis." Claimant's symptoms persisted. Dr. Brenneke diagnosed subacromial impingement syndrome and calcific tendonitis and recommended left shoulder surgery.

On October 1, 1999, the insurer issued a partial denial asserting that claimant's "conditions of calcific tendonitis, AC joint narrowing with AC joint degenerative joint disease, and type II and type III acromion of the left shoulder and subacromial impingement syndrome secondary to the type II and type III abnormalities" were not related to the accepted bursitis or to claimant's work activities. (Ex. 10). Claimant requested a hearing.

The ALJ upheld the insurer's denial of claimant's bilateral AC joint degenerative joint disease and Type II-III acromion, but set aside its denial of claimant's bilateral shoulder calcific tendonitis and subacromial impingement syndrome conditions. The insurer requests review, contending that the latter conditions are not compensable.

Claimant bears the burden of proving that her work activities were the major contributing cause of her tendonitis and impingement conditions. ORS 656.802.

Drs. Brenneke and Schilperoort provide the expert evidence addressing causation. Dr. Brenneke, treating physician, opined that claimant's "problem comes from the industrial activities with a secondary involvement of any predisposition." (Ex. 12). He also opined that the major contributing cause of claimant's work disability is tendonitis with associated calcific tendonitis. (Ex. 14). Dr. Brenneke described calcific tendonitis as an obscure ailment that may be only incidental. (*Id*). He noted claimant's "significant heavy lifting ten to fifteen times a day" at work and opined that

> "[t]his could easily give enough stress applied to the shoulder to cause a significant amount of irritation to the rotator cuff tendon. This irritation would be manifested as an impingement process." (*Id*).

Accordingly, considering claimant's history, Dr. Brenneke concluded "it is quite clear that this appears to be a work related phenomenon." (*Id*).

Dr. Schilperoort, examining physician, explained the interaction between claimant's anatomy and her impingement and tendonitis conditions, as follows.

Claimant's type II and type III acromion is a preexisting congenital and developmental abnormality that causes impingement. Claimant has calcium deposits at the maximum impact point of the impingement. Some form of trauma is required to create an environment of devascularization, before calcium deposits form.[1] Calcific tendonitis at this location

> "is not unlike having a rock in your shoe. Not only is it probable that impingement with a type III acromion created the calcium deposit, but [it is also probable] that the creation of the calcium deposit creates more impingement." (Ex. 15-2).

Thus, although claimant's door-lifting at work "could cause some irritation of the rotator cuff," Dr. Schilperoort opined that her preexisting anatomy caused her impingement and her impingement caused her tendonitis (and the tendonitis caused further impingement). Noting that impingement would occur with the type II acromion combined with calcific tendonitis with "each activity of abduction [with] external rotation[,] whether lifting a door or not," (Ex. 15-2),[2] Dr. Schilperoort concluded that claimant's industrial exposure was "contributory but only minor in nature." (Exs. 9B, 15).

The ALJ stated that Dr. Schilperoort opined that the major contributing cause of claimant's conditions is heredity or "genetic predisposition." He discounted the doctor's reasoning because neither claimant nor her family members have a prior history of shoulder problems. We disagree with the ALJ's reasoning and his characterization of Dr. Schilperoort's opinion.

First, the doctor stressed claimant's preexisting *anatomy* --her acromion type --, not her genetics or her family history. Second, Dr. Schilperoort identified claimant's shoulder anatomy as a preexisting causal contributor and his reasoning about the mechanism and development of claimant's condition (involving that anatomy) is logical and uncontradicted.[3]

Dr. Brenneke opined that claimant's door lifting at work was the major cause of her conditions because the activity caused stress to her shoulders which irritated her rotator cuff tendon -- and this "manifested" as an impingement process. But he did not refute Dr. Schilperoort's description of the process, or the involvement of claimant's anatomical "predisposition." And Dr. Brenneke did not explain why or how claimant's work activities contributed more to her tendonitis and impingement conditions than did her undisputed type II/III acromions or her off work shoulder use. Under these circumstances, we find Dr. Brenneke's opinion inadequately reasoned and we decline to rely on it. Accordingly, absent persuasive medical evidence establishing an occupational disease under ORS 656.802, we conclude that the claim fails.

ORDER

The ALJ's order dated February 3, 2000 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's partial denial of claimant's bilateral calcific tendonitis and subacromial impingement syndrome conditions is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

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[1] Dr. Schilperoort also suggested that claimant is probably genetically predisposed to develop calcium deposits.

[2] Such activities include brushing one's teeth, doing one's hair, and slipping a T-shirt on and off. Ex. 15-2).

[3] We note that the medical evidence focuses on claimant's left shoulder condition. Although there is no express opinion indicating that claimant's right shoulder is the same as her left shoulder (and no radiological evidence that she has a type II/III acromion on the right), the doctors do not differentiate between left and right, except that surgery is recommended for the left shoulder only. Under these circumstances, we conclude that the doctors' causation opinions apply to both shoulders.

In the Matter of the Compensation of
REUBEN J. PHELPS, Claimant
WCB Case No. 99-07615
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Hitt, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's current low back condition. In his brief, claimant requests a penalty based on the employer's allegedly unreasonable failure to accept an L4-5 disc herniation determined to be compensable by a prior ALJ's order. On review, the issues are compensability and penalties.

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

At hearing, claimant asserted entitlement to a penalty for the employer's alleged failure to accept an L4-5 disc herniation that was determined to be compensable by a prior ALJ. (Tr. 2). The ALJ's order did not address this issue.

Even assuming that the employer failed to formally accept the L4-5 disc condition (the record contains no formal Notice of Acceptance), and further assuming that such failure to do so was unreasonable, we would still decline to assess a penalty. That is, the record does not contain evidence that the employer failed to pay compensation after the prior order issued. Thus, we do not find that any compensation was "then due" at the time of the employer's alleged failure to accept the L4-5 disc herniation. Accordingly, because there are no amounts due upon which to base a penalty, claimant cannot prevail on that issue. *See* ORS 656.262(11); *Spivey v. SAIF*, 79 Or App 568 (1986). Moreover, under these circumstances, we find no unreasonable resistance to the payment of compensation. Therefore, we also decline to award an attorney fee under ORS 656.382(1).[2] *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993).

Claimant's attorney is, however, entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by the employer.[3] In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 3, 2000 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] Claimant challenges the procedural propriety of the employer's denial, arguing that it is an invalid "pre-closure" denial and should be set aside on that basis. We are not inclined to address this issue because it was 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). In any event, it is not necessary to determine whether the issue was properly raised inasmuch as we agree with the ALJ's reasoning that the employer's denial should be set aside on the merits.

[2] The parties have argued the issue of whether proposed surgery for claimant's current low back condition is reasonable and necessary. We do not have jurisdiction to decide whether particular medical services are reasonable and necessary. *See* ORS 656.704(3)(b)(B); ORS 656.245(6); *Murlaine Crawford*, 51 Van Natta 1783, 1784 (1999).

[3] Claimant's attorney is not entitled to an attorney fee for services concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

In the Matter of the Compensation of
CAROLYN S. RICKER, Claimant
WCB Case No. 99-08594
ORDER ON REVIEW
Walsh & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) affirmed an Order on Reconsideration award of temporary disability benefits; and (2) awarded claimant an assessed attorney fee. On review, the issues are temporary disability benefits and attorney fees.

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

On review, SAIF argues that claimant's counsel was not entitled to an assessed attorney fee in this case as "SAIF was not seeking a reduction in compensation awarded to claimant but was merely seeking the right to take an overpayment of temporary total disability...". (SAIF's Appellant's Brief, pg. 5). However, at hearing, SAIF's counsel agreed that the issue was whether temporary disability benefits should have been terminated on December 31, 1998, rather than being paid through June 1999. Counsel for SAIF also stated that, "[t]o the extent that time loss end up being overpaid, SAIF would request authorization for overpayment. But I think we're dealing with a substantive issue of how much time loss is due." (Tr. 3).

Accordingly, we agree with the ALJ that SAIF sought a reduction in claimant's temporary disability benefits. Therefore, an assessed attorney fee was appropriate.

ORDER

The ALJ's order dated February 28, 2000 is affirmed.

In the Matter of the Compensation of
ALBERT V. COOPER, Claimant
WCB Case No. 99-08057
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Wallace, Klor and Mann, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that found that the insurer had not *de facto* denied claimant's right torn rotator cuff condition. On review, the issue is compensability.

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

On review, claimant disagrees with the ALJ's finding that a diagnosis of a torn rotator cuff was not made until after the date of acceptance. Claimant contends that the dispositive issue is whether the *condition* was in existence at the time of acceptance, rather than a specific diagnosis. Even accepting claimant's contention, however, we are unable to find that the condition in this case *was* in existence at the time of acceptance. Without exception, the medical evidence in the record establishes that the rotator cuff developed after the acceptance of the initial claim and involved a condition other than the one initially accepted. (Exs. 7, 13, 22, 23, 25, 29). Therefore, we affirm the ALJ's conclusion that there has been no *de facto* denial of a torn rotator cuff condition.

ORDER

The ALJ's order dated March 13, 2000 is affirmed.

In the Matter of the Compensation of
BARBARA F. COOPER, Claimant
WCB Case Nos. 99-07161 & 99-06089
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Claimant requests reconsideration of our April 28, 2000 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's injury claim for right carpal tunnel syndrome. Claimant argues that Dr. Blake's opinion establishes compensability of her right carpal tunnel syndrome. In addition, claimant submits a March 23, 2000 medical arbiter's report and requests remand to the ALJ for purposes of reopening the record and considering that report. On May 25, 2000, we abated our order to consider claimant's motion. Having received and considered SAIF's response to the motion, we proceed with our reconsideration.

We first address claimant's request for remand. Claimant contends that the March 23, 2000 medical arbiter evaluation was not available at the time of the December 6, 1999 hearing. She argues that the arbiter's evaluation supports Dr. Blake's opinion and is reasonably likely to affect the outcome of the case. She requests remand to the ALJ for purposes of reopening the record and considering the medical arbiter's report.

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).

After reviewing the report from the medical arbiter, Dr. Dietrich, we find that his report is not reasonably likely to affect the outcome of the case. Dr. Dietrich did not discuss whether claimant's right carpal tunnel syndrome was caused, in major part, by her work activities. Therefore, even if we were to consider the March 23, 2000 report, it would not change the result. Because we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed, we deny claimant's motion for remand.

On reconsideration, claimant reiterates her argument that Dr. Blake's opinion establishes compensability of her carpal tunnel syndrome. After reviewing claimant's motion, we find that she essentially raises the same arguments that she raised on review. By adopting and affirming the ALJ's order, we have found that the facts and conclusions in that order express our opinion of the case. We have nothing to add to our previous order or to the ALJ's order.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our April 28, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARTHUR E. FREDRICKSON, Claimant
WCB Case No. 99-06104
ORDER ON RECONSIDERATION
Dennis O'Malley, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Trade Link, Inc., a noncomplying employer (NCE), requests reconsideration of our May 25, 2000 order that set aside the statutory processing agent's denial of claimant's injury claim that the agent had issued on behalf of the NCE. In reaching our decision, we found that claimant's injury arose out of and in the course of his employment.

Specifically, the NCE contends that our order failed to properly address the "arising out of" element as it has been interpreted by the Oregon Supreme Court and Court of Appeals. After considering the NCE's arguments, we continue to adhere to our prior order, with the following supplementation.

The phrases "arising out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. *Norpac Foods v. Gilmore*, 318 Or 363 (1994). As we stated in our original order, an injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." *Norpac Foods v. Gilmore*, 318 Or at 366. A causal connection requires more than a mere showing that the injury occurred at the workplace and during work hours (the "in the course of" element). *Wilson v. State Farm Ins. Co.*, 326 Or 413, 416 (1998). The "arising out of" element can be satisfied when claimant's injury is "linked to a risk connected with the nature of the work or a risk to which the work environment exposed [the] claimant." *Fred Meyer v. Hayes*, 325 Or 592, 601 (1997).

In our initial order, we applied the above-referenced tests to determine whether claimant's injury arose out of, and in the course of, his employment. (Order on Review at 3, 4). We did not, as the NCE argues, unduly focus our analysis on the "*Mellis*" factors. *See Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, *rev den* 300 Or 249 (1985). Rather, we stated that "we no longer rely on the *Mellis* factors as an independent and dispositive test of work connection," although we observed that "we may consider those [*Mellis*] factors that remain helpful under the *Norpac Foods* analysis." (Order on Review at 3).

Moreover, contrary to the NCE's contention, claimant's inability to specifically identify the cause of his fall, or to relate the cause of his fall to his job duties as a car salesman, is not fatal to the "arising out of" element of his claim. *Fred Meyer v. Hayes*, 325 Or at 601; *Phil A. Livesley Co. v. Russ*, 296 Or 25, 31 (1983). *See, e.g. Robert L. Dawson*, 50 Van Natta 2110 (1998), *aff'd mem* 160 Or App 700 (1999). (The claimant's ankle injury while descending a flight of stairs was compensably related to his employment notwithstanding the fact that no defect or hazard associated with the stairs was identified.)

Unlike the ALJ, we found that claimant credibly testified that he "hooked his toe on something" when he fell on the employer's premises on March 6, 1999. (Tr. 22, 68; Order on Review at 1). On reconsideration, we adhere to that specific finding, which constitutes proof of a hazard (albeit unidentified) connected to claimant's work activity. Therefore, even if evidence of a hazard connected to claimant's job duties were required under the "arising out of" prong of the unitary test announced in *Norpac Foods v. Gilmore* and *Fred Meyer v. Hayes, supra*, we have found that claimant has satisfied that element here.

Finally, neither the "arising out of" nor the "in the course of" elements are dispositive by themselves. *Norpac Foods*, 318 Or at 366. In other words, even if claimant's proof on the "arising out of" element is less supportive of a work connection than the evidence of "time, place and circumstances" related to whether claimant's injury arose "in the course of" his employment, we continue to find that the overall circumstances of claimant's injury support the fact that the injury arose out of and in the course of claimant's employment. *Redman Industries v. Lang*, 326 Or 32, 35 (1997).

Accordingly, we withdraw our May 25, 2000 order. On reconsideration, as supplemented herein, we republish our May 25, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD A. KNUDSEN, Claimant
Own Motion No. 00-0206M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The claimant has submitted a request for temporary disability compensation for claimant's compensable condition. Claimant's aggravation rights expired on November 18, 1993. SAIF opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; (2) surgery or hospitalization is not reasonable and necessary; and (3) claimant is not in the work force.

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

Here, the record does not establish that claimant requires surgery or hospitalization. As a result, we are not authorized to grant claimant's request to reopen the claim.[1]

Accordingly, we deny the request for own motion relief. *Id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

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[1] It appears from claimant's request that he is unclear as to his rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. He may call 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 97301

In the Matter of the Compensation of
ARLINE F. LINK, Claimant
WCB Case No. 99-05347
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Livesley's order that dismissed her request for hearing. With her request for review, claimant has submitted additional documents. We treat the document submission as a motion for remand for consideration of those documents. On review, the issues are remand and dismissal. We decline to remand and affirm the ALJ's order.

FINDINGS OF FACT

On July 7, 1999, claimant requested a hearing on the SAIF Corporation's occupational disease claim for bilateral carpal tunnel syndrome. On July 12, 1999, 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: "I authorize my attorney to perform all necessary services on my behalf."

A hearing was scheduled for October 4, 1999. The October 1999 hearing was postponed.

A January 21, 2000 Notice of Hearing rescheduled the hearing on March 13, 2000. On March 13, 2000, the ALJ placed a note in the hearing file that stated that claimant had authorized her attorney to withdraw the request for hearing. On March 14, 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 and asking for an Order of Dismissal without prejudice. The ALJ dismissed claimant's hearing request by a March 14, 1999 Order of Dismissal.

On April 13, 2000, the Board received claimant's April 12, 2000 letter requesting review of the ALJ's dismissal order. Claimant stated that dismissing the request for hearing was not in her best interest and enclosed documents that she would have presented at hearing.

CONCLUSIONS OF LAW AND OPINION

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).

The retainer agreement between claimant and her former attorney authorized the attorney to act on claimant's behalf. Claimant does not assert that her former attorney did not request dismissal of the hearing request. Nor does she assert that she was not represented by her former attorney at the time in question.

Under these circumstances, we find no reason to alter the dismissal order. *Donald J. Murray*, 50 Van Natta at 1133; *William A. Martin*, 46 Van Natta 1704 (1994).[1]

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[1] Inasmuch as we have affirmed the ALJ's dismissal, we need not address claimant's request to remand this matter for the submission of further evidence.

We note that claimant is presently unrepresented. Because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM OR 97301

ORDER

The ALJ's order dated April 14, 1999 is affirmed.

In the Matter of the Compensation of
RONALD D. REYNOLDS, Claimant
WCB Case No. 98-04171
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) directed it to pay claimant's temporary disability compensation based on an average weekly wage of $869.59; (2) found that SAIF was not authorized to offset wages allegedly paid to claimant while he was receiving temporary disability; and (3) awarded an attorney fee under ORS 656.382(2). On review, the issues are temporary disability, offset, 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 exceptions and supplementation.

We do not find that SAIF unilaterally terminated claimant's time loss benefits. (*See* Opinion and Order on Reconsideration/Remand, p. 2).

We do not adopt the "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Rate

We adopt and affirm the ALJ's conclusions and reasoning.

Offset and Attorney Fees

The ALJ found that SAIF failed to prove that claimant was paid wages during the time he was receiving temporary disability benefits. Therefore, the ALJ concluded that SAIF was not entitled to offset any portion of the temporary disability it had paid claimant. We agree and adopt the ALJ's opinion in this regard.

The ALJ also awarded claimant an attorney fee under ORS 656.382(2) (in addition to a fee out of the additional temporary disability compensation that was awarded), reasoning that "SAIF unsuccessfully sought a reduction in compensation."

SAIF contends that claimant is not entitled to an attorney fee under ORS 656.382(2) in any event, because no compensation had been *awarded* to claimant before SAIF's cross-request for hearing. We agree.

ORS 656.382(2) provides, in part:

> "If a request for hearing * * * is initiated by an employer * * *, and the Administrative Law Judge * * * finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer * * * shall be required to pay * * * a reasonable attorney fee * * * for legal representation * * * for the claimant at and prior to the hearing * * *."

Three conditions are required for an attorney fee award under the statute: First, the employer must initiate a request for a hearing or review to obtain a disallowance or reduction in the claimant's award of compensation or file a cross-appeal to do so; second, the claimant's attorney must perform legal services in defending the compensation award; and, third, the ALJ must find on the merits that the claimant's award of compensation should not be disallowed or reduced. *See Strazi v. SAIF*, 109 Or App 105, 107-08.

The first question is whether ORS 656.382(2) provides for a fee for services at hearing where claimant successfully defended compensation paid, but not formally "awarded" by administrative or litigation order. To answer the question, we must discover the meaning of the word "awarded" in the statute's phrase "compensation awarded to a claimant."

The work awarded (or the word award) is not defined in chapter 656. Therefore, we turn to the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). The word "awarded" is a term of common usage that should be given its "plain, natural, and ordinary meaning." *See PGE*, 317 Or at 611. As a verb, "award" means: "judge, decide [;] to give by judicial decree [;] assign after careful judgment [;] adjudge [;] to confer or bestow upon." *Webster's Third Int'l Dictionary*, 152 (unabridged ed. 1993) (usage examples omitted). Thus, based on the dictionary definition "awarded" could mean conferred formally or informally. However, the context indicates a claimant must successfully defend "compensation awarded" by formal process (not just paid).

"Awarded" modifies "compensation" in the statute. In other words, the claimant must defend the carrier's challenge, not just to any compensation, but to that "awarded" (*i.e.*, not just provided, or paid). This construction of "awarded" in ORS 656.382(2) is consistent with the overall context of ORS Chapter 656, which refers to compensation awarded by administrative or judicial process, *e.g.*, closure notices, judicial orders, and approved settlement agreements, but not otherwise.[1] *See Deaton v. Hunt-Elder*, 145 Or App 110, 117 (1996) ("Stipulated settlement agreements are recognized by the Workers' Compensation Board as an award of compensation[.]").

Accordingly, based on the text and context of ORS 656.382(2),[2] we conclude that a fee may be awarded under the statute only when the claimant successfully defends against the carrier's challenge to compensation that has *been awarded* through administrative or judicial processes or an approved settlement agreement. *See Ben E. Conradson*, 52 Van Natta 893 (2000) (An Order on Reconsideration's finding that a claim should be reclassified as disabling constitutes an "award" for purposes of granting an attorney fee under ORS 656.382(2)).

Here, because no compensation was awarded prior to hearing, claimant is not entitled to an attorney fee under ORS 656.382(2) for defending against SAIF's request for hearing.

Claimant's attorney is entitled to an assessed fee for services on review concerning the entitlement to temporary disability issues. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the temporary disability issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for services devoted to the ALJ's attorney fee award. *Dorson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 10, 1999, as amended August 13, 1999 and December 3, 1999, is reversed in part and affirmed in part. The ALJ's assessed attorney fee award of $6,000 is reversed. The remainder of the ALJ's order is affirmed. For services on Board review, claimant is awarded a $1,500 attorney fee, to be paid by SAIF.

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[1] *See Racing Com. v. Multnomah Kennel Club*, 242 Or 572 (1996) (When the legislature uses a term throughout statute, the court will presume it has the same meaning throughout); *compare* ORS 656.0005(8), which defines "compensation" to include "all benefits, including medical services, *provided* for a compensable injury. . . ." (Emphasis added).

[2] Because "awarded" is not reasonably subject to more than one interpretation based on the text and context of the statute, our inquiry into the meaning of the statute in this regard ends. *See PGE*, 317 Or at 611-12.

In the Matter of the Compensation of
JORGE CRUZ-LOPEZ, Claimant
WCB Case No. 99-05316
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's injury claim for a low back strain. On review, the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation. The insurer contends that claimant failed to prove that he sustained a compensable injury. In particular, the insurer argues that: (1) claimant's unsubstantiated testimony is not sufficient, when considered with claimant's consciously exaggerated degree of disability, to carry claimant's burden of proof that a compensable event occurred; and (2) Dr. Benton's opinion, upon which the ALJ relied, is insufficient to establish the work injury as the major contributing cause of claimant's combined condition. We disagree with each of the insurer's contentions.

We generally defer to an ALJs demeanor-based credibility findings, and we do so here. *See Bush v. SAIF*, 68 Or App 230, 233 (1984). Claimant, who is Spanish speaking, testified through an interpreter. His highest level of education is the seventh grade and all his schooling has been in Guatemala. (Tr. p. 7). The ALJ observed claimant's manner of testifying and his facial expressions. Based upon claimant's presentment at hearing, the ALJ found no reason to distrust him. (O&O p. 4). Because the ALJ had the opportunity to observe the claimant's testimony, he is in a much better position to assess his credibility and his determination is entitled to considerable weight. *See Sherri L. Williams*, 51 Van Natta 75, 77 (1999).

Turning to the substance of claimant's testimony, we note as did the ALJ that claimant's complaints of low back problems are supported by objective medical findings.[1] We also note that claimant complained of testicular pain. (Ex 1). Dr. Benton attributes the testicular pain to the nerves around the L1-L2 vertebra; he diagnosed the testicular pain as an "ilioinguinal nerve component." (Exs. 2, 28-5).

We do not dismiss the insurer's credibility argument lightly. First, we are troubled by the fact that claimant testified that he informed his foreman, John, about the injury on the day that it happened, but then did not produce John or explain why John was not called as a witness. In the same manner we are troubled by claimant's failure to produce Antonio Ramirez, the co-worker claimant identified he was working with at the time of his injury. We are further troubled by claimant's exaggerations of symptoms and of his degree of disability to his doctors as evidenced by surveillance movies taken on June 12, 1999.[2]

Nevertheless, considering all the evidence, including the objective medical findings of a low back condition, the substance of claimant's testimony as well as his limited education, and especially the ALJ's credibility finding based upon claimant's demeanor, we conclude that claimant is credible regarding the lifting incident at work. In other words, we are persuaded that claimant experienced low back pain as a result of performing his work activities.

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[1] Dr. Benton, the initial treating physician, noted asymmetry and bunching of the muscles in the low thoracic and upper lumbar portion of the right-paraspinous area. (Ex. 1, 2, 6, 9, 13). Dr. Weinman, who saw claimant at the request of Dr. Benton, noted muscle spasms. (Ex. 14-3). Dr. Lemley, who claimant saw for physical therapy, noted muscle tenseness in the dorsal areas. (Ex.18).

[2] Drs. Lemley and Weinman both reviewed the surveillance videos and opined that claimant moved differently on the video than he did in their respective offices. (Ex. 27, 29-8).

The parties do not contest the ALJ's conclusion that the compensability of claimant's low back strain injury is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that his low back strain is compensable, claimant must show that his work injury 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 101 (1997). Because of claimant's preexisting condition and the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

The ALJ determined that Dr. Benton's deposition testimony was sufficient to establish medical causation of a combined low back condition. The insurer argues that Dr. Benton's deposition testimony is insufficient to establish medical causation because: (1) is it based upon generalities and not claimants particular circumstances; and (2) it is unexplained. We disagree.

Dr. Benton is the initial treating physician. He has seen claimant for this condition on several occasions noting objective medical findings of injury and improvement in claimants condition over time. (Ex. 28-23). Dr. Benton could find no objective evidence that claimants spondylolysis was causing the muscle spasms. (Ex. 28-22). Dr. Benton opined that claimant's spondylolysis would probably have no direct bearing on an acute injury, but could delay healing of such an injury. (Ex. 28-12). Finally, taking his multiple examinations of claimant into account, Dr. Benton opined that at twelve weeks after injury, claimant's preexisting spondylolysis became the major cause of claimant's ongoing disability and need for treatment. (Ex. 28-28). Dr. Benton's opinion is supported by Dr. Weinman who opined that the likely cause of claimant's back spasms was his lifting injury. (Ex. 29-6). Considering all of these factors, we find Dr. Benton's opinion to be well explained and persuasive.

Citing *Georgia Telfer*, 50 Van Natta 1658 (1998), the insurer argues that Dr. Benton's opinion is based on generalities and, therefore, not persuasive. We disagree. In *Telfer*, we held that statistical studies not directed toward a claimants particular circumstances were not persuasive. 50 Van Natta at 1659. Here, Dr. Benton is not using statistical studies. Moreover, the medical maxims he relies on are part of his professional training, and used in conjunction with his objective medical findings and his examination of claimant to render his opinion. Our holding in *Telfer* is not applicable here.

In conclusion, based upon Dr. Benton's well reasoned and persuasive opinion, we find that claimants work injury was the major contributing cause of his disability and his need for treatment for his combined low back condition. Consequently, we affirm the ALJ's order that set aside the insurer's denial of that claim.

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

ORDER

The ALJ's order dated March 3, 2000 is affirmed. For services on review, claimant is awarded a $500 attorney fee, payable by the insurer.

In the Matter of the Compensation of
ANGELA L. GATES, Claimant
WCB Case Nos. 99-07790 & 99-03219
ORDER ON REVIEW
Linda Attridge, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's aggravation claim for a lumbosacral strain; and (2) awarded a $4,500 attorney fee. Claimant cross-requests review of those portions of the order that: (1) admitted into evidence surveillance videotapes of claimant; (2) upheld the employer's denial of her L5-S1 herniated disc; (3) declined to assess penalties or related attorney fees for the employer's allegedly untimely aggravation denial; (4) declined to award interim compensation; (5) declined to assess penalties or related attorney fees for the employer's allegedly unreasonable failure to pay interim compensation; and (6) declined to assess penalties for the employer's alleged failure to timely provide discovery. In its brief, the employer also contends that claimant's new injury claim is time-barred. On review, the issues are evidence, timeliness, aggravation, compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant compensably injured her low back in January 1998. The employer accepted a disabling lumbosacral strain. The claim was closed in July 1998 with no permanent disability award.

Although claimant had occasional symptoms in the left leg, she sought no medical treatment until December 30, 1998, when she returned to Dr. Sedgewick with low back complaints after performing three days of intense work from December 21 through December 23, 1998. Dr. Sedgewick diagnosed a lumbar strain and filed an aggravation claim. Dr. Sedgewick authorized time loss and approved a modified job beginning January 4, 1999. Claimant performed modified work until January 19, 1999, when she began an extended absence under the Family Medical Leave Act.

Dr. Sedgewick ordered physical therapy, which he discontinued on February 4, 1999. On March 2, 1999, Dr. Sedgewick concluded that claimant's symptoms had resolved and he released her to medium work.

On March 23, 1999, claimant returned to Dr. Sedgewick complaining of paresthesias in the left leg and recurrent pain in the buttocks and down the legs. An April 6, 1999 myelogram and CT scan revealed a herniated disc at L5-S1 obliterating the S1 nerve root sleeve.

On April 8, 1999, Dr. Woodward examined claimant for the employer.

On April 13, 1999, Dr. Sedgewick informed claimant that she had a herniated disc with S1 nerve root involvement and took her off work. He began a series of epidural steroid injections that did not benefit claimant.

On April 14, 1999, the employer denied claimant's aggravation claim. Claimant requested a hearing.

On June 18, 1999, Dr. Hart, orthopedic surgeon at Oregon Health Sciences University, examined claimant. He diagnosed a herniated disc at L5-S1 and authorized time loss the following day.

On July 6, 1999, claimant filed a "new injury" claim for the herniated disc based on her work activities of December 21 through 23, 1998.

On July 14, 1999, Dr. Hart performed an L5-S1 diskectomy.

On August 17, 1999, the employer denied the "new injury" claim. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

Evidence

The ALJ admitted into evidence a surveillance videotape of claimant allegedly made on March 18, 25, and 28, 1999. (Ex. 60). Claimant objected to its admission pursuant to the rules of evidence because it had not been authenticated. The ALJ admitted the videotape over claimant's objection because it had been relied upon by Dr. Sedgewick in formulating his opinion.

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).

Because Dr. Sedgewick relied on the videotapes in formulating his opinion regarding the cause of claimant's herniated disc, we agree with the ALJs assessment that the videotapes were relevant to the resolution of the compensability issue. Consequently, we find no abuse of discretion by the ALJ in admitting the videotapes.

Timeliness

The employer contends that claimant's July 6, 1999 "new injury" claim was untimely because it was filed more than 90 days after the December 21, 1998 date of injury and the employer had no knowledge of the new injury. We disagree.

Claimant contends that her back pain arose as a result of intense work on December 21, 1998 and worsened over the next two days.[1] Therefore, ORS 656.265 is the applicable limitations statute,[2] and the employer must have had knowledge of the injury within 90 days after the alleged injury date. *Jeffery E. Henderson*, 50 Van Natta 2340, 2342 (1998).

In *Argonaut Insurance v. Mock*, 95 Or App 1 (1989), the court discussed what constitutes "knowledge of the injury" for purposes of ORS 656.265(4)(a):

> "'[K]nowledge of the injury' must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. *Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate.*" *Id.* at 5. (Emphasis added.)

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[1] When symptoms occur over a discrete, identifiable period of time, are unexpected and due to a specific activity or event, the condition is properly analyzed as an injury. *See, e.g., James v. SAIF*, 290 Or 343 (1981); *Valtinson v. SAIF*, 56 Or App 184 (1982).

[2] ORS 656.265 provides, in pertinent part, as follows:

"(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer, but not later than 90 days after the accident. * * *

"* * * * *

"(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

"(a) The employer had knowledge of the injury or death[.]"

When claimant sought treatment on December 30, 1998, Dr. Sedgewick filed an aggravation claim with the employer for what he assumed was a worsening of claimant's prior lumbosacral strain condition. Moreover, claimant reported her increased back pain to her supervisor, Mr. Warrington, prior to seeking medical attention. Although neither claimant nor her doctor attributed her condition to a specific "new" injury, claimant nevertheless provided the employer with enough facts regarding her condition within 90 days for the employer to conclude that workers' compensation liability was a possibility. Therefore, we conclude that claimant's "new injury" claim is not time-barred under ORS 656.265.

Lumbosacral Strain - Aggravation or New Injury

The ALJ concluded that claimant had established an aggravation of her compensable January 1998 low back condition. On review, the employer argues that claimant has not established an "actual worsening" of her accepted lumbosacral strain condition. Specifically, the employer challenges the ALJ's application of the legal standard and his analysis of the medical evidence regarding the aggravation claim. Claimant contends that she has established an aggravation of her January 1998 low back condition, or, alternatively, that her December 1998 lumbar strain is a new, compensable injury.

Claimant's accepted condition is a lumbosacral strain, an unscheduled condition. Accordingly, to prove a compensable aggravation, claimant must prove (1) an "actual worsening" of that condition that (2) results in diminished earning capacity. ORS 656.273(1); *Intel Corp. v. Renfro*, 155 Or App 447 (1998).

The ALJ concluded that claimant had established an "actual worsening" of her low back condition. Subsequent to the ALJ's order, the Court issued *SAIF v. Walker*, 330 Or 102 (2000). In that case, the Court examined the legal standard for an aggravation. The Court held:

> "[E]vidence of worsened symptoms, while relevant, is not sufficient by itself to meet the proof standard created by ORS 656.273(1) (1995). However, * * * a physician may rely upon that kind of evidence in determining whether the compensable condition has worsened and in opining on that question to the factfinder or to the Board. In other words, the 'medical evidence * * * supported by objective findings' that is required under ORS 656.273(1) (1995) and ORS 656.273(3) to prove an 'actual worsening of the compensable condition' may include a physician's written report commenting that the worker's worsened symptoms demonstrate the existence of a worsened condition." *Id.* at 118.

Thus, if a medical expert concludes that the "symptoms demonstrate the existence of a worsened condition," a symptomatic worsening may meet the standard of proof for an actual worsening. *Id.* But evidence of a symptomatic worsening, in and of itself, does not permit a factfinder to infer an actual worsening. *See id.* at 119 (noting that the ALJ applied improper legal standard by inferring an actual worsening from evidence of symptomatic worsening).[3]

We turn to the case before us. On December 30, 1998, Dr. Sedgewick diagnosed claimant's current low back condition as a musculoligamentous strain. He based his diagnosis on objective findings of limited forward flexion, loss of lordosis, and a list to the right. (Exs. 49; 81-25 through -28, -30). When asked during his deposition whether claimant's condition was a worsening of the January 1998 lumbar strain, Dr. Sedgewick initially said he assumed so, explaining that claimant's

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[3] After considering the meaning of ORS 656.273(1), the Court considered the interplay between that statute and ORS 656.273(8), which provides that, if the aggravation is for an injury or disease for which permanent disability has been previously awarded, the worsening must be more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. Because claimant did not receive a permanent disability award at the time of claim closure, she is not required to establish that the worsening is more than waxing and waning of symptoms of the condition "contemplated by the previous permanent disability award." However, as with all aggravations, for disabling and nondisabling injuries alike, claimant must satisfy the actual worsening standard of ORS 656.273(1). *Lepage v. Rogue Valley Medical Center*, 166 Or App 627 (2000).

complaints of increasing pain in the lumbar spine was an aggravation of her previous musculoligamentous strain.[4] (Ex. 81-24, -28, -30, -31).

But in response to further questions regarding whether claimant's condition "actually worsened," as contrasted with a waxing and waning of symptoms, Dr. Sedgewick stated that he had no evidence that there was an actual pathologic worsening of the January 1998 strain. (Ex. 81-77). Moreover, Dr. Sedgewick agreed that claimant's condition did not amount to more than a continuing waxing and waning of symptoms, and not an actual worsening of her condition. (Ex. 81-77, -78, -89, -90).

We conclude that Dr. Sedgewick's opinion is insufficient to establish that claimant's symptoms after the December 1998 incident demonstrated the existence of an actual worsening of her compensable condition, as is required under *Walker*. Consequently, we conclude that claimant has not established an aggravation of her January 1998 lumbosacral strain.[5]

We now turn to claimant's alternative theory, that she experienced a new, compensable lumbosacral strain injury. We agree, for the following reasons.

As noted above, Dr. Sedgewick found objective findings of a lumbosacral strain. During his deposition, after being provided with a description of claimant's job activity from December 21 to 23, 1998, Dr. Sedgewick identified claimant's work activities as the major contributing cause of the lumbar strain he had diagnosed on December 30, 1998, and the resultant need for medical treatment and modified work. (Ex. 81-33, -34, -35, -37, -38). There is no contrary opinion.[6] Accordingly, we conclude that claimant has established compensability of a new lumbosacral strain condition that arose on December 21, 1998.

Compensability - L5-S1 Herniated Disc

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

Interim Compensation

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

Penalty - Untimely Discovery

Claimant requested discovery on April 21, 1999, and on June 4, 1999, in relation to claimant's aggravation claim. In light of our determination above that claimant's aggravation claim is not compensable and that claimant was not entitled to interim compensation, there are no "amounts then

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[4] After being told that the legal standard to establish an aggravation was "major contributing cause," Dr. Sedgewick opined that, to a reasonable medical probability, the accepted lumbosacral strain in January 1998 worsened in December 1998 and that the major contributing cause of the current low back strain was the work claimant performed in December 1998. (Ex. 81-29, -33 through -38). We do not rely on this portion of Dr. Sedgewick's opinion in relation to claimant's aggravation claim, as it takes into consideration claimant's subsequent work activities, rather than confining its focus to the relationship between claimant's current condition and the January 1998 strain.

[5] The employer denied claimant's aggravation claim on April 14, 1999. Assuming, without deciding, the timeliness of the employer's denial, we find that, because there is no compensation due, there has been no unreasonable resistance to the payment of compensation. Therefore, claimant is not entitled to a penalty-related attorney fee pursuant to ORS 656.382(1).

In addition, because the employer's aggravation denial is being reinstated, the ALJ's attorney fee award under ORS 656.386(1) is reversed.

[6] Dr. Woodward opined that claimant's current condition did not even amount to a waxing and waning of the January 1998 lumbosacral strain, as it had resolved by July 1998. Dr. Woodward did not provide an opinion regarding the causation of claimant's December 1998 lumbar strain.

Because Dr. Sedgewick's opinion satisfies the major contributing cause standard, it is unnecessary to determine whether the compensability of claimant's current condition has been established as a combined condition under ORS 656.005(7)(a)(B) or under a material contributing cause standard pursuant to ORS 656.005(7)(a).

due" on which to base a penalty pursuant to ORS 656.262(11), and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee under ORS 656.382(1). *See Lloyd A. Humpage*, 49 Van Natta 1784 (1996) (citing *SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 162 (1993) (no entitlement to penalty or assessed fee under ORS 656.382(1) for untimely claims processing where no amounts due at time of unreasonable delay)).

Attorney Fee ORS 656.386(1)

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the new injury claim. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to the compensability issue (lumbosacral strain), we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, 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 January 26, 2000 is affirmed in part and reversed in part. That portion of the order that set aside the self-insured employer's denial of claimant's aggravation claim is reversed. The employers aggravation denial is reinstated and upheld. The ALJ's award of an assessed attorney fee is also reversed. The employer's denial of claimant's claim for a new lumbosacral strain is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review regarding the new injury claim, claimant's attorney is awarded a fee of $4,000, to be paid by the employer. The remainder of the ALJ's order is affirmed.

June 20, 2000 Cite as 52 Van Natta 1041 (2000)

In the Matter of the Compensation of
SHEILA A. LEFORS, Claimant
WCB Case No. 99-07460
ORDER OF ABATEMENT
Welch Bruun & Green, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of our May 26, 2000 Order on Review that adopted and affirmed that portion of the Administrative Law Judge's (ALJ's) order that decreased claimant's award of unscheduled permanent disability from 17 percent (54.4 degrees), as awarded by an Order on Reconsideration, to zero. In addition, we supplemented our order and explained why we, like the ALJ, concluded that claimant's diminished range of motion was not due to her compensable low back strain. Asserting that we failed to address claimant's cervical impairment and her arguments regarding the instructions that were provided to the arbiter panel, claimant seeks reconsideration of our order.

In order to consider claimant's motion, we withdraw our May 26, 2000 order. The self-insured employer is granted an opportunity to respond. To be considered, the 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
BARBARA J. WARREN, Claimant
WCB Case No. 99-06401
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests, and claimant cross-requests, review of Administrative Law Judge (ALJ) Poland's order that affirmed an Order on Reconsideration that awarded 8 percent (10.8 degrees) scheduled permanent disability for loss of use or function of the right foot, whereas a Notice of Closure awarded no permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

On April 28, 1998, claimant compensably injured her right foot. The insurer initially accepted a disabling right foot sprain. (Ex. 17).

On August 27, 1998, Dr. Beaman, claimant's treating orthopedist, opined that the diagnosis was right sesamoid fracture and the work injury was the major cause of claimant's current condition and need for treatment. (Ex. 22). He also noted no preexisting or concurrent conditions. (*Id.*).

On September 11, 1998, the insurer issued an amended acceptance and accepted a right medial sesamoid fracture involving the great toe. (Ex. 26).

On February 10, 1999, Dr. Strum, orthopedist, examined claimant on behalf of the insurer. (Ex. 43). He found that the diagnostic studies documented preexisting metatarsophalangeal joint arthrosis. (Ex. 43-5).

On March 18, 1999, Dr. Beaman found claimant medically stationary without permanent impairment. (Ex. 45).

On April 7, 1999, Dr. Beaman concurred in part with Dr. Strum's February 10, 1999 report. (Exs. 43, 47). Although disagreeing with Dr. Strum's theory of the injury, Dr. Beaman agreed with his assessment of claimant's permanent impairment, stating:

> "Certainly [claimant] does have some underlying preexisting metatarsophalangeal joint arthrosis; however, this was, by report, asymptomatic prior to her injury, and I do agree that she is currently medically stationary and has recovered well from her injury and I do agree that the mild degree of permanent impairment is related to the preexisting arthrosis. * * * * *
>
> "Injury to the hallucal sesamoids often take longer than six to eight weeks to resolve, and I would say that the need for her treatment through the time when her symptoms completely resolved was due to her April 28, 1998 injury." (Ex. 47-1).

On April 8, 1999, the insurer closed claimant's claim with a Notice of Closure that awarded temporary disability benefits only and declared claimant medically stationary as of March 18, 1999. Claimant requested reconsideration and appointment of a medical arbiter.

Dr. Hanley, orthopedist, served as the medical arbiter and examined claimant on June 3, 1999. (Ex. 52).

On July 14, 1999 an Order on Reconsideration issued that relied on Dr. Hanley's report and awarded 8 percent scheduled permanent disability benefits for loss of range of motion in the right great toe and a chronic condition impairment in the right foot. (Ex. 53). That order also affirmed the Notice of Closure's award of temporary disability benefits and the medically stationary date. The insurer requested a hearing, seeking elimination of the permanent disability award.

CONCLUSIONS OF LAW AND OPINION

We agree with the ALJ that where, as here, an insurer objects to an Order on Reconsideration and seeks reduction of the award, it has the burden to show that the standards were incorrectly applied in the reconsideration proceeding.[1] *See* ORS 656.283(7); *Roberto Rodriguez*, 46 Van Natta 1722 (1994) (citing *Harris v. SAIF*, 292 Or 683 (1982)). Unlike the ALJ, however, we find that the insurer met its burden of proof under the facts of this case.

At hearing and on review, the insurer argues that Dr. Hanley's opinion is not persuasive because he does not address the effect of claimant's preexisting metatarsophalangeal joint arthrosis. The insurer also contends that Dr. Beaman's opinion is more persuasive. We agree with the insurer.

In determining claimant's permanent disability, we apply the standards set forth in WCD Admin. Order 98-055, the standards in effect at the time of the April 8, 1999 Notice of Closure. OAR 436-035-0003(2). OAR 436-035-0007(14) provides that where a medical arbiter is used on reconsideration, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

On July 9, 1998, Dr. Beaman began treating claimant. (Ex. 16). After obtaining MRIs, Dr. Beaman diagnosed a right medial sesmoid fracture and stated that the work injury was the major contributing cause of claimant's current condition and need for treatment. (Ex. 22). He also stated that he did not note any preexisting or concurrent conditions. (*Id.*). However, after reviewing Dr. Strum's report, Dr. Beaman agreed that claimant had some underlying preexisting metatarsophalangeal joint arthrosis, although it was asymptomatic prior to her injury. He also agreed that claimant's "mild degree of permanent impairment is related to the preexisting arthrosis." (Ex. 47-1).

In contrast, Dr. Hanley examined claimant in his capacity as a medical arbiter and made no mention of any preexisting condition. (Ex. 52). He stated that claimant's findings could be "considered valid," claimant had "residual impairment due to her accepted condition," he did not believe the findings were due to unrelated causes, and he was not aware of a contralateral great toe injury. (Ex. 52-2).

The insurer argues that Dr. Hanley's opinion is unpersuasive because there is no evidence that he reviewed the medical records or knew about the preexisting arthrosis condition. Claimant counters that Dr. Hanley had a complete history, noting that the Appellate Review Unit submitted a copy of claimant's record to him. (Ex. 51B-1). Dr. Hanley's brief history, however, does not indicate that he reviewed the record. To the contrary, the history appears to come from claimant, with no reference being made to the medical record. (Ex. 52-1).

In *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 court agreed with our holding in *Danboise*, concluding that "[t]he Board is correct that, when the record discloses no other possible source of impairment, medical evidence that rates the impairment and describes it as 'consistent with' the compensable injury supports a finding that the impairment is due to the compensable injury." *Id.* at 147 Or App 553. The record in the present case does not meet that standard. Here, the record not only discloses other possible sources of impairment, Dr. Beaman explicitly found that claimant's noncompensable preexisting arthrosis was the source of her impairment. *See William H. Pauley*, 49 Van Natta 1605 (1997).

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[1] Although she did not cross-request a hearing, claimant contended at hearing that she was entitled to an additional impairment rating of 15 percent under OAR 436-035-0200(4). The ALJ found that claimant had the burden of proving this additional impairment and failed to meet that burden. In her cross-request for review, claimant again argues that she is entitled to an additional 15 percent impairment under OAR 436-035-0200(4). We adopt the ALJ's reasoning and conclusion regarding this issue. In addition, for the reasons discussed below, we find that the compensable injury did not result in any permanent impairment.

In evaluating medical evidence, we rely on those opinions that are well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Given the fact that Dr. Hanley did not address claimant's preexisting arthrosis condition, we do not find his opinion persuasive. Instead, we rely on the opinion of the attending physician, Dr. Beaman, who treated claimant over time, displayed a better knowledge of the medical record, and found that any permanent impairment was caused by claimant's preexisting arthrosis condition.

In reaching this decision, we reject claimant's argument that Dr. Beaman's opinion is unpersuasive because it represents an unexplained change of opinion. Reading Dr. Beaman's opinions as a whole, we find that he explained his change of opinion. *See Kelso v. City of Salem*, 87 Or App 630, 634 (1987) (physician who changed his opinion found to be reliable because he provided a reasonable explanation for his changed opinion). In this regard, after carefully reviewing Dr. Strum's report, Dr. Beaman explained that he agreed with portions of that report, including the assessment that claimant's mild permanent impairment is related to the preexisting arthrosis. (Ex. 47). This is consistent with his closing exam, which also stated that claimant was "without impairment." (Ex. 45).

Accordingly, we find that the insurer has met its burden of proving that claimant is not entitled to any scheduled permanent disability.

ORDER

The ALJ's order dated January 19, 2000 is reversed. That portion of the order that affirmed the Order on Reconsideration's award of 8 percent (10.8 degrees) scheduled permanent disability benefits for loss of use or function of the right foot is reversed. The Notice of Closure award of no permanent disability is reinstated. The ALJ's assessed attorney fee award is reversed.

In the Matter of the Compensation of
JEANNIE WILLIAMS, Claimant
WCB Case No. C001391
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Robert J. Guarrasi, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Member Biehl and Meyers.

On June 8, 2000, 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 approve the proposed disposition despite an apparent typographical error.

The first page of the proposed CDA provides that the total amount due claimant is $28,975 and the total due claimant's attorney is $6,125. This would equal a total consideration of $35,100. However, the total consideration recited on the first page, as well as number 14, of the CDA is "$35,000," with claimant's attorney receiving $6,125.

In light of this, we interpret the reference on the first page of the CDA to a distribution to claimant of $28,975 and a $6,125 attorney fee (equaling a total consideration of $35,100) as a typographical error. In reaching this conclusion, we note that a payment of $28,875 to claimant would be consistent with a total consideration of $35,000 and an attorney fee of $6,125. Accordingly, we interpret the agreement as providing for a total consideration of $35,000, with claimant receiving $28,875 and claimant's counsel an attorney fee of $6,125.

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 $6,125, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CRAIG A. CARTER, Claimant
WCB Case No. 98-07929
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Crummé's order that: (1) upheld the SAIF Corporation's denial of his current back condition; (2) upheld SAIF's partial denial of his gastritis condition; (3) declined to assess penalties and attorney fees for an allegedly unreasonable denial; and (4) declined to make findings and conclusions regarding the issue of whether claimant was in the work force at the time his back condition allegedly worsened. In his appellant's brief, claimant requests that we remand to the ALJ for findings concerning the work-force issue should we find that his current back condition is compensable. On review, the issues are compensability, remand, penalties and attorney fees.

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

The ALJ upheld SAIF's current condition denial, concluding that claimant failed to prove that his compensable November 1982 injury was the major contributing cause of his current back condition. In reaching this conclusion, the ALJ evaluated, on the one hand, the persuasiveness of the opinions of the current attending physician, Dr. Schaffner, and a consulting physician, Dr. Eng, who both opined that the compensable 1982 injury is the major contributing cause of the current back condition, and, on the other, the opinion of Dr. Fuller, an examining physician, who reached the opposite conclusion. Although finding that Dr. Fuller's opinion had shortcomings, the ALJ nevertheless found it more persuasive than those of Drs. Schaffner and Eng. Therefore, the ALJ determined that claimant had failed to sustain his burden of proof.

On review, claimant contends that the ALJ should have deferred to Dr. Schaffner's opinion because, as attending physician, he had the opportunity to observe claimants condition over time and was, therefore, in the best position to address the causation issue.

Ordinarily greater weight is given to the opinion of an attending physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, we agree with the ALJ's reasoning in support of his decision not to give greater weight to Dr. Schaffners opinion. Moreover, we note that Dr. Schaffner did not begin treating claimant's back condition until July 1996, nearly 14 years after the compensable injury in 1982. Thus, Dr. Schaffner is in no better position than the examining physician, Dr. Fuller, in determining the cause of claimant's current back condition. *See McIntyre v. Standard Utility Contractors*, 135 Or App 298, 302 (1995) (a treating physician's opinion is less persuasive when the physician did not examine the claimant immediately following the injury).

Granted, Dr. Fuller's opinion has its shortcomings as noted by the ALJ. Nevertheless, it is claimant's burden of proof. *See* ORS 656.266.[1] Having reviewed this record *de novo*, we agree with the

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[1] ORS 656.266 provides:

"The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."

ALJ that Dr. Schaffner's opinion is not sufficient to establish that the compensable 1982 injury is the major contributing cause of the current back condition. Accordingly, we conclude that the ALJ properly upheld SAIF's current condition denial.[2]

The ALJ also upheld SAIF's denial of claimant's gastritis condition, finding that this condition was not compensable as a consequential condition under ORS 656.005(7)(a)(A).[3] Specifically, the ALJ determined that the compensable injury was not the major contributing cause of the gastritis condition, even though he found that claimant's use of anti-inflammatory medication for his low back condition was the major cause of the gastritis condition. The ALJ reasoned that the use of medication was for noncompensable degenerative conditions rather than the compensable thoracic and lumbar strains resulting from the 1982 injury.

Claimant contends that the ALJ incorrectly decided this issue. Claimant asserts that SAIF's denial of the gastritis condition should be set aside because the medical evidence establishes that this condition arose out of his long-term use of anti-inflammatory medication for his compensable injury. We disagree.

Inasmuch as we have determined that claimant's current back condition is not compensable, any medical opinion relating the gastritis condition to use of medication for the compensable injury must have factored out use related to the current back condition. Although Dr. Schaffner and a consulting gastroenterologist, Dr. Heinonen, related the gastritis condition to claimant's use of anti-inflammatories for relief of back pain (Exs. 14-3, 15, 17, 24-2), those opinions have not factored out claimants medication intake related to his noncompensable current back condition. Thus, we do not find Dr. Schaffner's or Dr. Heinonen's opinion establishes the compensability of the gastritis condition.

Accordingly, we find that the ALJ properly upheld SAIF's denial.

ORDER

The ALJ's order dated July 6, 1999 is affirmed.

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[2] Because we have determined that claimant's current back condition is not compensable, we find no compelling reason to remand the claim to the ALJ.

[3] That statute provides:

"No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

In the Matter of the Compensation of
CRAIG A. CARTER, Claimant
Own Motion No. 98-0400M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable thoracic and lumbar conditions. Claimant's aggravation rights on that claim expired on June 21, 1989.

On September 28, 1999, SAIF denied the compensability of claimant's current gastric condition. On November 3, 1998, SAIF denied the compensability of and responsibility for claimant's current low back condition. Claimant requested a hearing. (WCB Case No. 98-07929). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated July 6, 1999, Administrative Law Judge (ALJ) Crummé upheld SAIF's September 28 and November 3, 1998 denials. Claimant requested Board review of ALJ Crummé's order, and in an order issued on today's date, the Board affirmed ALJ Crummé'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 conditions 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.

June 23, 2000 Cite as 52 Van Natta 1047 (2000)

In the Matter of the Compensation of
SHEILA C. DELGADO, Claimant
WCB Case Nos. 99-04255 & 98-07487
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers, Bock and Phillips Polich.

The SAIF Corporation, on behalf of PAE Consulting Engineers, Inc. (PAE), requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its denial of compensability and responsibility of claimants upper extremity condition; and (2) upheld SAIF's responsibility denial, on behalf of Interface Engineering, Inc. (Interface), of the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except we change "cat operator" in the third paragraph to "CAD operator."

CONCLUSIONS OF LAW AND OPINION

Claimant worked at SAIF/PAE as a CAD operator between October 1996 and April 1998. Claimant worked in the same position at SAIF/Interface between April 1998 and September 1998. In May 1998, claimant sought treatment for bilateral upper extremity symptoms.

The dispute at hearing concerned the compensability of a condition diagnosed by examining orthopedic surgeon, Dr. Gritzka, as bilateral triangular fibrocartilage complex derangement (TFCD). Finding that Dr. Gritzka provided the most reliable opinion, the ALJ found that claimant proved compensability under ORS 656.802(2)(a). Applying the last injurious exposure rule, the ALJ further concluded that SAIF/Interface was responsible for the condition.

On review, SAIF/Interface continues to contest compensability. In particular, it contends that, because Dr. Gritzka's opinion is no more persuasive than the rebutting medical opinions, claimant did not carry her burden of proof.

After Dr. Gritzka examined claimant at claimant's attorneys request, he reported that claimant's work activities as a CAD operator were the major contributing cause of her condition. (Ex. 27-8). Although finding that her work at SAIF/PAE and SAIF/Interface contributed to the condition, Dr. Gritzka thought that work at SAIF/PAE contributed the most because claimant had worked for a longer time there. (*Id.*) Dr. Gritzka further stated that claimant did not have a preexisting condition. (*Id.*)

The panel of Dr. Arbeene, orthopedic surgeon, Dr. Gardner, neurologist, and Dr. Dordevich, rheumatologist, then examined claimant on behalf of SAIF. The panel disagreed with Dr. Gritzka's diagnosis of TFCD, finding no "abnormalities that would suggest dysfunction of the triangular

fibrocartilage complexes at either of the distal radial ulnar joints." (Ex. 30-6). The panel instead diagnosed possible bilateral carpal tunnel syndrome and found that the condition was unrelated to work because claimant did not perform "repetitive hand motions." (*Id.* at 5).

Dr. Gritzka reviewed the panels report and found that some examination findings showed derangement of the triangular fibrocartilage complex in the wrist. (Ex. 32-3). Dr. Gritzka also discussed studies showing a correlation between carpal tunnel syndrome and repetitive hand and wrist work activities. (*Id.* at 3-4).

Dr. Arbeene provided an additional report stating that, when the panel conducted its examination, it "paid particular attention" to Dr. Gritzka's TFCD diagnosis and the wrist joint. (Ex. 34-1). According to Dr. Arbeene, they found no "signs and symptoms to establish this diagnosis" and explained that the most typical cause of such a condition was a history of acute trauma, which was not reported by claimant. (*Id.*)

Dr. Gritzka was then deposed. Dr. Gritzka explained that, although trauma caused TFCD, there were no medical studies showing a correlation between the condition and hand activity. (Ex. 35-12). Dr. Gritzka believed, however, that because the condition occurred with people who performed hand intensive activities, "it would logically seem" that TFCD was causally related to such activity. (*Id.* at 13).

Dr. Gritzka then discussed whether claimant had a "subclinical rheumatologic disorder," finding that she probably had such a condition. (*Id.* at 34). According to Dr. Gritzka, this condition was a "contributing factor." (*Id.* at 35). With regard to major contributing cause, Dr. Gritzka stated that the answer was more a "statement of art" than scientific; he explained that, if claimant "hadn't been doing hand-intensive activities, its probable that this would have never occurred, and she would have pooped along all her life with an underlying condition that never became manifest in a syndrome." (*Id.* at 36).

Dr. Gritzka further explained that, although the TFDC condition was probably related to repetitive forearm supination and wrist motion, "lurking in the background," claimant also had a "tendonitis-like condition" the cause of which was more difficult to determine. (*Id.* at 37). Dr. Gritzka thought that work activities were the major contributing cause of the "condition becoming manifest," and that, if claimant had not performed her work, she would not have developed TFCD or forearm tendonitis. (*Id.* at 37-38). Dr. Gritzka and claimant's attorney then had the following exchange:

> "Q. I'm going to go back to my previous question. As I understand and I'm going to try and paraphrase what you told me. Your opinion is that work as the major contributing cause of the symptoms, the work at PAE was the major contributing cause of the symptoms, but you're unsure whether or not PAE was the major contributing cause of the underlying condition.
>
> "A. Right. Well, I think it was the cause of her symptoms, which are the result of an underlying diasthesis or tendency in her work activities combining to produce her symptoms. If she hadn't done the work, she probably wouldn't have developed the symptoms." (*Id.* at 39).

Dr. Gritzka then provided two additional reports. In the first, he detailed claimants work activities and stated that his review did not "change any of the opinions that I have rendered in this case[.]" (Ex. 36-4). Dr. Gritzka then clarified to SAIF his opinion that, although work at SAIF/Interface contributed to the development of claimants conditions, it was not the major contributing cause. (Ex. 39-2).

After carefully reviewing Dr. Gritzka's opinion, especially his deposition testimony, we find that he identified a preexisting condition (whether a subclinical rheumatological disorder or "tendonitis-like" condition) that contributed to her need for treatment. In this regard, Dr. Gritzka discussed how claimant had an "underlying condition" and a condition "lurking in the background." Several times, Dr. Gritzka stated that claimant's work activities caused her condition to "become manifest" and that she would not have developed her condition in the absence of such work activities.

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). 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, we understand Dr. Gritzka as indicating that claimant has a preexisting condition and that, but for her work activities, her condition would not have "become manifest." 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).

Furthermore, as he explained during his deposition, Dr. Gritzka was not relying on medical studies to find a correlation between TFCD and intensive hand/wrist activities but on his opinion that such a relationship seemed logical. Dr. Arbeene, however, rejected this theory and explained that, in the absence of acute trauma, he disagreed with the diagnosis. Because Dr. Gritzka's theory concerning the relationship between claimant's work activities and TFCD were rebutted, we find Dr. Gritzka's opinion, with regard to this reasoning, to be in equipoise with the remaining medical opinions. This conclusion is further supported by the fact that Dr. Gritzka saw claimant one time in order to evaluate causation rather than treat claimant and, thus, is not entitled to deference as a treating physician.

In response to the dissents argument that claimant in part carried her burden of proof because the ALJ found claimant credible based on demeanor, we emphasize that we have not rejected the ALJ's credibility finding. Instead, as the preceding discussion shows, we base our decision solely on an evaluation of the medical evidence and the particular conclusion that Dr. Gritzka's opinion was not sufficient to prove compensability. In medically complex cases such as this, it is not enough for claimant to be found credible, there must also be persuasive medical opinion evidence.

In sum, we find Dr. Gritzka's opinion insufficient to carry claimant's burden of proving that her work activities were the major contributing cause of her bilateral upper extremity condition. Thus, we conclude that she did not prove compensability. *See* ORS 656.802(2). In light of this conclusion, it is not necessary to determine responsibility.

ORDER

The ALJ's January 5, 2000 order is reversed. SAIF/PAE's and SAIF/Interface's denials of compensability are reinstated and upheld. SAIF/Interface's denial of responsibility also is reinstated and upheld. The ALJ's attorney fee award is reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not prove compensability. At hearing, claimant's credibility was challenged by SAIF and the employers. The ALJ carefully evaluated claimant's credibility and, based on her demeanor, found her credible. Thus, the ALJ relied on claimant's truthful testimony to decide that Dr. Gritzka based his opinion on an accurate history.

I would not disturb the ALJ's finding. As the person viewing the witnesses testifying, the ALJ has an advantage over the Board in deciding demeanor-based credibility. Accordingly, the ALJ's credibility finding is entitled to deference.

Moreover, I disagree that Dr. Gritzka's opinion is not sufficient to carry claimant's burden of proof. As the ALJ found, Dr. Gritzka provides the most complete, well reasoned and therefore most reliable and most persuasive medical causation opinion. Based on his careful interview of claimant concerning her job duties, Dr. Gritzka relied on an accurate history. Dr. Gritzka also thoroughly explained why claimant's hand intensive work caused her TFCD condition.

In short, because claimant is credible and Dr. Gritzka provided the most persuasive medical opinion, claimant unquestionably carried her burden of proof. Thus, I would affirm the ALJ's order finding that claimant proved compensability.

In the Matter of the Compensation of
JOHN W. HYATT, Claimant
WCB Case Nos. 99-01329 & 98-04242
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's aggravation claim for a left shoulder strain condition; (2) set aside its denial of claimant's occupational disease claim for a left shoulder arthritic condition; and (3) awarded a $7,500 assessed attorney fee under ORS 656.386(1). On review, the issues are aggravation, compensability and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable left shoulder injury on February 23, 1997, when he fell backwards and caught himself on a railing, twisting his arm and shoulder. The insurer accepted a left shoulder and upper back strain. (Exs. 23, 36). On August 8, 1997, the insurer issued a Notice of Closure awarding 12 percent unscheduled permanent disability. On September 11, 1997, Dr. Peterson wrote to the insurer and stated that the left shoulder condition was "not likely to undergo worsening." (Ex. 38). Claimant resumed his regular job.

On December 9, 1997, claimant returned to Dr. Peterson complaining of increased left shoulder pain. (Ex. 40). An arthrogram performed on December 12, 1997 was "negative." (Ex. 42). On February 6, 1998, claimant's treating physician, Dr. Chamberlain, diagnosed arthrosis of the acromioclavicular (AC) joint. (Ex. 44). On April 7, 1998, claimant filed an aggravation claim, alleging that his compensable left shoulder strain had worsened and required surgery. (Ex. 47). The insurer denied claimant's aggravation claim on April 30, 1998. (Ex. 51).

On June 8, 1998, Dr. Chamberlain performed an arthroscopy, subacromial decompression and Mumford procedure on claimant's left shoulder. (Ex. 56). On November 11, 1998, claimant filed an occupational disease claim alleging that his left shoulder condition was caused by "repetitive trauma from 1986-98." (Ex. 63). On February 5, 1999, the insurer denied claimant's occupational disease claim. (Ex. 65).

Dr. Chamberlain concluded that claimant's work activity was the major contributing cause of his left shoulder arthrosis condition, based on the "anecdotal" information provided to him, but not based on any scientific studies. (Ex. 68-21). Dr. Chamberlain reasoned that claimant's work activities caused inflammation in his shoulder joint, which then caused degeneration, or arthrosis. (Ex. 61-14, -16). Dr. Bald, who performed an examination at the request of the insurer, concluded that claimant's arthrosis condition was preexisting and degenerative in nature, and was more likely related to one or both of claimant's motor vehicle accidents from 1972 and 1986 than to claimant's February 23, 1997 compensable injury or to his work activities in general. (Ex. 64). Dr. Chamberlain originally concurred with Dr. Bald, then changed his opinion at his second deposition in reaction to additional information about claimant's motor vehicle accidents. (Ex. 68-28).

The ALJ set aside the insurer's denials, relying on the opinion of Dr. Chamberlain. In reaching this decision, the ALJ noted that Dr. Chamberlain's reasoning regarding claimant's work activity causing inflammation, which caused the arthrosis condition, was unrebutted. The ALJ found Dr. Bald's opinion unpersuasive, because he had relied on the incorrect information that claimant had injured his shoulder in one or both of his motor vehicle accidents.

The insurer contends that claimant did not meet his burden of proving either an aggravation or occupational disease claim based on his left shoulder arthrosis condition. We agree with the insurer in regard to the aggravation claim, but not with regard to the occupational disease claim.

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

Here, the insurer accepted only a left shoulder strain condition. (Exs. 23, 36). Therefore, claimant must prove that he has suffered a worsening of that condition. ORS 656.273(1). There is no evidence in the record that claimant's left shoulder strain condition worsened since the October 8, 1997 Notice of Closure. Rather, claimant seeks compensation for a new and different left shoulder arthrosis condition. All physicians in the record agree that claimant's February 23, 1997 injury did not itself cause claimant's left shoulder arthrosis condition. (Exs. 45, 50, 61-4, 64-6). Therefore, we reverse that portion of the ALJ's order that set aside the insurer's aggravation denial.

We agree with the ALJ, however, that claimant has proved that his work activities are the major contributing cause of his left shoulder arthrosis condition. ORS 656.802(2)(a). The insurer contends that claimant did not meet his burden because Dr. Chamberlain did not adequately explain his change in opinion after originally concurring with Dr. Bald. We disagree. A physician's change in opinion, if adequately explained, can still be persuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987).

Here, Dr. Chamberlain concurred with Dr. Bald's report on March 5, 1999. (Ex. 65A). However, at his January 4, 2000 deposition, Dr. Chamberlain reconsidered and then retracted his agreement with Dr. Bald when presented with the correct information that claimant did not sustain an injury to his left shoulder in either of his motor vehicle accidents. (Ex. 68-28; Tr. 31).

As the ALJ observed, Dr. Chamberlain's reasoning that the stress on claimant's shoulder from his repetitive work activities causes inflammation, which in turn causes degeneration (arthrosis), is unrebutted by any physician. (Ex. 61-14, -16). Dr. Chamberlain's reasoning therefore also was not based merely on a "temporal relationship" between claimant's work activity and his left shoulder condition, as the insurer contends, but rather on the physiological sequence described above. We find Dr. Chamberlain's opinion to be the most well-reasoned and therefore persuasive. *Somers v. SAIF*, 77 Or App 259 (1986).

Moreover, we find that Dr. Chamberlain's opinion is stated in terms of reasonable medical probability. Dr. Chamberlain acknowledged that he had reviewed no "scientific studies" which conclude that repetitive work activities can cause arthrosis in shoulders. (Ex. 68-14). However, Dr. Chamberlain stated his final opinion based on the history provided to him by claimant, on the absence of off-work activities that could contribute to the condition, and on the fact that claimant had not been injured in either of his motor vehicle accidents. (Ex. 68-21, -28). Under such circumstances, on this particular record, we find that Dr. Chamberlain's opinion is persuasive because it is based on complete and accurate information. *Somers v. SAIF*, 77 Or App at 263.

The insurer next argues that Dr. Chamberlain has reached an opinion merely by ruling out other, non-work-related causes. (*See* Ex. 68-29). Claimant may not meet his burden of proof merely by disproving other possible explanations of how the disease occurred. ORS 656.266. However, here, in addition to ruling out other possible causes, Dr. Chamberlain reasoned that claimant's work activities directly caused his AC joint arthrosis condition by creating inflammation over time. (Ex. 68-29, -30). This is medical evidence positively establishing compensability. We are therefore satisfied that claimant has not relied solely on medical evidence that disproves non work-related causes. *Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996).

Dr. Bald, in contrast, relied on an incorrect history of claimant's having injured his left shoulder in one or both of the automobile accidents. (Ex. 64-9). Medical opinions that are based on inaccurate information are not persuasive. *Miller v. Granite Construction*, 28 Or App 473, 478 (1977).

Finally, the insurer contends that the ALJ's $7,500 attorney fee award was excessive in light of the "uncomplicated" nature of this case. We agree, but for a different reason. In light of the fact that we have partially reversed the ALJ's order and reinstated the insurer's aggravation denial, we correspondingly reduce claimant's attorney fee award to $6,000.

In reaching this conclusion, we have particularly considered the factors enumerated in OAR 438-015-0010(4). The time commitment evidenced by this record is above average. Two hearings were convened, generating a total of 89 transcript pages. Three witnesses testified at the second hearing. This case was more medically complex than an ordinary case involving compensability. The parties submitted 68 total exhibits and participated in three medical depositions. We note that the predominant issue at hearing was compensability of claimant's occupational disease claim. Our review of the record, and in particular the deposition testimony, reveals that comparatively little time was spent by the parties in litigating the "aggravation" issue. (*See* Exs. 61, 62, 68).

The parties' positions were presented in a thorough and professional manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical evidence, there was a risk that claimant's counsel would go uncompensated. Accordingly, we modify the ALJ's attorney fee award in light of the factors in OAR 438-015-0010(4).

Claimant's attorney is entitled to an assessed fee for services on review regarding the occupational disease 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 attorney fee for claimant's attorney's services on review regarding the occupational disease issue is $640, 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 and claimant's attorney's uncontested statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated February 22, 2000 is affirmed in part, reversed in part, and modified in part. That portion of the order that set aside the insurer's denial of claimant's aggravation claim is reversed. The insurer's April 30, 1998 denial is reinstated and upheld. That portion of the ALJ's order that awarded a $7,500 assessed attorney fee is modified. In lieu of the $7,500 award, claimant's attorney is awarded $6,000, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $640, payable by the insurer.

In the Matter of the Compensation of
MICHAEL J. JOHNSON, Claimant
WCB Case No. 99-01535
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

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

Claimant requests review of Administrative Law Judge Brazeau's order that: (1) upheld the self-insured employer's denial of his current low back condition at L4-5; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

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

In upholding the employer's denial of claimant's L4-5 disc condition, the ALJ applied the major contributing cause standard of ORS 656.005(7)(a)(B) and determined that claimant had failed to sustain his burden of proof under that statute. Claimant contends on review that the ALJ "mistakenly inserted" the combined-condition issue because it was not raised by the parties and, further, that the record does not establish the presence of a "combined condition." We disagree.

In analyzing the compensability of claimant's L4-5 disc condition, the ALJ as fact-finder was required to determine the appropriate standard of compensability. *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)). Thus, the ALJ did not err in determining whether ORS 656.005(7)(a)(B) applied in this case.

The evidence concerning the existence of a "combined condition" is admittedly rather sparse. Nevertheless, Dr. Gerry, a physician who treated claimant, agreed that the on-the-job injury, "even when combined with the pre-existing degenerative condition," remained the major contributing cause of the L4-5 disc condition. (Ex. 60-2). This evidence supports the ALJ's conclusion that this case concerned a "combined condition." Accordingly, we conclude that the ALJ properly applied the major-cause standard of ORS 656.005(7)(a)(B). Moreover, for the reasons cited by the ALJ, we agree that the L4-5 disc condition is not compensable.

ORDER

The ALJ's order dated December 8, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's determination that claimant's current L4-5 disc condition is not compensable under ORS 656.005(7)(a)(B). This includes the ALJ's finding that claimant has a preexisting lumbar condition that "combined" with the compensable injury. However, there is scant evidence of a preexisting lumbar condition, let alone persuasive evidence that it combined with the compensable injury to cause disability or a need for treatment.

Dr. Gerry was the only physician to address the combined condition issue. Dr. Gerry agreed that claimant had some preexisting degenerative process, but that it was mild and consistent with claimant's age (44). Dr. Gerry did not indicate that the alleged preexisting condition contributed or predisposed claimant to disability or a need for treatment. (Ex. 60-2). Thus, without more, I would not find that this degenerative condition, which Dr. Gerry indicates was normal for someone of claimant's age, qualifies as a "preexisting condition" under ORS 656.005(24). Moreover, even if it could, I would not find that Dr. Gerry's opinion establishes that it "combined" with the compensable injury to cause a need for treatment

The statement of Dr. Gerry's to which the majority refers as support for its finding that there was a "combined" condition was cast in the form of a hypothetical. It does not reflect a definitive statement by Dr. Gerry that the alleged preexisting degenerative condition "combined" with the compensable injury to cause disability or a need for treatment.

In conclusion, on this record, I would not apply ORS 656.005(7)(a)(B). Therefore, I believe the majority has incorrectly affirmed the ALJ's application of that statute. Moreover, even if that statute was applicable, Dr. Gerry's well-reasoned opinion establishes compensability under its major contributing cause standard. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
JOHN J. McLAIN, Claimant
WCB Case No. 99-06832
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that increased an Order on Reconsideration's award of 21 percent (67.2 degrees) unscheduled permanent disability to 54 percent (172.8 degrees) for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

On August 24, 1995, claimant, a Feeder Operator in the employer's Rock Crusher department, compensably injured his low back when he fell down a ladder. After claimant underwent two surgeries at L5-S1, the claim was closed by an October 22, 1996 Notice of Closure that awarded 29 percent unscheduled permanent disability. (Ex. 3).

On June 18, 1997, Dr. Newby performed a laminectomy and fusion at L5-S1 for a recurrent disc herniation. (Ex. 5). On May 23, 1998, claimant was examined for SAIF by Drs. Melson, neurologist, and Neumann, orthopedic surgeon, who declared claimant medically stationary. (Ex. 7). Dr. Newby concurred with their examination. (Exs. 8, 10).

On September 2, 1998, SAIF issued a Notice of Closure that declined to redetermine the extent of unscheduled permanent disability because there had been no actual worsening of claimant's condition since the last arrangement of compensation, pursuant to OAR 436-035-0007(8)(b). (Ex. 9). Claimant requested reconsideration and appointment of a medical arbiter.

On January 9, 1999, Dr. Smith, orthopedic surgeon, performed a medical arbiter examination in which he determined that claimant's medical condition had actually worsened since the October 22, 1996 claim closure. (Ex. 15).

A January 21, 1999 Order on Reconsideration awarded claimant a total of 40 percent unscheduled permanent disability. (Ex. 16).

From February 8, 1999 until March 5, 1999, claimant was enrolled in an authorized training program (ATP) (truck driving school). (Exs. 15-2, 17).

On March 8, 1999, Dr. Newby examined claimant. (Exs. 18, 19).

On April 7, 1999, SAIF issued a Notice of Closure that decreased claimant's unscheduled permanent disability award to 22 percent. (Ex. 20). Claimant requested reconsideration. Claimant relied on Dr. Smith's January 9, 1999 medical arbiter examination. (Ex. 21).

An August 11, 1999 Order on Reconsideration reduced claimant's unscheduled permanent disability to 21 percent. Claimant requested a hearing, seeking to increase the permanent disability award.

CONCLUSIONS OF LAW AND OPINION

The ALJ modified the Order on Reconsideration's award, increasing it to 54 percent. The ALJ relied on Dr. Smith's evaluation of claimant's range of motion (ROM) and work restrictions. SAIF objects to the ALJ's order, asserting that claimant is entitled to no more than its prior award of 22 percent unscheduled permanent disability. Specifically, SAIF disagrees with the values for claimant's ROM, specific vocational preparation time (SVP), and residual functional capacity (RFC) and contends that the Notice of Closure award should be reinstated. SAIF relies on Dr. Newby's March 8, 1999 examination.

Claimant has the burden to prove that he is entitled to a greater award of unscheduled permanent disability for his cervical spine than that awarded by the reconsideration order. ORS 656.266.

We evaluate claimant's disability as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence. OAR 436-035-0007(14).

We agree with the ALJ that the arbiter's (Dr. Smith's) evaluation of claimant's permanent impairment due to his compensable injury is more persuasive than that of Dr. Newby, for the following reasons.

On March 8, 1999, Dr. Newby concurred with the arbiter's findings of January 9, 1999. (Ex. 18). Yet, on the same day, Dr. Newby provided a different set of ROM measurements to SAIF and released claimant to heavy work. (Exs. 18, 19). Later, when requested by the Appellate Review Unit to explain his apparent change of opinion, Dr. Newby merely referred back to his March 8, 1999 findings. (Ex. 22).

We do not find Dr. Newby's conclusory response regarding his conflicting opinions sufficient to establish a level of impairment different from that found by the arbiter, particularly in light of his failure either to clarify his concurrence or to explain his apparent change of opinion. Consequently, we find the arbiter's report more persuasive than that of the attending physician. *Somers v. SAIF*, 77 Or App 259 (1986) (we give the greatest weight to those opinions that are the most well-reasoned and that are based on the most accurate information).[1]

SAIF also contends that Dr. Smith's evaluation should not be used to determine impairment because Dr. Newby's examination was done closer in time to the Reconsideration Order. We do not agree.

Even though Dr. Newby examined claimant closer in time to the reconsideration order and reported increased low back range of motion, we do not find his report to be persuasive evidence that claimant's range of motion is greater than that measured by the arbiter. First, the fact that Dr. Newby examined claimant closer in time to the reconsideration order is not always decisive. *David J. Rowe*, 47 Van Natta 1295, 1297 (1995). Even though Dr. Newby's findings were made later in time, there was only a two-month period between Dr. Smith's and Dr. Newby's examinations. In the interim, claimant received no treatment and completed only a short three-week truck driver training program. Moreover, as discussed above, we have found that Dr. Smith provided the more persuasive medical opinion addressing claimant's permanent impairment. Because the arbiter's report is a more thorough and well-reasoned evaluation of claimant's impairment, we conclude that the medical evidence does not preponderate against a level of impairment different than that determined by the arbiter. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993) (Board will rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

SAIF next contends that Dr. Smith's evaluation should not be used because he reported that claimant's condition had actually worsened, thus indicating that claimant's condition had changed since the September 2, 1998 "pre-ATP" closure.

SAIF misinterprets Dr. Smith's statement. Dr. Smith was not referring to a "worsening" since the September 2, 1998 closure. Dr. Smith actually stated: "[Claimant's] condition has actually worsened since closure in 1996." Dr. Smith was referring to claimant's condition during the interval between the prior October 22, 1996 closure (which is not before us) and SAIF's first (September 2, 1998) closure during this open period.[2]

Finally, citing *Dana K. Moore*, 49 Van Natta 2045 (1997), SAIF asserts that Dr. Smith's report should not be treated as a medical arbiter report because there was no arbiter's examination performed as part of the reconsideration process for the "post-ATP" closure. This evidentiary issue was not raised at hearing and the ALJ did not address it. We have consistently held that we will not consider an issue raised for the first time on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *Phyllis G. Nease*, 49 Van Natta 195, 197 (1997); *see also Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997). Accordingly, we decline to consider the late-raised evidentiary issue in this case.

Education

The parties do not dispute the values for age (0) and formal education (1). The ALJ concluded that claimant had an SVP of 2 for an SVP value of 4. We disagree.

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[1] The ALJ found that Dr. Newby's findings were not correlated by the standard validity criteria and concluded that they were insufficiently valid for determining claimant's permanent disability. That analysis is incorrect. The ALJ may not substitute his own opinion regarding the validity of the range of motion findings, because determination regarding the validity of the testing must be made by the medical examiner performing the tests. *Michael D. Walker*, 46 Van Natta 1914 (1994).

[2] In any case, Dr. Smith's statement is not relevant to the redetermination of permanent disability. A change in a claimant's condition is not required to obtain a redetermination of extent of disability on completion of an ATP. ORS 656.268(9); *Hanna v. SAIF*, 65 Or App 649, 652 (1983); *Richard La France*, 48 Van Natta 427, 430 (1996).

A worker's SVP value is based on the highest SVP of any job the worker has performed or for which the worker has successfully completed an ATP or other training during the five years preceding the date of issuance of the Notice of Closure (April 7, 1999). OAR 436-035-0300(3). The highest SVPs of jobs claimant performed or completed training for during the five years prior to April 7, 1998 are Drier Tender, DOT # 563.585-010, for an SVP of 4 (Ex. 2);[3] and Truck Driver, DOT # 905.663-014, for an SVP of 4 (Ex. 20).[4] Because the highest SVP is 4, the SVP value assigned is 3. OAR 436-035-0300(4).

Adaptability

Adaptability is measured by comparing Base Functional Capacity (BFC) to the worker's maximum Residual Functional Capacity (RFC). OAR 436-035-0310(2). Here, claimant's job at injury was Drier Tender, DOT # 563.585-010, which is classified as "heavy." (Ex. 3).

SAIF contends that claimant's RFC is "heavy," based on Dr. Newby's opinion.

Under OAR 436-035-0310(5), RFC is the worker's greatest physical capacity, evidenced by:

"(a) The attending physician's release; or

"(b) A preponderance of medical opinion which includes but is not limited to a second-level PCE or WCE as defined in OAR 436-010-0005 and 436-009-0020(30) or any other medical evaluation which includes but is not limited to the worker's capability for lifting, carrying, pushing/pulling, standing, walking, sitting, climbing, balancing, stooping, kneeling, crouching, crawling and reaching. If multiple levels of lifting and carrying are measured, an overall analysis of the worker's lifting and carrying abilities should be provided in order to allow an accurate determination of these abilities."

For the reasons discussed above, we rely on Dr. Smith's evaluation.

Dr. Smith's January 9, 1999 report found that claimant was capable of lifting and carrying 20 pounds on an occasional to *frequent* basis, with restrictions on stooping, twisting or crawling. (Ex. 15-6). Based on Dr. Smith's evaluation, we find that claimant's RFC was "medium/light" with restrictions, which puts claimant in the light category. *See* OAR 436-035-0310(3)(g).

Comparing claimant's BFC of "heavy" with his RFC of "light" results in an adaptability factor of 5. OAR 436-035-0310(6).

The total value of claimant's age (0), education (1) and skills (3) is 4. That value is multiplied by the adaptability value of (5) for a total of 20. OAR 436-035-0280(6). When this value is added to the value for impairment (24), the result is 44. OAR 436-035-0280(7). Therefore, claimant's unscheduled permanent disability is 44 percent (140.8 degrees). Consequently, we modify the ALJ's order to reduce claimant's unscheduled permanent disability award from 54 percent to 44 percent. In other words, we increase claimant's unscheduled permanent disability award for a low back condition from 21 percent (67.2 degrees), as awarded by the Order on Reconsideration, to 44 percent (140.8 degrees).

ORDER

The ALJ's order dated January 26, 2000 is modified. In lieu of the ALJ's permanent disability award, claimant's unscheduled permanent disability award for a low back condition is increased from 21 percent (67.2 degrees), as awarded by the Order on Reconsideration, to 44 percent (140.8 degrees). Claimant's counsel's "out-of-compensation" attorney fee, as awarded by the ALJ, shall be modified accordingly.

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[3] We note that Exhibit 2 shows the SVP as 3. Although the SVP in the DOT for Drier Tender is 4, OAR 436-035-0300(4) provides that, after determining the highest SVP met by the worker, the next step is to assign a value according to the table in the rule. That value is 3.

[4] OAR 436-035-0300(3)(b)(B) provides that a worker has also met the SVP for a job after successfully completing an ATP for that job classification. Here, claimant successfully completed an ATP for truck driver. Accordingly, claimant qualifies for an SVP of 4 and a value of 3 for Truck Driver by virtue of the rule.

In the Matter of the Compensation of
DONNA J. BALOGH, Claimant
WCB Case No. 99-01547
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) remanded claimant's low back injury claim to the Appellate Review Unit (ARU) to consider evidence not submitted at the time of reconsideration; and (2) assessed a penalty for the employer's allegedly unreasonable claims processing. On review, the issues are remand to the ARU, penalties, and (potentially) extent of scheduled and unscheduled permanent disability.[1] We reverse.

FINDINGS OF FACT

As part of its investigation of claimant's January 1998 low back injury claim, the employer took a statement from claimant on February 5, 1998. (Ex. F). A low back strain was accepted on March 3, 1998, but an L4-5 disc protrusion was denied. (Ex. 18). Claimant requested a hearing.

The employer provided claimant's statement to claimant's attorney, along with all claims documents, on April 22, 1998, in anticipation of a hearing on the compensability of the disc protrusion. (Ex. C). The employer eventually agreed to accept the claim for the L4-5 disc protrusion. (Ex. 26).

On August 28, 1998, the claim was closed by Determination Order that awarded 6 percent unscheduled permanent disability and 5 percent scheduled permanent disability for loss of use or function of the right foot. (Ex. 33). On October 26, 1998, claimant requested reconsideration, raising all issues on the reconsideration request form. (Ex. 34). That same day, claimant's attorney requested that, before issuing a reconsideration order, the ARU provide to the parties a complete chronological, indexed list of all documents that were part of the "Appellate Unit Record." (Ex. 34-2).

On November 23, 1998, the ARU wrote claimant (with copies to all the parties) to advise that the reconsideration proceeding would be postponed pending a medical arbiter examination. (Ex. 37). The ARU advised that the Order on Reconsideration was scheduled to be issued by January 22, 1999, but that, if it was not mailed by that date, the reconsideration request would be "deemed denied" and the parties could proceed to hearing as if the claim closure had been affirmed in all respects.

After a medical arbiter's examination was performed, the ARU issued an Order on Reconsideration on January 21, 1999. (Ex. 40). The ARU declined to provide the indexed list of documents, concluding that, to do so, would result in excessive administrative cost to the system when the parties already had the information available to them. (Ex. 40-2). The ARU then proceeded to rate permanent disability. Claimant's unscheduled award was increased to 10 percent. The ARU also awarded 2 percent scheduled permanent disability for loss of claimant's left leg and 7 percent scheduled permanent disability for loss of the right leg. (Ex. 40-6).

In making the unscheduled award, the ARU noted that no educational or vocational history was submitted for reconsideration. Therefore, the medical record and claimant's job at injury were used to determine social/vocational factors. (Ex. 40-4). The ARU calculated the sum of the age and education factors as 2, which was multiplied by an adaptability factor of 1 for a product of 2. This product was added to an impairment value of 8, for a total of 10 percent unscheduled permanent disability. *Id.*

Claimant neither sought abatement of the Order on Reconsideration nor attempted to submit additional information regarding her claim. Instead, she requested a hearing from the reconsideration order.

[1] The Department has participated in these proceedings pursuant to ORS 656.726(4)(h).

CONCLUSIONS OF LAW AND OPINION

Although noting that the primary issue was extent of unscheduled permanent disability, claimant also observed at the hearing that the ARU did not have information regarding the education or social factors. Claimant further noted that her statement, which contained relevant information on the educational and social factors, was not submitted by the employer into the reconsideration record. Claimant requested that the statement be considered on the extent of disability issue or, alternatively, that the claim be remanded to the ARU for consideration of the statement. In addition, claimant sought a penalty for the employer's allegedly unreasonable failure to submit the statement to the ARU.

Although finding that the statement (Exhibit F) was relevant to the extent of disability issue and should have been submitted to the ARU, the ALJ declined to consider the statement on the merits of the permanent disability issue because it was not part of the reconsideration record. *See* ORS 656.283(7). The ALJ, however, determined that it was appropriate to remand the claim to the ARU for consideration of the statement. The ALJ reasoned that he had authority to do so under *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538 (1993), and that to not do so would leave claimant without a remedy and would allow the employer to ignore the administrative rules. Finally, the ALJ determined that the employer's failure to submit the statement to the ARU constituted an unreasonable resistance to the payment of compensation and warranted a penalty. Thus, the ALJ assessed a 25 percent penalty under ORS 656.262(11) based on any increase in compensation from the reconsideration order.

On review, the employer contends that the ALJ improperly remanded the claim to the ARU because he lacked authority to do so. Moreover, the employer contends that the ALJ incorrectly assessed a penalty. For the following reasons, we reverse the ALJ's decision to remand and to assess a penalty.

Remand

In arguing that this was not an appropriate case in which to remand to the ARU, the employer cited *Jeffrey L. Scott*, 49 Van Natta 503 (1997). The ALJ determined that *Scott* did not decide the issue of whether he was authorized to remand to the ARU for consideration of evidence not submitted as part of the reconsideration proceedings. Thus, the ALJ determined that *Scott* did not preclude a remand to the Department. While we agree with the ALJ that *Scott* did not decide the issue of whether the Board has authority to remand to the Department under circumstances similar to those presented here, we, nevertheless, find that *Scott* is helpful in resolving the remand issue.

In *Scott*, we affirmed an ALJ's order declining to remand the claim to the ARU to consider evidence not submitted at the time of reconsideration. The claimant contended that it was the carrier's duty to submit all evidence to the ARU. Nevertheless, we noted that the claimant was not precluded from submitting any relevant evidence. Furthermore, we observed that any oversight could have been brought to the ARU's attention, and the Order on Reconsideration could have been abated and withdrawn. Finally, we concluded that the claimant had failed to establish that inclusion of the omitted evidence in the reconsideration record might change the result. Accordingly, we did not find remand appropriate (assuming without deciding that we had the authority to remand the claim to the ALJ for further remand to the ARU). Therefore, we denied the claimant's motion for remand. 49 Van Natta at 503.

The employer in this case does not dispute that the social/vocational information contained in claimant's statement is relevant to the permanent disability issue, and, thus, that it may affect the outcome of the issue. However, there is no dispute that the employer had previously provided the statement to claimant. Therefore, like the claimant in *Scott*, claimant here could have submitted the statement for consideration by the ARU when she requested reconsideration. Moreover, as was true in *Scott*, it is similarly undisputed that any oversight could have been brought to the Director's attention, and the Order on Reconsideration could have been abated and withdrawn. *See* OAR 436-030-0135(1)(e).[2] Indeed, the reconsideration order itself plainly stated that the record contained insufficient

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[2] That rule provides that:

"When a party does not discover until after the reconsideration order has issued that additional documents were not provided by the opposing party in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information."

information regarding the social/vocational factors. Inasmuch as claimant (individually, as well as through her legal representative) had the relevant information, she, like the claimant in *Scott*, could have sought abatement of the reconsideration order.

Accordingly, we conclude as we did in *Scott* that remand is not appropriate (even assuming that the ALJ had authority to remand the claim to the ARU). Therefore, we conclude that the ALJ should have denied claimant's motion for remand.[3] Thus, we reverse.[4]

Penalty

Given our decision affirming the reconsideration order, we conclude that, even if the employer's failure to submit claimant's statement was unreasonable, there is no compensation due on which to base a penalty.[5] Thus, we also reverse the ALJ's decision to assess a penalty. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991).

ORDER

The ALJ's order dated December 13, 1999 is reversed. The January 21, 1999 Order on Reconsideration is affirmed. The ALJ's penalty assessment is reversed.

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[3] Citing our decision in *Jenny L. Boydston*, 50 Van Natta 691 (1998), the dissent argues that claimant's failure to seek abatement of the January 21, 1999 Order on Reconsideration was reasonable because, after January 22, 1999, the Department's authority to issue any reconsideration order ended. However, our interpretation of the relevant statute in *Boydston* (ORS 656.268(6)(d)) was incorrect. *See Boydston v. Liberty Northwest Insurance Corp.*, 166 Or App 336 (2000). In actuality, as the court's decision makes clear, there was no time limitation on the Department's authority in this case to abate and reconsider its prior order.

Moreover, the November 23, 1999 letter to claimant the dissent cites (Ex. 37) did not prohibit claimant from seeking post-January 22, 1999 abatement and reconsideration of any future order. It only stated that an Order on Reconsideration was scheduled to be issued on January 22, 1999 and that, if the order did not issue by that date, the reconsideration request would be "deemed denied" and that the parties could proceed to hearing. *Id.* Considering the circumstances of this case, we are persuaded that claimant could have sought abatement and reconsideration of the January 21, 1999 order.

[4] Given his disposition of the case, the ALJ did not reach the merits of the permanent disability issue. Moreover, the parties present no argument on extent of disability on review. At the hearing, however, claimant did identify his disagreement with the reconsideration order's calculation of unscheduled permanent disability. Claimant alleged that, based on her statement, her skills value should have been four instead of one and that her adaptability value should have been four instead of one. (Tr. 3). However, we are unable to consider claimant's statement inasmuch as it was not included in the reconsideration record. ORS 656.283(7). Having reviewed the reconsideration record *de novo*, we conclude that the ARU correctly calculated claimant's scheduled and unscheduled permanent disability based on that record. Therefore, we affirm the Order on Reconsideration's awards of permanent disability.

[5] In its brief, the Department alleges that the employer's failure to submit claimant's statement to the ARU was intentional. We agree, however, with the employer that this record does not establish that it intentionally failed to submit the statement.

Board Member Biehl dissenting.

Citing *Jeffrey L. Scott*, 49 Van Natta 503 (1997), the majority finds this was an inappropriate case in which to remand to the Department for consideration of important evidence the employer failed to submit during reconsideration proceedings. In so doing, the majority avoids the difficult issue of whether an ALJ has the authority to remand to the Department under circumstances such as these. Because I disagree with and would not apply the *Scott* rationale in this case, I dissent.

As noted by the majority, in *Scott*, we affirmed an ALJ's order declining to remand the claim to the ARU to consider evidence not submitted at the time of reconsideration. The claimant contended in *Scott* that it was the carrier's duty to submit all evidence to the ARU. However, we noted that the claimant was not precluded from submitting relevant evidence. Furthermore, we observed that any oversight could have been brought to the ARU's attention, and the Order on Reconsideration could have been abated and withdrawn. Finally, we held that the claimant had failed to establish that inclusion of the omitted evidence in the reconsideration record might change the result. Therefore, we did not find remand appropriate, even if we had the authority to remand the claim to the ALJ for further remand to the ARU. Accordingly, we denied the claimant's motion for remand in *Scott*.

It is true that, like the claimant in *Scott*, claimant here could have submitted her statement to the Appellate Review Unit (ARU) for consideration on the permanent disability issue. On the other hand, claimant had no reason to believe that the employer had not already done so. By following the *Scott* reasoning, the majority in essence requires both parties in a reconsideration proceeding to submit duplicate records in order to ensure that all records are before the ARU. This requirement is overly burdensome to claimants and is also unnecessary since carriers are already required to submit all relevant records under OAR 436-030-0135(5).

Granted, the January 21, 1999 Order on Reconsideration indicated to the parties that information regarding the social/vocational factors was missing. Arguably, claimant was then put on notice that additional information should be submitted to the Department. The majority asserts that claimant could have sought abatement of the reconsideration order. However, the ARU had informed claimant in November 1998 that, because a medical arbiter examination was scheduled, the reconsideration proceedings would be postponed. (Ex. 37). The ARU then informed claimant that a reconsideration order would issue by January 22, 1999. The reconsideration order ultimately issued on January 21, 1999.

In *Jenny L. Boydston*, 50 Van Natta 691 (1998), we held that the Department's authority to issue any reconsideration order ended after the expiration of the applicable statutory deadline for reconsideration. We subsequently adhered to that rationale in *George Allenby*, 50 Van Natta 1844 (1998). Thus, under that case authority, the Department could not have issued another reconsideration order after January 22, 1999.

I acknowledge that the Court of Appeals ultimately reversed our decision in *Boydston*. *See Boydston v. Liberty Northwest Insurance Corp.*, 166 Or App 336 (2000). Nevertheless, at the time of the proceedings in this case, the applicable case law held that the Department had no authority to issue a reconsideration order after a statutory deadline had passed. Therefore, we must assume that claimant was aware that she had only one day in which to request and obtain abatement and reconsideration of the January 21, 1999 Order on Reconsideration. I believe that, under these circumstances, it is unrealistic to expect claimant to have requested abatement of the Order on Reconsideration so that she could provide the missing statement.

I also note that the majority does not dispute that the omitted evidence in this case is likely to affect the outcome. This constitutes a "compelling reason" for remanding the claim to the Department. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). Moreover, this also provides an additional basis for distinguishing our decision in *Scott*, where, unlike this case, the claimant had failed to establish that inclusion of the omitted evidence in the reconsideration record might change the result.

Accordingly, based on the above reasoning, I would conclude that this was an appropriate case for the ALJ to remand to the ARU, assuming that such authority exists. I would, therefore, reach the merits of the issue of whether, under *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538 (1993), there is authority to remand to the ARU for submission and consideration of relevant and material evidence that a carrier fails to submit during reconsideration proceedings.

On that issue, I agree with the ALJ that *Gallino* provides sufficient authority for remand to the Department for consideration of claimant's statement because only the Department can grant the relief requested (that is, consider the omitted statement). By necessary implication, the Board has the power to remand the claim to the ARU and must do so. *Gallino*, 124 Or App at 542.

In conclusion, because the majority declines to remand the claim to the ARU, despite the fact that this is an appropriate case in which to do so, I must part company and dissent.

In the Matter of the Compensation of
DEBORAH L. DeHAVEN, Claimant
WCB Case No. 99-05191
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

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

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

The ALJ found that claimant had not met her burden of establishing the compensability of her C6-7 disc herniation condition. The parties agree that claimant suffers from preexisting degenerative disc disease in her cervical spine. Therefore, claimant must prove that her April 6, 1999 on-the-job injury was the major contributing cause of her disability and need for treatment for her cervical disc condition. ORS 656.005(7)(a)(B). *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997); *rev den* 326 Or 389 (1998).

Claimant's medical support comes from Dr. Gallo, a neurosurgeon who examined claimant on August 9, 1999. (Ex. 20). Generally, we will rely on the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, we agree with the ALJ that Dr. Gallo is not entitled to any deference as treating physician, given her one-time examination of claimant. In addition, Dr. Gallo did not examine claimant until four months after her on-the-job injury. In those circumstances, a treating physician is not entitled to any special deference. *See, e.g. Tina M. Valero*, 50 Van Natta 1475, 1476 (1998); *Cody L. Lambert*, 48 Van Natta 115 (1996).

Moreover, there is a reason to discount the persuasive weight of Dr. Gallo's opinion. Dr. Gallo concluded that claimant's April 6, 1999 injury was the major contributing cause of claimant's disability and need for treatment for her cervical disc herniation and radiculitis at C6-7. (Ex. 24). Dr. Gallo reasoned that claimant's work injury caused her previously degenerative C6-7 disc to herniate, thus resulting in radicular symptoms and need for treatment and surgery. (Ex. 24). However, in reaching this opinion, Dr. Gallo relied on an incorrect history of claimant's developing neck and arm pain when manipulating a pneumatic drill on April 5, 1999. (Ex. 25). In fact, claimant had pain only in her right shoulder after that incident, and she did not experience the onset of neck or arm pain until the next day, when she turned her head to the side. (Ex. 7; Tr. 16).

Medical opinions that rely on an inaccurate history are entitled to little, if any, weight. *Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977); *Gary A. Tebbetts*, 52 Van Natta 307 (2000). Accordingly, we agree with the ALJ that claimant did not meet her burden of proving the compensability of her claim. ORS 656.266.

ORDER

The ALJ's order dated March 13, 2000 is affirmed.

In the Matter of the Compensation of
ROSITA M. MEITHOF, Claimant
WCB Case No. 99-07293
ORDER ON REVIEW
Swanson, Lathen, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's aggravation claim for a bilateral trochanteric bursitis condition. On review, the issue is aggravation.

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

SAIF accepted claimant's claim for bilateral greater trochanteric bursitis on May 27, 1997. When claimant's condition was medically stationary in August 1997, Dr. Loberg, claimant's treating physician, released her to return to modified duty, which allowed her to modify her activities as needed when activity seemed to be flaring up her pain. (Ex. 7).

A February 5, 1988 Notice of Closure awarded claimant 11 percent scheduled permanent disability for loss of use or function of her right hip and 7 percent scheduled permanent disability for loss of use or function of her left hip (based on reduced range of motion). (Ex. 9). Claimant lost no work time and received no temporary disability. (*Id.*)

In early 1999, claimant's work activities exceeded her physical limitations and she suffered a worsening of symptoms related to her bursitis condition. (Exs. 20, 23, 27). Dr. Loberg took claimant off work due to her worsened condition. (Ex. 14).

The ALJ concluded that claimant had proved a compensable aggravation claim based on the reports of Dr. Loberg. In setting aside the insurer's denial, the ALJ reasoned that claimant's most recent exacerbation of symptoms, coupled with her inability to perform work she had done at the time of claim closure, amounted to an actual worsening of claimant's bursitis condition beyond a mere waxing and waning of symptoms, as confirmed by Dr. Loberg.

On review, SAIF contends that claimant has failed to meet her burden of proving a compensable aggravation claim in the absence of objective findings of a worsened condition. Moreover, SAIF contends that claimant has not demonstrated an increased, permanent loss of use or function of her left hip, associated with her trochanteric bursitis condition, and has therefore failed in meeting her burden of proof. We disagree with SAIF's arguments.

In *SAIF v. Walker*, 330 Or 102, 118-19 (2000), the Supreme Court held that evidence of a symptomatic worsening that exceeds the amount of waxing and waning anticipated by an original permanent disability award may prove an aggravation claim under ORS 656.273(1) if, but only if, a physician concludes, based on objective findings, that the underlying condition itself has worsened. In making this determination, the physician may rely on evidence of the claimant's increased symptoms. *See also LePage v. Rogue Valley Medical Center*, 166 Or App 627 (2000); *SAIF v. January*, 166 Or App 620, 624 (2000).

In accordance with the *Walker* Court's directive, we examine the record to determine if medical evidence establishes that claimant's symptomatic worsening represents an "actual worsening" of the underlying condition. If a medical expert offers an opinion that claimant's increase in symptoms signifies an actual worsening of a particular compensable condition, then the actual worsening standard of ORS 656.273 is satisfied. *See Roland A. Walker, on remand* 52 Van Natta 1018 (2000).

SAIF contends that claimant has not proved an actual worsening of her accepted condition because her aggravation claim is based on increased pain. However, as we explained above, a physician may rely on evidence of worsened symptoms in determining whether a worker's condition has actually worsened. *SAIF v. Walker*, 330 Or at 118.

Here, Dr. Loberg has opined that claimant has sustained an actual worsening of her trochanteric bursitis condition. (Exs. 23, 27). The worsening is more than just a waxing and waning of claimant's symptoms, according to Dr. Loberg. (Ex. 23). ORS 656.273(8); *compare LePage v. Rogue Valley Medical Center, supra,* 166 Or App at 630 (the claimant's attending physician stated that the claimant suffered from "continued waxing and waning of the symptoms that he had from before.")

In *Lepage,* the court stated that "the fact that claimant is less able to work due to his symptomatic worsening does not provide a basis for an aggravation claim in this case, either." 166 Or App at 633. The facts of *Lepage* are distinguishable from this case, because although claimant's treating physician has taken claimant off work, he also has expressly concluded that claimant suffered an actual worsening of her trochanteric bursitis condition. (Exs. 23, 27). Such expert medical evidence of an actual worsening was lacking in *Lepage.* 166 Or App at 634.

Finally, for a compensable aggravation claim, there is no requirement that claimant prove a *permanent* increased loss of use or function of her hips due to the worsened condition, as SAIF argues. *See Kelly R. Hollifield-Taylor,* 50 Van Natta 286 (1998). That is the relevant inquiry upon closure of a claim after an aggravation, when claimant seeks an additional award of permanent disability. *Stepp v. SAIF,* 304 Or 375 (1987).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 10, 2000 is affirmed. For services on review, claimant is awarded a $900 attorney fee, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
PAUL D. HAMILTON, Claimant
WCB Case No. 99-05803
ORDER DENYING RECONSIDERATION
Jon C. Correll, Claimant Attorney
Reinisch, et al, Defense Attorneys

On May 16, 2000, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of his injury claim for a neck condition. On June 16, 2000, we received a hand-written document from claimant entitled claimant's brief. We treat claimants submission as a request for reconsideration of our May 16, 2000 Order on Review. Because our prior order has become final, we lack authority to reconsider our decision.

A Board order is final unless, within 30 days after the date of mailing copies of the order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run unless the order had been "stayed," withdrawn or modified. *International Paper Co. v. Wright,* 80 Or App 444 (1986); *Fischer v. SAIF,* 76 Or App 656, 659 (1986).

The 30th day following our May 16, 2000 Order on Review was June 15, 2000. Although claimant express-mailed his request for reconsideration to the Board on June 15, 2000, we did not receive his request until June 16, 2000. Thus, before we could respond to claimant's request, the 30-day period of ORS 656.295(8) had expired.

Because our May 16, 2000 order has not been stayed, withdrawn, modified or appealed within 30 days of its mailing to the parties, we are without authority to alter our prior decision. *See* ORS 656.295(8); *International Paper Co. v. Wright,* 80 Or App at 447; *Fischer v. SAIF,* 76 Or App at 659; *Darlene E. Parks,* 48 Van Natta 190 (1996); *see also Barbara J. Cuniff,* 48 Van Natta 1032 (1996) (although

motion was hand-delivered to the Board's Portland office on the 30th day, the statutory period had expired by the time the motion was brought to the Board's attention). Consequently, claimant's motion for reconsideration is denied.[1]

IT IS SO ORDERED.

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[1] Had we retained authority to reconsider our decision, we would continue to adhere to our prior conclusion that the persuasive medical evidence does not support a determination that claimant's neck condition is compensable.

In the Matter of the Compensation of
DOUGLAS J. LAMBIE, Claimant
WCB Case Nos. C001446 & C001445
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Mitchell & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

On June 16, 2000, 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 approve the proposed disposition.

Here, two claims have been disposed of within one agreement. Two summary pages have been provided; one claim is being released for $19,000 (less a $4,000 attorney fee) and one provides that it is being released for $5,425 (less a $1,000 attorney fee). Thus, when these figures are added together, the total consideration for the two claims would equal $24,425. Yet, the total consideration expressly stated on page 4 of the agreement recites $24,500. . Additionally, page 5 of the proposed CDA provides that claimants attorney shall receive $5,000, which is consistent with the total of the attorney fees listed on the two summary pages.

After reviewing the two summary pages and the CDA as a whole, we conclude that the parties intent is for a total consideration of $24,500 (as provided in the body of the agreement), the disposition proceeds to be distributed as follows:

$19,500	Total Due Claimant
$ 5,000	Total Due Attorney

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $5,000, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DUANE J. PAPKE, Claimant
WCB Case No. 99-01727
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's injury claim for a left knee condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation to address the employer's contention that the ALJ incorrectly relied on the medical opinion of Dr. Snider, the attending orthopedic surgeon, instead of the medical opinion of Dr. Schilperoort, a physician who conducted a medical examination at the request of the employer.

Dr. Schilperoort indicated that he did not put a great deal of trust in MRI scans and that, if he were Dr. Snider, he would avoid a MRI scan and proceed directly to arthroscopy. (Ex. 10-7). At the same time, Dr. Schilperoort indicated he recommends MRI scan to establish diagnosis. (Ex. 10-6). Absent further explanation or elaboration, these two positions appear to be inconsistent. Moreover, Dr. Schilperoort's opinion that all horizontal and oblique meniscal tears are degenerative while vertical tears are traumatic is unsupported and not explained.[1] Without such an explanation, the opinion is merely an unsupported conclusion and as such, is not persuasive.

In contrast, Dr. Snider explained how claimant's work activities while kneeling causes knee flexion/hyperflexion that rolls the femoral condyle back on the posterior end of the medial meniscus; a common mechanism for injury to the posterior arm of the medial meniscus. (Ex 14-12). Dr, Snider's explanation is supported by the MRI scan showing an oblique tear through the posterior horn of the medial meniscus.[2] We therefore find Dr. Snider's opinion well reasoned and persuasive.

The employer argues that Dr. Snider's opinion is not persuasive in that it is based upon an inconsistent or incomplete history. In particular, the employer contends that claimant's history indicating an immediate popping and pain in the medial side on the knee on rising from a kneeling position is significantly different from his hearing testimony in which he indicated he rose from a kneeling position, walked 5 or 6 steps and then felt a popping and pain on the medial side of the knee. Dr. Snider has indicated it is the stress on the meniscus while in a kneeling position that likely caused the meniscus tear. (Ex. 14-12). Dr. Snider has further indicated that the popping and pain claimant felt is consistent with movement of the meniscus or a tear and movement of the meniscus. (Ex. 14-8). Consequently, he stated that as long as the popping and pain occurs either during kneeling or within a short time after arising from kneeling, his opinion regarding the relationship of the meniscal tear and the physical act of kneeling would remain the same. (Ex. 14-11). Accordingly, we conclude that the differences between claimant's history and his testimony are not significant. Thus, we disagree with the employer's contention that Dr. Snider's opinion was based upon an inaccurate history.

The employer also argues that the appearance of a degenerative cyst on the MRI scan supports Dr. Schilperoort's opinion that claimant's meniscal tear is degenerative in nature.[3] Again, we disagree. Assuming a cyst is present, Dr. Schilperoort does not explain how he concludes the cyst is degenerative

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[1] We note further that this broadly stated generality is contested. Dr. Snider indicated this statement is scientifically unfounded and medically unreasonable. (Ex 14-31 & 32).

[2] This interpretation of the MRI scan is by Dr. Erba, a radiologist. (Ex. 11).

[3] We note the existence of such a cyst has not been clearly established. Dr. Schilperoort, who examined the MRI film indicates such a cyst is present. (Ex. 12-2). Dr. Erba, the radiologist who originally interpreted the MRI, does not mention such a cyst in his report. In particular, Dr. Erba's report indicates there are "no other abnormalities" in claimant's knee beyond the meniscal tear. (Ex. 11).

and not traumatic.[4] Moreover, he does not indicate if the cyst he views on the MRI is the same condition he found on examination of claimants knee and described as a Baker's cyst.[5] (Ex. 10-4). Assuming that the cyst Dr. Schilperoort views on the MRI is the Baker's cyst he found on examination, he does not explain how he can determine that the cyst preexisted claimant's work event rather than developed during the three month period of time between the work event and his examination of claimant. Without such an explanation, the opinion is merely an unsupported conclusion and as such, is not persuasive.

In conclusion, we find Dr. Snider's opinion to be better explained and better reasoned than Dr. Schilperoort's opinion. We conclude that Dr. Snider's opinion is persuasive. Accordingly, we agree with the ALJ's conclusion that claimant's work injury was the major contributing cause of his disability and his need for treatment for his left knee 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 $2,025, 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, and his counsels uncontested attorney fee request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 7, 2000, as reconsidered March 17, 2000, is affirmed. For services on review, claimant is awarded a $2,025 attorney fee, payable by the employer.

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[4] Dr. Snider indicated a meniscal cyst could be either degenerative or traumatic. (Ex. 14-26).

[5] Stedman's Electronic Medical Dictionary, version 4.0 (1998), defines Baker's cyst as "a collection of synovial fluid which has escaped from the knee joint or bursa and formed a synovial-lined sac in the popliteal space." *See SAIF v. Calder*, 157 Or App 224, 227 (1998) (administrative agency may take judicial notice of facts capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned; a medical dictionary is such a source).

In the Matter of the Compensation of
LINA Q. VERGESON, Claimant
WCB Case No. C001451
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Steven M. Schoenfeld, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Member Haynes and Phillips Polich.

On June 16, 2000, 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 approve the proposed disposition.

The first page of the proposed agreement provides that the total amount due claimant is $4,725 and the total due claimant's attorney is $1,775, for a total consideration of $6,500. However, page 3 has been revised by handwritten interlineation to provide that claimant's attorney will receive an attorney fee in the amount of $1,625.

Absent extraordinary circumstances, attorney fees in CDAs are limited to 25 percent of the first $17,500, plus 10 percent of any amount in excess of $17,500. OAR 438-015-0052(1). Because the amount given for the attorney fee on the first page of the agreement ($1,775) is not consistent with OAR 438-015-0052(1), and because no extraordinary circumstances have been provided for a fee in excess of that allowed by the rule, we conclude that the revised reference in the body (pg. 3, number 12a) of the CDA to an attorney fee of "$1,625" accurately reflects the parties intentions and that the amount allocated to claimant and claimant's attorney on the first page of the document is an error. Accordingly, we interpret the agreement as providing for a total consideration of $6,500, of which $1,625 is an attorney fee.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $1,625, payable to claimant's counsel, is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DORA R. REDDING, Claimant
WCB Case No. 98-07922
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Scheminske, et al, 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 occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began work in May 1994 for the employer as an admitting registrar. In October of that year, claimant developed right thumb pain for which she sought treatment from Dr. Pierson. In his October 5, 1994 chart note, Dr. Pierson noted that claimant had a history of numbness in her hands that he suspected was carpal tunnel syndrome. (Ex. 2-1). Dr. Pierson opined that claimant did have an element of carpal tunnel syndrome that, while not claimant's primary problem, was a "preexisting condition" probably unmasked by a slight amount of swelling. *Id.* Splints were recommended for claimant to wear at night to minimize her carpal tunnel symptoms. No claim was filed for the carpal tunnel condition, although claimant did file a claim for her thumb condition that was accepted.

By October 31, 1994, claimant's numbness in her hands had ceased, according to Dr. Pierson. No further attention was directed toward the carpal tunnel syndrome. (Ex. 4).

On November 5, 1996, claimant consulted Dr. Gill for right hand numbness and pain. (Ex. 14-1). Dr. Gill diagnosed probable chronic right carpal tunnel syndrome, but also noted some elbow pain. On December 5, 1996, claimant filed a claim for right wrist, bilateral elbow and foot complaints. (Ex. 15). Claimant alleged that her condition was due to pulling files, lifting, typing, and moving in a roller chair while seated. Claimant, however, withdrew her claim on December 26, 1996, after Dr. Gill opined that the major cause of her carpal tunnel syndrome was "some type of constitutional factor rather than her specific work activities." (Ex. 18). Claimant explained that she had no way of knowing whether her work caused her carpal tunnel condition, but that it was easier to go through her private health carrier. (Ex. 19). At the time she withdrew her claim, the employer had taken no action regarding the claim.

On June 2, 1998, claimant filed a claim for her right hand numbness, allegedly due to constant keyboarding, writing, filing and handling files. (Ex. 20). On June 8, 1998, Dr. Sohlberg diagnosed mild right carpal tunnel syndrome. (Ex. 22). Claimant filed a bilateral wrist claim on August 22, 1998. (Ex. 24). After Dr. Radecki, an examining physician, attributed claimant's carpal tunnel condition to idiopathic factors, the employer denied the claim on September 16, 1998. (Ex. 26). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial. In doing so, the ALJ rejected the employer's argument that claimant's withdrawal of her first claim in December 1996 resulted in a preexisting noncompensable condition. The ALJ reasoned that claimant's withdrawal of her claim resulted in a null and void claim

with no preclusive effect or legal impact on the current occupational disease claim. The ALJ then proceeded to address the merits of the bilateral carpal tunnel claim, finding that claimant proved that her work activities were the major contributing cause of the carpal tunnel condition. In making this determination, the ALJ relied on the medical opinions of Dr. Sohlberg, Dr. Layman, who performed carpal tunnel surgeries in November and December 1998, and Dr. Long, a consulting physician.

On review, the employer contends that ALJ incorrectly determined there was no preexisting condition. It again asserts that, because claimant withdrew the December 1996 claim, her condition at that time constituted a noncompensable preexisting condition. Alternatively, the employer contends that Dr. Pierson's chart note in 1994 establishes that claimant's carpal tunnel condition was preexisting. Finally, the employer argues that claimant's obesity constitutes a preexisting condition. The employer asserts that, given the presence of a preexisting condition, claimant was required to prove that work conditions were the major contributing cause of the "combined condition" and of a pathological worsening of the disease under ORS 656.802(2)(b). It argues that the medical evidence does not satisfy claimant's burden of proof.

While we agree with the employer that claimant had a preexisting carpal tunnel condition, we need not decide whether the withdrawn claim or claimant's obesity resulted in a preexisting condition. That is, we find that Dr. Pierson's opinion establishes that claimant had a preexisting carpal tunnel condition.

In occupational disease claims, a disease or condition is "preexisting" if it contributes or predisposes the claimant to disability or a need for treatment and precedes either the date of disability or the date when medical treatment is first sought. *SAIF v. Cessnun*, 161 Or App 367 (1999). In response to claimant's complaints of numbness in her hands, Dr. Pierson stated on October 4, 1994 that claimant had an element of carpal tunnel syndrome that was a preexisting condition. (Ex. 2-1). Dr. Pierson recommended treatment consisting of splints. Based on this report, it appears that claimant's carpal tunnel preceded the date of first medical treatment, regardless of which date is considered the date of the first treatment for this claim. Inasmuch as the preexisting carpal tunnel condition has received treatment from Dr. Pierson and subsequent physicians, we conclude that it has contributed to claimant's need for treatment. Thus, we find that claimant's "pre-October 1994" carpal tunnel condition constitutes a noncompensable "preexisting condition" under the *Cessnun* rationale.

Accordingly, we conclude that claimant's carpal tunnel syndrome claim is based on the worsening of a preexisting disease/condition and, therefore, she must prove that her employment conditions were the major contributing cause of her combined condition and a pathological worsening of the disease. *See* ORS 656.802(2)(b).

Having reviewed this record, we conclude that the medical evidence does not establish a pathological worsening of the preexisting carpal tunnel syndrome. Dr. Sohlberg agreed that there was no evidence of a change in claimant's condition from Dr. Gill's examinations in 1996. (Ex. 31-1). Dr. Long and Dr. Layman opined that claimant's work activity was the major contributing cause of the carpal tunnel condition. However, neither doctor stated that claimant's employment conditions pathologically worsened the preexisting carpal tunnel condition. (Exs. 29B, 31, 32, 38-3). Finally, Dr. Radecki attributed claimant's carpal tunnel condition to idiopathic factors, such as body mass index, increased wrist ratios and aging. (Ex. 25). Thus, Dr. Radecki's opinion also does not establish that work activities were the major contributing cause of a pathological worsening of the preexisting carpal tunnel condition.

Therefore, we conclude that claimant failed to satisfy her burden of proving a compensable occupational disease under ORS 656.802(2)(b). Thus, we reverse.

ORDER

The ALJ's order dated February 3, 2000 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Biehl dissenting.

The majority reverses the ALJ's determination that claimant proved a compensable occupational disease claim for bilateral carpal tunnel syndrome. In so doing, the majority finds that claimant had a preexisting carpal tunnel condition, applies the more stringent compensability standard of ORS 656.802(2)(b), and concludes that the medical evidence does not satisfy claimant's burden of proof.

In contrast to the majority, I agree with the ALJ's determination that claimant did not have a preexisting condition. In that regard, I believe that the ALJ correctly determined that claimant's withdrawal of her initial claim in December 1996 did not result in a preexisting noncompensable carpal tunnel condition. The majority does not contend otherwise, instead concluding that Dr. Pierson's October 1994 chart note establishes that claimant had a preexisting carpal tunnel condition.

Although the majority finds this evidence persuasive, to me, Dr. Pierson's cursory reference to a possible preexisting carpal tunnel condition is not a sufficient basis for finding a preexisting condition. Moreover, the medical evidence does not causally link the carpal tunnel condition arguably present in 1994 with the current carpal tunnel condition for which claimant has filed a claim.

In light of this, I would not apply the compensability standard of ORS 656.802(2)(B). Instead, I would apply ORS 656.802(2)(a), which does not require a pathological worsening the carpal tunnel condition. Because I agree with the ALJ that the opinions of Drs. Layman, Long and Sohlberg establish that claimant's work activities are the major contributing cause of claimant's carpal tunnel syndrome, I would conclude that claimant has proved a compensable occupational disease claim under the latter statute. For this reason, I respectfully dissent.

In the Matter of the Compensation of
CHRISTINE SALVETA, Claimant
WCB Case No. 99-05697
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

We adopt and affirm the ALJ's order on the issue of compensability. On review, the insurer also contends that it is necessary for us to address the scope of claimant's request for acceptance and "clearly identify what it is, exactly, that the employer/insurer is responsible for." (Appellant's Brief, pg. 11).

Here, the ALJ found that there had been several diagnoses of claimant's bilateral upper extremity condition. Citing *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988), however, the ALJ found that the lack of a definitive diagnosis was not dispositive on the issue of compensability.

We agree with the ALJ's reasoning with regard to the fact that a definitive diagnosis is not required. Moreover, we have previously declined a carrier's request to define a diagnosis of the claimant's condition in such a case. *See Robert E. Roy*, 42 Van Natta 2000 (1990). In *Roy*, we held that a diagnosis of a condition is not required to establish a compensable claim under the applicable statute. Rather, the only requirement is medical services and/or disability that were caused by the work injury. We further held that, because a condition or diagnosis was not known, the carrier was not being ordered to accept a specific condition. Instead, the carrier was being ordered to accept the medical services and/or disability that were a result of the work injury. *Id.* Accordingly, consistent with *Roy*, in the present case, we conclude that the ALJ properly found that claimant had a compensable occupational disease of the hands and fingers and that the claim should be accepted.

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 $1,200 is a reasonable assessed attorney fee for claimant's counsel's services on review, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 20, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
ELLIS L. SEIFERT, Claimant
WCB Case No. 98-09066
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's "new" occupational disease claim for his current left shoulder condition. On review, the issue is claim processing.

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

In August 1993, claimant, a ramp serviceman for the employer airline, filed a claim for a left shoulder injury that allegedly occurred in April 1992 while unloading a large piece of airfreight. The employer accepted the claim as a left shoulder strain, even though claimant was not diagnosed with a "strain," but rather with glenohumeral arthritis of the left shoulder. Claimant, however, did not contest the employer's processing of the claim, which was closed in April 1995 with an award of unscheduled permanent disability for the left shoulder.

Claimant continued to work for the employer and later sought treatment in June 1997 from Dr. Hanley, who had previously treated claimant in connection with the 1992 claim. Dr. Hanley filed a Notice of Claim for Aggravation of Occupational Injury or Disease on claimant's behalf and referred claimant to Dr. Butters, who recommended a total left shoulder replacement because of the degenerative arthritic condition in the left shoulder.

On November 10, 1998, the employer accepted the claim as an aggravation of the 1992 claim, but denied that claimant had sustained a new injury or occupational disease. Claimant requested a hearing, alleging that the employer improperly accepted the claim as an aggravation and should instead accept the claim as a "new" occupational disease.

The ALJ determined that claimant's argument was meritorious, reversing the employer's denial and finding that claimant had established a "new" occupational disease. In so doing, the ALJ concluded that the medical evidence from Drs. Butters and Hanley established that claimant's work activities after the 1992 claim were the major contributing cause of a worsening of the underlying degenerative arthritic condition in his left shoulder and that such a worsening was sufficient to constitute a "new" occupational disease.

On review, the employer observes that the current diagnosis of claimant's left shoulder condition (glenohumeral arthritis) is the same diagnosis that claimant received in connection with the original claim. In light of this, the employer contends that claimant's current shoulder condition was properly accepted as an aggravation of the 1992 injury claim because the current left shoulder condition is the same as the one in 1993. In support of its position that claimant failed to prove a "new" occupational disease claim, the employer cites *David W. Bucknum*, 47 Van Natta 2055 (1995) and *Christopher H. Peppler*, 44 Van Natta 856 (1992).[1]

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[1] The employer also alleges that the occupational disease claim is untimely under ORS 656.807. However, we decline to address this issue raised for the first time on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing).

In *Bucknum*, the claimant was diagnosed with bilateral carpal tunnel syndrome (CTS) in February 1988 that a carrier accepted as a nondisabling claim. In January 1992, the claimant experienced bilateral carpal tunnel complaints. The carrier reopened his claim as an aggravation of his 1988 claim and then closed the claim by a Notice of Closure that awarded permanent disability. (Ex. 20). In February 1994, the claimant filed an occupational disease claim. The ALJ found that the claimant's 1988 CTS never resolved and determined that the claimant's 1992 CTS symptoms were related to his 1988 CTS and not a "new" occupational disease claim.

We affirmed, noting that the claimant may file a new claim to establish the compensability of a new and different condition that developed after closure of an earlier claim. However, we found that the claimant's 1988 CTS never resolved; therefore, we concluded that his 1992 CTS was not a "new" injury but an aggravation of his 1988 CTS. *Bucknum*, 47 Van Natta at 2056.

In *Peppler*, the claimant first sought compensation for a carpal tunnel condition in August 1988. In February 1990, the carrier accepted the condition as a nondisabling injury and closed the claim pursuant to former ORS 656.268(3). That closure was not contested and became final by operation of law 180 days after the date of its mailing. Accordingly, we held that the claimant's contention that the February 1990 acceptance of his carpal tunnel syndrome was improperly processed as an injury was barred by claim preclusion. Nonetheless, we noted that the claimant was entitled to file a new claim to establish that, after the February 1990 closure of the earlier claim, he had developed a "new and different" condition related to his work activities. We determined, however, that contention was not supported by the medical record. We found that the unrebutted medical evidence was that the claimant's current condition was the same as the condition previously accepted as an industrial injury. *Peppler*, 44 Van Natta at 857.

In contrast to *Bucknum* and *Peppler*, where the claimants failed to establish a new and different condition after claim closure, claimant in this case has done so. In this regard, we agree with the ALJ's finding that the medical evidence from Drs. Butters and Hanley establish that claimant's work activities after claim closure in 1995 were the major contributing cause of a pathological worsening of the left shoulder degenerative arthritis condition. Specifically, Dr. Butters testified that claimant's work activities were the major contributing cause of a worsening of the arthritic condition. (Ex. 41-36). Moreover, Dr. Butters testified that the objective findings that he elicited from claimant during his examinations were sufficient to allow him to conclude that there was a worsening of the underlying condition. (Ex. 41-38). Dr. Hanley essentially deferred to Dr. Butters' opinion. (Exs. 40, 42-13). But Dr. Hanley did opine that claimant's work activities were the major contributing cause of the acceleration and current need for treatment of the arthritic condition. (Ex. 42-11, 13, 14)

Having found that the medical evidence establishes a "post-closure" pathological worsening of the underlying left shoulder arthritic condition, we further conclude that the pathologically worsened left shoulder arthritis condition constitutes a "new and different" condition that developed after the 1995 claim closure. Thus, claimant has established a "new" occupational disease. *Cf. Betsy A. Preece*, 45 Van Natta 2320 (1993) (claim properly processed as an aggravation rather than a new occupational disease where the claimant failed to prove that her most recent work activities were the major contributing cause of a worsening of her underlying condition).

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

ORDER

The ALJ's order dated February 18, 2000 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
RAUL R. VELASQUEZ, Claimant
WCB Case No. 99-05249
ORDER ON REVIEW
Willner, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of a lumbosacral strain and L4-5 disc injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

L4-5 disc condition

On October 21, 1998, claimant injured his low back at work while he was lifting tables and chairs. Claimant was initially seen by Dr. Browning, who diagnosed a left sacroiliac strain. SAIF accepted the left sacroiliac strain.

After claimant had experienced prolonged and worsening back problems, a MRI was performed in August 1999, which showed a large herniated intervertebral disc at the L4-5 level which deformed the thecal sac.[1]

Relying on claimant's testimony describing his lifting of the tables and chairs, the corroborating testimony of a member of the employer's management team, and the medical opinion of Dr. Gritzka (who had examined claimant and reviewed the medical record at the request of claimants counsel) the ALJ concluded that claimant established the compensability of his L4-5 disc condition. The ALJ found Dr. Gritzka's opinion to be based upon complete information and the most persuasive in discussing all the aspects of claimant's symptoms, his early medical care for the injury, the various diagnostic tests, and the clinical findings.

SAIF contends that: (1) the ALJ incorrectly discounted the opinions of Dr. Browning, the original treating physician, and Dr. Jones, an examiner who saw claimant at the request of SAIF; (2) Dr. Johnson's opinions were inconsistent; (3) the ALJ incorrectly relied on the opinion of Dr. Gritzka which was conclusory and inadequate; and (4) claimant's history was inconsistent. We disagree with each contention.

January 1999 x-rays revealed very mild degenerative disc disease in the lumbar spine.[2] The parties do not contest the ALJ's conclusion that the compensability of claimant's L4-5 disc condition is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that his herniated intervertebral disc at the L4-5 level is compensable, claimant must show that his work injury 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). Because of claimant's preexisting condition and the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his 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, a persuasive medical opinion must evaluate the relative

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[1] Dr. Gritzka's interpretation of the MRI study. (Ex. 34-7).

[2] Specifically, the x-rays show very mild degenerative disk disease changes at L2-3, L3-4, and L5-S1. (Ex. 8). We note that L4-5, which is the level of concern in this claim is not mentioned in Exhibit 8.

contribution of the different causes of claimant's L4-5 herniated disc and explain why the October 1998 lifting injury at work contributed more to claimant's disability or need for treatment than his preexisting degenerative disc disease. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). Medical opinions based upon incomplete information are not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Neither Dr. Browning nor Dr. Jones has seen the August 1999 MRI.[3] Nor has either doctor reviewed or considered Dr. Gritzka's report. Under such circumstances, we consider their opinions to be based upon incomplete information. Accordingly, the ALJ correctly discounted their opinions.

Dr. Johnson, who in June 1999 reviewed the medical record at the request of claimant's counsel, originally opined that claimant's L4-5 disc condition could be the result of either the lifting incident in October 1998 or a preexisting condition. He further opined that he would defer to Dr. Browning regarding causation. (Ex. 31-2). Later, after reviewing Dr. Gritzka's opinion, Dr. Johnson concurred with Dr. Gritzka. SAIF argues that this change of opinion is wavering and inconsistent. We disagree. We view the change of Dr. Johnson's opinion as consistent with new information, namely the August 1999 MRI, which was not available when he originally deferred to Dr. Browning. Accordingly, we find his concurrence with Dr. Gritzka persuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987).

Relying on claimant's history, a review of the medical record and the MRI of August 1999, Dr. Gritzka opined that claimant was suffering from a chronic left sacroiliac joint sprain and a herniated intervertebral disc at L4-5, of which, the major contribution cause was claimant's work activities in October 1998.[4] Of particular interest to Dr. Gritzka was the August 1999 MRI, which he interpreted as showing a large herniated intervertebral disc at L4-5 deforming the thecal sac. He further interpreted the MRI as showing normal disc hydration at the adjacent levels and desiccation of the nucleus pulposis at L4-5 consistent with a disc herniation about a year old. (Ex 34-7). Based upon the August 1999 MRI, Dr. Gritzka concluded that claimant has a bona fide disc herniation with migration of the nucleus pulposis cephalad beneath the posterior longitudinal ligament. (Ex. 34-9). Dr. Gritzka's opinion is bolstered by the concurrence of Dr. Johnson. (Ex. 36).

SAIF, citing our decision in *Barbara J. James*, 44 Van Natta 888 (1992), argues that Dr. Gritzka's opinion is conclusory because it is based only on consistency between the mechanism of injury, claimant's symptoms, and the current diagnosis.[5] We disagree with SAIF's characterization of Dr. Gritzka's opinion.

Dr. Gritzka opined that the amount of desiccation of the nucleus pulposis at L4-5, as shown on the August 1999 MRI, is consistent with a disc herniation of about a year old. We do not interpret this to mean he is inferring some consistency between the mechanism of injury, in this case lifting a table, and claimant's current diagnosis. Instead we conclude that Dr. Gritzka is indicating that the amount of desiccation of the disc, as shown on the MRI, independent of any history from claimant, is what he would expect to find in any disc herniated about one year earlier. Accordingly, we find *James* distinguishable.

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[3] In making his diagnosis of claimant's condition from the x-ray and CT scan , Dr. Jones indicated that a MRI scan would have been better. (Ex. 16-5). We note that in a concurrence letter prepared for Dr. Browning by SAIF, an MRI is mentioned. (Ex. 33) We further note that the date of the letter as well as the date of Dr. Browning's signature, predate the August 23, 1999 MRI.

[4] SAIF has previously accepted the condition of left sacroiliac strain. (Ex. 5).

[5] SAIF also argues that Dr. Gritzka's opinion is not persuasive because he failed to rebut Dr. Browning's concerns about uncorrelated symptoms. However, as we noted earlier, Dr. Browning was not aware of the August 1999 MRI study. Consequently, she was trying to correlate claimant's symptoms to the accepted left sided sacroiliac joint strain and what she thought was a focal disc protrusion centrally and to the right of midline at L4-5. (Ex. 7). Because Dr. Browning was acting on incomplete information, we are not persuaded that Dr. Gritzka should have rebutted her concerns about uncorrelated symptoms.

Finally, SAIF contends that the ALJ erred in concluding that claimant's history was consistent during the course of the claim.[6] Claimant initially told Dr. Browning that he injured his back lifting tables and chairs. (Ex. 1). Essentially the same history is contained on the initial 827 form. (Ex. 2). Claimant testified his back started hurting after he had lifted more than 25 tables. (Tr. p. 4). The employer representative, who helped claimant fill out the 801 form, testified that he could not recall claimant mentioning that a specific table caused the back pain.[7] (Tr. p. 21). After reviewing this evidence, we consider claimant's version of his work injury to be reliable and we are not persuaded that the medical opinions were based upon an inconsistent or inaccurate history.

In conclusion, based upon Dr. Gritzka's well reasoned and persuasive opinion (as concurred in by Dr. Johnson), we find that claimant's work injury was the major contributing cause of his disability and his need for treatment for his L4-5 disc condition. Consequently, we affirm the ALJ's order that set aside SAIF's denial of that condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the L4-5 disc condition is $1,500, to be paid by the SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief, his counsels request, and SAIF's reply to that request), the complexity of the issue, and the value of the interest involved.

Lumbosacral strain

SAIF contends that the ALJ did not address the compensability of claimant's alleged lumbosacral strain. We agree that the ALJ's order does not clearly discuss the lumbosacral strain condition.

SAIF denied the compensability of the lumbosacral strain on May 18, 1999, in the same letter as SAIF denied the L-4-5 disc lesion. (Ex. 26-1). At hearing, SAIFs counsel responded to the ALJ's query about the issues as follows:

> "There's, I guess, a kind of a unique situation where we accepted a sacroiliac strain, and we've been asked to accept a lumbosacral strain. The medical evidence, I think, will explain that. They're fairly close, and I'll explain that in closing, as well." (Tr. p. 2).

Without specifically addressing claimant's lumbosacral strain claim, the ALJ set aside SAIF's denial in its entirety. On review, SAIF argues that: (1) claimant's previously accepted left sacroiliac strain is a more specific diagnosis and better conforms to that portion of claimant's pain complaints than the diagnosis of lumbosacral strain (Appellant's Brief, p. 7); and (2) the two diagnoses involve some of the same tissues, therefore, its previous acceptance of sacroiliac strain reasonably apprises claimant and the medical providers of the nature of the accepted condition. (Reply Brief, p. 3-4).

SAIF's remarks at hearing and its arguments on review appear to concede that claimant's lumbosacral strain is compensable; albeit under its prior acceptance of a left sacroiliac strain. Nevertheless, SAIF requests that we reinstate its denial of the lumbosacral strain. These two positions are internally inconsistent. In any event, to the extent that SAIF argues that the lumbosacral strain is within the scope of its acceptance of the left sacroiliac joint strain (thereby, not requiring it to amend its previous acceptance), this issue was not adequately raised before the ALJ. Accordingly, we will not consider it on Board review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991).

Finally, because the ALJ's order neglects to address the merits of the denied lumbosacral strain condition, we proceed to a review of that issue. The only two doctors in this record to discuss the lumbosacral strain are Drs. Gritzka and Johnson. (Ex. 1, 6, 10, 12, 31-1, 34-8). These physicians unequivocally attribute claimant's lumbosacral strain to his work activities. Based upon these opinions, we conclude that claimant's work was the major contributing cause of his need for medical treatment or disability of his lumbosacral strain condition. *See* 656.005(7)(a)(B), *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Consequently, we find claimant's lumbosacral strain condition compensable and set aside SAIF's denial.

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[6] We note that claimant is normally Spanish speaking and does not understand many of the subtleties of the English language. (Tr. p. 6,16).

[7] The 801 form was filled out several weeks after the October 1998 lifting incident and indicates merely lifting table and chairs for the description of the accident. (Tr. p. 21, Ex. 3).

ORDER

The ALJ's order dated February 24, 2000 is affirmed as modified herein. For services on review, claimant's counsel is awarded a $1,500 attorney fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
TERRI L. WALKER, Claimant
WCB Case No. 99-08815
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys

On June 12, 2000, we received claimant's "Appellant's Motion to Supplement the Record" in the above-captioned case. Because we issued an Order on Review in this matter dated June 8, 2000, we treat claimant's request as a motion for reconsideration. Among other things, our June 8, 2000 order affirmed an Administrative Law Judge's (ALJ's) Opinion and Order that found that the Hearings Division did not have jurisdiction over an issue of temporary disability benefits.

On reconsideration, claimant has submitted a June 2, 2000 letter from the Workers' Compensation Division which states that it is the Department's position that the issue is a matter concerning a claim which must be addressed by the Board's Hearings Division. Claimant apparently wishes to submit the letter in order to establish that the ALJ did have jurisdiction over this matter.

We need not decide whether the letter should be admitted into the record. On reconsideration, we agree with claimant that, insofar as an issue exists regarding a "timeloss differential" resulting from the fact that Liberty Northwest was ultimately assigned responsibility, the ALJ did have jurisdiction over the claim.[1] Accordingly, we reinstate claimant's request for hearing with regard to that issue.

Nevertheless, on reconsideration, we do not find that claimant has established an entitlement to any additional temporary disability benefits. As noted by the insurer, no temporary disability benefits were awarded by the Determination Order, and the order was not appealed. Consequently, at this time, we find that there is no entitlement to temporary disability benefits.[2]

Accordingly, claimant's request for reconsideration is granted. Our June 8, 2000 Order on Review is withdrawn. As supplemented and modified herein, we republish our June 8, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We continue to agree with the ALJ's conclusion that he did not have jurisdiction over issues involving monetary adjustments between the two carriers involved in this case.

[2] If, in the future, temporary disability benefits are paid at a rate that claimant believes is incorrect, claimant could at that time request a hearing on the issue.

In the Matter of the Compensation of
TROY R. WICKDAL, Claimant
WCB Case No. 99-07622
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of his claim for a right foot injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Opinion and Conclusion," with the following supplementation.

On review, claimant first contends that this case should be analyzed consistent with the court's decision in *SAIF v. Burke*, 145 Or App 427 (1996). In *Burke*, the claimant worked as a manager for the Oregon Shakespeare Festival. The claimant was injured when he attempted to assist an individual whom he believed to be a patron. In *Burke*, the Board and the court found that the injury was compensable because the claimant was in an area where his job required him to be; he believed that the individual who was in jeopardy was a patron; and the employer required its workers to assist its patrons whenever possible.

Here, however, claimant was acting outside of his job description as a flagger when he voluntarily attempted to brace a piece of cement involved in the construction work. Claimant had previously signed the employer's "Rules of Conduct" which provided that flaggers were hired to control traffic and were not to do other work or watch the operation while flagging. (Ex. 1-1; 1-3). Finally, in this case, the ALJ did not accept claimant's testimony that claimant acted out of concern for the safety of a co-worker. Accordingly, we do not find that the *Burke* case is applicable.

We therefore affirm the ALJ's order that found that claimant was not in the course and scope of employment at the time he was injured. *See Stan v. Constitution State Service Co.*, 168 Or App 92 (2000); *Andrews v. Tektronix, Inc.*, 323 Or 154 (1996).

ORDER

The ALJ's order dated January 7, 2000 is affirmed.

In the Matter of the Compensation of
VICKY C. SHAW, Claimant
WCB Case No. 99-03061
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

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

On review, the employer contends that the opinion of Dr. Hanley, claimant's treating doctor, is not persuasive. The employer argues that there has never been a definitive diagnosis. Additionally, the employer contends, Dr. Hanley's opinion is based on speculation. We disagree.

As the employer concedes, the lack of a specific diagnosis does not necessarily defeat a claim. *See Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988). Here, as the ALJ noted, although Dr. Hanley was not certain of the diagnosis, he stated that, whether claimant's condition was an overuse or inflammation condition, claimant's symptom complex was one that was regularly treated by medical professionals. (Ex. 35-16).

The causation issue, as opposed to the question of diagnosis, must be resolved, however. *Lori A. Sosa*, 42 Van Natta 1745 (1991). Here, the issue is of sufficient medical complexity as to require expert medical opinion. *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985).

After reviewing Dr. Hanley's reports and deposition, we agree with the ALJ that claimant has established that work activities were the major cause of her left ankle condition. Although Dr. Hanley agreed at one point in his deposition that arthritis could be the cause of claimant's condition and his opinion that work activities were the major cause was "rather speculative," he later clarified his opinion. Dr. Hanley's final opinion was that he did not believe that claimant had arthritis, and he believed that her work activities were the major cause of her condition. (Ex. 35-22; 35-17). Dr. Hanley testified that his opinion was based on his examination of claimant and his experience as an orthopedic surgeon. (Ex. 35-18). Finally, Dr. Hanley testified that he was not "guessing" with regard to the issue of causation. (Ex. 35-19).

Consequently, when read in its entirety, we agree with the ALJ that Dr. Hanley's opinion establishes that claimant's work activities were the major cause of her left ankle condition. We therefore affirm the ALJ's order.

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

ORDER

The ALJ's order dated January 24, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
GEORGE WARNEKE, Claimant
WCB Case No. 99-07604
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Neil W. Jones, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's L3-4 disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the last paragraph beginning on page 4, we delete the fourth sentence.

We write only to address the insurer's argument that there is no evidence that Dr. Berselli was aware of claimant's low back symptoms before the November 1996 work injury.

Dr. Berselli first examined claimant in November 1999. In his initial report, Dr. Berselli said that claimant had injured his back at work on November 22, 1996, when he was prying a car frame with a large pry bar. (Ex. 20). He reported that since that incident claimant had experienced ongoing back pain and left lower extremity radiculopathy-type pain. (*Id.*) Dr. Berselli noted that claimant "states that he has worked for about 20 years in body and fender work and has had a good deal of strain to his back during that period of time." (*Id.*)

Claimant had experienced minor left low back pain for five to nine months before the November 1996 injury, but he had not sustained a specific injurious event. (Ex. 1, Tr. 19). On November 22, 1996, however, claimant experienced a significant increase in low back pain with the onset of new radiating pain into the left leg after using a large pry bar under a car frame. (Ex. 6, Tr. 19).

At hearing, claimant testified that he had given Dr. Berselli a complete and accurate history. (Tr. 22). In addition, Dr. Berselli noted in his initial report that claimant had experienced "a good deal of strain to his back" during his 20 years in body and fender work. (Ex. 20). Based on Dr. Berselli's report and claimant's testimony, we find that Dr. Berselli had an accurate history of claimant's prior low back symptoms. We agree with the ALJ that Dr. Berselli's opinion is sufficient to establish a compensable injury claim for his current L3-4 disc condition under either ORS 656.005(7)(a) or 656.005(7)(a)(B).

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

ORDER

The ALJ's order dated February 27, 2000 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the insurer.

In the Matter of the Compensation of
ARTHELLA D. ANDERSON, Claimant
WCB Case No. 99-02602
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Bruce Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

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/occupational disease claim for a left knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant operated a large machine that fastened hardware to pieces of sheet metal. This required claimant to press a foot pedal with her right foot over 100 times per hour, while standing for long periods on her left leg. On November 3, 1998, claimant experienced pain in her left leg, as well as her low back. She sought treatment from Dr. Gabe, who, on November 10, 1998, diagnosed "Arthritis undoubtedly from overuse from working the job." Dr. Gabe noted that claimant had been standing for 10 hour days for the last two years. (Ex. 1).

On December 8, 1998, claimant filed a claim for her left knee condition that SAIF denied on February 1, 1999. Claimant filed a claim for a low back condition on April 8, 1999. SAIF amended its previous denial to deny both the left leg and low back conditions on October 20, 1999. Claimant requested a hearing from both denials, raising the additional issue of entitlement to a penalty for an allegedly unreasonable failure to timely accept or deny the low back claim.

The ALJ upheld SAIF's denial of claimant's low back condition and declined to assess a penalty for SAIF's allegedly unreasonable claim processing. Those aspects of the ALJ's order are not at issue on review. The ALJ, however, set aside SAIF's denial of claimant's left knee condition. SAIF has contested that portion of the ALJ's order.

In concluding that claimant's left knee condition was compensable, the ALJ determined that the claim was most appropriately analyzed an accidental injury claim because claimant's left knee problem appeared to arise during the course of a single day at work. The ALJ further reasoned that claimant had proved a compensable injury claim because Dr. Gabe had aspirated fluid from the left knee, thus indicating that claimant had a "real knee problem."

On review, SAIF contends that, regardless of whether the claim is analyzed an injury or an occupational disease, claimant failed to sustain her burden of proof. For the following reasons, we agree that the left knee claim is not compensable under either theory.

Three physicians expressed opinions on the causation issue: Dr. Gabe, the attending physician, Dr. Ballard, a consulting physician, and Dr. Fuller, who examined claimant's left knee condition on SAIF's behalf. 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, we find persuasive reasons not to give greater weight to the opinion of Dr. Gabe, claimant's attending physician.

As previously noted, Dr. Gabe diagnosed arthritis in claimant's left knee that he related to "overuse" from claimant's job. (Ex. 1). However, the nature of the "overuse" is unclear from that report, considering that the repetitive use in claimant's job involved the *right* foot. More importantly,

the ALJ found, and we agree, that the diagnosis of arthritis was effectively rebutted by Dr. Fuller, who opined that there was no arthritis condition. Accordingly, we do not find Dr. Gabe's initial statements on causation issue persuasive. Moreover, we do not find his later comments on the issue any more convincing.

On June 2, 1999, Dr. Gabe responded to an inquiry from claimant's counsel. (Ex. 13). In that report, Dr. Gabe stated:

> "I feel that [claimant's] left knee arthritis is materially causally related to employment at [SAIF's insured] and is the major causation of it. X-rays of the knee showed no evidence of arthritis and the pain seemed to increase primarily during the ten hour days she was at work." (Ex. 13).

We agree with SAIF that Dr. Gabe's analysis of the causation issue is conclusory and is, thus, unpersuasive for that reason alone. *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). In addition, as we previously observed, Dr. Fuller's opinion establishes that claimant does not have arthritis in the left knee. Indeed, Dr. Gabe referred to the lack of x-ray evidence of arthritis. However, Dr. Gabe does not address the contradiction between his apparent belief that claimant has arthritis and the lack of x-ray evidence of that condition. Therefore, we also find that Dr. Gabe's opinion is internally inconsistent. Finally, Dr. Gabe's opinion too heavily focuses on the temporal relationship between claimant's symptoms and her work. *See Paul R. Grasham*, 52 Van Natta 385 (2000) (finding physician's opinion unpersuasive because it was based primarily on a temporal relationship between the claimant's symptoms and the compensable injury). In sum, Dr. Gabe's opinion is insufficient to satisfy claimant's burden of proof under either a material or major causation standard.

Turning now to Dr. Ballard, he stated that the only occupational injury or disease would be that, when claimant stands and uses her right foot, she places all of her weight on the left foot and feels pain. Dr. Ballard opined that, if claimant had a history of a lifting injury with sudden onset of pain in the leg, he would believe that work would be the major cause of the current symptoms. However, there is no such history. In light of this, Dr. Ballard concluded that he could not state to a degree of medical probability that simply placing more weight on the left foot was the major contributing cause of the leg and back complaints. (Ex. 16-2).

Having reviewed Dr. Ballard's opinion, we do not find that it supports the compensability of an occupational disease claim. Moreover, because Dr. Ballard did not address the accidental injury standard of material causation, we do not find that his opinion supports compensability of an accidental injury, either.

The final opinion is from Dr. Fuller. Dr. Fuller did not support a causal relationship between claimants condition and her work activities.

In conclusion, claimant failed to prove by a preponderance of the evidence that she sustained a compensable occupational disease or injury. Accordingly, we conclude that the ALJ incorrectly set aside SAIF's denial of the left knee injury/occupational disease claim. Thus, we reverse.

ORDER

The ALJ's order dated February 25, 2000 is reversed in part and affirmed in part. That portion of the order that set aside SAIF's denial of claimant's left knee condition is reversed. SAIF's denials of the left knee condition are reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GERARDO AVILES, Claimant
WCB Case No. 99-06972
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that awarded 3 percent (9.6 degrees) unscheduled permanent disability for claimant's cervical condition.[1] On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

On September 17, 1998, claimant was compensably injured when two tree branches fell on him. (Ex. 1). Claimant was treated by Dr. Campbell. SAIF initially accepted a disabling scalp laceration and acute cervical strain. (Ex. 4). SAIF modified its acceptance to include a concussion and right trapezius strain. (Ex. 8).

On January 26, 1999, Dr. Tsai examined claimant on behalf of SAIF. (Ex. 7D). He reported the following cervical range of motion findings: flexion 52 degrees, extension 62 degrees, right lateral flexion 42 degrees, left lateral flexion 40 degrees, right rotation 68 degrees and left rotation 67 degrees. (Ex. 7D-20). Dr. Tsai noted that, throughout the long history-taking and examination, there was no evidence of any functional overlay, symptom embellishment or pain behavior. (Ex. 7D-24). Dr. Campbell concurred with Dr. Tsai's report. (Ex. 7E).

A Second-Level Physical Capacity Evaluation (PCE) was performed on March 18, 1999. (Ex. 10). The evaluators reported claimant's cervical range of motion findings as: flexion 25 degrees, extension 52 degrees, right lateral flexion 39 degrees, left lateral flexion 35 degrees, right rotation 74 degrees and left rotation 54 degrees. (Ex. 10-3). The evaluators said the test results were valid and no inconsistencies were noted. (Ex. 10-1). Dr. Campbell concurred with the March 18, 1999 PCE. (Ex. 11A).

Dr. Campbell examined claimant on April 1, 1999 and reported that he had full neck range of motion, but he experienced some tenderness with forward flexion and left lateral side bending. (Ex. 11B).

On May 12, 1999, Dr. Anderson examined claimant on behalf of SAIF. (Ex. 12). He reported "full active range of motion of all joints of the upper and lower extremities." (Ex. 12-3). Dr. Anderson diagnosed scalp laceration, treated and healed; cervical sprain and strain; and symptom magnification. (Ex. 12-4). He found no objective findings to support claimant's symptoms and concluded that claimant was medically stationary. (Ex. 12-5). He noted that claimant had "restricted motion, but he does this on a voluntary basis because of his pain complaints." (*Id.*)

Also on May 12, 1999, a Work Capacity Evaluation (WCE) was performed. (Ex. 13). Claimant's cervical range of motion findings were reported as: 30 degrees flexion, 50 degrees extension, 28 degrees right lateral flexion, 38 degrees left lateral flexion, 70 degrees right rotation and 52 degrees left rotation. (Ex. 13-7). The finding for left rotation was not valid. (*Id.*) The evaluator explained: "Most of [the cervical range of motion findings] are consistent among trials meeting validity criteria, however we are not sure whether or not they are actually valid for rating impairment due to guarding." (Ex. 13-4). The evaluator concluded that, in the absence of objective findings and in the presence of symptom magnification, claimant's demonstration was not reliable. (Ex. 13-5). Dr. Campbell concurred with the May 12, 1999 report from "Health in Industry." (Ex. 15).

A June 8, 1999 Notice of Closure awarded only temporary disability. (Ex. 19). Claimant requested reconsideration. (Ex. 23). An August 30, 1999 Order on Reconsideration affirmed the portion of the Notice of Closure that had not awarded permanent disability. (Ex. 24).

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[1] We modify the ALJ's order to note that, in addition to Exhibits 1 through 24, Exhibits 7A, 7B, 7C, 7D, 7E, 7F, 7G, 7H, 7I, 11A and 11B were admitted in evidence.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Campbell's concurrence with the May 12, 1999 WCE and concluded that, after excluding the invalid left rotation measurement, claimant was entitled to an award of 3 percent unscheduled permanent disability for reduced cervical range of motion.

Based on Dr. Campbell's concurrence with Dr. Anderson's May 12, 1999 report and the May 12, 1999 WCE report, SAIF contends that claimant is not entitled to an award of permanent disability.

For the purpose of rating permanent disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter's findings, if any, may be considered. *See* ORS 656.245(2)(b)(B), ORS 656.268(7); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). Under OAR 436-035-0007(14), impairment is established by the attending physician except where a preponderance of medical opinion establishes a different level of impairment.

Because claimant did not disagree with the impairment findings, there was no medical arbiter examination. (Ex. 23). Claimant relies on the May 12, 1999 WCE report, with which Dr. Campbell concurred, to establish his cervical impairment.

We find that the May 12, 1999 reports are more probative regarding claimant's impairment than earlier reports because they are closer in time to the August 30, 1999 reconsideration order. Dr. Campbell indicated that he concurred with the May 12, 1999 report from "Health in Industry." (Ex. 15). Because Dr. Anderson's May 12, 1999 report and the May 12, 1999 WCE are both from "Health in Industry" (Exs. 12, 13), we examine both reports to determine claimant's impairment.

On May 12, 1999, Dr. Anderson reported that claimant had "full active range of motion of all joints of the upper and lower extremities." (Ex. 12-3). He did not provide specific findings of claimant's cervical range of motion. Later in his report, he said claimant had "restricted motion, but he does this on a voluntary basis because of his pain complaints." (Ex. 12-5). It is unclear what restricted motion Dr. Anderson was referring to. In any event, he found there was symptom magnification and possible functional overlay. (Ex. 12-4, -6). Dr. Anderson found no objective findings to support claimant's symptoms and he concluded there was no objective evidence of impairment. (Ex. 12-5).

In the May 12, 1999 WCE, the evaluator reported that, regarding physical capacity testing, the evaluator had observed "no signs of maximum exertion[.]" (Ex. 13-3). She referred to inconsistencies in testing, explaining:

> "He participated in a two hour circuit working on a frequent basis with the exact same weights that he felt were representative of his maximum tolerance. Certainly this is inconsistent. One usually expects an individual to work with approximately twice as much, if not more than twice as much, if they are demonstrating near maximum strength capability. Interestingly, he completed the circuit without increasing his pain report, but rather decreased his pain report when he completed the two hour circuit." (*Id.*)

Regarding claimant's positional activities, the evaluator explained:

> "He completed the stair climbing screening for 10 repetitions in a reasonable time, at 3 minutes, stating that he was having disabling pain that radiated from the back of his head to his eyes while engaging in stair climbing. Certainly this is not making any sense on a physical basis." (Ex. 13-4).

The evaluator reported that claimant's cervical range of motion finding for left rotation was not valid. (Ex. 13-7). The evaluator explained:

> "Range of motion measurements of the cervical spine were taken using an inclinometer. These findings are outlined on page 2 of the attached form. Most of them are consistent among trials meeting validity criteria, however we are not sure whether or not they are actually valid for rating impairment due to guarding." (Ex. 13-4).

The evaluator provided the following conclusions:

> "[C]laimant reports subjective complaints in excess of objective findings. He complains of pain that is related to activity that is inconsistent, i.e., pain in his head from climbing stairs at a normal pace that is not present with walking at a normal pace. In addition, he participated at a frequent rate with the same load that he reported was the maximum amount that he was capable of moving on a one time per day basis.
>
> "It is our opinion that in the absence of objective findings and in the presence of symptom magnification today, his report and demonstration reliable [sic] are not reliable, and therefore recommendations were made based on normal work for a man of his age and on the job analysis of his job-at injury, which predominantly is the medium range but occasionally up into the medium-heavy range with 60# required occasionally. We feel that he can return to his job-at-injury based on his demonstration today where he does demonstrate the ability to engage in lifting and carrying 30-40# frequently." (Ex. 13-5).

Claimant contends that the May 12, 1999 WCE demonstrated reduced cervical ranges of motion, which entitles him to a 3 percent permanent disability award. According to claimant, the evaluator found that all the cervical range of motions met the validity criteria, except for left rotation.

In previous cases, we have held that the validity of range of motion testing must be determined by the medical examiner performing the tests. *E.g., Harvey Clark*, 47 Van Natta 136 (1995). We have found no basis for an award of permanent disability in cases in which the medical examiner has expressly questioned the validity of the findings. *Nestor P. Martinez*, 51 Van Natta 2033 (1999); *Dana M. Peterson*, 50 Van Natta 1554 (1998).

Here, Dr. Anderson found no objective findings to support claimant's symptoms and no objective evidence of impairment. (Ex. 12-5). He diagnosed symptom magnification. (Ex. 12-4). The WCE evaluator found that most of claimant's range of motion findings met the validity criteria, but she noted that "we are not sure whether or not they are actually valid for rating impairment due to guarding." (Ex. 13-4). The WCE evaluator described inconsistencies in testing claimant. (Ex. 13-3, -4, -5). In the summary portion of the report, the WCE evaluator reported that "in the absence of objective findings and in the presence of symptom magnification today," claimant's demonstration was not reliable. (Ex. 13-5). The WCE evaluator concluded that claimant was capable of returning to his regular job. (*Id.*)

Both Dr. Anderson and the WCE evaluator questioned the validity of claimant's cervical range of motion findings. Thus, regardless of whether the ranges of motion might satisfy a portion of validity criteria, the medical examiners expressly questioned the validity of the findings and, therefore, those findings are not sufficient to establish permanent disability. *See Dana M. Peterson*, 50 Van Natta at 1554. Dr. Campbell, claimant's treating doctor, concurred with the reports. (Ex. 15). Furthermore, we note that on April 1, 1999, approximately one month before the May 12, 1999 reports, Dr. Campbell had reported that claimant had full range of motion in his neck, with some tenderness. (Ex. 11B). We conclude that claimant is not entitled to an unscheduled permanent disability award for reduced cervical range of motion.

ORDER

The ALJ's order dated March 31, 2000 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
CHARLES W. BRACH, Claimant
WCB Case Nos. 99-05052 & 99-01454
ORDER ON REVIEW (REMANDING)
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denials of claimant's aggravation and new injury claims for his current right shoulder and right knee conditions. Claimant has attached several documents to his request for review. Claimant also contends that the ALJ erred in refusing to allow him to testify at hearing. We treat claimant's submissions and argument as a motion to remand. On review, the issues are remand and, potentially, compensability. We remand.

FINDINGS OF FACT

Claimant was compensably injured on September 5, 1998. The insurer accepted the claim as a head contusion, right shoulder strain, right wrist contusion, and cervical strain. The claim was closed on December 21, 1998, with no award of permanent disability.

Claimant sought treatment for right knee and shoulder pain on January 5, 1999. He filed a claim for a January 4, 1999 lifting injury, which the insurer denied. On June 21, 1999, the insurer also denied claimant's aggravation claim that had related his right knee problems to the accepted 1998 injury.

Claimant requested a hearing. On the day of the scheduled hearing, claimant appeared without counsel. Claimant indicated that he wished to proceed without an attorney. Claimant was not sworn in and did not testify with regard to his claim.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that he did not receive a fair and impartial hearing. Claimant argues that the ALJ erred in rejecting his claim without reviewing any of his medical records or allowing his testimony to be given. Additionally, claimant contends that he has discovered new evidence regarding his right knee condition.

Our review is limited to the record developed at hearing. ORS 656.295(5). We may remand to the ALJ if we find that the record has been improperly, incompletely, or otherwise insufficiently developed. *Id.*

Here, we find that, because claimant was not allowed to testify, the record has been improperly and incompletely developed. Although the ALJ asked claimant if he wished to obtain an attorney, there is no evidence that claimant was read his rights pursuant to ORS 183.413. Additionally, although claimant made it clear that he wished to testify with respect to his claim[1], the ALJ did not swear claimant in and there is no testimony on the record.

Therefore, we conclude that, because there is no indication on the record that claimant was made aware of his rights pursuant to ORS 183.413, and because claimant wished to testify but was not permitted to do so, a remand in this case is appropriate.[2]

---

[1] In discussing claimant's case, the following statements were made:

"ALJ: ...obviously a person feels like if they're presented with the opportunity to have a hearing, that they should have an opportunity to -- to say something about it. You know, but--

"Claimant: "Yeah, I--

"ALJ: But if it's not going to be meaningful, there's -- there's no point in your -- in your testifying about it." (Tr. 12).

[2] The ALJ advised claimant that he would not be able to prevail on the claims because expert medical opinion was required. (Tr. 4). However, claimant stated to the ALJ that he wanted to "straighten out" some of the inaccuracies in the record with respect to the doctors' opinions. (Tr. 5, 6). Such comments establish claimant's intention to proceed with the hearing and to offer testimony in response to the contrary medical evidence and in support of his denied claim. Under such circumstances, in the interests of obtaining an accurate and complete record, we conclude that claimant should have been permitted to testify.

Under these circumstances, we conclude that the record is inadequately developed. *See, e.g., Marsha E. Westenberg*, 49 Van Natta 2178 (1997) (citing *Eston Jones*, 49 Van Natta 1841 (1997)) (record inadequately developed and remand appropriate where ALJ reached merits of denial and dismissed request for hearing without taking evidence, even though the claimant wished to proceed to hearing).

Accordingly, we vacate the ALJ's order and remand the case to the ALJ. On remand, the ALJ shall advise claimant of his rights and take claimant's testimony. The ALJ shall also determine whether additional evidence should be admitted. The ALJ shall conduct the hearing in a manner consistent with this order and substantial justice.

ORDER

The ALJ's order dated December 30, 1999 is vacated. This matter is remanded to ALJ Mongrain to conduct further proceedings consistent with this order. After these further proceedings, the ALJ shall issue a final, appealable order.

In the Matter of the Compensation of
ROBERT E. DROPPA, Claimant
Own Motion No. 99-0379M
OWN MOTION ORDER
Walsh & Associates, Claimant Attorneys
Liberty Northwest Ins. Co., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable cervical condition. Claimant's aggravation rights expired on July 29, 1999. Claimant requested temporary disability compensation for his current cervical condition. On December 21, 1999, the Board postponed action on the own motion request because litigation on related issues was pending before the Hearings Division. (WCB Case No. 99-08908).

On April 6, 2000, Administrative Law Judge (ALJ) Lipton approved a "Stipulation and Order" which resolved the parties dispute pending before the Hearings Division. The parties agreed that the insurer would process claimants current cervical condition under the insurer's claim number C604549599. In addition, claimant's hearing request in the insurer's claim number 604416337, his 1993 injury claim, was dismissed with prejudice.

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).

Here, the insurers October 18, 1999 denial, as amended on December 22, 1999, of claimant's current cervical condition under his 1993 claim, remains in full force and effect. In light of such a stipulation, we are without authority to authorize temporary disability compensation for claimant's current cervical condition, as the insurer has not accepted responsibility for that condition under his 1993 claim. Should claimant's circumstances change, and the insurer accepts responsibility for his current cervical condition under his 1993 claim, claimant may again request own motion relief.

Accordingly, the request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
NORMA K. LAMERSON, Claimant
WCB Case No. 99-01965
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the self-insured employer's denial of her aggravation claim for a bilateral hand condition. On review, the issue is aggravation.

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

Citing *SAIF v. Walker,* 145 Or App 294 (1996), the ALJ held that claimant had failed to prove a compensable aggravation claim. Specifically, the ALJ determined that claimant had failed to prove an actual pathological worsening of her compensable condition since the last arrangement of compensation.

On review, claimant contends that the ALJ incorrectly found no actual worsening of her compensable bilateral hand condition for two reasons: (1) she testified that her condition was worse and the ALJ found her testimony credible and reliable; and (2) Dr. Long, a consulting physician, indicated, based on a comparison of nerve conduction studies, that there had been an increase in median sensory defects in claimants palms. For the following reasons, we conclude that this evidence does not prove an actual worsening of claimants compensable condition.

To prove a compensable aggravation, claimant must establish an "actual worsening" of the compensable condition since the last award of compensation. ORS 656.273(1). After the ALJ's order, the Supreme Court in *SAIF v. Walker,* 330 Or 102 (2000), affirmed the Court of Appeals opinion that had reversed a Board order that had set aside an aggravation denial based on claimant's symptomatic worsening. After analyzing the text of ORS 656.273(1), the Court determined that, to prove an aggravation claim, a worker must present evidence of a worsening of the compensable condition itself, not merely a worsening of the symptoms related to the underlying condition. Consequently, the Court concluded that a worker cannot satisfy the requirements of ORS 656.273(1) by presenting evidence of worsened symptoms alone. *Id.* at 110.

The Supreme Court next addressed the question of whether and to what degree a factfinder may consider evidence of worsened symptoms when determining whether a worker has presented medical evidence of an actual worsening of the compensable condition. Because the statutory text of ORS 656.273(1) (1995) was not helpful, the Court turned to the statutory context, as well as the applicable case law. In summarizing the relevant statutes, the Court observed that the 1995 legislature amended ORS 656.273(1) after years of case law had held that a worker could establish a "worsened condition" by presenting evidence of a worsening of the underlying condition itself *or* of its symptoms -- in the latter case, with a factfinder inferring the existence of a worsened condition from evidence of a symptomatic worsening. The Court further noted that the 1995 version of ORS 656.273(1) required something different: Proof, based upon medical evidence supported by objective findings, of a worsening of the underlying condition itself, not merely of its symptoms. Nonetheless, based on ORS 656.005(19), the Court reasoned that "objective findings" may include evidence of worsened symptoms. *Id.* at 117.

Finally, under ORS 656.273(8) (which had remained unchanged since its 1990 enactment), the Court commented that the statute -- as did the case law that preceded it -- continues to require that a worker with permanent disability establish that the "worsening" at issue is more than a waxing of symptoms associated with the underlying condition, that is, an increase in symptoms that exceeds the degree anticipated by the earlier award. When considered together, the Supreme Court determined that the text, context, and applicable case law surrounding the 1995 amendment to ORS 656.273(1) clarified the legislature's intended meaning of that statute, as well as the interplay between that statute and ORS 656.273(8).

Accordingly, the Court held that evidence of a symptomatic worsening that exceeds the amount of waxing anticipated by an original permanent disability award -- that is, the degree of worsening addressed in ORS 656.273(8) -- may prove an aggravation claim under ORS 656.273(1) (1995) if, but only if, a physician concludes, based on objective findings (which may incorporate the particular symptoms), that the underlying condition itself has worsened. Stated differently, the Court reasoned that, if, in a

physician's medical opinion, a symptomatic worsening that exceeds the degree anticipated does not demonstrate the existence of an actual worsening of the underlying condition, then the worker does not qualify for an aggravation award. *Id.* at 119.

Applying the *Walker* Courts reasoning to this case, we conclude that claimants testimony does not prove a compensable aggravation claim because, as the Court made clear, it is necessary that a *physician* conclude based on objective findings that the underlying condition has worsened. *Id.* Claimants testimony that her symptoms were worse does not prove a worsening of the underlying condition.

We now turn to Dr. Longs comment that there had been some interval increase in median sensory conduction defects in claimants palms since June 1996. We find that this statement does not establish a worsening of the underlying condition. First, we agree with the ALJ's reasoning that an examining physician, Dr. Radecki, provided the most persuasive comparison of nerve conduction studies. Dr. Radecki opined that these studies were unchanged. (Ex. 18-24). Second, even if we accepted Dr. Long's assessment that there had been some change in claimants nerve conduction studies, Dr. Long did not opine that this represented a worsening of the underlying condition. (Ex. 13).

Accordingly, we agree with the ALJ's conclusion that claimant failed to prove an actual worsening of the compensable condition. ORS 656.273(1). Therefore, we affirm the ALJ's decision upholding the employers aggravation denial.

ORDER

The ALJ's order dated March 14, 2000 is affirmed.

In the Matter of the Compensation of
ANITA E. JOHNSON-SLONE, Claimant
WCB Case No. 98-06102
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Atwood & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of her claim for a left foot injury. 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 should not have rejected the opinion of Dr. Beals on the ground that it did not rise to the necessary level of reasonable medical probability. Claimant argues that Dr. Beals' opinion regarding causation is based on probability, rather than on "possibility."

After reviewing Dr. Beals' deposition, we agree with the ALJ's assessment of Dr. Beals' opinion. Specifically, when asked the cause of claimant's foot condition, Dr. Beals testified that it was his "speculation or my guess was that it could have been due to some type of stress fracture." (Ex. 31-14). Dr. Beals further stated that he could not "prove that it was a stress fracture." (Ex. 31-15). Finally, Dr. Beals testified that the cause of claimant's condition was "in question." (Ex. 31-29).

Accordingly, when read in its entirety, we agree with the ALJ that Dr. Beals' opinion regarding causation is not stated in terms of medical probability. *See Lenox v. SAIF*, 54 Or App 551, 554 (1981) (to prove medical causation, a medical opinion must be based on medical probability). Therefore, claimant has not met her burden of proof. ORS 656.266.

ORDER

The ALJ's order dated March 1, 2000 is affirmed.

In the Matter of the Compensation of
TORIE M. MYERS, Claimant
WCB Case No. TP-00003
THIRD PARTY DISTRIBUTION ORDER
Bottini, Bottini & Oswald, Claimant Attorneys
Hallman & Dretke, Attorneys
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

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 (Business Insurance Company's - hereafter "BICO's") entitlement to a lien for future medical expenditures as projected for future surgery. For the following reasons, we conclude that BICO has not established that it is reasonably certain that it will incur such expenditures.

FINDINGS OF FACT

Claimant was compensably injured on October 9, 1997, when she was involved in an automobile/school-bus collision. (Ex. 1). Dr. Perry diagnosed a "[r]ight displaced three part proximal humerus fracture including the greater tuberosity and surgical neck." (Ex. 3). On October 10, 1997, Dr. Perry performed the following surgical procedures: (1) open reduction, internal fixation of displaced surgical neck and displaced and comminuted greater tuberosity fractures; (2) repair of rotator cuff tear; and (3) cancellous bone grafting to proximal humerus bone defect. (*Id.*) BICO accepted a disabling right proximal humerus fracture. (Ex. 5).

On February 13, 1998, Dr. Perry indicated that, based on claimant's injury and subsequent surgery, she was at risk for developing avascular necrosis during the first one to two years after the injury. (Ex. 5A).

A June 17, 1998 Determination Order awarded 7 percent (22.4 degrees) unscheduled permanent disability for claimant's right shoulder condition. (Ex. 9).

On September 29, 1998, Dr. Perry found no evidence of avascular necrosis and recommended another shoulder x-ray in a year. (Ex. 9A). He noted that, if claimant had not developed avascular necrosis by that time, it was "fairly safe" that it would not develop. (*Id.*)

Dr. Perry wrote to BICO on September 1, 1999 regarding claimant's right shoulder condition. (Ex. 12). He reported that claimant most likely had permanent loss of range of motion in her right shoulder, as well as strength loss. (Ex. 12-1). He felt the chance of avascular necrosis was "quite small at this time." (*Id.*) Nevertheless, Dr. Perry said that claimant "may need further surgery in the future, which might include diagnostic shoulder arthroscopy, manipulation, selective capsulotomy, rotator cuff repair although it is not currently torn, and even shoulder hemiarthroplasty or total joint replacement." (Ex. 12-3).

Dr. Switlyk examined claimant on October 26, 1999 and reported that her x-rays showed healing of her fractures and overall good maintenance of the shape of the humeral head. (Ex. 14A-2). He explained that the fact that claimant had not had progressive or significant avascular necrosis two years after the injury made that unlikely in the future. (Ex. 14A-3).

In a concurrence letter from BICO signed on April 19, 2000, Dr. Perry agreed that claimant had necrosis in a very small portion of the femoral head in her right shoulder. (Ex. 15). Dr. Perry agreed that it was reasonably certain claimant will require surgery in 10 years or more. (*Id.*)

Dr. Perry examined claimant again on May 12, 2000 and reported that her right shoulder range of motion and strength were much better than when he had seen her on July 6, 1999. (Ex. 16). Based on claimant's recent physical and radiographic examination, Dr. Perry believed it was only "possible" that claimant will require additional right shoulder surgery "within the next 10 years and even beyond." (Ex. 17-2).

Claimant initiated a third party claim, which was settled in the amount of $400,000. Claimant agrees that BICO is entitled to reimbursement of $26,621 for its actual expenditures. BICO also seeks reimbursement for future costs of $30,347, based on "future shoulder replacement surgery, 26 weeks of time loss, 20% additional impairment and medicals." (Ex. 13). Claimant has petitioned the Board, disputing BICO's entitlement to a lien for said specific future expenditures.

CONCLUSIONS OF LAW AND OPINION

Claimant argues there is no evidence to support BICO's lien for future expenditures in the amount of $30,347. Claimant contends the medical evidence shows only that future medical treatments are a possibility.

BICO relies on Dr. Perry's September 1, 1999 letter and his April 19, 2000 concurrence letter to argue that it is reasonably certain that claimant will require additional shoulder surgery.

ORS 656.578 provides that, if a worker sustains a compensable injury due to the negligence or wrong of a third party, the worker shall elect whether to recover damages from the third party. 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. *See 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. *Antonio Centurion*, 51 Van Natta 2017 (1999). ORS 656.593(1)(c) provides that the paying agency is entitled to compensation for the "present value of its reasonably to be expected future expenditures for compensation[.]" Thus, to support a lien for anticipated future medical expenses, the paying agency must establish that it is reasonably certain to incur such expenditures. *Centurion*, 51 Van Natta at 2017.

In *Sharon K. Falsetto*, 49 Van Natta 1202, *on recon* 49 Van Natta 1573 (1997), we found that the claimant's future surgery was only a possibility and was not reasonably certain to occur. Consequently, we concluded that the paying agency was not entitled to recover its projected lien for future claim expenses. Similarly, in *Antonio Centurion*, 51 Van Natta at 2017, we found that the medical evidence indicated that future surgery and medical treatment were only a possibility and, therefore, the paying agency was not entitled to recover for future medical expenses.

Here, BICO relies on Dr. Perry's April 19, 2000 concurrence letter from BICO in which he agreed that claimant had necrosis in a very small portion of the femoral head in her right shoulder. (Ex. 15). Dr. Perry agreed that it was reasonably certain claimant will require surgery in 10 years or more. (*Id.*) He also agreed it was only medically possible she will require additional surgery within the next 10 years. (*Id.*) Dr. Perry's opinion at that time was based on his most recent examination of claimant. (Ex. 17). BICO also relies on Dr. Perry's September 1, 1999 letter, which indicated claimant may need further surgery in the future. (Ex. 12-3).

Dr. Perry examined claimant again on May 12, 2000 and reported that claimant's right shoulder range of motion and strength were much better than when he had seen her on July 6, 1999. (Ex. 16). He was "thrilled" with her improvement in range of motion and resultant functionality. (*Id.*) Dr. Perry explained that claimant had "not had humeral head collapse but from the appearance of this x-ray she most likely did develop some avascular necrosis but which is probably resolved at this time to a great extent." (*Id.*)

Based on the May 12, 2000 examination, Dr. Perry changed his opinion concerning the likelihood of future shoulder surgery for claimant. On June 2, 2000, Dr. Perry said that when he previously agreed that it was reasonably certain claimant would require another shoulder surgery, he was basing his opinion on his previous examination. (Ex. 17-2). He explained:

> "Based upon [claimant's] recent physical and radiographic examination, I believe it is only possible that she will require additional right shoulder surgery within the next 10 years and even beyond. Therefore, I have changed my opinion based upon this recent information from 'reasonably certain' to now only 'medically possible.' On a more probable than not basis, I think it is more likely that [claimant] will not require surgical intervention in the future." (*Id.*)

In his June 2, 2000 letter, Dr. Perry noted that it was now more than 2-1/2 years after claimant's injury and, at this point, she was unlikely to develop humeral head collapse and the possible attendant sequelae of that type of problem. (Ex. 17-1).

Dr. Perry's later opinion that it was only "possible" that claimant may require future shoulder surgery is consistent with Dr. Switlyk's October 26, 1999 report. Dr. Switlyk explained that the fact that claimant had not had progressive or significant avascular necrosis two years after the injury made that unlikely in the future. (Ex. 14A-3). Dr. Perry had previously indicated that claimant was at risk for developing avascular necrosis during the first one to two years after the injury. (Ex. 5A).

After reviewing the medical evidence, we agree with claimant that BICO has not sustained its burden of proving that it is reasonably certain to incur expenditures for claimant's future medical expenses resulting from surgery. On June 2, 2000, Dr. Perry said it was only "possible" that claimant will require additional right shoulder surgery "within the next 10 years and even beyond." (Ex. 17-2). Although he had previously agreed that future surgery was reasonably certain, Dr. Perry adequately explained why he had changed his opinion. Furthermore, Dr. Perry's September 1, 1999 report indicating that claimant "may need further surgery in the future" (Ex. 12-3) is not sufficient to establish that such surgery is reasonably to be expected, particularly in light of his later reports.

Based on Dr. Perry's June 2, 2000 report, as supported by Dr. Switlyk's October 26, 1999 report, we find that future surgery is only a possibility and is not reasonably certain to occur. Consequently, we agree with claimant that BICO is not entitled to recover for future medical expenses associated with future surgery and it is "just and proper" for BICO to receive reimbursement for its actual expenditures, *i.e.*, $26,621. In the event that claimant has not yet reimbursed BICO for its actual expenditures, claimant's counsel is directed to forward the aforementioned sum ($26,621) to BICO.

IT IS SO ORDERED.

In the Matter of the Compensation of
PETER F. PARKER, Claimant
WCB Case No. 98-02710
ORDER ON REVIEW
Atwood & Associates, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral carpal tunnel syndrome and bilateral tenosynovitis. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first sentence of the findings of fact, we change the date to early September 1997.

To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of his bilateral carpal tunnel syndrome (CTS) and bilateral tenosynovitis. 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 CTS and tenosynovitis, 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 that the medical evidence is not sufficient to establish that claimant's employment conditions were the major contributing cause of his bilateral CTS. We supplement the ALJ's order to discuss the employer's denial of claimant's occupational disease claim for bilateral tenosynovitis.

Dr. Hebard examined claimant on January 26, 1998 and diagnosed bilateral CTS and bilateral tenosynovitis of the hands and wrists. (Ex. 11). At that time, Dr. Hebard reported that claimants work environment probably did create a tenosynovitis and possibly contributed to the development of his carpal tunnel syndrome. (Ex. 11-2).

In a deposition, Dr. Hebard said the symptoms for tenosynovitis can be the same as for CTS and he relies on EMG studies to determine whether a patient has CTS. (Ex. 16-17, -24, -25). Dr. Hebard explained that it was "possible" that claimant had a tenosynovitis as well as bilateral CTS. (Ex. 16-26, -27). However, he could not state, with medical probability, that claimant had tenosynovitis. (Ex. 16-26). At most, Dr. Hebard's opinion indicates only a possibility that claimant had bilateral tenosynovitis, which is not legally sufficient. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). There are no other medical opinions that establish that claimant had bilateral tenosynovitis or that it was caused, in major part, by his employment conditions. We conclude that claimant has failed to establish compensability of bilateral tenosynovitis condition.[1]

ORDER

The ALJ's order dated March 2, 2000 is affirmed.

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[1] We note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM OR 97301

In the Matter of the Compensation of
GARY A. BERTRAND, Claimant
Own Motion No. 00-0210M
OWN MOTION ORDER
Bennett, Hartman, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's condition. Claimant's aggravation rights expired on February 10, 1997. The insurer recommends that we authorize the payment 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 claimant is actually hospitalized or undergoes outpatient surgery. *Id.*

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning May 15, 2000, the date claimant was hospitalized for surgery. When claimant is medically stationary, shall close the claim pursuant to OAR 438-012-0055.

Finally, in its recommendation form, the insurer indicates that claimant is represented. Based on such a reference, claimant's attorney may be entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, on this record, we cannot approve such a fee because: (1) no current retainer agreement has been filed with the Board (*see* OAR 438-015-0010(1)); and (2) no evidence demonstrates that claimants attorney was instrumental in obtaining increased temporary disability compensation OAR 438-015-0080.

In conclusion, because no retainer agreement has been received to date and the record does not establish that claimants attorney was instrumental in obtaining increased temporary disability compensation, the prerequisite for an award of an out-of-compensation attorney fee have not been met at this time. Consequently, no out-of-compensation attorney fee award has been granted. In the event that a party disagrees with this decision, that party may request reconsideration and submit information that is currently lacking from this record. Because our authority to further consider this matter expires within 30 days of this order, any such reconsideration request must be promptly submitted.

IT IS SO ORDERED.

June 28, 2000 Cite as 52 Van Natta 1092 (2000)

In the Matter of the Compensation of
BARBARA A. NATHAN, Claimant
WCB Case No. 99-04501
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's bilateral leg injury claim. On review, the issue is whether claimant's injury arose out of the course and scope of her employment.

We adopt and affirm the order of the ALJ with the following supplement. The employer argues that claimant was not within the course and scope of her employment at the time of her injury. In particular, the employer argues that claimant's injuries are not compensable under the "traveling employee" exception, or any other exception to the "going and coming rule.' We disagree.

For an injury to be compensable under the workers compensation law, it must "arise out of and in the course of employment." ORS 656.005(7) (a). The requirement that the injury occur "in the course of employment" concerns the time, place and circumstances of the injury. *Norpac Foods, Inc.*, v. Gilmore, 318 Or 363 (1993). The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. *Id; Darlynda J. McLain*, 48 Van Natta 542, 543 (1996).

In *Iliafar v. SAIF*, 160 Or App 116, 121-22 (1999), the court offered the following as guidance in interpreting the phrase "arising out of and in the course of employment":

> "The statutory phrase 'arising out of and in the course of employment' must be applied in each case so as to best effectuate the socio-economic purpose of the Workers' Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. Various concepts have arisen from attempts to rationalize that purpose, *e.g.*, the going and coming rule, special errands, lunch hour cases, dual purpose trips, impedimenta of employment, horseplay, etc. Each is helpful for conceptualization and indexing, but there is no formula for decision. Rather, in each case, every pertinent factor must be considered as a part of the whole. It is the basic purpose of the Act which gives weight to particular facts and direction to the analysis of whether an injury arises out of and in the course of employment. *Allen v. SAIF*, 29 Or App 631, 633-34 (1977)."

The Supreme Court discussed the going and coming rule in *Fred Meyer, Inc. v. Hays*, 325 Or 592, 597 (1997):

> "Ordinarily, an injury sustained while a worker is going to or coming from work is not considered to have occurred 'in the course of' employment and, therefore, is not compensable. [Citations omitted.] That general rule is called the 'going and coming' rule. The reason for the 'going and coming' rule is that the relationship of employer and worker ordinarily is suspended from the time the worker leaves work to go home until he or she resumes work because, while going to or coming from work, the worker is rendering no service for the employer."

Here, claimant is an insurance underwriter and marketing person. (Tr. 4). A regular part of her job, about 15 percent, is spent away from the employer's premises visiting with agents, marketing, selling and performing public relations. (Tr. 7, 12). About one-half of claimant's out of the office activities is done locally, using her personal car. (Tr. 7, 12). The other half of her travel is out of state. (Tr. 12). Claimant is required by the employer to make 10 agent visits per month. (Tr. 17). Claimant is reimbursed for her expenses associated with her out of the office job activities, including mileage reimbursement when she uses her personal vehicle. (Tr. 9-10).

Where travel is a necessary part of employment, risks incident to travel are covered by the workers' compensation law even though the employee may not be working at the time of the injury. *Proctor v. SAIF*, 123 Or App 326, 329 (1993). In *Savin Corp. v. McBride*, 134 Or App 321, 324 (1995), the court quoted Professor Larson's explanation of the rule:

> "Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown." 1A Larson, Workmen's Compensation Law Sec. 25.00, 5-275 (1990).

On January 14, 1999, claimant, using her personal car, drove herself and her boss, Bill Groves, a senior underwriter and branch vice manager, to a business meeting with a reinsurance agent at a downtown Portland restaurant.[1] (Tr. 5, 11). After the meeting, claimant drove Groves home. (Tr. 5). Upon arriving at Groves' home, claimant asked to use the bathroom. (Tr. 6) They went up to the front door, but Groves did not have his house key and couldn't open the locked door. (Tr. 6). As claimant walked down the front steps, back to her car, she fell and injured her legs. (Tr. 6). Claimant was paid mileage for the entire trip from the office, to the restaurant, to Groves' house, and to her home.[2] (Tr. 10; Ex. 9A).

Considering the pertinent factors of this claim as a whole, claimant's testimony establishes that attending business dinners and meetings away from the employers premises, like the one on January 14, 1999, is a necessary and integral part of her job function performed in the furtherance of the business of the employer. We further conclude that this portion of claimant's job function necessitated travel, which was contemplated by the employer and for which claimant was reimbursed expenses. Accordingly, we conclude that on January 14, 1999, claimant was a traveling employee.[3]

The employer argues that even if claimant was a traveling employee on the evening of January 14, 1999, her injuries are not compensable as both the acts of driving Groves home and the attempt to use a bathroom at Groves' home were distinct departures from her employment. We disagree.

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[1] Claimant had been asked by Groves to provide him with transportation to the meeting and home as he did not have a company car available. (Tr. p. 5).

[2] Reimbursement for travel expenses is not by itself determinative; it is just one factor to be considered as a part of the whole. *Kathleen A. Mecone*, 43 Van Natta 166 (1991).

[3] The employer cites our decision in *Darlynda J. Mclain*, 48 Van Natta 542 (1996), to argue that on the evening of January 14, 1999, claimant was not a traveling employee. We disagree with the employer's argument. In *McClain*, the claimant was injured while on her way to attend an awards banquet sponsored by her employer. The banquet, which the claimant was expected, but not required, to attend, was at most a once-a-year event. Consequently, it was not a regular function of her job duties. (Some of the claimant's work did require local travel in her personal car. As we noted in our decision, had she been injured during one of these activities, we would have considered her a traveling employee.) In addition, the claimant in *McClain* did not expect to be reimbursed, and in fact, was not reimbursed for her mileage to attend the banquet. Accordingly, *McClain* is distinguishable.

When travel is part of the employment, "the risk of injury during activities necessitated by travel remains an incident to the employment," even though the employee may not actually be working when the injury occurs. *Savin Corp. v. McBride*, 134 Or App 321, 324 (1995); *Pacific Power & Light v. Jacobson*, 121 Or App 260, 263 (1993) (citing *SAIF v. Reel*, 303 Or. 210, 216, 735 P2d 364 (1987). In *McBride*, the court agreed with our reasoning that conducting a personal banking errand was reasonably related to the claimant's work status as a traveling employee.[4] *McBride*, 134 Or App at 325.

Consequently, considering all the circumstances involved, we conclude that claimant's driving her boss home after the business meeting and her subsequent attempt to use the bathroom were activities incident to her status as a traveling employee. Therefore, we agree with the ALJ's conclusion that the time, place and circumstances of claimant's injury were within the purview of her work duties and that the injury was from a risk incident to her employment. Accordingly, we affirm the ALJ's order that set aside the employer's denial of the claim.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, 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 February 28, 2000 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

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[4] In holding that the claimant's injury in *McBride* was compensable, we explained:

"claimant had traveled to Redmond on a work assignment, when she learned that the work order had been canceled and she was released for the rest of the day. Claimant stopped at a bank before traveling homeward to Bend, because she believed the banks in Bend would have been closed if she had driven home first. Thus, claimant's bank errand was for her personal convenience. There is no contention that claimant's belief or conduct was unreasonable, or that she disobeyed the employer in going to the Redmond bank. Under these circumstances, we conclude that claimant's personal bank errand in Redmond was reasonably related to her work status as a traveling employee." *Id.*

In the Matter of the Compensation of
HENRY M. PARNELL, Claimant
WCB Case Nos. 99-06167, 99-06166 & 99-06131
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) affirmed an Order on Reconsideration that classified claimant's right elbow injury claim as disabling; and (2) set aside its denial of claimant's new injury claim for a bilateral rotator cuff tendinitis condition. On review, the issues are claim classification and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claim Classification

The ALJ relied on Dr. Williams' medical arbiter report, which recorded loss of range of motion in claimant's elbow and attributed that loss of motion to the accepted epicondylitis, along with claimant's lack of improvement as documented in the chart notes of treating physician, Dr. Lundquist.

Concluding that claimant would likely have permanent impairment under the applicable rating standards, the ALJ changed the classification of claimant's injury claim from nondisabling to disabling. We agree.

A "disabling compensable injury" entitles the worker to compensation for disability or death. ORS 656.005(7)(c). When no temporary disability benefits are due and payable, an injury is not disabling, unless there is a reasonable expectation that permanent disability will result from the injury. *Id.*

Here there is no contention that claimant is entitled to temporary disability benefits.[1] Therefore, claimants right elbow condition is disabling only if there is proof of a reasonable expectation of permanent disability.

In construing ORS 656.005(7)(c) and determining whether a compensable injury is disabling, we require expert medical opinion indicating there is a reasonable expectation that a current condition could lead to ratable impairment under the applicable impairment standards. *SAIF v. Schiller*, 151 Or App 58, 63 (1997); *Lester B. Lewis*, 51 Van Natta 778, 779 (1999). A showing that a current condition is presently ratable under the standards is not required. *Schiller*, 151 Or App at 63.

The insurer argues that Dr. Williams' medical arbiter report is insufficient to prove a reasonable expectation that permanent disability will likely result from the accepted condition.[2] We disagree.

The only purpose of Dr. Williams' medical arbiter exam was to determine whether or not a likelihood of permanent disability existed as a result of the accepted claim. (Ex. 85-2). Dr. Williams specifically found reduced ranges of motion in claimants right elbow. (Ex. 81-2). Noting that claimant seemed to exhibit a waxing and waning of symptoms during periods of increased activity, Dr. Williams recommended that claimant reduce the repetitive use of his elbow during increased symptoms. (Ex. 81-2). Dr. Williams observed that lateral epicondylitis usually resolves, but occasionally has a protracted course. (Ex. 81-2). Finally, Dr. Williams reported that no findings were considered invalid and that any impairment noted today is due to the accepted condition. (Ex. 81-2).

In *Gerasimos Tsirimiagos*, 50 Van Natta 1627 (1998), we declined to classify an injury as disabling where a medical arbiter panel determined valid reduced ranges of motion attributable to the accepted conditions, but specifically noted that no loss of function of any of the claimants body parts was anticipated as a result of the accepted conditions. Here, unlike *Tsirimiagos*, the medical arbiter did not expressly conclude that no permanent loss of function was anticipated. To the contrary, the medical arbiter recommended that claimant reduce his repetitive activities during symptomatic periods. Moreover, the medical arbiter acknowledged that claimant's lateral epicondylitis condition occasionally had a protracted course. Under such circumstances, considering the valid reduced range of motion of claimant's elbow, Dr. Williams note that any impairment is attributable to the accepted condition, and because Dr. Williams' specific assignment was to issue an opinion on the likelihood of permanent disability, we conclude that his opinion, taken as a whole, supports a conclusion that there is a reasonable expectation that permanent disability will result from claimants injury.

Accordingly, we agree with the ALJ's decision to affirm the Order on Reconsideration which classified claimant's right lateral epicondylitis claim as disabling.

Compensability

We adopt and affirm that portion of the ALJ's order with the following supplementation to address the employer's contention that the ALJ incorrectly relied on the medical opinion of Dr. Lundquist, the attending physician, instead of the medical opinion of Dr. Schilperoort.

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[1] Neither party contends that temporary disability benefits are due and payable.

[2] The insurer contends that claimant's medical arbiter's exam is similar to exams in *Lester B. Lewis*, 51 Van Natta 778 (1999), and *Thomas G. Dobson*, 50 Van Natta 2390 (1998). We disagree. In *Lewis*, the medical arbiter expressly found, for the conditions under his consideration, that there was either no evidence of permanent disability or that it was too early to make such a determination. In *Dobson*, the medical evidence expressly indicated that it was undetermined whether the injury would cause permanent impairment. Consequently, we conclude that both *Lewis* and *Dobson* are distinguishable.

Claimant initially began seeing Dr. Lundquist in July 1998, for treatment of his lateral epicondylitis of the right elbow. (Ex. 63, 64). Dr. Lundquist's treatment was expanded to include claimant's shoulder complaints when those complaints developed in December 1998. (Ex. 76). Claimant contends that his bilateral rotator cuff tendinitis is either a consequential condition of his accepted right elbow epicondylitis condition or is new injury or occupational disease.

In order to establish that his bilateral rotator cuff tendinitis is compensable as a consequential condition of his accepted right elbow epicondylitis condition, claimant must show that the major contributing cause of the disability or need for treatment of his bilateral rotator cuff tendinitis is his right elbow epicondylitis. ORS 656.005(7)(a)(A). To establish that his bilateral rotator cuff tendinitis is compensable as a new injury, claimant must prove that his work injury is a material contributing cause of the disability or need for treatment of that shoulder condition. *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). If his bilateral rotator cuff tendinitis combined with a preexisting condition, claimants bilateral rotator cuff tendinitis condition is compensable only if the work injury was the major contributing cause of the disability or need for treatment for the shoulder condition.[3] ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 279, 283 (1993).

Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

Because the bilateral shoulder rotator cuff tendinitis arose in a discrete period of time in relation to a specific activity, the ALJ concluded that it should be analyzed as an injury rather than as an occupational disease. *Mathel v. Josephine County*, 319 Or 235 (1994); *James v. Cook*, 290 Or 343 (1981).[4] Relying on both claimant's description and a co-worker's description of claimant's work activities, as well as the medical opinion of Dr. Lundquist, claimant's attending orthopedic surgeon, the ALJ concluded that bilateral rotator cuff tendinitis claim was compensable. The ALJ found Dr. Lundquist's opinion that the major contributing cause of claimants disability and need for treatment for the bilateral rotator cuff tendinitis was claimant's work activity, to be based upon complete information and more persuasive than Dr. Schilperoort's in discussing all the aspects of claimant's condition, including the mechanics of claimant's work activities, claimant's symptoms of pain, the various diagnostic tests, and the clinical findings. We agree with the ALJ.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. Lundquist's opinion.

The employer argues that Dr. Schilperoort's opinion is as equally persuasive as Dr. Lundquist's and, because the two opinions are diametrically opposed, claimant fails in his burden of proof. We agree that the two opinions are diametrically opposed, but disagree that the two opinions are equally persuasive.

Dr. Schilperoort conceded that claimant's work activities, as described by claimant, have the potential of injuring claimant's shoulders. (Ex. 84-5). However, after reviewing x-ray imaging studies of claimant's shoulders, Dr. Schilperoort opined that claimant's bilateral shoulder condition was caused by a preexisting problem, a type III acromion on both shoulders.[5]

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[3] The ALJ analyzed the medical causation issue using the major contributing cause standard, without deciding whether or not preexisting conditions combined with claimants bilateral rotator cuff tendinitis. Neither party argues that the ALJ erred in using the major contributing cause standard. Consequently, we use the major contributing cause standard on review.

[4] Because the ALJ found a new injury, he did not address claimant's consequential condition theory or his occupational disease theory. The parties do not disagree with the ALJ's conclusion.

[5] A type III acromion is a structural anomaly of the acromion in which the anterior portion is directed downward in hook fashion. (Ex. 97-18). Dr. Schilperoort opined that the evidence of this anomaly was quite obvious on the imaging studies. (Ex. 93-1).

In contrast, Dr. Lundquist reviewed the x-ray imaging studies and specifically concluded there was no type III acromion defect present. (Ex. 97-19). Dr. Hahn, the radiologist who initially interpreted the x-ray imaging studies, refers to the x-rays as unremarkable. (Ex. 89). Such a reference supports Dr. Lundquist's conclusion that no type III acromion defect was present in claimant's shoulders.

Having found no persuasive reasons to do otherwise, we rely upon Dr. Lundquist's well reasoned and persuasive opinion, as supported by Dr. Hahn's interpretation of the x-ray imaging studies. Consequently, we find that claimant's work injury was the major contributing cause of his disability and his need for treatment for his bilateral rotator cuff tendinitis condition. Accordingly, we affirm the ALJ's order that set aside the insurer's denial of that claim.

Attorney Fees

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, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated February 23, 2000 is affirmed. For services on review, claimant is awarded a $1,800 attorney fee, payable by the self-insured employer.

June 28, 2000 Cite as 52 Van Natta 1097 (2000)

In the Matter of the Compensation of
AMELIA SANCHEZ, Claimant
WCB Case Nos. 99-03110 & 99-00948
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
James B. Northrop (Saif), 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 SAIF Corporation's partial denial, on behalf of Oregon Garden Products, Inc., (OGP), of claimant's consequential recurrent torn right medial meniscus; (2) upheld SAIF's denial, on behalf of Hines Horticulture, (Hines), of claimant's "new injury" claim for a right knee strain; and (3) declined to assess penalties for SAIF's allegedly unreasonable processing of the "OGP claim." On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last four sentences, with the following supplementation.

On August 25, 1998, claimant strained her right knee at work when she slipped out of a chair. Dr. Hermens provided medical treatment for this injury.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Claimant suffered a compensable right medial meniscus tear on July 22, 1995. Dr. Benz performed a right medial meniscectomy on November 13, 1995, but claimant's symptoms persisted. By late 1996, the medical experts agreed that most of claimant's ongoing knee problems were due to degenerative arthritis.

On June 20, 1997, claimant entered into a Disputed Claim Settlement (DCS) that upheld SAIF's denial of her right knee Grade III chondromalacia of the patellofemoral joint and Grade IV chondromalacia of the medial femoral condyle. On July 3, 1997, a Claim Disposition Agreement (CDA) settled all compensation, except medical services, for her 1995 claim.

Dr. Hermens began treating claimant's right knee on April 9, 1998. He performed a right knee partial meniscectomy, with debridement of chondromalacia, on July 31, 1998. Claimant returned to work. On August 25, 1998, she slipped out of a chair at work and strained her right knee. Dr. Hermens treated her right knee strain at her previously scheduled appointment on August 31, 1998.

By letter dated December 10, 1998, SAIF denied claimant's July 31, 1998 surgery and her "new injury" claim for the August 25, 1998 injury. On April 16, 1999, SAIF received a letter from claimant's counsel requesting that claimant's knee condition be processed under the 1995 injury claim. On June 28, 1999, claimant's counsel formally requested acceptance of her recurrent right medial meniscus tear as a new medical condition. By letter dated July 7, 1999, SAIF formally denied claimant's recurrent right medial meniscus tear as unrelated to the 1995 injury claim (the "OGP claim").

The ALJ upheld SAIF's denial of claimant's claim for a recurrent meniscus tear (the "OGP claim"), finding the medical evidence insufficient to establish that claimant's prior compensable meniscus tear was the major contributing cause of her current condition. The ALJ also upheld SAIF's denial of claimant's strain injury claim (the "Hines claim"), reasoning that the August 25, 1998 incident was not the major cause of any increased disability or of "any more need for treatment than was already taking place because of claimant's July 1998 surgery." We agree with the former conclusion, but not the latter.

Claimant is subject to the "major contributing cause" standard of proof regarding her claim for a recurrent torn right medial meniscus (the "OGP claim"), because the medical evidence indicates that claimant's noncompensable chondromalacia[1] combined with her meniscus condition to cause her disability and need for treatment for her right meniscus (as of and after her July 31, 1998 surgery). *See* ORS 656.005(7)(a)(B). Claimant is also subject to the "major contributing cause" standard of proof insofar as her recurrent meniscus tear is an indirect consequence of her prior meniscus tear and surgery. *See* ORS 656.005(7)(a)(A).

Dr. Hermens provides the only medical evidence arguably supporting the "OGP claim" regarding claimant's recurrent meniscus tear. He identified several causes contributing to that condition, including the 1995 meniscus tear, prior meniscus surgery, preexisting chondromalacia, and "post surgery" worsened chondromalacia.

Dr. Hermens indicated that claimant's recurrent meniscus tear was related to her prior meniscus tear because the recurrent tear occurred proximate to the prior surgery incision and the prior surgeon may have left too much damaged meniscus behind or the "post surgery wearing in process" may not have gone well. (Ex. 77; *see* Ex. 79-11-12, 79-14-15). Dr. Hermens also opined that claimant's 1995 torn meniscus and surgery probably accelerated her preexisting degenerative disease (chondromalacia). (Ex. 79-12-13). Dr. Hermens stated, "I believe it's not so much an acute tear but more a process of an abnormal remaining meniscus *and* ongoing activities *and* natural progression with the degenerative type tear." (Ex. 79-15; emphasis added). He also found it "harder to say" *which* of those factors caused claimant's "degenerative tear." (*See* Ex. 79-19-20). At one point, Dr. Hermens stated that he did not know whether claimant's recurrent tear significantly contributed to her symptoms as of her 1998 surgery. (Ex. 79-12). Later, he agreed that the "major reason that [claimant] had continued problems warranting the need for further surgery was because of the surgical finding of the meniscal tear." (Ex. 79-21). And Dr. Hermens ultimately concluded that he did not know whether claimant's tear or her chondromalacia contributed more to her symptoms. (Ex. 79-25).

Thus, Dr. Hermens' opinion supports a conclusion that claimant's 1998 need for surgery was due to her chondromalacia and the recurrent tear; and both of these conditions were due, *in part*, to her prior tear and surgery. But Dr. Hermens' conclusion relating claimant's 1998 condition to her prior compensable condition and surgery is insufficient to establish major causation, because the doctor did not discount or otherwise explain away the noncompensable portion of claimant's contributory

[1] Claimant released any rights to compensation for her right knee Grade III chondromalacia of the patellofemoral joint and Grade IV chondromalacia of the medial femoral condyle as of a June 20, 1997 DCS. (Ex. 59, *see* Ex. 60).

chondromalacia. Accordingly, because Dr. Hermens was unable to evaluate and explain the relative contributions of the compensable and noncompensable causes, his conclusion does not carry claimant's burden regarding the "OGP claim." *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).

The August 25, 1998 strain injury claim ("Hines claim") is a different matter. SAIF denied the claim on "major causation" grounds. (Ex. 75). But Dr. Hermens explained that the August 1998 strain did not involve the same "structures" as the meniscus or chondromalacia problems. (Ex. 77). Therefore, on this evidence, we find that claimant's 1998 knee strain did not combine with a preexisting condition[2] (either chondromalacia or the torn meniscus) and claimant is therefore subject to the material cause standard of proof regarding the right knee strain injury claim with Hines. *See* ORS 656.005(7)(a).

Moreover, although Dr. Hermens treated claimant for the strain at her previously scheduled appointment (for her recurrent meniscus tear, which we have found noncompensable), that does not obviate claimant's need for treatment for the strain. On the contrary, it is undisputed that the injury occurred (at work) and Dr. Hermens treated her for it. Under these circumstances, the claim for an August 25, 1998 knee strain is compensable. *See K-Mart v. Evenson*, 167 Or App 46 (May 3, 2000) (where an injury requires medical services, that is the "minimum degree of harm necessary for the existence of a 'compensable injury'" under ORS 656.005(7)(a)).

Claimant seeks a penalty based on SAIF's allegedly unreasonable failure to process her current right knee condition as part of her 1995 meniscus claim ("OGP claim"). We disagree. SAIF did not receive claimant's request to process her current right knee condition as part of the 1995 injury claim until April 16, 1999. (Ex. 75A). Moreover, claimant did not formally request such processing until June 28, 1999. (Ex. 77A). SAIF issued its denial on July 7, 1999, which was within 90 days of either request by claimant. (Ex. 77B). Under these circumstances, SAIF's claim processing was not unreasonable and therefore a penalty is not warranted.

Finally, claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the 1998 strain injury claim. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the strain injury compensability issue is $3,500, payable by the SAIF Corporation, on behalf of Hines. 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.[3]

ORDER

The ALJ's order dated January 21, 2000 is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial, on behalf of Hines Horticulture, of claimant's right knee strain injury claim is reversed. The denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review regarding the strain injury claim, claimant is awarded a $3,500 attorney fee, payable by SAIF on behalf of Hines.

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[2] "[I]n order for there to be a 'combined condition,' there must be two conditions that merge or exist harmoniously." *Luckhurst v. Bank of America*, 167 Or App 11 (May 3, 2000) (discussing *Multifoods Specialty Distribution v. McAtee*, 164 or App 652 (1999). Here, claimant's 1998 right knee strain did not merge with any other condition. Her conditions (strain, chondromalacia, and torn meniscus) existed at the same time and in the same *general* location -- her right knee. However, because Dr. Hermens unequivocally distinguished the strain from the other conditions (medically), we conclude that claimant does not have a "combined condition" involving her 1998 right knee strain and she is therefore not subject to the "major contributing cause" standard of proof regarding that claim. *See* ORS 656.005(7)(a)(B).

[3] We note that claimant did not prevail on the issue of compensability of a torn meniscus or in her attempt to secure a penalty assessment. We have considered these facts in awarding an attorney fee for services at hearing and on review regarding SAIF's strain injury denial.

In the Matter of the Compensation of
TERRY L. TOMPKINS, Claimant
WCB Case No. 99-08281
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration award of 43 percent (64.5 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist) and 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the last paragraph beginning on page 3 and continuing on page 4, we change the parenthetical after "Exhibit 15-4" to read: "(Dr. Rosenbaum referred to Dr. Bufton's January 28, 1998 evaluation and noted that from the ring finger, there was a clear dissociation between median and ulnar findings)."

We write only to address the employer's alternative argument that claimant is not entitled to a "chronic condition" award. The ALJ concluded that claimant was entitled to a 5 percent "chronic condition" award for each wrist. The ALJ relied on the report of Dr. Tobin, the medical arbiter, and reasoned that the record as a whole satisfied the "significant limitation" evidentiary standard.

The employer argues that Dr. Tobin's report is insufficient to establish that claimant is entitled to a chronic condition award for either wrist. For the following reasons, we disagree.

Claimant, a utility worker, was compensably injured on August 25, 1997, after holding a 2-1/2 inch fire hose at maximum pressure for a long period of time. (Exs. 1, 2). The employer initially accepted "Acute Neuritis Right & Left Hand & Strain - Right Forearm." (Ex. 8). Nerve conduction studies in January 1998 showed severe bilateral median neuropathy. (Ex. 10-3). Dr. Arbeene performed left and right carpal tunnel releases in June and July 1998. (Exs. 18, 22). On July 7, 1998, the employer accepted bilateral carpal tunnel syndrome and bilateral hand strain. (Ex. 21).

Under OAR 436-035-0010(5), a worker is entitled to a 5 percent scheduled chronic condition impairment value when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of the hand or wrist.

Dr. Tobin performed a medical arbiter examination on June 15, 1999. (Ex. 43). He reported that additional nerve conduction tests performed after claimant's carpal tunnel release surgeries were still abnormal, although they were improved from the studies before the surgeries. (Ex. 43-2). After the surgeries, claimant had a "[g]rossly abnormal nerve conduction study demonstrating significant abnormalities consistent with carpal tunnel syndrome." (Ex. 28-3). Dr. Tobin explained that claimant had returned to work, but was on light duty. (*Id.*) Claimant was not allowed to use any vibrating equipment and he was limited in his ability to climb and lift. (*Id.*) Claimant's arms continued to hurt and the distribution of pain was from the upper arms down into his hands. (*Id.*) His injuries had also affected his off-work activities, *i.e.*, he was unable to play baseball with his son because he could not throw the ball. (*Id.*)

In responding to specific questions, Dr. Tobin explained:

> "Due to the patient's accepted bilateral carpal tunnel syndrome, secondary to his injury, I would say that he is limited in ability to repetitively use his hands, right and left, again due to injury to the median nerve secondary to the incident on August 25, 1997." (Ex. 43-3, -4).

Dr. Tobin concluded that all of the findings were related to the accepted condition of bilateral carpal tunnel syndrome. (Ex. 43-4). He believed that the strain condition had resolved, but claimant had residuals of the bilateral carpal tunnel syndrome that had caused some permanent injury to his median nerves. (*Id.*)

Dr. Tobin did not use the term "significantly limited" in rendering his opinion. Nevertheless, a medical opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *Worldmark the Club v. Travis*, 161 Or App 644 (1999); *SAIF v. Strubel*, 161 Or App 516 (1999). When read as a whole, we agree with the ALJ that Dr. Tobin's report supports the conclusion that claimant is significantly limited in the repetitive use of each hand/wrist. We also agree that Dr. Tobin's report is the most persuasive. We conclude that claimant is entitled to 5 percent scheduled chronic condition impairment value for each forearm (wrist).

Claimant expressly waived his opportunity to file a respondent's brief. Therefore, he is not entitled to an assessed fee under ORS 656.382(2). *See Shirley M. Brown*, 40 Van Natta 879, 882 (1988).

ORDER

The ALJ's order dated January 27, 2000 is affirmed.

Board Member Meyers dissenting.

Because I disagree with the majority's conclusion that claimant is entitled to a scheduled permanent disability award, I respectfully dissent.

To begin, I agree with the employer that Dr. Arbeene, not Dr. Fox, was claimant's attending physician for purposes of rating his disability at claim closure. Although Dr. Fox examined claimant as late as December 1, 1998, the record indicates such evaluations were directed primarily toward claimant's shoulder rather than the accepted bilateral wrist condition. The record does not establish that attending physician status had reverted back to Dr. Fox. Further, as claimant's surgeon, Dr. Arbeene was in the best position to render an opinion concerning claimant's impairment. In light of his familiarity with claimant's condition, his assessment is more persuasive than Dr. Tobin's one-time evaluation of claimant.

Furthermore, the opinions of Drs. Arbeene, Farris, Woodward and Bernstein establish by a preponderance of evidence that claimant has sustained no permanent impairment as a result of the August 25, 1997 injury. Drs. Farris and Woodward examined claimant in January 1999 and concluded that his responses to two-point discrimination were variable and unreliable. (Ex. 32-6). Among other things, they noted that claimant's hands and fingertips were quite calloused and testing was prolonged to compensate for the callouses. (Ex. 32-4). Nevertheless, they found that claimant's responses were variable to a nonphysiologic degree. (*Id.*) Drs. Farris and Woodward concluded that claimant did not have any neurologic or orthopedic abnormalities that would support any permanent disability. (Ex. 32-6). Dr. Arbeene concurred with their report and later concurred with Dr. Farris' addendum report that said claimant did not have any permanent impairment related to the August 25, 1997 injury. (Exs. 33, 35, 36).

Finally, I agree with the employer that claimant is not entitled to a chronic condition award for either wrist. Dr. Tobin's report, when read as a whole, is not sufficient to establish that claimant is *significantly* limited in the repetitive use of either wrist. *See* OAR 436-035-0010(5). In further support, the preponderence of medical evidence not only fails to establish significant limitations, but instead indicates active use. For example, Drs. Farris and Woodward reported that claimant's hands and fingertips were quite calloused. (Ex. 32-4) . I would reverse the ALJ's order and conclude that claimant is not entitled to an award of permanent disability.

In the Matter of the Compensation of
GARY R. PLATT, Claimant
WCB Case No. 97-09977
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's denial of his aggravation claim for his current low back condition. On review, the issue is aggravation.

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

The reference in the first sentence of the third paragraph is changed from Dr. Fuller to Dr. Farris.

We add the following supplementation.

On review, claimant contends that the ALJ erred in disregarding his testimony about his low back condition. Claimant argues that, in such a case, his testimony must be considered.

We do not construe the ALJ's order as disregarding claimant's testimony. Rather, the ALJ found that the medical evidence did not establish an actual worsening of the compensable condition. The necessity for such medical evidence is set forth in the statute. ORS 656.273(1). Moreover, the ALJ relied on the opinion of Dr. Franks, the physician who treated claimant and performed his low back surgery.

Finally, although claimant argues that the opinion of Dr. Gritzka, who examined claimant on one occasion, should be relied on to establish a worsening, we agree with the ALJ that his opinion is not persuasive. In addition to the reasons relied upon by the ALJ, we find that it is not clear whether Dr. Gritzka took claimant's prior award of disability into consideration when he reached his conclusion that claimant's condition had worsened. ORS 656.273(8). Additionally, Dr. Gritzka did not rebut Dr. Franks' testimony that the scar tissue (which Dr. Gritzka found to represent a worsening) would have begun to develop right after surgery and the scar itself did not displace the nerve or put pressure on it. (Ex. 88-11). Therefore, the persuasive medical evidence suggests that the symptoms had been contemplated by the previous permanent disability award.

Under the circumstances, we agree with the ALJ that claimant has not established a compensable aggravation. *See SAIF v. Walker*, 330 Or 102 (2000); *Intel Corp. v. Renfro*, 155 Or App 447 (1998). We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated October 25, 1999 is affirmed.

WORKERS' COMPENSATION CASES

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Cite as 166 Or App 331 (2000) March 22, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of George L. Allenby, Claimant.
LIBERTY NORTHWEST INSURANCE CORPORATION
and CAVEMAN LOGGING, INC., Petitioners - Cross-Respondents,
v.
GEORGE L. ALLENBY, Respondent - Cross-Petitioner.
(WCB No. 97-02663; CA A103780)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 20, 1999.
David O. Wilson argued the cause and filed the briefs for petitioners - cross-respondents.
Tom Dzieman argued the cause and filed the brief for respondent - cross-petitioner.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LINDER, J.
On cross-petition, Board order setting aside March 20, 1997, order of the Department of Consumer and Business Services reversed and remanded for reconsideration; otherwise affirmed.
Landau, P. J., dissenting.

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166 Or App 333> On employer's petition and claimant's cross-petition, this case is on review from a Workers' Compensation Board (Board) order and raises the same issue presented in *Boydston v. Liberty Mutual Ins. Corp.*, 166 Or App 336, ___ P2d ____ (2000). As in that case, we reverse the Board's order and remand.

Following closure of claimant's accepted claim for a logging injury, claimant filed a request for reconsideration by the Department of Consumer and Business Services (DCBS). Within 18 days of the request, DCBS issued a notice of review by a medical arbiter and postponed reconsideration for an additional 60 calendar days. Before expiration of the additional 60 days, DCBS issued an order on reconsideration affirming the claim closure as not premature and awarding additional scheduled permanent partial disability. Thereafter, insurer accepted additional medical conditions that were not considered in DCBS's order on reconsideration. DCBS therefore abated its order and withdrew it before it became final. It later issued a second order on reconsideration declaring that insurer's notice of closure was premature. Insurer filed a request for hearing and suspended payment of procedural temporary disability benefits to claimant on the ground that DCBS's second order on reconsideration was invalid. Claimant filed a cross-request for hearing challenging insurer's suspension of procedural temporary disability benefits.

As in *Boydston*, the Board concluded in this case that ORS 656.268(6)(d) (1995) deprives DCBS of authority to reconsider its order after the time period specified in the statute for issuance of the order. In essence, the statute provides that reconsideration shall be completed within 18 working days from the date of the request for reconsideration. The 18 days may be postponed by an additional 60 days if, within the 18 days, DCBS issues a notice of review by a medical arbiter.[1] **<166 Or App 333/334>** In this case, therefore, DCBS had a total of 78 days to issue an order on reconsideration. It did so. After the 78 days, but before the order on reconsideration became final, it abated and withdrew that order and later issued a subsequent order on reconsideration. Following its reasoning in *Boydston*, the Board concluded that DCBS had no authority to do so after the 78-day time period.[2]

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[1] The full text of the statute is quoted in our decision in *Boydston*. As we observed there, the statute was amended in 1997, but the amendments do not apply and do not affect the analysis. Therefore, we discuss only the 1995 version of the statute.

[2] The Board departed from its decision in *Boydston*--and specifically disavowed it--on the question of whether the subsequent order was a nullity. In *Boydston*, it concluded that the subsequent order was of no force or effect. Consequently, the Board determined in *Boydston* that the claimant's request for hearing was untimely because it had to be filed within 30 days of the date of the first order on reconsideration. In this case, the Board revisited that portion of its decision in *Boydston* and concluded that, when DCBS abates an order and issues a new one, without authorization, the new order is voidable rather than void. The Board determined, therefore, that a dissatisfied party's remedy is to request a hearing from the subsequent order, challenge it as unauthorized, and seek to have it vacated and the prior order reinstated. We need not decide whether the Board was correct on that point given our determination that DCBS had authority to abate and withdraw its order and issue a second order on reconsideration.

Although this case involves a first order on reconsideration issued during the 78-day time period, rather than the 18-day time period if the deadline is not postponed, the analysis is the same as in *Boydston*. The statute's directive that an order on reconsideration issue within 18 days, or within an additional 60 days if DCBS issues notice of review by a medical arbiter, imposes a deadline for issuance of an order. Such a deadline does not provide the necessary clear expression of legislative intent to eliminate the agency's inherent authority after that deadline to withdraw and reconsider the decision embodied in the order. Hence, as in *Boydston*, we hold that DCBS had authority to withdraw and abate its first order on reconsideration because it did so before that order became final. Likewise, its subsequent order on reconsideration was authorized. The Board erred in invalidating that order.

On cross-petition, Board order setting aside March 20, 1997, order of the Department of Consumer and Business Services reversed and remanded for reconsideration; otherwise affirmed.

LANDAU, P. J., dissenting.

For the reasons stated in my dissent in *Boydston v. Liberty Mutual Ins. Corp.*, 166 Or App 336, ___ P2d ___ (2000), I dissent from the majority's holding that the Department of Consumer and Business Services has authority to abate and withdraw an otherwise timely order on reconsideration and then reissue the order after the time required by ORS 656.268(6)(d) (1995).

Cite as 166 Or App 336 (2000) March 22, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jenny L. Boydston, Claimant.
JENNY L. BOYDSTON, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and ANDERSEN CONSTRUCTION COMPANY and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.
(WCB 97-03081; CA A102008)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 19, 1999.
Darris K. Rowell argued the cause and filed the brief for petitioner.
Barbara A. Woodford argued the cause and filed the brief for respondents Liberty Northwest Insurance Corporation and Anderson Construction Company.
Denise G. Fjordbeck, Assistant Attorney General, argued the cause for respondent Department of Consumer and Business Services. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LINDER, J.
Reversed and remanded.
Landau, P. J., dissenting.

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166 Or App 338> Claimant seeks review of a Workers' Compensation Board (Board) order that dismissed as untimely her request for a hearing from an order on reconsideration of the Department of Consumer and Business Services (DCBS). The issue is whether DCBS had authority to abate and withdraw its own order, and later to issue a second order on reconsideration, after the 18-day period specified in ORS 656.268(6)(d) (1995).[1] Because we conclude that DCBS did have that authority, we hold that claimant's request for a hearing was timely. We therefore reverse the Board's order.

The relevant facts are procedural in nature and are not disputed. We therefore draw from the Board's order:

> "Claimant's claim was closed by a December 6, 1996 Determination Order. Claimant requested reconsideration of the Determination Order contesting the award of temporary total disability. Claimant's request for reconsideration was received by [DCBS] on February 3, 1997. Within 18 working days, an Order on Reconsideration issued on February 25, 1997. ORS 656.268(6)(d). No medical arbiter had been appointed pursuant to ORS 656.268(7).
>
> "Within 30 days of the issuance of the Order on Reconsideration, claimant filed a March 6, 1997 request asking [DCBS] to 'abate and withdraw' the February 25, 1997 Order on Reconsideration so that additional medical evidence could be considered. At that time, no party had requested a hearing before the Hearings Division. On March 12, 1997, [DCBS] issued an Order Abating and Withdrawing the Order on Reconsideration. On March 20, 1997, a Second Order on Reconsideration issued. Again, no medical arbiter had been appointed.
>
> "On April 14, 1997, claimant requested a hearing from the March 20, 1997 Second Order on Reconsideration."

The Board determined that claimant's request for a hearing was untimely and dismissed the request on that ground. The Board reasoned that, under the then-effective **<166 Or App 338/339>** provisions of ORS 656.268(6)(d), DCBS had 18 days after receipt of the request for reconsideration to "complete" the reconsideration process. The statute further provides that, if DCBS did not issue an order within that 18-day period, reconsideration is deemed denied. The Board viewed the 18-day period as "an express statutory limitation on [DCBS's] authority to reconsider a Determination Order or Notice of Closure." Thus, the Board concluded:

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[1] The statute was amended in 1997. The parties agree that the amendments do not apply to this case. All references to ORS 656.268 are to the 1995 version of the statute.

> "[DCBS's] authority to issue an Order on Reconsideration ended on February 28, 1997, 18 working days from receipt of claimant's request for reconsideration. Inasmuch as claimant did not request a hearing within 30 days from that date, her subsequent request for hearing was untimely and, therefore, * * * claimant's request for hearing should be dismissed."[2]

On review, the issue is whether ORS 656.268(6)(d) should be interpreted to limit DCBS's authority to withdraw and revise its own order on reconsideration after 18 days from the receipt of the request for reconsideration. That is a question that we review for legal error.

We begin with a discussion of two of our prior decisions, which are particularly instructive here. The first is *SAIF v. Fisher*, 100 Or App 288, 291, 785 P2d 1082 (1990). There, the claimant moved to dismiss the insurer's appeal from a Board order that the Board withdrew and abated after the petition for review was filed. The issue turned, in part, on whether the Board lacked authority to withdraw and abate its own order, in which case the prior order remained in effect. We observed in *Fisher* that the legislature had granted the Board the authority and responsibility to decide claims. With only one exception not relevant to that case, the legislature had not limited the Board's power, after having issued <166 Or App 339/340> a decision, to withdraw it and reconsider it. *Id.* We concluded that the authority to withdraw and reconsider a decision inheres in the legislative delegation of power to decide a matter and is plenary in the absence of express legislative limitation:

> "In the absence of a statutory provision limiting its authority to do so, an agency has plenary authority to decide matters committed to it by the legislature. That authority includes the authority to withdraw an order and to reconsider the decision embodied in the order."

Id. Thus, the relevant question is not whether the legislature has granted an agency authority to withdraw and reconsider its own decision--that authority resides inherently in the delegation of power and responsibility to decide a matter. The question is, instead, whether the legislature has limited the agency's authority in that regard. The only source of a limitation in *Fisher* was a statute declaring the Board's orders to be "final" 30 days after they issue if appellate court review is not sought. Until an order becomes final, we concluded, the board's authority to abate and to reconsider its own order was unrestrained. *Id.* at 291-92.

Lyday v. Liberty Northwest Ins. Corp., 115 Or App 668, 839 P2d 756 (1992), resolved a related question: whether a hearing referee's inherent authority to withdraw an order was limited by a statute requiring the order to issue within 30 days of the hearing. The referee in *Lyday* initially issued an order within the required 30-day time period. After the 30 days passed, the referee abated and withdrew the order, and then later reissued the order. We concluded that the statute did not preclude the referee from reconsidering the decision embodied in the order, reasoning:

> "Absent some clear indication that ORS 656.289(1) is intended to do more than set a 30-day period for the issuance of an order, we conclude that it is no more than a deadline for the issuance of an order. Failure to comply with the statute may subject the referee to mandamus, for example, but it does not deprive the referee of the power to act. We hold that the referee has authority to withdraw or abate a decision before the time for appeal to the Board has expired."

166 Or App 341> *Id.* at 671 (citation omitted).

Fisher and *Lyday*, together, set forth several principles that guide our analysis here. The starting point is the recognition that, without some legislative limitation, an agency has plenary authority to decide matters committed to it. That authority encompasses the authority to withdraw and reconsider the substance of a decision after it has been made. The legislature may, by statute, either retract that authority altogether, or it may place limits on how long that authority continues. But any retraction or

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[2] In *Liberty Northwest Ins. Corp. v. Allenby*, 166 Or App 331, ___ P2d ___ (2000), the Board reconsidered a portion of its conclusion in this case and reversed itself. The Board in that case adhered to its determination that DCBS lacked authority to abate its order and to issue a subsequent order on reconsideration more than 18 days after the request for DCBS reconsideration. Contrary to its conclusion in this case, however, a majority of the Board determined that the second order has force and effect unless and until it is challenged and set aside. Because of our resolution of the issue, we need not decide whether the subsequent orders in this case and in *Allenby* were of no force and effect, or whether they were effective unless and until challenged.

limitation must be clear. That is, there must be some statutory provision that is specifically directed to and limits the withdrawal authority itself. *See generally State ex rel Hall v. Riggs*, 319 Or 282, 293, 877 P2d 56 (1994). We have found such a limitation to be necessarily contained in a statute directing that, after a specified period of time, the agency's decision becomes final. *Fisher*, 100 Or App at 291-92. The same is not true, however, of a mere specification of a time within which a decision must be made. *Lyday*, 115 Or App at 671. The latter provides a deadline for making the decision but does not, in any necessary or express way, eliminate the agency's authority to withdraw and reconsider the decision previously made.

We turn to the statutes that bear on DCBS's authority in this case. Determination orders are issued by DCBS to determine the extent of an accepted disabling condition. *See generally* ORS 656.268. If the claimant or the insurer is dissatisfied with the determination order, it may request reconsideration by DCBS. *Id.* That request for reconsideration triggers a review by the "special evaluation appellate unit" within DCBS. ORS 656.268(6)(d) provides, in part:

> "Reconsideration shall be completed within 18 working days from the date of receipt of the request therefor and shall be performed by a special evaluation appellate unit within [DCBS]. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days [DCBS] mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date of the receipt of the request for reconsideration, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed, reconsideration **<166 Or App 341/342>** shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the date the order was due to issue."

The statute contains several provisions of significance. First, the statute sets a "deadline" of 18 days for completing reconsideration and mailing the order. Second, the statute provides for postponement of that deadline if, within the 18 days, DCBS submits the matter to review by a medical arbiter. Third, the statute specifies a consequence if the decision either is not made or postponed by submission to a medical arbiter within 18 days--*i.e.*, reconsideration is "deemed" denied and further proceedings occur as though an order affirming the determination order was mailed on the 18th day.

In concluding that the statute is a limit on DCBS's authority to abate and withdraw its orders, the Board focused in part on the statute's directive that reconsideration be "completed" within 18 days. We do not agree that the statute is significantly distinguishable in that respect from the one at issue in *Lyday*, which required a referee's order to issue within 30 days of the hearing. Implicit in any directive to issue an order within a certain time period or by a particular deadline is the idea that the underlying deliberative process must be completed within that time. The requirement in this statute to complete reconsideration of the determination order and to issue an order within 18 days is not meaningfully distinguishable from any other statute setting a deadline for issuing an order.

The Board here further focused on the fact that, if no order issues, then reconsideration is deemed denied and further proceedings are conducted as if an order affirming the determination order were mailed on the 18th day. That provision, however, likewise does not amount to a clear expression of a legislative design to terminate DCBS's authority to reconsider an order after the 18 days. The "deemed denied" language is directed to what happens if DCBS *fails* to make a decision and *fails* to issue an order embodying a deliberative determination. In the absence of such a provision, the statute **<166 Or App 342/343>** would be the equivalent of the statute in *Lyday*, and the conclusion would be the same: through mandamus or some other vehicle, DCBS could be forced to make a decision after the 18th day. Rather than require extraordinary measures to achieve a decision, the legislature provided for a default mode by which no decision results in a denial of reconsideration by operation of law. The case then goes forward accordingly. *See* ORS 656.268(6)(d) ("any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the date the order was due to issue"). The "deemed denied" provision ensures a decision in the absence of an order; it does nothing to express a legislative design to foreclose the agency's inherent authority to withdraw and abate its own decision after an order timely issues.

Nor do we find any other basis in the relevant statutes to conclude that the 18-day period for reconsideration limits DCBS's authority to withdraw a decision after the 18 days has passed. To the contrary, other provisions reinforce our conclusion. First, the 18-day time period specified in the statute is not absolute. DCBS may postpone a decision for an additional 60 days if it decides, within the 18 days, to submit the matter to a medical arbiter for resolution. ORS 656.268(6)(d). Similarly, under

subsection (6)(b) of the same statute, DCBS may postpone reconsideration for an additional 60 days for the purpose of taking new medical or other information.[3] Finally, the statute provides that a party has <166 Or App 343/344> 30 days from the date of the reconsideration order to seek a hearing before an administrative law judge. ORS 656.268(6)(f). It would be anomalous for the legislature to foreclose DCBS from altering an order issued on the 18th day after the request for a hearing, yet not have the order become final for another 30 days.

Consequently, we conclude that DCBS had authority in this case to withdraw and abate its order and to issue a second order on reconsideration. Because claimant timely requested a hearing to challenge that order, the Board erred in dismissing her hearing request.

Reversed and remanded.

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[3] ORS 656.268(6)(b) provides:

"If necessary, [DCBS] may require additional medical or other information with respect to the claims and may postpone the reconsideration for not more than 60 additional calendar days."

Claimant relies on that provision as authority for DCBS's withdrawal and abatement in this case, arguing that this subsection, unlike subsection (6)(d), does not expressly require that DCBS act within the 18-day period to allow a postponement. Claimant reasons, therefore, that DCBS may take that action any time before the reconsideration order becomes final--*i.e.*, within the 30 days for requesting a hearing. That interpretation is problematic. Although ORS 656.268(6)(b) does not expressly require DCBS to act within the 18 days stated in ORS 656.268(6)(d), the requirement seems implicit in its language permitting postponement of reconsideration for 60 "additional" days. That necessarily must mean 60 days in addition to the 18 days permitted by subsection (6)(d) to complete reconsideration, which in turn suggests that the director's authority to postpone the reconsideration must be exercised within the 18 days. We therefore rely on that subsection only as a reflection of the legislature's policy that the 18-day reconsideration period is not an unalterable deadline.

LANDAU, P. J., dissenting.

ORS 656.268(6)(d) (1995) provided that reconsideration of a determination order "*shall be completed* within 18 working days from the date of receipt of the request therefor * * *." (Emphasis added.) The Workers' Compensation Board concluded that the statute means what it says, namely, that reconsideration must be finished by the 18-day deadline. The majority concludes that "shall be completed within 18 days" means something else. According to the majority, the statute means only that an order on reconsideration must be issued within 18 days and that, notwithstanding the 18-day completion language in the statute, the Department of Consumer and Business Services is entitled to withdraw such an order and take an undefined amount of time to consider revising it. In my view, the Board was correct. "Shall be completed" means "shall be completed," and the majority errs in concluding otherwise.

As the majority correctly notes, although administrative agencies to whom the legislature has delegated decision-making authority obtain implicit authority to withdraw and reconsider their decisions, that implicit authority is subject to express legislative limitation. *See generally SAIF v. Fisher*, 100 Or App 288, 291, 785 P2d 1082 (1990). The question in this case is whether such express legislative limitation exists. In my view it does.

166 Or App 345> ORS 656.268(6)(d) (1995) provided:

> "*Reconsideration shall be completed within 18 working days* from the date of receipt of the request therefor and shall be performed by a special evaluation appellate unit within the department. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date of the receipt of the request for reconsideration, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the date the order was due to issue."

(Emphasis added.) The ordinary meaning of "shall be completed" seems straightforward enough. "Completed" usually means "brought to an end or a final or intended condition * * * CONCLUDED * * * [brought] to an end often into or as if into a finished or perfected state." *Webster's Third New Int'l*

Dictionary, 465 (unabridged ed 1993). That means that, under ORS 656.268(6)(d) (1995) reconsideration must be "brought to an end or a final intended condition" and "concluded" within 18 days. Moreover, the statute speaks not merely of a decision or an opinion issuing within 18 days, but rather the completion of "[r]econsideration,"--that is, the entire reconsideration process.

What is more, the statute makes clear that, if the Department does not act within the prescribed 18-day period, reconsideration will be "*deemed denied* * * * as though an order on reconsideration affirming the notice of closure or the determination order" had been timely made. ORS 656.268(6)(d) (1995) (emphasis added). Thus, the legislature has ensured that, one way or the other, by the 18th day after the filing of a request for reconsideration, a final, completed decision will have been made--either by the Department or by operation of law.

The "deemed denied" provision is particularly important, it seems to me. The cases make clear that the **<166 Or App 345/346>** abatement and withdrawal of an order on reconsideration has the effect of "nullifying" the decision. *Lyday v. Liberty Northwest Ins. Corp.*, 115 Or App 668, 671, 839 P2d 756 (1992). If that is so, then the withdrawal of an order on reconsideration issued within the 18-day period has the effect of nullifying the timely decision and automatically triggering the denial of reconsideration by operation of law, there having been no decision rendered within the 18-day period. Thus, the authority of the Department to abate and withdraw a decision simply cannot be reconciled with the language of ORS 656.268(6)(d) (1995).

The majority nevertheless concludes that the statute is not so clear in imposing an 18-day deadline for concluding the reconsideration process. It does so for two reasons, neither of which I find persuasive. First, the majority concludes that "completion" is indistinguishable from mere "issuance" of a decision. According to the majority, the command that reconsideration be "completed" within 18 days is akin to the statutory command at issue in *Lyday*, which required the mere "issuance" of a decision by a certain date and which we held did not preclude withdrawal and reconsideration. The majority's reasoning, however, neglects to take into account the phrasing of the statute at issue in this case, which refers to the conclusion of an entire process, not merely to the issuance of a single decision.

Second, the majority reasons that the 18-day completion date cannot be treated as "absolute," because the statute provides the Department with the authority to extend the deadline for 60 days to obtain additional medical information or to refer the case to a medical arbiter. ORS 656.268(6)(b), (d) (1995). Neither exception applies to this case, however. The fact that the legislature provided the Department with the authority to extend the deadline in some enumerated circumstances does not implicitly grant license to the Department to extend the deadline in *other* circumstances not covered by the exceptions detailed in the statute.

Moreover, the majority's reasoning fails to consider that, even in cases in which the enumerated exceptions apply, the Department's decision to extend the deadline itself must be made within the 18-day deadline, by virtue of the **<166 Or App 346/347>** "deemed denied" language of ORS 656.268(6)(d) (1995).[1] Either way, an affirmative decision must be made within the 18-day period either resolving the request for reconsideration or postponing resolution on a determination that a more involved deliberation process is warranted in the particular case. If neither of those determinations is made within 18 days, the reconsideration is deemed denied by operation of law. The legislature's intention that the reconsideration process be speedily concluded hardly could be clearer.

In that regard, the majority's reading of ORS 656.268(6)(d) (1995) is problematic for an additional reason. If the Department has the authority to withdraw a reconsideration order that was issued within the 18-day period, how long does it have to reconsider the order? If I understand the majority's opinion correctly, there is no limit to the time that the Department could take to reconsider such an order. I cannot reconcile such an open-ended reconsideration process with the language of the statute, which so clearly evinces the legislature's concern for timely resolution of reconsideration requests.

I respectfully dissent.

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[1] In fact, ORS 656.268(6)(d) (1995) makes clear that, apart from the "deemed denied" provision, there is an express requirement that a 60-day extension to refer a matter to a medical arbiter depends on the mailing of notice of the extension "on or before 18 working days from the date the reconsideration proceeding begins."

Cite as 166 Or App 396 (2000) April 5, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Darlene J. Molena, Claimant.

JELD-WEN, INC., Petitioner,
v.
DARLENE J. MOLENA, Respondent.
(97-08181; CA A105255)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 27, 1999.
Travis L. Terrall argued the cause for petitioner. With him on the brief was Scott H. Terrall & Associates.
Mustafa Kasubhai argued the cause for respondent. With him on the brief was Kasubhai & Sanchez.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Affirmed.

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166 Or App 398> Employer seeks review of an order of the Workers' Compensation Board holding that claimant suffered a compensable injury. We affirm.

Claimant was employed by Jeld-Wen. In her position, she worked with glue, alcohol, and other chemicals. On July 23, 1997, the glue overheated. Claimant and two of her coworkers became "headachy" and experienced "a feeling of nausea[.]" When the workers complained to the manager, he "suggested that [they] pour lacquer thinner * * * and clean the * * * glue rolls, because the glue was setting up." When the lacquer thinner was put on the rolls, the fumes caused at least one worker to vomit and the other workers to start choking. Claimant experienced watering eyes, burning in her chest, choking, and difficulty breathing. A fan was placed in the area to blow the fumes away, and claimant continued to work. Within half an hour, claimant passed out and was carried outside. A coworker took her to the hospital for treatment. Claimant sought compensation for a workplace injury.

A week later, claimant went to the hospital with continued complaints of chest discomfort and shortness of breath. Her chest x-ray showed evidence of a preexisting chronic obstructive pulmonary disease. At the hospital, Dr. Brunswick diagnosed claimant's condition as "shortness of breath secondary to chronic obstructive pulmonary disease." Employer denied the compensability of claimant's current medical condition on the ground that it was not a result of the July 23 industrial injury and did not arise out of or in the course of employment.

Claimant sought a hearing. The ALJ found:

> "(1) The claimant's exposure to vapors from the glue machin[e] in July, 1997 was a discrete and specific event. (2) The discrete and specific event experienced by the claimant in July, 1997 combined with a pre-existing respiratory condition and was the major contributing cause of the claimant's need for treatment of the combined condition."

166 Or App 399> Based on those and other findings, the ALJ concluded that claimant's condition was an injury rather than an occupational disease. The ALJ also explained why claimant's exposure to the fumes was the major contributing cause of her need for treatment of the combined condition. He reasoned:

> "[C]laimant had no significant breathing symptoms prior to July 23, 1997, despite her underlying condition. * * * [T]he evidence establishes the quantitative level of her exposure as relatively dramatic and substantial, certainly more than innocuous. The material to which the claimant was exposed apparently carries a warning of irritative

> effects from exposure to the fumes. Following her exposure the claimant became symptomatic as far as breathing difficulty. Dr. Bardana has reported that the claimant suffered a transient respiratory irritation and vasovagal syncope as a result of her employment exposure. Dr. Panossian, a pulmonologist, has stated that the claimant's work exposure precipitated her symptoms that required treatment. There is absolutely no reason to believe that the claimant's symptoms and need for treatment would have occurred had she not experienced the relatively substantial exposure to fumes on July 23, 1997. The claimant's lung function, despite her underlying condition, was not *that* significant in terms of symptom instability. Although a precipitating cause is not necessarily the major contributing cause, in my opinion all the above factors prove the exposure in this case was more than a precipitating cause, it was in fact the primary cause of the claimant's need for treatment of her combined condition."

(Emphasis in original.) The Board adopted the ALJ's findings and order.

On appeal, employer raises three arguments. First, it argues that the Board erred because ORS 656.802(1)(a)(A) requires, as a matter of law, that claimant's lung condition be treated as an occupational disease rather than as an injury. Our recent decision in *Weyerhaeuser Co. v. Woda*, 166 Or App 73, ___ P2d ___ (2000), resolves that issue adversely to employer. We held that exposure to fumes, vapors, and the like may result in an injury as well as an occupational disease.

Second, employer contends that, even if claimant's condition could be an injury, the evidence shows that her condition arose gradually and was thus an occupational disease. **<166 Or App 399/400>** There is substantial evidence in the record, however, to support the Board's finding that claimant's condition occurred suddenly. *See Burris v. SAIF Corp.*, 116 Or App 498, 500, 841 P2d 696 (1992), *rev den* 315 Or 442 (1993); *Morrow v. Pacific University*, 100 Or App 198, 200, 785 P2d 787 (1990). Although employer views the historical facts differently, the Board's findings of historical fact are supported by substantial evidence. They effectively resolve employer's claim that claimant's condition is an occupational disease rather than an injury. *See id.*

Finally, employer argues that the Board erred in finding that claimant's exposure to the fumes at work was the major contributing cause of her need for medical treatment. The Board's finding is supported by substantial evidence, as the portion of the ALJ's opinion quoted above demonstrates. *See Dietz v. Ramuda*, 130 Or App 397, 402, 882 P2d 618 (1994), *rev dismissed* 321 Or 416 (1995) (stating standard of review).

Affirmed.

Cite as 166 Or App 443 (2000) April 12, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dale W. Chipman, Claimant.

SAIF CORPORATION and DEPARTMENT OF ENVIRONMENTAL QUALITY, Petitioners,
v.
DALE W. CHIPMAN, Respondent.
(97-02766; CA A100859)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 20, 1999.
Julene M. Quinn, Special Assistant Attorney General, argued the cause for petitioners. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
Ralph E. Wiser III argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Deits, Chief Judge, and Armstrong, Judge.
EDMONDS, P. J.
Reversed.

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166 Or App 445> Petitioners SAIF Corporation and the Oregon Department of Environmental Quality seek reversal of an order of the Workers' Compensation Board awarding benefits to claimant on the ground that his computer-related work activities were the major contributing cause of his carpal tunnel syndrome. Petitioners assert that there is not substantial evidence to support the Board's conclusion. Petitioners also make a related argument that the Board erred in finding that the symptoms of carpal tunnel syndrome are the disease and thus that a finding that claimant's work caused the symptoms satisfied the substantial evidence standard. Because the assignments of error are interrelated, we address them together. For the following reasons, we reverse.

In December 1996, claimant filed a claim for ongoing carpal tunnel syndrome in his left hand resulting from his use of a computer terminal in the course of his employment. SAIF denied that claimant's employment was the major contributing cause of his condition. A hearing was held before an ALJ, who found claimant's condition to be compensable. The ALJ's findings were adopted and affirmed by the Board without opinion. The ALJ made the following factual findings: Claimant's job entails computer input for the major part of the day, and computer keyboarding involves repetitive hand activity. Claimant's symptoms began about the time that he began his computer duties. Claimant's physician diagnosed claimant's condition as carpal tunnel syndrome. Claimant then consulted Dr. Perrin, who did not perform nerve conduction studies but diagnosed carpal tunnel syndrome in claimant's left hand based on claimant's symptomology. Ultimately, Dr. Perrin performed surgery, which resolved claimant's symptoms.

The ALJ concluded, based on the evidence in the record, that claimant met his burden of proving that his keyboarding activity was the major contributing cause of his disease. The ALJ reasoned that Dr. Perrin's reports created "an inference that the symptoms are the disease and that the work is the cause of the symptoms." SAIF argues on appeal that that finding is not supported by the medical evidence in **<166 Or App 445/446>** the record. ORS 656.802(2) provides the governing legal standard. It states, in part:

> "(a) The worker must prove that employment conditions were the major contributing cause of the disease.
>
> "* * * * *
>
> "(d) Existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings."

In *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990), the court stated:

> "[S]ubstantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding. ORS 183.482(8)(c). A court must evaluate the substantiality of supporting evidence by considering *all* the evidence in the record. That is, the court must evaluate evidence against the finding as well as evidence supporting it to determine whether substantial evidence exists to support that finding. If a finding is reasonable in light of countervailing as well as supporting evidence, the findings is supported by substantial evidence." (Citations and internal quotation marks omitted.)

We turn to the record to determine whether substantial evidence supports the conclusion that claimant sustained his burden of establishing by medical evidence supported by objective findings the existence of an occupational disease and his burden of establishing that employment conditions were the major contributing cause of the disease. The record in this case contains evaluations from two physicians. Dr. Perrin described claimant's symptoms, and then stated:

> "Since [claimant's] history and findings were so consistent with carpal tunnel, after discussion with him, it seemed appropriate to surgically release the carpal tunnel to relieve median nerve compression. No nerve conduction studies were done. Following this surgery, he had dramatic relief of his symptoms and went on to heal the wound without problem. [Claimant] did state that his symptoms were aggravated during his work on the computer which was often 8-10 hours at a time. It is very difficult to prove that the constant finger motion with the wrist in fixed position will actually cause the symptoms of carpal tunnel to be **<166 Or App 446/447>** aggravated, but it appears to be a consistent finding. It relates to the occurrence of the nocturnal pain, where once again the wrist is relatively motionless. There are no symptoms to indicate [claimant] suffers from diabetes or thyroid deficiency, although specific studies for these conditions were not carried out by this office. To consider that he had a peripheral neuropathy consistent with late stages of these diseases does not seem appropriate in this case. [Claimant] is obviously overweight, weighing approximately 280 pounds at 6 ft. I think it would be inappropriate to assume that all obese people have carpal tunnel syndrome, there is normally no significant accumulation of fat cells within the carpal tunnel and I do not feel that this is a contributing factor to his problem."

In response to questions from claimant's attorney, Dr. Perrin further clarified:

> "I stated that there was no evidence that [claimant] had symptoms of diabetes or thyroid deficiency, no evidence of peripheral neuropathy, or demonstrated the likelihood that his characteristic carpal tunnel syndrome was due to his obesity. I also did not state that it was due to his work at the keyboard, although the symptoms developed during this pattern of use and by history apparently were aggravated by it."

Finally, claimant's attorney posed the following "yes or no" question to Dr. Perrin: "Based on reasonable medical probability (as opposed to speculation or certainty) was the major contributing cause of [claimant's] carpal tunnel syndrome or need for carpal tunnel release his work at the keyboard?" Dr. Perrin did not answer "yes or no," but answered: "Keyboard work can be a contributing factor to CTS but the degree to which it is responsible is not determinate."

Claimant also was examined by a neurologist, Dr. Reimer, at SAIF's request. Dr. Reimer summarized claimant's medical history and, in answer to a question concerning his opinion of the major contributing cause of claimant's carpal tunnel syndrome, stated:

> "First, I would like to know if he had a medical evaluation for diabetes mellitus or thyroid deficiency. If those two possibilities have been ruled out as causative factors then I would consider body habitus, fluid retention, **<166 Or App 447/448>** and obesity to be a significant and major consideration as part of a major contributing cause of carpal tunnel in this individual even though I realize that he spends a good deal of his time keyboarding. Most keyboarding is performed with the wrist in a relatively fixed position, much like one has when they [sic] are sleeping, driving an automobile, reading a newspaper, or holding something in their hand. A fixed position wrist does not assume that it is a causation [sic] for carpal tunnel syndrome."

On appeal, SAIF argues that claimant has failed to prove the existence of a compensable occupational disease. ORS 656.802(2)(a), (d). We agree with SAIF that claimant failed to meet his burden of proof and that the ALJ erred in inferring causation based on the medical reports of Dr. Perrin. The medical reports establish only that Dr. Perrin was unwilling to express an opinion about the causation of claimant's disease. Nonetheless, claimant argues that the ALJ properly inferred a nexus between the disease and the keyboarding activity on the grounds that claimant's symptoms are his disease, that his symptoms were caused by his work, and thus that no further medical evidence is required to establish compensability. The primary case relied on by claimant and the ALJ for this proposition is *Georgia-Pacific Corp. v. Warren*, 103 Or App 275, 796 P2d 1246 (1990), *rev den* 311 Or 60 (1991).

In *Georgia-Pacific*, we affirmed a Board determination that the claimant's carpal tunnel syndrome was a compensable occupational disease. In that case, two medical experts agreed that the "claimant's work with the employer was the major contributing cause of her current bilateral wrist and hand *symptoms*." *Id.* at 277 (emphasis in original). One of the physicians, however, expressed an opinion that claimant's disease was a slowing of the median nerve that was entirely idiopathic in origin, but he conceded that the condition was entirely asymptomatic until the onset of carpal tunnel syndrome. The other physician opined that claimant's employment was the cause of her carpal tunnel syndrome. *Id.* at 277 78. We stated that "sometimes the medical evidence will support the conclusion that the symptoms for which compensation is sought are the disease." *Id.* at 278 (emphasis in original). We went on to note that, even accepting the expert **<166 Or App 448/449>** opinion that the claimant had an asymptomatic idiopathic condition,

> "claimant seeks compensation for carpal tunnel syndrome, a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel. In the opinion of [both physicians], *the syndrome was brought on by claimant's work activity with employer.*" *Id.* at 278 (emphasis added).

Georgia-Pacific stands for the proposition that, if medical evidence supports a conclusion that symptoms are brought on by a claimant's work activity and the symptoms are, in fact, the occupational disease for which the claimant seeks treatment, substantial evidence could support a finding that employment conditions were the major contributing cause of the disease. Such reasoning, however, does not support the ALJ's conclusion in the present case. As emphasized above, both of the physicians in *Georgia-Pacific* held opinions that the claimant's "syndrome was brought on by claimant's work activity with employer." *Id.* The disagreement was over whether the claimant's occupational disease was carpal tunnel syndrome or a different, pre-existing condition that was asymptomatic until the claimant's work activity with the employer caused the claimant to need treatment.

Here, by comparison, neither physician expressed an opinion that claimant's carpal tunnel syndrome was brought on by claimant's work with employer. Dr. Perrin specifically "did *not* state that [claimant's carpal tunnel syndrome] was due to his work at the keyboard, although the symptoms developed during this pattern of use and by history apparently were aggravated by it." Dr. Reimer considered "body habitus, fluid retention, and obesity to be a significant and major consideration as part of a major contributing cause of carpal tunnel in this individual even though [he realized] that he spends a good deal of his time keyboarding." In short, neither physician was willing to express an opinion that claimant's symptoms were triggered by claimant's work with employer. *Compare SAIF v. Valencia*, 148 Or App 263, 939 P2d 623 (1997) (ambiguous or equivocal evidence of causation may constitute substantial evidence). Thus, even assuming that claimant established that the symptoms of **<166 Or App 449/450>** carpal tunnel syndrome are, in fact, the same as the disease, his proof still fails because no evidence in this case demonstrates the existence of an occupational disease for which claimant's work activity was the major contributing cause. ORS 656.802(2)(a), (d).

Reversed.

Cite as 166 Or App 620 (2000) April 19, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Edward M. January, Claimant.

SAIF CORPORATION and ST. HELEN'S ROOFING AND CONSTRUCTION, Petitioners,
v.
EDWARD M. JANUARY, Respondent.
(WCB 96-08893; CA A100221)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 18, 1999.
David L. Runner argued the cause and filed the brief for petitioners.
James O. Marsh argued the cause for respondent. With him on the brief was Carney, Buckley, Kasameyer & Hays.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LINDER, J.
Reversed and remanded for reconsideration.

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166 Or App 622> Employer seeks judicial review of a Workers' Compensation Board (Board) order allowing claimant's aggravation claim. *See* ORS 656.273(1). The issue is whether claimant carried his burden to establish an "actual worsening" of his condition. As framed on review, that issue encompasses the legal question of whether claimant presented the type of evidence required to satisfy the "actual worsening" requirement, as well as the factual question of whether the Board's finding of an "actual worsening" in this case is supported by substantial evidence. We conclude that the evidence on which the Board relied satisfies the legal standard for an aggravation. We also conclude, however, that we cannot meaningfully determine whether the Board's order is supported by substantial evidence because the Board failed to sufficiently explain its reliance on the particular medical opinion that it found persuasive. We reverse and remand for reconsideration.

Claimant, a roofer, was injured in 1994 when he fell while working on a roof. SAIF accepted a claim for multiple injuries, including a lumbar strain. That claim was closed in July 1995, with scheduled permanent partial disability awards for some of claimant's injuries but without an award of permanent disability for the lumbar strain. In May 1996, claimant experienced increased back pain while he was pulling nails with a hammer at work. Claimant subsequently filed a claim for aggravation of the original lumbar strain. Employer referred the matter to SAIF, which denied the claim on the ground that no "actual worsening" had occurred.

Claimant requested a hearing before an administrative law judge (ALJ) and, at the hearing, presented evidence of his treating physician's opinion that his "increased symptoms" represented a temporary worsening of his condition. The ALJ upheld SAIF's denial, and claimant sought Board review. The Board reversed the ALJ's order, determining that claimant's evidence satisfied the "actual worsening" requirement. As a predicate to its finding of an actual worsening, the Board first observed:

> 166 Or App 623> "It stands to reason that what constitutes a 'pathological worsening' depends on the nature of the compensable condition. For example, what constitutes a pathological worsening of a strain is not the same as what constitutes a pathological worsening of a herniated disc. * * * At issue in this aggravation claim is whether or not the accepted lumbar strain condition has compensably worsened."

(Underscoring in original.) Reviewing the evidence, the Board observed that the medical experts disagreed as to whether claimant's compensable lumbar strain condition had worsened. One of the independent medical examiners who examined claimant for the insurer concluded that claimant had suffered only a symptomatic flare-up of his lower back pain. In contrast, claimant's treating physician, Dr. Kelly, stated affirmatively that the increased symptoms represented a temporary worsening of the lumbar strain. Specifically, claimant's attorney sent a "check the box" letter to Kelly posing the following question:

> "In your opinion, in a situation such as this where the accepted condition is one of 'lumbar strain,' do the increased symptoms which [claimant] experienced in the lumbar region following the 5/22/96 incident represent a worsening, although perhaps only a temporary worsening, of that chronic lumbar strain?"

Kelly responded by circling the words "temporary worsening" and by checking the box marked "yes." Relying on that opinion by Kelly, the Board found that claimant had suffered an aggravation of his compensable condition.

On review, SAIF first challenges the legal standard that the Board applied in this case. SAIF asserts that, to prevail, claimant had to demonstrate an actual worsening by showing a "change in the tissues." According to SAIF, the Board relaxed claimant's evidentiary burden due to the nature of the injury (a "strain") and permitted claimant to prevail on medical testimony that inferred a worsening based on an increase in symptoms only, without demonstrating a physiological change in the compensable condition. SAIF concedes that it may be more difficult to demonstrate a physiological change for a strain than for a herniated disc but argues that the legal standard nevertheless requires a medical expert to do so.

166 Or App 624> In *SAIF v. Walker*, 330 Or 102, ___ P2d ___ (2000), the Supreme Court examined the legal standard for an aggravation in light of the 1995 amendments to the statute. The court reviewed at length the meaning of the legislature's requirement in ORS 656.273(1) that a "worsened condition" be established by "medical evidence of an actual worsening of the compensable condition." The court held that:

> "[E]vidence of worsened symptoms, while relevant, is not sufficient by itself to meet the proof standard created by ORS 656.273(1) (1995). However, * * * a physician may rely upon that kind of evidence in determining whether the compensable condition has worsened and in opining on that question to the factfinder or to the Board. In other words, the 'medical evidence * * * supported by objective findings' that is required under ORS 656.273(1) (1995) and ORS 656.273(3) to prove an 'actual worsening of the compensable condition' may include a physician's written report commenting that the worker's worsened symptoms demonstrate the existence of a worsened condition."

Id. at 118.

The Supreme Court's decision in *Walker* directly answers SAIF's contention in this case. Contrary to SAIF's position, a symptomatic worsening may meet the proof standard for an actual worsening if a medical expert concludes that the "symptoms demonstrate the existence of a worsened condition." *Id.* To be sure, evidence of a symptomatic worsening, in and of itself, does not permit a factfinder to infer an actual worsening. *See id.* at 119 (noting that the ALJ applied improper legal standard by inferring an actual worsening from evidence of symptomatic worsening). But if *medical* evidence--*i.e.*, a physician's expert opinion--establishes that the symptomatic worsening represents an actual worsening of the underlying condition, such evidence may carry the worker's burden. That is precisely the opinion that claimant's treating physician provided in this case. Whether that opinion is persuasive was for the Board to determine. But in all events, a medical expert's opinion that an increase of symptoms signifies an actual worsening of a particular compensable condition satisfies the actual worsening standard.

SAIF raises a second challenge to the Board's reliance on Kelly's opinion. SAIF points out that it wrote Kelly asking her if she agreed that, when she examined claimant, **<166 Or App 624/625>** claimant was experiencing "a temporary and acute waxing and waning of symptoms * * * and that you were providing care to stabilize this waxing and waning." Kelly circled the preprinted "I agree" statement on the letter. SAIF argues that the opinion expressed in Kelly's answer undermines her earlier opinion that there was an actual worsening. SAIF therefore contends that the Board was not entitled to rely on Kelly's earlier opinion even if, in isolation, it might otherwise be adequate to support the Board's aggravation determination.

The two opinions provided by Kelly do, in fact, have different legal significance in this context. Under ORS 656.245(1)(c)(L), a worker whose condition is medically stationary is entitled to "[c]urative care provided * * * to stabilize a temporary and acute waxing and waning of symptoms of the worker's

condition." The statute does not provide for further disability compensation--*i.e.*, time off work, loss of use, and loss of earning capacity. Thus, claimant was entitled only to "curative care" unless he could demonstrate an actual worsening of his condition. Here, Kelly gave one opinion that potentially would satisfy the "actual worsening" requirement of ORS 656.273(1) and a second opinion that potentially would mean that claimant was entitled only to curative care under the "waxing and waning" provision of ORS 656.245(1)(c)(L).

SAIF assumes that the net effect of the two opinions provided by Kelly is that the second opinion somehow nullifies the first, with the result that Kelly's opinion of an actual worsening "simply is not there." We do not agree with that conclusion, either as a matter of law or as a matter of logic. Legally, "[t]here is no reason why contradictory evidence from the same party or witness is less capable than inconsistent evidence from separate sources to create a disputed fact question. It is the fact finder's role to decide which is true." *Taal v. Union Pacific Railroad Co.*, 106 Or App 488, 494, 809 P2d 104 (1991) (discussing affidavit evidence at summary judgment stage in civil proceedings). Such inconsistencies may be explained by confusion, or the inconsistency may not exist when the circumstances are better understood. Likewise, given how records are developed in workers' compensation cases, apparent contradictions and inconsistencies sometimes may be due to the leading written questions posed **<166 Or App 625/626>** to the experts, coupled with the experts' limited opportunities to clarify their answers.

Our role on review is to evaluate whether the Board's decision is supported by substantial evidence, which means evidence that, in viewing the record as a whole, would permit a reasonable person to make a finding. ORS 183.482(8)(c); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). In addition to the requirement that findings be supported by substantial evidence, the Board must provide a "sufficient explanation to allow a reviewing court to examine the agency's action." *Schoch v. Leupold & Stevens*, 325 Or 112, 118, 934 P2d 410 (1997); *see also Drew v. PSRB*, 322 Or 491, 500-01, 909 P2d 1211 (1996) (agency must provide "*reasoning* that leads [it] from the *facts* that it has found to the *conclusions* that it draws from those facts" (emphasis in original)). The problem here is that the Board did not acknowledge the existence of Kelly's subsequent opinion, it did not reconcile her two opinions, and it did not explain why it found Kelly's opinion of an "actual worsening" persuasive notwithstanding her agreement that she was treating claimant for a "waxing and waning" of symptoms. The persuasive force that attends to Kelly's "actual worsening" opinion requires consideration of her possibly inconsistent opinion that claimant was undergoing a temporary and acute waxing and waning of symptoms requiring medical care to stabilize those symptoms. To be sure, whether Kelly's two opinions are fatally inconsistent is for the Board to consider and decide. But for us to meaningfully review the Board's reliance on Kelly's "actual worsening" opinion, the Board must explain its reasons for relying on it notwithstanding Kelly's subsequent "waxing and waning" opinion. *See Liberty Northwest Ins. Corp. v. Verner*, 139 Or App 165, 169, 911 P2d 948 (1996) (Board's decision accepting expert's opinion without explaining inaccuracies not supported by substantial reason).

Reversed and remanded for reconsideration.

Cite as 166 Or App 627 (2000) April 19, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ryan T. LePage, Claimant.

RYAN T. LEPAGE, Petitioner,

v.

ROGUE VALLEY MEDICAL CENTER, SOUTHERN OREGON VENDING and BUSINESS INSURANCE CO., Respondents.

(WCB 98-03638; 98-02233; CA A106615)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 13, 1999.

Robert F. Webber argued the cause for petitioner. With him on the brief was Black, Chapman, Webber & Stevens.

Adam T. Stamper argued the cause for respondents. With him on the brief was Hornecker, Cowling, Hassen & Heysell.

Before Landau, Presiding Judge, and Linder and Brewer, Judges.

LINDER, J.

Affirmed.

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166 Or App 629> Claimant seeks judicial review of an order of the Workers' Compensation Board (Board) denying his aggravation claim. Claimant argues that the Board erred in concluding that his treating physician's description of "microscopic changes" in his condition did not demonstrate an "actual worsening" of claimant's condition, as required by ORS 656.273(1). We affirm.

Claimant compensably injured his left foot in 1996, and his workers' compensation claim was accepted as nondisabling. In late 1997, claimant's treating physician, Dr. Sampson, declared that claimant's condition had become medically stationary. Shortly thereafter, claimant began to suffer from increased foot pain, which led Sampson to recommend that claimant reduce his work day. Claimant filed a claim for aggravation of his original injury. That claim was denied, and claimant requested a hearing before an administrative law judge (ALJ). Sampson provided the only medical opinion concerning claimant's aggravation claim, describing claimant as suffering from increased foot inflammation and pain. Although Sampson believed that the increased symptoms reflected microscopic changes in claimant's condition, he declined to characterize claimant's additional symptoms as an actual worsening. Rather, he described claimant as suffering from a symptomatic flare-up of his original condition. The ALJ found that, although claimant's condition "waxes and wanes with activity," it had not objectively worsened. The Board adopted the ALJ's findings and, based on Sampson's characterization of "claimant's 'worsened' condition as a waxing and waning of symptoms," concluded that claimant did not prove an actual worsening.

On judicial review, claimant first asserts that the Board erred in concluding that he did not suffer from an actual worsening. According to claimant, he demonstrated "functional and structural" changes in his condition in the form of "microscopic changes" in the tissues of his foot. Claimant argues that Sampson's opinion qualified as proof of an "actual worsening" as required to establish an aggravation under ORS 656.273(1).

166 Or App 630> The problem with claimant's evidence in this case is that his treating physician did not conclude that claimant's condition had actually worsened. Here, Sampson agreed that claimant's condition fluctuates "symptomatically" in response to claimant's activity level. He further determined, however, that claimant's underlying condition had "not changed at all." Sampson agreed with the following summary provided by employer's attorney:

> "We noted the legal significance of a reported pathological worsening ('aggravation') versus symptomatic fluctuations requiring palliative care. In this case, [claimant] has not developed any new injuries, conditions or pathological changes in the left foot. He continues to experience the same, intermittent left foot pain and related symptoms according to his level of physical activity. His condition is stationary, with a likely occasional need for some palliative treatment, as originally described [when the claim was declared medically stationary]."

Sampson reiterated that opinion in his deposition testimony. He again stated that claimant suffered from "continued waxing and waning of the symptoms that he had from before" and noted that he recommended that claimant restrict his activity because "it"--which, in context, apparently refers to the symptoms--"got worse." According to Sampson, the only structural change taking place was inflamation, a microscopic change that waxed and waned with the symptoms. As Sampson described, claimant's pain was caused by "little fibers that surround the edge of this bone, [where] there is a little sack * * * that becomes inflamed" and "nerve endings in that sack * * * transmit pain." When asked if claimant's condition could be characterized as having pathologically worsened, Sampson replied that "a pathological change in a condition like this would be * * * some major event like the tendon pulled off the bone or the bone eroded or some major arthritic change[.] * * * But waxing and waning of the symptoms, I would say that's not a pathological change, that is just kind of a coming and going." Thus, according to Sampson, the microscopic changes that claimant experienced were symptomatic only and did not reflect an actual worsening of claimant's underlying condition.

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.*"

(Emphasis added.) The Supreme Court construed that provision in its recent decision *SAIF v. Walker*, 330 Or 102, ___ P2d ___ (2000). Specifically, it reviewed at length the meaning of the legislature's requirement in ORS 656.273(1) that a "worsened condition" be established by "medical evidence of an actual worsening of the compensable condition." The court held that:

> "[E]vidence of worsened symptoms, while relevant, is not sufficient by itself to meet the proof standard created by ORS 656.273(1) (1995). However, * * * a physician may rely upon that kind of evidence in determining whether the compensable condition has worsened and in opining on that question to the factfinder or to the Board. In other words, the 'medical evidence * * * supported by objective findings' that is required under ORS 656.273(1) (1995) and ORS 656.273(3) to prove an 'actual worsening of the compensable condition' may include a physician's written report commenting that the worker's worsened symptoms demonstrate the existence of a worsened condition."

Id. at 118.

Thus, the court concluded that evidence of a symptomatic worsening by itself does not permit a factfinder to infer an "actual worsening" under ORS 656.273(1). Rather, there must be medical evidence--*e.g.*, a physician's medical opinion--establishing that the worsened symptoms demonstrate the existence of a worsened condition. Thus, as the court explicitly acknowledged in *Walker*, "if, in a physician's medical opinion, a symptomatic worsening does *not* demonstrate the existence of an actual worsening of the underlying condition, then the worker does not qualify for an aggravation claim." *Id.* at 119 (emphasis in original). Here, the only medical evidence was Sampson's opinion that there was no actual worsening. Accordingly, the Board correctly concluded **<166 Or App 631/632>** that claimant did not satisfy his burden to demonstrate an aggravation.

Claimant also argues that, even if the evidence establishes only a worsening in the form of waxing and waning of symptoms, such a worsening establishes an aggravation where the claimant has not received a permanent disability award. Claimant relies on ORS 656.273(8), which expressly provides that, to prove an aggravation of a permanently disabling claim, a worker must establish "more than waxing and waning of symptoms." That is so because, under ORS 656.214(7), a permanent disability award "contemplates future waxing and waning of symptoms of the condition." Together, those provisions clarify that a worker who has received a prior permanent disability award and who experiences only a "waxing" of symptoms relating to the underlying condition will not qualify for an aggravation award. *See generally Walker*, 330 Or at 114-15 (discussing interplay of ORS 656.214(7) and ORS 656.273(1) and (8)). Conversely, then, according to claimant, where a worker has not been awarded permanent disability, "to the extent that claimant suffered a flare up of symptoms that significantly restricted his pre-injury ability to work and made him worse than he was prior to his claimed aggravating event, claimant has suffered a worsening."

There are several problems with claimant's position. First, the "actual worsening" requirement of ORS 656.273(1) applies both to disabling and nondisabling conditions. See ORS 656.273(4)(a) (time limits for filing aggravation claim for disabling condition); ORS 656.273(4)(b) (same for nondisabling condition). In *Walker*, the court construed that phrase to require more than evidence of worsened symptoms. Claimant's position, therefore, would require us to give a single statutory standard two different and inconsistent meanings. There is no logical or legally principled way to do that. We cannot, in the guise of judicial interpretation, interfere with the statute's plain application to all aggravation claims.

Second, as the court explained in *Walker*, ORS 656.273(8) and ORS 656.273(1) serve "different functions":

> "ORS 656.273(8) provides that the worker's proof must consist of something more than a waxing of symptoms of the **<166 Or App 632/633>** condition contemplated by the previous award. That statute serves to preclude an aggravation award if the evidence consists of only a worsening of symptoms within the contemplated range. However, the legislature's description in ORS 656.273(8) of the threshold below which no worker's proof may fall does not state the proof standard that a valid claim for aggravation must satisfy. That function is fulfilled by ORS 656.273(1) (1995)."

330 Or at 117. In other words, all aggravation claims, for disabling and nondisabling injuries alike, must satisfy the "actual worsening" standard. In addition, where the original compensable condition is disabling, the claimant further must establish that, to the extent the actual worsening is established by a symptomatic worsening, the waxing of symptoms must be more than that contemplated by the previous award. The fact that a second hurdle exists for a disabling injury is not a basis to lower the first and only hurdle for a nondisabling injury. In short, ORS 656.273(8) simply has no relevance here.

In addition, claimant's position overlooks ORS 656.245(1)(c)(L). Under that statute, a claimant who suffers from "a temporary and acute waxing and waning of symptoms" is entitled to "[c]urative care" for the treatment of those symptoms (*i.e.*, medical expenses for an otherwise medically stationary condition). *See also SAIF v. January*, 166 Or App 620, ___ P2d ___ (2000). If claimant were correct that waxing and waning of symptoms, without more, could establish an aggravation for a nondisabling injury, claimant would be entitled to time loss benefits and a reevaluation of permanent disability, in addition to medical expenses. Claimant's position thus would largely nullify the provisions of ORS 656.245(1)(c)(L), or at least eclipse them, because the curative care benefit for temporary waxing and waning of symptoms would be redundant.

Finally, the fact that claimant is less able to work due to his symptomatic worsening does not provide a basis for an aggravation claim in this case, either. To be sure, *Walker* suggests that a physician may consider the disabling effects of worsened symptoms in forming an opinion as to whether the worker's condition has actually worsened. *See Walker*, 330 Or at 118 (citing *Gwynn v. SAIF*, 304 Or 345, **<166 Or App 633/634>** 352, 745 P2d 775 (1987)). However, Walker makes clear that the Board cannot infer an actual worsening from evidence of worsened symptoms, even if those symptoms result in a loss of earning capacity. Any inferences that can be drawn from such evidence must be drawn by the physician, not the factfinder.

In sum, the Board did not err in denying claimant's aggravation claim. Contrary to claimant's position, Sampson's medical opinion did not suffice to establish an actual worsening of claimant's condition. Nor does the fact that claimant did not receive a permanent disability award for his original compensable condition mean that he can establish an aggravation on a showing of waxing and waning of symptoms.

Affirmed.

Cite as 166 Or App 642 (2000) April 19, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jodie M. Dubose, Claimant.

SAIF CORPORATION and EVERGREEN RESTAURANT GROUP, Petitioners,

v.

JODIE M. DUBOSE, Respondent.

(WCB 97-01993; CA A103853)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 1, 1999.

Julene M. Quinn argued the cause and filed the brief for petitioners.

Edward J. Harri argued the cause for respondent. With him on the brief were James C. Egan and Kryger, Alexander, Egan and Elmer, P.C.

Before Landau, Presiding Judge, and Linder, Judge, and Brewer, Judges.

LINDER, J.

Reversed and remanded.

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166 Or App 644> SAIF petitions for review of a Workers' Compensation Board (Board) order setting aside SAIF's denial of a claim, which SAIF based on claimant's failure to cooperate and assist in its investigation. At issue here is whether ORS 656.262(15) requires a worker specifically to request an "expedited hearing" on a claim denied for "worker noncooperation." We conclude that it does and that, because claimant did not request an expedited hearing, the administrative law judge (ALJ) did not have authority to consider claimant's excuse for noncooperation. Consequently, the Board erred in affirming the ALJ's order. We therefore reverse and remand.

Claimant filed a claim for workers' compensation benefits based on a diagnosis of carpal tunnel syndrome and situational anxiety, the cause of which she attributed to her work as an assistant manager of a McDonald's restaurant. SAIF scheduled claimant for an independent medical examination (IME), notified her of the date, time, and place of the IME, and reminded claimant of her obligation to cooperate and assist in the investigation of her claim. *See* ORS 656.262(14). Claimant did not attend the IME. On January 24, 1997, the Department of Consumer and Business Services (DCBS) notified claimant that it would be suspending her compensation benefits for "noncooperation" based on her failure to attend the IME. DCBS later issued an order suspending benefits and allowing SAIF to deny the claim unless claimant cooperated within 30 days of the January 24 notice. Claimant did not appeal that order. Nor did she communicate with DCBS or SAIF during the 30-day period. SAIF denied the claim on February 25, 1997, citing claimant's failure to cooperate as the sole reason for the denial.

On March 5, 1997, claimant requested a hearing on SAIF's denial by filling out a standardized form provided by the Board. That form stated: "A hearing is requested for the reason(s) checked below." Claimant checked "DENIAL" and, as the reason for the denial, marked "Compensability - complete claim denial." Claimant did not check the box identifying a denial based on "Worker noncooperation."[1]

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[1] That portion of the form appeared as follows:

"A hearing is requested for the reason(s) checked below:

"[X] **A** DENIAL (*Date*) 2/25/97

"[X] **B** Compensability - complete claim denial

"[ ] **X** Partial denial after a claim acceptance

"[ ] **Z** Challenge to notice of acceptance *ORS 656.262*

"[ ] **V** Worker noncooperation *ORS 656.262(15)*

"[ ] **K** Aggravation *ORS 656.273*

"[ ] **L** Responsibility *ORS 656.307*"

(Font and emphasis variations in original.)

A hearing was scheduled for June 2, 1997, almost three months after claimant's hearing request. At the beginning of the hearing, the ALJ identified the issues before it as "compensability of the claim and a carrier-paid fee if claimant prevails." SAIF clarified that its denial was not based on noncompensability but was based, instead, on claimant's noncooperation. SAIF argued that claimant should not be allowed to proceed because she had failed to request an expedited hearing as required by ORS 656.262(15), which provides, in part:

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

(Emphasis added.) The ALJ did not consider claimant's failure to request an expedited hearing to "be of significance" and determined that claimant should be allowed to present evidence establishing the reasonableness of her failure to attend the IME. Claimant put on evidence that she was unable to attend the IME due to hazardous weather conditions, and the ALJ concluded that claimant's failure to cooperate was beyond her control. Accordingly, the ALJ set aside SAIF's denial and ordered that SAIF process the claim.

On review of the ALJ's order, the Board agreed with SAIF that a worker first must challenge a noncooperation denial before he or she is entitled to a hearing on the merits **<166 Or App 645/646>** of the claim for compensation. The Board determined, however, that ORS 656.262(15) does not provide that an expedited hearing is the "only" avenue for challenging a noncooperation denial. Specifically, the Board said:

> "For instance, the statute does not provide that 'the worker first requests and establishes only at an expedited hearing * * *.' In the absence of such limiting language, we find that the statute shows that an expedited hearing is an option, not a requirement.
>
> "* * * Under ORS 656.291 and OAR 438-013-0010(1)(c), the Board assigns certain cases to the Expedited Claims Service. In other words, there is no statutory procedure for the worker to request an expedited hearing."

(Emphasis in original.) Thus, the Board concluded that a worker need only make a generic request for a hearing and that the Board has the option, but not a mandatory duty, to provide a hearing on an expedited basis. The Board therefore affirmed the ALJ's order. SAIF argues on judicial review, as it did below, that claimant must request an expedited hearing, that it is then entitled to receive a hearing on an expedited basis, and that because the hearing in this case was not expedited, SAIF was entitled to have its noncooperation denial upheld. We agree.

The first flaw in the Board's reasoning is its conclusion that an expedited hearing for a noncooperation denial is provided at the Board's option. ORS 656.262(15) explicitly states that, after a noncooperation denial, the worker shall not receive a hearing on the merits of the worker's claim "unless the worker first requests and establishes at an expedited hearing under ORS 656.291" either that the worker fully cooperated with the investigation or was excused from doing so. That language could not be clearer. The procedure for setting aside a noncooperation denial is an expedited hearing under ORS 656.291, plain and simple. The language permits no other conclusion. For the Board to deem an expedited hearing merely optional all but nullifies the statute.

The Board's rules similarly compel the conclusion that an expedited hearing process must be used if a worker challenges a noncooperation denial. Under ORS 656.291(1), **<166 Or App 646/647>** the Board is charged with administering the expedited hearing process. OAR 438-013-0010(1) provides that a request for a hearing "shall be referred" to the Expedited Claims Service if, among other reasons, "[t]he request involves a denial under ORS 656.262(15) for a worker's failure to cooperate in a claim investigation." The Board's rule is as clear as the statute itself. Even if there were leeway under the statute to provide an expedited hearing for some noncooperation denials and not others, the Board's

own rule would require it to provide such a hearing for all noncooperation denials. *See Burke v. Children's Services Division*, 288 Or 533, 538, 607 P2d 141 (1980) (an administrative rule remains an effective statement of existing practice or policy until it is either judicially invalidated or repealed through proper APA procedures, and an agency is obligated to follow it).

The second flaw in the Board's reasoning is its conclusion that there is no burden on a claimant to request an expedited hearing. The statute expressly provides that, when a noncooperation denial has issued, a worker cannot have the merits of the compensation claim considered "unless the worker first requests and establishes at an expedited hearing under ORS 656.291" that the noncooperation denial should be set aside. The statute plainly places a burden on the worker to make an effective request for the necessary hearing.

We reject the Board's premise that the lack of a formal statutory mechanism for requesting an expedited hearing evinces a legislative intent that a worker has no obligation whatsoever to request an expedited hearing. The statutes do not, in other regards, specify precise forms to be used or exact hearing request procedures to be followed for the myriad workers' compensation hearings and review proceedings available to the parties. Those kinds of implementing mechanisms are left to the agencies--here, the Board--that are charged with administration of the various aspects of the procedures to be followed. The Board, in administering its responsibilities, has provided a reasonable mechanism for making a request for an expedited hearing on a noncooperation denial. As discussed above, the Board provides a standardized form for requesting a hearing. On that form, the worker first indicates that the hearing is for a claim denial. **<166 Or App 647/648>** The form then requires the worker, in a simple check-the-box-that-applies format, to identify the reason for the denial. Included is a box for indicating a denial based on "Worker noncooperation," followed by citation to the relevant statute, ORS 656.262(15). A worker who accurately fills out that form satisfies the statutory requirement to request an expedited hearing for a noncooperation denial. The Board's administrative obligation, both under the statute and pursuant to its rules, is then to provide that hearing.

Here, claimant did not fill out the form accurately. She indicated that she was requesting a hearing on a denial for compensability, not a denial for noncooperation. Nothing in the way claimant filled out the form, or in her accompanying cover letter, would have alerted the Board that the matter should be placed on the expedited hearings docket. Claimant therefore did not do what she needed to do to trigger an expedited hearing. The Board, which was understandably under the impression that claimant was requesting a hearing on a compensability denial, did not assign the claim to the expedited hearing docket. The hearing, instead, was scheduled for almost three months after claimant's request. By the time the ALJ decision issued, the claim was almost a year old. In contrast, under the Board's rules for expedited hearings, a hearing would have been scheduled no more than 30 days after the request for a hearing, and the ALJ decision would have issued within 10 days after the record was closed. OAR 438-013-0025; OAR 438-013-0040(1). SAIF argues that the reason for requiring expedited hearings for noncooperation denials is to ensure that an insurer's right to a prompt investigation of the claim is not prejudiced. *See* ORS 656.262(14) (detailing worker's duty to cooperate and assist the insurer or self-insured employer in the investigation of the claim). A worker, whose interim benefits and right to a hearing on the merits of the claim are cut off by a noncooperation denial, surely has an equal interest in prompt resolution of a challenge to the denial. Suffice it to say that, from both perspectives, we agree with SAIF that, under the statute, "time is of the essence" if the noncooperation denial is to be reviewed. Given claimant's failure to do the minimum necessary to request an expedited hearing, and because an expedited hearing in fact was not held, SAIF was entitled to have the noncooperation denial upheld.

Claimant, nonetheless, maintains that she was not obligated specifically to request an expedited hearing in this particular instance. She advances two arguments to support her position: (1) her claim was not subject to the expedited hearing procedure because it exceeds the "amount in controversy" limit of ORS 656.291(2)(a); and (2) SAIF waived an expedited hearing by not requesting one. Each argument is quickly answered.

In asserting that her claim is not subject to an expedited hearing because the amount in controversy for her claim for compensation exceeds $1,000, claimant relies on ORS 656.291. That statute provides for expedited hearings where the "only matters unresolved do not include compensability of the claim and the amount in controversy is $1,000 or less" or the only matters in dispute are "attorney

fees or penalties." ORS 656.291(2)(a) and (b). Claimant's argument misunderstands the interplay between ORS 656.262(15) and the expedited hearings process as established by ORS 656.291. ORS 656.262(15) explicitly requires an expedited hearing "under ORS 656.291." There is no qualification as to amount in controversy or otherwise. That cross-reference automatically invokes the expedited hearing process. In other words, ORS 656.262(15) establishes a separate category of claims that require an expedited hearing, one that is in addition to the categories identified in ORS 656.291(2).[2] If claimant's interpretation were correct, ORS 656.262(15) would be pointless. Noncooperation denials would be subject to an expedited hearing process pursuant to the criteria of ORS 656.291(2). ORS 656.262(15) was plainly intended to be an independent basis for providing expedited hearings.

Finally, claimant argues that "[i]f SAIF believed that ORS 656.291 controlled, it should have informed the Hearings Division of that fact." We reiterate: ORS 656.262(15) provides that a worker "shall not" be granted a **<166 Or App 649/650>** hearing "unless the *worker* first requests" an expedited hearing. (Emphasis added.) The statute places the duty to request an expedited hearing on the worker, not on the insurer. To the extent that claimant is suggesting that SAIF has not preserved error, claimant is wrong. SAIF raised the issue at the outset of the ALJ hearing. The statutory scheme requires no more.

In sum, we hold that ORS 656.262(15) unambiguously requires an expedited hearing process for challenging a denial for noncooperation and places the onus on the worker to make a request for an expedited hearing. Using the form developed by the Board, claimant could have made a proper request by accurately indicating that SAIF denied her claim for noncooperation, thus providing the Board with the information needed to assign the claim to the Expedited Claims Service. Because claimant failed to avail herself of the appropriate procedure for challenging a noncooperation denial, the ALJ had no authority to set aside SAIF's denial. The Board erred in concluding otherwise.

Based on our disposition, we need not reach SAIF's remaining assignments of error.

Reversed and remanded.

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[2] The Board's rule is structured in the same way. OAR 438-013-0010(1) requires a referral to an expedited hearing if: (1) all unresolved matters involve issues other than compensability or responsibility and the amount is controversy is $1,000 or less; (2) the only unresolved matters are attorney fees and penalties; or (3) the request involves a denial under ORS 656.262(15) for a worker's failure to cooperate in a claim investigation. Those are *alternative* bases on which an expedited hearing is required, not cumulative ones.

Cite as 167 Or App 11 (2000) May 3, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dustin Luckhurst, Claimant.

DUSTIN LUCKHURST, Petitioner,
v.
BANK OF AMERICA, Respondent.
(WCB No. 97-03907; CA A102856)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 9, 1999.
Robert G. Dolton argued the cause for petitioner. On the brief was Pil S. Hwang.
Paul L. Roess argued the cause for respondent. With him on the brief was Moscato & Hallock.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
DEITS, C. J.
Affirmed.

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167 Or App 13> Claimant seeks review of a Workers' Compensation Board (Board) order that upheld employer's denial and held that claimant's current left knee condition was not compensable. Claimant contends that the Board erred in concluding that he suffered from a combined condition and in applying the legal standard of ORS 656.005(7)(a)(B), rather than that of ORS 656.225(1). We review for errors of law and substantial evidence and affirm.

We derive the facts from the ALJ's findings, the Board's summary of those findings--which it adopted--and from the medical evidence in the record. Claimant was injured on December 4, 1996, while he was working as a courier for employer. Claimant was moving a 32-gallon trash can containing approximately 75 to 80 pounds of paper. The can was on a wheeled platform, and when claimant attempted to lift the can onto a curb, the wheels came off. Claimant tripped, fell forward, and landed on his left knee on the flat edge of the concrete curb. Claimant sought and received medical treatment, and his claim was accepted as a "left knee contusion."

Claimant's left knee significantly improved until February 1, 1997, when he felt severe pain as he bent forward and "touched" his knee to the ground. An MRI revealed an osteochondral fragment "consistent with osteochondritis dissecans." Employer issued a denial, asserting that claimant's current condition, need for treatment, and disability were not compensable. Ultimately, claimant twice had arthroscopic surgery in an attempt to remove the fragment or fragments. Following the second surgery, claimant has done well.

Claimant's treating surgeon, Dr. McLean, explained that osteochondritis dissecans, or OD, is a condition of "the articular surface of a bone involving the joint, wherein, for reasons not well understood, the vascular supply to that region of bone becomes interrupted and the bone essentially dies." As a "secondary result of the destruction of the bone," the articular cartilage also loses strength. The ALJ found, **<167 Or App 13/14>** and all the medical evidence indicates, that claimant's osteochondritis dissecans was a preexisting condition.[1] According to McLean, claimant's OD increased the risk that cartilage or bone fragments would break off, but a "forceful activity," such as the fall onto claimant's left knee, would be required to cause the formation of a loose body in the knee. McLean testified, and the ALJ found, that claimant's fall caused a cartilaginous fragment or fragments to break loose in his knee. McLean also testified that, as a result of claimant's fall, his OD worsened from grade one to grade three.

The ALJ found that the knee contusion "combined with [his preexisting] OD lesion resulting in a loose body in claimant's left knee," which caused a worsening of the preexisting OD. The ALJ concluded that the claim was not compensable as a "combined condition" under ORS 656.005(7)(a)(B), but that it

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[1] Employer also issued a compensability denial with respect to claimant's osteochondritis dissecans. Claimant does not challenge that denial.

was compensable under ORS 656.225(1) because claimant's injury was, in the words of the statute, "the major contributing cause of a pathological worsening of the preexisting condition," here claimant's OD.

On review, the Board reversed. The Board agreed with the ALJ's finding that the knee contusion combined with claimant's preexisting condition to cause the need for treatment. It concluded that "the record shows that claimant's treatment was directed to a 'combined condition' within the meaning of ORS 656.005(7)(a)(B)." It also agreed with the ALJ's conclusion that claimant had not proved the compensability of his current condition as a "combined condition" under the terms of ORS 656.005(7)(a)(B). The Board also noted that claimant did not challenge the ALJ's determination that he did not prove that his injury was the major contributing cause of the need for treatment of the combined condition under ORS 656.005(7)(a)(B). The Board, however, disagreed with the ALJ's conclusion that claimant had established compensability under ORS 656.225(1). The Board concluded that this statute was not applicable because claimant's treatment was not directed "solely" to his preexisting condition, as the terms of that statute require.

167 Or App 15> On review, claimant assigns error to the Board's decision to uphold employer's denial. He contends that the Board erred in finding that his treatment was for a combined condition and in its consequent conclusion that the pertinent statute was ORS 656.005(7)(a)(B), rather than ORS 656.225(1).

ORS 656.005(7)(a)(B) provides that a "compensable injury" is one that "aris[es] out of and in the course of employment requiring medical services or resulting in disability or death," if the claim is "established by medical evidence supported by objective findings, subject to the following limitation[]:"

> "(B) If an otherwise compensable injury *combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable* only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of *the combined* condition or the major contributing cause of the need for treatment of *the combined condition.*" (Emphasis added.)

ORS 656.225 provides, in part, that:

> "In accepted injury or occupational disease claims, *disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless*:
>
> "(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, *work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.*" (Emphasis added.)

As noted here, the Board found that claimant had a "combined condition" within the meaning of ORS 656.005(7)(a)(B) but that the condition was not compensable because claimant had not satisfied the major contributing cause test. As discussed above, claimant does not dispute the latter conclusion, but he argues that he does not have a "combined condition" within the meaning of the statute and, therefore, it simply does not apply. Accordingly, the initial question that we must resolve is whether the Board was correct in determining that this case involves a "combined condition." That question is a mixed question of law and fact.

167 Or App 16> In our recent decision in *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 993 P2d 174 (1999), we discussed the legal meaning of the term "combined condition" as used in ORS 656.005(7)(a)(B). We stated that:

> "The term 'combine' has a broader common meaning [than the term 'involves,' as used in ORS 656.308(1)]. ['Combine'] is an adjective derived from the verb 'to combine,' which has several pertinent, plain, and ordinary meanings: 'to bring into close relationship: to join in physical or chemical union; * * * to cause to unite or associate harmoniously * * *; to cause * * * to mix together: * * * to become one: coalesce, integrate.' [Webster's *Third New Int'l Dictionary*, 452 (unabridged ed 1993)]. Thus, a combined condition may, but need not, integrate or join together two distinct conditions. A combined condition may merely bring those conditions into a close relationship or

> cause them to associate 'harmoniously.' There is nothing in the text or context of ORS 656.005(7)(a)(B) to suggest that the legislature intended to limit the term 'combined' to only one of those possible common meanings. We therefore conclude that a combined condition may constitute either an integration of two conditions or the close relationship of those conditions, without integration. *See* ORS 174.010; *J.R. Simplot Co. v. Dept. of Rev.*, 321 Or 253, 261, 897 P2d 316 (1995) (the court may not narrow the broad ordinary meaning of a statutory term when the text and context do not justify the limitation). Thus, a condition that 'combines' with another does not necessarily 'involve' the other." *Id.* at 662 (ellipses in original).

Here, the Board found that the knee contusion combined with claimant's preexisting OD. That finding is supported by substantial evidence in the record. As discussed above, the treating surgeon, McLean, stated that claimant's preexisting OD increased the risk that cartilage would break loose in his knee, but that a "forceful activity," such as claimant's fall onto his knee, would be required to complete the formation of a loose body in his knee. The surgeon also testified that claimant's fall broke loose the cartilaginous fragments in his knee. McLean characterized claimant's condition as a combined condition of the preexisting OD and the fall and the trauma.

As the definition of a "combined condition" is explained in our decision in *Multifoods*, in order for there to **<167 Or App 16/17>** be a "combined condition," there must be two conditions that merge or exist harmoniously. The Board's order does not discuss claimant's conditions in exactly those terms; the order was issued before our decision in *Multifoods*. Specifically, the Board did not explicitly find that there were two conditions here, rather than one condition made worse by claimant's fall. However, the Board's findings and conclusions implicitly indicate that it believed that there were two conditions here that combined. We hold that the Board's findings and conclusion that this claim involved a "combined condition" is within the legal meaning of the terms.

The remaining issue here is whether the Board was correct in its conclusion that ORS 656.225(1) is not the applicable statute. The Board concluded that that statute is not applicable, because the treatment claimant received was not directed *solely* at claimant's preexisting condition. The Board's findings that surgery was directed at a condition that resulted from a combination of the preexisting condition and the results of the knee contusion support the Board's conclusion. The text and context of ORS 656.225 clearly provide that, in order to fall within the terms of that statute, the medical services must be directed *solely* to a claimant's preexisting condition. That is not the case here. Accordingly, we conclude that the Board did not err in upholding employer's denial.

Affirmed.

Cite as 167 Or App 46 (2000) May 3, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Patsy J. Evenson, Claimant.

K-MART, Petitioner,
v.
PATSY J. EVENSON, Respondent.
(97-07020; CA A103326)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 10, 1999.
Karen O'Kasey argued the cause for petitioner. With her on the brief was Schwabe, Williamson & Wyatt.
Robert E. Nelson 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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167 Or App 48> Employer seeks judicial review of the Workers' Compensation Board's order that determined that claimant's claim is compensable. Employer's sole contention is that the Board misunderstood and misapplied the statutory definition of the term "compensable injury." ORS 656.005(7)(a). We therefore review for errors of law, ORS 656.298(7), ORS 183.482(8), and affirm.

The facts are not disputed. At the hearing, employer and claimant stipulated to many of the pertinent facts, and employer does not argue that any of the Board's findings are not supported by substantial evidence. We take the following facts from the parties' stipulation, from the Board's and Administrative Law Judge's findings, and from the record. Claimant works as a store manager for employer. While working on May 25, 1997, claimant assisted a man who was in a wheelchair. The man had defecated and had feces and blood on his hands. In the process, claimant was exposed to the blood and feces, which also got on her hands. At the time, claimant had sores on her hands, which were the result of an unrelated medical condition. Afterwards, the man told claimant that he was HIV positive, and he appeared to be very ill. Claimant was unable to leave work immediately because other employees were absent. However, an emergency room physician urged her over the telephone to come to the hospital as soon as possible and to seek prophylactic treatment for possible exposure both to HIV and hepatitis. At the request of both the emergency room physician and her own treating doctor, claimant later received testing and prophylactic treatment for HIV and hepatitis A and B. The test results so far have been negative.

Although employer paid claimant's medical bills on what it terms a "diagnostic basis," it denied her claim.[1] After a hearing, the ALJ set aside the denial, finding that the claim **<167 Or App 48/49>** is compensable. On review, the Board agreed with the ALJ. The Board determined that:

> "it is undisputed that claimant was exposed at work to bodily fluids of another person infected with HIV. It is also undisputed that she *required* prophylactic and preventative medical services as a result of this exposure. Based on the undisputed medical evidence establishing that medical services were required as a result of the work incident, we agree with the ALJ that claimant suffered a compensable injury under the statute." (Emphasis in original.)

On review, employer argues that the Board erred when it concluded that claimant suffered a compensable injury within the meaning of the workers' compensation statutes. Employer contends that claimant did not prove that she had contracted any disease or suffered from any symptoms. Based on

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[1] We agree with employer that the fact that it paid for claimant's treatment does not alone establish compensability. ORS 656.262(10) ("Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability * * *").

that contention, employer argues that "[i]t is well settled that an exposure that does not result in actual physical or mental harm does not in and of itself constitute an injury or disease." We agree that claimant has not shown that she has any disease or symptoms, but such a showing is not necessarily required to prove the existence of a "compensable injury."

The term "compensable injury" is defined in ORS 656.005(7)(a), as follows.

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings[.]"[2]

In analyzing the meaning of the statutory term "compensable injury," we use the methodology prescribed in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). We, therefore, begin with the text and context of the statute. *Id.* at 610.

167 Or App 50> The statute does not define the word "injury." That word generally means:

> "1 a: an act that damages, harms or hurts * * *;
>
> "* * * * *
>
> "2: hurt, damage, or loss sustained * * * <injuries to health> * * * <suffered severe injuries in the accident>;
>
> "**syn** INJURY, HURT, DAMAGE, HARM and MISCHIEF mean in common the act or result of inflicting on a person or thing something that causes loss, pain, distress, or impairment. INJURY is the most comprehensive, applying to an act or result involving an impairment or destruction of right, health, freedom, soundness, or loss of something of value <sustain a leg *injury* in a fall> <mental or emotional upset is just as truly an *injury* to the body as a bone fracture, a burn, or a bacterial infection-G.W. Gray b. 1886> * * *."

Webster's Third New Int'l Dictionary, 1164 (unabridged ed 1993) (boldface and italics in original). Under the terms of ORS 656.005 (7)(a), the harm, damage or hurt that is sufficient to amount to an "injury" is one "requiring medical services or resulting in disability or death[.]" (Emphasis added.) The statute does not require that a claimant's injury must both result in medical services and in disability or death. It is sufficient if the injury "requir[es] medical services." The statute provides a clear definition of the minimum degree of harm necessary for the existence of a "compensable injury."

Our conclusion is buttressed by an examination of the statutory context. By statute, a "compensable injury" may be either "disabling" or "nondisabling." ORS 656.005(7)(c), (d). The statute defines a "nondisabling compensable injury" as one that "requires medical services *only*." (Emphasis added.) The medical services need not be directed toward the cure of any existing, identifiable disease; diagnostic or other medical services will suffice. *Finch v. Stayton Canning Co.*, 93 Or App 168, 173, 761 P2d 544 (1988) (holding that ORS 656.005(7)(a)--then ORS 656.005(8)(a)--"makes no distinction between [medical] diagnosis and treatment."); *Collins v. Hygenic Corp. of Oregon*, 86 Or App 484, 739 P2d 1073 (1987).

167 Or App 51> Employer argues, however, that our prior case law requires that a "compensable injury" be one that results "in actual physical or mental harm[.]" Employer cites to our decisions in *Brown v. SAIF*, 79 Or App 205, 717 P2d 1289, *rev den* 301 Or 666 (1986), and *Johnsen v. Hamilton Electric*, 90 Or App 161, 751 P2d 246 (1988), as supporting its position. In *Brown*, the claimant had been exposed to asbestos during a two-week period. He later became concerned and sought medical advice. He was not diagnosed with asbestosis or any other condition, and no physician indicated that he

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[2] That definition is subject to certain statutory limitations that do not apply here.

needed or "required" medical treatment. We held that his exposure was noncompensable. As we later explained, the decision in *Brown* merely stands for the proposition that "[t]he fact that one has *sought* medical services does not [alone] establish that one has a compensable injury." *Barkley v. Corrections Div.*, 111 Or App 48, 53, 825 P2d 291 (1992) (emphasis added). Instead, the statute provides that the injury require medical services. ORS 656.005(7)(a).

Our decision in *Johnsen* is similar to that in *Brown*. Although employer argues that *Johnsen* holds that a claimant must "have an injury or disease in addition to a requirement for medical treatment," we said in that case, assuming the claimant had a condition related to his employment, that "the question remain[ed] whether, in the absence of disability, symptoms *or a need for treatment*, [the] claimant suffered from an 'occupational disease' so as to enable him to recover benefits for reasonable and necessary medical services." 90 Or App at 164 (emphasis added). Because the claimant did not have a disability, symptoms *or* a need for treatment, his claim was not compensable.

The principles we have outlined above are applicable here. Unlike the claimants in *Brown* and *Johnsen*, claimant's exposure "required" medical services. She had been exposed to serious, even life-threatening, pathogens, and the emergency room physician she consulted believed that the exposure required both testing and prophylactic treatment. Indeed, when claimant was slow to arrive at the emergency room because of her continuing work duties, the physician phoned her urging her to come to the hospital and seek treatment as soon as possible. Claimant's treating physician later **<167 Or App 51/52>** agreed that testing and treatment were required in claimant's situation. We hold under the circumstances that claimant's injury was a compensable one because it "requir[ed] medical services." ORS 656.005(7)(a).[3]

Affirmed.

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[3] Employer does not contend that this claim is not compensable because it is not supported by objective findings.

Cite as 167 Or App 327 (2000) May 17, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Albert D. Avery, Claimant.

SAIF CORPORATION and FORESTEX COMPANY, Petitioners,

v.

ALBERT D. AVERY, Respondent.

(96-01975, 95-13779; CA A99912)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 6, 1999.

David L. Runner argued the cause and filed the brief for petitioners.

Gerald C. Doblie argued the cause for respondent. With him on the brief was Doblie & Associates.

Before De Muniz, Presiding Judge, and Haselton and Wollheim, Judges.

WOLLHEIM, J.

Affirmed.

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167 Or App 329> Employer and its insurer, SAIF, petition for judicial review from the Workers' Compensation Board's (Board) order and order denying reconsideration affirming the holding (1) that claimant established good cause for his late request for hearing; (2) that claimant's mental condition of dementia was compensable; and (3) that employer did not establish a compelling reason for remanding this case to the administrative law judge (ALJ) for taking into evidence post-hearing medical reports. We affirm.

We take the facts, which are largely undisputed, from the Board's orders. Claimant, a long-time employee, loaded sheets of fiberboard onto carts and then placed the carts into a dehumidifying oven. In June 1993, a cart dragged claimant into the oven, where the temperature was between 170 and 200 degrees Fahrenheit. It was about 10 minutes before co-workers discovered that claimant was inside the oven, and it took approximately 30 minutes for co-workers to remove claimant. During a portion of that time, claimant's head was wedged between the oven wall and the cart. Claimant filed a claim and employer accepted that claim.

Shortly after the accident, claimant's wife began noticing that claimant had difficultly communicating and was unusually quiet, symptoms that did not exist before the injury. The claim was closed in December 1993, and claimant did not appeal that closure.

In June 1995, SAIF issued an aggravation denial, based, in part, on claimant's handwritten letter stating that he did not wish to reopen the claim. The following month, on July 28, 1995, SAIF denied a claim for memory loss or dementia. On December 21, 1995, more than 60 days after the denial but less than 180 days after the denial, claimant filed a request for hearing protesting the July 1995 denial.

At hearing, claimant contended that his memory loss or dementia was compensable. Employer argued that claimant was barred from litigating the compensability of his dementia because he had failed to request a hearing within 60 days of the July 28, 1995, denial and could not establish good cause, under ORS 656.319(1), for the late request. The **<167 Or App 329/330>** ALJ found that claimant established good cause and set aside the denial. Employer appealed to the Board and the Board affirmed. Employer filed a request for reconsideration and sought remand of the case to the ALJ for consideration of post-hearing medical reports, which employer attached to the reconsideration motion. Claimant opposed reconsideration but also submitted additional post-hearing medical reports. The Board denied reconsideration and denied the request to remand the claim to the ALJ. This petition for review followed.

We first address employer's argument that the Board erred in holding that claimant established good cause for the late hearing request. At the relevant time ORS 656.319 (1993) provided, in part:

> "(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforced unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial.

"(2) Notwithstanding subsection (1) of this section, a hearing shall be granted even if a request therefor is filed after the time specified in subsection (1) of this section if the claimant can show lack of mental competency to file the request within that time. The period for filing under this subsection shall not be extended more than five years by lack of mental competency, nor shall it extend in any case longer than one year after the claimant regains mental competency.

"(3) With respect to subsection (2) of this section, lack of mental competency shall only apply to an individual suffering from such mental disorder, mental illness or nervous disorder as is required for commitment or voluntary admission to a treatment facility pursuant to ORS 426.005 to 426.223 and 426.241 to 426.380 and the rules of the Mental Health and Developmental Disability Services Division."

167 Or App 331> Citing *McPherson v. Employment Division*, 285 Or 541, 591 P2d 1381 (1979), SAIF states that the standard of review for this assignment of error is for errors of law.[1] That is incorrect. In *Ogden Aviation v. Lay*, 142 Or App 469, 921 P2d 1321 (1996), we discussed the correct standard for reviewing the Board's determination of good cause under ORS 656.319. We held that good cause, as used in ORS 656.319, is a delegative term under *Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980). *Ogden Aviation*, 142 Or App at 473. We concluded that "[o]ur review here, thus, is to see whether the agency's determination of 'good cause' is within 'the range of discretion delegated to' the Board by ORS 656.319(1). ORS 183.482(8)(b)." *Id.* at 476. Thus, here we determine whether the Board's determination of good cause in this case is within the range of its delegated authority.

There is no question that claimant's request for hearing was filed more than 60 days after claimant's wife acknowledged receiving the denial. Claimant was required to establish good cause for the late hearing request. Good cause means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71 B(1). *Hempel v. SAIF*, 100 Or App 68, 70, 784 P2d 1111 (1990). Claimant argued that his mental condition caused him to be mentally incapacitated and thus he established good cause. The Board agreed.

SAIF argues that if the reason for the late request is mental incapacity, then subsections (2) and (3) of ORS 656.319 apply and require that claimant establish his lack of mental capacity under the standards set out in those subsections, which are the standards for commitment at a mental health treatment facility. The Board rejected SAIF's argument and held that the requirements contained in ORS 656.319(2) and (3) only apply to requests for hearing filed more than 180 days after the denial.

167 Or App 332> We need not decide whether the Board was correct in holding that ORS 656.319(2) and (3) do not apply to the first 180 days after a denial, because we conclude that those subsections apply only to cases of alleged mental incompetency. Here, claimant did not allege that mental incompetency excused his late filing; rather he alleged that his mental incapacity was good cause for the late hearing request. A mental problem less than incompetency could satisfy the requirement of good cause. It was within the range of the Board's discretion to determine that claimant established good cause based on his mental incapacity, and we conclude that the Board did not abuse its discretion.

In its second assignment of error, SAIF argues that the Board erred in holding that claimant's dementia is compensable. SAIF contends that the Board erred, as a matter of law, in relying on speculative medical opinions regarding the compensability of claimant's dementia. SAIF is wrong. This case, like those that Chief Judge Joseph discussed in *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988), involves conflicting medical evidence. Without further discussion, we hold that substantial evidence supports the Board's decision that claimant's dementia is compensable.

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[1] Claimant cites ORS 183.482(7) and (8) and states that review is "for errors of law, abuse of discretion, and substantial evidence." Such a recitation is neither helpful nor consistent with ORAP 5.45(6), which requires the brief to identify the "applicable standard of review." Normally, the applicable standard of review is not a multiple choice answer.

Finally, SAIF argues that the Board erred in failing to remand the claim to the ALJ for consideration of post-hearing medical records. SAIF argues that the Board applied the incorrect legal standard and also abused its discretion in refusing to remand the case to the ALJ. For the reasons that follow, we hold the Board did not abuse its discretion.

ORS 656.295(5) states that the Board's review "shall be based upon the record submitted to it * * *." If a party seeks to submit new evidence at the time of Board review, it must request remand to the ALJ. The Board may remand a claim if it determines that the claim was "improperly, incompletely or otherwise insufficiency developed." ORS 656.295(5).

In *Bailey v. SAIF*, 296 Or 41, 672 P2d 333 (1983), the court interpreted ORS 656.295(5) to require a two-step process:

> **167 Or App 333>** "First, the Board reviews the record, as defined, and determines whether the case has been 'improperly, incompletely or otherwise insufficiently developed.' Second, if this question is resolved in the affirmative, the Board exercises its discretion to determine whether to remand the case." *Id.* at 44.

We have said that there must be a compelling reason for remanding a case to the ALJ for the taking of additional evidence. *Warner v. SAIF*, 63 Or App 280, 283, 663 P2d 820, *rev den* 295 Or 730 (1983).

Formerly, this court had authority to "hear additional evidence concerning disability that was not obtainable at the time of hearing." ORS 656.298(6) (1985).[2] In *Compton v. Weyerhaeuser Co.*, 301 Or 641, 724 P2d 814 (1986), the Supreme Court interpreted ORS 656.298(6) (1985) to allow the Court of Appeals to hear new evidence when there was a compelling reason to do so. *Id.* at 646. The court said that a compelling reason exists when the new evidence (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. Id.

Here, the Board applied the tests set forth in both *Bailey* and *Compton* to determine whether the case should be remanded under ORS 656.295(5). It stated:

> "[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."

We acknowledge that *Compton* was about whether the Court of Appeals could take new evidence under former ORS 656.298(6), and its holding does not directly apply to the question whether the Board may remand under ORS 565.295(5). However, the statutory similarities permit reliance on *Compton* by analogy. We and the Supreme Court have held under both statutes that there must be a compelling reason to consider new post-hearing evidence. *Id.*; *Warner*, 63 Or App at 283. In *Compton*, the court reasoned **<167 Or App 333/334>** that the same compelling reason standard applied in both circumstances. 301 Or at 646. Thus, the Board did not err in applying that analysis in determining whether to remand to the ALJ for additional post-hearing evidence.

The Board noted that the medical experts at the time of the hearing were divided. The new medical reports concerned whether claimant's condition was static or changing.[3] Those medical reports continued to demonstrate that the medical experts' opinions on causation were divided. Based on the continuing conflict in the medical reports, the Board said that it could not find that the record at hearing was "improperly, incompletely or otherwise insufficiently developed" and concluded that there was no compelling basis for remand. Given the nature of the record and the proposed new evidence, we cannot say that the Board abused its discretion in refusing to remand the case under ORS 656.295(5).

Affirmed.

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[2] When this court lost *de novo* review of workers' compensation cases, it also lost the authority to consider evidence that was not part of the record below.

[3] According to SAIF, if claimant's condition continued to worsen, then this would support SAIF's theory that the compensable injury was not the cause of the dementia.

Cite as 167 Or App 343 (2000) May 17, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JAMES NEIGHBORS, Petitioner,
v.
DONALD BLAKE, CAROLYN BLAKE, COUNTRY MUTUAL INSURANCE COMPANY, and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.
(H98-011; CA A102041)

Judicial Review from Department of Consumer and Business Services.
Argued and submitted April 6, 1999.
Richard F. McGinty argued the cause and filed the brief for petitioner.
Vera Langer argued the cause for respondents Donald Blake, Carolyn Blake and Country Mutual Insurance Company. With her on the brief was Scheminske, Lyons & Bussman, LLP.
Philip Schradle, Assistant Attorney General, waived appearance for respondent Department of Consumer and Business Services.
Before De Muniz, Presiding Judge, and Haselton and Wollheim, Judges.
WOLLHEIM, J.
Reversed and remanded for determination of penalty.

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167 Or App 345> Claimant seeks reversal of a final order of the Director of the Department of Consumer and Business Services (DCBS) declining to assess a penalty under ORS 656.262(11).[1] Because we conclude that the late payment was unreasonable as a matter of law, we reverse.

The facts are uncontested. Claimant suffered an industrial accident that resulted in the traumatic amputation of his right forearm. In September 1997, pursuant to ORS 656.236, claimant and insurer entered into a claims disposition agreement (CDA) to dispose of all claimant's rights to workers' compensation benefits and payments except for payment of compensable medical expenses for which insurer was responsible. The CDA contained two provisions relevant to the case. The first stated that

> "the term 'compensation and payments of any kind due or claimed' does not include: (1) attorney fees or penalties associated with any act, or failure to act, occurring only after the day the [Workers' Compensation] Board receives this agreement[.]"

The second stated:

> "The parties further stipulate that payment pursuant to this agreement shall be timely if paid within *14 days after approval by the Workers' Compensation Board.*" (Emphasis added.)

The second provision is an express exception to the default requirements of OAR 436-060-0150(10) and OAR 438-009-0030(7). Those rules provide that payment of a CDA "shall be made no later than the 14th day after the Board *mails notice of its approval* of the agreement to the parties, unless otherwise stated in the agreement." (Emphasis added.) Insurer's attorney drafted the CDA.

167 Or App 346> The Board approved the CDA on October 16, 1997. Thus, by the terms of the CDA, payment was to be made by October 30. Also on October 16, the Board mailed a notice of approval to claimant's attorney, who received the notice on October 17. However, the Board did not mail notice to insurer until October 23. Insurer received that notice on October 24. On October 27, insurer issued a request for payment of the CDA funds to insurer's home office in Illinois. Due to interoffice mail delays, the payment checks were not received by insurer's Oregon office until November 3. Insurer mailed the CDA payment to claimant that same day, four days after the payment deadline.

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[1] ORS 656.262(11)(a) states, in part:

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

Claimant, consistent with the CDA, petitioned for an assessment of a penalty under ORS 656.262(11) due to insurer's late payment of compensation. The Sanctions Unit of the Workers' Compensation Division refused to order insurer to pay a penalty. DCBS concluded that insurer did not unreasonably delay the payment pursuant to the CDA and affirmed the denial of a penalty. In its order, DCBS noted that "[t]he problem in this case arises because of the terms of the CDA and because the Board mailed the Notice of Approval to the claimant seven days prior to mailing the Notice of Approval to the insurer." DCBS reasoned that holding insurer to the date established by the CDA would create an inequity because the late payment was not due to the fault of the insurer or to its lack of diligence.

On judicial review, claimant argues, *inter alia*, that the terms of the CDA dictate when a payment is considered timely and that any payment made after the agreed-to date was unreasonable. Therefore, claimant reasons, insurer should pay a penalty for the late payment. Insurer argues that the Board's CDA approval was not effective until it mailed the notice of approval to insurer and, thus, the payment was not untimely. In the alternative, insurer argues that it obtained notice of the CDA approval later than claimant through no fault of its own and, therefore, the four-day delay was not unreasonable.

Whether a delay is reasonable or unreasonable involves both legal and factual questions. First, DCBS makes **<167 Or App 346/347>** a factual finding about reasonableness. We review that finding for substantial evidence. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591, 763 P2d 408 (1988). Substantial evidence supports a finding when the record permits a reasonable person to make the finding. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990). In doing so, we must evaluate the evidence against the finding, as well as the evidence supporting it, to determine whether substantial evidence exists to support that finding. *Id.* In some instances, reasonableness or unreasonableness is determined as a matter of law. *See Finley v. SAIF*, 34 Or App 129, 132, 578 P2d 432 (1978). We conclude that no reasonable finder of fact could find that insurer's actions were reasonable in this instance and, therefore, the late payment was unreasonable as a matter of law. Two factors lead us to that conclusion: (1) the terms of the CDA; and (2) the factors under insurer's control that led to untimely payment.

We interpret the terms of a CDA as if it were a contract. *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455, 459, 909 P2d 187 (1996). The CDA unambiguously states that payment will be timely if made within 14 days after *approval* by the Board. That provision expressly states approval as the determining date, not mailing of notice as generally provided by regulation. Even if the CDA provision were to be considered ambiguous, any ambiguity in the CDA is resolved against insurer as the drafters of the CDA. *Heinzel v. Backstrom*, 310 Or 89, 96, 794 P2d 775 (1990). Because insurer drafted the CDA, it was incumbent on insurer to monitor when the CDA was approved by the Board. The terms of the CDA govern the determination of whether payment was timely and those terms must be considered when determining whether a late payment was unreasonable.

The Board's late mailing of the notice of approval was not the sole factor leading to the lateness of the CDA payment. Insurer cited several factors as contributing to the delay. The first factor was the Board's error. Insurer was informed of the Board's approval one week after claimant. The second factor was a delay in the request for payment sent to insurer's main office in Illinois. The record demonstrates that had the Oregon office requested payment from the home office the day insurer received notice, the check to claimant **<167 Or App 347/348>** would have been timely. Insurer knew it was operating on a 14-day clock from the date of approval, yet it failed to process the payment diligently. The third factor was a delay in processing the check request in the home office. The normal procedures dictated a same-day or next-day processing of checks. By using e-mail and overnight delivery, that procedure usually resulted in a 24- to 48-hour turn around time for payment checks to arrive in Oregon. Beyond an ambiguous "delays in interoffice mail" excuse, insurer offered no reason why, when the checks were requested on October 27, the checks did not arrive in Oregon until November 3. By seeking to avoid responsibility for its own unexplained errors, insurer attempts to shift onto claimant the burden of insurer's home office's failure to adhere to its own processing time line. The fourth factor concerns another of insurer's internal processing procedures. The record indicates that, had the home office mailed payment directly to claimant, payment would have been timely. However, insurer's processing procedures required that checks be routed first to the Oregon office, then to claimant. Again, insurer expects claimant to bear the consequences of insurer having adopted that practice. The final factor insurer claims contributed to the late payment was that the employee responsible for handling the payment was ending her employment on October 30. Insurer states that, for unexplained reasons, the

person who was supposed to take over the account was not informed of that fact until after the deadline for payment had passed. Regardless of whether that factor actually contributed to a delay in payment, it is not reasonable to expect claimant to make certain that insurer's employees were informed of, and properly processed, claimant's CDA payment.

Four of the five factors cited by insurer as leading to the delay in payment were under the control of insurer. Importantly, it was not impossible nor overly burdensome for insurer to comply with the CDA time line even with the Board's late notice--the one factor not under insurer's control. It is unreasonable to expect claimant to bear the burden of late payment due to factors under insurer's control. Claimant is entitled to prompt payment and insurer is required to pay compensation in a timely manner. ORS 656.262(2); *Lester v. Weyerhaeuser Co.*, 70 Or App 307, 311, 689 P2d 342, **<167 Or App 348/349>** *rev den* 298 Or 427 (1984). Insurer's internal problems do not justify the late payment of compensation to claimant. Internal processing errors and delays do not always constitute an unreasonable delay. However, in this instance, where the parties agreed to a particular time in a CDA drafted by insurer, where four of the five factors contributing to the late payment were under the control of insurer, and where timely payment was readily feasible despite delay by the Board, insurer's late payment of compensation was unreasonable as a matter of law. We therefore reverse and remand to DCBS to determine the proper penalty.

Claimant's final assignment of error does not warrant discussion.

Reversed and remanded for determination of penalty.

Cite as 167 Or App 425 (2000) May 24, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DOROTHY HARDIE, Appellant,
v.
LEGACY HEALTH SYSTEM, Respondent.
(9610-07813; CA A99826)

Appeal from Circuit Court, Multnomah County.
Jeffrey Kilmer, Judge pro tempore.
Argued and submitted October 21, 1998.
Jennifer Lanfranco argued the cause for appellant. On the briefs were Richard C. Busse, Scott N. Hunt, and Busse & Hunt.
Charles F. Hinkle argued the cause for respondent. With him on the brief were Christine Kitchel, David E. Van't Hof, and Stoel Rives LLP.
Before Landau, Presiding Judge, and Deits, Chief Judge,* and Wollheim, Judge.
WOLLHEIM, J.
Reversed and remanded on claim of retaliatory discrimination; otherwise affirmed.
Deits, C. J., concurring.
Landau, P. J., dissenting.

*Deits, C. J., *vice* Rossman, S. J.

167 Or App 427> Plaintiff commenced this action for damages against defendant, her former employer, alleging claims for retaliatory discrimination, ORS 659.410 (1995),[1] discrimination based on disability and perceived disability, ORS 659.425, and defamation, all arising out of defendant's treatment of plaintiff and ultimate termination of plaintiff's employment. The trial court granted defendant's motion for summary judgment, ORCP 47 C, and entered a judgment of dismissal on each claim. Plaintiff appeals and argues that there are genuine issues of material fact. We reverse and remand the judgment for defendant on the claim for retaliatory discrimination only. We otherwise affirm.

Viewing the evidence in the light most favorable to plaintiff, we review to ascertain whether defendant has shown that there are no genuine issues of material fact and that defendant is entitled to judgment as a matter of law. ORCP 47 C;[2] *Jones v. General Motors Corp.*, 325 Or 404, 408, **<167 Or App 427/428>** 939 P2d 608 (1997); *Quillen v. Roseburg Forest Products, Inc.*, 159 Or App 6, 9, 976 P2d 91 (1999).

[1] In all instances, we refer to the 1995 version of ORS Chapter 659 and to that version's accompanying administrative rules.

[2] ORCP 47 C (1997) provided, in part:

"The judgment sought shall be rendered forthwith if the pleadings, depositions, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. No genuine issue as to a material fact exists if, based upon the record before the court viewed in a manner most favorable to the adverse party, no objectively reasonable juror could return a verdict for the adverse party on the matter that is the subject of the motion for summary judgment."

Or Laws 1999, ch 815, amended ORCP 47 C. Section one of the act made only a few changes to the text quoted from the 1997 rule above. Significantly, however, it added the following:

"The [*judgment sought shall be rendered forthwith*] **court shall enter judgment for the moving party** if the pleadings, depositions, **affidavits** and admissions on file[, *together with the affidavits, if any,*] show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter law. No genuine issue as to a material fact exists if, based upon the record before the court viewed in a manner most favorable to the adverse party, no objectively reasonable juror could return a verdict for the adverse party on the matter that is the subject of the motion for summary judgment. **The adverse party has the burden of producing evidence on any issue raised in the motion as to which the adverse party would have the burden of persuasion at trial. The adverse party may satisfy the burden of producing evidence with an affidavit under section E of this rule.**" (Italics and boldface in original.)

Here, defendant bears the burden of showing the absence of any triable issues. *Jones*, 325 Or at 420. Indeed, where a plaintiff has established a prima facie case for recovery and a defendant has "identified a factual question on which [the] plaintiff would have the burden at trial, [the] defendant[] cannot prevail on summary judgment." *Id.* Defendant must show that "no objectively reasonable juror could return a verdict" for plaintiff. *Id.* at 412.

Because plaintiff's case rests primarily on inferences, rather than on direct evidence, we discuss the evidence in some detail. The evidence most favorable to plaintiff establishes that she was an employee of defendant, Legacy Health System, and its predecessor from 1988 until late April 1996, when defendant discharged plaintiff. Until December 1995, plaintiff received generally positive work performance reviews in her positions in the accounts payable and purchasing departments. However, plaintiff admitted that some of those reviews noted inconsistency in her work performance and morale. In October 1995, Lisa Davis became plaintiff's supervisor in the purchasing department. At that time, plaintiff held the position of "Capital Buyer" with the corporate office.

In mid-December 1995, plaintiff and Davis had a work-related disagreement, in which Davis noted plaintiff's "insubordination" toward Davis. Several days later, Davis **<167 Or App 428/429>** conducted her first performance review of plaintiff and made a preliminary determination that plaintiff's performance was "unacceptable." Davis noted plaintiff's frequent absences due to illness, her frequent tardiness and smoke breaks, and her chronic backlog of work. Davis concluded that she was unable, at that time, to complete the review and informed plaintiff that she would complete it at a later time after further observation. From the beginning of January until plaintiff called in sick on the 23rd, plaintiff was late to work every day that she reported for work.[3]

On January 24, 1996, plaintiff left a voice mail message for Davis indicating that plaintiff would be absent for an "indeterminate period of time" due to stress. Davis learned from Dennis Phister, her supervisor in the human resources department, that plaintiff planned to file a workers' compensation claim for emotional problems and stress and that plaintiff had arranged for her personal belongings to be picked up by a friend. Davis stated that January 24 was the first day that she learned of plaintiff's emotional distress. Davis and Phister met that day regarding plaintiff. In Davis's notes from that meeting, she wrote "*Termination Plan*" at the top of the page. Further down the page, she specifically mentioned plaintiff's "*Workers' Compensation/Stress*" claim and resolved to "post job immediately" as well as to "be ready for her if/when she does return." Other notes drafted by Davis concerning plaintiff also chronicled plaintiff's work deficiencies and noted her frequent absences due to illnesses. On January 29, 1996, Davis wrote a note to the file concerning plaintiff. In that note, Davis recorded her observations that plaintiff was often sick. She also noted that:

> "When [plaintiff] called in sick with another migraine on 1/23/96, it was not a surprise. * * *
>
> "[Plaintiff] appears to have things in her personal life which are causing her to be unable to perform her work, and she needs to get treatment and find resolution. I support whatever services Legacy makes available to its employees at times such as this in an individual's life.

Section two of the act provides that "[t]he amendments to ORCP 47 C * * * apply to all actions pending on or commenced after the effective date of this 1999 Act."

This case was pending before the Court of Appeals, not the circuit court, when the amendment went into effect. The parties do not argue that any changes effected by the amendment to ORCP 47 C should be applied in this case in the first instance on appeal, and we decline to apply those amendments on our own motion. *See Doe v. American Red Cross*, 322 Or 502, 910 P2d 364 (1995) (in affirming reversal of summary judgment on the ground that the moving party had failed to demonstrate the absence of a genuine issue of material fact, Supreme Court did not apply on its own motion the 1995 amendments to ORCP 47 C that applied to "all actions, whether commenced before, on or after the effective date" of the amendments); *cf. Jones v. General Motors Corp.*, 139 Or App 244, 264, 911 P2d 1243 (1996), *aff'd on other grounds* 325 Or 404, (939 P2d 608 (1997) (applying revised summary judgment standard on appeal would violate due process); *see also State v. Meyers*, 153 Or App 551, 559-60, 958 P2d 187 (1998) (changing the rules of evidence retroactively raises serious questions of due process).

[3] Plaintiff was absent from work on January 4 and 5 due to panic attacks.

"* * * * *

> **167 Or App 430>** "Should [plaintiff] recuperate from her stress and wish to return at Legacy, it is my understanding that the organization is obliged to find a position for her which is amenable to her prognosis for coping and performance at that time. There is not any anticipated diminishment of stress in the Purchasing Department over the coming year, inasmuch as we have taken on substantial additional commitment of work in support of the organization."

On January 31, 1996, plaintiff filed her workers' compensation claim for panic attacks and stress, originating from her negative performance review with Davis. Davis stated that that was the first time that she learned that plaintiff suffered from panic attacks. Plaintiff also stated that she suffered from agoraphobia.[4] Dr. Goranson, a psychiatrist, evaluated plaintiff in March 1996. Goranson diagnosed plaintiff with "adjustment disorder with mixed emotional features now mostly resolved," and concluded:

> "I don't think that there will be any permanent impairment related to her current psychiatric condition (which I think is work related only in the sense of it being related to reasonable disciplinary action). With respect to the question whether she is able to return to work, I would think she could return to work, from a psychiatric standpoint. Given her feelings about that particular workplace, it is doubtful that such a situation would work out to anyone's satisfaction."

Plaintiff remained on leave with time loss pay until March, when Legacy offered plaintiff a "light duty" position at another facility. Plaintiff was offered the same rate of pay for operating a photocopier machine 40 hours a week. After a day and a half of work, plaintiff left that position because she experienced panic attacks. Plaintiff requested that she be transferred back to her original facility in the purchasing department. No action was taken on that request.

In early April 1996, Davis received an inquiry from a Legacy accountant regarding a questionable purchase originating from Davis's department. Davis retrieved the purchase order and discovered that plaintiff had authorized an employee purchase of a microwave for herself in October **<167 Or App 430/431>** 1995 and that plaintiff had yet to pay for the microwave. Davis then wrote to Phister about her "serious concern" that plaintiff "abused her position as a Buyer for personal gain, and did so without authorization or knowledge of anyone in the department." She also explained that plaintiff "did not pay * * * for the item, allowing [defendant] to pay the vendor for it. [Plaintiff] had ample opportunity to make payment for this purchase, if she was to make a legitimate transaction, but she did not."

Defendant had a policy to be fair to employees and to withhold judgment until an investigation of wrongdoing is completed. On April 17, 1996, Phister and Davis met with plaintiff about the purchase. No written policy existed for employee purchases. It appears those purchases were allowed, and plaintiff believed she followed most of the normal procedures for making such a purchase. Plaintiff, however, admitted that a supervisor, not the employee purchaser, was supposed to authorize the purchase and that buyers were supposed to avoid even the appearance of impropriety. At the meeting, plaintiff told Phister and Davis that she had authorized the purchase and had paid for it. However, when she returned home, she discovered that she had not paid for the item.[5] The next day she sent a check and a note of apology, recognizing her "serious error" and that she thought she had paid for the item. Plaintiff stated that she viewed the matter "as serious an issue as [Phister and Davis] obviously * * * did."

Davis recommended to Phister that plaintiff's employment be terminated because of the employee purchase. On April 23, 1996, Phister terminated plaintiff's employment. In the termination letter, Phister cited only plaintiff's unauthorized employee purchase of the microwave as the reason for discharge. He noted that, because plaintiff was an "experienced Buyer," she knew the purchasing process from start to finish and was familiar with the need for prior approval of employee purchases. Thus, her failure to **<167 Or App 431/432>** obtain approval and to pay for the item until five months after receiving the item represented "poor judgment" and constituted cause for termination.

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[4] Plaintiff defined agoraphobia as a fear of leaving her home.

[5] Plaintiff later indicated that she attempted to pay for it when she picked up the appliance but was told to wait to pay until the invoice arrived. She claims that she was not informed when the invoice arrived, and plaintiff never inquired again about the invoice.

At some date after plaintiff's discharge, an employee of defendant told a third party, Maggie Brister, that plaintiff purchased an appliance through defendant "without paying for it." That statement was made in the context of plaintiff's discharge. Two months after her discharge, plaintiff accepted employment with a different employer as an accounts payable clerk. At the time of the motion for summary judgment, plaintiff worked as an office manager at a local business.

Plaintiff filed a complaint alleging four claims for relief. The first claim alleged that her employment was terminated in retaliation for filing her workers' compensation claim. The second and third claims alleged, in essence, that defendant discriminated against plaintiff, based on her disabilities or perceived disabilities of agoraphobia and panic attacks, by failing to accommodate her disability in the work place and by discharging her. Plaintiff's fourth claim was for defamation regarding the statements made to Brister about plaintiff's discharge.

The trial court found that plaintiff was not disabled under ORS 659.425(1), because plaintiff's disability was only temporary with no lasting effects. It also concluded that defendant discharged plaintiff because of her unauthorized employee purchase and not in retaliation for her workers' compensation claim or due to any disability or perceived disability. Last, the court concluded that the statements to Brister about plaintiff's employee purchase were not defamatory, in part because plaintiff admitted that the unauthorized employee purchase raised a "serious issue" about her honesty and fitness. We agree that merely reciting the stated basis for plaintiff's discharge is not, under these circumstances, defamatory. We, therefore, affirm the trial court's ruling on the defamation claim and limit our discussion to the three discrimination claims.

We first address plaintiff's retaliatory discrimination claim. ORS 659.410(1) makes it unlawful for an employer to discriminate against a worker who files a workers' compensation claim. To establish a *prima facie* case for **<167 Or App 432/433>** retaliatory discrimination under ORS 659.410(1), plaintiff must show

> "(1) that the plaintiff invoked the workers' compensation system; (2) that the plaintiff was discriminated against in the tenure, terms or conditions of employment; and (3) that the employer discriminated against the plaintiff in the tenure or terms of employment because he or she invoked the workers' compensation system." *Stanich v. Precision Body and Paint, Inc.*, 151 Or App 446, 457, 950 P2d 328 (1997).

Plaintiff satisfied the first two elements by producing evidence that she filed the workers' compensation claim and that defendant subsequently terminated her employment. Thus, to complete a *prima facie* case, plaintiff must establish that defendant discharged her *because* she had filed a workers' compensation claim. Considering the totality of the circumstances, we focus on whether a triable issue exists concerning defendant's motive for plaintiff's discharge.

An employer may discharge an employee "for cause," notwithstanding the existence of a workers' compensation claim, so long as the discharge is not motivated by the claim. *Vaughn v. Pacific Northwest Bell Telephone*, 289 Or 73, 91, 611 P2d 281 (1980) ("[A]n employer may discharge for cause and not violate the statutory discrimination provisions. But an employer may not discharge if the motivation is discrimination proscribed by statute.").

Here, plaintiff alleges that filing her workers' compensation claim was a "substantial factor," but not the only factor, contributing to her discharge. Because she is claiming that her "discharge [was] motivated in part by * * * misconduct and in part by unlawful discrimination by the employer," plaintiff's claim alleges a "mixed motive" for her discharge. *Shaw v. Doyle Mining Co.*, 297 Or 251, 256, 683 P2d 82 (1984). Defendant denies any discriminatory motive and asserts a nondiscriminatory reason for its termination of plaintiff, namely an unauthorized employee purchase. Viewing the evidence in the light most favorable to plaintiff, we conclude, for the purposes of review here, that plaintiff's workers' compensation claim played some factor in the decision to terminate her and that her claim is a "mixed motive" claim.

"Mixed motive," as used in employment discrimination claims arising under Oregon law, is not the term of art it is under federal discrimination claims. Under federal law, the factfinder analyzes a discrimination claim as either a "pretext" claim, which carries a shifting burden of production, or as a

"mixed motive" claim, which carries a shifting burden of production *and* persuasion when the plaintiff can produce "direct evidence of discriminatory animus." *Price Waterhouse v. Hopkins*, 490 US 228, 278, 109 S Ct 1775, 104 L Ed 2d 268 (1989) (O'Connor concurring). *See also Fernandes v. Costa Brothers Masonry, Inc.*, 199 F3d 572, 579-81 (1st Cir 1999) (describing the two approaches); *Fuller v. Phipps*, 67 F3d 1137, 1141-44 (4th Cir 1995) (also describing legislative changes to the "mixed motive" analysis established by *Price Waterhouse*). Under the federal scheme, a claim is designated as a "mixed motive" claim only when the plaintiff meets a heightened evidentiary burden, not from the mere existence of multiple motives. *Id.* at 1142. If this were a federal claim, we would have to determine whether Davis's notes from the January 24 meeting, where plaintiff's workers' compensation claim and a termination plan were discussed, constituted "direct evidence of discriminatory animus" sufficient to invoke the shifting burden of proof for a "mixed motive" claim. Oregon employment discrimination analysis differs from the federal approach.

The Oregon Supreme Court has rejected the shifting burden of production scheme for "pretext" claims (sometimes referred to as "simple" or "either-or" claims) brought under Oregon law. *City of Portland v. Bureau of Labor and Ind.*, 298 Or 104, 114-15, 690 P2d 475 (1984). In prior opinions, this court has questioned whether the burden-shifting scheme employed for federal "mixed motive" claims applies to similar claims arising under Oregon law. *See Marconi v. Guardian Management Corp.*, 149 Or App 541, 550-51, 945 P2d 86 (1997); *McCall v. Dynic USA Corp.*, 138 Or App 1, 8, 906 P2d 295 (1995); *Callan v. Confed. of Oreg. Sch. Adm.*, 79 Or App 73, 78, 717 P2d 1252 (1986). Because the Supreme Court has rejected the shifting burden of production scheme for "pretext" discrimination claims, we believe it would also reject the more onerous shifting burden of proof for "mixed motive" claims. We therefore hold that there is no shifting burden of **<167 Or App 434/435>** proof for "mixed motive" employment discrimination claims brought under Oregon law. Consequently, there is no distinction between how "pretext" claims and "mixed motive" claims are analyzed under Oregon law. Because we reach this conclusion, the concerns about the procedural distinctions between the two types of claims that Chief Judge Deits expresses in her concurrence are not an issue.

To prevail in a "mixed motive" claim, a plaintiff must be able to "show that he or she 'would not have been fired but for the unlawful discriminatory motive of the employer.'" *McCall*, 138 Or App at 8 (quoting *Vaughn*, 289 Or at 92). We have not further clarified the meaning of the "but for" standard in employment discrimination cases. However, *NLRB v. Whitfield Pickle Company*, 374 F2d 576, 582 (5th Cir 1967), a case cited by *Vaughn*, 289 Or at 92, describes "but for" causation as meaning "in the absence of the [discriminatory motive, the employer] would have treated the employee differently."[6] We have also described the evidentiary standard for employment discrimination claims by using language other than "but for." In *Seitz v. Albina Human Resources Center*, 100 Or App 665, 675, 788 P2d 1004 (1990), we held that the protected activity must be a "substantial factor" in the wrongful discharge.[7] In *Estes v. Lewis and Clark College*, 152 Or App 372, 381, 954 P2d 792, *rev den* 327 Or 583 (1998), we held that an employer's wrongful purpose must be "a factor that made a difference." The crux of the standard, regardless of which phraseology is attached to it, is whether, in the absence of the discriminatory motive, the employee would have been treated differently. We conclude that plaintiff's **<167 Or App 435/436>** evidence raises a genuine issue of material fact regarding whether defendant would have fired plaintiff but for her decision to file a workers' compensation claim.

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[6] In *Price Waterhouse*, 490 US at 240, the United States Supreme Court explained:

> "But-for causation is a hypothetical construct. In determining whether a particular factor was a but-for cause of a given event, we begin by assuming that that factor was present at the time of the event, and then ask whether, even if that factor had been absent, the event nevertheless would have transpired in the same way."

If an event would have transpired in the same way, a factor is not a "but for" cause.

[7] In *Seitz*, we imported that qualification from Title VII of the Federal Civil Rights Act and the tortuous wrongful discharge jurisprudence, noting that Oregon's employment discrimination laws are modeled after Title VII. Thus, that federal case law is instructive in Oregon employment discrimination cases. *Id.* at 672-73; *see also Winnett v. City of Portland*, 118 Or App 437, 442, 847 P2d 902 (1993) (applying "substantial factor" test to ORS 639.030(1)(b)).

Plaintiff's evidence focuses on the actions of her supervisors, Phister and Davis. Plaintiff can survive the motion for summary judgment only if the evidence permits a jury to find either (1) that as the supervisor who actually discharged plaintiff, Phister was motivated to discharge plaintiff because of her workers' compensation claim; or (2) that Davis was the wrongfully motivated supervisor and was so influential in the decision to discharge plaintiff as to be a "substantial factor" in the discharge. *Id.* at 382.

Plaintiff argues that a jury may infer from her evidence that Phister discharged her because of her workers' compensation claim. She points to Davis's notes from the January 24 meeting between Davis and Phister. In these notes, Davis specifically mentioned a "termination plan" in connection with plaintiff's workers' compensation claim. Davis's notes indicate that Phister and Davis discussed terminating plaintiff more than two months *before* either was aware of the purchase of the microwave. Thus, a reasonable juror could infer that Phister reached his decision to fire plaintiff because she filed a workers' compensation claim. Even if we assume that Davis's notes cannot supply direct evidence of Phister's motives, the notes, at the very least, supply evidence of Davis's discriminatory motive. Further, the record reveals that, as plaintiff's direct supervisor, Davis's recommendation to Phister to discharge plaintiff "made a difference" in the decision to terminate plaintiff's employment. *Estes*, 152 Or App at 381. Interpreting these facts in the light most favorable to plaintiff, we conclude that plaintiff has made a *prima facie* case of employment discrimination.

Defendant offers a nondiscriminatory motive for the discharge of plaintiff. Indeed, plaintiff admitted violating the unwritten policy about employee purchases, that the violation was a "serious error," and that she bore a duty to avoid even the "appearance of impropriety." Defendant also refutes some of plaintiff's evidence of pretext--namely by arguing that the investigation into the employee purchase was fair, **<167 Or App 436/437>** and that, regardless of whether or not the employee purchase policy was written, plaintiff admitted to violating defendant's policy. However, on summary judgment, defendant bears the burden to show that there are no genuine issues of material fact. In *Callan*, we explained that we understand plaintiff's *initial prima facie* burden in employment discrimination cases "as being so minimal that it is virtually impervious to a motion based on evidentiary sufficiency." 79 Or App at 78 n 3. Likewise, the Ninth Circuit, applying Oregon law, concluded that where an employee establishes a *prima facie* claim of unemployment discrimination, summary judgment is inappropriate even in the face of assertions by the defendant of nondiscriminatory action. *Messick v. Horizon Industries Inc.*, 62 F3d 1227, 1232 (9th Cir 1995). Furthermore, in *Henderson v. Jantzen, Inc.*, 79 Or App 654, 658, 719 P2d 1322, *rev den* 302 Or 35 (1986), we said "[a] plaintiff's *prima facie* case does not disappear merely because a defendant asserts a nondiscriminatory reason which may or may not persuade the trier of fact." Defendant's evidence does not negate the inference that plaintiff's workers' compensation claim motivated defendant's "termination plan."

We note that this case is not analogous to *Estes*, where we affirmed summary judgment in favor of the employer. In *Estes*, as here, the employer advanced a nondiscriminatory motive to discharge the plaintiff. However, in *Estes*, the plaintiff was unable to adduce *any* evidence to support an inference of discriminatory motive on the part of the supervisors who actually discharged her. In contrast, here, plaintiff has produced evidence sufficient to support such an inference. Defendant's evidence does not, in turn, negate the inference from which an objectively reasonable juror could conclude that, more probably than not, plaintiff's workers' compensation claim was a "substantial factor" in defendant's motivation to discharge plaintiff. *Estes*, 152 Or App at 381. Thus, a "triable issue" remains, and we therefore reverse the trial court's grant of summary judgment on the workers' compensation discrimination claim and remand that claim for trial.[8]

167 Or App 438> We turn next to plaintiff's claims of discrimination based on disability and perceived disability. ORS 659.425(1) makes it unlawful for an employer to discriminate against an individual because

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[8] The dissent argues that, because defendant took no steps to fire plaintiff for four months after it learned about plaintiff's workers' compensation claim and fired plaintiff only after it learned about plaintiff's employee purchase, the evidence proves only that defendant contemplated discharging plaintiff in retaliation for her workers' compensation claim. We do not agree. Rather, the strength of plaintiff's inference makes it possible for a reasonable jury to conclude that the employee purchase was merely a pretext for discharging her and that she "would not have been fired but for the unlawful discriminatory motive of the employer." *McCall*, 138 Or App at 8 (quoting *Vaughn*, 289 Or at 92). Indeed, that is the very *fact* issue of this case, which is in the jury's, not the judge's, province to resolve.

"(a) An individual has a physical or mental impairment which, with reasonable accommodation by the employer, does not prevent the performance of the work involved;

" * * * * *

"(c) An individual is regarded as having a physical or mental impairment."

On appeal, plaintiff argues that the evidence demonstrates a disputed question of fact as to whether defendant failed to "reasonably accommodate" her disabilities of agoraphobia and panic attacks. She also argues that the evidence creates a disputed question of fact as to whether defendant discriminated against her through adverse employment actions, including termination, because it perceived her as disabled. We conclude that summary judgment was appropriate, because the record demonstrates neither a genuine issue as to a material fact regarding whether plaintiff is a "disabled person" nor whether defendant perceived plaintiff as disabled.

To make out a *prima facie* case for disability discrimination under ORS 659.425, plaintiff must present sufficient evidence that she is a "disabled person." *Marconi*, 149 Or App at 547-48. ORS 659.400(1) defines a "disabled person" as "a person who has a physical or mental impairment which substantially limits one or more major life activities * * *." We assume, without discussion, that plaintiff's alleged conditions of agoraphobia and panic attacks are cognizable "mental impairments" under ORS 659.400(1). A "major life activity" includes employment. ORS 659.400(2)(a). Plaintiff must **<167 Or App 438/439>** establish that her disabilities prevented her from performing "the work involved," as opposed to employment generally, or employment with a particular employer in a position of plaintiff's choosing. *Winnett*, 118 Or App at 446-47. The work involved here is that of "buyer." It is undisputed that, at one point, plaintiff was unable to report to her job and complete the duties of buyer. It is also undisputed that plaintiff is now able to work, generally. Thus, we must consider whether her alleged disabilities still prevent her from completing the duties of "buyer."

Defendant argues that, even accepting plaintiff's reports of panic attacks and self-diagnosis of agoraphobia, those mental impairments were only temporary and thus not a "disability." Alternatively, defendant argues that, to the extent plaintiff's conditions still impede her employment capabilities, those conditions only prevent her from working as a capital buyer under the supervision of Davis in the purchasing department. "Short term physical or mental impairments leaving no residual disability or impairment are not disabilities * * *." OAR 839-06-240(1) (1996). Plaintiff counters that there is evidence that her conditions are "mutable" and are therefore disabilities. OAR 839-06-240(3) (1996). "Mutable conditions [are those] which are controllable by diet, drug therapy, psychotherapy, or other medical means * * *." *Id.*

Plaintiff's workers' compensation claim form and the medical testimony indicate only that she could not perform the duties of buyer *under the supervision of Davis*. On plaintiff's self-report, Davis was the source of her stress and resulting panic attacks and agoraphobia. Indeed, even Goranson specifically noted that plaintiff's attitudes toward defendant's work environment was the only impediment to her returning to work. Goranson also concluded that there would be no "permanent impairment related to [plaintiff's] current psychiatric condition," and that plaintiff could return to work "from a psychiatric standpoint." Thus, Goranson concluded that plaintiff's psychological conditions would dissipate and not impede her ability to work. Nothing in the record allows a fact finder to infer that plaintiff is incapable of performing the work of "buyer," generally. We therefore conclude that there is no issue of material fact as to whether **<167 Or App 439/440>** plaintiff is a "disabled person" under ORS 659.425 and affirm summary judgment for defendant on that claim.

Similarly, the record is devoid of any indication that Davis, Phister, or any other employee of defendant perceived plaintiff as disabled. Davis's January 29 notes and other memos suggest that Davis perceived plaintiff as prone to migraine headaches and other illnesses and that the absences attendant to such illnesses affected plaintiff's ability to complete her work. Such notations, made both before and after plaintiff's panic attacks began to occur, do not, under the circumstances, give rise to a question of whether Davis perceived plaintiff's stress and panic attacks as incapacitating plaintiff indefinitely.[9]

[9] We do not mean to infer that a plaintiff must actually suffer from a disability before we can recognize an employer's perception of disability. Perceived disabilities do not have to be real. *OSCI v. Bureau of Labor and Industries*, 98 Or App 548, 553, 780 P2d 743, *rev den* 308 Or 660 (1989). However, in this case, the timing of the onset of plaintiff's alleged disability is probative of what her employer perceived.

Rather, Davis's January 29 notes indicate that Davis perceived plaintiff's personal situation as temporary and that Davis contemplated its resolution and plaintiff's recuperation. The most that can be inferred from Davis's notes is that her *particular department* may not be amenable to plaintiff because of the stress involved in *that department*, but it does not support an inference that Davis believed that plaintiff could not perform the work of a buyer. The evidence does not support an inference that Davis perceived plaintiff as disabled. Accordingly, we affirm the summary judgment in favor of defendant on the issue of perceived disability.

We reverse judgment in favor of defendant on the retaliatory discrimination claim, ORS 659.410, and remand that claim for trial. We affirm judgment in favor of defendant on the disability discrimination, ORS 659.425, perceived disability discrimination, ORS 659.425, and defamation claims.

Reversed and remanded on claim of retaliatory discrimination; otherwise affirmed.

DEITS, C. J., concurring.

I agree with the lead opinion's holding, including its conclusion that there are genuine and disputed questions of material fact that preclude summary judgment against plaintiff on her claim for retaliatory discrimination. However, I do not agree with the lead opinion's analysis of the "mixed motive" doctrine and of how that doctrine applies to this and other employment discrimination cases arising under ORS chapter 659.

In *Vaughn v. Pacific Northwest Bell Telephone*, 289 Or 73, 91, 611 P2d 281 (1980), the Oregon Supreme Court adopted a variation of the federal mixed motive doctrine for application in discrimination actions under the Oregon statutes. It may be, as the lead opinion suggests, that the doctrine is somewhat discordant in the context of Oregon discrimination law as it has evolved since *Vaughn* was decided. It also appears to be the case that federal law on the subject has changed considerably since the decision in *Vaughn*, while Oregon mixed motive law has remained more or less static. Nevertheless, *Vaughn* remains a controlling interpretation of an Oregon statute by the Oregon Supreme Court.

In my view, neither the lead opinion nor the dissent correctly apply *Vaughn* or the mixed motive doctrine as it has been formulated in that and the other pertinent Oregon cases. The lead opinion correctly distinguishes between "pretext" cases, where the issue is simply whether the employer acted out of a discriminatory motive, and mixed motive cases, where the employer had both lawful and unlawful motives and the issue is whether the discharge or other employment action would have been taken but for the unlawful one. 167 Or App at 434-35. The lead opinion is also correct in stating that the Oregon courts have held that the "shifting burden" formulation of the federal case law is inapplicable in pretext-type actions under the state statute. The lead opinion concludes:

> "Because the Supreme Court has rejected the shifting burden of production scheme for 'pretext' discrimination claims, we believe it would also reject the more onerous shifting burden of proof for 'mixed motive' claims" 167 Or App at 435.

167 Or App 442> With all respect, I think that the lead opinion misses the point. The "shifting burden" rubric that has been adopted by the federal courts and rejected by the Oregon cases pertains only to the mechanics of proof of the *plaintiff's* case, and it applies only in the *pretext* case context. Those mechanics were explained in *Lewis and Clark College v. Bureau of Labor*, 43 Or App 245, 252, 602 P2d 1161 (1979), *rev den* 288 Or 667 (1980) (Richardson, J., dissenting):

> "[The employer] concedes that [the female claimant] made a prima facie showing of discrimination. That means, in essence, that she proved she applied for the position, that she was qualified for the position, that she was not interviewed or hired, and that a male applicant was interviewed and hired. Those facts constitute a prima facie case under the United States Supreme Court's decision in *McDonnell Douglas Corp. v. Green*, 411 US 792, 93 S Ct 1817, 36 L Ed 2d 668 (1973), and later decisions relating to burden and order of proof in discrimination cases under Title VII of the Civil Rights Act of 1964 (42 USC section 2000e *et seq.*). Under *McDonnell Douglas*, after the complainant makes such a prima facie showing, the burden shifts to the employer to 'articulate some

> legitimate, nondiscriminatory reason' for its action. 411 US at 802. If the employer articulates such a reason, the burden is on the complainant to prove that the employer's purported reason is not the actual reason or is a pretext."

Conversely, under the mixed motive doctrine, as presently formulated by the Oregon statutes and decisions, there is no question about the burden of proof--shifting or otherwise--that applies to the establishment of the *plaintiff's* case. Rather, the existence of the concurrent lawful motive is a "matter of defense," Vaughn, 289 Or at 80, that, like any other affirmative defense, the defendant has the burden of proving. As the Supreme Court explained in *Shaw v. Doyle Milling Co.*, 297 Or 251, 255-257, 683 P2d 82 (1984):

> "Employer argues that under our decision in *Vaughn v. Pacific Northwest Bell Telephone, supra, Shaw* cannot prevail because he did not prove that he would not have been discharged 'but for' a discriminatory motive of his employer. In *Vaughn* we stated:
>
> **167 Or App 443>** "'If the worker is discharged for just cause, the employer can prove this * * * as a matter of defense in a suit pursuant to ORS 659.121.'
>
> "289 Or at 80. We formulated the 'just cause' issue:
>
> "'The question then is what effect the employer's evidence of just cause for discharge has on the court's remedial authority in OR 659.121(1).'
>
> "289 Or at 90. We did state that in cases of mixed motives for the discharge, *i.e.*, where the discharge is motivated in part by poor work record or misconduct and in part by unlawful discrimination by the employer, the employee could not prevail unless the court
>
> "'finds that the employee would not have been discharged but for the unlawful discriminatory motive of the employer.'
>
> "289 Or at 92. In the case at bar the invocation of that language from *Vaughn* is of no avail.
>
> "* * * * *
>
> "In the instant case, Employer did not establish any just cause for discharge; therefore, Shaw did not have to show that he would have been reinstated 'but for' Employer's unlawful employment practice."

See also Callan v. Confed. of Oreg. Sch. Adm., 79 Or App 73, 78, 717 P2d 1252 (1986) and authorities there cited; *cf. Lane County Public Works Assn. v. Lane County*, 118 Or App 46, 52, 846 P2d 414 (1993) (stating analogous principle as to "mixed motive" doctrine in context of labor law case).

In my opinion, when the mixed motive doctrine in the Oregon cases is properly understood and applied, it does not, as the lead opinion indicates, place a "more onerous" burden of proof on plaintiffs than the one that applies in simple "pretext" cases. 167 Or App at 435. In both instances, the plaintiff employee has the ultimate burden of establishing that the employer acted with an unlawful motive that contributed causally to the discharge or other employment action. It *may* be that, in mixed motive cases, the "but for" test of causation is higher than the causation test in straight "pretext" cases. However, before that heightened test becomes applicable, the employer must prove not only that **<167 Or App 443/444>** there was an alternative reason for the discharge than the discriminatory motive that the plaintiff must prove in any event, but that the alternative reason amounts to objective "just cause." Ironically, notwithstanding its concern over placing a more onerous burden on the plaintiff, the end result of the lead opinion's analysis is to apply the "but for" causation test to the plaintiff, without placing any intervening burden on the defendant to establish affirmatively that it was motivated by anything other than discrimination.

Under any conceivable standard of who must prove what, however, I agree with the lead opinion that the evidence in this summary judgment proceeding was such that a trier of fact could infer that defendant's improper motive was the reason for plaintiff's discharge.[1]

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[1] It is important to emphasize that federal and state law on the mixed motive doctrine have never been identical--except possibly for the fleeting moment that *Vaughn* was decided. This opinion is based on my understanding that *Vaughn* and *Shaw* continue to embody Oregon law, despite the fact that the federal cases have passed them from a variety of directions since their decision.

LANDAU, P. J., dissenting.

Although I agree with the majority's disposition of plaintiff's other claims, I do not agree with its decision to reverse the trial court's entry of summary judgment in favor of defendant on the retaliatory discharge claim. In my view, the trial court was correct in concluding that defendant is entitled to judgment on that claim as a matter of law.

As I understand the law, to establish a retaliatory discharge claim, a plaintiff must show that "he or she 'would not have been fired but for the unlawful discriminatory motive of the employer.'" *McCall v. Dynic USA Corp.*, 138 Or App 1, 8, 906 P2d 295 (1995) (quoting *Vaughn v. Pacific Northwest Bell Telephone*, 289 Or 73, 92, 611 P2d 281 (1980)).

In this case, at most, the facts show that defendant *contemplated* terminating plaintiff near the time when her supervisors learned that she intended to file a workers' compensation claim. It was then, in January 1996, that plaintiff's supervisors met to discuss a "*Termination Plan*" and, at that same meeting, also mentioned plaintiff's "*Workers' Compensation/Stress*" claim. Plaintiff, however, must prove more **<167 Or App 444/445>** than that defendant thought about terminating her position. Instead, a reasonable juror must be able to find that she "'*would not have been fired* but for the unlawful discriminatory motive of the employer.'" *McCall*, 138 Or App at 8 (quoting *Vaughn*, 289 Or at 92) (emphasis added). That is the missing step in plaintiff's proof in this case. After the January 1996 meeting, defendant took no steps to fire plaintiff. On the contrary, plaintiff remained on leave with time loss pay until March, when defendant offered plaintiff a "light duty" position. Even after plaintiff worked only a day and a half at that position, before leaving because she experienced panic attacks, defendant still did not seek to terminate plaintiff's position.

On this record, the undisputed evidence is that, however defendant may have felt about plaintiff and about the fact that she had filed a workers' compensation claim, defendant did not fire her or take any steps to fire her until her supervisors learned, in April 1996, that she had made an unauthorized purchase for which she never reimbursed defendant. That was some four months after plaintiff left her job and three months after she filed her workers' compensation claim. Only then did defendant decide to fire her and terminate her job. On this evidence, no reasonable juror could find that plaintiff "would not have been fired but for the unlawful discriminatory motive of the employer," if any. *McCall*, 138 Or App at 8. Indeed, the evidence is all to the contrary. For that reason, the trial court did not err in granting summary judgment to defendant on plaintiff's claim of retaliatory discrimination.

I respectfully dissent.

Cite as 167 Or App 468 (2000) May 24, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jon E. Ball, Claimant.

JON E. BALL, Petitioner,
v.
THE HALTON COMPANY, Respondent.
(99-00312; CA A107202)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 20, 1999.
Dean Heiling argued the cause for petitioner. With him on the brief was Dean Heiling & Associates.
Brad G. Garber argued the cause for respondent. With him on the brief was Myers, Radler, Replogle, Roberts & Miller.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
BREWER, J.
Affirmed.

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167 Or App 470> Claimant seeks review of an order on reconsideration of the Workers' Compensation Board affirming the administrative law judge's (ALJ's) order that set aside an order of the Department of Consumer and Business Services (the Department) on reconsideration rescinding employer's notice of closure as premature pursuant to OAR 436-030-0015(2)(c). He seeks reversal of the Board's order and remand to the Appellate Review Unit of the Department for a medical arbiter's examination and a reevaluation of his permanent disability.

We summarize the undisputed facts. On April 9, 1998, claimant injured his back while working for employer as a warehouse worker. Claimant's attending physician, Dr. Jura, diagnosed lumber, thoracic, and cervical strains. On June 2, employer's consulting physician, Dr. Farris, diagnosed a thoracic strain caused by work. In his view, claimant was medically stationary without a need for additional treatment. On July 7, employer's consulting physician, Dr. Fuller, examined claimant and reported that claimant's thoracic strain was medically stationary with no evidence of permanent impairment. On July 17, employer simultaneously accepted cervical and lumbosacral strains and closed the claim by a notice of closure, pursuant to ORS 656.268(4)(a), with a medically stationary date of July 17. Employer made no award of permanent partial disability.

On August 13, claimant filed a request for reconsideration of the notice of closure, raising only the issue of entitlement to permanent partial disability. The form for requesting reconsideration provides "CLAIMANT REQUESTS THREE MEDICAL ARBITER PANEL." In the order on reconsideration, issued September 18, the Department noted that

> "other than the record developed at the time of claim closure and submitted by the insurer on August 19, 1998, no new, additional or clarifying information has been received for reconsideration. We therefore rely upon the record developed at the time of claim closure in issuing this Order on reconsideration."

167 Or App 471> The Department referred to the medical opinions of Farris and Fuller, but said that

> "there is no evidence that attending physician [Jura] concurred, as required in OAR 436-030-0015; OAR 436-010-0280; and OAR 436-035-0007(13). Neither is there any evidence that the insurer sought Dr. Jura's opinion with respect to claimant's status."

In fact, simultaneous with the reconsideration process, the Department's Medical Review Unit was considering a medical service review request submitted by employer. In connection with that matter, claimant's attending physician, Jura, had sent a report to the Department's Medical Review Unit on September 3, 1998, indicating that claimant was medically stationary, had returned to work, and had no

permanent impairment. The report apparently had not been noticed by the Department's Appellate Review Unit, but it is agreed that the document is a part of the record on reconsideration. The Department's September 18 order on reconsideration rescinded the notice of closure on the ground that there was insufficient medical evidence to permit an insurer's closure of the claim. Employer requested a hearing, challenging the Department's rescission of the notice of closure.

In the reconsideration process, the Department is to consider all of the medical evidence presented on reconsideration for the purpose of determining the extent of the claimant's disability. *See* ORS 656.268(4)-(7) (1997). In determining that the notice of closure had been issued prematurely, the Department relied on OAR 436-030-0020(4)(a), which provides that when an insurer closes a claim, it shall issue a notice of closure to the worker within 14 days after evidence is received from the attending physician that shows the worker's condition is medically stationary, "and information is sufficient to determine the extent of any disability." Under OAR 436-030-0020(6), medical information is "sufficient" if it includes the information required in OAR 436-030-0015(2) and (3), among other rules, which describe the information that an insurer must provide when it seeks claim determination by the Department.[1] OAR 436-030-0015(2)(c) requires **<167 Or App 471/472>** the insurer to provide to the Department a closing medical examination report that describes in detail all permanent residuals attributable to the accepted claim. The Department reasoned that, because there had been no closing examination, the medical evidence was insufficient to determine the extent of any disability.

ORS 656.268(4)(a) and (b) (1997) describe two facets of an insurer's obligation with respect to closure of a claim. Subsection (4)(a) describes the prerequisites for an insurer's closure of a claim: (1) the worker's condition resulting from the compensable injury has become medically stationary, and (2) the worker's attending physician has released the worker to return to regular or modified work; or the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition. When a claim is closed before those events have occurred, the closure is regarded as premature. *See Hewlett Packard Co. v. Leonard*, 151 Or App 307, 948 P2d 1256 (1997); *Schuening v. J. R. Simplot & Company*, 84 Or App 622, 625, 735 P2d 1, *rev den* 303 Or 590 (1987). Subsection (4)(b) of the statute describes the requirements for the contents of the notice of closure.

At the hearing, the only question before the ALJ was whether the claim had been closed prematurely and whether the notice of closure could be rescinded by the Department on that ground. The ALJ considered employer's challenge to the Department's rescission of the July 17, 1998, notice of closure. Claimant contended that the Department had acted properly, pursuant to OAR 436-030-0015(2)(c), because employer had no authority to close the claim before receiving a closing medical examination report, describing in detail all permanent residuals attributable to the accepted conditions. Claimant made no alternative contention at hearing about entitlement to permanent partial disability in the event that **<167 Or App 472/473>** the ALJ reversed the department. The ALJ reversed the Department and reinstated the notice of closure. Relying on the Board's order in *Estella M. Rogan*, 50 Van Natta 205 (1998), the ALJ reasoned that, although there had been no closing examination, the Department had no authority to set aside the notice of closure.

In *Rogan*, the insurer closed the claim by notice of closure based on the attending physician's determination that the claimant's condition was medically stationary without permanent disability. On reconsideration, the Department rescinded the closure notice on the ground that, because no closing examination had been performed pursuant to OAR 436-030-0015(2)(c), the insurer lacked adequate closing information. The Board noted that, under the then-existing version of ORS 656.268(4)(a),[2] no closing examination is required as a prerequisite to an insurer's closure of a claim. As the statute then read, an insurer may close a claim by notice of closure when

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[1] In its order in *Estella M. Rogan*, 50 Van Natta 205 (1995), the Board noted that OAR 436-030-0020(6) sets forth the medical information required to be sufficient "[f]or the purposes of section (3) of this rule." The Board noted that the reference to "section (3)" appears to be error, because OAR 436-030-0020(3) does not include any requirement for sufficient medical information. Rather, the requirement for sufficient medical information is found in section (4). The Board interpreted OAR 436-030-0020(6) as setting forth the information deemed sufficient for purposes of section (4) of the rules. The parties here appear to accept the Board's explanation of the cross-reference in *Rogan* and assume that OAR 436-030-0020(6) is applicable here.

[2] The statute was amended in 1999. The previous version is applicable to this case.

> "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 contributing cause of the worker's combined or consequential condition or conditions * * *."

The Board held that, despite the absence of medical information required by OAR 436-030-0015(2)(c), the Department is not authorized to set aside an insurer's closure notice as premature for the reason that the insurer did not obtain a closing examination report, because obtaining such a report is not a statutory prerequisite to the issuance of a notice of closure. The Board further concluded that to the extent that the Department's administrative rule, OAR 436-030-0020(4)(a), could be read to require a closing examination report before the issuance of a notice of closure, that rule exceeded the Department's authority under ORS 656.268(4)(a) and should be given no effect.

Here, the Board found, the medical evidence available at the time of reconsideration established that claimant was medically stationary and had been released for modified work at the time of employer's notice of closure. Thus, it concluded that the statutory requirements for issuance of a notice of closure had been satisfied. Further, the Board adhered to its holding in *Rogan* that when the insurer has complied with the provisions of ORS 656.268(4)(a), the Department has no authority to rescind a notice of closure.

We conclude that the Board's interpretation of the statute is correct. Under ORS 656.268(4), a closing examination is not a prerequisite to the insurer's closure of the claim. Therefore, notwithstanding OAR 436-030-0020(4)(a), the Department's rescission of the claim closure for lack of a closing examination was not authorized under the statute. In addition, substantial evidence supports the Board's determination that employer *did* satisfy the statutory requirements for closure.

We turn briefly to claimant's argument on reconsideration of the Board's order. On reconsideration, claimant asserted that, pursuant to ORS 656.268(7) (1997),[3] he was entitled to have the case remanded to the Appellate Review Unit for a medical arbiter's examination and the processing of his request for permanent partial disability. We conclude that the Board properly declined to consider claimant's argument, because it was not raised at the hearing. *Fister v. South Hills Health Care*, 149 Or App 214, 942 P2d 833 (1997).

Affirmed.

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[3] ORS 656.268(7) (1997) provides, in part:

> "(a) If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, or if the director determines that sufficient medical information is not available to estimate disability, the director shall refer the claim to a medical arbiter appointed by the director.
>
> "(b) At the request of either of the parties, a panel of three medical arbiters shall be appointed."

Cite as 168 Or App 14 (2000) May 31, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CITY OF SALEM, an Oregon Municipal corporation, Respondent,
v.
STEVEN P. SALISBURY, GEORGE R. FINCH, and THEODORE J. KISTNER, Appellants, and SALEM POLICE EMPLOYEES' UNION, by and through Terry Locke, Intervenor-Appellant.
(96C12377; CA A103039)

Appeal from Circuit Court, Marion County.
Richard Barber, Judge.
Argued and submitted October 6, 1999.
J. Michael Alexander argued the cause and filed the briefs for appellants Steven P. Salisbury and Theodore J. Kistner. With him on the briefs was Burt, Swanson, Lathen, Alexander & McCann, P. C.
Aaron E. Clingerman argued the cause and filed the briefs for appellant George R. Finch. With him on the briefs was Law Offices of Michael B. Dye.
Daryl S. Garrettson argued the cause and filed the briefs for intervenor-appellant Salem Police Employees' Union. With him on the briefs was Hoag, Garrettson, Goldberg, Fenrich & Makler.
Joseph D. Robertson argued the cause for respondent City of Salem. With him on the brief were Kim E. Hoyt, and Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P. C.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
EDMONDS, P. J.
Reversed and remanded with instructions to dismiss claims for declaratory relief as to issues involving collective bargaining agreement and for further proceedings not inconsistent with this opinion.

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168 Or App 17> This case involves a declaratory judgment proceeding under ORS chapter 28 brought by the City of Salem (city) seeking a determination of its statutory and contractual obligation to supply uninsured motorists benefits to its police officers. Defendants and intervenor, Salem Police Employees' Union (union), appeal from the trial court's grant of the city's motion for summary judgment. ORCP 47. Defendants include Officers Steven Salisbury and Theodore Kistner, members of the union, and Officer George Finch, who is not a union member. We reverse.

The underlying facts are not disputed. Defendants, acting as police officers, were injured in traffic accidents involving drivers operating uninsured vehicles. Defendants filed workers' compensation claims for their injuries, and those claims have been closed. In addition, defendants filed claims, as insureds, with the city, which is self-insured, asserting that the city was required to furnish them with uninsured motorist coverage.

In its second amended complaint, the city seeks declarations (1) that defendants' claims against it are barred by ORS 656.018 (the exclusive remedy provision of the workers' compensation law);[1] (2) that, in the event the claims are not barred by that statute, the city can elect the coverage limit set forth in ORS 806.070 and offset from the amounts payable under that statute the amounts paid to defendants under their workers' compensation claims; and, (3) that if the court finds that the city is obligated under the collective bargaining agreement with the union to provide coverage, that the city can offset those amounts by the amounts paid on the workers' compensation claims.

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[1] ORS 656.018(1)(a) provides:

"The liability of every employer who satisfies the duty required by ORS 656.017 (1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions, except as specifically provided otherwise in this chapter."

168 Or App 18> After the city filed its complaint, but before the trial court ruled on the city's motion for summary judgment, the union filed a grievance under the collective bargaining agreement. In response to the grievance, an arbitrator ruled that the city was required to furnish benefits to injured union members. In addition, the city and the union stipulated that the arbitrator would retain jurisdiction over any dispute about amounts to be paid to the injured officers. In the circuit court proceeding, the city moved for summary judgment. In contravention to the summary judgment motion, all defendants argued that ORS 278.215 requires the city to provide them uninsured motorist benefits to whatever extent their damages are not compensated by workers' compensation benefits. The union and defendants Salisbury and Kistner also asserted that the circuit court did not have jurisdiction to decide the issue of what was required under the collective bargaining agreement and the city's complaint should be dismissed. In addition, they argued that, under the collective bargaining agreement with the city, the city is required to provide uninsured motorist coverage for union members.

The trial court rejected defendants' arguments and entered summary judgment for the city on its first claim, declaring that

> "any and all claims, other than claims under ORS Chapter 656, that the defendants and other members of the intervenor would otherwise have against the City arising out of injuries allegedly sustained by defendants in uninsured or underinsured motor vehicle accidents are barred by ORS 656.018."

Also, the trial court dismissed as moot the city's second and third claims for relief.

Initially, we discuss the claims for declaratory judgment as they pertain to defendants Salisbury and Kistner. As they did below, those defendants assert that the Employment Relations Board (ERB) has exclusive jurisdiction over the issue of whether the city is obligated under the collective bargaining agreement to provide uninsured motorist coverage. ERB has the duty of hearing and deciding all unfair labor practice complaints concerning public employers. *Trout v. Umatilla Co. School Dist.*, 77 Or App 95, 98, 712 P2d 814 **<168 Or App 18/19>** (1985), *rev den* 300 Or 704 (1986). ORS 243.672 provides, in relevant part:

> "(1) It is an unfair labor practice for a public employer or its designated representative to do any of the following:
>
> "* * * * *
>
> "(g) Violate the provisions of any written contract with respect to employment relations including an agreement to arbitrate or to accept the terms of an arbitration award, where previously the parties have agreed to accept such awards as final and binding upon them."

The collective bargaining agreement between the union and the city provides that unresolved grievances are subject to arbitration and that "[t]he decision(s) of the arbitrator shall be binding on both parties to this contract." As defined in the agreement, a grievance is "a dispute regarding the meaning or interpretation of a particular clause of this contract or regarding an alleged violation of this contract." The agreement also provides that "changes in existing conditions of employment relating to wages, hours, and working conditions shall be subject to mutual agreement before becoming effective."

The arbitrator found that "[p]rior to 1992, the City maintained a UM [uninsured motorist] policy covering unit employees to a maximum combined limit of $50,000." She concluded, "[t]he former uninsured motorist insurance policy of $50,000 was a benefit covered by the Existing Conditions Article of the Contract." Also, we are mindful of the fact that ERB has exclusive jurisdiction over the interpretation of the parties' contract and the issues involving arbitration under the contract. *Reinwald v. Dept. of Employment*, 148 Or App 75, 80, 939 P2d 86 (1997). In addition, ERB also has exclusive jurisdiction over any unfair labor practice, although the circuit court may have jurisdiction to enforce remedies "beyond those that ERB can order." *Id.*

Here, the city proceeded to circuit court for declaratory relief without engaging in the procedures established by the collective bargaining agreement. Because ERB has exclusive jurisdiction over the issue regarding the meaning of the **<168 Or App 19/20>** collective bargaining agreement, the city could not

circumvent the exercise of that jurisdiction by obtaining a judgment in circuit court for declaratory relief. Therefore, the trial court should have dismissed the city's claim for a declaration regarding defendants Salisbury's and Kistner's ability to recover uninsured motorist benefits under the collective bargaining agreement.

The remainder of our opinion focuses on the issues presented on appeal as they relate to the ability of defendants to make claims for uninsured motorist coverage under ORS 278.215, apart from any rights under the collective bargaining agreement. On review of a summary judgment, we determine whether there exists any genuine issue of material fact and whether the moving party is entitled to a judgment as a matter of law. ORCP 47 C (1997).[2] We review the record in the light most favorable to defendants, the nonmoving parties. *Id.* Whether summary judgment is permissible in this case involves the interpretation of several statutes. The first level of statutory analysis requires us to examine the text and context of the statutes for evidence of the legislature's intent.

We begin with ORS 278.215, which provides:

> "(1) Any insurance or self-insurance provided by moneys from the Insurance Fund for or on account of the operation of motor vehicles within the state's or public body's control, shall provide the uninsured motorist coverage required under ORS 742.500 to 742.504 and, except as specified in ORS 278.205, may provide the personal injury protection benefits required under ORS 742.520 to 742.542.
>
> "(2) Any local public body, as defined in ORS 30.260, which establishes a self-insurance fund under ORS 30.282 for or on account of the operation of motor vehicles within the local public body's control, shall provide the uninsured motorist coverage required under ORS 742.500 to 742.504 **<168 Or App 20/21>** and may provide the personal injury protection benefits required under ORS 742.520 to 742.542.
>
> "(3) The uninsured motorist coverage provided under this section shall be excess over any other collateral benefits to which an injured person is entitled, including, but not limited to, other uninsured motorist coverage, insurance benefits, governmental benefits or gratuitous benefits."

The city does not dispute that it is required to provide uninsured motorist coverage under ORS 278.215. Instead, it argues that the coverage required by the statute is applicable only to "non-employees injured in an uninsured motorist accident" and that the workers' compensation law provides the exclusive remedy to city employees injured under the same circumstances.

ORS 278.215 requires that a public body "shall provide the uninsured motorist coverage required under ORS 742.500 to 742.504." ORS 742.504 provides, in relevant part:

> "Every policy * * * shall provide uninsured motorist coverage which in each instance is no less favorable in any respect to the insured or the beneficiary than if the following provisions were set forth in the policy. However, nothing contained in this section shall require the insurer to reproduce in such policy the particular language of any of the following provisions:
>
> "(1)(a) The insurer will pay all sums which the insured * * * shall be legally entitled to recover as general and special damages from the owner or operator of an uninsured vehicle because of bodily injury sustained by the insured caused by accident and arising out of the ownership, maintenance or use of such uninsured vehicle. Determination as to whether the insured * * * is legally entitled to recover such damages, and if so, the amount thereof, shall be made by agreement between the insured and the insurer, or, in the event of disagreement, may be determined by arbitration as provided in subsection (10) of this section.

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[2] This case was pending before us when Oregon Laws 1999, chapter 815 (amending ORCP 47 C), went into effect. The parties do not argue that any changes effected by the amended version of ORCP 47 C should be applied in this case in the first instance on appeal, and we decline to apply those amendments on our own motion. *See Graham v. State of Oregon*, 164 Or App 747, 757 n 5, 995 P2d 1167 (2000).

"* * * * *

"(2) As used in this policy:

"(a) 'Insured,' when unqualified, means when applied to uninsured motorist coverage:

"* * * * *

168 Or App 22> "(C) Any other person while occupying an insured vehicle provided the actual use thereof is with the permission of the named insured.

"(b) 'Insured vehicle,' except as provided in paragraph (c) of this provision, means:

"(A) The vehicle described in the policy or a newly acquired or substitute vehicle, as each of those terms is defined in the public liability coverage of the policy, insured under the public liability provisions of the policy; or

"(B) A nonowned vehicle operated by the named insured or spouse if a resident of the same household; provided the actual use thereof is with the permission of the owner of such vehicle and such vehicle is not owned by nor furnished for the regular or frequent use of the insured or any member of the same household.

"(c) 'Insured vehicle' does not include a trailer of any type unless such trailer is a described vehicle in the policy.

"* * * * *

"(i) 'Occupying' means in or upon or entering into or alighting from.

"* * * * *

"(k) 'Vehicle' means every device in, upon or by which any person or property is or may be transported or drawn upon a public highway, but does not include devices moved by human power or used exclusively upon stationary rails or tracks.

"* * * * *

"(4)(a) * * *

"* * * * *

"(c) This coverage does not apply so as to inure directly or indirectly to the benefit of any workers' compensation carrier, any person or organization qualifying as a self-insurer under any workers' compensation or disability benefits law or any similar law or the State Accident Insurance Fund Corporation.

" * * * * *

168 Or App 23> "(7)(a) The limit of liability stated in the declarations as applicable to 'each person' is the limit of the insurer's liability for all damages because of bodily injury sustained by one person as the result of any one accident and, subject to the above provision respecting each person, the limit of liability stated in the declarations as applicable to 'each accident' is the total limit of the company's liability for all damages because of bodily injury sustained by two or more persons as the result of any one accident.

"(b) Any payment made under this coverage to or for an insured shall be applied in reduction of any amount which the insured may be entitled to recover from any person who is an insured under the bodily injury liability coverage of this policy.

"(c) *Any amount payable under the terms of this coverage* because of bodily injury sustained in an accident by a person who is an insured under this coverage *shall be reduced by*:

"(A) All sums paid on account of such bodily injury by or on behalf of the owner or operator of the uninsured vehicle and by or on behalf of any other person or organization jointly or severally liable together with such owner or operator for such bodily injury including all sums paid under the bodily injury liability coverage of the policy; and

"(B) *The amount paid* and the present value of all amounts payable on account of such bodily injury *under any workers' compensation law, disability benefits law or any similar law.*

"* * * * *

"(9)(a) Except as provided in paragraph (c) of this subsection, with respect to bodily injury to an insured while occupying a vehicle not owned by a named insured under this coverage, the insurance under this coverage shall apply only as excess insurance over any other insurance available to such occupant which is similar to this coverage, and this insurance shall then apply only in the amount by which the applicable limit of liability of this coverage exceeds the sum of the applicable limits of liability of all such other insurance.

"(b) With respect to bodily injury to an insured while occupying or through being struck by an uninsured vehicle, **<168 Or App 23/24>** if such insured is an insured under other insurance available to the insured which is similar to this coverage, then the damages shall be deemed not to exceed the higher of the applicable limits of liability of this insurance or such other insurance, and the insurer shall not be liable under this coverage for a greater proportion of the damages than the applicable limit of liability of this coverage bears to the sum of the applicable limits of liability of this insurance and such other insurance.

"(c) With respect to bodily injury to an insured while occupying any motor vehicle used as a public or livery conveyance, the insurance under this coverage shall apply only as excess insurance over any other insurance available to the insured which is similar to this coverage, and this insurance shall then apply only in the amount by which the applicable limit of liability of this coverage exceeds the sum of the applicable limits of liability of all such other insurance." (Emphasis added.)

ORS 656.018 provides, in relevant part:

"(1)(a) *The liability of every employer who satisfies the duty required by ORS 656.017 (1) is exclusive and in place of all other liability* arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such conditions, except as specifically provided otherwise in this chapter.

"* * * * *

"(c) Except as provided in paragraph (b) of this subsection, all agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void.

"(2) *The rights given to a subject worker* and the beneficiaries of the subject worker under this chapter for injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment *are in lieu of any remedies they might otherwise have* for such injuries, diseases, symptom complexes or similar conditions against **<168 Or App 24/25>** the worker's employer *under ORS 654.305 to 654.335 or other laws, common law or statute,* except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury, disease, symptom complex or similar condition.

"* * * * *

"(6) *Nothing in this chapter shall prohibit payment, voluntarily or otherwise, to injured workers or their beneficiaries in excess of the compensation required to be paid under this chapter.*

"(7) The exclusive remedy provisions and limitation on liability provisions of this chapter apply to all injuries and to diseases, symptom complexes or similar conditions of subject workers arising out of and in the course of employment whether or not they are determined to be compensable under this chapter." (Emphasis added.)

Also, we consider in the first level of analysis the prior enacted versions of the operative statutes as context for the existing statutes as well as the preexisting common law and statutory frameworks within which the laws were enacted in our effort to discern the legislature's intent. *State v. Webb*, 324 Or 380, 390, 927 P2d 79 (1996); *Goodyear Tire & Rubber Co. v. Tualatin Tire and Auto*, 322 Or 406, 416-17, 908 P2d 300 (1995), *on recons* 325 Or 46, 932 P2d 1141 (1997). The statutory predecessors of ORS 742.500 through 724.504 were initially enacted in 1959 as *former* ORS 736.317 and were replaced by ORS 743.786 through 743.792 (1967). Or Laws 1959, ch 413; Or Laws 1967, ch 482. In 1959, ORS 736.317 required insurance policies to provide uninsured motorist coverage on vehicles, with the exception of motor trucks "where the insured has employes who operate the motor trucks *and such employes are covered by workmen's compensation.*" ORS 736.317(3) (emphasis added).

In 1965, the legislature made workers' compensation insurance coverage compulsory, whereas previously it had been voluntary. As part of the statutory scheme, the legislature enacted an exclusive remedy provision and the existing language found in ORS 656.018(2) that "[t]he rights given to a subject worker * * * are in lieu of any remedies * * * **<168 Or App 25/26>** against the workman's employer under * * * other laws, common law or statute * * *." Or Laws 1965, ch 285, section 6. When the legislature repealed ORS 736.317 in 1967 and replaced it with ORS 743.786 through 743.792, it retained the exception for motor trucks and added busses and taxicabs to the exception. Or Laws 1967, ch 482; ORS 743.786(2)(b) (1967). In other words, the legislature continued to permit employers to exclude certain vehicles from uninsured motorist coverage at that time, *if* workers' compensation coverage was provided to their employees.[3] When the legislature enacted ORS 278.215, requiring public bodies to provide uninsured motorist coverage in 1979, it also amended ORS 743.786(2)(b)(1977) so that the exclusion from uninsured motorist coverage applied only to trucks. Or Laws 1979, ch 842, sections 5 and 7; ORS 278.200. In 1989, ORS 743.786(2)(b)(1987) was renumbered ORS 742.500(2)(b).[4]

There is no express language in the text of ORS 278.215 or ORS 742.500 through 742.504 that convinces us that the legislature meant to require a public body to provide uninsured motorist benefits only to nonemployees. The statutes make no express distinction between employees and nonemployees, and ORS 742.504(4)(c), (7)(c)(B), and (9) expressly contemplate that, in some circumstances, the injured person may recover from multiple sources. If anything, the statutory predecessors to ORS 742.500 through 742.504 demonstrate that the legislature knew how to **<168 Or App 26/27>** eliminate the requirement for uninsured motorist coverage for those who were covered by workers' compensation. The present statute does not contain such an exception except for certain trucks

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[3] In *Safeco Insurance Co. v. Christensen*, 248 Or 550, 436 P2d 270 (1968), the court considered the exclusion for trucks in ORS 736.317. The court explained that "[t]he purpose of the subsection was to relieve truckers of the cost of providing uninsured motorist protection for their employees if the employees were given equivalent protection through 'workmen's compensation.'" *Christensen*, 248 Or at 553.

[4] ORS 742.500(2) provides:

"'*Motor vehicle*' means every self-propelled device in, upon or by which any person or property is or may be transported or drawn upon a public highway, but *does not include*:

"(a) Devices used exclusively upon stationary rails or tracks;

"(b) Motor trucks as defined in ORS 801.355 that have a registration weight, as defined by ORS 803.430 of more than 8,000 pounds, *when the insured has employees who operate such trucks and such employees are covered by any workers' compensation law, disability benefits law or any similar law*; or

"(c) Farm-type tractors or self-propelled equipment designed for use principally off public highways." (Emphasis added.)

and other exceptions to the definition of "motor vehicle." ORS 742.500(2). Likewise, ORS 278.215(3) provides that the uninsured motorist coverage "*shall be excess over* any other collateral benefits to which an injured person is entitled, including, but not limited to, *other uninsured motorist coverage, insurance benefits, government benefits or gratuitous benefits.*" (Emphasis added.) Also, ORS 742.504(7)(c) provides that any amounts payable under the statute for bodily injury "shall be reduced" by workers' compensation benefits. In summary, the text and context of the above statutes suggest that before 1979 employees of private sector employers could collect uninsured motorist benefits subject to reduction because of duplicative workers' compensation benefits and that ORS 278.215 was enacted to place employees of public bodies in a similar posture.

Nonetheless, the language in ORS 656.018 could be understood to controvert that understanding. ORS 656.018 was already in place when ORS 278.215 was enacted in 1979. If ORS 278.215 is intended as one of the "laws" or "statute[s]" to which ORS 656.018 refers as being subject to its exclusivity provision, then the trial court did not err. As the court emphasized in *Kilminster v. Day Management Corp.*, 323 Or 618, 637, 919 P2d 474 (1996), "ORS 656.018(2) explicitly states that no 'other laws * * * or statute[s]' provide a worker, who is injured in the course and scope of employment, with a remedy not provided in the Workers' Compensation Act."

Defendants argue that ORS 656.018 is not implicated because they do not seek a tort-like remedy against the city. Rather, their claims are based on their relationship with the city as insureds. According to them, relationships between insureds and insurer are viewed in contractual terms, and the uninsured motorist statutes operate to create obligations whether or not the coverage appears in an agreed-upon policy. *Fox v. Country Mutual Ins. Co.*, 327 Or 500, 503-506, 964 P2d 997 (1998). They explain:

> "The recognized purpose of the exclusive remedy provision is to supplant the *common law* method of recovery. **<168 Or App 27/28>** ORS 656.012(1)(b). The entire worker's compensation system has traditionally been a substitute for *tort* claims by an employee against an employer. *Hale v. Port of Portland*, 308 Or 508, 521, 783 P2d 506 (1990), citing *Evanhoff v. State Industrial Acc. Com.*, 78 Or 503, 154 P 106 (1915). The 1995 revisions of the statute were in response to the case of *Errand v. Cascade Steel Rolling Mills [Inc.]*, 320 Or 509, 888 P2d 544 (1995), which allowed a tort claim against an employer arising from an injury which arose on the job, but was not compensable because of insufficient causation. Such legislation made it clear that even employees who suffered non-compensable injuries in the course of their employment would have no tort remedies against their employer. Again, the pertinent issue was a potential tort claim." (Footnote omitted.)

Defendants' argument finds some support in Supreme Court interpretations of ORS 656.018, which we consider in the first level of statutory analysis. *Holcomb. v. Sunderland*, 321 Or 99, 105, 894 P2d 457 (1995). In *Hale*, the court explained:

> "[T]he Oregon Legislature * * * eliminated the haphazard system of liability of employers to some employees for some injuries occurring under a limited number of circumstances, and replaced it with a system that made employers liable for the medical expenses of their injured workers without regard to fault. The scheme penalized some members of both camps--those plaintiffs who could prove actionable negligence of their employers, and so obtain damages beyond their medical expenses, and those employers who could defeat liability either because they had not been negligent or because they could show the worker was guilty of contributory negligence or assumption of the risk." 308 Or at 521-22.[5]

Also in *McGarrah v. SAIF*, 296 Or 145, 160-61, 675 P2d 159 (1983), the court described the workers' compensation system as where "[i]n exchange for * * * relief under this no-fault recovery system, employes are limited to a fixed schedule of recovery and must abandon any common law right of action against their employers." In *Hale* and *McGarrah*, the court's **<168 Or App 28/29>** references to "fault" and "no-fault recovery" support defendants' interpretation of ORS 656.018 as applying to liability arising from traditional common law tort actions involving negligence. Nonetheless, the court held in *Kilminster* that a non-negligence based claim under the Oregon Racketeer Influenced and Corrupt Organization Act statute was governed by ORS 656.018. 323 Or at 637.

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[5] Although in *Hale* the court was not interpreting the exclusive remedy provision, the court has quoted this language when interpreting ORS 656.018. *Errand*, 320 Or at 524.

In light of the arguable conflict between the exclusive remedy provision of ORS 656.018 and the language in ORS 278.215 and ORS 742.504 providing expressly for a reduction from uninsured motorist benefits because of workers' compensation benefits, we conclude that an ambiguity arises in ORS 278.215 regarding the legislature's intent. The legislature could have said, as it did in *former* ORS 736.317(3), that there was no uninsured motorist coverage for employees covered by workers' compensation. However, it did not. On the other hand, it could have amended ORS 656.018 in 1979 to except uninsured motorist coverage from the statute's exclusivity language, and it did not do that either. Therefore, we turn to the legislative history under ORS 278.215 to seek further guidance.

ORS 278.215 was introduced in the Senate as Senate Bill 245 at the request of the Department of General Services to ensure that state-owned motor vehicles had adequate and complete coverage. Testimony, Senate Judiciary Committee, SB 245, January 26, 1979, Ex D (statement of Bob Elgin, General Services). Initially, the legislative history underlying the statute indicates that its focus was to "allow the State to include medical and uninsured motorist coverage as a part of its self-insurance tort liability" because "[t]he present tort liability act [did] not provide any medical insurance and uninsured motorist coverage for passengers or drivers of vehicles who are not employees of the State or local public agencies." *Id.* At a Senate Judiciary Committee hearing early in the legislative session, there were questions raised about the language of the proposed bill. Senate Judiciary Committee, SB 245, March 5, 1979, Ex G (letter from the Department of General Services to Diana Godwin, Counsel for the Senate Judiciary Committee). An Ad Hoc committee reviewed the bill and prepared amendments that included the language that became the basis for section 2 of **<168 Or App 29/30>** the bill. *Id.* Section 2, which would be modified and would become ORS 278.205[6] provided:

> "The Department of General Services may issue a certificate of motor vehicle liability insurance and make assessments therefor which insurance shall be in an amount not greater than the amounts provided in ORS 30.270. Such insurance may also include 'uninsured motorist' and 'personal injury protection' in at least the minimum coverages and amounts set forth in ORS 743.786 to 743.835 as to the following motor vehicles:
>
> "(1) State owned vehicles furnished for public use pursuant to state law, other than to another governmental agency.
>
> "(2) Motor vehicles owned by local public bodies insured under the liability fund pursuant to ORS 30.282." Senate Judiciary Committee, SB 245, March 5, 1979, Ex G (letter from the Department of General Services to Diana Godwin, Counsel for the Senate Judiciary Committee).

Also, in the committee process, Senator Vern Cook amended the bill to include other amendments to ORS 742.500 through 742.542. Tape recording, Senate Judiciary Committee, SB 245, April 30, 1979, Tape 37, Side 1. In addition, legislative counsel proposed amendments to include a section 4 that would require all self-insured public bodies to provide the same coverage as section 2. Senate Judiciary **<168 Or App 30/31>** Committee, SB 245, April 30, 1979, Ex Q (proposed amendments to A-Engrossed Senate Bill 245 by Legislative Counsel). Section 4 as approved by the committee provided:

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[6] ORS 278.205 presently provides:

"(1) The Oregon Department of Administrative Services may issue a certificate of motor vehicle liability insurance and make assessments therefor.

"(2) When issued on vehicles owned by local public bodies, such insurance shall also include uninsured motorist coverage and may include personal injury protection benefits and shall provide at least the minimum coverages and amounts set forth in ORS 742.500 to 742.542. However, at the request of a local public body, the department may provide uninsured motorist coverage or personal injury protection benefits for the motor vehicles owned by the local public body in amounts greater than those required under ORS 742.500 to 742.542.

"(3) When issued on state-owned vehicles furnished for public use including, but not limited to, use authorized under ORS 276.598, such insurance shall include uninsured motorist coverage and personal injury protection benefits and shall provide at least the minimum coverages and amounts set forth in ORS 742.500 to 742.542.

"(4) The department by rule may provide personal injury protection benefits in excess of those specified in this section."

> "(1) Any self-insurance provided by moneys from the Liability Fund against liability of the State of Oregon and its officers, agents or employes, or against the liability of a participating local public body and its officers, agents or employes, for or on account of the operation of motor vehicles within the state's or public body's control, shall provide the uninsured motorist coverage required under ORS 743.789 and 743.792 and the personal injury protection benefits required under ORS 743.800 and 743.805.
>
> "(2) Any local public body, as defined in ORS 30.260, which establishes a self-insurance fund under ORS 30.282 against liability of the local public body and its officers, agents or employes, for or on account of the operation of motor vehicles within the local public body's control, shall provide the uninsured motorist coverage required under ORS 743.789 and 743.792 and the personal injury protection benefits required under ORS 743.800 and 743.805.
>
> "(3) The uninsured motorist coverage and personal injury protection benefits provided under this section shall be excess over any other collateral benefits to which an injured person is entitled, including, but not limited to, other uninsured motorist coverage or personal injury protection benefits, insurance benefits, overnmental benefits or gratuitous benefits." B-Engrossed SB 245, 1979 Legislative Assembly.

Section 4 eventually became ORS 278.215.

At a Senate Judiciary Committee work session on Senate Bill 245, the committee discussed the precise issue raised by this case. Tape recording, Senate Judiciary Committee, SB 245, April 30, 1979, Tape 37, Side 1. Senator James Gardner inquired about the references to workers' compensation in the bill,[7] and, in response, Senator Cook explained that those provisions were intended to prevent duplicate recovery for the same injuries. Legislative Counsel **<168 Or App 31/32>** Diana Godwin confirmed that the provisions dealt with collateral sources of recovery. After considerable discussion about whether any excess over workers' compensation benefits could be collected by an injured person, Senator Gardner asked specifically whether a bus driver could recover from the uninsured motorist policy of the bus company. Godwin replied that if the legislature required a bus company to carry uninsured motorist coverage, "we're going to allow the driver not only to collect workers' compensation but to collect on the UM policy of the bus company." *Id.* Senators Brown and Cook agreed, explaining that it would put the bus driver in the same position as an operator of privately-owned vehicles.

Not entirely persuaded, Senator Gardner asked to hear from the Tri-Met representative. Tri-Met's attorney, Bill Hallmark, related the history underlying the existing uninsured motorist statute, including the former exception for busses, taxis and trucks and that those exceptions were based on the definition of "motor vehicle." Senator Gardner asked again whether, under the proposed bill's amendments to ORS 742.500 through 742.504, bus drivers could get a duplicate recovery. Hallmark responded negatively and explained that the provisions of the existing law allowed for a reduction of uninsured motorist benefits for workers' compensation benefits received in the event of a double recovery problem. Godwin restated Senator Gardner's question:

> "If I am working for a private employer and he has private vehicles with private insurance, UM and PIP [personal injury protection] is automatically covered. If an employee is injured while driving one of those company cars on company time and I am injured by an uninsured motorist, I am covered by workers' compensation because I am an employee. Also, the car had UM and PIP coverage. Am I allowed to go against my employer's UM and PIP coverage in excess above my workers' compensation limit?" Tape recording, Senate Judiciary Committee, SB 245, April 30, 1979, Tape 37, Side 1.

Hallmark replied: "It's really not an excess situation. You're allowed to, within the limits of the UM and PIP coverage, if the workers' compensation doesn't satisfy those limits, you **<168 Or App 32/33>** can get the difference, but you wouldn't stack one on top of the other." *Id.*

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[7] So far as we can ascertain, the inquiry regarded the language presently in ORS 742.504(7)(c)(B).

When the bill went to the House Judiciary Subcommittee, the Department of General Service's representative, Kenneth Dory, explained about the department's original purpose in introducing the bill and pointed out:

> "Senator Cook's amendments include UM and PIP by private insurers for any coverage they write for buses, taxi cabs and any privately owned vehicles which are used as a public livery conveyance. The original bill was aimed at public agencies who are self-insured by adding UM and PIP to state-owned vehicles and other public vehicles used by public agencies. The senate amendments made the bill cover Tri-Met and other types of busses like Greyhound and taxi cabs." Tape recording, House Judiciary Subcommittee 3, SB 245, June 14, 1979, Tape 88, Side 1.

Representative Mason asked if, "by definition, the *uninsured motorist* will always be the non-government driver." *Id.* (emphasis added). Dory, perhaps misunderstanding the question to be about the *recipient* of the uninsured motorist coverage, replied: "Yes, it would be the passenger." Mason questioned, "of the government vehicle?" and Dory responded, "yes, of the government vehicle * * * the driver could be if he were a volunteer and not have insurance and driving a government vehicle." *Id.* Representative Lombard stated "that was going to be my question. What was the need for UM and PIP coverage when it would seem in the first place that in most instances, state employees driving state vehicles are going to be covered for the type of things * * * under the state medical plan?" *Id.* Elgin explained that the state found itself lacking insurance coverage for certain kinds of state activities and gave the example of vehicles owned by the state but driven by volunteers who were not insured. He said that the department's impetus for sponsoring the bill was to obtain coverage for vehicles driven in different kinds of volunteer programs but that, as the bill progressed through the Senate Judiciary Committee, "other loopholes in the law" were cleaned up by amendments. *Id.* However, to the extent that the discussion in the House Judiciary Subcommittee could be understood to demonstrate an understanding that only nonemployees would be eligible for **<168 Or App 33/34>** uninsured motorist benefits, the House made no changes in the proposed bill that came from the Senate that would reflect that understanding. Eventually, the bill with sections 2 and 4 intact was passed out of the committee, enacted by the legislature and signed by the governor.[8]

In summary, there has never been language in the uninsured motorist statutes that prevented injured individuals from obtaining benefits based on their status as employees. Rather, ORS 742.504 and its predecessor statutes excluded certain types of *motor vehicles* from the coverage requirement. The exclusions applied when workers' compensation benefits were provided to the operators. When the legislature considered what is now ORS 278.200 through 278.215 in 1979 and amended ORS 742.500 through 742.504 to eliminate certain of the motor vehicle exclusions, every indication is that it intended to expand uninsured motorist coverage to cover those injured in public vehicles, regardless of their employment status. The discussion in the Senate Judiciary Committee specifically raised the issue of whether a public body employee could recover both uninsured motorist benefits and workers' compensation benefits. Although ORS 656.018 was never specifically mentioned, so far as we can ascertain, the legislature is deemed to have existing statutes in mind when it enacts new legislation. *Owens v. Maass*, 323 Or 430, 438, 918 P2d 808 (1996).

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[8] The House and the Joint Conference Committee removed the requirement for personal injury protection benefits in sections 2 and 4, but the language requiring public bodies to provide uninsured motorist coverage remained.

Thus we have considered the text, context and the legislative history of ORS 278.215 and its relationship with statutes regarding uninsured motorist coverage. We conclude that the most plausible understanding of the statutes supports defendants' contention that the 1979 legislature did not intend that ORS 656.018 bar employees of public bodies from recovering uninsured motorist coverage under ORS 278.215.[9] Accordingly, the trial court erred in granting summary judgment to the city on its first claim.[10]

168 Or App 35> Reversed and remanded with instructions to dismiss claims for declaratory relief as to issues involving collective bargaining agreement and for further proceedings not inconsistent with this opinion.

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[9] Our review of the changes to ORS 656.018 after 1979 does not change our conclusion that the 1979 legislature's intent controls the determination of the issue before us.

[10] Plaintiff relies on the reasoning in two federal district court opinions that conclude otherwise. *Great West Casualty Company v. Johnston*, No. 96-1558-MA (D Or 1997), *rev'd* No. 97-35925 (9th Cir) (Oct 7, 1998); *Maloy v. Pony Express Courier Corp.*, No. 94-865-JE (D Or 1995)). In an unpublished opinion, the Ninth Circuit Court of Appeals reversed the district court in *Great West Casualty Company*, No. 97-35925 (9th Cir) (Oct 7, 1998). There is no indication that the district courts considered the prior enacted versions of the statutory schemes or the legislative history of the pertinent statutes. Consequently, we are not persuaded by the reasoning of those opinions.

Cite as 168 Or App 36 (2000) May 31, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of Vocational Assistance.
DAVID GONZALEZ, Respondent,
v.
SCHROCK CABINET COMPANY, Petitioner,
and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondent.
(H96-056; CA A99970)

En Banc
Judicial Review from Department of Consumer and Business Services.
Argued and submitted September 10, 1998; resubmitted en banc October 13, 1999.
Vera Langer argued the cause for petitioner. With her on the brief was Scheminske, Lyons & Bussman, LLP.
Michael A. Gilbertson argued the cause and filed the brief for respondent David Gonzalez.
Denise G. Fjordbeck, Assistant Attorney General, argued the cause for respondent Department of Consumer and Business Services. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
Before Deits, Chief Judge, and Edmonds, De Muniz, Landau, Haselton, Armstrong, Linder, Wollheim, Kistler, and Brewer, Judges.
DE MUNIZ, J.
Affirmed.
Edmonds, J., concurring.
Landau, J., dissenting.

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168 Or App 39> Employer petitions for review of an order of the Director of the Department of Consumer and Business Services (Director) finding that claimant is eligible for vocational assistance benefits. We affirm.

The parties' dispute involves the 1995 enactment of Senate Bill 369, which divested the Workers' Compensation Board of jurisdiction for vocational assistance matters and vested that jurisdiction in the Director. Under the procedure established by the legislation, the initial decision on a vocational assistance dispute is made by the Rehabilitation Review Unit (RRU), as the Director's designee. A party that is dissatisfied with the order must request a contested case hearing before the Director within 60 days. A final order from the contested case hearing is subject to appellate review under ORS 183.482. The changes became effective on June 7, 1995. The bill's provisions for retroactive application made the new legislation applicable to unresolved claims. *Volk v. America West Airlines*, 135 Or App 565, 568, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

To accomplish an orderly processing of cases under the new legislation, the Director adopted temporary OAR 436-001-0015 (1995), which provided:

> "(1)(a) Any appropriate request for review that was filed with the board or its Hearings Division (the board) before June 7, 1995, where review now lies with the director, will be considered a timely filing with the director provided that:
>
> "(A) the review request filed with the board was timely and consistent with prevailing Oregon law as it existed on the date of such filing; and,
>
> "(B) the requesting party formally files for review in writing with the director within 90 days of the effective date of this rule.
>
> "(b) On or after June 7, 1995 and before September 17, 1995, any appropriate request for review filed with the Board or its Hearings Division (the board) on a matter where review now lies with the director * * * shall be deemed a timely filing with the director provided that:

168 Or App 40> "(A) the review request made with the board was within the time lines to file with the director as set forth under the new law; and,

"(B) the requesting party formally files for review in writing with the director within 90 days of the effective date of this rule.

"* * * * *

"(e) * * * [T]hese provisions provide a temporary grace period during which a timely filing with the Board will be deemed a filing with the director."

We turn to the case before us. Claimant sustained a compensable back injury in 1993, which resulted in permanent impairment to his low back. He was released to light work, and, in March 1994, employer offered claimant a position as a paint room associate, employer's "only open position." Claimant accepted the offer and began work. However, the position required constant standing and walking, and claimant suffered leg pain while performing the job duties. When he advised his supervisor that he needed to sit down for a few minutes to control his pain, the supervisor sent him home. This occurred on several occasions, and claimant finally stopped returning to work. His employment was terminated, and claimant applied for vocational assistance. On August 2, the RRU issued an order determining that claimant was not eligible for vocational assistance, and claimant filed a request for hearing with the Board pursuant to the pre-1995 version of ORS 656.283. After a hearing, the Administrative Law Judge (ALJ) reversed the RRU's order and found that claimant was eligible for vocational assistance.

Employer sought review by the Board. While employer's request was pending, the legislature enacted the changes to the Board's jurisdiction outlined above. On February 16, 1996, the Board dismissed the vocational assistance matter for lack of jurisdiction and vacated the order that directed employer to provide vocational assistance.[1]

Sixteen days later, claimant filed a request for a contested case hearing with the Director. Employer filed a **<168 Or App 40/41>** motion to dismiss on the ground that claimant's request was not timely. The Director originally allowed employer's motion but withdrew that order and, on reconsideration, held that the time for filing a valid request was "effectively tolled" under the circumstances of this case and denied employer's motion to dismiss. The Director then held that claimant was entitled to vocational assistance.

On judicial review, employer first assigns error to the Director's denial of its motion to dismiss. Employer's position is that, as a result of the jurisdictional changes, claimant's original request for a hearing, which was filed with the Board on August 10, 1994, became "ineffective," and, under *temporary* OAR 436-001-0015 (1995), claimant was obligated to refile his request for a contested case hearing with the Director within 90 days from August 18, 1995, the date on which the Director promulgated the rule. Employer argues that, because claimant did not do so, his subsequent March 1996 request was not timely.

Under the rule, the "requesting party" was obligated to refile the request for hearing. Employer's argument, thus, is predicated on its position that claimant was the "requesting party." However, that is not how the Director interpreted his rule. The Director held that claimant had complied with the administrative procedure applicable when he requested a hearing on the denial of vocational assistance and that the proceedings before the Board did not conclude until after expiration of the temporary rule. Under the Director's interpretation, thus, it was employer, not claimant, who was the "requesting party" obligated to refile with the Director, and the temporary rule had no application to claimant's situation. We agree with the Director that claimant's subsequent request for review by the Director was timely.

At the time of the jurisdictional changes, claimant had succeeded in overturning the August order of the RRU. Having prevailed, there was no reason for claimant to request further review by the Board. However, employer requested Board review. Because of the pending review, the RRU order

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[1] Claimant did not request review of that order, which became final. Neither party makes any arguments regarding the validity of that order.

denying claimant benefits was not finally resolved when the jurisdictional changes occurred. *See Volk*, 135 Or App at 573 (review of Board's order had been sought **<168 Or App 41/42>** but not finally resolved at time of effective date of amendments). Under the temporary rule, employer, as the party requesting Board review, was the party obligated to refile the new request with the Director. Employer did not refile, and the Board determined that it had no jurisdiction to decide employer's request for review, dismissed review of the vocational assistance matter, and vacated the order directing employer to pay benefits. When the Board's action effectively reinstated the RRU order denying benefits, claimant filed his request for a contested case hearing within 60 days, as required by ORS 656.383(2). We find no basis on which to say that the Director's interpretation that the rule did not apply to claimant's circumstances was erroneous.

The dissent assumes that, as of the effective date of the 1995 amendments, the ALJ's decision reversing the RRU decision was a nullity. 168 Or App at 46. The dissent is wrong.

Nothing in the 1995 enactment of Senate Bill 369 compels the conclusion that validly existing orders were rendered a "nullity" without further action by the parties or the agency. In describing the ALJ's order as a "nullity," the dissent can only mean that the order was void. The dissent incorrectly implies that we "acknowledge" that the ALJ's decision was "rendered without jurisdiction" and therefore "is void." 168 Or App at 47. An order or judgment is void and hence a nullity only when the court or agency lacks jurisdiction at the time the order or judgment is entered. *SAIF v. Roles*, 111 Or App 597, 601, 826 P2d 1039, *rev den* 314 Or 391(1992) (judgment is void only when tribunal rendering it has no jurisdiction of the parties or subject matter.) It is true that, as of June 7, 1995, the effective date of Senate Bill 369, the Hearings Division had no jurisdiction to decide questions of vocational assistance. However, at the time the ALJ's order awarded claimant vocational assistance benefits, the Hearings Division of the Workers' Compensation Board had jurisdiction over the parties and the dispute and the authority to enter an order. All that the "retroactivity clause" of SB 369 accomplishes is to render the ALJ's order subject to being set aside via an adjudicative act. Here, employer knew that the ALJ's order was not "void" or a "nullity" but "voidable," **<168 Or App 42/43>** and that is why it requested the Board not just to dismiss the pending request for review but to vacate the ALJ's order as well. The legal efficacy of the ALJ's order did not cease until February 16, 1996, the date the Board vacated it.

The RRU decision was not reinstated until the Board vacated the ALJ's order. That did not occur until February 16, 1996. At that time, the Board dismissed the pending request for review, thereby rendering the RRU decision final. Claimant filed for review of the RRU order with the Director on March 4, 1996, within the 60 days of the effective date of the RRU order. Although it may have been clumsy for the Director to decide the issue under the rubric of "tolling," the Director's decision that claimant's request was timely was nevertheless correct.

Employer next assigns error to the Director's grant of claimant's motion to strike the testimony of employer's Human Resources Manager. Employer argues that the proffered evidence was relevant to show that employer would have been able to accommodate claimant in the offered position. However, the manager testified that he was hired in 1997 and that he had no direct knowledge of how the paint room, where claimant worked before the manager began employment, was supervised. The Director did not err in holding that evidence irrelevant where the manager did not have direct knowledge of the circumstances surrounding the termination of claimant's employment, which was central to the vocational assistance issue.

Employer also assigns error to the Director's holding that, in denying vocational assistance benefits, the RRU abused its discretion. The Director did not err.

The RRU found that a paint room associate is required to walk or stand for eight hours. However, the medical evidence shows that claimant cannot walk or stand for that length of time, and the RRU erred in interpreting the medical evidence otherwise. Claimant did not have the capacity to do the job in the way that employer required, and the job offered to him was not suitable. The RRU's denial of vocational assistance benefits clearly was against the evidence.

168 Or App 44> Employer's final assignment of error is that the Director erred in failing to apply the statutory requirements of ORS 656.340(6)(a) for eligibility for vocational assistance. Employer argues that claimant presented no evidence that there was no suitable employment available to him, as

the statute requires.[2] However, employer did not raise the issue until closing argument. The Director did not err in declining to consider a new issue raised for the first time after the evidentiary record was closed. *Fred Meyer, Inc. v. Hofstetter*, 151 Or App 21, 26, 950 P2d 322 (1997) (board did not abuse its discretion in refusing to consider issue not raised before the ALJ because claimant would be unfairly prejudiced if it were to decide the issue on the record before it).

Affirmed.

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[2] The applicable statutory provision at that time provided that, to be eligible for vocational assistance, the worker must also have a "substantial handicap to employment," meaning that the worker "lacks the necessary physical capacities" to be employed in suitable employment. ORS 656.340(6)(b)(A).

EDMONDS, J., concurring.

The issue in this case is whether employer or claimant was obligated to file a request for hearing before the Director under *temporary* OAR 436-001-0015 (1995). According to the majority and the dissent, the resolution of the issue turns on whether the administrative law judge's (ALJ's) decision became "void" or "voidable" as the result of the retroactive effect of Senate Bill 369 (1995). The majority holds, "[a]ll that the 'retroactivity clause' of SB 369 accomplishes is to render the ALJ's order subject to being set aside via an adjudicative act." 168 Or App at 42. The dissent would hold that "[t]he ALJ's decision was void as of the effective date of the 1995 amendments. Therefore, the employer was not obliged to seek review of that decision." 168 Or App at 48.

I agree with the dissent that the ALJ's decision was a legal nullity once the 1995 amendments became effective. By transferring jurisdiction over the matter to the Director from the Hearings Division, the retroactive legal effect of the amendments operated as if the ALJ's decision had not occurred. However, the amendments left unaddressed the procedural status of employer's appeal to the Board. That **<168 Or App 44/45>** issue is governed by *temporary* OAR 436-001-0015 (1995). Until the Board acted on employer's appeal by vacating the order that directed employer to provide vocational assistance, claimant could not have been deemed a "requesting party" under the rule.

Temporary OAR 436-001-0015 (1995) provided, in pertinent part:

"(1) * * *

"* * * * *

"(b) On or after June 7, 1995 and before September 17, 1995, any appropriate request for review *filed with the Board or its Hearings Division* (the Board) on a matter where review now lies with the director * * * shall be deemed a timely filing with the director provided that:

"* * * * *

"(B) the requesting party formally files for review in writing with the director within 90 days of the effective date of this rule." (Emphasis added.)

The Director's decision that claimant could not become a "requesting party" under the rule until after the Board dealt with employer's appeal constitutes a plausible interpretation of its own rule that promotes orderly administrative procedure. Under the Director's interpretation, employer, not claimant, was the party who, in the language of the rule, had an appropriate request for review pending with the Board. Claimant could not have become a "requesting party" under the rule until the Board acted to divest itself procedurally from all claims pending before it. Thus, it is immaterial whether the ALJ's decision was "void" or "voidable."[1] The proper question before us is whether the Director's decision to deem employer as the "requesting party" is a plausible interpretation of its own rule, and I would uphold the Director's decision on that basis under *Don't Waste Oregon Com. v. Energy Facility Siting*, 320 Or 132, 881 P2d 119 (1994).

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[1] I question the propriety of applying common law concepts about judgments to the administrative law process. In my view, the question is whether the Director had the authority to fashion a subset of its own rule to accomodate the circumstances of this claim. I would hold that it had such authority.

168 Or App 46> LANDAU, J., dissenting.

I disagree with the majority's disposition of this case for two reasons. First, the majority incorrectly concludes that employer was obligated to seek review of a decision that the enactment of 1995 amendments to the vocational assistance statute had rendered a nullity. The majority, without citation of authority or explanation, simply declines to give effect to the statute. Second, and apart from that, the majority condones the Director's decision to "toll" a statutory filing deadline. The majority characterizes the Director's decision as merely "clumsy," but apparently not legally incorrect. I disagree.

I begin with the conclusion that the employer was obligated to seek review of the disputed decision. The majority holds:

> "At the time of the jurisdictional changes, claimant had succeeded in overturning the August order of the RRU. Having prevailed, there was no reason for claimant to request further review by the Board. However, employer requested Board review. Because of the pending review, the RRU order denying claimant benefits was not finally resolved when the jurisdictional changes occurred. Under the temporary rule, employer, as the party requesting Board review, was the party obligated to refile the new request with the Director. Employer did not refile, and the Board determined that it had no jurisdiction to decide employer's request for review, dismissed review of the vocational assistance matter, and vacated the order directing employer to pay benefits. When the Board's action effectively reinstated the RRU order denying benefits, claimant filed his request for a contested case hearing within 60 days, as required by ORS 656.383(2). We find no basis on which to say that the Director's interpretation that the rule did not apply to claimant's circumstances was erroneous."

168 Or App at 41-42 (citation omitted).

The problem with the majority's analysis is that it ignores the effect of the 1995 amendments depriving the Board and the Hearings Division of jurisdiction to consider vocational assistance disputes. Those amendments expressly apply *retroactively* to pending matters such as this case. **<168 Or App 46/47>** Indeed, the legislature's intentions hardly could have been made more clear:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, *and this Act is intended to be fully retroactive* unless a specific exception is stated in this Act."

Or Laws 1995, ch 332, section 66(1) (emphasis added). That means that, on the effective date of the 1995 amendments, the jurisdiction of the ALJ to issue an order reversing the RRU decision had been revoked, and the revocation was "fully retroactive." To give full retroactive effect to the revocation necessarily means that whatever authority the ALJ once had to make such a decision was lost. An agency decision rendered without jurisdiction is void. *Shurman v. Bureau of Labor*, 36 Or App 841, 844, 585 P2d 758 (1978). Thus, in this case, the ALJ's decision became void on the effective date of the 1995 amendments. In that light, to suggest that employer was obligated to request review before the Director makes no sense. The ALJ's decision no longer existed as of the effective date of the 1995 amendments. There was no decision adverse to employer for the Director to review.

The majority acknowledges that the effect of the statute was to deprive the Board and the Hearings Division of jurisdiction and that the statute was intended to apply retroactively. It further acknowledges that a decision rendered without jurisdiction is void. The majority nevertheless declines to embrace the logical consequence of those principles. The majority simply declares that "[a]ll that the 'retroactivity clause' of SB 369 accomplishes is to render the ALJ's order subject to being set aside via an adjudicative act." 168 Or App at 42.

Interestingly, the majority offers no analysis in support of its conclusion that the retroactivity clause in the 1995 amendments affects pending cases only by means of a subsequent "adjudicative act." In particular, it does not make any attempt to establish the legislature's intentions with respect to the effect of the retroactivity clause. It does not, for example, examine the relevant statutory language and

explain **<168 Or App 47/48>** how it is giving effect to the legislature's "fully retroactive" intentions by holding that the ALJ's decision remained valid a full eight months after the effective date of the 1995 amendments that deprived the ALJ of the jurisdiction to make such decisions.

Likewise, the majority declines to examine any cases construing the retroactivity clause at issue. In point of fact, we have previously construed the very same retroactivity clause and have concluded that it has the effect of changing the law without a subsequent "adjudicative act." *See, e.g., Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996). The majority declines to explain--and I am at a loss to understand--how the very same retroactivity clause meant one thing in *Volk* and another thing entirely in this case. In my view, the clause means what it says. The ALJ's decision was void as of the effective date of the 1995 amendments. Therefore, the employer was not obliged to seek review of that decision.

I turn then to the other flaw in the majority's reasoning, concerning the disposition of the Director's decision to "toll" the filing period of 60 days described in ORS 656.283(2). The Director held:

> "[T]he board's adjudicative process concluded after the temporary rule's effective period was not within claimant's control. Therefore, absent any direction from statute or rule, the time in which the claimant had to file for a contested case hearing was effectively tolled during the hearing process before the board. It follows then, that pursuant to ORS 656.283(2)(d), the claimant had 60 days from the date of the board's order to request a contested case hearing before the director."

The majority concludes that, in so holding, the Director was "clumsy," but not in error. I disagree.

Such a "tolling" period cannot be found in the language of the statute. ORS 656.283(2)(d) provides that an appeal of an RRU decision "must be made within 60 days of the review date." It does not say--as the Director held--that, in some cases, an appeal may be taken within "60 days from the date of the board's order," dismissing an appeal of an ALJ's decision. ORS 174.010 provides that courts may not **<168 Or App 48/49>** insert into a statute language that the legislature has not included. Administrative agencies are no less subject to the same constraint. In fact, the Director's conclusion that, in the absence of a statute or rule prohibiting him from doing so, he is free to toll statutory deadlines is precisely backwards. Unless a statute affirmatively grants him that authority, he lacks it. *See Severy v. Board of Parole*, 318 Or 172, 176 n 7, 864 P2d 368, *rev den* 318 Or 326 (1993) (agency may not expand its authority beyond that granted by statute); *Oregon Occupational Safety v. Don Whitaker Logging*, 123 Or App 498, 501, 861 P2d 368 (1993) (agencies are limited to the authority conferred by statute).

For either reason, the Director erred, and his decision should be reversed and remanded for reconsideration. The majority likewise errs in affirming the Director, and I respectfully dissent from that decision.

Haselton, J., joins in this dissent.

Cite as 168 Or App 62 (2000) May 31, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

NANCY J. STORM, personal representative for the Estate of Jon E. Storm, deceased,
Respondent - Cross-Appellant,
v.
RICK McCLUNG, Cross-Respondent, and
CITY OF OREGON CITY, a municipal corporation, Appellant - Cross-Respondent.
(CCV9605004; CA A99618)

Appeal from Circuit Court, Clackamas County.
Robert D. Herndon, Judge.
Argued and submitted February 19, 1999.
Robert E. Franz, Jr., argued the cause and filed the briefs for appellant - cross-respondent City of Oregon City and cross-respondent Rick McClung.
W. Eugene Hallman argued the cause and filed the brief for respondent - cross-appellant.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
ARMSTRONG, J.
On appeal, reversed and remanded for new trial on damages on behalf of Myrtha Storm only; affirmed on cross-appeal.

*Kistler, J., *vice*, Warren, P.J., retired.

168 Or App 64> Plaintiff, the widow of Jon Storm and personal representative of his estate, brought this wrongful death action against the City of Oregon City (the City) for the benefit of Storm's mother, Myrtha Storm, and his daughters, Sonia and Tami Storm. ORS 30.020. The City appeals from a judgment for plaintiff that was based on the jury's finding that the City and Storm were each 50 percent negligent in Storm's death. We hold that Sonia and Tami have each received a substantial remedy under the Workers' Compensation Law and that plaintiff is not, therefore, entitled to any recovery on their behalf. We therefore reverse and remand for retrial on the issue of damages solely on behalf of Myrtha.

Storm was an employee of Bud's Towing, an Oregon City business owned by Del Bullock.[1] Bullock was active in civic affairs, at times loaning his business equipment and employees for city projects. Storm was similarly involved; among other things, he was a member of the Arbor Day Clean Up Committee, which Rick McClung, the City's director of public works, chaired.[2] The members of the committee other than McClung were, like Storm, volunteers interested in the "beautification and enhancement of the city."

Storm died on May 4, 1994, in the process of an Arbor Day project at the City's Clackamette Park, which is located at the confluence of the Clackamas and Willamette rivers. The city wanted to top a number of cottonwood trees in the park, both because the trees were potentially dangerous and to create nesting sites for birds. It had previously paid a **<168 Or App 64/65>** professional tree service to fell a number of trees in the park; city employees did not believe that they were qualified to do the work safely. The jury could have found that topping a tree is more dangerous than felling it. A city

[1] We base this summary of the facts on our review of the record, assisted by plaintiff's helpful statement in her brief. In its brief, the City fails either to describe the facts most favorably to the jury's verdict or to do so in narrative form. Rather, it summarizes each witness' testimony *seriatim*, requiring the court to attempt to determine the relationship between the events that the various witnesses described. In the first respect the City fails to comply with the appropriate standard of review. In the second, it violates both ORAP 5.40(8) and the basic principles of effective appellate practice. *See Myers v. Cessna Aircraft*, 275 Or 501, 506 n 2, 553 P2d 355 (1976); *State ex rel Kilian v. City of West Linn*, 112 Or App 549, 554 n 3, 829 P2d 1029, *rev den* 314 Or 391 (1992).

[2] McClung is also a defendant. The court's order dismissing the claims against him is the subject of plaintiff's cross-appeal; we affirm that order without discussion.

employee examined the trees in April 1994 and identified six that were particularly dangerous because of their location and condition. The City knew from the employee's written report that tree "F" contained rotten wood, which increases the dangerousness of a cottonwood. McClung suggested that the Arbor Day committee include topping those six trees among the projects for its spring clean-up period, which ran for several weeks in May and June. If the City had been unable to find volunteers, either through the committee or otherwise, it would again have hired a contractor; its own employees would not have done the job.

Storm was one of the volunteers who worked on topping the trees. Bud's Towing provided equipment for use on the job. Bullock was present for only a small part of the time, but Storm participated throughout the day. The equipment that Bud's Towing provided included a crane that had a bucket at one end; of those present, only Storm and Bullock were qualified to operate it. Michael Huffman, the person cutting the trees, stood in the bucket thirty feet above the ground in order to top the trees. Storm did not originally do any of the cutting because he had to operate the crane. After the group successfully topped several trees, it turned to tree "F." After Huffman had cut a significant distance through the trunk of that tree, the top began to move toward him, rather than away from him. The movement ultimately trapped the saw within the cut. Huffman shut off the saw, and the group spent about an hour discussing what to do next. Bullock arrived during the discussion.

The group ultimately decided that Storm would go up in the bucket, at least to retrieve the saw and see exactly what the situation was, while Bullock operated the crane. Storm went up, pounded wedges into the saw cut, and freed the saw. Instead of coming down at that point, he started the saw and attempted to finish topping the tree. The top again moved toward the saw rather than away from the crane, but this time it came completely down. In doing so, the top knocked the crane off the truck, threw Storm out of the **<168 Or App 65/66>** bucket, and landed on top of him. Storm died soon afterwards. City employees observed and videotaped the entire proceedings, but they were not involved in the decisions and did not warn Storm or anyone else of the dangers that the trees presented.

The jury found that Storm and the City were each 50 percent negligent in causing Storm's death. There is evidence that supports that finding. The jury then determined that the estate's economic damages were $147,923 and that its noneconomic damages, on behalf of Tami, Sonia and Myrtha, were $400,000. In accordance with the jury's finding of comparative fault, the court entered judgment against the City for $73,961.50 in economic damages and $200,000 in noneconomic damages. It thereafter entered an order of distribution under ORS 30.050, apportioning economic damages of $24,653.83 each to Sonia and Tami and $24,653.84 to Myrtha, and noneconomic damages of $75,000 each to Sonia and Tami and $50,000 to Myrtha.

The City makes a number of assignments of error, most of which do not require extended discussion. Its argument that the court erred in submitting the specifications of negligence to the jury is based on the City's view of the evidence, not on the view that plaintiff wanted the jury to take, that it apparently did take, and that the evidence permitted. The City also objects to the court's giving instructions that the City originally requested on its obligations to a licensee and an invitee. The City, not unnaturally, does not assert that those instructions are incorrect statements of the law. Contrary to its current position, the instructions remained appropriate even though the City withdrew its requests after the close of the evidence.[3] Under defendant's theory of the case, Storm was a licensee who came into the park for a project that the City permitted but did not sponsor or encourage; under plaintiff's theory of the case, Storm was an invitee who **<168 Or App 66/67>** at the time of his death was voluntarily working on the City's business, at the City's request, on the City's land.

The City also assigns error to the denial of its motions for directed verdict based on the Recreational Land Act, former ORS 105.655 to 105.680, *repealed* by Or Laws 1995, ch 456, section 9, and the Woodcutting Act, *former* ORS 105.685 to 105.697, *repealed* by Or Laws 1995, ch 456, section 9. Both acts provided significant immunity from tort claims to landowners who permitted or invited persons to

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[3] It is not clear why the court gave the instructions after the City withdrew its request. According to plaintiff's brief, she did not request them. However, defendant's counsel, before stating his exceptions to the instructions, said that plaintiff had requested them after he withdrew his request. Because the discussion concerning instructions apparently occurred in chambers and, as too often happens, was not reported, we cannot resolve that conflict.

come onto their land for recreational purposes or in order to cut and remove wood. The problem with the City's position is the same under both statutes: under the evidence, viewed most favorably to plaintiff, Storm was not simply a person invited or permitted to enter the City's land. Rather, he was present at the City's request, with the City's assistance, in order to benefit the City. He was not a person described in either act, and they therefore do not apply to this case.

The remaining assignments of error involve, directly or indirectly, the relationship between the Tort Claims Act and the Workers' Compensation Law. The issues arise from ORS 30.265(3)(a), which is part of the Tort Claims Act. That statute provides immunity from liability to every "public body and its officers, employees and agents acting within the scope of their employment or duties" for "[a]ny claim for injury to or death of any person covered by any workers' compensation law." The statute applies to this case, because at the time of his death Storm was covered by workers' compensation as an employee of Bud's Towing. Plaintiff, in her capacity as Storm's wife rather than as personal representative of his estate, and Sonia and Tami, as Storm's daughters, have received workers' compensation benefits. The record does not indicate that Myrtha received anything. Plaintiff, in her capacity as Storm's wife, recognizes that the benefits that she has received bring her within the prohibition of ORS 30.265(3)(a) and, therefore, does not make any claim on her own behalf.

ORS 30.265(3)(a) affects the City's assignments of error that the trial court erred in submitting certain elements of damage to the jury and that it erred in denying the City's motion for a directed verdict as to plaintiff's claims on **<168 Or App 67/68>** behalf of Sonia and Tami. Those assignments also relate to the nature of the damages that the Wrongful Death Act permits plaintiff, as personal representative of Storm's estate, to seek. Under ORS 30.020(2) wrongful death damages are limited to an amount that:

> "(a) Includes reasonable charges necessarily incurred for doctors' * * * [and] other medical services, burial services and memorial services rendered for the decedent;
>
> "(b) Would justly, fairly and reasonably have compensated the decedent for disability, pain, suffering and loss of income during the period between injury to the decedent and the decedent's death;
>
> "(c) Justly, fairly and reasonably compensates for pecuniary loss to the decedent's estate;
>
> "(d) Justly, fairly and reasonably compensates the decedent's spouse, children, * * * and parents for pecuniary loss and for loss of the society, companionship and services of the decedent; and
>
> "(e) [Punitive damages]."

The normal application of ORS 30.265(3)(a) is to prevent the estate from recovering *any* of the damages that the statute describes, including those on behalf of the decedent's relatives, when the decedent is covered by a workers' compensation law. However, the Supreme Court has held that that limitation violates Article I, section 10, of the Oregon Constitution[4] when applied to someone who does not receive a substantial remedy from the workers' compensation system. In *Neher v. Chartier*, 319 Or 417, 879 P2d 156 (1994), the plaintiff's daughter was killed when a Tri-Met bus struck her while she was in a marked crosswalk and the "walk" signal was in her favor. She was in the course and scope of her employment at the time. Because she had no dependents, the only workers' compensation benefits to which anyone was entitled as a result of her death was a maximum $3,000 for burial expenses, payable to her estate. The plaintiff, as personal representative of her estate, sued the bus driver and **<168 Or App 68/69>** Tri-Met for her injuries. The trial court dismissed the case on the ground that ORS 30.265(3)(a) made both Tri-Met and the driver immune.

On appeal, the Supreme Court held that the application of ORS 30.265(3)(a) to that case was unconstitutional. After discussing its previous cases concerning the right to a remedy under Article I, section 10, the court concluded that legislation extending tort immunity to public officers and employees

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[4] Article I, section 10, provides in relevant part that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation."

violates the constitution "if the effect of the immunity provisions is to render tort plaintiffs 'without remedy.'" *Neher*, 319 Or at 426. Although the decedent's estate was not entirely without a remedy because of the burial benefit, the estate was not the only real party in interest in a wrongful death action. Under ORS 30.020(1), the estate brings the action on behalf of others that include the decedent's surviving spouse, children, and parents. ORS 30.020(2)(d) entitles those people to compensation "for pecuniary loss and for loss of the society, companionship and services of the decedent." In *Neher*, however, the workers' compensation system left the decedent's parents entirely without a remedy. It abolished their remedy not only against the public body but also against the public body's negligent employees. That, the court concluded, was inconsistent with its previous cases under Article I, section 10. *Id.* at 427-28.

The court summarized its holding in Neher at the end of its opinion:

> "ORS 30.265(3)(a), which provides that public bodies and their officers, employees, and agents, acting within the scope of their employment are immune from liability for claims for injury to or death of any person covered by any workers' compensation law, violates Article I, section 10, of the Oregon Constitution, because it has left plaintiff without a remedy."

319 Or at 428. We have had only one previous occasion to apply the holding in *Neher*.[5] In *Brentano v. Marion County*, 150 Or App 538, 946 P2d 705 (1997), the plaintiff argued, based on the Supreme Court's introductory and concluding **<168 Or App 69/70>** statements in *Neher*, that the court had held that ORS 30.265(3)(a) is unconstitutional in all situations. We examined the *Neher* decision and concluded that the plaintiff was wrong. Rather, we held, the court had limited its holding to the facts of the case, in which the parents were *wholly* without a remedy. We noted that the court had held in *Hale v. Port of Portland*, 308 Or 508, 523, 783 P2d 506 (1989), that the liability limits of the Tort Claims Act did not violate Article I, section 10, because that act provided a substantial remedy, even if one that was not as great as the tort system would otherwise allow. We therefore concluded that ORS 30.265(3)(a) is unconstitutional only to the extent that the workers' compensation system does not provide the plaintiff a substantial remedy. In *Brentano*, the plaintiff received $35,000 from the workers' compensation system, which we held was a substantial remedy.

Plaintiff argues that ORS 30.265(3)(a) is unconstitutional as to plaintiff's claims on behalf of Sonia and Tami, each of whom at the time of trial had received workers' compensation benefits of over $5,000 ($5,412.50 for Tami and $5,660.60 for Sonia), and each of whom is entitled to an additional $215 for every month that she attends college. Plaintiff argues that those amounts are not substantial in light of the jury's determination that each daughter suffered total damages of $199,306 and of the judgment that awarded each daughter a total of $99,653. That argument, of course, relies on the benefit of hindsight after trial and ignores that the court, not the jury, allocated the total verdict among the various beneficiaries. There is, however, a more basic problem with plaintiff's position.

At the heart of plaintiff's argument is her assumption that all that is relevant to determining the substantiality of a remedy is comparing the amount that the plaintiff could have recovered in a tort action with the amount that the beneficiary received from the workers' compensation system. That assumption does not directly flow from the relevant decisions, which appear to focus more on the absolute amount of the alternative recovery. In *Brentano*, we noted that the plaintiff had received $35,000 in workers' compensation benefits. We did not describe the extent of the plaintiff's injuries, whether the benefits were for wage loss, medical services, or other purposes, or the amount that the **<168 Or App 70/71>** plaintiff might have recovered in a tort action. We simply held that the amount that he received was a substantial remedy and that, for that reason, the statute was not unconstitutional as applied to him. Similarly, in *Hale*, which it decided before *Neher*, the Supreme Court determined that the limit of $100,000 that the Tort Claims Act then provided was a substantial remedy, even though that amount was only about a sixth of the plaintiff's actual medical bills. The court held that Article I, section 10, does not require that the remedy that the legislature provides must be precisely of the same type or extent; it is enough if the remedy is a substantial one. *Hale*, 308 Or at 523.

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[5] We recently discussed *Neher* in *Brewer v. Dept. of Fish and Wildlife*, 168 Or App 173, ___ P2d ___ (2000), concluding that it remains controlling in this precise context. *Id.* at 187-88.

Those cases do not resolve the issue, however. Exactly what makes an alternative remedy "substantial" for purposes of Article I, section 10, is not entirely clear. The cases contain only bald statements that a certain amount is or is not substantial, with no significant analysis to support their conclusion. There are, however, some resources to help flesh out these statements. Because the issue is the meaning of a word, we begin with the dictionary. The relevant definitions suggest that, to be substantial, something must at least be significant, either in absolute terms or in relationship to what the word describes. Those definitions include "considerable in amount, value, or worth <made a [substantial] gain on the transaction>"; "being that specified to a large degree or in the main <a [substantial] victory> <a [substantial] lie>"; and "of or relating to the main part of something[.]" *Webster's Third New Int'l Dictionary*, 2280 (unabridged ed 1993). Under the first definition, a remedy may be substantial if it is large in an absolute sense; that would be consistent with the holdings in *Hale* and *Brentano* and with at least some of their reasoning. The second and third definitions, however, imply that a substituted remedy must be substantial in relationship to the previous remedy, which supports plaintiff's assumption.

Some cases, however, appear to suggest a criterion that is not in the dictionary. They hold that whether a substituted remedy provides a benefit as well as a detriment may be more important to its substantiality than either its absolute or relative size. In *Hale*, the court noted that the legislature, in adopting the Tort Claims Act, had struck a new balance between municipal corporations and those to whom **<168 Or App 71/72>** the corporations could have been liable before the adoption of the act: it both *limited* the amount of a municipality's liability and *widened* the class of plaintiffs to whom municipalities could be liable by abolishing the distinction between proprietary and governmental functions. "A benefit has been conferred, but a counterbalancing burden has been imposed. This may work to the disadvantage of some, while it will work to the advantage of others. But all who had a remedy continue to have one." *Hale*, 308 Or at 523. The court had previously taken similar positions under Article I, section 10, with regard to the Workers' Compensation Law, which substitutes a certain but relatively small remedy for an uncertain but potentially large one, *see Evanhoff v. State Industrial Acc. Com.*, 78 Or 503, 523-24, 154 P 106 (1915), and ORS 30.160, which limits the damages recoverable in a defamation action if the defendant publishes a correction or retraction. *See Davidson v. Rogers*, 281 Or 219, 222, 574 P2d 624 (1978). In each case, the plaintiff will receive a remedy that is qualitatively different from that available under the common law but that, the court has held, satisfies the constitutional requirement. The fact that for some plaintiffs the substituted remedy will be superior to the original remedy appears to be important. In *Hale*, which first treated the issue as whether the substituted remedy was "substantial," that qualitative superiority appears to be part of what made the new remedy substantial.

Finally, in *Neher* the court noted that ORS 30.010 recognizes a right of recovery on behalf of surviving relatives "for pecuniary loss and for loss of the society, companionship and services of the decedent" and that the adoption of ORS 30.265(3)(a) left the decedent's parents without the ability to recover for those losses against anyone--and, thus, without a remedy of any sort. 319 Or at 428. Because nondependent parents are not entitled to any workers' compensation death benefits, *see* ORS 656.204, there was no issue in *Neher* of whether the workers' compensation benefits themselves constituted a substantial remedy. Thus, among other things, the court did not need to decide whether the failure of the workers' compensation system to provide compensation for the loss of the decedent's society and companionship affected the substantiality of the remedy.

168 Or App 73> Those cases lead us to some tentative conclusions. First, it appears to be acceptable under Article I, section 10, to eliminate any compensation for noneconomic damages, such as loss of society and companionship, provided that there continues to be some source of compensation for economic damages. Second, the substituted remedy must provide some benefit to the class of potential plaintiffs in addition to simply eliminating or reducing the previous remedy. The benefit may be different in quality from the previous remedy, but it must exist. The workers' compensation system, which eliminates all right to recover for noneconomic damages but provides compensation for economic injuries without the necessity of proving fault, is the classic example of these first two conclusions. The Tort Claims Act, which eliminates the distinction between proprietary and governmental functions, in exchange for a limitation on the total amount recoverable from a public body, is an example of the second conclusion. Finally, the substituted remedy must only be substantial; it need not be equivalent to the previous remedy, even for the same kind of injuries. Thus, comparing the amount actually available under the workers' compensation system with a potential tort recovery is inappropriate. The question is whether the amount actually recovered is substantial.

We have some difficulty in applying these conclusions to this case. Plaintiff's recovery was against the City, while Sonia and Tami received workers' compensation benefits through Storm's employment with Bud's Towing. ORS 30.265(3)(a), in essence, uses the remedy that the workers' compensation law provides against Storm's employer to deny Sonia and Tami a remedy against a third party who would otherwise be liable. There is no obvious substitute remedy for them, or other potential plaintiffs in their situation, in exchange for the loss of their tort remedy against the City. Nevertheless, *Neher* and, more expressly, *Brentano* appear to suggest that that is acceptable, so long as the workers' compensation remedy is otherwise substantial. In any event, plaintiff defends the denial of the City's motion for directed verdict solely on the ground that the *amounts* that Sonia and Tami received are not substantial; she does not argue that **<168 Or App 73/74>** denying her any remedy against the City is itself a constitutional violation. We will therefore decide the issue that the parties raise.

We conclude that Sonia and Tami each received a substantial remedy from the workers' compensation system. Each has already received over $5,000 and, depending on how far each pursues her schooling, each may ultimately receive over $10,000. The nature of the workers' compensation system allowed them to recover without regard to whether Storm's negligence was the primary cause of his death, something that, as the jury's verdict shows, was a close question. That trade-off justifies a smaller recovery than the tort system would provide because the recovery is certain. In addition, the recovery is based on a formula that is related to the monetary contribution that Storm would have made if he had lived, and the amounts themselves are not insignificant. In reaching this conclusion, we determine substantiality without considering the jury's verdict, because the issue is how the statute treats the entire class of potential plaintiffs. The fact that the jury might well have concluded that Storm's negligence was greater than 50 percent and, thus, have awarded nothing, illustrates the importance of that approach. Because these amounts were substantial, applying ORS 30.265(3)(a) to Sonia and Tami would not violate Article I, section 10. The trial court should have granted the motions for partial directed verdicts as to them.

The last issues involve the trial court's instructions permitting the jury to award plaintiff reasonable and necessary hospital and medical service and burial expenses and instructing the jury that plaintiff could recover any pecuniary loss to Storm's estate. Each of those instructions is inconsistent with ORS 30.265(3)(a). Medical and burial expenses are damages that the estate suffered directly. The authority to recover them comes from ORS 30.020(2)(a) and (c). They are not part of compensating Storm's surviving relatives for their loss under ORS 30.020(2)(d). The Tort Claims Act, thus, forecloses the estate from recovering them. On the retrial the court should not instruct the jury concerning those damages.

The evidence on which the jury based its award of damages involved all three claimants, Myrtha, Sonia and **<168 Or App 74/75>** Tami. Because the court erred in submitting Sonia's and Tami's claims to the jury, and because the jury considered that improper evidence in reaching its verdict, we cannot affirm the entirety of the jury's award. There is nothing in the record that would permit us to determine what the jury would have awarded if the evidence had been limited to Myrtha's claim. Although the trial court allocated the damages among Myrtha's, Sonia's and Tami's claims, that allocation was based on the court's authority under ORS 30.050. It does not purport to reflect a jury determination. Because the record does not allow us to remand for entry of a judgment for a specific amount, there must be a retrial. On the other hand, because we reverse only on damage issues, and because none of those issues could have affected the jury's determination of liability, we limit the remand to a retrial on the amount of damages that plaintiff is entitled to recover under ORS 30.020(2)(d) on behalf of Myrtha Storm. *See Turnbow v. K.E. Enterprises, Inc.*, 155 Or App 59, 72-73, 962 P2d 764 (1998).

On appeal, reversed and remanded for new trial on damages on behalf of Myrtha Storm only; affirmed on cross-appeal.

Cite as 168 Or App 92 (2000) May 31, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Florian D. Stan, Claimant.

FLORIAN D. STAN, Petitioner,
v.
CONSTITUTION STATE SERVICE CO., and USF REDDAWAY, INC., Respondents.
(98-01004; CA A105650)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 6, 1999.
Edward J. Hill argued the cause for petitioner. With him on the brief was Carney, Buckley, Kasameyer & Hays.
Jerald P. Keene argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Affirmed.

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168 Or App 94> Claimant seeks review of a Workers' Compensation Board order holding that claimant's injury did not arise out of his employment because it resulted from prohibited conduct. We affirm.

The Board found the following facts:

> "Claimant sustained a left foot injury on August 20, 1997, when a co-worker's fork lift truck ran over his foot. At the time of injury, claimant was returning to his work station on the employer's premises after a paid break. The accident occurred when the co-worker drove forward as claimant was reaching for a control device on his co-worker's lift truck. The record establishes that reaching for the control devices of another lift truck was prohibited activity."

In a footnote, the Board agreed with employer that claimant "was most likely engaged in 'horseplay'" when the accident occurred.

The Board correctly recognized that the fact that the act that produced the injury was prohibited does not mean that the injury is not compensable. *See Andrews v. Tektronix, Inc.*, 323 Or 154, 165, 915 P2d 972 (1996). Rather, the "facts that an employer has instructed a worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, are only two of many factors that must be considered in the over-all calculation of work-connectedness." *Id.* Among the "additional factors are the degree of connection between what the worker is authorized to do and is forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, the relative risk to the worker when compared to the benefit to the employer, and the like." *Id.*

Applying those factors, the Board reasoned:

> "In this case, claimant clearly disobeyed the employer's prohibition against tampering with the controls of another forklift. Moreover, we agree with the employer that, unlike *Andrews*, this case involved more than a prohibited method of accomplishing claimant's job. Claimant here had not resumed his work when he made multiple attempts to **<168 Or App 94/95>** reach the controls [of] a co[-]worker's fork lift truck. Claimant was not involved in any work activity when he was injured. Further, no decree of judgment or latitude was involved in claimant's actions. The employer clearly prohibited interfering with the lift controls of another worker's fork lift. As the employer notes, the risk of injury to claimant was great, while there was no benefit to the employer in reaching multiple times for the controls of the fork lift. Finally, we find that the prohibition

> against manipulating the controls of another worker's fork lift was made clear to all employees. Indeed the witnesses unanimously agreed that this conduct was strictly forbidden and would, and did, result in disciplinary action. Accordingly, * * * we conclude that claimant failed to prove a sufficient work connection between his injury and his employment."

The Board observed that "[i]n reaching this conclusion, we reject any suggestion in claimant's testimony that his actions were motivated by safety concerns."

Before turning to the issue that claimant raises on review, it is helpful to note what is not at issue. Claimant has not argued that, although he was engaged in horseplay, employer previously had acquiesced in that sort of conduct notwithstanding its rules prohibiting it. Had claimant made that argument before the Board, the Board would have been required to decide whether employer's acquiescence, if any, in the horseplay meant that claimant's injury arose out of his work. *See Stark v. State Industrial Acc. Com.*, 103 Or 80, 100-01, 204 P 151 (1922); *Kammerer v. United Parcel Service*, 136 Or App 200, 204-05, 901 P2d 860 (1995); *Brown v. Liberty Northwest Ins. Co.*, 105 Or App 92, 95, 803 P2d 780 (1990), *rev den* 311 Or 261 (1991).

Claimant instead pursued a different course before the Board. Before the Board, he argued that his efforts to grab the other worker's forklift controls were prompted by his concerns over his safety. He relied on employer's failure to enforce its work place safety rules consistently to justify his own attempts to protect himself by grabbing at the forklift controls. As noted above, the Board did not accept claimant's view of the facts; it rejected his claim that he was acting for his own safety. Although claimant makes the same factual argument on review that he made before the Board, the **<168 Or App 95/96>** Board's factual findings rejecting that argument are supported by substantial evidence. *See Perez v. Employment Dept.*, 164 Or App 356, 992 P2d 460 (1999) (identifying standard of review). Given the argument that claimant raised below, the Board did not err.

Affirmed.

Cite as 168 Or App 278 (2000) June 7, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Complaint of Blair Fountain.

TYREE OIL, INC., Petitioner,
v.
BUREAU OF LABOR AND INDUSTRIES, Respondent.
(10-98; CA A102804)

Judicial Review from Bureau of Labor and Industries.
Argued and submitted May 10, 1999.
Dennis W. Percell argued the cause for petitioner. With him on the briefs was Arnold, Gallagher, Saydack, Percell & Roberts, P.C.
Richard D. Wasserman, Assistant Attorney General, argued the cause for respondent Bureau of Labor and Industries. With him on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
No appearance for respondent Blair Fountain.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Reversed.

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168 Or App 280> Petitioner Tyree Oil, Inc. (Tyree), seeks review of an order of the Commissioner of the Bureau of Labor and Industries (BOLI) requiring it to reinstate as an employee an individual who was injured while working for another company whose assets Tyree purchased. Tyree argues that it is not the injured individual's employer and is not obligated to reinstate that individual to a job that does not exist. We agree and reverse.

The pertinent facts are not disputed. Cumberland Distributing, Inc. (Cumberland), was in the business of selling and distributing fuel and petroleum products and served trucking, logging, and fishing industry customers along the Oregon Coast. It maintained offices in Reedsport and Coos Bay. Cumberland employed Blair Fountain as a truck driver. It employed eight other full-time and two part-time employees. Tyree also is in the business of selling and distributing petroleum products, primarily serving trucking, mining, railroad, and construction customers. In 1996, it employed 23 employees and maintained offices in Eugene and Roseburg. In the spring of that year, Cumberland planned to sell its assets to Tyree. In May 1996, the president of Cumberland told the company's employees about the plan.

On May 30, Fountain injured his back while working as a tanker truck driver for Cumberland. He filed a workers' compensation claim, which was accepted. Tyree was not informed of the injury or the claim. Fountain was disabled from work from June 7 to July 7, 1996.

Meanwhile, in June 1996, Tyree and Cumberland entered into an "Agreement for Sale and Purchase of Business Assets," by which Tyree purchased Cumberland's assets, including equipment, rolling stock, office equipment, furniture, tools, fixtures, inventories, equipment leases, real property leases, distributorship agreements, and rights to sales orders and purchase orders. Tyree did not purchase Cumberland's accounts receivable. Nor did it assume its accounts payable or any obligations to Cumberland's employees. The agreement specifically provided that all of Cumberland's obligations and liabilities not listed were to remain **<168 Or App 280/281>** Cumberland's obligations and liabilities. The agreement also provided that Cumberland would terminate its employees and would pay each employee any accrued compensation, including vacation and overtime pay.

On June 17, Cumberland terminated the employment of all of its employees, including Fountain. That same day, Tyree hired eight of the former Cumberland employees. Fountain was not among the employees that Tyree hired. The employees that Cumberland hired were treated as new employees with respect to health and other benefits. Some of the employees performed the same jobs that they had performed for Cumberland, while others were shifted to different duties. Tyree continues to operate

primarily out of its Eugene and Roseburg offices. It uses some of Cumberland's facilities in Reedsport and Coos Bay; some of the facilities are leased out to unrelated tenants. It also uses the equipment and other assets that it purchased, although it has made some changes in business operation and the uses of the equipment. Following the transfer of assets, Cumberland continued its corporate existence.

On July 8, Fountain was released by his doctor for regular work. He sought reinstatement with Tyree, but Tyree responded that it had no obligation to reinstate him, because he never had been a Tyree employee. Fountain filed a complaint with BOLI, and BOLI concluded that, although Tyree had not employed him, it was the successor to Cumberland, which had employed him and thus was obligated to reinstate him in his former position. It is that conclusion that Tyree challenges on review.

According to Tyree, the applicable statute provides that an injured worker's employer is obligated to reinstate and that it is not Fountain's employer. BOLI concedes that Tyree is not, and never has been, Fountain's employer. It nevertheless insists that Tyree assumed the obligations of Fountain's employer when it purchased substantially all of Cumberland's assets. Tyree rejoins that the general rule is that a company that purchases assets of another company does not assume that company's liabilities. BOLI agrees that that is the general rule, but argues that, "at least in general terms," Tyree's purchase of assets falls into an exception to **<168 Or App 281/282>** the rule when the purchase of assets amounts to a merger of the companies.

ORS 659.415(1) provides:

> "A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position."

On its face, the statutory requirement applies only to "the worker's employer." The question in this case is whether a company that purchases assets of a worker's employer becomes the worker's employer for purposes of ORS 659.415. The statute itself does not address that question. In examining the meaning of a statutory term, however, its common-law context sometimes is helpful in providing a backdrop against which the statute was enacted. *See, e.g., Denton and Denton*, 326 Or 236, 241, 951 P2d 693 (1998); *Owens v. Maass*, 323 Or 430, 438, 918 P2d 808 (1996).

It has long been the general rule in Oregon that, when one corporation purchases all of the assets of another corporation, the purchasing corporation does *not* become liable for the debts and liabilities of the selling corporation. *Erickson v. Grande Ronde Lbr. Co.*, 162 Or 556, 568, 92 P2d 170, 94 P2d 139 (1939). There are four recognized exceptions to that rule:

> "(1) Where the purchaser expressly or impliedly agrees to assume such debts; (2) where the transaction amounts to a consolidation or merger of the corporations; (3) where the purchasing corporation is merely a continuation of the selling corporation; and (4) where the transaction is entered into fraudulently in order to escape liability for such debts."

Id. (quoting *West Texas Refining & D. Co. v. Commissioner of Int. Rev*, 68 F2d 77, 81 (10th Cir 1933)).

BOLI concedes that the first, third, and fourth exceptions do not apply. It argues only that Tyree should be held to have acquired Cumberland's obligations under ORS 659.415(1) because its purchase of Cumberland's assets amounted to a consolidation or merger of the two companies. **<168 Or App 282/283>** In support of that argument, BOLI relies on a nine-factor analysis that has been adopted by several federal courts in employment discrimination cases. *See, e.g., In re National Airlines*, 700 F2d 695, 698 (11th Cir 1983); *Slack v. Havens* 522 F2d 1091, 1094-95 (9th Cir 1975); *EEOC v. MacMillan Bloedel Containers, Inc.*, 503 F2d 1086, 1094 (6th Cir 1974). Those nine factors are:

> "(1) Whether the successor company had notice of the charge, (2) the ability of the predecessor to provide relief, (3) whether there has been a substantial continuity of business operations, (4) whether the new employer uses the same plant, (5) whether he uses the same or substantially the same work force, (6) whether he uses the same or substantially the same supervisory personnel, (7) whether the same jobs exist under substantially the same working conditions, (8) whether he uses the same machinery, equipment and methods of production, and (9) whether he produces the same product." 503 F2d at 1094.

We express no opinion as to whether ORS 659.415(1) applies to successor employers or as to whether, if it does, the nine-factor test that BOLI proposes should be employed as a matter of Oregon law. Even assuming the statute applies to successor employers and that the nine-factor test applies, we conclude that, on this record, Tyree did no more than purchase Cumberland's assets and is not therefore a successor employer. In arriving at that conclusion, we note that Tyree received no notice of Fountain's claim until after the asset purchase had been completed. We also note that Cumberland still exists as a separate entity and that the two companies have completely different ownership and management. Tyree did hire eight of Cumberland's employees, but they constitute a relatively small portion of Tyree's workforce. Similarly, Tyree operates primarily out of Eugene and Roseburg. It continues to use some of Cumberland's facilities in Reedsport and Coos Bay, although it leases out some of the premises. It also has initiated a number of changes to the jobs of the former Cumberland employees and made changes to the use of the equipment and other assets.

168 Or App 284> BOLI acknowledges the foregoing distinctions between Tyree and Cumberland, but it emphasizes in its analysis the fact that Tyree continues to use Cumberland's plant and machinery in producing the same products. That is true enough, but it can hardly be controlling. Tyree would not have purchased the assets if it had not intended to put them to use. Indeed, if the mere use of such assets were controlling, virtually any purchase of assets would amount to a merger, a conclusion that is manifestly contrary to the general rule.

We conclude that the Commissioner erred in concluding that Tyree is obligated under ORS 659.415(1) to reinstate Fountain.

Reversed.

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