VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 52

(Pages 1-616)

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

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

JANUARY-MARCH 2000

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

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In the Matter of the Compensation of
RAGIE D. DUNCAN, Claimant
WCB Case No. 99-00020
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Craig A. Staples, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the self-insured employer's denial[1] of claimant's injury claim for a neck and upper back condition. On review, the issue is compensability.

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

On review, claimant concedes that this "is a case of credibility only." (App. Br. at 1). In other words, as the ALJ stated, if claimant did suffer an injury to his neck at work on November 17, 1998, then that incident is the major contributing cause of his disability and need for treatment for his combined neck condition. See ORS 656.005(7)(a)(B). The ALJ found claimant's testimony that he suffered an incident at work on November 17, 1998 not to be credible. For the following reasons, we agree with the ALJ that claimant is not credible.

Ordinarily we will defer to the ALJ's demeanor-based credibility findings. *International Paper v. McElroy*, 101 Or App 61 (1990). Here, there is no indication that the ALJ made his credibility finding based on claimant's demeanor at hearing. Nevertheless, we agree with the ALJ that several other factors combine to cast serious doubt on claimant's credibility. Claimant was the only witness at hearing, despite the fact that both his wife and his supervisor, Terry Morgan, allegedly could provide corroborative testimony to the fact that he suffered an injury at work on November 17, 1998. Because claimant identified his wife and his supervisor as witnesses in his favor, yet failed to call them or offer an explanation for why they were not called, we construe claimant's failure to call these witnesses against claimant. *See John Mahon*, 47 Van Natta 1647, 1648 (1995).

Moreover, claimant's own testimony as to his alleged on-the-job injury was inconsistent. In his recorded statement to a representative of the employer on December 2, 1998 (Ex. 2), claimant stated that he had asked for some medication from Morgan on the date of his injury, but had not actually informed Morgan that he had been injured. (Ex. 2-47). Later in the same interview, claimant said that he "probably should have told them [his supervisors]" at the time of the injury, but he did not realize the extent of his injury at the time, and he wanted to see if he would be "all right" after a ten-day layoff. (Ex. 2-67). At hearing, claimant testified that he had told Morgan right away about the injury. (Tr. 47).

Claimant has also recently been convicted of felony crimes involving false statements and dishonesty. (Tr. 36). He has lied to his employer to further his financial interests and the interest of his family on several occasions. In fact, claimant filled out his 801 form on the same date (November 30, 1998) that he learned that he would not have enough accrued vacation time with which to serve an impending jail sentence. (Ex. 1; Tr. 37, 40). Taking all of these factors together, we agree with the ALJ that claimant has not met his burden of proving that he was injured at work on November 17, 1998.

To the extent that claimant's treating physician's supported compensability on a medical basis, their opinions are not sufficiently persuasive given the non-credible history on which they are built. *Miller v. Granite Construction*, 28 Or App 473 (1977).

ORDER

The ALJ's order dated August 4, 1999 is affirmed.

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[1] The order refers to a denial dated December 2, 1998. We note that the correct date of the employer's denial is December 21, 1998. (Ex. 3).

In the Matter of the Compensation of
THOMAS R. GASSNER, Claimant
WCB Case No. 99-03525
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the SAIF Corporation's partial denial of claimant's current L4-5, L5-S1 disc condition. On review, the issue is compensability.

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

Dr. Kendrick, treating physician, opined that claimant's August 28, 1997 work injury caused his disc protrusions because claimant had no prior significant back problems and the discs were discovered after the injury. Based on claimant's history of ongoing back symptoms since the work injury and the similarity of his problems after his symptoms worsened (following elk hunting and snowmobiling incidents), Dr. Kendrick opined that claimant's current low back condition remains related to the work injury.

Dr. Young, radiologist, interpreted claimant's imaging studies. He noted joint space narrowing and mild anterior end plate spurs at L4-5 and L5-S1, facet arthropathy at L5-S1, and advanced degenerative disc dessication and bulging discs at both levels.[2] Dr. Young related these findings to underlying degenerative joint and disc disease, explaining that claimant did not develop "this degree of degenerative disease" between the work injury and the films. (Ex. 27). He also opined that the work injury did not materially or pathologically worsen claimant's preexisting degenerative disc condition, because there was no objective evidence of radiculopathy after the injury. In addition, after reviewing claimant's "post injury" history, Dr. Young concluded that claimant's current problems are due to the hunting and snowmobiling injuries, not the work injury.

Even assuming that claimant injured his disc at work in 1997, we would not otherwise defer to the treating doctor's opinion, as explained below. Dr. Kendrick described claimant's degeneration as preexisting, but mild. (Exs. 6, 11). He opined that claimant's MRI findings were acute, not degenerative, noting that would be consistent with claimant's absence of prior back problems. Accordingly, based on claimant's history, clinical findings and diagnostic studies, Dr. Kendrick opined that claimant did not have a "meaningful preexisting condition, and his current condition is due to the trauma in 1997 rather than any degenerative process." (Ex. 21-2-3; *see* Ex. 24). But Dr. Kendrick did not explain why he believes that claimant's disc protrusions are injury-related rather than degenerative, except to say that his view is more consistent with claimant's history (his lack of pre-injury problems and his ongoing post-injury problems). (*See* Ex. 29-2). And Dr. Kendrick did not address Dr. Young's specific findings and reasoning to the contrary. Under these circumstances, and considering Dr. Young's specialized expertise as a radiologist and his detailed discussion of claimant's imaging studies and their significance, we find Dr. Kendrick's opinion inadequately explained. For these reasons, as well as those set out by the ALJ, we conclude that the claim must fail.

ORDER

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

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[1] The first sentence of the third paragraph of the "Findings of Fact" is corrected to reflect that claimant's work injury occurred on August 28, 1997.

[2] Dr. Young's interpretation appears consistent with the studies. (*See* Exs. 2, 3, 15).

In the Matter of the Compensation of
MICHAEL V. LIM, Claimant
WCB Case No. 98-09487
ORDER ON REVIEW
Lauren Paulson, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that dismissed his request for hearing as untimely. In his brief, claimant requests a new hearing due to the allegedly inadequate services of the interpreter. We treat claimant's request as a Motion for Remand. On review, the issues are remand and dismissal.

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

Claimant's second issue on review is couched as a request for a new hearing on the grounds of "interpreter misconduct." We treat claimant's request as a Motion to Remand to the ALJ for the taking of additional evidence.

We may remand to the ALJ only if we find 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 other compelling basis. *Keinow's Food Stores v. Lyster*, 79 Or App 416 (1986). 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. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, we deny claimant's Motion to Remand because claimant did not request a postponement or continuance to obtain the services of another interpreter, and because any additional evidence is not reasonably likely to affect the outcome of this case. At the continued hearing on May 10, 1999, claimant's counsel raised issue with the fact that the interpreter, Ms. Mao, was evidently not translating claimant's answers literally. (May 10, 1999 Tr. 30). Ms. Mao conceded as much. (Id.). However, claimant's counsel then stated that, although he would like all future translations to be literal, "the point has been made adequately." (May 10, 1999 Tr. 31). Thereafter, claimant did not make a motion to postpone or continue the hearing to obtain the services of another interpreter.

Moreover, we find that a remand for an additional hearing would not be reasonably likely to affect the outcome of this case. The ALJ dismissed claimant's request for hearing as untimely pursuant to ORS 656.319, and none of claimant's testimony regarding his failure to file a request for hearing within 60 days has been disputed. Therefore, claimant's Motion to Remand is denied.

ORDER

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

In the Matter of the Compensation of
LARRY J. MORGAN, Claimant
WCB Case Nos. 98-09689 & 97-09267
SECOND ORDER ON RECONSIDERATION
Donald M. Hooten, Claimant Attorney
Lundeen, et al, Defense Attorneys

On November 26, 1999, we abated our October 28, 1999 Order on Reconsideration that adhered to our August 25, 1999 Order on Review affirming an Administrative Law Judge's (ALJ's) order that reduced claimant's unscheduled permanent disability award for a head injury from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to zero. We took this action to consider claimant's motion for reconsideration. Having received the insurer's response, we now proceed with our reconsideration.

In our August 25, 1999 Order on Review, we found that Dr. Taylor, claimant's attending physician, provided the most thorough and well reasoned assessment of claimant's injury-related impairment. In doing so, we noted Dr. Taylor's opinion that claimant had not suffered permanent brain damage was based on his understanding that claimant had been performing volunteer firefighting duties since July 1996. Claimant objected to Dr. Taylor's opinion because it was allegedly based on hearsay provided by the insurer that was not corroborated by direct evidence in the record. We were unpersuaded by this argument because a prior ALJ had expressly found that claimant had a full-duty release to the fire department from July 8, 1996 to March 20, 1997. In a footnote, we further concluded that it was the "law of the case" that claimant performed firefighting work between July 1996 and March 20, 1997.

Claimant requested reconsideration of our order. In his reconsideration request, claimant renewed his objection to Dr. Taylor's opinion, noting that a release to full duty does not necessarily mean that full duty was actually performed. Claimant further noted Dr. Taylor's initial conclusion on March 7, 1997 that claimant was medically stationary with permanent disability associated with chronic, ongoing headaches related to his compensable concussion. (Ex. 25-1). However, claimant further observed that, after being informed by the insurer's attorney on March 20, 1997 that claimant had been performing "extensive fire fighting work," Dr. Taylor then concluded that claimant was not disabled because of an alleged inconsistency between the information the insurer provided and claimant's statements regarding his inability to work. *Id.*

Claimant alleged that Dr. Taylor's change of opinion was based on "fictitious," uncorroborated information that is contradicted elsewhere in the record by claimant's reported statements that his activity at the fire department was limited to conversing with friends. (*e.g.* Ex. 15-7). Claimant argued that Dr. Taylor's "change of opinion" was, therefore, unreliable and that his initial opinion should be found more persuasive. We disagreed.

We noted that this claim was initially closed by Notice of Closure on June 17, 1997 with no award of permanent disability. (Ex. 29). Claimant requested reconsideration, including promulgation of a temporary rule to address impairment due to chronic, recurrent post-concussion headaches. (Ex. 34). The Department found that the "standards" adequately addressed claimant's disability and that, therefore, there was no reason to promulgate a temporary rule. The October 16, 1997 reconsideration order awarded no permanent disability. (Ex. 35).

Among the documentary records considered by the Department were Dr. Taylor's March 7, 1997 and March 20, 1997 reports, as well as Dr. Taylor's June 2, 1997 letter in which he concluded that claimant had not suffered brain damage. (Ex. 35-1). We reasoned that claimant would have had the opportunity to correct the information on which Dr. Taylor relied in his March 20, 1997 "change of opinion" (which claimant contended was "fictitious") prior to the June 1997 closure (as well as during the reconsideration proceedings). *See* ORS 656.268(6)(a). Moreover, we observed that the prior reconsideration order specifically found the March 20, 1997 report from Dr. Taylor to be "accurate and reliable." (Ex. 35-1).

Because claimant neglected to "correct" the basis for Dr. Taylor's so-called "change of opinion," we considered claimant's current challenges to Dr. Taylor's opinion to be unpersuasive. Accordingly, we concluded that this record did not establish that the information on which Dr. Taylor relied (although provided by the insurer and not directly corroborated in the record) was incorrect. Thus, we rejected claimant's contention that Dr. Taylor's March 20, 1997 opinion was based on "fictitious" information.

In his second reconsideration request, claimant notes that he requested a hearing challenging the October 16, 1997 Order on Reconsideration. Thus, claimant argues that the reconsideration order cannot be the basis for precluding him from challenging a finding that he was performing extensive firefighting activities.

Claimant, however, withdrew his hearing request regarding the October 16, 1997 reconsideration order. (Tr. 2). That request for hearing was dismissed. (Opinion and Order p. 5). In any event, claimant misconstrues the basis for our first reconsideration order. The fundamental issue in this case is the persuasiveness of Dr. Taylor's March 20, 1999 opinon. Contrary to claimant's understanding, we did not apply issue preclusion in rejecting claimant's contention that the basis for Dr. Taylor's March 20, 1997 opinion was "fictitious." In other words, we did not hold that claimant's failure to litigate the October 16, 1997 reconsideration order precluded him from challenging the basis of Dr. Taylor's opinion; *i.e.* his understanding that claimant was performing extensive firefighting activities. To the contrary, we merely noted that claimant had the opportunity in the prior reconsideration proceeding to correct any allegedly erroneous information on which Dr. Taylor relied and to establish that Dr. Taylor's report was not "accurate and reliable." In light of claimant's failure to correct the alleged inaccuracies in the reconsideration record (even though authorized to do so under ORS 656.268(6)(a)), we determined, based on our *de novo* review of the entire record, that Dr. Taylor's March 20, 1997 opinion was a reliable and persuasive assessment of claimant's impairment. We find no reason on reconsideration to depart from that determination.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 25, 1999 and October 28, 1999 orders. 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
GEORGE M. BROWN, Claimant
Own Motion No. 99-0335M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Patrick Mackin, Claimant Attorney

On September 8, 1999, claimant submitted a request for temporary disability compensation for his compensable 1985 injury. Claimant also sought penalties and attorney's fees for the self-insured employer's "unreasonable delay" in processing his request. The insurer denied the compensability of claimant's current condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 99-10024).[1]

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that the assigned Administrative Law Judge (ALJ) in WCB Case No. 99-10024 submit a copy of the eventual order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise us of their respective positions regarding claimant's request for own motion relief.

IT IS SO ORDERED.

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[1] The insurer is required to make a written recommendation to the Board within 90 days of receiving claimant's own motion request. OAR 438-012-0030. That recommendation must include the information specified in OAR 438-012-0030. To date, the insurer has not submitted a written recommendation under OAR 438-012-0030(1). The insurer is reminded, pending the resolution of the current litigation, that it must also file a fully *completed* own motion recommendation form.

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

On October 11, 1999, we received claimant's request for authorization to receive own motion benefits in the form of "education towards another direction of employment." Claimant argues that his attending physician will not release him to his regular employment because he required "less activity and strain on [his] back."

We are limited by law as to the type of benefits we may grant injured workers and under what conditions we may grant those limited benefits. 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, on February 3, 1999, we issued an Own Motion Order authorizing the provision of temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery. The record does not establish that the claim has been closed pursuant to OAR 438-012-0055. Consequently, the claim remains in open status.

In his recent request, claimant is requesting additional benefits in the form of vocational assistance. By law, we are unable to grant that request. Claimant's 1987 claim was first closed on March 28, 1988. Therefore, his aggravation rights expired five years later, on March 28, 1993. ORS 656.273(4)(a). Because claimant's aggravation right have expired, his claim is in own motion status. The only benefits available to a claimant whose claim is in own motion status are those referred to in ORS 656.278(1). Where, as here, the compensable injury occurred on or after January 1, 1966, the injured worker is entitled only to the payment of certain medical benefits and temporary disability compensation for the time allowed by statute. ORS 656.278(1)(a). Under own motion, there is no statutory authority for an award of any other additional benefits, including vocational services. *All American Air Freight v. Meissner*, 129 Or App 104 (1994); *Harsh v. Harscho Corp.*, 123 Or App 383 (1993), *rev den* 318 Or 661 (1994). In fact, by statute, benefits for claims in own motion status "do not include vocational assistance benefits." ORS 656.278(2).

Therefore, although claimant is entitled to lifetime medical benefits related to his compensable injury, his only entitlement to future benefits is restricted to time loss benefits under the limited circumstances discussed above, that is, when his condition requires surgery or hospitalization. ORS 656.278(1)(a). Thus, we cannot award claimant vocational assistance benefits in this claim. ORS 656.278(2).

Accordingly, claimant's request for additional benefits in the form of vocational assistance is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBBIE S. THOMAS, Claimant
WCB Case No. 99-02822
ORDER ON REVIEW
Emerson G. Fisher, Claimant Attorney
Lundeen, et al, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's injury claim for a right knee condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following modification and supplementation.

We do not find that claimant "never had" *left* knee symptoms, because Dr. Duff observed and reported "2+ retropatellar crepitants" *bilaterally*. (Ex. 8-3).

We also note that claimant is 5 feet 2 inches tall, she weighs 180-200 pounds, and her patella are aligned with a moderate lateral deviation bilaterally.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a housekeeper for the insured. On February 2, 1999, she experienced a sudden onset of infrapatellar right knee pain while scrubbing a shower on her knees at work. She treated conservatively and filed an injury claim, which the insurer denied.

The medical evidence regarding causation is provided by Dr. Carvalho, who treated claimant beginning April 9, 1999, and Dr. Duff, who examined claimant for the insurer. We agree with the ALJ that Dr. Carvalho's opinion is more persuasive, based on the following reasoning.

The threshold question is whether claimant had a preexisting right knee condition that combined with her February 2, 1999 work injury to cause her subsequent disability and need for treatment. *See* ORS 656.005(7)(a)(B).

Dr. Duff provides the only expert evidence suggesting that claimant had a preexisting right knee condition. He opined that claimant's right knee impairment is "primarily attributable to degenerative changes in the patellofemoral cartilage surfaces, which in turn is mostly attributable to a lateral deviation of the extensor mechanism of the right knee and the patient's weight." Therefore, Dr. Duff concluded that claimant's work activities merely aggravated a previously "silent" degenerative condition. (Ex. 8-5).

However, after reviewing claimant's MRI report, Dr. Duff acknowledged that it "does not suggest any significant pathology." (Ex. 9B). This reading of the MRI is consistent with the report itself, which described claimant's right knee tendons and ligaments as "intact." (Ex. 7A). The MRI also revealed a small (noncontributory[1]) Baker's cyst and *possible* intrasubstance degeneration of "questionable significance." (*Id*).

Although Dr. Duff noted that claimant's MRI revealed no significant pathology, he continued to believe that claimant's right knee condition is due to preexisting degeneration rather than her work injury. (Ex. 9B). Based on this inconsistency and the MRI report, we conclude that Dr. Duff's "degeneration" diagnosis is speculative and unpersuasive.[2] Under these circumstances, we conclude

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[1] *See* Ex. 9B.

[2] We find Dr. Redmond's concurrence with Dr. Duff's opinion unpersuasive for the same reasons.

that claimant probably did not have a contributory preexisting right knee condition[3] and she is therefore subject to the "material contributing cause" standard of proof under ORS 656.005(7)(a).[4]

Dr. Carvalho noted claimant's history that "she never had any pain or problems with both knees prior to February 2, 1999, neither did she see a physician at any time for her knees and [she] was not taking any medicine for knee pain." (Ex. 10-1). The doctor also noted that an MRI had ruled out a torn meniscus and x-rays had ruled out degeneration. Further noting that claimant's right knee pain and swelling occurred while she was on her hands and knees working, Dr. Carvalho concluded that claimant suffered a right knee strain, due to her February 2, 1999 work injury.

We find Dr. Carvalho's opinion persuasive because it is consistent with claimant's "post-injury" symptoms and findings.[5] Under these circumstances, and considering her advantage as claimant's treating physician, we rely on Dr. Carvalho's opinion and conclude that claimant has carried her burden under ORS 656.005(7)(a). *See Weiland v. SAIF*, 64 Or App 810 (1983).

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 August 5, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

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[3] We also note Dr. Carvalho's opinion that claimant's x-ray results ruled out degenerative arthritis. (Ex. 10).

[4] The dissent stresses that claimant has malaligned patellae and she weighs about 200 pounds. Dr. Duff did mention these facts, in passing. But he went on to rule out claimant's work exporsure (essentially without considering it), concluding that claimant's condition is due to presumed preexisting degeneration (related to her anatomy and weight). As we have explained, Dr. Duff's reasoning is particularly unpersuasive because even he acknowledged that claimant's MRI revealed no significant pathology. As we have noted, the MRI suggests only *possible* intrasubstance degeneration of "questionable significance." Under these circumstances, the dissent's focus on claimant's weight and anatomy (and a *possible* degnerative condition) is not medically supported.

[5] We acknowledge that Dr. Carvalho's "pre-injury" history was inaccurate to the extent that she believed that claimant "never" had prior right knee problems before February 1999: Claimant testified that she did have right knee symptoms in October 1998, but not thereafter, until her injury. (Tr. 9; *cf.* Ex. 1). We do not find this inaccuracy to be material, because Dr. Carvalho *correctly* understood that claimant had no prior right knee treatment and *that* history is consistent with her lack of significant preexisting pathology. Moreover, as we have explained, there is no persuasive evidence contradicting claimant's contention that her work activities on February 2, 1999 were a *material* contributing cause of her subsequent disability and need for treatment for her right knee.

Board Member Haynes dissenting.

The majority relies on Dr. Carvalho's opinion, "considering her advantage as claimant's treating physician." I disagree for the following reasons.

First, it is undisputed that claimant has malaligned patellae *and* she weighs about 200 pounds, on a frame measuring only 5 feet 2 inches tall. These factors have been reasonably identified as contributing to her knee problems. But Dr. Carvalho fails to mention them, much less explain them away. Under these circumstances, Dr. Carvalho's opinion is inadequately reasoned and unpersuasive.

Second, Dr. Carvalho relied on a materially inaccurate history that claimant "never had any pain or problems" with her knees before this episode. (Ex. 10-1). This history is clearly inconsistent with claimant's testimony that her right knee *did* bother her for over a week in October 1998, (Tr. 9), and the *first* examining physician's history that claimant's right knee problems had been *ongoing* since the October onset, (Ex. 1). Considering Dr. Carvalho's failure to rule out claimant's undisputed preexisting malalignment condition, her inaccurate history is especially significant.

Finally, Dr. Carvalho first examined claimant in April 1999, over two months after claimant's February 2, 1999 onset of right knee pain. Thus, Dr. Carvalho was not in a contemporaneously advantageous position to observe claimant's condition and there is no good reason to defer to her opinion because she eventually treated claimant. *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."); *William D. Brizendine*, 50 Van Natta 21, 22 (1998).

In sum, the majority errs in relying on Dr. Carvalho's opinion because it is inadequately reasoned, based on an inaccurate history, and entitled to no deference. Because the medical evidence is clearly insufficient to carry claimant's burden, I must respectfully dissent.

In the Matter of the Compensation of
THOMAS D. CAWARD, Claimant
Own Motion No. 99-0454M
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 expired on September 6, 1977. SAIF agreed that claimant's current right hip condition was causally related to his accepted condition and that it is responsible for claimant's current condition. However, SAIF opposed reopening on the grounds that claimant was not in the work force at the time of the current disability.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). Here, claimant must prove that he was in the work force on July 25, 1999, when he underwent surgery for his current condition. A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In response to SAIF's work force contentions, claimant asserts that he was disabled due to an unrelated work injury. Claimant submitted a copy of a check stub which demonstrates that he was disabled and collecting temporary disability compensation through July 19, 1999 due to an injury to his left shoulder.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). In other words, the relevant time period for which claimant must establish that he was in the work force is the time prior to his July 25, 1999 surgery, when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser Co. v. Kepford*, 100 Or App 410 (1980); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, on July 25, 1999, claimant underwent a open reduction internal fixation of the right hip. Just a few days prior to that time, claimant was receiving temporary disability under an accepted left shoulder claim incurred while working with another employer. Since claimant was receiving temporary

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

disability compensation under another workers' compensation claim at the time of his disability in this claim, he is considered to be in the work force. *See Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

Therefore, we conclude that, at the time of claimant's current disability, he did not voluntarily remove himself from the work force, but, rather, was disabled due to another compensable injury. Consequently, we find that claimant has established that he was in the work force at the time of disability.

Accordingly, we authorize the reopening of claimant's 1970 claim to provide temporary disability compensation beginning July 25, 1999, the date he was hospitalized for the proposed surgery.[2] When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[2] In making this authorization, we note that claimant sustained a separate work injury for which he received time loss benefits. Claimant is not entitled to receive double the statutory sum for the same period of time loss because he has two separate disabling injuries. *Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den* 296 Or 350 (1984). Therefore, if claimant received time loss for his left shoulder injury claim for a period coinciding with his temporary disability award under this claim, SAIF is free to petition the Compliance Division for a pro rata distribution of payments between the two claims. *See* OAR 436-060-0020(8); *Leroy R. Fowler*, 41 Van Natta 1468 (1989).

In the Matter of the Compensation of
LISA D. BUSHMAN, Claimant
WCB Case No. 98-08647
ORDER DENYING RECONSIDERATION
Steven M. Schoenfeld, Claimant Attorney
Stoel Rives LLP, Defense Attorneys

Claimant requests abatement and reconsideration of our December 13, 1999 Order on Review. In that order, we adopted and affirmed Administrative Law Judge (ALJ) Lipton's order that found that the medical evidence established that claimant's work was not the major cause of her left medial epicondylitis condition. On reconsideration, claimant contends that our order is insufficient for appeal because we did not specifically address the issue of compensability or discuss our reasons for adopting and affirming the ALJ's order.

In considering each case presented for its review, the Board conducts a thorough and methodical review of the file, which necessarily includes the ALJ's order and the parties' respective written arguments. In accordance with ORS 656.295(6), the Board may affirm, reverse, modify or supplement the ALJ's order and make such disposition of the case as it determines to be appropriate.

By adopting and affirming the ALJ's order, our order specifically addressed the issue of compensability. *See Jorge Pedraza*, 49 Van Natta 1019 (1997); *George V. Richard's Food Center*, 90 Or App 639 (1988) (Board Order need not set forth its own findings of fact and conclusions if it affirms or adopts an ALJ's order that is itself sufficient for substantial evidence review). Claimant asserts no other basis for reconsideration. Accordingly, the request for abatement and reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our December 13, 1999 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH M. ENFIELD, Claimant
WCB Case No. 99-00403
ORDER OF DISMISSAL
Sather, Byerly & Holloway, Defense Attorneys

Claimant, *pro se*, has requested review of Administrative Law Judge (ALJ) Lipton's October 25, 1999 order. Contending that claimant neglected to provide notice of his appeal to all parties to the proceeding within 30 days of the ALJ's order, the self-insured employer moves for dismissal of the request for Board review. Because the record does not establish that all parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On October 25, 1999, the ALJ issued an Opinion and Order that upheld the employer's denial of claimant's right shoulder condition. Copies of that order were mailed to claimant, the employer, its claim processing agent and its attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for review must be mailed to the other parties within the 30-day appeal period.

On November 22, 1999, the Board (*via* its Portland office's receipt) received claimant's letter requesting Board review of the ALJ's October 25, 1999 order. Claimant's request, which was enclosed in an envelope postmarked November 18, 1999, did not indicate that copies had been provided to the other parties to the proceeding.

On December 3, 1999, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins, Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1985); *Argonaut Insurance Co. v. King, supra.*

Here, the 30th day after the ALJ's October 25, 1999 order was November 24, 1999. Inasmuch as claimant's request for review was received by the Board on November 22, 1999, it was timely filed. *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

However, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, based on the employer's counsel's submission, the employer's first notice apparently occurred when it received a copy of the Board's December 3, 1999 letter acknowledging claimant's request for review. Under such circumstances, the employer's notice of claimant's appeal is untimely. *Loris D. Whitton*, 49 Van Natta 2183 (1997). Consequently, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's October 25, 1999 order.[1] Therefore, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

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[1] In the event that claimant can establish that he provided notice of his request for Board review to the other parties to the proceeding within 30 days after the ALJ's October 25, 1999 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file his submission as soon as possible.

Finally, we are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
LONNY W. GALLAGHER, Claimant
WCB Case Nos. 99-00300 & 98-09621
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld Medford Corporation's denial of claimant's occupational disease claim for a hearing loss condition; and (2) upheld the SAIF Corporation's denial of occupational disease claim for the same condition. On review, the issues are compensability, and potentially, responsibility.[1]

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

Claimant argues that presbycusis is not a preexisting condition under Workers' Compensation Law. 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). However, it is immaterial whether claimant's presbycusis is a "preexisting condition" within the meaning of ORS 656.005(24). Here, claimant must prove that work exposure was the major contributing cause of his hearing loss. *Willard A. Hirsch*, 49 Van Natta 1311 (1997); *See also Clifford C. Doolin*, 50 Van Natta 99 (1998) (hearing loss claim found compensable where work-related exposure, rather than presbycusis or other off-work causes, was the major contributing cause of the claimant's hearing loss). The greater weight of the medical evidence establishes that claimant's hearing loss was caused in major part by age-related presbycusis, not noise exposure.

ORDER

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

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[1] Medford Corporation requests remand in the event we reversed the ALJ's order for the determination of the responsibility issue. Because we affirm the ALJ's order, we do not address the request.

Board Member Phillips Polich specially concurring.

I write separately to agree that, on this record, claimant has not established that his work exposure is the major contributing cause of his hearing loss regardless of whether presbycusis is considered a preexisting condition. However, I continue to assert that presbycusis, which is expected hearing loss due to aging, is a measure of "normal" hearing loss, as opposed to abnormal hearing loss, and, therefore, does not rise to the level of a "preexisting condition" under ORS 656.005(24). *See Thomas K. Osborne*, 51 Van Natta 1262 (1999), Phillips Polich dissenting.

In the Matter of the Compensation of
PAUL N. LACEY, Claimant
WCB Case No. 98-06173
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) upheld the insurer's denial of his occupational disease claim for carpal tunnel syndrome (CTS); (2) upheld the insurer's denial of his aggravation claim for CTS; and (3) declined to assess a penalty or penalty-related attorney fee for the insurer's allegedly unreasonable claims processing. On review, the issues are compensability, aggravation and penalties.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address claimant's arguments concerning compensability of his CTS and penalties.

Compensability of CTS

To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of his CTS. ORS 656.802(2)(a). Claimant relies on the opinions of Drs. Jansen and Wilson to establish that his work activities for the employer were the major contributing cause of his CTS. On *de novo* review, we agree with the ALJ that claimant has failed to establish compensability of his CTS.

Dr. Jansen first treated claimant on September 27, 1995 and diagnosed forearm tendinitis, beginning thoracic outlet syndrome and possible CTS, "by history, occupation-related." (Ex. 3). She noted that claimant's hand symptoms had developed on September 10, 1995. (*Id.*) She recommended physical therapy, medication and work restrictions. (Exs. 3, 8). A nerve conduction study on October 27, 1995 showed "bilateral focal median neuropathies at the wrists (carpal tunnel syndrome)" and "bilateral focal ulnar neuropathies at the elbows." (Ex. 10-1).

On November 16, 1995, Dr. Jansen diagnosed bilateral CTS with mild ulnar nerve irritation at the elbow. (Ex. 13-1). She indicated that the CTS was "occupation-related." (*Id.*) In a report to the insurer on the same date, she said: "[i]n my opinion, his [CTS] condition is mainly work-related." (Ex. 12). On the other hand, she did not believe the ulnar nerve irritation was work-related. (*Id.*) Dr. Jansen examined claimant again in February 1998, reporting that claimant had "very mild" bilateral CTS. (Ex. 19). Her report did not indicate what type of work claimant was performing at that time.

In 1995, Dr. Jansen had related claimant's CTS to his work activities based on his "history." (Exs. 3, 8). Nevertheless, we are not persuaded that Dr. Jansen had an accurate history. Claimant's "801" form showed his "date of injury or occupational disease" as September 10, 1995, although his description noted that his symptoms had been "progressive." (Ex. 6). At hearing, claimant testified that his CTS symptoms began a few months before October 1995, when he completed the "801" form. (Tr. 4-5). In contrast, Dr. Jansen's initial report said that claimant's symptoms developed on "September 10, 1995, when he was working with more difficulty [sic] cables." (Ex. 3). Dr. Jansen's report indicated that claimant's symptoms began on September 10, 1995 rather than a few months earlier. We are not persuaded by Dr. Jansen's opinion on causation because her report indicated that she did not have an accurate history of the onset of claimant's symptoms. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977).

Moreover, Dr. Jansen's opinion on causation that claimant's CTS was "mainly work-related" is not persuasive because she did not provide an adequate explanation as to why claimant's work activities for the employer were the major contributing cause of his CTS. Dr. Jansen reported that claimant had "worked in assembly" for the employer since May 1995 and she said his symptoms developed "when he was working with more difficulty [sic] cables." (Ex. 3). She provided no further discussion of claimant's work activities and did not explain how his employment conditions caused CTS. Furthermore, Dr. Jansen did not explain why she believed claimant's CTS was work-related, but his ulnar nerve irritation was "not necessarily work-related." (Ex. 12). We agree with the ALJ that Dr. Jansen's opinion on causation is not sufficient to establish that claimant's work activities for the employer were the major contributing cause of his CTS.

Claimant also relies on Dr. Wilson's opinion to establish compensability. Absent persuasive reasons to do otherwise, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). In this case, Dr. Wilson examined claimant on one occasion. Under these circumstances, we do not grant any particular deference to Dr. Wilson's opinion.

We are not persuaded by Dr. Wilson's opinion because it is inconsistent and lacks adequate explanation. Dr. Wilson examined claimant on one occasion, on September 17, 1998. (Exs. 21, 26-7). He reported that claimant felt like he had gloves on both hands and he described a numb feeling. (Ex. 21-1). Dr. Wilson referred to claimant's current job, which was trimming ivy and weeds, and noted that claimant felt it was "the easiest work he has had." (*Id.*) Dr. Wilson felt claimant had a "worsening" of the condition and he referred him to a hand surgeon. (Ex. 21-2).

In a "check-the-box" letter from claimant's attorney, Dr. Wilson agreed that claimant still had a diagnosable CTS condition and he agreed that the major contributing cause of his condition was his employment with the employer in 1995. (Ex. 21A).

In later reports, however, Dr. Wilson concurred with Dr. Jewell's report. (Exs. 24, 25). Dr. Jewell, a plastic surgeon and hand surgeon, had reported that he did not believe that claimant had evidence of CTS, noting that there was a poor correlation between claimant's hand symptoms and the minor electrical abnormalities noted in the nerve conduction tests. (Ex. 22-4). Dr. Jewell said that claimant's musculoskeletal pain complaints did not "really fit into any accepted pattern of industrial overuse or repetitive motion disorder." (Ex. 22-5). Dr. Jewell did not believe claimant's work for the employer was the major contributing cause of the electrical abnormalities of the median nerve or his "alleged CTS." (*Id.*)

Although Dr. Wilson had concurred with Dr. Jewell's report, he later said that he disagreed with Dr. Jewell's conclusion that claimant did not have CTS. (Ex. 26-26). Dr. Wilson testified that claimant's clinical symptoms in September 1998 were consistent with CTS. (*Id.*) On the other hand, Dr. Wilson explained that the typical pattern for "true" CTS was numbness and tingling in the first, second and third finger, but it should exclude the fourth and fifth finger. (Ex. 26-36). Dr. Wilson acknowledged, however, that claimant's hands in general were numb, not just specific areas. (Ex. 26-36, -37). Thus, Dr. Wilson's testimony indicates that claimant's hand symptoms were inconsistent with "true" CTS. Dr. Wilson said it was possible claimant had something other than CTS and he explained that was one reason he had recommended that claimant see an "expert." (Ex. 26-37, -38). Dr. Wilson believed that claimant needed further testing and evaluation by a hand specialist. (Ex. 26-30).

In light of Dr. Wilson's one-time examination of claimant and his lack of expertise as a hand specialist, his opinion that claimant had CTS is not particularly persuasive. In any event, even if we assume that claimant has CTS, we find that Dr. Wilson's opinion is not sufficient to establish causation. Dr. Wilson's chart note referred only to claimant's current work as a weeder, but did not refer to his previous work for the employer. (Ex. 21). Claimant said he had not worked for the employer since approximately January or February 1996. (Tr. 6). Dr. Wilson testified that it was unclear what had taken place with claimant from December 7, 1995 until February 23, 1998, when he returned to Dr. Jansen. (Ex. 26-14). Although Dr. Wilson agreed that claimant's CTS had developed as a result of repetitive hand use as an electronics assembler (Ex. 26-32, -51), he did not provide an explanation of claimant's work activities for the employer, nor did he explain why any such activities caused CTS. In fact, Dr. Wilson noted that it was "more debatable" in the literature as to whether overuse can cause CTS. (Ex. 26-31). Dr. Wilson felt that claimant's CTS symptoms had worsened, but he said "[i]t's unclear as to why they worsened." (Ex. 26-48). He indicated that claimant's subsequent work activities after leaving the employer had contributed to his condition. (Ex. 26-39, -40).

After reviewing Dr. Wilson's reports and his deposition, we are not persuaded by his opinion on causation because it is not well-reasoned and lacks adequate explanation. We agree with the ALJ that Dr. Wilson's opinion on causation is not sufficient to establish that claimant's work activities for the employer were the major contributing cause of his CTS.

Penalties

Claimant argues he is entitled to a penalty or penalty-related attorney fee for the insurer's allegedly unreasonable claims processing. In light of our conclusion that claimant's CTS is not

compensable, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support an award of a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty or a penalty-related attorney fee.

ORDER

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

In the Matter of the Compensation of
KIMA L. LANGSTON, Claimant
WCB Case No. 98-07374
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its denial of claimant's mid-back strain injury claim; and (2) awarded a $3,500 insurer-paid attorney fee. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

On June 15, 1998, claimant sought treatment from her family physician, Dr. Krause, complaining of a one-week history of abdominal pain, fever, and "shakiness." Claimant specifically denied that she was experiencing back pain. (Ex. 16-34). Claimant returned to Dr. Krause on June 17, 1998, this time reporting pain to the mid-back radiating across the left flank into the umbilicus region and a "band sized" area of paresthesias. (Ex. 1). Dr. Krause reported mid-thoracic back pain to palpation and subjective light touch sensation loss along the T7-8 dermatome. His diagnosis was back pain with radiculopathy. Dr. Krause recommended an MRI of the thoracic spine.

A June 22, 1998 MRI revealed a moderate sized central disc protrusion at T7-8. (Ex. 2). After discussing the MRI with claimant on June 24, 1998, Dr. Krause referred claimant to Dr. Wayson, neurosurgeon, for consultation. (Ex. 3).

On June 26, 1998, claimant filed a workers' compensation claim, alleging for the first time that her mid-back problems were a result of employment activity, specifically, pushing a large patient in a stretcher up a slope on June 8, 1998. (Ex. 4).

Dr. Wayson evaluated claimant's mid-back condition on July 14, 1998 and could not relate claimant's mid-back symptoms to a T7-8 disc. (Ex. 7-2).

On July 28, 1998, examining physicians, Drs. Marble and Zivin, evaluated claimant's back condition. They agreed with Dr. Wayson that the T7-8 disc was unrelated to claimant's complaints and concluded that claimant did not have a work-related condition. (Ex. 8-8). The panel specifically opined that claimant's condition was not the result of a thoracic strain. (Ex. 8-7).

Dr. Hourihane, a neurologist, first examined claimant on July 31, 1998 for a variety of complaints, including numbness in several places, diffuse pain, lightheadedness and loss of appetite. (Ex. 9). He eventually opined at a deposition in April 1999 that claimant sustained a musculoskeletal injury as a result of the June 8, 1998 incident . (Ex. 18-24).

In the meantime, the employer had denied claimant's back injury claim on August 14, 1998. (Ex. 12). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, concluding that claimant had satisfied her burden of proving that she sustained a musculoskeletal mid-back injury claim. In so concluding, the ALJ found

claimant's testimony that she injured her back pushing a hospital gurney credible based on his observation of her attitude, appearance and demeanor. Moreover, the ALJ found the medical opinion of Dr. Hourihane persuasive in establishing medical causation.

On review, the employer contends that Dr. Hourihane's belated April 1999 diagnosis of a musculoskeletal injury is unpersuasive and does not satisfy claimant's burden of proof. In addition, the employer contends that, despite the ALJ's demeanor-based credibility finding, the contemporaneous medical records provide a more accurate history than claimant's subsequent recollections at the hearing. For the following reasons, we find that claimant failed to prove a compensable injury claim.

A compensable injury is established by proof that claimant's work exposure was a material contributing cause of her disability or need for treatment, if the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); *see Mark N. Weidle*, 43 Van Natta 855 (1991). Claimant bears the burden of proving compensability. ORS 656.266.

Considering the delayed report of injury, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. *See Barnett v. SAIF*, 122 Or App 279 (1993). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. *See Somers v. SAIF*, 77 Or App 259 (1986). In addition, we generally give greater weight to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983); *Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988). In this case, we find persuasive reasons not to give greater weight to Dr. Hourihane's opinion.

Dr. Hourihane first treated claimant 7 weeks after the alleged injury. Under these circumstances, we cannot say that Dr. Peterson was in an advantageous position as attending physician to render an opinion regarding the relationship between the alleged June 8, 1998 injury and claimant's mid-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).

Moreover, Dr. Hourihane did not diagnose a musculoskeletal injury until an April 1999 deposition, approximately 10 months post-injury. On the other hand, the four physicians who examined claimant before Dr. Hourihane (Drs. Krause, Wayson, Zivin and Marble) did not diagnose a musculoskeletal injury. In fact, Drs. Zivin and Marble specifically ruled out a thoracic strain. (Ex. 8-7). In addition, Dr. Hourihane's chart notes were not focused on localized mid-back pain but rather on diffuse symptomatology such as numbness and radiating pain.[1] Under these circumstances, we do not find Dr. Hourihane's belated diagnosis of a work-related musculoskeletal injury persuasive.[2]

Accordingly, we find that claimant failed to sustain her burden of proving that the alleged June 8, 1998 incident was a material contributing cause of disability or need for treatment of a mid-back condition. Thus, we disagree with the ALJ's decision to set aside the employer's denial. Therefore, we reverse.

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[1] Claimant agreed at hearing that she had a variety of coincidental neurological symptoms at the time she first sought treatment in June 1998 and that they were not work-related. (Opinion and Order p. 2)

[2] We recognize that the ALJ determined that claimant's testimony regarding the alleged June 8, 1998 incident was credible based on her demeanor. We generally defer to the ALJ's demeanor-based credibility finding. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990). However, we are in as good a position as the ALJ to evaluate the credibility of a witness based on an objective review of the substance of the record. *See Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987); *Davies v. Hanel Lumber Co.*, 67 Or App 35 (1984); *Rob R. Hartley*, 49 Van Natta 2011 (1997). Inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible. *See Gail A. Albro*, 48 Van Natta 41, 42 (1996); *Angelo L. Radich*, 45 Van Natta 45 (1993). In this case, we have concerns regarding the credibility of claimant's testimony regarding the existence of the alleged gurney incident, inasmuch as it was not reported in contemporaneous medical records. (Exs. 1, 3, 16-12, 16-34). Nevertheless, even assuming that such an incident did occur, we do not find the medical evidence establishes that it resulted in a musculoskeletal injury requiring medical services or disability.

ORDER

The ALJ's order dated June 17, 1999 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

January 7, 2000 Cite as 52 Van Natta 17 (2000)

In the Matter of the Compensation of
DENNIS E. McCORMICK, Claimant
WCB Case No. 98-01720
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of his injury claim for a right knee medial meniscus tear condition. On review, the issue is compensability.

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

The ALJ upheld the insurer's denial based on lack of proof of either a "twisting event," or an "abnormal weight distribution" when claimant injured his right knee descending a ladder at work on August 5, 1997. Claimant contends that Dr. Greenleaf, his treating physician and surgeon, supports compensability because he acknowledged in his deposition that claimant's "bad knees" likely created an abnormal weight distribution during the ladder injury, sufficient to cause the medial meniscus tear. (Ex. 24-14).

However, claimant did not testify to any abnormal weight distribution caused by favoring his "bad" (left) knee. At hearing, claimant stated that ". . . I was about halfway down that ladder, and I just felt something kind of give laterally behind my right knee, enough to make me stop and go, 'What was that?'" (Tr. 9). This testimony is consistent with claimant's October 30, 1997 801 form, where claimant stated: "While descending the ladder by ribbon deck, I felt a pulling sensation behind right knee [*sic*], then a crunching behind the knee - then pain - still pain." (Ex. 9). In none of his descriptions of the August 5, 1997 injury did claimant describe a twisting event or other "abnormal weight bearing," such as favoring his left leg because of his "bad knees."

For these reasons, we agree with the ALJ's conclusion that there was a lack of proof of a twisting event or other abnormal weight bearing during the ladder descent on August 5, 1997. Absent such a history, Dr. Greenleaf's opinion does not support claimant's burden of proving that the injury was the major contributing cause of his disability and need for treatment for his combined right knee medial meniscus tear condition. ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated July 6, 1999 is affirmed.

In the Matter of the Compensation of
GEORGIA MOORE, Claimant
Own Motion No. 99-0435M
SECOND INTERIM OWN MOTION ORDER CONSENTING TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Nicholas M. Sencer, Claimant Attorney

On December 9, 1999, we declined to consent to the Department designating a paying agent under ORS 656.307 because the record contained no evidence that surgery or hospitalization was requested for claimant's current right knee and low back conditions. Since issuance of our order, claimant has submitted further information regarding her need for surgery. Claimant's aggravation rights on her 1991 Liberty Northwest Insurance Corporation (Liberty Northwest) claim expired March 25, 1998.

In addition, the Benefits Section of the Workers' Compensation Division (WCD) has further provided notification that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer (including Liberty Northwest under claimant's 1991 claim) has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Under such circumstances, WCD seeks our response to its request for consent to an order designating a paying agent under ORS 656.307.

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

Here, on January 8, 1999, Dr. Mason, claimant's attending physician, recommended that claimant undergo re-exploration of her left lumbar nerve root irritability. Because the record establishes that claimant's current condition requires surgery, and, thus, has met the requirements of ORS 656.278 for authorization of temporary disability compensation, we conclude that claimant would be entitled to own motion relief if the own motion carrier (Liberty Northwest) should be ultimately found responsible for the payment of compensation. *See Gary W. Yeager, Sr.*, 48 Van Natta 2293 (1996); *Steven M. Rossiter*, 47 Van Natta 34 (1995); *Robyn Byrne*, 47 Van Natta 213 (1995).

Inasmuch as claimant would be entitled to own motion relief if the own motion insurer (Liberty Northwest) is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1991 own motion claim, beginning the date claimant is hospitalized for the proposed surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307.

When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if the own motion carrier (Liberty Northwest) is ultimately found to be the responsible carrier; and/or (2) issue an order denying reopening of an own motion claim, if the own motion carrier (Liberty Northwest) is ultimately not found responsible, or if a non-own motion carrier is ultimately found to be the responsible carrier. Furthermore, if the own motion carrier (Liberty Northwest) is ultimately determined to be responsible for claimant's current condition, the parties are requested to submit their respective positions regarding own motion relief.[1]

IT IS SO ORDERED.

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[1] This order, which is based on a record supporting a conclusion that claimant's undisputed compensable condition requires surgery, replaces our December 29, 1998 order.

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

On December 17, 1999, we issued an Order on Reconsideration adhering to our July 13, 1999 Order on Review that: (1) found that the employer's failure to appear at the hearing was unjustified and constituted a "waiver of appearance" under OAR 438-006-0071; and (2) denied the employer's motion to remand for submission of additional evidence.

AIG seeks abatement and reconsideration of our decision, asserting that: (1) it has rebutted the presumption of mailing; (2) it has suffered actual prejudice from its inability to present evidence and put on a defense at hearing; and (3) insurers, like claimants who fail to attend a hearing, should be given an opportunity to show good cause for their failure to appear at hearing. We consider each of AIG's arguments in turn.

As we discussed in our Order on Reconsideration, it is well-established that notification occurs upon *mailing*, not upon a party's *receipt* of the notice of hearing. *E.g., Norton v. Compensation Department*, 252 Or 75 (1968) ("Notified" means deposited in the mails). In order to rebut the presumption of a successful mailing, a party must provide evidence that the request for hearing was not properly mailed. Here, AIG offers no evidence that the notice of hearing was not properly mailed to the employer and AIG as documented in the Hearings' Division's file; instead, its claim processing agent simply states that she did not timely *receive* it. Thus, AIG has failed to rebut the presumption of successful mailing.[1]

AIG next contends that it has suffered actual prejudice because the evidentiary record is incomplete. We disagree. As used in this particular case, "actual prejudice" pertains to the failure to provide notice of the hearing to the *insurer*. AIG's assertion pertains to the merits of the case itself. "Actual prejudice" in this instance focuses on procedural notice regarding the convening of the hearing. As we discussed in our Order on Reconsideration, we found that no prejudice to the insurer was established by the failure to directly mail a copy of the notice of hearing to the insurer. Specifically, we reasoned that the employer and AIG, which was appointed by the insurer as its claims processing agent, were properly mailed copies of the notice of hearing and the record establishes (and the insurer does not dispute) that had the insurer received such a copy it would not have attended the hearing; *i.e.*, other notices to the insurer were being sent in care of AIG.

Finally, AIG contends that claimants who fail to appear at hearing are given the opportunity to respond to an "Order to Show Cause" and then granted an opportunity for another hearing. AIG contends that insurers should be given the same opportunity. AIG cites *Mark Totaro*, 49 Van Natta 69 (1997) in support of its argument. Again, we disagree.

Totaro and its progeny are cases in which a claimant's request for hearing was dismissed for failure to appear at the hearing,[2] whereas this is a "waiver of appearance" case; *i.e.* the hearing request is not at risk for dismissal. In any event, the carrier received its equivalent of an "order to show cause"

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[1] AIG cites *Bruce C. Darr*, 45 Van Natta 305 (1993), and *Anton V. Mortenson*, 40 Van Natta 1171, *on recon* 40 Van Natta 1702 (1988), in support of its position. These cases are inapposite. Unlike the issue in this case, the issue in each of those cases was whether the claimant's request for hearing on a Determination Order was timely filed. Here, timeliness of the filing of a claimant's request for hearing is not at issue. Rather, the issue is whether the notice of hearing had been successfully mailed by the Board's Hearing Division to the employer and AIG.

[2] Under such circumstances, OAR 438-006-0071(2) provides that, if the party that waives appearance is *the party that requested the hearing*, that party may establish extraordinary circumstances to justify postponement or continuance of the hearing. In those cases where the ALJ did not have an opportunity to rule on the motion to postpone or continue the hearing, we remand the matter to the ALJ for consideration of the motion. As we discussed in *Lura F. Carter*, 51 Van Natta 1226, 1228 (1999) (citing *Richard R. Merriman*, 51 Van Natta 167 (1999), this rule only contemplates the possibility of postponement or continuance for the party that requested the hearing.

as a result of the ALJ's consideration of its request for reconsideration and the ALJ's ensuing orders on reconsideration. In effect, the ALJ found, and we agree, that the carrier failed to show good cause for its failure to appear. Moreover, the arguments regarding the grounds for the employer's failure to appear that were preserved on Board review would not change that determination that the employer's failure to appear was a waiver of appearance.

Accordingly, we withdraw our December 17, 1999 Order on Reconsideration. On reconsideration, as supplemented herein, we republish our December 17, 1999 Order on Reconsideration and July 13, 1999 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY J. WATKINS, Claimant
WCB Case No. 99-03487
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

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

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

Dr. McMartin agreed with Dr. Radecki that "personal factors can increase the risk for carpal tunnel syndrome." (Ex. 14-1). However, Dr. McMartin did not discount or rule out the personal factors that Dr. Radecki identified as contributing causes in claimant's case. For this reason, as well as that set out by the ALJ, we conclude that Dr. McMartin's opinion is inadequately explained.

ORDER

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

In the Matter of the Compensation of
HARRY L. LYDA, Claimant
WCB Case No. 98-04115
ORDER ON REVIEW
Burt, Swanson, Lathen, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Michael V. Johnson'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 concluded that, although claimant was permanently incapacitated from regularly performing work at a gainful and suitable occupation, claimant failed to establish that he was willing to seek regular employment. The ALJ also found that claimant had not made reasonable efforts to obtain employment, and, even if the work search would have been futile, had not demonstrated that he would have been willing to work "but for" the compensable injury. In making the latter finding, the ALJ stated that there was "no evidence" that claimant was willing to work but for the compensable injury.

On review, claimant contends that the ALJ erroneously concluded that there was "no evidence" of his willingness to work but for the compensable injury. To the contrary, claimant asserts that the record establishes that he was willing to work but for the compensable injury. For the following reasons, we disagree.

Even if 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. *SAIF v. Stephen*, 308 Or 41 (1989). In other words, a finding of futility alone is not sufficient to support an award of permanent and total disability benefits because a finding that claimant is willing to work is a prerequisite to entitlement to such benefits. *See* ORS 656.206(3); *Champion International v. Sinclair*, 106 Or App 423 (1991).

Here, claimant cites two examples in the record which he alleges satisfy the willingness to work requirement. First, claimant notes his statement to a vocational consultant that he "would love to return to work," but felt that he would never be able to do so again because of muscle spasms and pain from his injury. (Ex. 360-8). Second, claimant cites his comment that he made several attempts to return to work, but was unable to focus on the tasks of his work because of his chronic pain. (Ex. 360-2).

We do not find that these two isolated statements by claimant in this voluminous record are sufficient to establish claimant's willingness to work but for the compensable injury. Verification of claimant's alleged efforts to return to work is absent in this record. Moreover, claimant's statement that he wished to return to work is not supported by the record. For example, seven positions were identified as being within the physical limitations identified by a physical capacities evaluation. (Ex. 360). As far as this record demonstrates, claimant evidenced no interest in any of the positions.

Having reviewed this record, we agree with the ALJ that the evidence fails to establish that claimant was willing to work "but for" the compensable injury. Because claimant has not carried his burden to prove that he was willing to work within the meaning of ORS 656.206(3), we conclude that his claim for permanent total disability must fail.

ORDER

The ALJ's order dated June 30, 1999, as corrected on July 2, 1999, is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's finding that claimant is not permanently and totally disabled. In so doing, it also affirms the ALJ's determination that it would not have been futile for claimant to seek employment and that claimant failed to establish that he would have been willing to work "but for" the compensable injury. Because I disagree with the majority's analysis of the "futility" and willingness to work issues, I must respectfully dissent.

At the outset, I note the ALJ's finding that it would not have been futile for claimant to have sought employment and his reasoning that claimant is too bright and capable not to have tried to find work simply because the long-time attending physician, Dr. Athay, has stated that claimant is not employable. The ALJ's personal assessment of claimant's abilities and intelligence notwithstanding, those qualities are not determinative of the futility issue. Dr. Athay has clearly and repeatedly opined that claimant is not capable of performing regular, gainful employment of any type and, further, is also not capable of even trying to find such employment. (Exs. 290, 292, 321, 331, 344). In light of Dr. Athay's opinion, it is clear that it would be futile for claimant to attempt to find work, even assuming the ALJ's evaluation of his intelligence and capabilities is correct. Additionally, it was reasonable for claimant to rely on the advice and opinion of his physician regarding his employability. Because it is the product of his long-term status as attending physician, Dr. Athay's assessment is entitled to the greatest weight on the futility issue. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983).

In addition to finding that it would be futile for claimant to attempt to work, I would further conclude that claimant was willing to work "but for" the compensable injury. There is no evidence rebutting claimant's statements that he tried to return to work and, further, that he would "love" to return to work. In fact, the ALJ expressly finds claimant was a credible witness and that he has been credible with Dr. Athay. It is inconsistent for the ALJ to conclude that it would not have been futile for claimant to have sought employment once he found Dr. Athay and claimant credible.

The majority cites the lack of evidence that claimant was interested in seven jobs identified as appropriate for him as proof that claimant is not willing to work. With all due respect to its analysis, the majority asks too much of a person whom the attending physician has stated cannot seek, let alone perform, regular gainful work. It is unrealistic to expect claimant to show much interest in the identified positions when his attending physician clearly and unequivocally states that he is not employable. Moreover, in light of the restriction on "post-reconsideration" evidence in ORS 656.283(7), claimant is prevented from establishing an interest in the identified positions even if he tried to perform them.

In summary, the majority expects far more than the law requires in establishing permanent total disability as it relates to willingness to work. Dr. Athay's persuasive medical opinion proves it would be futile for claimant to seek work. Because claimant's unrebutted statements regarding his willingness to work establish that element of a permanent total disability claim, I would find claimant permanently and totally disabled. Because the majority concludes otherwise, I must dissent.

In the Matter of the Compensation of
MICHAEL S. DOLAN, Claimant
WCB Case No. C992898
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
J. Michael Casey, Claimant Attorney
Jill Blendinger (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

On December 7, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration for payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

On page 3, lines 9 - 12, the CDA provides, in part:

> "SAIF Corporation waives its right to collect overpayments, excepting those monies which claimant is paid in temporary disability benefits between the date claimant signs this Claim Disposition Agreement and the date of Board approval."

Payment of non-medical benefits, including temporary disability benefits, is not stayed until the date the CDA is submitted to the Board. *See* ORS 656.236(1). In addition, temporary and permanent disability benefits legally due and payable prior to submission of the CDA may not be considered an "advancement" of the CDA proceeds. *See Robert Derderian*, 45 Van Natta 1042 (1993). Stated more

simply, temporary or permanent disability benefits that are legally due and payable *prior to the submission of the CDA* must continue until the *date of submission to the Board. George T. Taylor,* 43 Van Natta 676 (1991). A CDA shall be deemed to have been submitted as of the date the agreement is received by the Board. OAR 438-009-0025(2).

SAIF's waiver of its right to collect pre-submission overpayments is consistent with the aforementioned points and authorities; moreover, the parties agreement to effectively allow SAIF to apply post-submission benefits to its CDA obligation is essentially an advancement of CDA proceeds and, as such, is permissible. *See Robert Derderian,* 45 Van Natta at 1042.

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.

January 10, 2000 Cite as 52 Van Natta 23 (2000)

In the Matter of the Compensation of
THOMAS OLSON, Claimant
WCB Case No. C992617
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Biehl and Bock.

On November 1, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, for payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30-day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b). In response to this statute, the first page of the CDA should contain a "statement indicating whether or not the parties are waiving the '30-day' approval period of ORS 656.236(1)(a)(C) as permitted by ORS 656.236(1)(b)." OAR 438-009-0022(3)(k).

In this case, the parties' CDA did include a "30-day waiver" on the first page. Nonetheless, because claimant is unrepresented, the Board was without statutory authority to waive the 30-day statutory period. Because of this, the Board sent an addendum, requesting that the parties remove the waiver language and provide additional postcards. Although the Board did receive the postcards, the parties stated that an addendum to the agreement would follow. To date, however, the Board has not received an addendum.

In the meantime, the statutory 30-day "cooling off" period has expired. Consequently, our prior concerns regarding the "waiver" provision have become moot. Therefore, we have proceeded with our review of the agreement.

Having reviewed the CDA, we conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the CDA is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
FRANKLIN D. BAUMAN, Claimant
WCB Case No. 99-00579
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's injury claim for his left shoulder condition. On review, the issue is compensability.

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

On review, the employer argues that claimant did not meet his burden of proof in that the evidence claimant presented is too indeterminate to accept any view as the preponderant one concerning causation. We disagree and write only to address the employer's contention that the ALJ's deference to Dr. Moser's opinion was misplaced.

The employer argues that Dr. Moser's opinion should not be given deference because her opinion was based on an incorrect assumption of the facts (*i.e.* falling directly on his left shoulder). However, we do not consider Dr. Moser's opinion to be based on the precise mechanism of claimant's fall but rather its awkwardness. (Ex. 18). Additionally, Dr. Moser's opinion, as correctly noted by the ALJ, relies on a complete medical history of claimant. The opinion was based on Dr. Moser's own independent examination of claimant as well as taking into consideration claimant's prior medical treatment including the documented objective findings of Mr. Wilson and Dr. Frank.[1] The record is sufficient to give deference to Dr. Moser's opinion. *See Somers v. SAIF*, 77 Or App 259 (1986).

Accordingly we agree with the ALJ that claimant met his burden of proving that his fall at work was a material contributing cause of his need for medical treatment or disability for his left shoulder condition.

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

ORDER

The ALJ's order dated September 9, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,400, payable by the employer.

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[1] We note that on p. 3 of ALJ's order Mr. Wilson is incorrectly referred to as "Mr. Williams."

In the Matter of the Compensation of
ROBERT E. KELLY, Claimant
WCB Case Nos. 98-07668 & 98-07667
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that held that the Hearings Division was not authorized to consider claimant's challenge to the self-insured employer's classification of his occupational disease claim as nondisabling because the challenge was filed more than one year after the date of injury under ORS 656.277. On review, the issue is claim processing.

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

As the ALJ found, *Alcantar-Baca v. Liberty Northwest Insurance Corp.*, 161 Or App 49 (1999), and *Shaw v. Paccar Mining*, 160 Or App 60 (1999), control under the facts of this case. *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.

Although claimant acknowledges these holdings and recognizes that *Shaw* addressed an occupational disease claim, he argues that the court's decision was incorrect because ORS 656.277 does not address occupational disease claims and nothing in the Workers' Compensation Law justifies treating the date of an occupational disease claim as the "date of injury" under ORS 656.277. Claimant is mistaken. As the ALJ pointed out, ORS 656.804 provides that occupational disease claims are to be considered as injury claims except as otherwise provided in the occupational disease statutes. 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 low back occupational disease claim was February 1997, the date claimant first sought treatment for his low back condition. Following litigation that found claimant's occupational disease claim compensable, the employer accepted the claim as a nondisabling lumbar strain on September 1, 1998. Shortly thereafter, claimant requested the employer to submit the claim to the Director for reclassification of 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).

Claimant also argues that, as interpreted by the court in *Alcantar-Baca* and *Shaw*, ORS 656.277(2) is unconstitutional, contending that it unconstitutionally: (1) denied him a remedy in violation of Article 1, Section 10 of the Oregon Constitution;[2] (2) violated his rights under Article 1, Section 20 of the Oregon Constitution in that it defines two classes, those whose claims are accepted within a year from

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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] Article I, section 10 of the Oregon Constitution, 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."

the date of injury and those whose claims are accepted thereafter, and grants privileges and immunities to the first class while denying like privileges and immunities to the second class; and (3) violated the Fourteenth Amendment of the United States Constitution by denying him "recovery of permanent disability [benefits] without any process whatsoever." Appellant's Brief, page 1-2. The employer argues that claimant's constitutional arguments are precluded as untimely because he did not raise them at the March 31, 1999 hearing. While we find that claimant timely raised his constitutional challenge, we do not find it persuasive on the merits.

The court issued *Alcantar-Baca* and *Shaw* on June 2, 1999, after the March 31, 1999 hearing and just two days before the ALJ issued his June 4, 1999 Opinion and Order that relied on those decisions in determining that claimant's route to seek reclassification of his claim was limited to a claim for aggravation under ORS 656.273. Claimant requested reconsideration of the ALJ's order, contending that ORS 656.277, as interpreted by the court, was unconstitutional. On reconsideration, the ALJ declined to declare ORS 656.277 unconstitutional. Thus, on the facts of this case, claimant raised his constitutional challenge at the earliest possible time. Therefore, we find the issue timely raised.

Nevertheless, on the merits, we do not agree with claimant's arguments. Contrary to claimant's arguments, he has a remedy available to receive benefits related to a disabling claim, *e.g.*, temporary and/or permanent disability benefits. The statutory scheme merely prescribes a different procedural route to obtain those benefits when the challenge to claim classification occurs more than a year from the date of injury. Under such circumstances, the route to obtain benefits is through an aggravation claim under ORS 656.273. *See Koskela v. Willamette Industries, Inc.*, 159 Or App 229 (1999) (unavailability of opportunity to provide in-person testimony in extent of permanent disability process not violation of due process rights; procedures available provided due process rights).

Finally, claimant notes, and the employer does not disagree, that the 1999 legislature amended ORS 656.277 to prospectively address this issue. *See Kempf v. Carpenters and Joiners Union*, 229 Or 337, 343 (1961) (the general rule is that, when the legislature fails to express any intention with respect to retroactivity, a statute will be applied only prospectively if it "impair[s] existing rights, creates new obligations or impose[s] additional duties with respect to past transactions"). Specifically, the amendment 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). Because that amendment applies prospectively, it does not apply to claimant's claim. Nevertheless, for the reasons discussed above, lack of retroactive applicability does not mean that the former version of ORS 656.277 is unconstitutional. *See also Jesus Fletes, Dcd.*, 48 Van Natta 197 (1996) (1995 retroactive amendment to ORS 656.027(3)(b) that increased statutory amount required to define "subject worker" from $200 to $500 not unconstitutional).

ORDER

The ALJ's order dated June 4, 1999, as reconsidered on July 13, 1999, is affirmed.

In the Matter of the Compensation of
CASEY R. SHERRELL, Claimant
WCB Case No. 99-02150
ORDER ON RECONSIDERATION
Parker, Bush & Lane, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our December 21, 1999 Order on Review that reinstated and upheld the SAIF Corporation's denial of claimant's low back injury claim. In moving for reconsideration, claimant contends that the Board erred in finding that the treating physician, Dr. Barlow, did not review claimant's previous medical records and imaging studies when the parties stipulated that claimant sent Dr. Barlow those records when soliciting his report. Furthermore, claimant contends that, because "there is proof that Dr. Barlow reviewed claimant's previous records," his opinion is sufficiently persuasive to carry claimant's burden of proof.

We acknowledge the parties' stipulation that claimant provided his medical record, including the imaging studies, to Dr. Barlow. (Tr. 2). Even assuming, however, that Dr. Barlow received and reviewed those documents, as discussed in our first order, he provides no explanation for why he related the lumbar strain to the November 1998 work incident. Nor does Dr. Barlow explain why claimant's preexisting degenerative condition is an "incidental finding" when Dr. Schilperoort attributed claimant's need for treatment to this condition.

In sum, we continue to find persuasive reasons not to defer to Dr. Barlow's opinion. *See Weiland v. SAIF*, 56 Or App 259 (1984). Thus, we continue to hold that claimant did not prove compensability.

Accordingly, we withdraw our December 21, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our December 21, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTOPHER STEWART, Claimant
WCB Case No. 99-03292
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's left shoulder injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order. *See Crowe v. Jeld-Wen*, 77 Or App 81, 86 (1985), *rev den* 301 Or 76 (1986) ("The fact that activity at the second employment caused a condition acquired in the first employment to flare up or worsen does not convert the occupational injury into an occupational disease.").

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 August 20, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

In the Matter of the Compensation of
RICHARD M. MAZZA, Claimant
WCB Case No. 97-08021
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order affirming an Order on Reconsideration that set aside a Determination Order as prematurely issued. On review, the issue is premature claim closure. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable cervical and thoracic spine injury on May 21, 1994. He came under the care of Dr. Wenner, an orthopedist, who first declared claimant's condition medically stationary on July 13, 1995. (Ex. 14). Claim closure did not occur immediately, however. On March 6, 1996, Dr. Wenner again declared claimant's condition medically stationary. (Ex. 22). Dr. Wenner reconfirmed claimant's status in July 1996. (Ex. 29-2).

On February 25, 1997, Dr. Wenner reported that claimant returned for a follow-up visit for the first time since August 1996. Claimant indicated that his condition, while very painful, had not worsened to any degree. (Ex. 31). Dr. Wenner once more stated that claimant's condition was medically stationary even though there was a reasonable likelihood of future surgery. On April 27, 1997, Dr. Wenner confirmed that claimant's condition was medically stationary on March 6, 1996. (Ex. 32).

On May 29, 1997, a Determination Order issued, closing the claim and finding claimant's condition medically stationary as of March 6, 1996. (Ex. 34). A short time later, however, on June 6, 1997, claimant returned to Dr. Wenner. (26A). Dr. Wenner stated that claimant's "neck and arm pain has actually gotten worse in the interim." Referring claimant to Dr. Amstutz, a neurosurgeon, Dr. Wenner further wrote that claimant "has been medically stationary, but I think with this worsening that consideration should be given to opening this patient's claim again and to see if something definitive can be done to help him." *Id.*

In a June 6, 1997, letter to Dr. Amstutz, Dr. Wenner reported claimant's statement that he was "much worse" over the last few months. (Ex. 26B). Dr. Amstutz' evaluation occurred on July 3, 1997, as a result of which cervical surgery was recommended. Dr. Amstutz opined that he did not believe that claimant "has ever been completely medically stationary." (Ex. 29A-3).

On July 11, 1997, Dr. Wenner wrote the employer's claim processor, informing the carrier that he believed that claimant's condition was medically stationary on March 6, 1996 because, while claimant's condition was painful, claimant was not interested in surgery and there had not been significant progression of his condition. Dr. Wenner stated that claimant's condition had worsened over time to the point where he now a surgical candidate. According to Dr. Wenner, "this certainly suggests that [claimant] has not actually been medically stationary over that period of time." (Ex. 35).

Claimant requested reconsideration of the May 29, 1997 Determination Order on July 28, 1997, alleging that the claim was prematurely closed. (Ex. 36-1). On September 26, 1997, an Order on Reconsideration rescinded the Determination Order, finding the claim was prematurely closed. (Ex. 40-2). The employer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ first held that it was the employer's burden to prove that claimant's compensable condition was medically stationary at closure. Concluding that claimant's medically stationary status as of the date of the reconsideration order was determinative, the ALJ then found that the claim was prematurely closed. In making this finding, the ALJ relied on Dr. Amstutz' opinion that claimant's

condition was not medically stationary. Alternatively, the ALJ found that claimant's condition was not medically stationary when the May 29, 1997 Determination Order issued, reasoning that claimant's condition had deteriorated in "linear" fashion between February 25, 1997, Dr. Wenner's last "pre-closure" examination, and June 6, 1997, when Dr. Wenner indicated that claimant's condition had worsened in the "interim."

On reconsideration, the ALJ acknowledged that the date of the Determination Order, not the reconsideration order, was the "benchmark" for determining whether claimant's condition was medically stationary. Nevertheless, the ALJ reiterated his alternative reasoning, based on Dr. Wenner's opinion, that claimant's condition was not medically stationary on the date of claim closure.

On review, the employer contends that claimant has the burden of proving that the May 29, 1997 claim closure was premature. It also asserts that the medical evidence establishes that claimant's condition was medically stationary when the claim was closed.

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). We need not decide, however, whether the employer's contention regarding the burden of proof is correct. That is, even if the ALJ properly allocated the burden of proof, we find that the medical evidence establishes that the claim closure was proper. We reason as follows.

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).

The propriety of the closure turns on whether claimant was medically stationary at the time of the May 1997 Determination Order, 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, the ALJ reasoned that claimant's condition was not medically stationary when the claim was closed on May 29, 1997 based on the assumption that claimant's condition deteriorated in a "linear" manner between Dr. Wenner's February 25, 1997 examination and June 6, 1997. This assumption was apparently based on Dr. Wenner's comment on June 6, 1997 that claimant's neck and arm pain had worsened in the "interim." However, there is no direct support for the assumption that claimant's decline began before the May 29, 1997 claim closure. Dr. Wenner did not explicitly confirm this. Indeed, in his June 6, 1997 report, Dr. Wenner reiterated that claimant's condition "has been medically stationary." (Ex. 26A).

In his July 11, 1997 report, Dr. Wenner opined that claimant's condition had worsened over time to the point that he was now a surgical candidate. (Ex. 35). According to Dr. Wenner, "this certainly suggest[ed] that [claimant] has not actually been medically stationary over that period." We agree, however, with the employer that a "suggestion" that claimant's condition was not medically stationary does not rise to the required level of medical probability. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). Moreover, Dr. Wenner did not retract any of his numerous pre-closure opinions that claimant's condition was medically stationary.

Therefore, considering his numerous unambiguous pre-closure statements that claimant's condition was medically stationary, Dr. Wenner's post-closure "suggestion" that claimant's condition was not, in fact, medically stationary is not sufficient to prove that the claim closure was premature.

Nor do we find persuasive Dr. Amstutz' opinion that claimant's condition has never been "completely medically stationary." Dr. Amstutz first treated claimant in July 1997, well after the May 1997 closure. Because Dr. Amstutz lacked Dr. Wenner's pre-closure familiarity with claimant's medical condition, we do not find Dr. Amstutz' opinion offsets Dr. Wenner's statements that claimant's condition was medically stationary prior to claim closure.

Accordingly, we disagree with the ALJ's determination that the claim was prematurely closed. Thus, we reverse.

ORDER

The ALJ's order dated January 5, 1999, as reconsidered on July 7, 1997, is reversed. In lieu of the September 26, 1997 Order on Reconsideration, the May 29, 1997 Determination Order is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

The majority finds that the claim was not prematurely closed, relying on Dr. Wenner's "pre-closure" statements that claimant's condition was medically stationary. I would find, however, that Dr. Wenner's "post-closure" medical reports establish that claimant's condition was, in fact, not medically stationary prior to claim closure. Therefore, I would affirm the ALJ's determination that the claim was prematurely closed. For this reason, I must dissent.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Because the employer requested a hearing from the reconsideration order, I agree with the ALJ that it bears the burden of proving that claimant's condition was medically stationary at closure. *See Roberto Rodriguez*, 46 Van Natta 1722 (1992).

At the outset, I would agree with the majority that Dr. Wenner's "pre-closure" reports indicated that claimant's condition was medically stationary. Nevertheless, I cannot concur with the majority's narrow interpretation of Dr. Wenner's "post-closure" opinions that, to me, clearly indicate that he had changed his mind regarding claimant's medically stationary status after reviewing additional information. Nothing prevents a doctor from changing his mind regarding a reasonable expectation of material improvement and a change of opinion is precisely what occurred in this case.

Dr. Wenner commented on June 6, 1997 that claimant's neck and arm pain had worsened in the "interim." Although the majority does not find that this necessarily supports a conclusion that the worsening began before the May 29, 1997 closure, I believe that the ALJ properly drew this inference from the evidence. Even if Dr. Wenner's June 6, 1997 report does not necessarily establish a reasonable expectation of improvement prior to claim closure, surely Dr. Wenner's subsequent report on July 11, 1997 makes this point abundantly clear.

According to Dr. Wenner, the worsening suggested that claimant's condition had not been medically stationary. While the majority nit-picks the word "suggests," asserting that it not sufficiently definite, there is no requirement that a physician use magic words or mimic statutory language. *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986). Further, the court has explained that a medical opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516 (1999); *Worldmark the Club v. Travis*, 161 Or App 644 (1999). Here, when Dr. Wenner's July 11, 1997 report is evaluated in its context, it is sufficient to establish that claimant's condition was not medically stationary when the claim was closed. The majority erred in concluding otherwise.

In summary, I would conclude that Dr. Wenner changed his opinion regarding claimant's medically stationary status prior to claim closure. Because the medical evidence from Dr. Wenner in its totality (as supported by Dr. Amstutz) proves that the claim closure was premature, I would affirm the ALJ's order. Thus, I respectfully dissent.

In the Matter of the Compensation of
DAVID L. SHOSTAK, Claimant
WCB Case No. 99-00575
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's injury claim for an L5-S1 disc protrusion condition. On review, the issue is compensability.

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

In setting aside the employer's denial with regard to the L5-S1 disc protrusion condition, the ALJ relied on the opinions of claimant's treating physicians, Dr. Thomas and Dr. Swiridoff. We generally give greater weight to the opinions of claimant's treating physicians, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). For the following reasons, we agree with the ALJ that Dr. Thomas and Dr. Swiridoff offered the most persuasive opinions on the issue of causation.

The employer argues that the ALJ failed to consider Exhibit 59, Dr. Thomas' April 16, 1999 concurrence letter. We disagree. The ALJ cited verbatim to Exhibit 63, Dr. Thomas' June 7, 1999 concurrence letter in which he reconciled his earlier conflicting reports to counsel. (O&O at 5, 6). Therefore, as did the ALJ, we have taken into account all prior statements on causation by Dr. Thomas, and have determined that Dr. Thomas fully explained any change in his opinion. Moreover, Dr. Thomas' final opinion expressed in his June 7, 1999 concurrence letter relies on a correct history of a gradually developing radiculopathy into the legs (developing "several weeks after the injury.") (Ex. 63).

Similarly, as the ALJ noted, Dr. Swiridoff's opinion was fully presented in his May 18, 1999 deposition. (Ex. 62). Dr. Swiridoff stated his opinion, to a reasonable degree of medical probability, that claimant's L5-S1 disc protrusion was caused in major part by his work activities in July of 1998, even when considering the effects of a degenerative process at that level. (Ex. 62-54).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 25, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,750, to be paid by the employer.

Board Member Haynes dissenting.

Because I believe that claimant did not meet his burden of proving that his L5-S1 disc protrusion condition is compensably related to his August 17, 1998 injury, I respectfully dissent.

Multiple doctors examined claimant in August of 1998, none of whom even mentioned any pain radiating into claimant's legs. (Exs. 2, 4, 9, 10). The only stray mention of potential leg pain was a positive straight leg raising test administered by Dr. Swiridoff on August 21, 1998. (Ex. 11). Despite that finding, Dr. Swiridoff diagnosed a "lumbar strain." (Id.) In his deposition, Dr. Swiridoff explained that not all straight leg raising tests are indicative of a herniated disk. (Ex. 61-9).

Dr. Swiridoff performed two other straight leg raising tests on September 2, 1998 and September 16, 1998, both of which were negative. (Exs. 16, 61-10). When asked whether he could reliably indicate when claimant herniated the disc at L5-S1, given these negative findings, Dr. Swiridoff conceded that he could not. (Ex. 61-25). However, Dr. Swiridoff then agreed with claimant's attorney that claimant's work activities were the major contributing cause of the L5-S1 disc. (Ex. 61-49, 61-52). Dr. Swiridoff's retreat from his earlier opinion is unexplained and internally inconsistent. As such, it should be given little weight. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

Similarly, Dr. Thomas' opinion relies on an inaccurate history of a "lifting injury" on August 17, 1998 and is therefore unpersuasive. There is no evidence of a discrete lifting injury at any time. Instead, claimant's lower back pain came on gradually during the last week of July, 1998. *(See* Ex. 9-1). Because Dr. Thomas relies on an inaccurate history, his opinion is not persuasive. *Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977).

Finally, the ALJ characterized Dr. Thomas' opinion regarding the causation of claimant's L4-5 disc as "conclusory," yet did not indicate why Dr. Thomas' opinion as to the L5-S1 disc condition was any less so.

For these reasons, I am not persuaded that claimant's July 1998 work activities were the major contributing cause of L5-S1 disc condition. I respectfully dissent.

In the Matter of the Compensation of
ROGER K. ANDERSON, Claimant
Own Motion No. 99-0354M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on June 7, 1994. The insurer denied the compensability of and responsibility for claimant's current condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 99-08626).

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. However, pursuant to a May 28, 1991 Claim Disposition Agreement (CDA), claimant has released his rights to the following workers' compensation benefits: temporary disability benefits, permanent disability benefits, vocational rehabilitation, survivor's benefits and aggravation rights, and all other workers' compensation benefits except compensable medical services under ORS 656.245.

In light of the fact that claimant has permanently relinquished his rights to temporary disability compensation, the compensability and responsibility issues are moot in regards to the temporary disability compensation issue before us. In other words, as a result of the May 28, 1991 CDA, claimant is no longer entitled to any temporary disability compensation related to his June 7, 1989 work injury. *See* ORS 656.236(1); *Jack F. Stewart*, 51 Van Natta 22 (1999); *Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994), *aff'd Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
SANDRA L. SHUMAKER, Claimant
WCB Case No. 98-08409
ORDER ON RECONSIDERATION (REMANDING)
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Claimant and the self-insured employer request reconsideration of our December 15, 1999 Order on Review that vacated an Administrative Law Judge's (ALJ's) order and remanded the case for further proceedings.

The employer argues that the case should not be remanded, because the ALJ "affirmed" claimant's objection to litigating causation and therefore claimant was not "surprised" by the causation issue. Under these circumstances, the employer contends that the ALJ properly upheld its denial of claimant's aggravation claim--on causation grounds.

Claimant agrees with the employer that the case should not be remanded, but for different reasons. In her view, the employer specifically "waived" a causation defense and therefore the issue is limited to "worsening." But claimant cites no evidence of waiver of the causation defense and we find none.[1] *See Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 685 (1995) (Waiver is "the intentional relinquishment of a known right.") (quoting *Drews v. EBI Companies*, 310 Or 134, 150 (1990)).

Absent waiver of the causation defense, the employer was entitled to amend its denial at hearing to include that defense. *See* OAR 438-006-0031. If the ALJ had allowed the amendment, claimant would have been entitled to a continuance (based on surprise or prejudice) to cure her asserted lack of adequate notice that causation was at issue.

As we explained in our initial order, the ALJ should have permitted the employer to include causation grounds for its aggravation denial. Because claimant lacked notice of that basis for the denial, it is appropriate to remand this case to the ALJ to allow claimant an opportunity to claim surprise at the raising of the "causation" issue and to seek a continuance to further develop the record.[2] *See id.*

The employer also contends it is not pursuing a causation defense and remand will only cause delay, because there is no evidence that claimant's accepted condition worsened. The employer relies on the ALJ's factual finding that claimant's "entire problem" is a condition *unrelated* to her work injury. As explained in our prior order, we have interpreted the employer's defense to the aggravation claim to include a causation ground. Thus, the employer is effectively pursuing the same "causation" defense that surprised claimant at hearing. Under these circumstances, we continue to conclude that remand is appropriate.

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[1] The ALJ stated that the denial was specifically amended to delete the paragraph dealing with "the effect, if any, of the ganglion cyst." (Tr. 8). Claimant apparently understood that to mean that causation would not be litigated; the employer clearly believed that causation and worsening were both at issue. Although their divergent beliefs did not surface until the ALJ decided the case on causation grounds, the ALJ's order and the parties' current disagreement indicate that there was no waiver of the causation defense (despite the pre-hearing discussion of the issue to be litigated).

[2] Claimant contends that she "was not surprised by the new defense because the defense was waived." But the basis for claimant's at-hearing contingent request for a continuance was lack of notice of the causation defense (*i.e.*, "surprise"). Based on pre-hearing discussion, she understood that the case would be litigated on worsening grounds only. But she was "surprised" again when the ALJ decided the case on causation grounds after all. As we explained in our prior order, the employer was entitled to contest causation. That determination requires remand to the ALJ so that claimant may decide whether she wishes to seek a continuance as a cure for any surprise related to the "causation" defense. *See Neely v. SAIF*, 43 Or App 319, 323, *rev den* 288 Or 493 (1979) ("If claimant had been given no opportunity to present evidence on [the causation] issue in the hearing below, the proper procedure would be for the Board to remand the case to the referee, ORS 656.295(5), for the taking of evidence on that issue."); *Gregg Muldrow*, 49 Van Natta 1866 (1997). Finally, should claimant choose not to request a continuance to further develop the record to address the causation issue, she may so advise the ALJ. In that event, the ALJ may proceed to resolve the aggravation issue on the record as currently developed.

Accordingly, we withdraw our December 15, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our December 15, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANNETTE SKOWRON-GOOCH, Claimant
WCB Case No. 99-02418
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that increased claimant's unscheduled permanent disability award for a cervical condition from 4 percent (12.8 degrees), as awarded by an Order on Reconsideration, to 14 percent (44.8 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured in a motor vehicle accident on April 11, 1996. The insurer accepted a cervical and lumbar strain. (Exs. 3, 16, 23, 34). On October 9, 1998, a Determination Order awarded 17 percent unscheduled permanent disability, which included 14 percent impairment based on claimant's reduced cervical range of motion. (Ex. 35).

The insurer requested reconsideration. (Ex. 36). Dr. Tobin performed a medical arbiter examination on February 23, 1999. (Ex. 38). On March 5, 1999, an Order on Reconsideration issued, which awarded 4 percent impairment for reduced cervical range of motion and 4 percent impairment for reduced lumbar range of motion, for a total 8 percent unscheduled permanent disability award. (Ex. 39). The Appellate Reviewer noted that the Department had requested clarification from the medical arbiter regarding the cervical range of motion findings, but had not yet received a response. (Ex. 39-2). Therefore, the Appellate Reviewer rated impairment based on the medical arbiter's valid cervical range of motion findings. (*Id.*) Dr. Tobin responded to the request for clarification on March 8, 1999. (Ex. 40).

The ALJ relied on WCD Bulletin 239 and determined that the medical arbiter's report was incomplete. Alternatively, the ALJ found that, even if the medical arbiter's range of motion testing was complete, the PCE provided the most thorough evaluation of claimant's cervical impairment. The ALJ reinstated the Determination Order's award of 14 percent unscheduled permanent disability for claimant's reduced cervical range of motion.[1]

The insurer argues that the ALJ misinterpreted the language of WCD Bulletin 239 and it contends that the medical arbiter's report provided the most persuasive evidence concerning claimant's impairment. On the other hand, claimant argues that the May 29, 1998 physical capacities evaluation (PCE), which was concurred in by Dr. Tihanyi, her attending physician, provides the most thorough, complete and well-reasoned evaluation of her impairment. For the following reasons, we agree with claimant.

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[1] The ALJ noted that claimant's permanent disability award regarding her low back condition was not contested.

OAR 436-035-0007(14) (WCD Admin. Order No. 98-055) provides that on reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion established a different level of impairment. We rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Claimant's attending physician at the time of closure was Dr. Tihanyi. Claimant was determined to be medically stationary on April 28, 1998. On that date, Dr. Tihanyi reported that claimant continued to have a lot of neck spasm and had not attained her preinjury status. (Ex. 28). She noted that claimant's range of motion findings were not normal and she referred claimant for a PCE to provide measurements by inclinometer. (*Id.*)

A PCE was performed on May 29, 1998. (Ex. 30). Claimant participated in a 2-hour evaluation that included inclinometry measurements, maximum voluntary effort testing and functional work activity assessment. (Ex. 30-6). The measurements were considered valid for rating purposes. (Ex. 30-6, -7). Claimant's cervical ranges of motion were measured as: flexion 22 degrees; extension 30 degrees; right lateral flexion 24 degrees; left lateral flexion 20 degrees; right rotation, 44 degrees; and left rotation, 50 degrees. (Ex. 30-5). Dr. Tihanyi concurred with the PCE. (Ex. 31).

Dr. Tobin performed a medical arbiter examination on February 23, 1999. (Ex. 38). He reported that claimant's cervical range of motion was limited in all planes, but he noted that "[s]ome of the range of motion findings of the cervical spine may be considered invalid due to variation in the three measurements." (Ex. 38-3). The worksheet attached to Dr. Tobin's report concerning claimant's cervical range of motion referred to the following measurements: flexion 32 degrees; extension 36 degrees; right lateral flexion 28 degrees; left lateral flexion 24 degrees; right rotation 54 degrees; left rotation 50 degrees. (Ex. 38-6). Dr. Tobin said that four of the six measurements were invalid, which included extension, right lateral flexion, left lateral flexion and right rotation. (*Id.*)

The WCD Appellate Reviewer sought clarification from Dr. Tobin regarding the cervical range of motion findings. (Ex. 39-2). On March 8, 1999, Dr. Tobin reiterated that his report had noted that some of the cervical range of motion findings "may" be considered invalid. (Ex. 40). That comment related to cervical extension, right lateral flexion, left lateral flexion and right rotation. (*Id.*) Dr. Tobin explained: "[t]he reason they *may* be considered invalid is that they do not fit the criteria laid out on the sheet 'Are measurements within +/- 10% or 5 degrees (whichever is greater).'" (*Id.*; emphasis supplied).

On this record, we find that the PCE, which Dr. Tihanyi concurred with, provides the most thorough, complete and well-reasoned assessment of claimant's cervical impairment. The PCE report included specific findings that the measurements were considered valid for rating purposes (Ex. 30-6, -7), and the therapist found that claimant "put forth full effort and evaluation results are considered a valid and accurate representation of current physical capacities." (Ex. 30-7). Dr. Tihanyi concurred with the PCE. (Ex. 31). In a previous report, Dr. Tihanyi had commented that claimant was "straightforward" with her symptoms and there was no secondary gain. (Ex. 22-3).

In contrast, we find that Dr. Tobin's report is, at best, equivocal. He reported that "[s]ome of the range of motion findings of the cervical spine *may* be considered invalid due to variation in the three measurements." (Ex. 38-3; emphasis supplied). In a March 8, 1999 report, Dr. Tobin explained: "[t]he reason [the measurements] *may* be considered invalid is that they do not fit the criteria laid out on the sheet 'Are measurements within +/- 10% or 5 degrees (whichever is greater)." (Ex. 40; emphasis supplied). In light of Dr. Tobin's equivocal statement that the cervical range of motion findings "may" be considered invalid, his opinion is not persuasive. Moreover, even if we assume that Dr. Tobin found that the some of the cervical measurements were invalid, we are unable to determine from his report whether he believed that three or four of those measurements were invalid. Although his worksheet indicated that four of the six cervical measurements were invalid (Ex. 38-6), another portion of his report said that "[s]ome of the range of motion findings of the cervical spine may be considered invalid due to variation in the *three* measurements." (Ex. 38-3; emphasis supplied).

In sum, we agree with the ALJ that the PCE, which Dr. Tihanyi concurred with, provides the most thorough, complete and well-reasoned evaluation of claimant's cervical impairment. Consequently, we agree with the ALJ that the Determination Order's award of 14 percent (44.8 degrees) unscheduled permanent disability for claimant's reduced cervical range of motion should be reinstated. *See* OAR 436-035-0360.

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 August 20, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
CHRISTIAN TAYLOR, Claimant
WCB Case No. 99-02208
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral cubital tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation. We supplement the ALJ's order to note that Exhibits A, 1 through 14, 8a-23 and 8a-30 were admitted in evidence.

ORDER

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

Board Member Phillips Polich dissenting.

The majority upholds the self-insured employer's denial of claimant's occupational disease claim for bilateral cubital tunnel syndrome. In doing so, the majority agrees with the ALJ that Dr. Sova did not have an accurate history of claimant's preexisting hand and wrist problem. Because I disagree with the ALJ's and the majority's rationale for discounting Dr. Sova's opinion, I respectfully dissent.

To begin, I do not agree that claimant has a preexisting hand and wrist problem. Dr. Farris, who examined claimant on behalf of the employer, indicated claimant recalled "many aches and pains over the years in the upper extremities," but Dr. Farris concluded there was no specific diagnosis of a preexisting medical condition." (Ex. 8-5, -6). At most, Dr. Farris' comments indicate only a *possibility* of a preexisting condition. *See Gormley v. SAIF*, 52 Or App 1055 (1981). Consequently, the employer has failed to sustain its burden of proving the existence of a preexisting hand and wrist condition. *See Beverly Enterprises v. Michl*, 150 Or App 357 (1997); *Joseph L. Cilione*, 50 Van Natta 1828 (1998). For that reason, I am not persuaded that Dr. Sova had an inaccurate history of claimant's preexisting hand and wrist problem. I would defer to Dr. Sova's opinion and find the claim compensable.

In the Matter of the Compensation of
HARVEY L. WILLIAMS, Claimant
WCB Case No. 99-01007
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that set aside its partial denial of claimant's claim for a consequential C4-5 condition. On review, the issue is compensability.

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

We do not find that "Dr. Silver opined that *if* claimant's symptoms are not due to a compression of the spinal cord, *then* they are a result of the anterolisthesis at C4-5." (Opinion and Order, p. 3, emphasis added; *see* Ex. 174A). Instead, we find that Dr. Silver opined that the proposed C4-5 surgery would be appropriate "if there is significant stenosis and/or nerve root compression." (Ex. 174A-5).[1]

We do not find that "No physician attributes claimant's symptoms to degenerative disease." (Opinion and Order, p.4). Instead we find Dr. Farris' opinion to that effect unpersuasive because there is no evidence that any such condition preexisted claimant's work injury. (*See* Exs. 169-3, 175).

Finally, we agree with the ALJ that a preponderance of the persuasive medical evidence indicates that claimant's current C4-5 condition[2] is due to his work injury and its sequelae, especially his two surgeries. (*See* Exs. 148-5-6, 163-1, 171, 176-2-3). *See Barrett Business Services v. Hames*, 130 Or App 190, 193, *rev den* 320 Or 492 (1994) (where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)).

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 August 17, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

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[1] However, we specifically agree with the ALJ that the appropriateness of the proposed surgery is a matter outside our jurisdiction.

[2] Claimant's current neck problems are probably at C4-5, even though it is *possible* that his disability and need for treatment arise elsewhere. (*See* Exs. 140, 153, 159, 163-1, 165-1, 176-3; *see also* Ex. 174A-5). *See e.g., Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988) (A claimant need not establish a specific or certain diagnosis in order to have a compensable claim).

In the Matter of the Compensation of
PATRICIA A. WILLIAMS, Claimant
WCB Case No. CV-99002
ORDER ON RECONSIDERATION (CRIME VICTIM ACT)

The Department of Justice Crime Victims' Compensation Fund (Department) has objected to Special Hearings Officer Celia M. Fitzwater's December 15, 1999 Proposed Order (Crime Victims' Act) (Remanding) that denied the Department's motion to dismiss and remanded the claim to the Crime Victims' Compensation Fund for consideration of a police report. Specifically, the Department argues that the request for review of the Department's Order on Reconsideration was untimely and that the appeal should have been dismissed based on lack of standing. After considering the Department's contentions and the response from the decedent's mother (Ms. Williams), we issue the following order.

Citing a statute and rule pertaining to contested case hearings and the Attorney General's Administrative Law Manual, the Department argues that it had authority to set a 60 day appeal period for requesting Board review of its Order on Reconsideration. The cited statute, ORS 183.415(2), and rule, OAR 137-003-0001, pertain to notices in contested case hearings. ORS 183.415(2) sets out the requirements for a notice in a contested case hearing. The statute does not require a time limit for an appeal. OAR 137-003-0001 states that the contested case notice shall specify the time within which a person may request a hearing. The Department's administrative law manual states that when no time limit is provided by statute for requesting a hearing, the time period shall be reasonable under the circumstances.

Where the statute itself does not include a time limit with which an appealing party may seek a hearing, we are not inclined to find that the Department had authority to provide such a limit. *See, generally, Benino T. Orn*, 46 Van Natta 254 (1994) (Board not inclined to rely on rule that attempted to set a time limit on a party's right to hearing under *former* 656.327(2) where statute contained no such limitation). Here, neither the rule, nor the statute, set any specific time limitation on an appeal of an Order on Reconsideration issued by the Department under ORS 147.145. In short, we find no statutory or other binding authority that supports the Department's argument that the request for Board review is untimely because it was not filed within 60 days.

The Department next asserts that Ms. Williams lacks standing to challenge the Order on Reconsideration because she was not the same applicant who initiated the application for compensation. As the special hearing officer noted, the definition of an "applicant" in ORS 147.005(1) includes a survivor of a deceased victim. "Survivor" includes a parent of a deceased victim. ORS 147.005(12).

Here, Ms. Williams is the mother of the deceased and thus is a "survivor" who appears to meet the statutory definition of an applicant. ORS 147.155 provides that "Any applicant who requests review by the Department of Justice under ORS 147.145 and who disagrees with the decision of the department on review may appeal to the Workers' Compensation Board." Because Ms. Williams requested review by the Department of the Order on Reconsideration, ORS 147.145 requires the Department to "reconsider any order for which a request for review is received." In response to Ms. Williams' request, the Department issued a letter stating that there were no further appeal rights on the claim. (The Department did not object to Ms. Williams' request on the ground that she lacked standing to appeal the order. The Department, instead, treated the request as if it had been submitted by the initial applicant and rejected it on timeliness grounds). We, thus, agree that Ms. Williams satisfied the prerequisites of ORS 147.145 in that she was an applicant who had requested review by the Department and disagreed with the Department's decision. Under such circumstances, we agree with the hearing officer that Ms. Williams had standing to request Board review under ORS 147.155.

The Department cites to language in ORS 147.005, the definitional statute, that says: "As used in ORS 135.905 and 147.005 to 147.365 unless the context requires otherwise" followed by definitions of thirteen terms used in Chapter 147, including "applicant," "compensable crime," "survivor," "victim." The Department argues that, as used in ORS 147.155(1), the context requires that the definition contained in ORS 147.005(1) of "applicant" should not apply. The Department cites to ORS 147.105 to argue that the context of ORS 147.155(1) establishes that the "applicant" means the same person who filed the application for crime victim compensation. ORS 147.105 does provide that an "applicant" for compensation must file an application including information specified in the statute.

Even if we assume that the statutory context requires the applicant to be the same person who filed the original application, we would find that this requirement has been satisfied. In this regard, Patricia Williams submitted the request on behalf of Kim Armstead Williams who is the original applicant. Kim Armstead Williams participated in the telephone hearing conducted by the Special Hearings Officer and expressed no objection to Ms. Williams' pursuit of the claim. Moreover, Patricia Williams states in her letters to the Hearings Officer and the Department that she is not claiming compensation for herself. Rather, she states that she requested compensation for her son's wife and children. Thus, even assuming that only Kim Armstead Williams may challenge the Department's order, we find that Patricia Williams challenged the Department's order on behalf of Kim Armstead Williams and not on behalf of herself. We therefore reject the Department's argument that the appeal should be dismissed for lack of standing.

After carefully reviewing this matter and considering the Department's arguments, we agree with the order of the Special Hearings Officer. Accordingly, as supplemented herein, we adhere to the Hearings Officer's December 15, 1999 order remanding this matter to the Department for consideration of the police report.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTOPHER W. FULLBRIGHT, Claimant
WCB Case No. 98-09532
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

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

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. The following corrections are made to the ALJ's order. The correct WCB number in this matter is WCB Case No. 98-09532, and the correct date of injury is 7/1/98.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not met his burden of establishing that a lifting incident at work on July 2, 1998 was the major contributing cause of claimant's disc herniation and his need for medical treatment. For the following reasons, we agree with the ALJ's conclusions.

The persuasive medical evidence establishes that claimant has a preexisting degenerative condition that combined with the work injury. (Exs. 18-6, 19-2, 20). Pursuant to ORS 656.005(7)(a)(B), where a compensable injury combines with a preexisting condition, claimant must establish that the compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. *SAIF v. Nehl*, 148 Or App 101, *on recon* 104 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 (1994); *rev dismissed* 320 Or 416 (1995).

Here, there are three expert opinions that discuss the issue of causation. Dr. Fuller, orthopedic surgeon, examined claimant on behalf of SAIF. Dr. Fuller noted that claimant had previously treated with a chiropractor in 1995 and in early 1998. Dr. Fuller reported that the records showed a history of a

work incident on July 2, 1998 that resulted in low back pain radiating down the left leg to the knee.[1] Dr. Fuller noted that claimant's MRI showed degenerative disc disease at three levels, and claimant had evidence of back pain in his late teens. Dr. Fuller further reported that claimant recovered from the acute work episode in early July 1998, which led him to believe that the incident caused waxing and waning of the underlying degenerative condition but did not cause the disc herniation. (Ex. 18).

While Dr. Fuller felt that claimant's preexisting disease combined with claimant's athletic activities, work activities and off-work incidents, he believed that claimant's personal weightlifting activity in August 1998 precipitated the final herniation of the right-sided L4-5 disc. Nevertheless, Dr. Fuller believed that the major contribution to the disc herniation was not the weight lifting incident, but rather, the presence of degenerative disc disease. In Dr. Fuller's opinion, claimant's "disc was ready to blow and probably would have herniated with a sneeze or other such trivial mechanism given time." (Ex. 18-8).

Dr. Anderson reviewed claimant's records on behalf of SAIF and found that claimant's preexisting degenerative condition was unusual for someone of claimant's age, but was not rare. Dr. Anderson believed that claimant's recreational and work activities contributed to his condition and the July 1998 work injury combined with the preexisting condition. Dr. Anderson noted that claimant had previously experienced symptoms related to physical activities outside of work with symptoms consistent with nerve root involvement and believed that claimant's underlying degenerative condition kept him at a high risk of recurrent symptoms. After considering claimant's records and the possible contributing factors to his current condition, Dr. Anderson concluded that the degenerative condition was the major cause of claimant's disability and need for treatment. (Ex. 19-2).

Finally, claimant's treating doctor, Dr. Erkkila, agreed that claimant had a preexisting degenerative condition that played a role in the disc herniation. Nevertheless, Dr. Erkkila disagreed with Dr. Fuller's opinion that the preexisting condition was the major cause of claimant's disc herniation. Dr. Erkkila based his disagreement on the fact that claimant started having pain radiate down his leg following the July 1998 work incident. In reaching his opinion, Dr. Erkkila relied on claimant's report of no radicular symptoms before the work injury, low back pain and radicular symptoms following the lifting injury at work, and the mechanism of that lifting injury. Dr. Erkkila also felt that claimant's off work activities did not cause the disc to herniate because he did not have the onset of radicular symptoms following any of his off work activities such as playing basketball, racquetball, lifting weights, playing with children or lifting a waffle iron. (Ex. 20-2).

After reviewing the expert medical opinions in the record, we agree with the ALJ that Drs. Fuller and Anderson have provided the most persuasive medical opinions in this case. Those doctors have reviewed claimant's medical records and have discussed, in detail, the contributing factors that led to claimant's herniated disc condition. Specifically, Drs. Fuller and Anderson have emphasized that claimant has an unusually severe preexisting degenerative condition for someone that is only 26 years old.[2] Dr. Erkkila has not responded to these comments.

We are not persuaded by the opinion of Dr. Erkkila for several additional reasons. First, the record shows that claimant was able to return to playing basketball and racquetball following the July 1998 work incident. (Ex. 4). On July 14, 1998, claimant reported that he had been actively participating in athletics and had been having "very little low back pain." On July 21, 1998, a chiropractor noted that claimant had "no additional pain in his leg." (Ex. 4-2). However, on August 25, 1998, claimant reported pain in his low back and pain going down the back of his right leg. The pain was "shooting and nerve like" and was "going to the back of his knees." Prior to that date, claimant had been working out, doing weightlifting which included dead lifts with 90-100 pounds. (Ex. 4-2).

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[1] Dr. Fuller noted that, at the time he examined claimant in January 1999, claimant reported that the pain he had experienced on July 2, 1998 was actually in the right leg, not the left. (Ex. 18-3).

[2] We disagree with the dissent's contention that Dr. Fuller did not have an accurate history. Dr. Fuller was aware of claimant's work activities. Moreover, claimant's claim is for an injury, rather than for an occupational disease. With respect to a work incident, Dr. Fuller was aware that claimant injured himself lifting a mold at work. (Ex. 18-3).

After reviewing the medical records, we agree with the ALJ's conclusion that Dr. Erkkila had an inaccurate history with regard to the onset of claimant's radicular symptoms. Dr. Erkkila believed that the radicular symptoms began immediately after the July 1998 work incident, and that belief was the sole reason for his conclusion that the work incident was the major cause of claimant's disc herniation. (Ex. 20-2). However, the contemporaneous medical records do not support Dr. Erkkila's conclusion.

When Dr. Erkkila first examined claimant, he took a history of low back and right leg pain since July 2, 1998, when claimant was lifting molds at work. (Ex. 15). Dr. Erkkila subsequently diagnosed a clinical L4-5 disc with impingement of the right L5 nerve root. However, the first doctor to examine claimant following the July 2 work incident reported that claimant had low back pain and pain down the left side of the back to the left lateral leg down to the knee. (Ex. 2). A pain diagram signed by claimant on July 3, 1998 also describes left leg symptoms and shows a drawing of the areas of pain to include the low back and left leg. (Ex. 3). As the ALJ found, although there are numerous chartnotes describing claimant's continuing low back symptoms throughout July 1998, there is no mention of right leg radicular symptoms until August 25, when claimant described "shooting and nerve like" pain down the back of his right leg. (Ex. 4-2).[3]

Consequently, we find that Dr. Erkkila's opinion which is based on a belief that claimant's radicular leg symptoms began in early July 1998 after a lifting incident at work is inaccurate. Because his opinion is based on such an error, and because claimant has other significant contributing factors, we agree with the ALJ that claimant has not met his burden of proof. Accordingly, we affirm the ALJ's order.

ORDER

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

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[3] Dr. Leman, who treated claimant in Immediate Care on September 11, 1998, took a history of claimant not remembering exactly how he hurt his right leg or low back , but claimant complained of injuring his right leg or back "probably around August 15...". (Ex. 6). Similarly, on the First Medical Report filled out by claimant on the day he treated with Dr. Leman, claimant described his accident as a herniated disc and "lost movement to all of my right leg." Claimant listed the date of injury as August 15, 1998. (Ex. 5).

Board Member Phillips Polich dissenting.

For the following reasons, I respectfully dissent from the majority's opinion in this case. First, I conclude that there is no persuasive reason to reject the opinion of Dr. Erkkila, claimant's treating doctor. Dr. Erkkila had a complete and accurate history of claimant's work injury and his off work activities. Dr. Erkkila also considered all possible factors that contributed to claimant's disc herniation, including the preexisting degenerative condition. After taking all those factors into consideration, Dr. Erkkila continued to believe that claimant's July 1998 work injury was the major cause of the L4-5 disc herniation.

I would also find that Dr. Erkkila's opinion is persuasive because he had an accurate history of claimant's condition following the injury. Dr. Erkkila reported that claimant had the onset of low back and radicular pain[1] following lifting and moving heavy objects (weighing over 100 pounds) at work. (Ex. 20-2). Dr. Erkkila concluded that claimant had a weakened spot in the annulus of the L4-5 disc, and when he lifted/moved heavy objects at work, the pressure increased, which caused tearing and then the eventual disc herniation. Under such circumstances, Dr. Erkkila believed that the work injury was the major contributing cause of the disc herniation. (Ex. 20-2).

I disagree with the majority's opinion that Dr. Fuller's opinion is persuasive, because I find that it is not based on a complete and accurate history. Specifically, claimant testified at hearing that Dr. Fuller did not allow him to provide the details of his work activities. For example, claimant testified that he was not able to explain, in detail, how he picked up molds at work and flipped them over. (Tr. 52-53). On the other hand, claimant did describe his work to Dr. Erkkila and was able to demonstrate how he actually performed his work duties. (Tr. 54).

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[1] Dr. Erkkila considered claimant's history of no radicular symptoms before the work injury and the fact that, following the work injury, claimant had low back and radicular symptoms, whereas, following his off work activities, claimant did not experience the onset of such symptoms. (Ex. 20-2).

Accordingly, based on Dr. Erkkila's persuasive opinion, I find that claimant has met his burden of proof pursuant to ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
JOSEPH H. KELLER, Claimant
WCB Case No. 98-09663
ORDER ON REVIEW
Lauren Paulson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes 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 a left ankle injury on the ground that the claim was barred due to an untimely filing. On review, the issue is timeliness of the claim.

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

On review, claimant contends that the ALJ incorrectly found that claimant's claim for his left ankle injury was untimely.[1] Claimant argues that the employer conceded at hearing that he knew that claimant's ankle was injured within one year of the date of the accident. First, as noted by the ALJ, an employer must have had knowledge of the injury within 90 days after the alleged injury date. *See Jeffery E. Henderson*, 50 Van Natta 2340, 2342 (1998); ORS 656.265(4)(a). Moreover, as SAIF argues, the employer in this case was not aware that claimant's ankle injury occurred at work. (Tr. 18, Ex. 7A-2). *See e.g. Argonaut Insurance v. Mock*, 95 Or App 1 (1989); *Henderson*, 50 Van Natta at 2343, n2 (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). Accordingly, we conclude that the ALJ correctly found that the claim was not timely filed.[2]

ORDER

The ALJ's order dated August 31, 1999 is affirmed.

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[1] In his brief, claimant takes issue with the ALJ's exclusion of Exhibit A (a statement authored by one of claimant's co-workers) on the ground that the co-worker was not present at hearing. Claimant disagrees with the ALJ's ruling that the co-worker could not be cross-examined (with respect to Exhibit A) via telephone at the time of hearing. On review, claimant argues that Exhibit A would have corroborated claimant's testimony that an accident occurred at work. However, the ALJ accepted claimant's testimony that the accident occurred at work. Accordingly, such evidence would be cumulative on that issue. Moreover, there is no evidence that claimant's co-worker was in a supervisory position for purposes of establishing that the co-worker's knowledge could somehow be imputed to the employer. *See e.g. Danny G. Luehrs*, 45 Van Natta 889 (1993). Consequently, we find that the proffered exhibit would not have changed the outcome of this case. Therefore, we need not decide whether the ALJ properly excluded the exhibit at the time of hearing.

[2] In his brief, claimant contends that the ALJ's order incorrectly omitted a reference to Exhibit 7A. We agree that the ALJ admitted the exhibit at hearing and the ALJ's order is modified to reflect that Exhibit 7A was received and admitted. (Tr. 17).

In the Matter of the Compensation of
MARILYN D. MONROE, Claimant
WCB Case No. 99-00203
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) affirmed an Order on Reconsideration's award of temporary disability from March 20, 1998 to December 19, 1998; (2) assessed a 25 percent penalty for the insurer's allegedly unreasonable claim processing; and (3) affirmed the reconsideration order's award of 9 percent (28.8 degrees) unscheduled permanent disability for claimant's low back injury. On review, the issues are temporary disability, penalties, and extent of unscheduled permanent disability. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the exception of the finding that Dr. Asby authorized time loss "commencing" March 18, 1998. We also do not adopt the ALJ's "Ultimate Findings of Facts."

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The ALJ affirmed an Order on Reconsideration's award of temporary disability from March 20, 1998 to December 19, 1998, finding that the insurer failed to sustain its burden of proving that the reconsideration order's temporary disability award was incorrect.[1] In so doing, the ALJ determined that the attending physician, Dr. Asby, impliedly authorized commencement of temporary disability beginning March 18, 1998 and did not declare claimant medically stationary or release her to regular work until December 19, 1998. Moreover, the ALJ found that the insurer's failure to pay temporary disability during the disputed period was unreasonable, thus justifying assessment of a 25 percent penalty. The ALJ reasoned that the insurer never clarified the temporary disability issue and that Dr. Asby's authorization of temporary disability would "naturally continue" until claimant was released to work.

On review, the insurer contends that the medical evidence only establishes authorization of temporary disability for one day (March 18, 1998), which it paid, and that, because there was no contemporaneous authorization of temporary disability after that date as required by ORS 656.262(4)(g), the ALJ incorrectly affirmed the reconsideration order's temporary disability award. For the following reasons, we agree with the insurer.

On March 28, 1998, Dr. Asby reported that claimant had experienced increasing low back discomfort, "requiring her to be off work March 18, 1998. She subsequently returned to work but needs clearance." (Ex. 6). That same day, Dr. Asby signed a Notice of Aggravation of Occupational Injury or Disease. (Ex. 7). On that form, Dr. Asby indicated that time loss was being authorized and, in the space where the attending physician was requested to give dates of authorized time loss and describe limitations, Dr. Asby wrote: "3/18/98-no work."

The ALJ concluded that Dr. Asby was impliedly authorizing temporary disability commencing on March 18, 1998. We disagree with that interpretation of Dr. Asby's records. Instead, we find that the above evidence indicates that, on March 28, 1998, Dr. Asby retroactively authorized temporary disability for one day, March 18, 1998. In addition, Dr. Asby did not authorize temporary disability during

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[1] Because the insurer requested a hearing challenging the reconsideration order's temporary disability award, we agree with the ALJ's allocation of the burden of proof. *See Roberto Rodriguez*, 46 Van Natta 1722 (1992).

subsequent examinations of claimant in July and December 1998. (Exs. 7A, 10). Thus, there was no contemporaneous authorization of temporary disability as required by ORS 656.262(4)(g) for periods after March 28, 1998.[2]

In conclusion, we disagree with ALJ's finding that the award of temporary disability in the reconsideration order was correct. Thus, we modify that portion of the reconsideration order that awarded temporary disability from March 20, 1998 to December 19, 1998. In lieu of that award, we instead award temporary disability for one day, March 18, 1998.

Penalty

Because we have modified the award of temporary disability in the Order on Reconsideration as described above, it follows that the insurer's failure to pay temporary disability for the period in dispute was not unreasonable.[3] Therefore, we reverse the ALJ's assessment of a 25 percent penalty.

Permanent Disability

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

Attorney Fees

The ALJ awarded claimant a $2,000 attorney fee pursuant to ORS 656.382(2) for prevailing over the insurer's request for hearing that attempted to reduce or eliminate the awards of unscheduled permanent disability and temporary disability in the reconsideration order. Because we have reduced claimant's temporary disability award, we also reduce the ALJ's attorney fee award to $1,000 for claimant's counsel's services at hearing. In reaching this conclusion, we have considered the factors set forth in OAR 438-015-0010(4), particularly the time devoted to the extent of permanent disability issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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

ORDER

The ALJ's order dated August 17, 1999 is reversed in part, modified in part and affirmed in part. That portion of the ALJ's order that affirmed the reconsideration order's award of temporary disability is modified. In lieu of the temporary disability award in the Order on Reconsideration, claimant is awarded temporary disability for March 18, 1998. The ALJ's penalty assessment is reversed. The ALJ's $2,000 assessed fee award is reduced to $1,000, to be paid by the insurer. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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[2] ORS 656.262(4)(g) provides:

"Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

[3] As previously noted, the insurer paid claimant temporary disability for the undisputed period - March 18, 1998.

In the Matter of the Compensation of
WALLACE M. PRINCE, Claimant
WCB Case No. 98-00458
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) declined to admit Proposed Exhibit 28AA;[1] and (2) found that claimant's claims for right shoulder tendinitis and torn rotator cuff conditions were precluded by a prior dismissal order.[2] The self-insured employer cross-requests review of those portions of the order that: (1) found that claimant's claims for right shoulder conditions were not entirely precluded; and (2) set aside its *de facto* denial of claimant's claim for a right shoulder impingement condition. On review, the issues are claim preclusion and, if the claims are not precluded, compensability. We reverse in part and vacate in part.

FINDINGS OF FACT

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

Claimant had persistent right shoulder pain since his October 10, 1996 work injury.[3]

Claimant's right shoulder tendinitis and rotator cuff tear conditions were first diagnosed on September 8, 1997 and claimant's attorney received the medical report with these diagnoses on September 19, 1997. (Ex. 24). Claimant wrote to the employer requesting acceptance of those conditions on September 25, 1997. (Ex. 26).

Claimant's right shoulder impingement condition was first diagnosed on February 3, 1998. (Ex. 30).

Claimant's "later-diagnosed" right shoulder conditions existed when the employer accepted claimant's initial injury claim for cervical and lumbar conditions on November 7, 1996. (*See* Ex. 34-9-10).

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a security officer for the employer since about 1979. On October 10, 1996, claimant tripped and fell on his right shoulder and hip at work. On November 7, 1996, the employer accepted his claim for lumbar and cervical strain/sprain injuries. On May 30, 1997, the employer issued a partial denial of claimant's "current disability and/or treatment." Claimant requested a hearing.

The day before the scheduled September 4, 1997 hearing, claimant withdrew his hearing request. A prior ALJ issued an order dismissing claimant's request for hearing with prejudice on October 15, 1997.[4]

Claimant wrote to the employer requesting acceptance of his right shoulder tendinitis and rotator cuff tear conditions on September 25, 1997. (Ex. 26). On January 26, 1998, when the employer had not responded to claimant's acceptance request, claimant filed a request for hearing protesting the employer's *de facto* denial of his right shoulder tendinitis and rotator cuff tear conditions.

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[1] We do not address whether the ALJ erred in refusing to admit Proposed Exhibit 28AA (an "Amended Notice of Claim Acceptance" dated November 5, 1997), because the result would be the same even if it had been admitted.

[2] Claimant requested that the Board entertain oral argument in his briefs. However, he has withdrawn his request.

[3] Dr. Nemess diagnosed a right trapezius strain on January 27, 1997. (Ex. 10; *see* Ex. 16-6; *see also* Ex. 34-12-13, -15). Claimant's right shoulder was apparently injected once for pain relief in July 1997. (*See* Exs. 28C-1, 30-2).

[4] The employer requested dismissal with prejudice. Claimant did not object to the request with regard to his claims for lumbar and cervical conditions, but asked that the dismissal not affect his claim for benefits for a right shoulder condition for which he was in the process of making a claim.

At the April 7, 1998 hearing, the issues were whether claimant's claims for right shoulder tendinitis and torn rotator cuff were precluded and, if they were not precluded, compensability of the conditions. (Tr. 2-4).

Right Shoulder Tendinitis and Torn Rotator Cuff

The ALJ held that the claims for right shoulder tendinitis and rotator cuff tear conditions were precluded by claim preclusion because claimant had an opportunity to litigate compensability of those conditions before the October 15, 1997 Order of Dismissal became final on November 14, 1997.[5] We disagree, based on the following reasoning.

All three of claimant's right shoulder conditions existed when the employer issued its initial acceptance (of cervical and lumbar strain/sprains). (*See* Exs. 28C-1, 34-9-10). Because claimant's initial injury claim was accepted for cervical and lumbar strains only, his right shoulder claims are analyzed as conditions omitted from the acceptance under ORS 656.262(6)(d). *See Mark A. Baker*, 50 Van Natta 2333 (1998). The employer argues that claimant is foreclosed from proving the shoulder claims on procedural grounds. Therefore, the threshold question is whether claimant perfected claims for the shoulder conditions under the statute. *See Ralph L. Morris*, 50 Van Natta 69, 71 (1998) (*citing Shannon E. Jenkins*, 48 Van Natta 1482 (1996), *aff'd mem Jenkins v. Continental Baking Co.*, 135 Or App 436 (1997)).

ORS 656.262(6)(d) provides:

> "An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice. The insurer or self-insured employer has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time."

Here, claimant wrote to the insurer requesting acceptance of his right shoulder tendinitis and rotator cuff tear conditions on September 25, 1997, after the employer's November 7, 1996 initial acceptance. (Ex. 26). The employer did not respond and the parties agreed to litigate issues relating to the tendinitis and rotator cuff tear conditions at the April 7, 1998 hearing. (Tr. 2-4).[6] Under these circumstances, we conclude that claimant initiated objection to the initial notice of acceptance and perfected these "shoulder" claims as required by ORS 656.262(6)(d).

The next question is whether claimant is precluded from litigating the compensability of his right shoulder tendinitis and rotator cuff tear conditions because his 1997 hearing request was dismissed.

Since the ALJ's order, we held in *Olive M. Bonham*, 51 Van Natta 1710 (1999), that the claimant's "new medical condition" claim for a disc condition was not precluded by prior litigation regarding compensability of her "then-current" low back condition. We reasoned that ORS 656.262(7)(a) authorized the claimant to "*initiate* an new medical condition claim *at any time*," and thus the statute created an exception to "claim preclusion." Even though the *Bonham* claimant could have litigated the compensability of her "new medical condition" at the prior litigation, we held that her failure to do so did not preclude her from later initiating the claim under ORS 656.262(7)(a).

In reaching this conclusion, we focused on the last sentence of the statute: "Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time" and found, in this sentence, explicit statutory permission to "*initiate* a new medical condition claim *at any time*." *Bonham*, 51 Van Natta at 1712-14.

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[5] We need not address the ALJ's claim preclusion analysis or his finding that the prior opportunity to litigate the shoulder claims extended until the order dismissing the prior request for hearing became final -- because we hold herein that claim preclusion does not apply.

[6] The employer acknowledged that "there's really not much question that there was a claim for the shoulder injury[.]" (Tr. 11).

Here, the tendinitis and torn rotator cuff claims are for conditions omitted from the employer's acceptance (rather than "new medical condition" claims, as we have explained), under ORS 656.262(6)(d). But the statute includes essentially the same permissive phrase: Under ORS 656.262(6)(d), the worker may "*initiate* objection to the notice of acceptance *at any time.*" We see no reason why the *Bonham* reasoning should not apply to construction of ORS 656.262(6)(d) in this regard and conclude that this statute creates another exception to claim preclusion.[7] Accordingly, because claimant is authorized to "*initiate* objection to the notice of acceptance *at any time,*" claim preclusion principles do not apply and the claims for right shoulder tendinitis and a torn rotator cuff are not precluded. And, because the medical evidence uniformly relates these conditions to claimant's compensable October 10, 1997 injury, we further conclude that the claims are compensable.

Right Shoulder Impingement

The ALJ reached a different result regarding the claim for a right shoulder impingement syndrome condition. He found that claimant had no prior opportunity to litigate that condition because it was not diagnosed until February 3, 1998 (after dismissal of claimant's prior hearing request became final) and therefore concluded that the claim was not precluded. Although neither party raised compensability of claimant's impingement condition at hearing, the ALJ found that they agreed to litigate the issue,

> "[b]ased on the employer's involvement with and awareness of the various medical reports regarding the cause of claimant's right shoulder impingement syndrome and its attempt to bar litigation of that condition on claim preclusion grounds[.]" Second Order on Reconsideration, p. 17.

Further finding that the medical evidence overwhelmingly established that claimant's compensable October 10, 1996 injury was the major contributing cause of his right shoulder impingement syndrome, the ALJ concluded that the claim was compensable.

The employer argues[8] that the ALJ lacked authority to address the impingement claim (and claimant may not pursue that claim) because claimant did not file a written request for acceptance of that condition. The employer also contends that it did not agree to litigate whether the impingement condition is compensable. We find no evidence in the record that the parties agreed to litigate the issue.[9] And we agree with the employer that claimant may not pursue the impingement claim at this time, as explained below.[10]

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[7] As we explained in *Bonham*, issue preclusion principles remain viable. 51 Van Natta at 1716-17. In other words, if the parties had previously *actually litigated* the compensability of the right shoulder tendinitis and a torn rotator cuff conditions, those compensability issues *would* be precluded now.

[8] The employer's first argument on cross-appeal is that its May 30, 1997 denial denied the compensability of claimant's entire then-current condition, including his shoulder condition (and therefore the prior dismissal order has preclusive effect). But claimant's right shoulder impingement, tendinitis, and rotator cuff tear conditions were not even diagnosed until months after the denial. Because the denial simply could not deny unknown conditions, we reject this argument. *See Jay D. Perkins*, 51 Van Natta 970 (1999).

[9] Claimant argues that the employer implicitly agreed to litigate the issue because it questioned a doctor about claimant's impingement condition during a "post-hearing" deposition and defended against the claim in closing arguments. We do not find the employer's conduct sufficient to infer waiver of its otherwise ongoing procedural defenses against all *asserted* right shoulder claims.

Claimant's request for hearing specifically protested *de facto* denials of tendinitis and rotator cuff conditions only and the impingement condition was not "litigated" until Dr. Peterson's "post-hearing" deposition. Under these circumstances, an impingement claim was not properly before the ALJ. *Compare Cupertino A. Lopez*, 50 Van Natta 1452, 1453 (1998) (Where the claimant's hearing request raised compensability and medical services generally, "*pre*-hearing" depositions addressed the compensability of a cyst condition, and the employer did not object to litigating that issue, the parties agreed to litigate compensability of the cyst condition.).

[10] *See also James E. Templeton*, 51 Van Natta 975, *on recon* 51 Van Natta 1061 (1999) (where the claimant had not filed a "new medical condition" claim before an order dismissing a prior hearing request, the current "new medical condition claim" was not precluded).

Claimant's right shoulder impingement condition claim is, like the other shoulder condition claims, a claim for a condition omitted from the employer's initial claim acceptance (*i.e.*, it existed when the initial injury claim was accepted). Because the employer objects to litigating the claim on procedural grounds, the threshold question is whether claimant perfected the claim as required by ORS 656.262(6)(d). *See* 50 Van Natta at 71. Because there was no "communication in writing" regarding the impingement claim by claimant that preceded his request for hearing, claimant is precluded from proceeding to hearing on the issue of "de facto" denial. *See id.* Furthermore, there is no evidence in the record that claimant requested acceptance of his impingement condition in writing after filing his hearing request. Under these circumstances, we conclude that the impingement claim was not perfected. And, since the employer challenged the procedural validity of this claim, it was inappropriate for the ALJ to consider it. *See Vicki L. Davis*, 49 Van Natta 603 (1997) (Where no claim filed, denial was a nullity without legal effect). Accordingly, we vacate this portion of the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the right shoulder tendinitis and torn rotator cuff conditions. 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 related to these conditions at hearing and on review is $7,900, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's counsel's statement of services, the record, and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated November 17, 1998, as reconsidered December 29, 1998 and April 5, 1999, is reversed in part and vacated in part. That portion of the order that upheld the self-insured employer's *de facto* denials of claimant's claims for right shoulder tendinitis and rotator cuff tear conditions is reversed. The *de facto* denials are set aside and the claims for right shoulder tendinitis and rotator cuff tear conditions are remanded to the employer for processing according to law. That portion of the order that set aside the employer's *de facto* denial of claimant's claim for a right shoulder impingement syndrome is vacated. In lieu of the ALJ's attorney fee award, claimant is awarded a $7,900 fee for services at hearing and on review regarding the claims for right shoulder tendinitis and rotator cuff tear conditions.

In the Matter of the Compensation of
JUDY L. MAGILL, Claimant
WCB Case Nos. 99-00277 & 98-07960
ORDER OF ABATEMENT
Welch, Bruun & Green, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

On December 15, 1999, the Board reversed an Administrative Law Judge's order that upheld the self-insured employer's denial of claimant's aggravation claim for a current low back condition. Asserting that we erred in evaluating the evidence, the employer requests reconsideration.

In order to further consider this matter, we withdraw our December 15, 1999 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
RICHARD L. SAUNDERS, Claimant
Own Motion No. 99-0471M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable right shoulder condition. Claimant's aggravation rights expired on October 19, 1999. SAIF agrees that claimant's current right shoulder condition is causally related to his accepted condition for which it is responsible. However, SAIF contends that claimant was not in the work force at the time of the current worsening.

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

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

On November 9, 1999, Dr. Whitney, claimant's attending physician, recommended that claimant undergo right shoulder rotator cuff tear repair. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). In other words, the relevant time period for which claimant must establish that he was in the work force is the time prior to November 9, 1999 surgery, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser Co. v. Kepford*, 100 Or App 410 (1980); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

SAIF contends that claimant was not in the work force at the time of his current worsening "because he has not worked since January of 1999, has not looked for work due to personal problems and has made application for Social Security Disability." In response, claimant attests that he is willing to work and has been seeking employment through the assistance of the State Employment Department. Additionally, claimant reports that he has been receiving unemployment benefits prior to and subsequent to November 9, 1999. In support of his representations, claimant submitted copies of his work search record, copies of job referrals and unemployment checkstubs for the period between June 1999 and December 1999.

In order to satisfy the second *Dawkins* criterion, claimant must show that, although he is not working, he is willing to work and was seeking work. Here, claimant has established that he received unemployment benefits from June, 1999 through December 1999. The receipt of unemployment benefits is *prima facie* evidence that claimant is willing to work and is making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991). Additionally, claimant submitted documentation which demonstrates his work search efforts. Thus, we are persuaded that claimant is willing to work and has been seeking work. Therefore, we find that claimant was in the work force at the time of his current worsening.

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

IT IS SO ORDERED.

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

In the Matter of the Compensation of
JACK L. SWEET, Claimant
Own Motion No. 99-0071M
OWN MOTION ORDER ON RECONSIDERATION
Dale C. Johnson, Claimant Attorney
Saif Legal Department, Defense Attorney

On December 17, 1999, we withdrew our November 16, 1999 Own Motion Order which declined to reopen claimant's 1981 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization. Claimant requested reconsideration of our November 16, 1999 order and submitted additional medical documentation, which he contends support his contentions.

On December 17, 1999, we abated our November 16, 1999 Own Motion Order and allowed SAIF an opportunity to respond to claimant's submission. We requested that such response be received within 14 days from the date of the order. We received no response from SAIF. Inasmuch as the 14 day period has expired, we have proceeded with our review.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In order to satisfy the third *Dawkins* criterion, claimant must first establish that he was willing to work. Failing to demonstrate his willingness to work, a claimant would not be considered a member of the work force, and thus, not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996); *Arthur R. Morris*, 42 Van Natta 2820 (1990).

In our prior order we were persuaded that claimant had demonstrated his willingness to work. We based our conclusion on claimant's affidavit and a summary of an interview with the SAIF Corporation. On reconsideration, and based on the record before us, we continue to find that claimant was and is willing to work.[1]

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his April 1, 1999 hospitalization when his condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

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[1] Claimant submitted an affidavit, stating that "I was willing to work, but given * * * my doctor's restrictions pending surgery, it was impossible to find suitable work." Further, SAIF submitted a summary of an interview conducted by one of its investigators in which claimant states that, although retired, he would like to find suitable part-time work. Based on his affidavit and this interview, we were persuaded that claimant was willing to work.

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

On reconsideration, claimant submits a December 14, 1999 concurrence report from Dr. Davis, his treating physician. Dr. Davis agreed that just prior to claimant's April 1, 1999 surgery, he was unable to work and that it would have been futile for him to seek work due to his compensable condition. This opinion is unrebutted. Thus, we are persuaded that claimant is willing to seek employment but unable to do so because of his compensable condition.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning April 1, 1999, the date he was admitted to the hospital. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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
CHARLES R. DREW, Claimant
Own Motion No. 98-0491M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant, *pro se*, requests reconsideration of our September 20, 1999 Own Motion Order, in which we affirmed the insurer's April 21, 1999 Notice of Closure. In his request, claimant contends that he continues to have pain and requires "further treatment for [his] injured knee," which demonstrates that he was not medically stationary at the time his claim was closed.

On October 20, 1999, we abated our September 20, 1999 order, and allowed the insurer 14 days in which to file a response to the motion. The time for a response having expired, we proceed with our review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 21, 1999 Notice of Closure, considering claimant's condition at the time of closure and *not on subsequent developments*. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

Claimant contends that his condition was not medically stationary at closure and that he continues to require medical treatment.[1] However, he does not offer any medical documentation which supports a conclusion that his compensable condition was not medically stationary at the time his claim was closed on April 21, 1999.[2] In this regard, we reiterate our previous finding that Dr. Matteri's, claimant's treating physician, medical opinion supported the conclusion that claimant was medically stationary at the time of closure. Claimant does not offer any new medical evidence which would persuade us to come to a contrary conclusion.

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[1] 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).

[2] On December 15, 1999, we requested that claimant provide copies of medical reports which pertain to the medical appointments he contended demonstrate his need for further treatment for his compensable condition. In order to be considered, we granted claimant 21 days in which to submit further medical documentation and/or written argument. Claimant has not responded to our request. Inasmuch as the 21 day period has elapsed, we have proceed with our review.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.[3]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 20, 1999 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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[3] From our review of the record, it would appear that claimant is seeking review of his closure because of his belief that his condition has worsened. If claimant's compensable condition has worsened since the April 21, 1999 Notice of Closure to the extent that surgery and/or inpatient hospitalization was required, he may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

Further, it appears from claimant's request that he is unclear as to his rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter St NE
Salem, OR 97310
Telephone: 1-800-927-1271

In the Matter of the Compensation of
GAYLYNN GRANT, Claimant
Own Motion No. 99-0129M
SECOND ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for claimant's compensable left shoulder and neck condition. Claimant's aggravation rights expired on February 21, 1997. On January 26, 1999, claimant underwent a cervical myelogram. That same date, Dr. Brett, claimant's attending physician, requested authorization to perform cervical surgery related to claimant's compensable condition. Subsequently, the MCO disapproved this surgery request. Although SAIF agreed that claimant's current condition was causally related to the accepted condition, it recommends against reopening the claim for own motion relief on the grounds that surgery or hospitalization is not appropriate for the compensable injury.

Pursuant to ORS 656.327, claimant requested the Director to review the requested medical treatment. (Medical Review Case No. 10234). On August 5, 1999, we postponed action on claimant's request for own motion relief pending resolution of the medical review litigation.

By order dated October 7, 1999, the Director's Medical Review Unit (MRU) determined that: (1) the proposed surgery is compensable under ORS 656.245(1)(c)(L) as post-medically stationary curative care provided to stabilize a temporary and acute waxing and waning of symptoms of claimant's condition; and (2) SAIF is barred from disputing the appropriateness of the proposed surgery due to its failure to comply with the provisions of OAR 436-010-0250. Administrative Order MS 99-384. SAIF requested a contested case hearing before the Director regarding this order. ORS 656.327(2). On October 25, 1999, claimant underwent the cervical surgery[1] that was the subject of the dispute in Administrative Order MS 99-384.

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[1] This surgery consisted of an anterior cervical diskectomy, foraminotomy, and neural decompression followed by instrumented interbody fusion at C5-6 and C6-7.

Claimant makes two arguments regarding her entitlement to own motion relief. First, she argues that she is entitled to own motion relief beginning January 26, 1999, the date of the cervical myelogram, which she contends is an outpatient surgical procedure under ORS 656.278(1)(a). In the alternative, relying on the MRU's October 7, 1999 order, claimant argues that she is entitled to own motion relief regarding the cervical surgery she underwent on October 25, 1999. For the following reasons, we reject claimant's first argument and find that, due to the pending litigation regarding the October 1999 surgery, we must continue to postpone action on the own motion matter regarding that surgery.

Under our own motion authority, we may award temporary disability benefits in those cases where 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). We interpret "surgery" to be an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta 1538 (1990) (finding that neither a myelogram nor facet injections, in and of themselves, qualified as "surgeries" within the meaning of ORS 656.278(1)(a) because there was no persuasive evidence that either procedure resulted in or was likely to result in temporary disability; in addition, because neither procedure required an overnight stay, neither procedure qualified as "hospitalization" sufficient to justify claim reopening). In addition, diagnostic tests, even those that are invasive in nature, if not provided as curative treatment, do not establish that a claimant has sustained a worsening of a compensable injury as prescribed in ORS 656.278(1)(a). *Kenneth C. Felton*, 48 Van Natta 194 (1996); *Everett G Wells*, 47 Van Natta 1634 (1995); *Roger D. Jobe*, 41 Van Natta 1506 (1989).

We find our decision in *Smith* directly on point. Specifically, here, as in *Smith*, there is no persuasive evidence that the January 26, 1999 cervical myelogram was undertaken for a curative purpose or resulted in or was likely to result in temporary disability. In addition, there is no indication that the myelogram required an overnight stay in the hospital. Instead, the record indicates, and claimant agrees, that this was an outpatient procedure. Thus, the procedure would not qualify as "hospitalization" sufficient to justify claim reopening. Finally, Dr. Brett referred to this procedure as "diagnostic." Nothing in the record indicates that this procedure was provided as curative treatment. Under these circumstances, we find that claimant's January 1999 cervical myelogram does not qualify as surgery or hospitalization under ORS 656.278. Therefore, we deny reopening claimant's claim for own motion relief based on the cervical myelogram.

In the alternative, relying on the MRU's October 7, 1999 order, claimant argues that we should reopen her claim based on the October 1999 cervical surgery. There is no dispute that this surgery qualifies as "surgery" under ORS 656.278(1)(a). Nevertheless, in order to entitle a worker to have a claim reopened for own motion relief, the surgery or hospitalization in question must be compensable. Furthermore, in order to establish compensability of disputed medical services, a claimant must prove both the necessary causal relationship between the medical services and the compensable injury and the reasonableness and necessity of the medical services. See ORS 656.245. *Van Blokland v. Oregon Health Services University*, 87 Or App 696, 698 (1987) (applying former ORS 656.245, the court determined that a proposed weight reduction program to treat preexisting obesity was both causally related to the compensable injury and reasonable and necessary treatment, concluding that the claimant had established the program was a compensable medical treatment); *James v. Kemper Ins. Co.*, 81 Or App 80, 84 (1986) (applying *former* ORS 656.245 and citing *Wetzel v. Goodwin Brothers*, 50 Or App 101, 108 (1981), the court held that "[p]alliative medical expenses are compensable only to the extent that they are reasonable and necessary"); *West v. SAIF*, 74 Or App 317, 320 (1985); *Douglas A. Eichensehr*, 44 Van Natta 1755 (1992). If either element is lacking, the medical services are not compensable. The Director has jurisdiction to determine the reasonableness and necessity of a medical treatment.

Here, there is no dispute that the necessary causal relationship between the cervical surgery and the compensable injury has been established. Nevertheless, the reasonableness and necessity of that surgery remains in dispute due to SAIF's request of a contested case review by the Director regarding the MRU's order. Therefore, we find it appropriate to continue postponing action pending resolution of this related matter. Accordingly, we defer action on this request for own motion relief and request that the Director send to the Board a copy of the appealable order(s) issued under ORS 656.327 regarding this medical services issue. Thereafter, the parties should advise us of their respective positions regarding the effect, if any, the Director's decision has on claimant's request for Own Motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS K. GREEN, Claimant
Own Motion No. 99-0311M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Kryger, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's October 8, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from June 4, 1999 through September 29, 1999. SAIF declared claimant medically stationary as of September 29, 1999.

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 claim closure turns on whether claimant was medically stationary at the time of the September 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 letters dated November 8 and December 3, 1999, we requested that 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 December 10, 1999, however, no further response has been received from claimant. Therefore, we will proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's claim closure. The most common issue raised is that the claimant was not medically stationary at claim closure. A second issued raised less often, is that, although medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant simply requests review of SAIF's October 8, 1999 Notice of Closure. We interpret claimant's request for review as a challenge to both the medically stationary determination and the temporary disability compensation award. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

On September 7, 1999, claimant was examined by Dr. Gripekoven, an insurer-arranged medical examiner, who reports that claimant was medically stationary and did "not need curative treatment." On September 29, 1999, Dr. Long, claimant's attending physician, concurred with Dr. Gripekoven's assessment. These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on September 29, 1999. Inasmuch as temporary disability was paid through September 29, 1999, and the claim was closed on October 8, 1999, we conclude that claimant is not entitled to additional temporary disability and that SAIF's claim closure was proper.

Accordingly, we affirm SAIF's October 8, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JODY R. BIELBY, Claimant
WCB Case No. 99-02063
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that increased claimant's unscheduled permanent disability award for her lower back condition from zero, as awarded by Order on Reconsideration, to 23 percent (73.6 degrees). On review, the issue is extent of unscheduled permanent disability.[1] We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The insurer contends that the ALJ erred in increasing claimant's unscheduled permanent disability award for her accepted lumbar strain condition to 23 percent from zero, as awarded by an Order on Reconsideration. (Ex. 71). The parties agree that claimant's social/vocational factors equal 16 percent. Consequently, the dispute is over claimant's impairment rating.

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). OAR 436-035-0007(14) provides: "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[.]" We rely on the most thorough, complete and well-reasoned explanation of the claimant's injury-related impairment. *Edwin W. Propper*, 51 Van Natta 1531 (1999).

Here, the ALJ used the impairment ratings provided by the medical arbiter, Dr. Tiley. (Ex. 67). Dr. Tiley found valid reductions in claimant's range of motion in her lumbar spine. (Ex. 67-7). However, the ALJ declined to defer to the arbiter in regard to whether that impairment was related to the accepted lumbar strain condition.

In his January 30, 1999 medical arbiter report, Dr. Tiley diagnosed: "Lumbar degenerative spondylosis, L5-S1," and "Lumbar back strain, of November 6, 1997, resolved." (Ex. 67-3). Dr. Tiley stated that "[t]here appears to be no objective findings due to the accepted condition. All findings appear to be secondary to preexisting, unrelated degenerative causes, still existing." (Ex. 67-5).

Claimant's treating physician, Dr. Hanesworth, stated that "approximately 70% of Ms. Bielby's permanent disability is non preexisting and is due to her work. The remaining 30% is preexisting." (Exs. 64, 68). Yet, Dr. Hanesworth found claimant's deficits in range of motion to be invalid. (Ex. 36).

The ALJ found Dr. Hanesworth's opinion on apportionment more well-reasoned than that of the medical arbiter, Dr. Tiley. However, Dr. Hanesworth's opinion is not significantly more detailed than Dr. Tiley's, even when considering his comments from his November 20, 1998 chart note[2], (Ex. 41) which were not made in conjunction with his 70 percent allocation of claimant's work-related disability.

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[1] The insurer also contends that the ALJ should have found that claimant's failure to appeal a later Determination Order (Ex. 76) precluded any challenge to the March 1, 1999 Order on Reconsideration. However, because we agree with the insurer that claimant's unscheduled permanent disability should be reduced to zero on this factual record, we need not address this alternative issue.

[2] In that chart note, Dr. Hanesworth stated: "I think that the large percentage of her decrease in range of motion is due to her lumbar injury on November 6, 1997, and not due to the preexisting degenerative disease at L5/S1. Findings of degeneration at levels are quite common on asymptomatic people and would not alone be expected to cause decreased motion. I'd say greater than 51% of her loss of motion is due to her work injury."

(Ex. 64). Moreover, Dr. Hanesworth found claimant's deficits in range of motion to be invalid based on straight leg raising validity tests. (Ex. 36). Therefore, his opinion is not sufficient to meet claimant's burden of proving permanent disability due to the compensable injury. *Cheryl A. Boone*, 51 Van Natta 616 (1999).

Under these circumstances, we consider the medical opinions insufficient to establish that claimant sustained permanent impairment due to the compensable injury. ORS 656.266. *See, e.g., Marcia D. Williams*, 49 Van Natta 313 (1997). Therefore, we are not persuaded that claimant is entitled to a permanent disability award.

ORDER

The ALJ's order dated September 3, 1999 is reversed. The March 1, 1999 Order on Reconsideration is affirmed. The ALJ's attorney fee award is also reversed.

January 14, 2000 Cite as 52 Van Natta 56 (2000)

In the Matter of the Compensation of
KEELY M. BRADSHAW, Claimant
WCB Case Nos. 99-03455 & 99-00712
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys
Bottini, Bottini, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Hartford Underwriters (Hartford) requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) set aside its denial of claimant's injury claim for a left knee condition; (2) upheld Giesy, Greer & Gunn's denial of claimant's injury occupational disease claim for the same condition; and (3) awarded $4,000 in attorney fees under ORS 656.386(1) and 656.308(2)(d). On review, the issues are responsibility and attorney fees.

We adopt[1] and affirm the ALJ's order, with the following supplementation regarding the attorney fee issue.

The ALJ awarded a $3,000 attorney fee under ORS 656.386(1) for claimant's counsel's services in prevailing over Hartford's denial of claimant's injury claim and a $1,000 fee under ORS 656.308(2)(d) for claimant's counsel's services in prevailing over Hartford's denial of responsibility for the same claim. Hartford argues that claimant is entitled to no fee on the responsibility issue because claimant took no relevant position.[2] We disagree.

Entitlement to an attorney fee under ORS 656.308(2)(d) does not depend on claimant's counsel advocating a certain result. On the contrary, the statute authorizes a fee in responsibility cases[3] even if the claimant's attorney unsuccessfully argues assignment of responsibility. *See Paul R. Huddleston*, 48 Van Natta 4, *on recon* 48 Van Natta 203 (1996).

Accordingly, having considered the parties' arguments, the factors set out in OAR 438-015-0010(4), especially the value of the interest involved, and claimant's counsel's successful hearing request, we conclude that the ALJ's $1,000 attorney fee award was reasonable.

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[1] The first sentence of the "Order" portion of the Opinion and Order is corrected by deleting the phrase "is upheld."

[2] Claimant responds that her attorney's participation in the 3 1/2 hour hearing was active and meaningful, he submitted several exhibits before hearing, and there was a risk that he would go uncompensated. Based on the factors set out in OAR 438-015-0010(4), claimant contends that the ALJ's fee was appropriate.

[3] However, attorney fees in responsibility cases arising under ORS 656.307are governed by that statute.

Claimant is not entitled to an additional attorney fee for services on review under ORS 656.308(2)(d), because the ALJ already awarded a $1,000 fee under that statute and there is no showing of extraordinary circumstances justifying a higher fee. *See Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997); *Fred L. Dobbs*, 50 Van Natta 2293, 2297 (1998).

Finally, because the ALJ's order addressed the compensability of claimant's condition, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue which was potentially at risk by virtue of our de novo review of the ALJ's order. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252-53 (1992), *mod* 119 Or App 447 (1993); *Paul R. Huddleston*, 48 Van Natta at 11. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, payable by Hartford. In reaching this conclusion, we have particularly considered the nature of the proceeding, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated August 24, 1999 is affirmed. For services on review, claimant is awarded a $500 attorney fee, payable by Hartford.

In the Matter of the Compensation of
CINDY M. VISCAINO, Claimant
WCB Case No. 99-02288
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Martha Brown's order that affirmed the Order on Reconsideration award of 28 percent (89.6 degrees) for claimant's lumbar, thoracic, cervical and hip conditions. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first paragraph of the findings of fact, we change the date in the second sentence to "August 6, 1997."

We supplement the ALJs order only to address the employers argument that the ALJ should have relied on the opinion of Dr. Marjanovic, claimants attending physician, in determining the extent of claimants unscheduled 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). OAR 436-035-0007(14) (WCD Admin. Order No. 98-055) provides that on reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion established a different level of impairment. In evaluating permanent impairment, we do not automatically rely on a medical arbiter's opinion but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

At the time of claim closure, Dr. Marjanovic was claimants attending physician. A PCE was performed on October 12, 1998, which said claimant could work at the medium physical demand level. (Ex. 2-279). The therapist indicated claimant's "diagnosis" was right hip and back pain. (Ex. 2-276, -278). The therapist believed claimant had "non-physiological" pain. (Ex. 2-279). Although Dr. Marjanovic indicated she agreed with the PCE opinions and conclusions, she wrote on the report "not

clear what is 'medium physical demand.'" (Ex. 2-283). In light of Dr. Marjanovic's comment, we are not persuaded that Dr. Marjanovic fully concurred with the October 12, 1998 PCE. Furthermore, the PCE mistakenly said that claimant's "diagnosis" was right hip and back pain, whereas the employer has accepted a low back strain, mid back strain, right wrist strain, hematuria, neck strain, right hip contusion, right rib contusion and sciatic contusion. (Exs. 2-81, 2-125).

We rely on the medical arbiter's unscheduled impairment findings, because a preponderance of the relevant medical evidence does not establish a different level of impairment. Dr. Donahoo examined claimant on February 1, 1999 for the accepted conditions of cervical, thoracic and lumbar spine, right hip and right wrist. (Ex. 3). He documented claimant's ranges of motion of the cervical, thoracic and lumbar spine, as well as her hips and wrists. (*Id.*) After reviewing the record, we agree with the ALJ that Dr. Donahoo provided range of motion findings and did not explicitly state that the findings were invalid. We agree with the ALJ's interpretation of Dr. Donahoo's opinion.

We conclude that the medical arbiter's report is the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. The fact that the arbiter examination is performed closer in time to the reconsideration order is not always decisive. *See, e.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). Here, however, in addition to the reasons discussed previously, and in light of the gap between the October 12, 1998 PCE and Dr. Donahoo's February 1, 1999 arbiter examination, we consider Dr. Donahoo's findings to be more reflective of claimant's permanent impairment at the time of the March 10, 1999 Order on Reconsideration.

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

ORDER

The ALJ's order dated July 20, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
DARREN J. WILCOXEN, Claimant
WCB Case No. 99-04073
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the SAIF Corporation's denial of claimant's current right knee condition. On review, the issue is compensability.

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

We would reach the same result even without relying on the opinions of Drs. Jones and Thompson, because we find Dr. Berselli's opinion inadequately explained.

In December 1997, Dr. Berselli stated that claimant's preexisting condition combined with the November 1997 injury and the preexisting condition was major contributing cause of the combined condition and the disability and treatment needed. (Ex. 51-1). Then, in August 1999, he opined that the November 1997 injury "remained" the major contributing cause of claimant's right knee condition because it caused internal derangement that "set in motion the process" that led to claimant's current condition. (Ex. 94-1). Dr. Berselli never explained why the very significant "pre 1997" condition became less important after 1997 or how the November 1997 injury "set in motion" a process, when

claimant already had a very significant preexisting condition.[1] (*See also* Exs. 63, 82). Because we are unable to reconcile Dr. Berselli's opinions, we agree with the ALJ that the claim must fail. *See Gary D. Baxter*, 50 Van Natta 634 (1998) (Where doctor did not explain the material inconsistencies between his various opinions, his opinion "as a whole" was unpersuasive because it lacked adequate explanation for those variations).

ORDER

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

[1] We also note that Dr. Berselli did not explain what caused claimant's "significant" patellar chondromalacia or how much it contributes to his current need for treatment. (*See* Exs. 71, 83, 88-6, 90-1).

In the Matter of the Compensation of
CORINNE L. BIRRER, Claimant
Own Motion No. 98-0279M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schneider, et al, Claimant Attorneys
Argonaut Ins. Co., Insurance Carrier

Claimant requests review of the insurer's September 13, 1999 Notice of Closure which closed her claim with an award of temporary disability compensation from September 1, 1998 through November 30, 1998. The insurer declared claimant medically stationary as of November 30, 1998. Claimant contends that she is entitled to additional benefits because her condition was not medically stationary on November 30, 1998.

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 September 13, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

On September 1, 1998, claimant underwent total knee replacement surgery for her compensable right knee condition. On October 20, 1998, claimant was examined by her treating physician, Dr. McLean. At that time, Dr. McLean stated that claimant was released to "return to the job market at the end of November. I would like to see her back in six months." In a computer generated medical report of that same date, it was noted by Dr. McLean that his plan was to release claimant to work and that time loss was authorized for the period of September 1, 1998 through November 29, 1998.

By an 828 Form completed by Dr. McLean and dated August 31, 1999, Dr. McLean indicated that claimant was medically stationary in November 1998. Dr. McLean also indicated that: (1) he last treated claimant on October 20, 1998; and (2) he released her to modified work in November 1998 with no heavy lifting, squatting or kneeling.

Claimant contends that she was not medically stationary on November 30, 1998 because: (1) Dr. McLean did not released her to regular work but rather to work in a modified capacity; (2) Dr. McLean asked to see her again in six months time; and (3) Dr. McLean's September 13, 1999 responses on Form 828 were based on conjecture because he had not seen her since October 1998.

The medical record does not support such claimant's contention that she was not medically stationary when the insurer closed her claim. As noted above, Dr. McLean opined that claimant was medically stationary in November 1998. Claimant does not offer any medical evidence to rebut Dr.

McLean's opinion. Furthermore, there is no evidence that claimant was not medically stationary at the time her claim was closed on September 13, 1999. Finally, there is no evidence in the record demonstrating that claimant would be medically stationary six months following her October 1998 examination with Dr. McLean.

Accordingly, based on the uncontroverted medical evidence, we find that claimant has not met her burden of proving that she was not medically stationary on the date her claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's September 13, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID E. HORTON, Claimant
WCB Case No. 99-03497
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that declined to hold that an unappealed Order on Reconsideration was null and void. In its respondent's brief, the insurer requests that we sanction claimant's attorney for a frivolous request for review. ORS 656.390. On review, the issues are jurisdiction and sanctions.

We decline to impose sanctions and adopt and affirm the ALJ's order with the following supplementation.

Claimant argues that he need not have timely appealed the June 6, 1997 Order on Reconsideration because a current condition denial which had been in place when the Order on Reconsideration issued has since been held invalid by the Court of Appeals. Claimant cites to *Knapp v. Weyerhaeuser*, 93 Or App 670 (1988) in support of his argument. *Knapp* is distinguishable. In *Knapp*, the court held that a claimant need not request a hearing within 60 days from a denial which had "no basis in law." 93 Or App at 674. Therefore, the ordinary time limitation in ORS 656.319(1)(a) did not apply to foreclose the claimant's hearing request from the invalid denial. (*Id.*)

Here, however, claimant seeks to apply *Knapp* to an Order on Reconsideration. Claimant needed to have requested a hearing from the Order on Reconsideration within 30 days. ORS 656.268(6)(g). The June 6, 1997 Order on Reconsideration, at a minimum, was valid when it issued. There is no "good cause" exception to requests for hearing from orders on reconsideration. *Paul D. Field*, 50 Van Natta 1731 (1998). Claimant must have pursued all objections to the order, including any argument that the order was invalid, through a direct appeal. Absent a timely appeal, claimant cannot now mount a collateral attack on the order. *Jenny L. Boydston*, 50 Van Natta 691 (1998).

As a separate issue on appeal, the insurer contends that claimant's attorney should be sanctioned for requesting Board review with no reasonable prospect of prevailing. ORS 656.390(2). We agree with the ALJ and the insurer that claimant cannot now challenge the June 6, 1997 Order on Reconsideration given the fact that it was not appealed within 30 days and has become final. ORS 656.268(6)(g). *Hammon Stage Line v. Stinson*, 123 Or App 418, 423 (1993). However, claimant presented at least a colorable argument that *Knapp* allowed him to challenge the Order on Reconsideration at this time, given the status of litigation over the insurer's current condition denial. *See Westfall v. Rust International*, 314 Or 553, 559 (1992); *Arlene J. Bond*, 50 Van Natta 2426 (1998). Therefore, the insurer's request for sanctions is denied.

ORDER

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

In the Matter of the Compensation of
CAROLINE S. NORDYKE, Claimant
Own Motion No. 97-0429M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Allison Tyler, Claimant Attorney
Cigna Ins. Co., Insurance Carrier

Claimant requests review of the insurer's September 17, 1999 Notice of Closure, which closed her claim with an award of temporary disability compensation from February 25, 1998 through August 9, 1999. The insurer declared claimant medically stationary as of August 9, 1999.

In a November 8, 1999 letter, we requested the insurer to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on November 23, 1999. Claimant has not submitted a response to the insurer's submission. Therefore, we proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of a carrier's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second potential issue 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 simply requests review of the insurer's September 17, 1999 Notice of Closure. We interpret claimant's request for review as a challenge to both the medically stationary determination and the temporary disability compensation award. 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.

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 September 17, 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 insurer submitted an August 9, 1999 chart note and a August 26, 1999 check-the-box letter from Dr. Walker, claimant's attending physician, in support of its contention that claimant was medically stationary at the time it closed her claim. In his August 9, 1999 chart note, Dr. Walker opined that claimant was "better" and that he did not know whether there was "much we need to do for her back." In the August 26, 1999 letter, Dr. Walker agreed that claimant was medically stationary on August 9, 1999. Based on this information, the insurer closed claimant's claim on September 17, 1999

Claimant relies on an October 21, 1999 chart note from Dr. Walker to support her position that she was not medically stationary at the time of claim closure. Dr. Walker recommended that claimant undergo further diagnostic studies to determine if there was instability in her back that would explain her level of pain. He stated that "[i]f we do not see anything in her back that requires surgery, such as instability, [he thought that] the treatment at this point would be pain management." Dr. Walker noted that claimant had been experiencing pain in her low back but he does not relate the symptom and possible need for further medical care to her compensable condition. He affirmatively concludes that even if she were to require pain management, there is nothing "in her back that requires surgery."

Although evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure, we find Dr. Walker's October 1999 opinion a "post-closure" development which does not focus on claimant's condition at the time of the September 17, 1999 closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Rather, Dr. Walker's October 1999 opinion focuses on claimant's current need for treatment, not her condition when her claim was closed.

Finally, even if we were to conclude that Dr. Walker's October 1999 opinion relates to claimant's condition at closure, he opines that she may need pain management but not surgery. 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). Thus, although claimant may require treatment in the form of pain management, we reiterate 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.

Based on this uncontroverted medical evidence, we find that claimant was medically stationary on the date her claim was closed. Inasmuch as temporary disability was paid through August 9, 1999 and because the claim was closed on September 17, 1999, we conclude that claimant is not entitled to additional temporary disability and that the insurer's claim closure was proper.

Should claimant's compensable condition subsequently worsen to the extent that surgery and/or inpatient hospitalization is eventually required, she may again request reopening of her claim for the payment of temporary disability. *See* ORS 656.278(1).

Accordingly, we affirm the insurer's September 17, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY M. SCHMIDT, Claimant
WCB Case No. C000035
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

On October 29, 1999, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, in consideration for payment of a stated sum, claimant released certain 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 $19,425 and the total due claimant's attorney is $5,075. This would equal a total consideration of $24,500. However, the total recited on the third page of the CDA is "$25,000" instead of $24,500. Finally, on page four, the total consideration is stated as $24,500, with claimant receiving $19,425 and claimants attorney receiving $5,075.

Upon review of the document as a whole, we are persuaded that the reference on the third page of the CDA to a total consideration of $25,000 is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $24,500, with $5,075 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 $5,075, 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
JOHN B. SHAW, SR., Claimant
WCB Case No. 96-10371
ORDER ON REMAND
Craine & Love, Claimant Attorneys
VavRosky, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Shaw v. Paccar Wagner Mining*, 161 Or App 60 (1999). The court has reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that declined to reclassify claimant's November 27, 1987 injury claim as disabling. Relying on ORS 656.277(2) and *Alcantar-Baca v. Liberty Northwest Ins. Corp.*, 161 Or App 49 (1999), the court concluded that, because claimant's request for reclassification was made more than one year after the date of his injury, the request must be "made pursuant to ORS 656.273 as a claim for aggravation." Consequently, the court has remanded for reconsideration in light of *Alcantar-Baca*, 161 Or App at 65.

As set forth in the court's opinion, claimant worked for the employer for 26 years. In January 1988, he filed a claim for an occupational disease involving the neck, arm and shoulder and listed the date of onset as November 24, 1987. Although claimant sought treatment for his condition, he did not miss work. The employer, who was self-insured at the time, provided benefits for claimant's medical treatments, but did not send a formal notice of claim acceptance.

In December 1994, claimant underwent surgery on his neck. In a 1995 Opinion and Order, a prior ALJ found that claimant's then-current cervical condition and need for treatment was compensably related to his prior occupational disease claim and concluded that the employer remained responsible for claimant's condition. The Board affirmed the order.

In November 1996, nine years after claimant first sought treatment, the employer issued a formal notice of acceptance of the 1987 claim. Pursuant to ORS 656.262(6), the claim acceptance advised claimant that the claim was accepted as nondisabling.

After receiving the formal notice of acceptance, claimant requested a hearing seeking reclassification of the claim as disabling. Claimant asserted that although his condition was not disabling in 1987, it had become disabling by the time the employer formally accepted the claim in November 1996.

The ALJ first determined that the Hearings Division was authorized to consider claimant's reclassification request under ORS 656.283[1] even though the request was made more than one year after the 1987 injury.[2] On the merits, the ALJ found that claimant's claim was not misclassified because he was not disabled within one year of the date of the original injury. The ALJ also held that claimant could not make an aggravation claim because his aggravation rights had already expired.

On review, the Board adopted and affirmed the ALJ's order. Claimant sought judicial review. In challenging the Board's order, claimant renewed his assertion that his claim classification should be determined based on his condition at the time of the notice of acceptance, rather than his condition within one year of the date of injury.

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[1] This section provides, in pertinent part, as follows:

"(1) [A]ny party . . . may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute . . . ."

[2] *Former* ORS 656.277(2) provides that a claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made as claim for aggravation pursuant to ORS 656.273. But, relying on *DeGrauw v. Columbia Knit, Inc.*, 118 Or App 277, *rev den* 316 Or 527 (1993) and *Donald R. Dodgin*, 45 Van Natta 1642 (1993), the ALJ found that claimant was not required to comply with this provision because it was not his fault that he could not challenge the classification of his claim within one year of the injury.

The court declined to address the particulars of claimant's arguments. Instead, based on *Alcantar-Baca v. Liberty Northwest Ins. Corp.*, 161 Or App 49, the court held that, given the explicit language of *former* ORS 656.277(2), claimant's 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. The court explained that, contrary to the Board's holding in *Donald R. Dodgin*, 45 Van Natta 1642 (1993),[3] *DeGrauw v. Columbia Knit, Inc.*, 118 Or App 277, *rev den* 316 Or 527 (1993) does not stand for the proposition that a claimant may request reclassification under *former* ORS 656.277(1) more than one year after the date of injury. The court reasoned that because *former* ORS 656.277(2) allows for no exceptions--equitable or otherwise--the Board's approach in *Dodgin, i.e.*, that such a request can be considered under ORS 656.283, was erroneous.

On remand, therefore, we must consider claimant's request for reclassification as a claim for aggravation under *former* ORS 656.273. *See former* ORS 656.277(2). But, pursuant to *former* ORS 656.273(4)(b), where, as here, the injury has been in nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years of the date of injury. Because more than five years have elapsed since claimant's original, nondisabling injury in 1987, claimant's aggravation rights have expired. Consequently, we lack jurisdiction to consider claimant's aggravation claim.[4]

ORDER

The ALJ's order dated April 25, 1997 is vacated. Claimant's request for hearing is dismissed.

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[3] As noted above, in *Dodgin*, we held that where a claimant is precluded, through no fault of his own, from seeking reclassification by the Department because the claim was initially classified as nondisabling more than one year after the date of injury, the claimant may request a hearing on the matter pursuant to ORS 656.283(1).

[4] 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 Kempf v. Carpenters and Joiners Union*, 229 Or 377, 343 (1961) (the general rule is that, when the legislature fails to express any intention with respect to retroactivity, a statute will be applied only prospectively if it "impair[s] existing rights, creates new obligations or impose[s] additional duties with respect to past transactions").

Special Concurrence by Board Member Phillips Polich.

I share the majority's conclusion that we lack jurisdiction to consider claimant's aggravation claim. I write separately to express my concerns regarding a problem in the Workers' Compensation Law where claimant filed a 1987 occupational disease claim that was formally accepted as "nondisabling" *nine* years later, in 1996. Consequently, any remedy regarding classification was eliminated by the insurer's failure to furnish written notice of acceptance of the claim within 60 days, as required by *former* ORS 656.262(6), or even within one year of the date of the occupational disease. Although the 1999 legislature has amended ORS 656.277, its failure to make the amended statutes retroactive prevents us from providing a remedy in this case. This flies in the face of the objective of the Workers' Compensation Law to provide a fair and just administrative system for delivery of medical and financial benefits to this injured worker.

In the Matter of the Compensation of
JOHN B. SHAW, SR., Claimant
WCB Case No. 96-0277M
OWN MOTION ORDER ON REMAND
Craine & Love, Claimant Attorneys
VavRosky, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals.[1] *Shaw v. Paccar Wagner Mining*, 161 Or App 60 (1999). The court has reversed our prior order in WCB Case No. 96-10371 that adopted and affirmed an Administrative Law Judge's (ALJ's) order that declined to reclassify claimant's November 27, 1987 injury claim as disabling. Relying on ORS 656.277(2) and *Alcantar-Baca v. Liberty Northwest Ins. Corp.*, 161 Or App 49 (1999), the court concluded that, because claimant's request for reclassification was made more than one year after the date of his injury, the request must be "made pursuant to ORS 656.273 as a claim for aggravation." The court reasoned that because ORS 656.277(2) allows for no exceptions -- equitable or otherwise -- the Board's approach in *Donald R. Dodgin*, 45 Van Natta 1642 (1993), *i.e.*, that such a request can be considered under ORS 656.283, was erroneous. Consequently, the court remanded for reconsideration in light of *Alcantar-Baca*, 161 Or App at 65.

On today's date, we issued a separate order on remand in our "regular" jurisdiction in which we determined that, pursuant to the court's instructions, we were required to consider claimant's request for reclassification as a claim for aggravation under ORS 656.273. *See* ORS 656.277(2). We also determined that, under ORS 656.273(4)(b), where, as here, the injury has been in nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years of the date of injury. Because more than five years had elapsed since claimant's original, nondisabling injury in 1987, claimant's aggravation rights had expired. Consequently, we found that we lacked jurisdiction in our "regular" capacity to consider claimant's aggravation claim, vacated the ALJ's order, and dismissed claimant's request for hearing.

Thus, because claimant's aggravation rights have expired, his claim is within our "own motion" jurisdiction. *Miltenberger v. Howard's Plumbing*, 93 Or App at 477. That brings us to the question of whether claimant is entitled to own motion relief, *i.e.*, the payment of temporary disability benefits, for his 1987 injury claim.

Our prior orders denied claimant's request for reopening of his 1987 injury claim for the payment of temporary disability benefits because he had not established that he remained in the work force at the time of disability. Claimant's arguments were adequately addressed in our prior orders, and we have nothing further to add to our prior orders regarding Own Motion Case No. 96-0277M.

Accordingly, on remand, as supplemented herein, we adhere to and republish our December 6, 1996 order, as reconsidered on January 2, 1998 and April 6, 1998. The parties' right of appeal shall begin to run from the date of this order.

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

IT IS SO ORDERED.

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[1] In this regard, claimant appealed two Board decisions to the Court of Appeals, one issued by the Board in its "regular" jurisdiction (WCB Case No. 96-10371) and a related decision issued by the Board in its "own motion" jurisdiction. (Own Motion No. 96-0277M). The Board's "own motion" jurisdiction extends to claims for worsened conditions which arise after the expiration of aggravation rights. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). While the court's reasoning focused on our decision issued under our "regular" jurisdiction, it referenced both case numbers and, ultimately, reversed and remanded for reconsideration. Under these circumstances, we find that the court reversed and remanded both decisions for reconsideration. Therefore, we find that this own motion matter is before the Board on remand from the Court of Appeals.

In the Matter of the Compensation of
KEVIN J. SILVA, Claimant
WCB Case No. 99-03050
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On March 1, 1999, claimant, a store manager for a retail fabric store, filed a claim for a low back injury, alleging that, on January 19, 1999, he felt a "pop" in the low back when he lifted a 25 pound box and turned. (Ex. 8). Claimant had previously developed low back and left leg symptoms in February 1992 that resulted in surgery at L4-5 in March 1992. This was apparently not a work-related condition.

In December 1993, claimant was involved a motor vehicle accident that was not job related. This resulted in an increase in low back pain for about two months.

On or about October 20, 1998, claimant sustained an on-the-job low back strain. The claim was accepted as "nondisabling" and the strain resolved by early November 1998.

On January 21, 1999, two days after the alleged January 19, 1999 injury, claimant sought treatment from Dr. Hanson, reporting left posterior thigh pain for the last day or so. Claimant stated he was unaware of anything that may have precipitated the pain such as unusual lifting or straining. Dr. Hanson diagnosed left thigh myalgia. (Ex. 8aA).

Claimant then sought treatment from Dr. Laurie on January 25, 1999. Dr. Laurie wrote that claimant had done heavy lifting over the past three months and had developed left low back pain the previous week, radiating down the left lateral thigh and calf. (Ex. 8A). Dr. Laurie diagnosed probable sciatica with positive neurological findings and referred claimant for a neurosurgical consultation, as well as an occupational medicine evaluation. Dr. Laurie opined that claimant's condition "might be related to his job at work."

Dr. Wilson, an occupational medicine specialist, examined claimant on January 26, 1999 and reported a history that claimant developed low back pain on January 21, 1999 "without a specific etiology." (Ex. 9). Dr. Wilson further reported that there was no trauma or injury and that claimant did his regular and customary duties the day before. According to Dr. Wilson's history, claimant "awoke with severe pain in the lower back that radiated into his left leg." Dr. Wilson diagnosed acute low back pain, left sciatica and opined that claimant's condition appeared related to his 1992 problems. *Id.*

On February 18, 1999, an MRI of the lumbar spine was performed that revealed a small left sided disc herniation at L5-S1 that was the presumed source of claimant's left radiculopathy. (Ex. 10).

As previously noted, claimant filed his worker's compensation claim on March 1, 1999, the same day of his neurosurgical consultation with Dr. Keiper, who reported that claimant was lifting at work on January 19, 1999 and felt a "pop" in his back. Recommending an L5-S1 hemilaminectomy, Dr. Keiper opined that claimant's S1 radiculopathy was work related. (Ex. 11-3).

Dr. Keiper performed the recommended surgical procedure on March 9, 1999. The insurer denied the claim on March 12, 1999. (Ex. 14). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial, finding that the alleged January 19, 1999 injury combined with a preexisting degenerative disc disease to cause disability or a need for treatment for an L5-S1 disc herniation. In reaching this conclusion, the ALJ determined that the evidence established that claimant

probably experienced the injury on January 19, 1999 as alleged. The ALJ then reviewed the medical evidence to determine whether claimant sustained his burden of proof under ORS 656.005(7)(a)(B). The ALJ determined that Dr. Wilson's opinion was not persuasive because he lacked a history of the lifting incident at work and that Dr. Keiper's opinion was likewise unpersuasive because he did not have a correct history regarding claimant's 1992 condition. The ALJ, however, held that the medical opinion of a panel of examining physicians (Drs. Tiley and Coulter) established that the alleged work injury of January 19, 1999 was the major contributing cause of the disability and need for treatment of the combined condition under ORS 656.005(7)(a)(B).

On review, the insurer contends that the Tiley/Coulter opinion is not persuasive because it is conclusory and, therefore, cannot satisfy claimant's burden of proof under ORS 656.005(7)(a)(B). Moreover, the insurer argues that the record fails to establish that claimant in fact experienced the alleged lifting incident on January 19, 1999. For the following reasons, we find the insurer's arguments persuasive.

Under ORS 656.005(7)(a)(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.

To satisfy the "major contributing cause" standard, claimant must establish that his otherwise 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, persuasive medical opinion must evaluate the relative contribution of different causes and explain why the otherwise compensable injury to claimant's low back contributed more to the claimed condition than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of claimant's preexisting injuries and belated report of injury, this claim presents a complex question of medical causation which requires expert medical evidence for its resolution. *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985); *Uris v. Compensation Department*, 247 Or 420, 424 (1967). We give greater weight to medical opinions that are well-reasoned and based on complete and accurate histories. *Somers v. SAIF*, 77 Or App 259 (1986).

In this case, the compensability of claimant's alleged low back injury must be established by the Tiley/Coulter opinion. That is, we agree with the ALJ's reasons for finding Dr. Keiper's opinion unpersuasive. In addition, Dr. Wilson's opinion relating claimant's current low back condition to the non-work related 1992 condition does not assist claimant in proving compensability.[1]

Drs. Tiley and Coulter opined that degenerative disc "degradation" preexisted the alleged January 19, 1999 injury and that the degraded disc at L5-S1 probably "set the stage" for the January 19, 1999 injury. (Ex. 18-5). Nevertheless, the panel opined that the "major contributing cause of [claimant's] disc herniation of January 19, 1999, is that lifting incident of January 19, 1999." *Id.* However, because the panel did not provide any explanation of why the alleged injury is the major contributing cause of the disc herniation, as opposed to the preexisting degenerative condition (which the panel conceded set the stage for the injury), we do not find the Tiley/Coulter opinion persuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (conclusory and unexplained medical opinion rejected). Therefore, even assuming the January 19, 1999 incident occurred as alleged, we find that the medical evidence does not establish a compensable claim.

Alternatively, even if the Tiley/Coulter opinion contained sufficient reasoning to satisfy claimant's burden of proof, we would still find that opinion unpersuasive because it is based on an inaccurate history. That is, we find insufficient evidence that the alleged January 19, 1999 injury occurred as claimant alleges.

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[1] We recognize that Dr. Laurie opined that claimant's condition "might be related to his job at work." (Ex. 8A). However, this statement was not made to a degree of medical probability. In addition, Dr. Laurie did not relate claimant's condition to the alleged lifting and popping incident on which this claim is based, but rather to claimant's "work." Claimant specifically stated at hearing he was not challenging the employer's denial on an occupational disease basis. (Tr. 1).

Claimant's testimony supported the history reported in documents beginning with the March 1, 1999 form 801 and Dr. Keiper's neurosurgical consultation report of the same day. (Tr. 11). The ALJ determined that claimant's testimony was credible based on his observation of claimant's demeanor. We generally defer to such demeanor-based credibility finding. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990).

However, in this case, we are in as good a position as the ALJ to evaluate the credibility of a witness based on an objective review of the substance of the record. *See Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987); *Davies v. Hanel Lumber Co.*, 67 Or App 35 (1984); *Rob R. Hartley*, 49 Van Natta 2011 (1997). Moreover, inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible. *See Gail A. Albro*, 48 Van Natta 41, 42 (1996); *Angelo L. Radich*, 45 Van Natta 45 (1993). Where a claimant's reporting is inconsistent or incomplete, a medical opinion based on that reporting is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) ("[The doctor's] conclusions are valid as to the matter of causation only to the extent that the underlying basis of those opinions, the reports of claimant as to the circumstances of the accident and the extent of the resulting injury, are accurate and truthful."); *James D. Shirk*, 41 Van Natta 90, 93 (1989) (a physician's opinion based on a patient's history is only as reliable as the history is accurate).

Here, the contemporaneous medical records do not contain any mention of the alleged January 19, 1999 lifting incident in which claimant noted a "pop" in his low back after lifting. (Exs. 8aA, 8A, 9). In fact, Dr. Wilson noted that there was no specific etiology of claimant's low back pain and that claimant "awoke" with severe back pain. (Ex. 9). Yet, claimant reported to Dr. Keiper on March 1, 1999 that he experienced an "immediate" onset of pain after feeling the pop in his low back on January 19, 1999. (Ex. 11-1; *see also* Ex. 18-2).

The ALJ explained the apparent inconsistencies in the record by surmising that claimant's prior back injuries and conditions may have made communication about claimant's history more complicated, increasing the likelihood that the doctors may not have fully or correctly understood the history provided. The ALJ also speculated that claimant might have felt that the pop he experienced was not trauma and that he might not have considered the alleged lifting of 25 pounds to have been out of the ordinary.

The problem, however, with the ALJ's reasoning is that claimant did not testify about communication problems, nor did he testify regarding his understanding of what "trauma" means or his understanding of what constitutes unusual work duties. The contemporaneous medical records also give no indication that the physicians had difficulty obtaining an accurate history from claimant. The ALJ's rationale for discounting the inconsistencies in the record is, therefore, unsupported speculation.[2]

On this record, we find the history contained in the contemporaneous medical reports more persuasive than claimant's testimony and belated reports of a work-related injury beginning in March 1999. Based on those contemporaneous medical reports, we find insufficient evidence to establish that a lifting incident did in fact occur on January 19, 1999. Accordingly, we conclude that medical opinions provided by the Drs. Tiley and Coulter that relied on that history are unpersuasive.

Thus, we find that claimant failed to sustain his burden of proving a compensable injury occurred on January 19, 1999. Therefore, we reverse.

ORDER

The ALJ's order dated August 16, 1999 is reversed. The insurer's March 12, 1999 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] Claimant also testified that he reported his injury to Joyce Noll, the employer's operations manager, shortly after it occurred. (Tr. 11, 21). Noll testified, however, that claimant never informed her of an injury prior to March 1, 1999. (Tr. 27). The ALJ discounted this contradictory evidence by speculating that claimant may not have made himself clear or that Noll may have misunderstood or misinterpreted claimant's remarks. There is no indication, however, in the testimony of claimant or Noll that there were communication difficulties between the two of them.

Board Member Phillips Polich dissenting.

The majority finds that claimant failed to prove a compensable injury occurred on January 19, 1999. In doing so, it concludes that the opinion of Drs. Tiley and Coulter is unpersuasive. Because the insurer's physicians' opinion is well-reasoned and based on an accurate history, I would affirm the ALJ's determination that claimant satisfied his burden of proof.

First, it is important to remember that, although claimant did not file his claim for the January 19, 1999 injury until March 1, 1999, the claim was filed within the 90-day statutory time frame. *See* ORS 656.265. The majority focuses on the absence of references in the initial medical reports to a "pop" in claimant's low back. However, claimant's testimony supported the history contained in the form 801 and in the Tiley/Coulter opinion. The ALJ made an express finding that claimant's testimony was credible based on demeanor. The alleged inconsistencies in the record are not sufficient for us to depart from our usual practice of deferring to demeanor-based credibility findings. *See e.g. Emelia Villanueva*, 50 Van Natta 1577 (1998), citing *International Paper Co. v. McElroy*, 101 Or App 61 (1990).

Therefore, I conclude that the Tiley/Coulter panel had an accurate history on which to render an opinion. That opinion clearly supports compensability. Contrary to the majority's assessment, I find that opinion well reasoned. The panel fully considered the degenerative disc condition that preceded the January 19, 1999 incident and concluded that the lifting incident was the major contributing cause of claimant's disc herniation. (Ex. 18-5). This is sufficient to establish compensability under *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

In conclusion, the ALJ's order was well-reasoned, legally sound and supported by the record. The majority errs in reversing it. For this reason, I dissent.

In the Matter of the Compensation of
MICHAEL D. MAYBERRY, Claimant
WCB Case No. 98-05561
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Scheminske, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the insurer's partial denial of his depression condition; and (2) upheld the insurer's denial of his claim for his current right shoulder condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability of depression condition

Claimant has an accepted right wrist injury and seeks to establish compensability of his depression condition as a consequence of the accepted injury. As a secondary consequence of a physical injury, claimant is required to show that the physical injury is the major contributing cause of the mental disorder. ORS 656.005(7)(a)(A); *Jackie T. Ganer*, 51 Van Natta 116 (1999), *aff'd mem Ganer v. Sisters Of Providence*, 164 Or App 177 (1999).

There are three expert opinions in the record that discuss the issue of causation of claimant's depression condition. Claimant's treating psychiatrist, Dr. Friedman, noted that claimant might have some predisposition to depression due to a family history of the disease. Dr. Friedman also found that

claimant went through a previous depressive episode during his divorce and during a time when he was unable to work because he needed to care for his children. Dr. Friedman diagnosed major depression, chronic right shoulder and wrist pain, migraine headaches and psychosocial stressors including chronic pain with disability preventing construction work, and financial stress. (Ex. 67A-5).

Dr. Wicher, psychologist, examined claimant on behalf of the insurer. Dr. Wicher reported that claimant did not meet the diagnostic criteria for any depressive disorder, and that claimant himself described his symptoms more in terms of frustration than clinical depression. Dr. Wicher believed that claimant's current complaints were related to his "underlying personality structure." (Ex. 63-11).

Finally, Dr. Glass, psychiatrist, examined claimant on behalf of the insurer and diagnosed drug dependence and abuse, pain disorder, malingering and personality disorder. Dr. Glass reported that the diagnoses of major depressive disorder or dysthymic disorder were not clearly documented due to inconsistencies in claimant's presentation and history. (Ex. 71-30).

After reviewing the expert medical opinions in the record, we find no persuasive reason to reject the opinion of Dr. Friedman, claimant's treating psychiatrist. Dr. Friedman stated her reasons for objecting with Drs. Wicher and Glass regarding their diagnosis of a personality disorder. For example, Dr. Friedman noted that claimant had a good work history and a happy second marriage. Dr. Friedman also considered claimant's predisposition to depression, but continued to conclude that the work injury was the major cause of claimant's depression condition. (Ex. 77-2).[1]

Moreover, we do not find that the opinions of Drs. Wicher and Glass to be persuasive. Those doctors have attributed claimant's symptoms of depression to his narcotic use. (Ex. 63-11). However, the same doctors have disagreed with Dr. Friedman's diagnosis of depression. Under the circumstances, we find that such reasoning is inconsistent and unpersuasive.

Accordingly, based on the opinion of claimant's treating psychiatrist, Dr. Friedman, we find that claimant has met his burden of proving that the compensable work injury is the major contributing cause of his depression condition. We therefore reverse the ALJ's order on that issue.

Right shoulder condition

We adopt and affirm the ALJ's Conclusions of Law and Opinion on the issue of compensability of claimant's right shoulder condition.

Attorney fees

Claimant's counsel is entitled to an assessed attorney fee for services at hearing and on review concerning the issue of compensability of his depression condition. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review is $3,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for those portions of his attorney's services devoted to the issue of compensability of the right shoulder condition.

ORDER

The ALJ's order dated April 19, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the insurer's denial of claimant's depression condition is reversed. The insurer's denial of that condition is set aside and the claim is remanded to the insurer for processing according to law. Claimant's counsel is awarded an assessed attorney fee of $3,500, to be paid by the insurer, for services at hearing and on review concerning the depression condition. The remainder of the ALJ's order is affirmed.

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[1] The ALJ found that Dr. Friedman was not persuasive because she was not informed about claimant's continuing use of and seeking of narcotic medications. However, we do not find evidence that claimant's use of such medications was inappropriate. Dr. Friedman addressed this issue and reported that claimant's use of anti-depression drugs had helped his depression. (Ex. 77-2).

Board Member Haynes dissenting in part.

I disagree with that portion of the majority's opinion that finds that claimant has met his burden of proving compensability of his depression condition. The ALJ discounted Dr. Friedman's opinion because she was unaware that claimant continued to use and seek narcotic medications. On June 15, 1998, Dr. Friedman reported that, since February 1998, claimant had gone off all of his medication and he had only taken Tylenol and Advil since that time. (Ex. 67A-1). Dr. Friedman subsequently disagreed with Dr. Glass's diagnosis of a psychogenic pain disorder and his statement that claimant was embellishing his symptoms to manipulate others and to maintain his chemical dependency and narcotic abuse. (Ex. 81-2).

The record shows that claimant referred himself to Dr. Jayaram in March 1998, who provided him with a prescription for Oxycontin. (Exs. 52, 53). In April 1998, claimant received Demerol and Vistaril in the emergency room for shoulder and wrist pain, and was given a prescription for Vicodin. (Ex. 57-2). Claimant subsequently requested stronger pain medication on his next two visits to Dr. Gerry. (Exs. 58, 59). In November 1998, when claimant was seen by Dr. Layman following an auto accident, he listed his medications as Paxil, Darvocet, and Oxycontin. (Ex. 73A-1). Finally, at hearing, claimant testified that he had been treating with Dr. Jayaram on a regular basis and that the doctor was "monitoring all the medications that he's giving me." (Tr. 97).

I agree with the ALJ that it is clear that Dr. Friedman is not aware of claimant's continued medication use. Alternatively, if Dr. Friedman was aware, as claimant contends, of his continued use of such drugs, I would find her opinion to be conclusory and unexplained, particularly in light of the opinion provided by Dr. Glass which raises the issue of embellishment of symptoms and narcotic abuse.

Additionally, the majority has found that Drs. Glass and Wicher are inconsistent because they note symptoms of depression but do not agree with Dr. Friedman's diagnosis of such a condition. However, when the opinions are read in their entirety, they are not inconsistent. For example, Dr. Wicher noted that continued use of narcotic pain medication could produce symptoms of depression. She did not find that claimant met the criteria for such a condition and explained that what claimant labeled as depression was more accurately described as frustration. (Ex. 63-11). Although Dr. Gerry, claimant's attending physician, did not feel qualified to assess claimant's psychological status, it is important to note that he did agree with the findings of Dr. Wicher. (Ex. 68).

Finally, the majority concludes that Dr. Friedman's opinion is persuasive because she has reported that claimant's drug use is appropriate. However, Dr. Friedman's belief in that regard is not of assistance if she believed, as she stated, that claimant had not continued to use drugs after February 1998. Thus, I would find that any reliance on Dr. Friedman's belief regarding claimant's drug use is misguided. I would also note that Drs. Glass and Wicher are not the only doctors who have expressed concern in this record about claimant's use of narcotic medication. *See* Exs. 34, 37, 38, 42, 49, 59. Under the circumstances, I find it problematic that Dr. Friedman's opinion dismisses, without discussion, claimant's drug use and its connection to his symptoms of depression.

For the above reasons, I respectfully disagree with the majority's decision to reverse the ALJ's order on the issue of compensability of claimant's depression condition.

Board Member Phillips Polich dissenting in part.

I disagree with the portion of the majority's opinion affirming the ALJ's conclusion that claimant did not prove compensability of his right shoulder condition. After reviewing the record, I would find that the expert medical evidence establishes that claimant's work activities and his right wrist condition are the major contributing cause of his current right shoulder condition. *See* Ex. 78-2. Dr. Edelson relied on claimant's history and diagnosed calcific tendinitis and AC joint irritation which resulted from claimant's repetitive overuse. Dr. Edelson also believed that claimant's right wrist condition contributed to his shoulder problem. Finally, Dr. Edelson discussed the fact that such a condition is not degenerative or acute, but is typically caused by chronic overuse of the shoulder. (Ex. 78).

I would also find that claimant's testimony supports compensability and is not inconsistent with the medical evidence. Claimant testified that he did advise several doctors of his shoulder pain even though his complaints are not documented. However, such a discrepancy is explained by the fact that the doctors were, at the time, treating claimant for a serious right wrist condition.

Under the circumstances, I conclude that claimant has met his burden of proving compensability of his right shoulder, either as a consequential condition or as an occupational disease. I would therefore reverse the ALJ on this issue.

In the Matter of the Compensation of
DONALD W. BEDARD, Claimant
Own Motion No. 99-0239M
OWN MOTION ORDER ON RECONSIDERATION (DISMISSING)
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our June 23, 1999 Own Motion Order which declined to reopen his 1990 claim because he failed to establish that surgery was requested and/or was reasonable and necessary. On reconsideration, claimant contended that there was litigation pending regarding the responsibility for his current condition. (WCB Case No. 99-01476). On July 14, 1999, we withdrew our prior order and postponed action pending resolution of that litigation.

On November 29, 1999, Administrative Law Judge (ALJ) Menashe approved a "Stipulation and Disputed Claim Settlement Agreement (DCS)" which resolved the parties' dispute concerning the compensability of claimant's current low back condition which was pending before the Hearings Division. Pursuant to that settlement, claimant agreed that SAIF's February 3, 1999 denial would remain in full force and effect. In addition, claimant stipulated 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). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

We requested the parties' positions regarding the effect, if any, the DCS had on claimant's request for own motion benefits relating to his 1990 claim. In response to our inquiry, claimant's attorney stated that "[claimant] respectfully withdraws his request for Own Motion [b]enefits."

Accordingly, we conclude that claimant has withdrawn his request for Own Motion relief regarding his 1990 injury claim (in other words, he is not seeking temporary disability benefits regarding that claim). Therefore, the request for own motion relief is dismissed.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFERY A. DRENNAN, Claimant
WCB Case No. 98-09892
ORDER ON REVIEW
J.R. Perkins III, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) found that his request for reconsideration of a Determination Order was untimely; and (2) denied all relief requested by claimant. In its brief, the employer objects to the admission of Exhibits 13 and 16 on the ground that the exhibits were not submitted at the time of reconsideration. On review, the issues are evidence and whether claimant's request for reconsideration was timely.

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

On review, the employer objects to Exhibits 13 and 16 on the ground that the exhibits were not submitted to the Department during the reconsideration process. However, we conclude that, because the exhibits would not change the outcome of this case, we need not consider whether the exhibits were properly admitted at the time of hearing.

The ALJ found that claimant's request for reconsideration of a Determination Order was untimely. The ALJ relied on OAR 436-030-0145(2), which provides that a request for reconsideration shall be mailed within 60 days of the mailing date of the Determination Order or Notice of Closure...". The ALJ also cited to OAR 436-030-0005(5), which provides, in part, that "mailing," for the purposes of determining timeliness, means the date a document is postmarked.

On review, claimant argues that the Director's enactment of a rule that defines "mailing" exceeds the Department's authority to interpret ORS 656.268(5)(b). Specifically, that statute provides that a request for reconsideration must be made to the Department within 60 days of the date of the Determination Order. ORS 656.268(5)(b).

Claimant argues that the statute does not provide that a request for reconsideration must be postmarked prior to the expiration of the 60 day period. Rather, claimant contends, a party should be allowed to prove in any manner that the request for reconsideration was *made* within 60 days of the Determination Order. For example, in this case, claimant argues that it should be sufficient that he has established that he deposited the request in the U.S. mail on the 60th day following the Determination Order. Claimant further contends that the fact that the mail was not collected and his request was not postmarked until the following day (the 61st day) should not be dispositive, as his placing the request in the mail on the previous day should be construed as making a request for reconsideration within the 60 day period.

In *Schultz v. Springfield Forest Products*, 151 Or App 727 (1997), the court held that the Board had the authority to review the validity of a Director's rule to determine if it is consistent with the applicable statutes. Here, after reviewing the Director's rule and the statute, we decline to find the rule invalid. The Department's rule defines "mailed" or "mailing date" as the date the document is postmarked. OAR 436-030-0005(5). We do not find that, by enacting such a rule or definition, the Department has amended, altered, enlarged or limited the terms of the statute. *See Cook v. Workers' Compensation Department*, 306 Or 134, 138 (1988).

In *Ronald D. Fuller*, 50 Van Natta 1023, n 1 (1998), we concluded that a Director's rule was not an improper enlargement of the Department's statutory authority concerning its redetermination of permanent total disability benefits. We noted that ORS 656.726(3) charged the Director "with duties of administration, regulation and enforcement of [ORS Chapter 656]." We found that, in the discharge of his duties, ORS 656.726(3)(g) authorized the Director to "[p]rescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to [ORS Chapter 656] regarding all matters other than those specifically allocated to the board of the Hearings Division." Accordingly, we concluded that the Director was authorized under ORS 656.726(3)(g) to prescribe "procedural rules" for the redetermination proceeding. *Fuller*, 50 Van Natta at 1024.

Here, we similarly find that the Director has the authority to prescribe procedural rules concerning the reconsideration proceeding. In this regard, we find that the Director did not improperly enlarge his statutory authority by using the postmark date to define when a request for reconsideration is made. Moreover, we note that the remainder of the rule also provides that "mailing" may take place via electronic transmission (facsimile) or by hand delivery. OAR 436-030-0005(5). Accordingly, we disagree with claimant that the rule is arbitrary and provides only a limited opportunity for establishing a timely request for reconsideration.

Therefore, we reject claimant's request that we find the rule invalid, and we conclude that the ALJ properly applied the rule in this matter. Accordingly, we affirm the ALJ's conclusion that the request for reconsideration was not timely.

ORDER

The ALJ's order dated August 4, 1999 is affirmed.

January 20, 2000 Cite as 52 Van Natta 74 (2000)

In the Matter of the Compensation of
DYANE L. LLOYD, Claimant
Own Motion No. 99-0022M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on January 28, 1998. SAIF issued a denial of the compensability of claimant's current left knee condition on January 13, 1999. Claimant timely appealed that denial. (WCB Case No. 99-00680). In addition, SAIF opposed authorization of temporary disability compensation, contending that: (1) it is not responsible for claimant's current condition; (2) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (3) claimant was not in the work force at the time of disability.

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

Here, claimant did appeal the January 13, 1999 denial; however, she failed to appeal at the scheduled hearing. The Administrative Law Judge found that there were no extraordinary circumstances for her failure to appear and issued an Order of Dismissal on December 6, 1999. That order has not been appealed. Thus, the current left knee condition for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted claimant's current condition as compensable. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
STANLEY M. SHAW, Claimant
WCB Case No. 97-08533
SECOND ORDER ON REMAND (REMANDING TO APPELLATE UNIT AND TO HEARINGS DIVISION)
Susan L. Frank, Claimant Attorney
Lundeen, et al, Defense Attorneys

On December 23, 1999, we issued an Order on Remand in which we (1) remanded to the Director for the consideration of the promulgation of a temporary rule to address the permanent disability of the deceased claimant; and (2) vacated the Administrative Law Judge's (ALJ's) order and remanded the remainder of the case to the Presiding ALJ to hold the case in abeyance to await Director action regarding the promulgation of a temporary rule.

Claimant[1] seeks abatement and reconsideration of our decision, requesting that we determine claimant's impairment under the existing disability rating standards, as if the worker had survived. In *Shaw v. Steinfelds Products, Inc.*, 160 Or App 77 (1999), the court determined that the Director's rule applied by the Board, the ALJ and the Director to determine claimant's permanent partial disability is inconsistent with ORS 656.218, because it does not encompass the full benefits to which the worker would have been entitled had he survived. The court remanded the case for reconsideration of the deceased claimant's entitlement to benefits under ORS 656.218.

After examining the record, we determined on remand that the record established that, under the Director's rules for *living* claimants, had claimant survived, he would have experienced a number of permanent impairments resulting from his compensable injury. We concluded that, because the Director's rules do not provide for impairment values for those impairments for *deceased* claimants, claimant's permanent impairment was not adequately addressed in the disability standards. Citing *Gevers v. Roadrunner Construction*, 156 Or App 168 (1998), in which the court held that, if a claimant's condition is not ratable under the Director's rules (and the court so held in *Shaw*), the Board is required, under ORS 656.726(3)(f)(C) to remand to the Director for adoption of a temporary rule that assesses the claimant's disability, regardless of whether the adoption of a temporary rule has been requested). Accordingly, we remanded the case to the Director for consideration of promulgation of a temporary rule to address the permanent disability of the deceased claimant.

Claimant makes alternative arguments on reconsideration. First, claimant requests that we determine claimant's impairment under the existing disability rating standards, as if the worker had survived. Alternatively, claimant requests that we ask the court for clarification of what it intended in holding that determination and calculation of impairment is to proceed in accordance with ORS 656.268 as if the worker had survived. In response, the insurer states that remand to the Director is appropriate.

For purposes of determining injury-related permanent partial disability, 656.268(4)(b), ORS 656.283(7), and 656.295(5), require application of the "standards" for the evaluation of disabilities adopted by the Director.[2] We have previously held that the standards may not be applied "loosely or

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[1] Claimant is deceased; for convenience, the decedent's beneficiary is referred to as claimant.

[2] ORS 656.268(4)(b) provides in relevant part:

"Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the Department of Consumer and Business Services."

ORS 656.283(7) provides in relevant part:

"The Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726."

ORS 656.295(5) provides in relevant part:

"The board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the Director of the Department of Consumer and Business Services pursuant to ORS 656.726."

by analogy," because they are specific and precise. *Terry W. Prater*, 43 Van Natta 1288, 1291 (1991); *see Kelly D. Mustoe*, 46 Van Natta 285, *aff'd mem Mustoe v. Career Management Consultants*, 130 Or App 679 (1994); *Ralph A. Neeley*, 42 Van Natta 1638, 1639 (1990). Here, because the rules for the evaluation of disabilities for deceased claimants are inconsistent with ORS 656.218, and the current Director rules are applicable only to *living* claimants, we conclude that the "standards" do not provide for a rating under these particular circumstances. Therefore, no rating is available. *Margo A. Readye, Jr.*, 50 Van Natta 177 (1998).

Moreover, we find no conflict with our analysis of the particular circumstances of this case and the court's holding that determination and calculation of impairment is to proceed in accordance with ORS 656.268 as if the worker had survived. *See* ORS 656.268(4)(b).[3]

Accordingly, we withdraw our December 23, 1999 Order on Remand (Remanding to Appellate Unit and to Hearings Division). On reconsideration, as supplemented herein, we republish out December 23, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[3] Claimant contends that the Board's action in remanding to the Director is in violation of the court's decision. The court stated that ORS 656.218 establishes that both the payment and calculation of benefits are to be made as if the deceased worker had survived. The court also found that, had he survived, the worker would have experienced permanent loss of range of motion and loss of use of his right ankle. The court accordingly remanded the case to the Board for reconsideration of claimant's entitlement to benefits under ORS 656.218. Nevertheless, the problem still remains. The Board has no statutory authority to adopt standards to evaluate claimant's disabilities in this case. Rather, pursuant to ORS 656.726(3)(a), it is the Director's statutory responsibility to promulgate standards that the Board can apply. *See also* OAR 436-035-0001. Therefore, in order to achieve a proper evaluation of claimant's disabilities, the Board is taking an appropriate legal approach by remanding to the Director for *consideration* (not the *ordering*) of the promulgation of a temporary rule to address the permanent disability of the deceased claimant, as if claimant had survived. On remand, the Director will have the benefits of the court's opinion for guidance in determining the appropriate standards for evaluating the extent of the deceasedclaimant's permanent disability. Those standards may be identical to those for a living claimant. Nontheless, that determination must be made by the Director.

Board Members Phillips Polich and Biehl dissenting.

We disagree with the majority's analysis and conclusion for the following reasons. The court held that ORS 656.218 requires that "benefits are to be *determined* and paid to the worker's beneficiaries pursuant to ORS 656.268 as if *the worker had survived.*" (Emphasis in original.) The court further noted that, under ORS 656.268(4)(b), the insurer's or self-insured employer's findings regarding disability must be pursuant to the standards prescribed by the department. After our review of ORS 656.218 and the applicable provisions of OAR 436-035 *et seq.*, we think claimant's disability is rateable under the standards prescribed by the department. We would, accordingly, rate claimant's permanent impairments under the standards. For these reasons, we respectfully dissent.

In the Matter of the Compensation of
ROBERT L. WILLIAMS, Deceased
WCB Case No. CV-99002
PROPOSED ORDER (CRIME VICTIMS' ACT) (REMANDING)
Kristin Preston, Assistant Attorney General

Pursuant to notice, a telephonic hearing was conducted and concluded by Celia M. Fitzwater, special hearings officer, on November 30, 1999, in Salem, Oregon. On behalf of Robert Williams (the deceased) were: Patricia Williams, Robert Williams, Sr., Kim Armstead Williams, LaWonda Williams, Andrea Williams Howard, LaTonya Williams, Norman Marris, and LaDovic Montlin. The Department of Justice Crime Victims' Compensation Fund (Department) was represented by Kristin Preston, Assistant Attorney General. On behalf of the Fund was Jason Barber. The court reporter was Joellen Jarvis.

The following exhibits were admitted: Section A, Exhibits 1-3; Section B, Exhibits 1-9; Section C, Exhibits 1-3; and Section D, Exhibit 1. The record closed on November 30, 1999.

Patricia Williams requested a hearing by the Workers' Compensation Board of the Department's July 25, 1996 Order on Reconsideration. By its order, the Department denied the claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on the finding that the deceased's injuries were attributable to the wrongful act of the deceased.

FINDINGS OF FACT

On February 7, 1996, Robert Williams died of gunshot wounds to his chest and right lung. (Ex. D1). According to the Certificate of Death, the manner of death was "Homicide." (*Id.*)

On June 3, 1996, the deceased's wife, Kim Armstead Williams, applied for crime victims' benefits. (Ex. B1). On June 20, 1996, the Department issued a Determination Order and Notice denying the application. The order found that, according to the police officer "in charge" of investigating the death, "Robert was shot to death after illegally entering the home of Mr. Jenkins and firing shots at Mr. Jenkins." The order further stated that a "grand jury has determined that Mr. Jenkins shot Robert in self defense and therefore no criminal act occurred." Consequently, the order concluded that Robert Williams was not "an innocent victim of crime" and that his actions "were substantially wrongful, substantially provoked and contributed to his own death."

On July 4, 1996, Kim Armstead Williams requested reconsideration, asking the Department to "please make a thorough investigation." (Ex. B4).

The Department's July 25, 1996 Order on Reconsideration found "no basis for reversing the original order." Specifically, citing to "evidence provided to the Department from various law enforcement officials working the case, (two lead detectives and the deputy district attorney assigned to the case)," the Department continued to find that Robert Williams was shot and killed in self-defense. The order also contained a provision that a request for review by the Board could be requested within 60 days of the order.

On May 29, 1999, the deceased's mother, Patricia Williams, wrote to the Department asking it to reconsider its decision in light of the police report (which was not previously considered). (Ex. B7). That request was denied. The case was referred to the Board.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Prior to the hearing, the Department submitted a motion to dismiss the hearing. In moving for dismissal, the Department first alleged that, because Kim Armstead Williams, and not Patricia Williams, applied for compensation, Patricia Williams lacked standing to request a hearing because she was not the "applicant."

Under the applicable statutes, after the Department reconsiders its order, "[a]ny applicant" who requested review by the department under ORS 147.145 "and who disagrees with the decision of the department on review may appeal to the Board." ORS 147.155(1). Thus, a person may appeal to the Board if: (1) he or she is "any applicant"; and (2) has requested review by the Department under ORS 147.145 and disagrees with its decision on review.

"Applicant" includes any "person who is a survivor of a deceased victim." ORS 147.005(1)(b). "Survivor" is "any spouse, parent, grandparent, guardian, sibling, child or other immediate family member of a deceased victim." ORS 147.005(11). Because Patricia Williams is a "parent" of Robert Williams, she qualifies as an "applicant." Furthermore, because ORS 147.155(1) refers to "any applicant," I conclude that she satisfies this part of the provision even though she was not the same "applicant" who first submitted the claim.

With regard to the second requirement, under ORS 147.145, "the applicant" may request review by the department of an order entered pursuant to ORS 147.135. The provision further provides that the "department shall reconsider any order for which a request for review is received." Here, Patricia Williams wrote to the Department, asking it to reconsider its July 25, 1996 Order on Reconsideration. The Department's response was a letter to Ms. Williams stating that "the three-year life of the claim has expired (June 20, 1999) and there are no further appeal rights available to you." (Ex. B8).

Given the broad language in the statute that the Department must reconsider "*any* order for which a request for review is received," and because Ms. Williams asked for review and disagreed with the Department's response, I find that Patricia Williams requested review by the Department and disagreed with its decision on review.

In sum, because Patricia Williams qualifies as "any applicant" and she otherwise satisfied the statute, I conclude that she has "standing" to request a hearing by the Board under ORS 147.155(1).

The Department's other ground for dismissal is its allegation that Patricia Williams did not timely file her request for hearing because it was not within 60 days of the July 25, 1996 Order on Reconsideration. There is no dispute that Patricia Williams did not ask for a hearing until nearly three years after the order issued. After carefully reviewing the applicable statues and rules, however, I find no authority supporting the Department's position that the request for review was required to be filed within 60 days of the Order on Reconsideration. The Department's motion to dismiss merely cites to language in the Order on Reconsideration, which itself cites to no statute or administrative rule.

Finding an absence of any statutory or administrative authority that the request for hearing had to be filed within any time period following the Order on Reconsideration, I also conclude that Patricia Williams' request for hearing was not untimely filed.

Thus, I deny the Department's motion to dismiss.

Remand

At hearing, both parties indicated that, if the hearing was not dismissed, the case should be remanded to the Department for consideration of the police report. Based on the relevance of such evidence, I agree.

Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Fund for further consideration of this record, consistent with this order. The Department is directed to reconsider the record, including the police report. If the applicant is dissatisfied with the Department's new reconsideration order, she may request Board review of that decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES L. BATSON, SR., Claimant
WCB Case No. 99-01559
ORDER ON REVIEW
Lawrence A. Castle, Claimant Attorney
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) Hazelett's order that increased claimant's unscheduled permanent disability award for a neck condition from 11 percent (35.2 degrees), as awarded by an Order on Reconsideration, to 31 percent (99.2 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant, age 49 at the time of hearing, worked for the employer as a meat product salesman. His work requires him to perform demonstrations using a microwave oven at approximately 15 retail stores to which he drove each day. He carried the microwave oven in his car and lifted and carried it from his car to the demonstration location and back again.

In May 1997, claimant experienced pain in his upper back and numbness in his left arm that radiated into his hand while lifting and carrying the oven. Claimant was diagnosed with a herniated disc at C5-6, for which Dr. Keenen performed a diskectomy and arthrodesis in September 1997. (Ex. 6).

Claimant's left arm symptoms resolved, although he continued to experience back pain and dysesthesias in his right arm. (Ex. 6A-1). Keenen released him to modified work and prescribed physical therapy. (Ex. 6A-2). Claimant's condition did not improve and Keenen prescribed a work hardening program. (Ex. 6C).

At a May 1998 followup examination, Keenen noted that claimant continued to have neck and bilateral upper extremity pain. Keenen declared claimant medically stationary and requested a physical capacity evaluation (PCE). (Ex. 8).

The PCE was performed on June 2, 1998; the evaluator noted that "the results of this evaluation are not valid because of inconsistencies." (Ex. 9). Keenen concurred with the examination on June 10, 1998. (Ex. 10).

On August 10, 1998, SAIF issued an Updated Notice of Acceptance at Closure for trapezius strain and C5-6 disc herniation. (Ex. 11).

An August 31, 1998 Determination Order awarded 31 percent unscheduled permanent disability and temporary disability. (Ex. 12).

In his response to a September 16, 1998 letter from the vocational rehabilitation consultant who asked about claimant's physical restrictions in light of the PCE's invalidity findings, Keenan stated: "Although not felt valid by the therapist, the PCE limitations seem appropriate to me." (Ex. 13).

On October 2, 1998, SAIF requested reconsideration of the Determination Order, disagreeing with the impairment findings and the rating of unscheduled permanent disability. (Ex. 14).

On October 7, 1998, an MRI revealed postoperative change with anterior fusion at C5-6 and a disc hernation at the same level. (Exs. 15, 16). Keenen opined that additional surgery was not then appropriate. (Ex. 16). On November 9, 1998, Keenen filed an aggravation claim that SAIF subsequently denied. (Exs. 17, 19).

Drs. Staver, German and Howieson performed a medical arbiter examination on January 8, 1999. (Ex. 18).

A January 26, 1999 Order on Reconsideration reduced the Determination Order's unscheduled permanent disability award to 11 percent. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ modified the Order on Reconsideration's award, increasing it to 31 percent unscheduled permanent disability. On review, SAIF contends that the ALJ applied the wrong date to determine claimant's disability and that, relying on the arbiter panel's findings, the Order on Reconsideration's award should be reinstated. We agree.

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 Reconsideration Order. ORS 656.283(7).[1] Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). The determination of impairment is further explained in OAR 436-035-0007(14), which provides in material part, that "[o]n 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."

Here, the medical arbiter panel opined:

> "The entire examination is considered invalid because the examinee appeared to be making less than a reasonable effort in demonstrating ranges of motion. This was accompanied by marked pain behavior such as grimacing and grunting. The motor examination was characterized by give way weakness in all motions affecting shoulder, elbows, wrists and fingers." (Ex. 18).

The physical capacities examiner stated: "It is felt that the results of this evaluation are not valid because of inconsistencies described herein. Throughout the course of the evaluation, the examinee was not observed to demonstrate pain behaviors." (Ex. 9-1). Without further explanation of these ambiguous comments, after listing claimant's cervical spine range of motion measurements, the examiner then stated: "The validity criteria was met." (Ex. 9-2). Dr. Keenan, claimant's attending physician, concurred with the PCE in its entirety. (Ex. 10).

Later, when Keenan was queried regarding the evaluator's statement that "the results of this evaluation are not valid because of inconsistencies," Keenan stated: "Although not felt valid by the therapist, the PCE limitations seem appropriate to me."

We do not find Keenen's conclusory comment on the confusing PCE report sufficient to establish a level of impairment different from that found by the arbiter panel, particularly in light of his failure either to clarify the report or to explain his apparent change of opinion. Consequently, we find the arbiters' 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).[2]

Because the arbiter panel found claimant's range of motion findings invalid, the findings receive a value of zero. *See* OAR 436-035-0007(28). The value for the C5-6 discectomy and fusion, the first surgical procedure involving one disc and/or up to two vertebrae in the cervical region, is 8 percent. *See* OAR 436-035-0350(2). The parties do not dispute the non-impairment factors. Therefore, the impairment value of 8 percent and the non-impairment value of 3 percent are assembled for a total value of 11 percent. *See* OAR 436-035-0280. We accordingly reinstate the Order of Reconsideration's 11 percent unscheduled permanent disability award.

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[1] ORS 656.283(7) provides that the ALJ shall evaluate claimant's disability as of the date of the Reconsideration Order. Although the ALJ chose to use the date of the Determination Order as the date to determine disability because he determined that claimant's condition had worsened with the discovery of a newly herniated disc, the ALJ does not have discretion to choose a different date. *SAIF v. Hernandez*, 155 Or App 401 (1998).

[2] The ALJ acknowledged that each set of examiners reported "subjective impressions" of the invalidity of the examination findings. Nevertheless, he found that the findings were correlated by the standard validity criteria and concluded that they were sufficiently 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).

ORDER

The ALJ's order dated August 6, 1999 is reversed. The ALJ's attorney fee award is reversed. The Order on Reconsideration is reinstated and affirmed.

Board Member Phillips Polich dissenting in part.

I agree with the portion of the majority opinion that determined that the ALJ shall evaluate claimant's disability as of the date of the Reconsideration Order. I disagree, however, with the majority's conclusion that claimant is not entitled to an award of 31 percent unscheduled permanent disability for his cervical spine injury.

Specifically, I would agree with the ALJ's evaluation of the medical evidence. As discussed by the ALJ, Dr. Keenan concurred with a physical capacities examination in which the PCE examiner stated that the results may not be valid because of inconsistencies *described in the report.* (Ex. 9-1). The only problem documented in the PCE was grasp strength. (Ex. 9-2). The PCE examiner *reported that the range of motion findings were valid.* (Ex. 9-2). Moreover, Dr. Keenan's endorsement of the limitations documented in the PCE uphold the validity of the findings.

As for the arbiters' report, they did not consider that claimant made an adequate effort. Nevertheless, the arbiters' report measured range of motion, and those measurements were consistent with the valid range of motion results obtained in the PCE. In addition, the arbiters indicated that those findings were consistent with the accepted injuries. Finally, the arbiters did not refer to any specific testing that demonstrated that the results were invalid, in contrast to the PCE, which stated that validity criteria were met.

For these reasons, I would not find the arbiter's report persuasive and, like the ALJ, would rely on the complete and better-reasoned PCE, with which the attending physician concurred, to conclude that a different level of impairment has been established than that found by the arbiters.

In the Matter of the Compensation of
GERALD PHILLIPS, Claimant
Own Motion No. 99-0449M
OWN MOTION ORDER
Starr & Vinson, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable bilateral leg condition. Claimant's aggravation rights expired on November 4, 1996. The insurer opposes reopening on the grounds that claimant was not in the work force at the time of the current worsening.

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

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

Claimant's attorney a letter wherein he asserts that claimant "does not wish to pursue time loss." 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
ROBIN L. STEVENS, Claimant
WCB Case No. 98-03511
ORDER ON RECONSIDERATION
Bischoff, Strooband & Ousey, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

The insurer requests reconsideration of our December 30, 1999 order that affirmed the Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's claim for a back injury. Specifically, the insurer argues that we did not address whether claimant's history to Dr. Keiper was inaccurate and did not address its arguments regarding the persuasiveness of Dr. Keiper's or Dr. Farris' opinions.

Because we *adopted* the ALJ's order, we did not consider it necessary to repeat all of her conclusions regarding the medical evidence. We point out that the ALJ thoroughly addressed the opinions of both Drs. Keiper and Farris. The ALJ found Dr. Farris' opinion unpersuasive because the doctor believed that claimant's fall was "insignificant," a conclusion that was not supported by the description of the fall given by claimant or her supervisor, who was an eyewitness to the fall. We agree with and have adopted the ALJ's reasoning and conclusions regarding the medical evidence. Contrary to the insurer's argument, we did not "ignore" Dr. Farris' opinion.

We supplemented the ALJ's order to address the insurer's argument that Dr. Keiper did not have an accurate history of claimant's prior low back problems. We found that Dr. Keiper knew that claimant had prior, mild low back problems, but did not change his opinion regarding causation. After again reviewing his deposition testimony and the remainder of the medical evidence, we adhere to our prior conclusion.

Prior to the January 1998 work injury, claimant had low back pain in May and September 1997. On January 19, 1998, claimant slipped at work, but did not fall down. She sought treatment for her back the following day from Dr. Floyd. After seeing Dr. Floyd, claimant went to work. Later that day, she slipped on a wet floor and fell. When she fell, her feet went up in the air and she landed on her buttocks. Claimant's supervisor witnessed the fall. Two weeks after the fall, claimant began having leg symptoms.

Based on his deposition testimony, Dr. Keiper did not believe that claimant's back pain prior to the fall necessarily indicated that claimant had the herniation prior to the fall. (Ex. 27-19 to 22). He believed that claimant's history was believable and correlated with her MRI. (Ex. 27-21). Thus, we concluded that Dr. Keiper ultimately was aware of the prior back problems and it did not change his causation opinion.

The insurer's remaining arguments were adequately addressed by the ALJ's order. We withdraw our December 30, 1999 order. On reconsideration, as supplemented herein, we republish our December 30, 1999 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
OCTAVIO AMBRIZ, Claimant
WCB Case No. 98-09572
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

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

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

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated july 15, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

Board Member Haynes dissenting.

The majority affirms the ALJ's conclusion that claimant proved compensability of his right knee injury claim. Based on the following reasoning, I respectfully dissent.

Claimant sprained his right ankle at work in July 1998. Dr. Fulper diagnosed a right fibula[1] sprain, placed claimant in an ankle stirrup splint, and recommended that claimant not bear weight on the ankle. About a week later, x-rays revealed degenerative changes in claimant's knee. In a follow-up examination, Fulper diagnosed a clinical fracture of the right fibula and continued to recommend that claimant not bear weight on the ankle. Additional x-rays confirmed degenerative changes and lateral osteophyte formations in the right knee, as well as osteophytes off the superior and inferior aspects of the patella. The employer accepted claimant's claim for a nondisabling right ankle sprain.

In August 1998, Fulper diagnosed a "healing sprain, right fibula." He referred claimant to Dr. Carpenter, orthopedist. Carpenter diagnosed a right ankle strain and right knee pain with possible torn cartilage and degenerative arthritis in the right knee, which he attributed to the July 1998 injury. Subsequently, Dr. Becker, who examined claimant for the employer, determined that claimant had sustained a right knee contusion and right ankle sprain. He also diagnosed right knee conditions of degenerative arthritis, three-compartment disease, more advanced right lateral knee joint changes, and degeneration and tears of both menisci. The employer partially denied claimant's right knee condition. Claimant requested a hearing.

It is claimant's burden to prove by a preponderance of the evidence that he sustained a compensable injury to his right knee. ORS 656.266; *Hutchinson v. Weyerhaeuser*, 288 Or 51 (1980). Moreover, if claimant's compensable injury combined with a preexisting condition, claimant must prove that the injury is the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B). Given the nature of claimant's condition and delay in seeking treatment, the issue of causation is sufficiently complex to warrant proof by expert medical evidence. *Barnett v. SAIF*, 122 Or App 279 (1993).

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[1] The fibula is the lateral and smaller of the two bones of the leg; it is not-weight bearing and articulates with the tibia above and the tibia and talus below. *Stedman's Electronic Medical Dictionary*, v. 4.0, 1998.

Although claimant was involved in a work incident in July 1998, which resulted in a sprained ankle, I am not persuaded that that incident caused or materially contributed to claimant's current right knee condition. To the contrary, as discussed by Dr. Becker, the contemporaneous medical records show that claimant experienced no significant knee problems until weeks after the work incident.

Dr. Fulper treated claimant immediately after the July 1998 work incident and continued to do so until the end of August. Although his notes reflect that claimant was experiencing some pain throughout his leg, including his knee, he did not deem the knee involvement significant enough to warrant treatment or even a discrete diagnosis. Moreover, the tests Fulper performed on claimant's right knee were all negative, and he noted the absence of any effusion. When Fulper examined claimant's leg again on July 15, he again reported that the knee was within normal limits. During his six weeks of treatment, Dr. Fulper did not ascribe *any* knee problems to claimant's work injury. These contemporaneous medical records do not support claimant's testimony that he experienced immediate and continuous pain in his knee as a result of the work incident, as claimant surely would have reported them to Fulper at some time during his six weeks of treatment.

Moreover, Dr. Becker agreed that claimant's documented lack of initial knee problems was *medically* significant. On the basis of that history and his extensive findings of right knee degeneration, Becker determined that claimant's need for treatment of his knee was entirely the result of his preexisting arthritis.

Dr. Becker further concluded that the meniscal changes in claimant's right knee (for which Dr. Carpenter proposed surgery) predated the July 1998 injury and were not significantly changed by that injury. Becker explained his reasoning as follows. Becker had observed calluses on the front of claimant's left knee, but not the right, which indicated that claimant had avoided kneeling on his right knee for a considerable time.[2] Becker also noted that the MRI taken shortly after the injury revealed moderately advanced degenerative changes. Finally, Becker determined that the mechanism of the alleged right knee injury was a contusion to the anterior lateral aspect of the right knee and not a weight-bearing twisting injury, and that there was no effusion found in the knee on repeated examination. In sum, Dr. Becker based his opinion on the lack of medical records showing right knee involvement, the mechanism of the injury and the lack of right knee effusion, the left knee calluses, and the MRI findings.

Dr. Carpenter, who did not treat claimant until the end of August 1998, opined that claimant probably had a lateral meniscus tear, which would usually require a twisting injury with a load applied to the knee at the time of the injury. But Dr. Becker persuasively pointed out that this was not the type of injury claimant sustained. Carpenter also stated that in most cases involving a meniscal tear there is swelling and a positive McMurry's test. This is contrary to Fulper's contemporary findings showing no swelling and a normal test. In addition, Carpenter acknowledged torn menisci can result from ongoing degeneration in the absence of acute injury. In light of these facts, I would find Dr. Carpenter's opinion unpersuasive.

In sum, because claimant's six weeks of treatment with Dr. Fulper did not involve his knee, objective tests conducted on the knee just after the work incident were normal, x-rays revealed only preexisting arthritis in the knee, and findings revealed that claimant had avoided kneeling on his right knee for some time, I would find an insufficient basis to establish compensability.

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[2] Becker reported that when he asked claimant about prior knee problems, claimant avoided looking Becker in the eye when he said he did not recall any, thus inserting an element of doubt regarding his right knee history.

In the Matter of the Compensation of
CHRISTOPHER S. ANDERSEN, Claimant
WCB Case No. 99-02676
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that reduced his unscheduled permanent disability award for mid and low back conditions from 5 percent (16 degrees) to zero. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the "Finding of Ultimate Fact," with the following supplementation.

Claimant has valid permanent thoracic and low back impairment due to his compensable thoracic-lumbar strain and L4-5 herniated disc conditions.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his mid and low back lifting at work on April 7, 1997. His claim was accepted as a disabling thoracic-lumbar strain and L4-5 disc herniation.

Dr. Sedgewick provided conservative treatment and released claimant to regular work on October 20, 1997. He recommended that claimant undergo epidural steriod injections to determine whether ongoing pain was discogenic or neurogenic. (Ex. 22). No injections were provided and Dr. Sedgewick did not see claimant after April 27, 1998. On May 4, 1998, Dr. Sedgewick wrote that he would not anticipate permanent impairment. But he did anticipate continued pain, which he felt would be due to degenerative disc disease.

Claimant did not attend the closing examination scheduled with Dr. Sedgewick for September 2, 1998.

An October 8, 1998 Determination Order closed the claim administratively, without a permanent disability award. Claimant requested reconsideration and a medical arbiter examination. Dr. Woodward, medical arbiter, examined claimant on February 10, 1999. He measured and reported reduced thoracic and lumbar range of motion.

A March 4, 1999 Order on Reconsideration awarded 5 percent unscheduled permanent disability, based on the arbiter's report. The employer requested a hearing.

The ALJ set aside the reconsideration order's award, finding no valid injury-related permanent impairment, based on Dr. Sedgewick's May 1998 letter. The ALJ found no reason not to defer to Dr. Sedgewick's opinion, reasoning that it was more thorough, complete, and well-reasoned than the arbiter's report. Specifically, the ALJ found that: Dr. Woodward had an incomplete and inaccurate history because he did not have claimant's imaging studies; without the studies (which revealed claimant's degenerative disc disease), Dr. Woodward inaccurately believed that claimant had no preexisting condition; and Dr. Woodward doubted the validity of claimant's range of motion findings "without qualification." Opinion and Order, p. 2. We disagree with the ALJ's reasoning and conclusions.

ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based on objective findings." Determination of impairment is further explained in OAR 436-035-007(14)[1], which provides that impairment is determined by the medical arbiter, unless a

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[1] OAR 436-035-007(14) provides:

"Impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0280 except where a preponderance of medical opinion establishes a different level of impairment pursuant to 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."

preponderance of medical opinion establishes a different level of impairment.[2] The employer bears the burden of proving that claimant's reconsideration award should be reduced.[3]

The employer relies on Dr. Sedgewick's May 4, 998 letter discussing claimant's then-current diagnoses of a mild central disc herniation and degenerative disc disease. Based on these diagnoses, Dr. Sedgewick anticipated continued low back *pain* (which he would attribute to degenerative disease), but no permanent impairment. He also opined that claimant's mild herniation "would keep him at a lifting restriction of no greater than 50 lbs." (Ex. 23-1).

To the extent that Dr. Sedgewick's May 1998 opinion is read to address claimant's low back impairment (not just his ongoing pain[4]), it differs from the arbiter's reduced lumbar range of motion findings. However, Dr. Sedgewick made no impairment findings regarding claimant's accepted conditions--thoracic or lumbar. Because there is no evidence that he "undertook to evaluate" claimant's compensable thoracic and low back conditions, there is no evaluation of impairment within the meaning of OAR 436-035-0007(14) that is "'different' from and could be weighed against the [arbiter's] report, which found impairment." *Snyder v. Barrettt Business Services, Inc.*, 147 Or App 619, 625 (1997).[5] Under these circumstances, even if Dr. Sedgewick's May 1998 letter addressed claimant's impairment, we would not find it more thorough and complete than the arbiter's examination report and we would not rely on the letter to rate claimant's permanent impairment. *See id.*

The ALJ relied on Dr. Sedgewick's letter in part because the doctor "anticipated" that claimant's future low back pain would be due to degenerative disc disease, not the accepted strain or disc conditions. The ALJ reasoned that the arbiter's evaluation was based on an inaccurate and incomplete history because he did not review claimant's imaging studies and therefore did not know that claimant had preexisting degenerative disease. (*See* Exs. 11, 14, 23). We evaluate the evidence differently, for the following reasons.

First, in our view, Dr. Sedgewick addressed only claimant's pain, not his impairment, and he did not consider claimant's compensable thoracic condition at all. Second, as we have explained, he made no impairment findings. Third, we rate claimant's impairment as of reconsideration and Dr. Sedgewick did not see claimant after April 27, 1998--eleven months before the March 1999 reconsideration proceeding. Under these circumstances, Dr. Sedgewick's opinion that claimant's future pain would not be injury-related does not persuade us that claimant's otherwise ratable permanent impairment is not injury-related.[6] Accordingly, we do not find a preponderance of the medical evidence that establishes a level of impairment different from that found by the arbiter.[7]

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[2] We do not automatically rely on the medical arbiter's opinion regarding claimant's permanent impairment.

[3] *See Lanny K. Sigfridson*, 49 Van Natta 1433 (1997); *Roberto Rodriguez*, 46 Van Natta 1722, *on recon* 46 Van Natta 2230, *on recon* 46 Van Natta 2530 (1994).

[4] Pain is considered under the standards only "to the extent that it results in measurable impairment." *See* OAR 436-035-0320(3); *Daniel L. Carter*, 50 Van Natta 1145, 1146 (1998), *Kelly D. Mustoe*, 46 Van Natta 255, 286, *aff'd mem Mustoe v. Career Management Consultants*, 130 Or App 679 (1994).

[5] *Former* OAR 436-35-007(9), which is substantively similar to OAR 436-035-0007(14), provided, in material part, that

> "[o]n reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment."

In *Snyder*, the court explained that the rule set forth the methodology for analysis when there are multiple, conflicting reports about impairment. However, when there is no other report evaluating a particular impairment that can be weighed against the arbiter's report, it is inappropriate to rely on another report's failure to address impairment. 147 Or App at 625.

[6] *See Fred R. Countryman*, 50 Van Natta 2202, 2203 (1998) (Arbiter's inadequately explained conclusion that condition "resolved" less persuasive than treating doctor's impairment findings).

[7] *See SAIF v. Danboise*, 147 Or App 550, 553 (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).

The ALJ also declined to rely on the medical arbiter's impairment findings because she found that Dr. Woodward doubted the validity of claimant's range of motion measurements "without qualification." Opinion and Order, p. 2. We disagree, because a close reading of the arbiter's report reveals that the arbiter distinguished carefully between valid and invalid findings.

The arbiter stated that claimant's "findings appear to be self-limited *as I will discuss later.*" (Ex. 31-3, emphasis added). His only subsequent discussion of self-limited findings specifically addressed "thoracic flexion in that the first measurement was considerably greater than any other measurement." (*Id*). And the arbiter's actual thoracic measurements were *all* (*i.e.*, including flexion) "within +/- 10% or 5 [degrees]" of each other. (Ex. 31-5). Under these circumstances, we conclude that the arbiter's thoracic range of motion measurements are valid impairment findings, unaffected by "self-limiting."[8]

Finally, we note that the arbiter stated:

> "The maximum sacral angle was 9 degrees, which is inconsistent even with the unrealistically limited straight leg raising angle. Thus, I believe the lumbar flexion and extension angles are invalid." (Ex. 31-3).

Based on the arbiter's conclusion that claimant's lumbar flexion and extension findings were invalid, the Order on Reconsideration awarded permanent disability for claimant's reduced lumbar right and left lateral flexion, but not for reduced lumbar flexion and extension. (Ex. 32-2). Because the arbiter "invalidated" only claimant's lumbar flexion and extension measurements, we conclude that the Department properly rated claimant's remaining lumber findings. *See Harvey Clark*, 47 Van Natta 136 (1995) (The validity of range of motion testing must be determined by the medical examiner performing the tests).

In summary, we conclude that the Department properly awarded permanent disability for claimant's valid injury-related impairment findings--reduced lumbar flexion and rotation and reduced thoracic flexion and right and left rotation, for a total of 5 percent unscheduled permanent disability. Consequently, we reinstate the Order on Reconsideration award.

Because we have reinstated the unscheduled permanent disability awarded by the Order on Reconsideration, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. *See* ORS 656.386(2); OAR 438-015-0055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *aff'd Volk v. America West Airlines, 135* Or App 565 (1995).

ORDER

The ALJ's order dated August 27, 1999 is reversed. The March 4, 1999 Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order, not to exceed $3,800. In the event that this "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in *Jane A. Volk.*

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[8] *Compare Nicolas Garcia-Guerroero*, 50 Van Natta 513 (1998) (No permanent impairment where the treating doctor took no measurements and the arbiter took repeat measurements, enumerated wide fluctuations, and explained why the findings were invalid). Moreover, even if the arbiter's thoracic flexion findings were invalid in this case, claimant's thoracic impairment would still be 2 percent, because the combined value for right and left thoracic rotation, 1.6 percent, would be rounded up to 2 percent.

In the Matter of the Compensation of
WARREN L. BENFIELD, Claimant
Own Motion No. 99-0201M
OWN MOTION ORDER
Starr & Vinson, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable left knee condition. Claimant's aggravation rights expired on September 23, 1976. On May 14, 1999, SAIF submitted an Own Motion Recommendation Form that recommended against reopening on the grounds that: (1) surgery or hospitalization is not appropriate for the compensable injury; and (2) claimant was not in the work force at the time of disability. SAIF requested Director's review of the requested medical treatment. (Medical Review Case No. 13463).

On May 24, 1999, we postponed action pending resolution of medical issues which were before the Director. On November 8, 1999, SAIF submitted an amended Own Motion Recommendation Form that recommended reopening claimant's 1970 claim for the provision of temporary disability compensation. In addition, in its amended recommendation, SAIF agreed that: (1) claimant's current condition requires surgery; (2) this current condition is causally related to the accepted condition; (3) SAIF is responsible for the current condition; (4) the surgery is reasonable and necessary; and (5) claimant was in the work force at the time of the current disability. Furthermore, on November 1, 1999, SAIF withdrew its request for Director's review regarding the appropriateness of the recommended surgery.

Subsequently, by letter dated November 24, 1999, SAIF changed its latest recommendation and recommended against reopening the claim. Specifically, SAIF disputed claimant's work force evidence and requested that the work force matter be referred to the Hearings Division "for live testimony with [claimant] present." Claimant responded that the work force evidence is sufficient to establish that he was in the work force at the time of disability and, therefore, his claim should be reopened for own motion relief.

Inasmuch as the medical dispute formerly pending before the Director has been resolved, we proceed with our review of claimant's request for own motion relief, *i.e.*, 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.*

On October 13, 1999, claimant underwent a total knee replacement regarding his compensable left knee condition. Therefore, it is undisputed that claimant's compensable condition requires surgery or hospitalization.

Nevertheless, in order to be entitled to own motion relief, claimant must also prove that he was in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). For the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction, the "date of disability" 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 October 13, 1999, the date he underwent surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997). Finally, a claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Claimant submitted copies of his payroll records, which consist of weekly forms that provide blank spaces to be filled in for various categories, including hours, pay rate, gross earnings, deductions,

and net pay. These spaces were filled in by hand, and detailed the hours worked, the gross amount earned, the taxes deducted (including federal and state income taxes and Medicare and social security taxes), and the net earnings paid. Although not all of these payroll records were dated, those that were span the time period from April 1999 to October 12, 1999. Several of these forms were copied on letterhead that listed the address and name of the business. The business name indicated that it dealt with television and electronics. Additionally, in a letter dated October 8, 1999, and sent to SAIF, the "Owner-Operator" stated that he had been informed of SAIF's attempt to contact him to verify claimant's employment. He stated that he hired claimant on April 12, 1999, and claimant had worked full time for him since April 26, 1999.

In a September 28, 1999 letter to SAIF on the employer's letterhead, claimant referenced that letterhead as listing the "working address," and stated the employer "has no phone, or if he does it's unlisted, I see him at the shop, my house or on occasionally [*sic*] by pager." Finally, a work release from Dr. Verhoogen, M.D., stated that claimant was totally incapacitated from October 12, 1999, and would be undergoing a total knee replacement on October 13, 1999.

SAIF argues that the information submitted by claimant does not prove that he was in the work force because it has been unable to contact the alleged employer. Specifically, when it attempted to locate a telephone number for the employer, SAIF discovered that there was no listing for a business with the name listed on claimant's submissions. SAIF contacted the agency handling business licensing in the Idaho city where the alleged business is located and was informed there was no business listed by the name on claimant's submissions. The agency also informed SAIF that if the business was run out of a residence, which the address for the business listed on claimant's submissions indicated, it must have a "Home Occupation Permit," and no record of such a permit was found. Based on its unsuccessful attempts to verify the existence of claimant's employer, SAIF contends that claimant has failed to prove that he was in the work force at the time of his current disability; therefore, SAIF requests that we deny reopening the claim for own motion relief. In the alternative, SAIF requests that the work force matter be referred to the Hearings Division "for live testimony with [claimant] present."

SAIF's challenge is to the "legitimacy" of the employer's business. SAIF does not expressly contest claimant's representations/submissions that he was paid for services rendered. ORS 656.005(30) (in relevant part, defines "worker" as any person who "engages to furnish services for remuneration, subject to the direction and control of an employer"). In any event, the record is sufficiently developed and supports the conclusion that claimant qualified as a "worker" at the time of disability. In other words, the record establishes that claimant furnished services for remuneration, subject to the direction and control of an employer, during the period before his October 1999 surgery. Therefore, whether or not the employer was properly licensed to conduct business, claimant was in the work force at the time of disability. Consequently, we consider it unnecessary to refer the matter to the Hearings Division to explore the legitimacy of the employer's business status or whether claimant was in the work force at the relevant time.

Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning October 13, 1999, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, 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
ROBERT F. MARTINOT, Claimant
WCB Case No. 99-02696
ORDER ON RECONSIDERATION
Nicholas M. Sencer, Claimant Attorney
Scheminske, et al, Defense Attorneys

The insurer requests reconsideration of our December 30, 1999 Order on Review that reversed the Administrative Law Judge's (ALJ's) order upholding the insurer's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. In moving for reconsideration, the insurer renews it motion to dismiss claimant's appeal, asserting that the compensability issue is moot or, alternatively, the claim is precluded by its unappealed July 16, 1999 denial of claimant's second claim for the same condition. On the merits, the insurer argues that we should rely on Dr. Button, examining physician, rather than Dr. Harpole, treating physician.

We withdraw our December 30, 1999 order. On reconsideration, after considering the insurer's arguments on reconsideration, we adhere to our prior reasoning and conclusions, with the following supplementation.

Motion to Dismiss

The insurer seeks dismissal of claimant's appeal, asserting that the compensability issue is moot or, alternatively, the claim is precluded by its unappealed July 16, 1999 denial of claimant's second claim for the same condition.

The insurer relies on *SAIF v. Mize*, 129 Or App 636 (1994), in support of its contention that we should dismiss claimant's request for review as moot. In *Mize*, the carrier accepted the previously denied claim before it petitioned the court for review of our order finding the claim compensable. The court held that the controversy was moot because the claim had been accepted. *Mize*, 129 Or App at 640.

The "post-hearing" denial in this case differs fundamentally from the "post-review" acceptance in *Mize*. In *Mize*, the dispositive fact was claim *acceptance*: The acceptance ended the existing dispute, rendering it moot. There was nothing left to litigate in *Mize*, once the claim was accepted. Here, the second denial merely reasserted the existing controversy.[1] The insurer continued to dispute the compensability of claimant's condition after the second denial, so the second (duplicative) denial rendered nothing moot. *See William G. Rankin*, 47 Van Natta 975 (1995) (Where second denial was merely duplicative, no additional request for hearing was necessary to place the matter before the Referee, and the employer's motion to dismiss was denied); *Judy D. Fairchild*, 45 Van Natta 421, *aff'd mem* 124 Or App 681 (1993) (Where the second denial was surplusage, the claimant's failure to request a hearing from the latter duplicative denial did not bar her from litigating issues raised by both denials); *Jean M. Bates*, 43 Van Natta 2280, 2284 (1991), *aff'd mem* 115 Or App 757, *rev den* 315 Or 271 (1992).

The insurer also argues that this claim is precluded by claimant's failure to appeal its denial of claimant's "post-hearing" claim for the same condition. However, as we explained in our initial order, the unappealed second denial does not preclude the present litigation because there has been no *final determination* following a *prior* opportunity to litigate this claim. Under these circumstances, we do not dismiss claimant's request for review on "mootness" or claim preclusion grounds.

Compensability

The insurer argues that Dr. Harpole's opinion is insufficient to carry claimant's burden of proof primarily because claimant provided him with an exaggerated version of his work activities as a baker. Specifically, the insurer contends that we erred in finding that it does not matter that claimant told Dr. Harpole that he handled up to 1,000 bread pans per hour when he worked "tail off," while Dr. Button more accurately understood that claimant handled only 400 pans per hour in that position.

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[1] In *Mize*, by accepting the previously denied claim, the carrier effectively rescinded the very denial that was litigated in the case appealed to the court. Here, the insurer has not withdrawn the litigated denial. Furthermore, claimant has neither explicitly nor implicitly withdrawn its appeal of the ALJ's compensability decision that upheld the first denial.

We note at the outset that the insurer does not dispute the following summary of claimant's relevant work activities (as set out in our initial order):

Claimant worked as a baker for about 20 years before experiencing the onset of CTS symptoms. He worked in the "tail off" position for over a year--mostly in 1998, but also previously, in the "jobber" position. This job required repetitive gripping and lifting of pans loaded with bakery items. Claimant loaded trays with product and gripped and lifted loaded trays to place them on 7 foot racks with nine shelves. Loaded trays weighed between 10 and 20 pounds, depending on the product. Claimant placed 5-7 trays per minute onto the racks and he handled between 440 and 1000 trays per hour throughout his work day.

Considering these work activities, we continue to find that Dr. Harpole correctly understood that claimant's work activities required "a great deal of handling of bread pans" and "frequent firm gripping." (Exs. 7-2, 9-21). Thus, because claimant's bakery work *was* repetitive and hand intensive, we continue to conclude that Dr. Harpole's history was materially complete and accurate and his causation conclusion is consistent with that history. (*See e.g.* Ex. 9-10-11).[2]

We also note that Dr. Harpole considered and ruled out or discounted potentially contributory nonwork causes. (Exs. 7-2, 9-17-18). He acknowledged that claimant's obesity probably contributed to his CTS. However, considering the nature of claimant's job,[3] Dr. Harpole reasoned that the work activities (not his weight) were the major cause of the condition. (*Id*).

The insurer argues that we improperly discounted Dr. Button's opinion as internally inconsistent because the examiner only considered hand dominant/ usage-related CTS as a "hypothetical." However, Dr. Button stated that CTS is "seen far more frequently in the dominant vs. nondominant side. In this instance, this difference perhaps would relate to some anatomic variation within the carpal tunnel region. . ." (Ex. 5-5; *see* Exs. 10-7-8, -10-11). We see nothing "hypothetical" about Dr. Button's observation that CTS occurs more frequently on the dominant side. And we continue to find this observation at least potentially inconsistent with Dr. Button's premise that most CTS is "ideopathic." In addition, Dr. Button's conclusion does not follow logically from his premise in claimant's case because there is no evidence that claimant has any such left-sided anatomic variation. Moreover, Dr. Harpole explained that *he* has seen CTS greater on one side than the other, unrelated to hand dominance, so the fact that claimant's left hand has "slightly more involved" CTS does not "demonstrate anything." (Exs. 9-8-9; 6a-1). We find no reason in the record to prefer either doctor's observation about hand dominance and we need not resolve their disagreement: Claimant's work may or may not explain why his left CTS is "slightly more involved." In any event, the fact remains that claimant has *significant* bilateral CTS. (Ex. 6a-1). And we continue to find Dr. Harpole's opinion persuasive because it is well-reasoned, more internally consistent, and based on a materially accurate history.

Accordingly, our December 30, 1999 order is withdrawn. On reconsideration as supplemented herein, we adhere to and republish our December 30, 1999 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

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[2] The insurer asserts that Dr. Harpole acknowledged that the history he received from claimant was "in complete contradistinction to" the correct history. (*See* Ex. 6a-1). We read the above quotation differently, considering its context. *See Worldmark The Club v. Travis*, 161 Or App 644 (1999); *SAIF v. Strubel*, 161 Or App 516 (1999). Dr. Harpole discussed Dr. Button's examination report with claimant, including Dr. Button's description of claimant's job. Dr. Harpole opined that Dr. Button "significantly underplayed the patient's activities at work[,]" and quoted him stating that claimant initially had "no particular problem symptomwise" at work. (*Id*). Dr. Harpole then reported claimant's response that "most days" he gripped and lifted "up to 1,000" pans per hour for a year and a half; he finally changed jobs because of his symptoms; and the change did not help much. "In summary," Dr. Harpole concluded that claimant's "description of his job and history of symptoms is in complete contradistinction to Dr. Button's." (*Id*). Thus, Dr. Harpole disagreed with Dr. Button because the examiner "underplayed" claimant's symptoms and the *significance* of claimant's work activities, not because of the exact number of pans handled. Accordingly, we continue to find that Dr. Harpole's opinion is based on a materially accurate history: He correctly understood that claimant's work activities required "a great deal of handling of bread pans" and "frequent firm gripping." (Exs. 7-2, 9-21; *see* Ex. 9-10-11).

[3] Contrary to the insurer's contention, Dr. Harpole *was* aware that claimant's most recent work was not very repetitive. (*See* Ex. 7-1).

In the Matter of the Compensation of
KATIE J. OPDENWEYER, Claimant
WCB Case No. 98-08728
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that awarded claimant 8 percent (25.6 degrees) unscheduled permanent disability for her bilateral temporal mandibular joint dysfunction (TMJ) condition. On review, claimant contends that this matter should be remanded to the Director for promulgation of a temporary rule addressing her impairment. Claimant also seeks a penalty assessed against the Director for his refusal to promulgate a temporary rule following a remand from the ALJ. On review, the issues are whether this matter should be remanded to the Director for a temporary rule, and penalties.

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

In the Order on Reconsideration, the Director specifically found that claimant's disability was addressed by the standards. The Director noted that, although claimant had undergone multiple surgeries for her TMJ condition, such surgeries did not necessarily result in loss of function or earning capacity, and surgeries could improve a condition. The Director also found that, although the standards provided for an award for prosthetic replacements for joints in the lower extremities, a replacement in the jaw was distinguishable from such situations. (Ex. 49).

On review, claimant contends that the Director improperly declined to promulgate a temporary rule following a remand from the ALJ. In an interim order, the ALJ found that claimant's disability (stemming from her TMJ condition) was not addressed by the standards. Consequently, the ALJ remanded to the Department for a temporary rule.

Here, after reviewing the record and the ALJ's interim order, we conclude that remand was not appropriate. In *Terry Hockett*, 48 Van Natta 1297 (1996), we reversed an ALJ's order that remanded to the Director for a temporary rule for the claimant's hypersensitivity of the foot. We noted that, in the Order on Reconsideration, the Director had made an express finding that the worker's disability was adequately addressed by the standards. We also disagreed with the claimant's contention that, because other workers had been awarded impairment for cold sensitivity of the hands, that an award was appropriate in the claimant's case (which involved his foot). Finally, we found that the Director had identified several impairments, which were the basis of the claimant's award on reconsideration. *Hockett*, 48 Van Natta at 1288.

Similarly, in the present case, the Order on Reconsideration specifically states that claimant's disability was addressed by the standards. (Ex. 49-4). The order also addressed claimant's argument that other workers had been awarded impairment for prosthetic joint replacement (for example of the hip and knee) and found that the joints of the lower body had different functions than the jaw which affected digestion (with mastication) and speech. (Ex. 49-3). The order noted that the standards provided values for impairment due to chewing limitations, cranial nerve status and speech dysfunction. (Ex. 49-3). Moreover, in the present case, claimant was awarded an impairment value of 8 percent for impairment in mastication. (Ex. 49-3).

Under the circumstances, we conclude that the ALJ's interim decision to remand was not appropriate, as claimant failed to prove that the standards did not adequately address her disability. ORS 656.266; *Susan D. Wells*, 46 Van Natta 1127 (1994). Because the ALJ subsequently affirmed the Order on Reconsideration award, however, we affirm the ALJ's Opinion and Order.[1]

ORDER

The ALJ's order dated July 20, 1999 is affirmed.

[1] In light of this decision, claimant's penalty request is denied.

In the Matter of the Compensation of
EDWARD D. RIGGS, Claimant
Own Motion No. 99-0028M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Kirkpatrick & Zeitz, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's October 13, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from March 8, 1999 through September 27, 1999. The insurer declared claimant medically stationary as of September 27, 1999. Claimant seeks additional benefits, contending that he was not medically stationary when his claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that 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 13, 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).

Claimant's claim was accepted for right shoulder and cervical strains and right elbow lateral epicondylitis. On January 8, 1999, Dr. Puziss, claimant's attending physician, recommended that claimant undergo a right tennis elbow lateral release with epicondylectomy and extensor slide. The insurer recommended reopening of claimant's 1986 claim. On January 22, 1999, we issued our Own Motion Order which authorized reopening of claimant's 1986 claim for the provision of temporary disability compensation beginning the date claimant was hospitalized for surgery. Claimant underwent the recommended surgery on March 8, 1999.

In August 1999, Dr. Puziss noted that claimant had a possible internal derangement in his right wrist. He recommended that claimant undergo some diagnostic testing to his right wrist. In September 1999, Dr. Puziss requested authorization to proceed with a right wrist arthroscopic debridement. However, claimant's right wrist condition is not part of his compensable 1986 claim. Thus, regardless of whether he requires surgery for his right wrist, that matter is not relevant to whether he was medically stationary regarding the compensable conditions at the time the insurer closed his 1986 claim.

On September 27, 1999, claimant was examined by Dr. Courogen, an insurer-arranged medical examiner. Dr. Courogen noted that claimant's recovery from his elbow surgery had been slow but gradual. He opined that claimant's compensable condition "had stabilized as of June 4, 1999, and he [was] medically stationary at [that] time and no further treatment [was] indicated." Based on Dr. Courogen's report, the insurer closed claimant's claim on October 13, 1999.

Claimant has submitted several medical reports authored by his attending physician, Dr. Puziss. In a July 7, 1999 medical report, Dr. Puziss reported that claimant was objectively better although continued to have mild pain. He released claimant to light work and requested that he return in six weeks for a "possible final follow-up." In August 1999, Dr. Puziss reported that claimant was not working, but he had continued physical therapy and his strength was better. He noted that claimant still wore his tennis elbow band and exhibited a trigger point in that area. Dr. Puziss reiterated that claimant was capable of performing "very light work."

Dr. Puziss again saw claimant on September 17, 1999. He noted that claimant's elbow pain was improving and that he continued to wear his elbow brace. Dr. Puziss released claimant to work "regular duties four hours per day," and noted that this would increase with the passage of time. He scheduled claimant to return for a follow-up in six weeks.

In an October 29, 1999 medical report, Dr. Puziss disagreed with Dr. Courogen that claimant was medically stationary. Reasoning that claimant had shown material improvement over the past several months, Dr. Puziss observed that claimant was steadily increasing his work hours and his subjective complaints had improved. Under such circumstances, Dr. Puziss expected claimant to continue to increase his tolerance on-the-job and eventually be released to ten hours per day. Inasmuch

as claimant was increasing his hours and work tolerance, Dr. Puziss concluded that claimant was not medically stationary.

Dr. Puziss disagreed with Dr. Courogen's opinion that claimant was medically stationary in September 1999. Dr. Puziss reported that claimant had increased his work hours with continued medical treatment in the form of medications, icing his elbow and supplements. We interpret Dr. Puziss' observations to mean that with continued medical treatment, claimant would materially improve sufficient to increase his work hours. Dr. Puziss' October 29, 1999 report was based on a medical examination conducted on that date, just two weeks after the insurer closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between the October 13, 1999 claim closure and Dr. Puziss' October 29, 1999 examination (*i.e.* claimant's condition continued to materially improve with continued medical treatment), we conclude that Dr. Puziss' October 29, 1999 opinion addresses claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622, 625 (1987). (Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure).

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). In this case, we find no persuasive reason not to defer to the opinion of Dr. Puziss, claimant's long time treating physician. We do not find Dr. Courogen's opinion persuasive in that he had only examined claimant one time and his report is primarily focused on claimant's wrist complaints which are currently not a compensable part of his 1986 injury. In contrast, Dr. Puziss treated claimant before and after his condition worsened requiring surgery and had examined him prior to and subsequent to claim closure. Under such circumstances, we find Dr. Puziss' opinion to be more persuasive.

Dr. Puziss' reports establish that there was a reasonable expectation at the time of the October 13, 1999 claim closure that claimant's right elbow condition would continue to materially improve with further treatment and the passage of time. ORS 656.005(17). Therefore, we find that claimant's compensable right elbow condition was not medically stationary on October 13, 1999, the date of claim closure.

Accordingly, we set aside the Notice of Closure as premature. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT E. KILLION, Claimant
WCB Case No. 99-02409
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the SAIF Corporation's "de facto" partial denial of right shoulder adhesive capsulitis and impingement syndrome. On review, the issue is scope of acceptance.

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

The ALJ found that SAIF's acceptance of right shoulder strain and right rotator cuff tear reasonably apprised claimant and medical providers of the nature of his compensable conditions, including adhesive capsulitis and impingement syndrome under ORS 656.262(7)(a).[1]

Here, based on the medical evidence from claimant's treating physician, Dr. Lundsgaard, the issuance of acceptances of right shoulder adhesive capsulitis and right shoulder impingement would not "add anything to" claimant's claim from a medical standpoint. (Exs. 21; 23). Claimant argues that the acceptance does not reasonably apprise future medical providers of the nature of his claim. There is, however, no evidence to support claimant's contention. In addition, although claimant is unaware of the specific diagnoses for his compensable right shoulder condition, the statute does not require specific knowledge of the diagnoses. It merely requires that claimant be "reasonably apprised" of the nature of the compensable right shoulder injury. Based on this record, we are unable to conclude that the acceptance does not reasonably apprise claimant or medical providers of the nature of his compensable condition. Under such circumstances, we affirm the ALJ's order.

ORDER

The ALJ's order dated July 19, 1999, as reconsidered on September 2, 1999, is affirmed.

[1] The statute provides, in relevant part: "The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions."

In the Matter of the Compensation of
EVERY MENDENHALL, Claimant
WCB Case Nos. 99-06923 & 99-03672
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Cobb & Woodworth, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Poland's order that directed it to process claimant's new medical condition claims for L5-S1 and right antalgia conditions claims to closure and redetermine claimant's permanent disability. On review, the issue is claim processing.

We adopt and affirm the ALJ's order. *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 "post-closure" accepted "new medical conditions"). *John R. Graham*, 51 Van Natta 1740, 1745 (1999) (ORS 656.262(7)(c) requires claim reopening for a compensable "new medical condition claim, "without limiting the 'reopening' in any manner).[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 $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 8, 1999 is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by the insurer.

[1] *See also Johansen v. SAIF*, 158 Or App 672, 680-81 (1999) (ORS 656.262(7)(a) gives no indication of an intention to exclude the new medical condition claim from the processing requirements for claims generally that are provided in ORS 656.262 and ORS 656.268. . . .[A] new medical condition claim must be processed as any other claim[.]"

In the Matter of the Compensation of
GINNY D. WATERMAN, Claimant
WCB Case No. 98-07952
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the second full paragraph on page 2, we change the date in the fifth sentence to "November 1998." On page 4, we delete footnote 4.

We supplement the ALJs order to address SAIFs argument that claimant failed to prove that working conditions were the major contributing cause of her combined mental condition.

SAIF argues that claimant failed to meet the statutory requirements for compensability of the worsening of an occupational disease under ORS 656.802(2)(b). According to SAIF, claimant does not contend that she has a combined condition and, therefore, her claim must fail.

In reviewing the record of a workers' compensation claim, the Board's first task is to determine which provisions of the Workers' Compensation Law are applicable. *Dibrito v. SAIF*, 319 Or 244, 248 (1994). The Board has *de novo* review, which includes determining which law applies to the facts of a particular case. The Board applies the law as the record/evidence leads it. *See Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard Co. v. Renalds*, 132 Or App 288 (1995)).

To establish a compensable occupational disease, claimant must prove that her employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If 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 find that ORS 656.802(2)(b) applies to this case. Dr. Heck examined claimant on behalf of SAIF and diagnosed two preexisting conditions, a dysthmic disorder and personality disorder, not otherwise specified. (Exs. 13-22, -23). Dr. Henderson, claimants treating psychiatrist, agreed with Dr. Heck that claimant had a dysthmic disorder and an Axis II diagnosis of personality disorder, not otherwise specified. (Ex. 16-1). Dr. Henderson said that claimant had some preexisting/predisposing psychiatric conditions that would predispose her to being traumatized by the stressful work conditions she experienced. (*Id.*) There are no contrary medical opinions. Based on the reports from Drs. Heck and Henderson, we find that claimant's mental disorder 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).

The ALJ found that claimants work exposure was the major contributing cause of the pathological worsening of her mental disorder. Both Dr. Heck and Dr. Henderson concluded that claimants dysthmic disorder was pathologically worsened as a result of claimants work exposure. (Exs. 13-25, 16-1).

SAIF concedes that the medical reports indicated that claimant suffered a pathological worsening. SAIF argues, however, that claimant failed to prove that working conditions were the major contributing cause of her combined condition. SAIF relies on the opinion of Dr. Heck.

Dr. Heck concluded that the major contributing cause of claimants need for mental health treatment was a result of her personality make-up, which resulted in overreaction and overpersonalization of inherent conditions in the work place." (Ex. 13-25). He believed that claimant's symptoms derived primarily from an exacerbation of her preexisting dysthmic disorder and to some extent, her personality disorder. (*Id.*)

On the other hand, Dr. Henderson concluded that claimants work environment was the major contributing cause of her mental disorder. (Ex. 16-1). He said her mental disorder was caused by conditions other than those generally inherent in every working situation. (*Id.*)

In evaluating the medical evidence concerning causation, we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reason not to rely on Dr. Henderson's opinion. Unlike Dr. Heck, who examined claimant on one occasion, Dr. Henderson had an opportunity to meet with claimant on several occasions. Although SAIF argues that claimant did not give Dr. Henderson an in-depth understanding of her prior history, we agree with the ALJ that Dr. Henderson had the benefit of reviewing Dr. Heck's report, which included a detailed discussion of claimant's previous problems.

SAIF contends that Dr. Henderson's statement that claimant's working conditions were the "last straw" indicated that he did not properly weigh claimant's prior psychological condition. SAIF argues that Dr. Henderson mistakenly believed that a precipitating cause equals a major contributing cause.

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 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. *Id.*

Dr. Henderson acknowledged that claimant had some preexisting or predisposing psychiatric conditions that would predispose her to being traumatized by the stressful work conditions she experienced. (Ex. 16-1). He said claimant had functioned at a good level while working for the employer until she was stressed by two specific coworkers. (Ex. 16-2). Dr. Henderson explained: Her prior childhood life experiences made her more sensitized to their yelling and demeaning behavior. Hence, her pre-existing psychiatric condition would be a minor cause, and the last straw, so to speak, would be the working environment which was the major contributing cause of her above mental disorder. (*Id.*)

Dr. Henderson noted that claimant had done well psychiatrically since she was no longer exposed to those particular coworkers. (*Id.*)

When taken out of context, Dr. Henderson's reference to the "last straw" could indicate that he viewed the work incidents merely as precipitating events leading to claimant's mental disorder, rather than the major contributing cause of her disability or need for treatment. Nevertheless, we conclude that, when read as a whole, Dr. Henderson's report establishes that he properly evaluated the relative contribution of the various causes of claimant's mental disorder. He referred to claimant's preexisting/predisposing psychiatric conditions and explained the effect they had on claimant, but he specifically opined that the preexisting psychiatric condition was a "minor" cause, whereas claimant's employment conditions were the major contributing cause of her mental disorder. (Ex. 16-2). Neither Dr. Henderson nor Dr. Heck referred to any non-work-related stressors. Based on Dr. Henderson's opinion, we conclude that claimant's employment conditions were the major contributing cause of her combined condition and a pathological worsening of the disease. *See* 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 $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 30, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

In the Matter of the Compensation of
RICHARD R. YOREK, Claimant
Own Motion No. 99-0161M
OWN MOTION ORDER ON RECONSIDERATION

On July 28, 1999, we withdrew our June 28, 1999 Own Motion Order, which denied claimant's request for own motion relief on the ground that he was not in the work force at the time of his current worsening. We took this action to consider claimant's submission of documentation regarding his willingness to work. Having considered the self-insured employer's response and the parties' respective positions, 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.*

Claimant underwent surgery for his compensable low back condition on May 12, 1999. Thus, 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). Claimant has the burden of proof on this issue. 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).

Under the Board's own motion jurisdiction,[1] the "date of disability," for the purpose of determining whether claimant is in the work force is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to May 12, 1999, when he was hospitalized for 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).

Claimant was not working during the time prior to his May 1999 surgery. He contends that, although he was willing to work, he could not do so because of the compensable low back injury. Thus, claimant is arguing that he is in the work force under the third *Dawkins* criteria. In order to satisfy the third *Dawkins* criterion, claimant must establish both that: (1) he is willing to work; and (2) a work search is futile because of the work-related injury. Failure to prove either element results in a determination that claimant is not in the work force. Based on the following reasoning, we find that claimant has met his burden of proof.

First, we address the futility element. Previously, in a 1991 order, we affirmed a Referee's order that rescinded claimant's "permanently and totally disabled" status and found that claimant could return to sedentary work. *Richard R. Yorek*, 43 Van Natta 1401 (1991) (found claimant able to perform sedentary work both physically and vocationally).

On March 29, 1999, claimant underwent an insurer-arranged medical examination performed by Drs. Melson, neurologist, and Neumann, orthopedist. They noted that diagnostic studies indicated that claimant had lumbar spinal stenosis and claudication of the spinal cord. These changes were not present in the 1991 diagnostic studies of claimant's lumbar spine. As a result, Drs. Melson and Neumann opined that claimant's compensable low back condition had worsened requiring surgery. They further opined that as a result of his deteriorated condition, claimant was unable to perform any or all of his regular job duties. Finally, Drs. Melson and Neumann stated that claimant "has been disabled for many years."

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

We find that the unrebutted opinion of Drs. Melson and Neumann establishes that claimant's low back condition has worsened since it was determined by prior litigation that he could work in a sedentary capacity. In addition, read as a whole, we find that their opinion establishes that claimant was unable to work at the time of his current worsening and that it would have been futile for him to seek work due to the compensable condition.

Based on the following, we also find that claimant has established that he was willing to work. Despite his inability to work due to his compensable condition, claimant contends that he sought work at various places of business but was not hired because of his physical limitations. Claimant also contends that he has tried to "work at my chosen profession but could not succeed at doing for any length of time."

In support of his contentions, claimant submitted several documents on reconsideration. These include affidavits from several potential employers stating that claimant has applied for employment "numerous times over the past several years," but they did not have a position for him mainly due to his physical condition. Based on claimant's statements and submissions, we find that he has demonstrated his willingness to work.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning May 12, 1999, the date he was admitted to the hospital. 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
JOHN G. BACHMAN, SR., Claimant
WCB Case No. 99-01994
ORDER ON REVIEW
John C. DeWenter, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that increased claimant's unscheduled permanent disability award for a low back condition from 15 percent (48 degrees), as awarded by an Order on Reconsideration, to 24 percent (76.8 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury while performing his duties as a boiler operator. (Exs. 1, 3). An MRI showed an L4-5 disc herniation and Dr. Goodwin performed a left L4-5 diskectomy on March 27, 1998. (Exs. 2, 5). The insurer accepted an L4-5 disc herniation with left L5 radiculopathy. (Ex. 10).

A Physical Capacities Evaluation (PCE) performed on October 20, 1998 indicated claimant was capable of working at the "light-medium" category and he was restricted to occasional bending, squatting, kneeling and crawling. (Ex. 13). Dr. Goodwin, claimant's treating physician, concurred with the PCE. (Ex. 19).

A November 25, 1998 Notice of Closure awarded claimant, among other things, 15 percent (48 degrees) unscheduled permanent disability, based in part on his return to regular work. (Ex. 16). A February 25, 1999 Order on Reconsideration affirmed the Notice of Closure. (Ex. 20).

Claimant requested a hearing, arguing that social-vocational factors should be considered in determining impairment and contending that he was entitled to an award of 24 percent unscheduled permanent disability.

The ALJ found that claimant was not in fact released to return to all the duties of his at-injury job. The ALJ noted that the only evidence regarding claimant's duties as a boiler operator was the Dictionary of Occupational Titles, DOT # 950.382-010 (Ex. 22), which indicated the duties required "medium" strength. The ALJ reasoned that Dr. Goodwin's reference in his November 3, 1998 chart note to the fact that claimant could perform his regular job without difficulty was likely a reference that claimant was able to perform the duties of the job he had been doing since his return to work. The ALJ found no evidence that job was the same as claimant's at-injury job. The ALJ concluded that, absent evidence that claimant's at-injury job was a "light-medium" physical capacity job rather than a "medium" job, it must be concluded that Dr. Goodwin had not released claimant for regular work in the form of his at-injury job. The ALJ increased claimant's unscheduled permanent disability award to 24 percent.

The insurer argues that claimant's treating physician released him to "regular work" and claimant in fact returned to "regular work" and, therefore, impairment is the only factor to be considered in evaluating claimant's disability. For the following reasons, we agree with the insurer.

ORS 656.726(3)(f)(D) provides, in part:

> "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[.]"

Similarly, OAR 436-035-0270(3)(a) (WCD Admin. Order 98-055) provides that, in unscheduled claims, only impairment shall be rated for those workers who return to regular work. "'Regular work' means the job the worker held at the time of injury, or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-035-0005(17)(c).

Dr. Goodwin performed a left L4-5 diskectomy on March 27, 1998. (Ex. 5). On May 22, 1998 Dr. Goodwin imposed restrictions when he released claimant to return to work. (Ex. 8B). Dr. Goodwin explained:

> "I think he can return to his regular job. The only physical portion of his job involves shoveling about a half a pickup truck full of gravel for about 10 minutes each day. He uses a large scoop shovel for that but thinks he can get a smaller shovel. I have recommended that he do that." (*Id.*)

On June 19, 1998, Dr. Goodwin reported that claimant was "doing much better" and he released claimant from restrictions. (Ex. 9).

On September 17, 1998, Dr. Goodwin recommended a PCE for claimant's closing exam. (Ex. 12). A PCE performed on October 20, 1998 indicated claimant was capable of working at the "light-medium" category and he was restricted to occasional bending, squatting, kneeling and crawling. (Ex. 13). The therapist explained:

> "[Claimant] appears well suited for his present job as it fits into a LIGHT-MEDIUM category according to his description. It has the advantages of being self-paced and of not requiring constant or frequent lifting. I have not seen an official job description." (Ex. 13-1).

Dr. Goodwin concurred with the PCE. (Exs. 14, 19).

On November 3, 1998, Dr. Goodwin reported that claimant was "doing well" and had been "working regularly without missing a day at work." (Ex. 14). He had reviewed the PCE and said claimant's "physical capacities is [sic] rated at a light medium job and he is able to perform his regular job duties without difficulty." (*Id.*) Dr. Goodwin concluded that claimant was medically stationary and he was "released to his regular job without restriction." (*Id.*)

Although Dr. Goodwin had originally imposed work restrictions on May 22, 1998, he released claimant from those restrictions on June 19, 1998. (Exs. 8B, 9). In early November 1998, Dr. Goodwin reported that claimant was "doing well" and had been "working regularly" and was performing his regular duties without difficulty (Ex. 14). Based on Dr. Goodwin's reports, we find that claimant was released to "regular work" without any restrictions. There is no evidence in the record that there has

been a change in the job duties that claimant performed before his injury. *See, e.g., Diane C. Leonetti*, 50 Van Natta 2060 (1998) (the claimant remained capable of performing the same job she was doing at the time of injury); *Margaret M. Morgan*, 49 Van Natta 1934, *on recon*, 49 Van Natta 2072 (1997) (because the record did not establish there had been any change in job duties that the claimant had performed before injury, we found that the claimant had returned to "regular work").

Claimant contends that the best and most persuasive evidence of the physical requirements of his job at injury is DOT # 950.382-010, which showed a strength level of "medium." In *James I. Dorman*, 50 Van Natta 1649, *on recon* 50 Van Natta 1773 (1998), we found that, although the DOT description for "log truck driver" had a strength category of "medium," there was an absence of affirmative evidence showing that the DOT category accurately described the claimant's job at injury. We found that the claimant was performing the same truck driver job that he had performed at the time of injury, with the same duties, responsibilities, knowledge, skills and abilities. Under those circumstances, we concluded that the claimant had returned to "regular work."

We reach a similar conclusion in this case. There is no evidence in the record to support the ALJ's finding that claimant was not in fact released to return to all the duties of his at-injury job. To the contrary, Dr. Goodwin's reports establish that claimant returned to his regular work held at the time of injury. Under these circumstances, the only factor we rate is claimant's impairment. *See* ORS 656.726(3)(f)(D)(i). Consequently, we reinstate the February 25, 1999 Order on Reconsideration.

ORDER

The ALJ's order dated September 10, 1999 is reversed. The Order on Reconsideration award of 15 percent (48 degrees) unscheduled permanent disability is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

January 26, 2000 Cite as 52 Van Natta 101 (2000)

In the Matter of the Compensation of
JORGE L. BENAVIDES, Claimant
WCB Case No. 98-08336
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that: (1) upheld the insurer's denial of his left leg injury claim; and (2) declined to award penalties and attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability, penalties and attorney fees.

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

The ALJ upheld the insurer's denial, even though the only medical opinion on causation related claimant's treatment in October 1998 for a diagnosed left hamstring strain to an alleged incident of injury on June 9, 1998. The ALJ reasoned that the medical evidence was not persuasive because it was based on an inaccurate understanding of the June 1998 incident. Specifically, the ALJ noted that claimant testified that the June 1998 incident resulted in pain in the front and outside of the left thigh. Yet, when claimant finally sought treatment in October 1998, his symptoms were on the posterior portion of the thigh, resulting in a diagnosis of a hamstring strain. The ALJ observed that there was no discussion in the medical evidence to support a finding that the treating doctors were aware the alleged injury affected the front and outside portion of the thigh, rather than the posterior hamstring area.

On review, claimant contends that the ALJ incorrectly substituted her lay opinion for that of the medical experts. We disagree.

On multiple occasions, claimant testified that the June 1998 incident resulted in pain on the front and lateral aspect of the upper leg. (Trs. 16, 27, 39, 40, 47). Claimant further testified that, when he sought treatment in October 1998, his pain was in the same area. (Tr. 40). However, we agree with the

ALJ that the medical records indicate that claimant's symptoms were in a different area in October 1998, the posterior or hamstring area of the thigh. (Exs. 4, 6-2, 7-1). Given the discrepancy between claimant's testimony and the medical reports, we are unable to conclude that the physicians who examined claimant had an accurate understanding of the alleged June 1998 injury. *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).

Therefore, we find that the medical evidence does not satisfy claimant's burden of proving that the June 1998 incident materially resulted in claimant's need for treatment.[1] Accordingly, we affirm.[2]

ORDER

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

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[1] Given claimant's delay in seeking medical treatment, we find that expert medical evidence is required to establish medical causation. *See Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985), *rev den* 300 Or 546 (1986); *Jan M. Chrisman*, 48 Van Natta 2225, 2226 (1996).

[2] In light of our conclusion that the insurer's denial was proper, it follows that the denial was not unreasonably issued or maintained. Thus, we also reject claimant's request for a penalty.

In the Matter of the Compensation of
CAROLINE D. DAVIS, Claimant
WCB Case No. 99-01421
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that awarded 5 percent (16 degrees) unscheduled permanent disability for claimant's right shoulder muscle injury, whereas an Order on Reconsideration did not grant such an award. 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 the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant's compensable right rhomboid and trapezius strain claim was closed without permanent disability by a June 22, 1998 Determination Order. An Order on Reconsideration affirmed the Determination Order. Claimant requested a hearing, challenging the reconsideration order. The ALJ awarded 5 percent unscheduled permanent disability for a "chronic condition." The insurer contests this award.

A worker may be entitled to scheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a scheduled body part due to a chronic and permanent medical condition. OAR 436-035-0010(6). There must be medical evidence from which it can be concluded that claimant has at least a partial loss of ability to repetitively use the body part. *See Weckesser v. Jet Delivery Systems*, 132 Or App 325 (1995); *Donald E. Lowry*, 45 Van Natta 749, *on recon* 45 Van Natta 1452 (1993).

In rating claimant's permanent disability, we apply the "standards" set forth in WCD Administrative Order 97-072 (effective February 15, 1997), which were in effect at the time of the June 22, 1998 Determination Order. OAR 436-035-0003(2). Because a medical arbiter panel was used, claimant's impairment is determined by the arbiters except where a different level of impairment is established by a preponderance of medical opinion from the attending physician or other physicians with whom the attending physician concurs. ORS 656.245(2)(b)(B); ORS 656.268(7); *former* OAR 436-035-0007(12) and (13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).

Dr. Thomas, medical arbiter, opined that claimant had a partial loss of ability to repetitively use her left shoulder. Thomas based his opinion on claimant's statement that she experienced occasional, intermittent pain posteriorly in the right shoulder when she works overhead with her right arm. (Ex. 24-1, -2). On examination, Thomas found that claimant's right shoulder range of motion (ROM) findings were somewhat reduced; however, he also noted that the ROM findings in the uninjured left shoulder were the same as in the right shoulder. He also found that claimant had no loss of strength in any of the muscles of both shoulders. (Ex. 24). Nevertheless, neither Thomas nor any other physician recommended that claimant not repetitively use her right arm.

In contrast, Dr. Hamby, whose examination report was concurred in by Dr. Lisk, attending physician, opined that claimant had not sustained any permanent impairment as the result of the industrial injury. Hamby found claimant's bilateral ROM to be full in all planes of motion. He also found somewhat reduced ROM in the neck, but concluded that those findings were related to claimant's body habitus (5'7" and 238 pounds) and not her shoulder strain injury. He found no tenderness or spasm with palpation throughout the upper back. Finally, he noted that claimant had subjective pain symptoms, but no valid objective abnormalities, and concluded that those subjective pain symptoms were unrelated to her injury. (Ex. 11).

"Impairment" is established by a preponderance of medical evidence based on objective findings. ORS 656.726(3)(f)(B). In this regard, the arbiter's reliance on claimant's lay testimony alone regarding over-the-shoulder work is insufficient to establish impairment under the standards. *William K. Nesvold*, 43 Van Natta 2767, 2768 (1991); *see* OAR 436-35-005(5) (impairment defined as decrease in function as measured by a physician). Moreover, even if we were to infer that the arbiter's opinion suggests that claimant should avoid using her right arm to avoid shoulder symptomatology, such a suggestion is insufficient to support an impairment value for a chronic condition. *See Kathleen L. Hofrichter*, 45 Van Natta 2368 (1993), *aff'd mem* 129 Or App 304 (1994); *Rae L. Holzapfel*, 45 Van Natta 1748 (1993), *aff'd mem* 127 Or App 208 (1994). Accordingly, because the record here does not establish a repetitive use limitation other than the possible suggestion to avoid symptomatology, we conclude that claimant has not established entitlement to an unscheduled impairment value for a chronic right shoulder condition under the standards.

Accordingly, we rely on Dr. Hamby's complete and well-reasoned evaluation of claimant's injury-related impairment, with which attending physician Lisk concurred, to conclude that a different level of impairment has been established other than that found by the arbiter. Accordingly, we reverse the ALJ's order and reinstate the Order on Reconsideration.

ORDER

The ALJ's order dated August 19, 1999 is reversed. In lieu of the ALJ's award, the Order on Reconsideration is reinstated and affirmed in its entirety. The ALJ's "out-of-compensation" attorney fee is also reversed.

In the Matter of the Compensation of
ROBERT A. EDWARDS, Claimant
WCB Case No. 98-06984
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of his injury claim for a right ankle condition. On review, the issue is compensability.

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

We agree with the ALJ's reasoning and conclusion that Dr. Hansen's opinion is not sufficient to establish compensability of claimant's right ankle condition. We write only to address claimant's argument that Dr. Farris' opinion supports compensability.

Dr. Farris examined claimant on behalf of the employer and concluded that claimant's significant preexisting pathology in the right foot and ankle constituted the major contributing cause of claimant's need for treatment after the August 7, 1998 work incident. (Ex. 16-8). In a deposition, he adhered to his previous conclusions. (Ex. 24-12). After reviewing claimant's September 15, 1998 surgical report, Dr. Farris said that all of the procedures done in the operation were to reconstruct claimant's preexisting Charcot-Marie-Tooth condition and was not anything to do with the traumatic work event. (Ex. 24-12, 13).

Claimant argues that Dr. Farris said that claimant's work injury is the major cause when he was given the correct history. Claimant relies on the following portion of Dr. Farris deposition testimony:

If [claimant] had fallen off his truck or came down hard, really hard, and twisted his ankle or had a fracture or something, then I think I would probably indict the injury as the cause of his problem. (Ex. 24-15, -16).

The record does not support Dr. Farris hypothetical fact situation. Claimants 827 form said: After hooking up trailer, I stepped off truck backwards onto rocky ground. Twisting right ankle. (Ex. 5). At hearing, claimant said that was an accurate description. (Tr. 28). Claimant testified: [W]hen I stepped off the truck I felt -- my ankle snapped, like youd snap a joint in your finger. (Tr. 9). Claimant said his ankle was not painful at that time. (*Id.*) His foot did not become painful until he was back at home, about an hour after the incident. (Tr. 10). Claimant said the only thing different about stepping out of the truck on that occasion was that he stepped off onto a rock and felt a snap. (Tr. 9-10). Claimant agreed that he had not jumped off the step. (Tr. 26, 29). We are not persuaded that claimant fell off his truck or came down really hard while twisting his ankle on August 7, 1998. We do not agree with claimant that Dr. Farris' opinion supports compensability of the claim.

ORDER

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

In the Matter of the Compensation of
GENE A. HILBY, Claimant
WCB Case No. 99-03399
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that declined to award temporary disability compensation for the period beginning April 5, 1999. On review, the issue is temporary disability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated August 25, 1999 is affirmed.

Board Member Phillips Polich specially concurring.

Claimant compensably injured his left shoulder on August 26, 1998. He missed no work time for medical reasons before September 10, 1998, when the employer fired him citing "lack of productivity." Thereafter, claimant sought treatment for his shoulder and he was released to modified work. His injury claim was accepted as disabling.

Claimant's attending physician reviewed and approved a modified job. Then the employer informed claimant that he would have been offered the approved modified job if he had not been fired for unsatisfactory performance and his temporary disability benefits would be reduced as if he had been offered and accepted that job. On April 5, 1999, claimant's treating physician approved another analysis of the same job and the employer again notified claimant that he would have been offered the job if he had not been fired for unsatisfactory performance and his temporary disability would be reduced accordingly.

Claimant requested a hearing seeking temporary disability benefits for the period beginning April 5, 1999. He argued at hearing, and he argues on review that the employer did not comply with ORS 656.325(5)(b), because his employment was not "terminated for violation of work rules or other disciplinary reasons" within the meaning of ORS 656.325(5)(b).[1]

In adopting the ALJ's order, the majority concludes that claimant is not entitled to the temporary disability in question because "the *propriety* of claimant's termination, including whether the asserted 'lack of productivity' was due to the limitations resulting from his injury, is not within the purview of ORS 656.325(5)(b) specifically, or the Workers' Compensation Law in general."

I agree with the result in this case, because claimant has not come forward with evidence that he was fired for reasons related to his injury. This conclusion is consistent with Board cases indicating that it is the claimant's burden to show that he or she was terminated because of an inability to work due to the compensable injury in order to prove entitlement to temporary disability benefits after termination. *See Terri Link*, 47 Van Natta 1711 (1995) (Claimant not entitled to temporary disability because she did not "show that she was terminated because of an inability to work due to her compensable injury[.]); *compare Peggy J. Baker*, 49 Van Natta 40 (1997) (Claimant entitled to temporary disability, based on evidence that she was terminated "at least in part because of her inability to perform her regular work activity due to her compensable injury"--not because of violation of work rules or other disciplinary reasons).

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

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

But ORS Chapter 656 *requires* employers to provide injured workers with modified work or pay temporary disability benefits, so long as the worker's inability to perform regular work is injury related (with certain exceptions not relevant here). And ORS Chapter 659 specifically prohibits firing a worker because he or she is injured. *See* ORS 659.410; 659.415; 659.420. Accordingly, although I agree with the ALJ and the majority that the propriety of a worker's termination is not *generally* within the purview of workers' compensation law,[2] I write separately to express my concern that injured workers *are* often fired because they are injured. Because such firings often occur under the rubric of "lack of productivity," I believe the Board has a duty to inquire whether the worker's diminished productivity is, in fact, injury-related in these cases.[3] In other words, where the employer alleges lack of productivity as a basis for firing, I believe the burden of proof should then shift to the employer and the employer should be required to prove that the claimant's lack of productivity and firing were, in fact, *not* injury related. Nonetheless, because I am bound by the Board's precedent (*Terri Link, supra*), I reluctantly concur in the result in this case.

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[2] *Legality* of firing is not a workers' compensation issue. But the *cause* of the firing *is* a workers' compensation issue whenever the firing is injury-related.

[3] Such evidence is not be readily available to fired injured workers, because employers are not presently required to explain a firing beyond what it takes to satisfy "violation of work rules or other disciplinary reasons." *See* ORS 656.325(5)(b); *Glenn E. Hall*, 48 Van Natta 1452, 1453 n.2 (1996).

January 26, 2000 Cite as 52 Van Natta 106 (2000)

In the Matter of the Compensation of
REBECCA S. MUNDELL, Claimant
WCB Case No. 99-03761
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) found that claimant's injury claim was not prematurely closed; (2) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for her right thigh contusion, nasal contusion, cervical strain, and mild closed head injury conditions; and (3) denied claimant's request to remand to the Director for promulgation of a temporary rule. On review, the issues are premature closure, extent of unscheduled permanent disability, and remand for a temporary rule.

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

Claimant argues that the ALJ should have granted her an award of unscheduled permanent disability for valid reductions in cervical range of motion identified by the medical arbiter panel. (Ex. 10-3). However, the arbiters characterized claimant's range of motion in her cervical spine as "normal for this individual." (*Id.*) We agree with the ALJ that this comment by the arbiters precludes an award of permanent disability because it fails to relate the decreased range of motion to the compensable injury.

ORDER

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

In the Matter of the Compensation of
DOUGLAS D. POWER, Claimant
WCB Case No. 99-02694
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that awarded no scheduled permanent disability for loss of use or function of the left knee. With his request for review, claimant has attached several documents not presented at hearing. We treat this submission as a motion for remand. On review, the issues are remand and extent of scheduled permanent partial disability.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's submission of additional documents.

Claimant has included several medical documents with his request for review that were not admitted at hearing. Because the Board is without authority to admit such evidence, we treat this submission of additional documentary evidence as a motion to remand the case to the ALJ for admission of the documents. *See Darwin K. Saunders*, 50 Van Natta 934 (1998). For the following reasons, we deny remand.

We may remand to the ALJ only if we find 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 other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). 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. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Initially, we note that claimant's appended medical records, with the exception of Dr. Fox's December 7, 1998 report, do not appear to have been part of the reconsideration record, and therefore cannot be considered on the issue of extent of permanent disability. (Ex. 23). ORS 656.268(7)(g); 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); *Brent Harper*, 51 Van Natta 1002 (1999).

Because the evidence would not be admissible at hearing, there is no compelling reason to remand this matter to the ALJ for further proceedings. The consideration of these documents would not affect the outcome of this case. *Compton v. Weyerhaeuser*, 301 Or at 646. Consequently, we decline to remand this matter to the ALJ.[1]

ORDER

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

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[1] The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board cannot extend advice to the parties. Nonetheless, the Board notes that claimant is unrepresented. Under such circumstances, if he has further questions, he 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
CRAIG J. PRINCE, Claimant
WCB Case No. 99-0186
OWN MOTION ORDER ON RECONSIDERATION (POSTPONING ACTION)
Scott M. McNutt, Sr., Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our June 21, 1999 Own Motion Order, which authorized the insurer to reopen his March 20, 1991 injury claim for the payment of temporary total disability compensation beginning June 30, 1998, the date he was hospitalized for surgery. Specifically, citing *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579 (1999), claimant contends that his claim is subject to the processing requirements of ORS 656.262 and 656.268 and requests that we remand the claim to the insurer for processing under those statutes.

In order to allow sufficient time to consider claimant's motion for reconsideration and to allow the insurer an opportunity to respond, we abated our order on July 8, 1999. Having received the insurer's response, we proceed with our reconsideration.

FINDINGS OF FACT[1]

On March 20, 1991, claimant compensably injured his low back while working for the insured. The day after that injury, claimant sought medical treatment for low back pain and his injury was diagnosed as an acute lumbar strain. The insurer accepted the injury claim as a disabling lumbar strain. On May 6, 1991, the insurer closed the claim with no award of permanent disability compensation. Claimant's aggravation rights expired five years later, on May 6, 1996.

Claimant continued his regular work with the insured. His low back pain continued and gradually worsened. By February 21, 1998, he had begun to experience mild, intermittent radicular symptoms. A May 1998 MRI of claimant's low back showed significant L4-5 and L5-S1 degenerative disc disease/spondylosis. On June 30, 1998, claimant underwent laminectomies, discectomies, and foraminotomies at L4-5 and L5-S1 and an L4 to S1 fusion.

By letter dated October 22, 1998, claimant requested that the insurer expand the accepted conditions regarding the March 20, 1991 work injury to include "degenerative and herniated disc disease at L4-5 and L5-S1."[2]

On November 19, 1998, the insurer issued a partial denial denying claimant's L4-5 and L5-S1 degenerative disc disease and disc herniations. Claimant requested a hearing on that denial.

On April 14, 1999, ALJ Howell issued an order that set aside the insurer's partial denial of claimant's L4-5 and L5-S1 degenerative disc disease/spondylosis condition and remanded the claim to the insurer for acceptance and payment of compensation due. That order was not appealed and became final by operation of law.

On May 5, 1999, the insurer submitted a "Carrier's Own Motion Recommendation" form that recommended that claimant's March 20, 1991 low back injury claim be reopened. On this form, the insurer noted that claimant's "accepted" condition regarding the 1991 injury was "lumbar strain" and his current condition was "degenerative disc disease/spondylosis [at] L4-5 & L5-S1."

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[1] With its Own Motion Recommendation Form, the insurer submitted a copy of Administrative Law Judge (ALJ) Howell's April 14, 1999 Opinion and Order that set aside the insurer's partial denial of claimant's L4-5 and L5-S1 degenerative disc disease/spondylosis conditions. We take our "Findings of Fact" primarily from ALJ Howell's order, which was not appealed and has become final by operation of law. *See Groshong v. Montgomery Ward Co.*, 73 Or App 103 (1985) (Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned," which includes agency orders).

[2] We make this finding based on the parties' briefs to the Board regarding the reconsideration request currently before us. Both briefs refer to claimant's attorney's October 22, 1998 letter that requested that the insurer expand/amend its acceptance to include these conditions.

By Own Motion Order dated June 21, 1999, we authorized the reopening of claimant's March 20, 1991 injury claim to provide temporary total disability compensation beginning June 30, 1998, the date claimant was hospitalized for surgery. We also ordered the insurer to close the claim under OAR 438-012-0055 when claimant was medically stationary.

On July 2, 1999, claimant requested reconsideration of our June 21, 1999 Own Motion Order. Specifically, claimant contended that the insurer was required to process the claim under ORS 656.262 to closure, including closure under ORS 656.268. On July 8, 1999, we abated our order and allowed the insurer an opportunity to respond to claimant's motion for reconsideration.

CONCLUSIONS OF LAW AND OPINION

The Board, in its Own Motion jurisdiction, may authorize monetary benefits in the form of temporary disability benefits from the time a worker is hospitalized or undergoes surgery for a worsening of a compensable injury until the worker becomes medically stationary. ORS 656.278(1)(a).[3] On the other hand, 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."[4]

In *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), we addressed the applicability of ORS 656.262(7)(c) to a "new medical condition" claim made after the expiration of a claimant's aggravation rights. In *Graham*, 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. The claimant then requested that those new conditions be rated and closed under ORS 656.268. Litigation followed after the carrier took no action on that request.

Following a hearing, an ALJ found that: (1) the claimant's claim was in Own Motion status; and (2) the issue of entitlement to permanent disability was not yet ripe. The ALJ remanded the newly accepted medical condition claims to the carrier for reopening and processing as provided by law. That order was not appealed and became final by operation of law. Thereafter, the carrier submitted an Own Motion recommendation that opposed reopening the claim, in part, because no surgery or hospitalization had been requested. The carrier also requested that the Board authorize it to "reclose" the claim without any additional awards of compensation.

In response to the carrier's request, the Board issued an Own Motion Order that found that the claim did not qualify for reopening under ORS 656.278 because the claimant did not require surgery or hospitalization. *John R. Graham*, 50 Van Natta 1508 (1998). We also noted that we could not "authorize" the "closure" of a claim that had not been reopened under ORS 656.278. *Id.* at 1508 fn 1. That order was not appealed and became final by operation of law.

Thereafter, the claimant in *Graham* requested a hearing raising, *inter alia*, the issue of failure to close his claim. Following a hearing, an ALJ remanded the new medical condition claims to the carrier for reopening and processing to closure, including a determination of the claimant's permanent disability with respect to the new medical condition claims. The carrier requested Board review of the ALJ's "enforcement" order.

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[3] ORS 656.278 provides, in relevant part:

"(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] 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 the meantime, the carrier issued an Own Motion Notice of Closure that stated that it closed the newly accepted medical conditions and awarded no temporary or permanent disability. The claimant requested that the Board in its Own Motion jurisdiction review the carrier's Own Motion Notice of Closure.

As a result of the parties' requests in *Graham*, we issued two separate, but related orders, one in our "regular" review capacity and another in our "Own Motion" capacity. In our "regular" review capacity, after reviewing the text, context, and legislative history of ORS 656.262(7)(c), and the court's decisions in *Johansen* and *Labor Ready, Inc. v. Mann*, 158 Or App 666 (1999),[5] 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. 51 Van Natta at 1744.

In reaching this determination, we explained that the legislature provided different processing procedures for the various types of claims, including initial claims, ORS 656.262 and 656.268, aggravation claims, ORS 656.273, Own Motion claims, ORS 656.278, and new medical condition claims, ORS 656.262, 656.268, and 656.262(7). But we further reasoned that the legislature did not provide for any exceptions regarding new medical condition claims where the initial claim is in Own Motion status. Therefore, we determined that the procedure for new medical condition claims includes claims where the original claim is in Own Motion status. 51 Van Natta at 1744. Likewise, we concluded that benefits for a new medical condition claim accepted after closure and reopened under ORS 656.262(7)(c) must be provided under ORS 656.262 and ORS 656.268. Accordingly, we agreed with the ALJ that the claimant's new medical condition claims should be remanded for reopening under ORS 656.262(7)(c) and processing to closure under ORS 656.268. 51 Van Natta at 1745.

In a separate order in our Own Motion jurisdiction, we addressed the claimant's request for review of the carrier's Own Motion Notice of Closure that purported to close his new medical condition claim with an award of zero temporary disability compensation. 51 Van Natta at 1746. Inasmuch as we had issued a separate order in our "regular" jurisdiction directing the carrier to close the claimant's new medical condition claim under ORS 656.268, we reasoned that the claim should not be closed under ORS 656.278. We also relied on our prior Own Motion Order that held that the initial claim did not qualify for reopening under ORS 656.278. Consequently, we held the carrier's Own Motion Notice of Closure did not "close" any "reopened" own motion claim and, thus, the closure was a nullity. 51 Van Natta at 1747. Accordingly, we set aside the Own Motion Notice of Closure.

To summarize, in *Graham*, we found that a "new medical condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the original claim is in the Board's Own Motion jurisdiction.

Here, claimant's aggravation rights have expired on his March 1991 claim and he was hospitalized for surgery regarding that claim. Thus, under his 1991 strain injury claim, claimant is entitled to have his claim reopened under ORS 656.278 for the payment of temporary total disability compensation beginning the date of his hospitalization. Claimant contends, however, that he is entitled to have his claim reopened under ORS 656.262 on the basis that his L4-5 and L5-S1 disc conditions are subject to ORS 656.262(7)(c). On the other hand, the employer contends that claimant's benefits are limited to those available under ORS 656.278.

Pursuant to the reasoning in *Graham*, it may be appropriate for claimant's claim to be processed pursuant to ORS 656.262(7)(c). But the question remains whether the Board, in its "Own Motion" capacity under ORS 656.278, has the authority to direct a carrier to process a claim under ORS 656.262(7)(c). Based on the following reasoning, we find that we do not have such authority.

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

Our authority in our "Own Motion" capacity is strictly limited by the provisions of ORS 656.278 and those provisions do not include the authority to direct processing under ORS 656.262(7)(c). However, claimant is not without a remedy in this situation. In this regard, the issue of whether the claim should be processed under ORS 656.262(7)(c) is a "matter concerning a claim" and, under ORS 656.283, any party "may at any time request a hearing on any matter concerning a claim," with certain exceptions not applicable here. In addition, our Own Motion rules provide for circumstances in which matters normally within our "Own Motion" authority interrelate with matters within the authority of other levels of the workers' compensation system, *e.g.*, claims for own motion relief that involve medical service disputes within the Director's jurisdiction and/or compensability disputes within the Hearings Division's jurisdiction. *See* OAR 438-012-0050.

Specifically, OAR 438-012-0050 provides that the Board will act promptly upon a request for relief under the provisions of ORS 656.278 and our rules unless: (1) the claimant has available administrative remedies under the provisions of ORS 656.273; (2) the claimant's condition is the subject of a contested case under ORS 656.283 to 656.298, ORS 656.307 or ORS 656.308; or (3) the claimant's request for payment of temporary disability compensation is based on surgery or hospitalization that is the subject of a Director's medical review under ORS 656.245, 656.260, 656.327. Under any of those circumstances, the Board may postpone its review of the merits of claimant's request for Own Motion relief if the available remedies set forth above could affect the Board's authority to award compensation under the provisions of ORS 656.278. That is the case here.

In light of our decision in *Graham*, we treat claimant's request that his claim be processed under ORS 656.262(7)(c) 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. WCB Case No. 00-00561. We postpone action on claimant's request for Own Motion relief pending resolution of this related litigation.

At the hearing, the Administrative Law Judge (ALJ) assigned to conduct the hearing shall resolve the claim processing issue raised by claimant's contention (as well as any other issues properly raised by the parties). In addition, the assigned ALJ shall make findings of fact and conclusions of law and opinion regarding the effect of his or her decision on this claim processing matter on claimant's Own Motion claim.

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to this Own Motion matter and a copy of the appealable order issued in WCB Case No. 00-00561. In addition, if the matter is resolved by stipulation, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding Own Motion relief.

Accordingly, we withdraw our June 21, 1999 Own Motion Order. Further action on this case shall be postponed pending resolution of the dispute pending before the Hearings Division.

IT IS SO ORDERED.

In the Matter of the Compensation of
TIMOTHY R. SOWELL, Claimant
WCB Case No. 99-03285
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Randy Rice, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside an Order on Reconsideration as premature. On review, the issues are premature closure and, if the Order on Reconsideration is reinstated, the extent of unscheduled permanent disability. We reverse the ALJ's premature closure finding and affirm the Order on Reconsideration.

FINDINGS OF FACT

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

In January 1998, claimant filed a low back injury claim. (Ex. 13). On April 15, 1998, Dr. Peterson performed a diskectomy at level L5-S1, as well as decompressing the L4, L5, and S1 nerve roots. (Ex. 24, 25). On November 9, 1998, Dr. Peterson performed a closing examination concluding that claimant was medically stationary as of October 5, 1998. (Ex. 42-2, 42-3). On December 31, 1998, the employer accepted claimant's low back injury claim for a L5-S1 disc herniation. (Ex. 46). Also on December 31, 1998, the employer denied claimant's current lower back condition, including the L4-5 disc condition. (Ex. 47).

On January 4, 1999, the employer issued a Notice of Closure closing the claim for the L5-S1 herniated disc. (Ex. 51). Claimant was awarded 12 percent unscheduled permanent disability. (Ex 50).

Claimant requested reconsideration. On March 31, 1999, an Order on Reconsideration affirmed the January 4, 1999 Notice of Closure in its entirety. (Ex. 63).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the accepted low back injury claim was prematurely closed. In doing so, the ALJ reasoned that Dr. Peterson's opinion as to claimant's medical stability was inconsistent and, therefore, not persuasive. Additionally, the ALJ considered both claimant's accepted L5-S1 disc herniation and his unaccepted L4-5 condition in finding claimant was not medically stationary when the Notice of Closure issued on January 4, 1999.

On review, the employer contends that the claim was properly closed. Specifically, assuming that the only accepted condition at closure was claimant's L5-S1 disc herniation, the employer argues that the accepted condition was medically stationary when the January 4, 1999 Notice of Closure issued. We agree with the employer's contention and reverse.

"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). Deference should be given to claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983); *Georgia Barklow*, 49 Van Natta 1261 (1997). 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, Dr. Peterson, claimant's treating orthopedist, declared claimant's L5-S1 disc condition medically stationary as of October 5, 1998.[1] (Ex. 42). Dr. Peterson had the opportunity to examine

[1] We note that there is a dispute as how Dr. Peterson arrived at this date and that Dr. Peterson did not examine claimant on October 5, 1998. However, the exact date is immaterial because Dr. Peterson noted that claimant was medically stationary on November 9, 1998, when he performed his closing examination. Because either date preceded the issuance of the January 4, 1999 Notice of Closure, the medical evidence supports the conclusion that claimant's accepted L5-S1 disc herniation was medically stationary at claim closure.

claimant several times over the course of claimant's treatment. (Ex. 17, 21, 22, 24, 27, 28, 31, 33, 39, 42). During his treatment of claimant, Dr. Peterson noted that he believed only the L5-S1 disc was involved in claimant's January 1998 work injury. (Ex. 33, 42). Dr. Peterson's closing examination specifically notes that the July 13, 1998 MRI showed resolution of the disc herniation at L5-S1. Therefore, it is reasonable to conclude that when Dr. Peterson declared claimant medically stationary as of October 5, 1998, he was referring to claimant's L5-S1 disc condition. Additionally, there is no other medical evidence presented in the record showing claimant's L5-S1 disc condition was not medically stationary on October 5, 1998 or at claim closure on January 4, 1999. Therefore, we find no persuasive reason to discount Dr. Peterson's medical opinion as to the stability of claimant's L5-S1 disc condition.

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). 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. *Nancy L. Sabin*, 51 Van Natta 2035 (1999); *James L. Mack*, 50 Van Natta 338 (1998). Moreover, if a condition is subsequently found compensable, the proper procedure to follow is the reopening the claim for processing of the new condition. *See Nancy L. Sabin*, 51 Van Natta at 2036 (1999); *Michael C. Reddin*, 50 Van Natta 1396 (1998).

Here, there was only one condition accepted at the time of claim closure, that of the L5-S1 disc condition.[2] Additionally, we defer to Dr. Peterson's finding that claimant was medically stationary as of October 5, 1998. Inasmuch as Dr. Peterson's opinion concerns only the accepted L5-S1 condition, the claim was not prematurely closed on January 4, 1999.[3]

Accordingly, we conclude that at the time of the January 4, 1999 claim closure, no further material improvement for the accepted L5-S1 disc condition was reasonably expected from either medical treatment or the passage of time. Thus, claimant failed to establish he was not medically stationary on the date of closure. We reinstate the Order on Reconsideration and Notice of Closure.

Extent of Unscheduled 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 of unscheduled permanent partial disability (PPD). Since we find the record sufficiently developed to resolve the PPD issue, we proceed with our review.

Claimant has the burden to prove the extent of disability resulting from his compensable injury. ORS 656.266. Claimant was awarded 12 percent PPD based on an allowance of 9 percent for surgery, 1 percent for age, 1 percent for work experience, and 1 percent for education. (Ex. 50, 63). Claimant asserted at hearing that he was entitled to increased PPD award.[4] (Closing Argument, p 3-10). Claimant bases this assertion on the premise that his award of PPD should have rated him for all of the disabilities he had at the time of the evaluation, including those disabilities from any unaccepted conditions. (Closing Argument p. 4). We disagree.

Claimant is only entitled to have those disabilities arising from an accepted condition rated in a determination of PPD. ORS 656.214(5); *Robin V. Spivey*, 48 Van Natta 2363 (1996). We have reviewed the record and find that claimant's PPD for his accepted condition was properly rated. Therefore, claimant has not established that he is entitled to an increased PPD award.

ORDER

The ALJ's order dated August 23, 1999 is reversed. The January 4, 1999 Determination Order and the March 31, 1999 Order on Reconsideration are reinstated and affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

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[2] The issue of whether the unaccepted L4-5 disc condition was medically stationary at the time of claim closure is irrelevant to the determination of whether the claim was prematurely closed.

[3] Based on our finding that claimant was medically stationary at the time of claim closure, we find OAR 436-030-0034(4)(a) inapplicable in that this rule only applies if the claimant is not medically stationary.

[4] On review, claimant does not assert any argument requesting an increase of his award of PPD.

In the Matter of the Compensation of
CARL E. VOLNER, Claimant
WCB Case Nos. 99-04224 & 98-09470
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) upheld the insurer's denial of his aggravation claim for his cervical disc condition; (2) upheld the insurer's denial of his occupational disease claim for his C5-6 disc herniation; and (3) declined to assess penalties for allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

On review, claimant first argues that the ALJ incorrectly found there was no definitive medical evidence of an actual worsening of the previously accepted cervical strain condition. We disagree.

To establish a compensable aggravation claim, claimant must establish causation between the compensable injury and his current condition and an "actual worsening" of the compensable injury. ORS 656.273(1). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Audrey Keeland,* 50 Van Natta 2041 (1998); *Gloria T. Olson,* 47 Van Natta 2348 (1995). If the evidence indicates claimant suffers from a preexisting condition that has combined with his compensable injury, claimant must show that the compensable injury is the major contributing cause of his current need for treatment for his combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl,* 148 Or App 101 *recon* 149 Or App 309 (1997) *rev den* 326 Or 389(1998). Once compensability is established, an "actual worsening" of the compensable injury may be established by direct medical evidence of a pathological worsening or, for a symptomatic worsening to constitute an actual worsening, a medical expert must conclude that the symptoms have increased to the point that it can be said that the injury has worsened. *SAIF v. Walker,* 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997).

We first must determine whether claimant's current C5-6 disc herniation is a compensable condition. Since the evidence indicates that claimant's preexisting cervical degenerative condition combined with his 1996 compensable cervical strain injury, claimant must prove that the 1996 compensable injury was the major contributing cause of the need for treatment of his C5-6 disc herniation.

Claimant relies on the medical opinion from Dr. Miller for support. (Ex. 12, 13, 18-2). However, Dr. Miller changed his medical opinion regarding the major contributing cause of claimant's current need for treatment. Dr. Miller's current medical opinion is that claimant's work exposure over the last 4-5 years is the "most significant cause" of claimant's current need for treatment. (Ex. 18-2, 18-3, 22-1, 22-2). Additionally, all other medical opinions in the record concerning claimant's aggravation claim, including all four physicians that conducted insurer-arranged medical examinations, conclude that claimant's 1996 compensable injury is not the major contributing cause of claimant's current need for medical treatment. (Ex. 14, 19, 20). Therefore, the medical evidence does not support the compensability of claimant's aggravation claim and we agree with the ALJ that claimant's aggravation claim was properly denied.

Next, we address claimant's argument that the ALJ incorrectly found that claimant had not proven that work exposure was the major contributing cause of the combined condition of his C5-6 disc herniation and the pathological worsening of his degenerative cervical disc disease (DDD). We disagree.

If an occupational disease claim is based on the worsening of a preexisting condition pursuant to ORS 656.005(7), claimant must prove that the employment conditions are the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). The existence of the worsening of the preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2)(d).

Additionally, where compensability involves a complex medical question, we must rely on expert medical opinion. *Uris v. Compensation Department,* 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.,* 76 Or App 105 (1985); *Barnett v. SAIF,* 122 Or App 281 (1993). The expert medical opinion must evaluate the relative contribution of each cause. *Dietz v. Ramuda,* 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). Where there is a division of experts, we rely on those opinions that are most well-reasoned and based on complete information. *Somers v. SAIF,* 77 Or App 259 (1986).

Claimant argues that Dr. Miller's opinion, finding claimant's work activities the major contributing cause of claimant's worsening DDD, should be given deference as claimant's treating physician. We give deference to the medical opinions of the claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF,* 64 Or App 810 (1983). Here, we find persuasive reasons to do otherwise.

First, deference is given to the treating physician because generally the treating physician had a much better opportunity to evaluate the claimant over several examinations and has a more complete history of the claimant. *Weiland v. SAIF,* 64 Or App at 813. However, as noted by the ALJ, Dr. Miller has examined claimant only once.

Dr. Miller's opinion also does not adequately weigh the relative contribution of each cause. Dr. Miller summarily dismisses the possibility that claimant's preexisting condition could have significantly contributed to his current condition. Dr. Miller states, "whatever he had was certainly not symptomatic and, therefore, I think his employment * * * is the predominate cause..." (Ex. 18-2). Again, Dr. Miller offers no explanation as to his opinion beyond "it is probably the cumulative use with wear and tear on his disk is going to be the most significant cause." (Ex. 18-2). While Dr. Miller repeatedly expresses the opinion that claimant's current condition is caused by his work activities, no where in the record does it show that Dr. Miller has a clear idea of claimant's work activities.

Dr. Miller also changed his opinion on the major contributing cause of claimant's current condition. Dr. Miller's original opinion was that claimant's current condition was an aggravation of his 1996 accepted cervical sprain condition. He later stated that claimant's work activities were the major contributing cause to claimant's current condition. Dr. Miller provides no explanation for changing his opinion. Therefore, we agree with the ALJ that Dr. Miller's opinion is not persuasive.

In contrast, Dr. Denekas and Dr. Arbeene, insurer-arranged medical examiners, and Dr. Young, a radiologist, provide well-reasoned and complete medical reports. All three physicians expressed the opinion that the natural progression of claimant's DDD, not his work activities, was the major contributing cause of claimant's current condition.

Accordingly, we agree with the ALJ that claimant's occupational disease claim for the C5-6 disc herniation is not compensable.

In light of our conclusions upholding denials of claimant's claims for aggravation and occupational disease, there are no amounts then due on which to assess a penalty, and there has been no unreasonable resistance to the payment of compensation giving rise to an attorney fee. ORS 656.262(11)(a), 656.382(1). For this reason, we affirm the ALJ's ultimate decision that claimant is not entitled to penalties and/or attorney fees for the insurer's allegedly unreasonable claim processing.

ORDER

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

In the Matter of the Compensation of
JEFF A. VOSBURG, Claimant
WCB Case No. 99-03164
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that increased claimant's scheduled permanent disability award for loss of use or function of his left leg (knee) from 2 percent (3 degrees), as awarded by an Order on Reconsideration, to 7 percent (10.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last paragraph of the findings of fact on page 2.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his left knee on February 19, 1998. The insurer accepted a torn anterior cruciate ligament, left knee. (Exs. 5, 11). On April 17, 1998, Dr. Jones performed anterior cruciate reconstruction. (Ex. 9).

A December 29, 1998 Notice of Closure, which was modified on January 5, 1999, did not award any permanent disability. (Exs. 15, 16). Claimant requested reconsideration. (Exs. 17, 18). Dr. Filarski performed a medical arbiter examination on March 12, 1999. (Ex. 20). An April 1, 1999 Order on Reconsideration awarded 2 percent (3 degrees) scheduled permanent disability award for loss of use or function of claimant's left leg (knee). (Ex. 21). Claimant requested a hearing.

The ALJ relied on Dr. Filarski's report to conclude that claimant was entitled to an additional 5 percent "chronic condition" award for his left knee, for a total scheduled permanent disability award of 7 percent.

The insurer relies on the opinion of claimant's treating physician, Dr. Jones, to argue that claimant has failed to prove that he has a chronic condition that permanently and significantly limits the repetitive use of his left knee.

Under OAR 436-035-0010(5) (WCD Admin. Order 98-055), claimant 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 his left lower leg (below knee/foot/ankle) or his left upper leg (knee and above). (Emphasis supplied).

On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14). 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). The Board will 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).

Dr. Jones performed claimant's anterior cruciate reconstruction on April 17, 1998. (Ex. 9). On May 19, 1998, Dr. Jones reported that claimant was having no pain and could return to sedentary work. (Ex. 12). On August 18, 1998, Dr. Jones said claimant had no discomfort and was "able to kneel, squat, turn and twist but realizes he should not do this on an extended basis." (Ex. 12-2). He noted that claimant was currently doing steel fabrication, but was not doing heavy lifting. (*Id.*)

On December 4, 1998, Dr. Jones found claimant was medically stationary and noted claimant had been "very aggressive in both rehabing and returning to work." (Ex. 13). Dr. Jones explained:

> "[Claimant] states that he is having no problems with his knee. He has an occasional ache, but that is very minimal. He has noted patellofemoral crepitus with flexion and extension, but he has no problem going up and downstairs, kneeling, squatting and turning and twisting. He has been working in metal fabrication." (*Id.*)

Dr. Jones said that claimant demonstrated "2 cm of quad atrophy" and had mild crepitus with patellofemoral manipulation, but no pain with patellofemoral manipulation. (*Id.*) Dr. Jones released claimant to "return to work with full activities." (*Id.*)

Dr. Filarski performed a medical arbiter examination on March 12, 1999. (Ex. 20). He reported that claimant had been laid off at the end of November 1998. (Ex. 20-1). According to Dr. Filarski, claimant "felt he was unable to perform the bending and lifting activities of his job as a steel fabricator and welder, and relates that he tended to bend at the back level to protect his knee." (*Id.*) Claimant noted a "crepitant sensation interarticularly" with deep discomfort and he was concerned about balance and stability. (Ex. 20-2). On examination, Dr. Filarski reported that claimant's left-sided toe walking was associated with apparent giveaway. (Ex. 20-3). Claimant was "unwilling" to participate in left-sided hopping for fear of injury, but he was able to do so with stationary table support. (*Id.*)

Dr. Filarski concluded that claimant's left knee had "excellent stability but with mild patellofemoral chondromalacia and persistent thigh mass deficit." (Ex. 20-4). Although no findings were considered invalid, Dr. Filarski said claimant demonstrated some symptom magnification and mild giveaway weakness. (*Id.*) He felt that claimant had "[i]ncomplete rehabilitation." (*Id.*)

For the following reasons, we find that Dr. Jones' reports provided the most thorough, complete, and well-reasoned evaluation of claimant's impairment. Although Dr. Jones reported on December 4, 1998 that claimant was medically stationary and had "no problem going up and downstairs, kneeling, squatting and turning and twisting" (Ex. 13), claimant told Dr. Filarski that he had been laid off at the end of November 1998 and "felt he was unable to perform the bending and lifting activities of his job as a steel fabricator and welder[.]" (Ex. 20-1). Dr. Filarski examined claimant one time. In contrast, Dr. Jones had the opportunity to treat claimant on several occasions and, therefore, we are more persuaded by his opinion. In addition, although Dr. Jones reported that claimant had been "very aggressive in both rehabing and returning to work" (Ex. 13), Dr. Filarski felt that claimant had "[i]ncomplete rehabilitation." (Ex. 20-4). Again, we are more persuaded by Dr. Jones' opinion because he had the opportunity to treat claimant on several occasions.

In any event, we find that Dr. Filarski's opinion is insufficient to establish that claimant has a chronic and permanent medical condition and is *significantly* limited in the repetitive use of his left leg. *See* OAR 436-035-0010(5). Although Dr. Filarski did not consider any findings invalid, he reported that claimant demonstrated some symptom magnification in presentation and mild giveaway weakness by examination. (Ex. 20-4). He said that claimant's left-sided toe walking was associated with "apparent giveaway" and claimant was "unwilling" to participate in left-sided hopping for fear of injury, but he was able to do so with stationary table support. (Ex. 20-3). Dr. Filarski said claimant's ankle testing was "within normal limits with apparent giveaway weakness[.]" (*Id.*) In addition, although claimant told Dr. Filarski he was concerned about balance and stability, Dr. Filarski found claimant had "excellent stability." (Ex. 20-2, -4). In light of Dr. Filarski's comments, we are not persuaded that claimant was significantly limited in the repetitive use of his left leg. Moreover, because Dr. Filarski indicated that "[r]ehabilitative efforts" would decrease claimant's symptoms and their "consequent impairment," his opinion indicates claimant's condition may not be "chronic and permanent" pursuant to OAR 436-035-0010(5).

In sum, based on Dr. Jones' reports, we conclude that claimant is not entitled to a 5 percent "chronic condition" award for his left knee. Consequently, we reinstate the Order on Reconsideration award of scheduled permanent disability.

ORDER

The ALJ's order dated September 23, 1999 is reversed. The Order on Reconsideration award of 2 percent (3 degrees) scheduled permanent disability is reinstated. 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
LOU E. MARKS, Claimant
WCB Case No. 98-09254
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the SAIF Corporation's denial of claimant's claim for a consequential cervical condition; and (2) declined to award penalties for allegedly unreasonable claim processing. SAIF moves to strike portions of claimant's Appellant's Brief that allegedly rely on evidence that is not in the record. On review, the issues are motion to strike, compensability, and penalties.

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

The last sentence on page 1 of the ALJ's order is completed as follows: "A May 25, 1994 MRI showed a large right posterior lateral disc protrusion indenting the cervical cord and occupying the region of the exiting nerve root." (*See* Ex. 2).

SAIF moves to strike portions of claimant's Appellant's Brief that allegedly rely on evidence that is not in the record. We deny the motion because we do not find that claimant relies on evidence outside the record in her initial brief.[1]

In addition, to the extent that SAIF's motion relates forward to claimant's subsequent arguments and submissions, we offer the following reasoning.

Claimant submits 8 pages of documents with her Reply Brief (copies of September 26, 1988 and October 3, 1988 Determination Orders; an October 3, 1988 Department referral for a physical capacities assessment requesting detailed measurements of the function of claimant's back and right leg, a December 2, 1988 Determination Order, and an October 30, 1991 Opinion and Order). 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. In addition, we need not determine whether facts supported by the proposed evidence would be properly subject to administrative notice--again, because such facts would not affect the outcome of the case. 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]

On the merits, we agree with the ALJ that the medical evidence is insufficient to prove the claim for a consequential cervical condition.[5] Dr. Berselli, treating physician, ultimately could only say that claimant's 1986 work injury *could* have caused the 1994 fall (when she herniated her C6-7 disc), noting

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[1] We treat claimant's statements referencing evidence "missing" from the record as argument, not fact. *See* n. 4. *See Gilbert T. Hale*, 43 Van Natta 2329, 2330 (1991) (Board is capable of ignoring unsupported assertions of fact).

[2] Claimant was represented by an attorney at hearing. We acknowledge claimant's contention that her legal representation was inadequate (along with her explicit request that the case *not* be remanded). 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).

[5] Claimant argues that examining physicians' histories were inaccurate and/or incomplete because SAIF withheld medical evidence from the doctors and her claim was therefore prejudiced. Assuming that her assertions are true, claimant's argument does not aid her cause, because we would reach the same result without considering the examining physicians' opinions (as explained by the ALJ and herein). In short: Claimant's testimony and arguments are not sufficient to establish causation, because this case is medically complex. *See Uris v. Compensation Department*, 247 Or 420, 426 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993) (Persuasive *medical* evidence required to prove medically complex claim).

that the passage of time since the work injury made it difficult to determine the cause of the 1994 fall. (Exs. 23, 24). Brant Lewis, claimant's physical therapist, opined that claimant fell in 1994 because her leg gave out and her leg gave out because of weakness due to the 1986 injury. (Ex. 8). But Mr. Lewis did not explain this conclusion and Dr. Berselli *did* explain his inability to relate the 1994 fall to the 1986 injury. Under these circumstances, we cannot say that Mr. Lewis' opinion is more persuasive than Dr. Berselli's explained inability to reach a causation conclusion. Under these circumstances, and considering Dr. Berselli's greater diagnostic expertise, we conclude that the claim must fail.

ORDER

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

January 27, 2000 Cite as 52 Van Natta 119 (2000)

In the Matter of the Compensation of
REBECCA M. OAKES, Claimant
WCB Case Nos. 98-06423, 98-06422 & 98-02873
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Bock, Haynes, and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that set aside claimant's occupational disease claim for a C5-6 condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

The first page of the ALJ's order states that Exhibits 56 and 51 were withdrawn at hearing. The record itself indicates, however, that Exhibits 56 and 57 were withdrawn at hearing. (Tr. 3). Thus, we conclude that Exhibit 51, a June 6, 1998 records review by Dr. William Smith, remains part of the record.

Compensability

Relying on Dr. Goodwin's medical opinion, the ALJ concluded that claimant had established compensability of her occupational disease claim for an osteophytic spur at C5-6. On review, the insurer asserts that Dr. Goodwin's opinion is insufficient to meet claimant's burden under ORS 656.802(2)(b). Particularly, the insurer argues that Dr. Goodwin's opinion is insufficient to establish that there was a pathological worsening of the preexisting degenerative disc disease. Claimant argued at hearing that Dr. Goodwin's opinion was persuasive because he alone accurately diagnosed the spur at C5-6 and observed the spur at surgery. Claimant further argued that Dr. Goodwin's opinion established a pathological worsening of the preexisting degenerative condition and that the C5-6 spur was compensable as an occupational disease.

The parties appear to agree with the ALJ that claimant has a preexisting degenerative disease and that ORS 656.802(2)(b) applies to analyze the compensability issue. That statute provides that 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.

There are three medical opinions that address the nature and cause of claimant's cervical condition. Dr. Goodwin, claimant's treating physician and surgeon, felt that claimant had an occupational disease process caused in major part by her work activities. When asked by claimant's

counsel if the major contributing cause for claimant's need for treatment at C5-6 was her work activity, Dr. Goodwin answered in the affirmative. Dr. Goodwin further agreed that the work exposure had combined with the preexisting degenerative disc disease and that the exposure had caused a pathological worsening of the disease. (Ex. 54a).

In his deposition, Dr. Goodwin indicated that the work activities caused a symptomatic aggravation of the degenerative condition. (Ex. 58-14). Dr. Goodwin also indicated that the spurring at C5-6 was part of the degenerative disc disease process. Dr. Goodwin believed that claimant's work activities contributed to the degenerative disc disease, but he could not say that it was a major cause of that condition. (Ex. 58-21). He did, however, believe that the work activities were the major cause of the need for treatment. When asked if the work activities caused a pathological worsening of the preexisting condition, Dr. Goodwin stated: "Yes. It gets back to what you asked earlier. Her symptoms occurred while she was at work and aggravated her need for treatment, caused her need for treatment." (Ex. 58-23). Claimant's attorney then asked whether the degenerative process itself was worsened pathologically. Dr. Goodwin answered: "I think that's what I said earlier. I would agree that that's what I said earlier." *Id.*

As we stated previously, in order to establish compensability, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. Here, the combined condition is the spur at C5-6. Dr. Goodwin's opinion establishes only that claimant's work activities are the major contributing cause of her need for medical treatment and does not establish that the work activities are the major cause of the spur (the combined condition) itself. Moreover, Dr. Goodwin's deposition testimony suggests that he believed the work activities caused a symptomatic, as opposed to a pathological, worsening. Although Dr. Goodwin uses the words "pathological worsening," he describes only a symptomatic worsening. Thus, we are not persuaded that claimant has established compensability of her C5-6 condition.

The remaining medical opinions from Drs. Gardner and Anthony Smith, who examined claimant on behalf of the insurer, and from Dr. William Smith, who performed a records review at the insurer's request, do not support compensability. Drs. Gardner and Anthony Smith believed that the preexisting degenerative disease was the major contributing cause of claimant's current condition and that her work activities caused only a symptomatic aggravation. Dr. William Smith reviewed claimant's medical records and opined that claimant's work was a symptomatic aggravator, but had no effect pathologically on the degenerative process.

Based on this record, we are not persuaded that claimant has established compensability of her combined condition under ORS 656.802(2)(b).

ORDER

The ALJ's order dated June 28, 1999, as amended June 29, 1999, is reversed. The insurer's denial is reinstated and upheld. The attorney fee award is also reversed.

Board Member Biehl dissenting.

I would affirm the ALJ's opinion finding claimant's C5-6 osteophytic spur compensable. Claimant submitted proof that satisfies her burden under ORS 656.802(2)(b). In Exhibit 54a, Dr. Goodwin opined that claimant's work activities caused a pathological worsening of her degenerative disc disease at C5-6. Dr. Goodwin's opinions also establish that claimant's work activities were the major contributing cause of the disability and need for treatment of the combined condition. I believe that this evidence is sufficient to prove compensability of the combined condition and a pathological worsening of the disease. Isolated portions of the doctor's deposition are insufficient, in my view, to impeach the doctor's causation opinion.

Based on this record, claimant has established all that the statute requires. On this basis, I disagree with the majority's conclusion and offer this dissent.

In the Matter of the Compensation of
DOROTHY A. RONALD, Claimant
WCB Case Nos. 99-01159 & 99-00674
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Howells order that set aside its denial of claimants low back injury claim. On review, the issue is compensability.

We adopt and affirm the ALJs order, with the following supplementation and correction.

On review, the employer asserts that, by finding persuasive the opinion of claimants treating chiropractor, Dr. Clifton, the ALJ in effect shifted the burden of proof to the employer. For the reasons stated by the ALJ, we agree that there are no persuasive reasons not to defer to Dr. Cliftons opinion. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). That is, Dr. Clifton is the treating physician, his opinion is based on an accurate history and well-reasoned and, thus, is persuasive. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

At hearing, the employer argued that claimants current symptoms were a continuation of her August 1997 injury rather than a new injury resulting from a November 1998 incident. We disagree with the employer that the ALJs comment that Dr. Cliftons opinion is as logically plausible as the position taken by the employer means that the burden of proof was shifted to the employer. Rather, we understand the ALJ as explaining that, although the employers theory as to causation was legally possible, because it was unsupported by any medical evidence and rebutted by Dr. Cliftons persuasive opinion, the employers theory was not sufficient to prevent claimant from carrying her burden of proof under ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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.

Finally, we correct the Order portion of the ALJs order to state that the employers December 14, 1998 denial, rather than the February 4, 1999 denial, is set aside.

ORDER

The ALJ's order dated August 3, 1999 is affirmed. For services on review, claimants attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
PAMELA M. CHRISTMAN, Claimant
WCB Case Nos. 99-04174 & 99-01430
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation, on behalf of Charles H. Day Co., Inc., requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for a right carpal tunnel condition; and (2) upheld Wells Fargo's responsibility denial of the same condition. On review, the issue is responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last sentence of the findings of fact on page 3.

CONCLUSIONS OF LAW AND OPINION

Claimant has been employed as an accounts receivable clerk for the past 12 years. Her inital employment was with Protection One, until late 1994. Protection One is not a party to this proceeding. In late 1994 or early 1995, claimant began working for First Interstate Bank (now Wells Fargo), and continued to work there until April 17, 1996, when she began working for SAIFs insured, Charles H. Day Co., Inc.

In October 1998, claimant filed a claim for carpal tunnel syndrome (CTS). (Ex. 3). On March 5, 1999, Dr. Brett performed a right carpal tunnel release. (Ex. 11). Both SAIF and Wells Fargo denied compensability and responsibility of claimants right CTS condition. (Exs. 10, 13, 14).

The ALJ concluded that claimants CTS problems were due in major part to her work activities over the past 12 years. The ALJ applied the last injurious exposure rule in assigning responsibility. The ALJ found that the onset of disability occurred while claimant was employed at SAIFs insured and, therefore, responsibility was assigned to SAIFs insured.

SAIF argues that the ALJ applied the wrong legal standard for assigning responsibility. SAIF contends that it is not responsible for claimants CTS because she first sought medical treatment for her wrist condition before her employment with SAIFs insured.

Wells Fargo contends that the medical evidence is not clear that claimant first sought medical treatment before her employment with SAIF's insured. Wells Fargo and claimant respond that, even if initial responsibility is assigned to another employer, claimants CTS condition pathologically worsened during her employment with SAIFs insured and, therefore SAIF is responsible.

The last injurious exposure rule provides that when a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). If a claimant receives medical treatment for a compensable condition before experiencing time loss due to the condition, then the date of first medical treatment is determinative for assigning initial responsibility for the claim. *Reynolds Metal v. Rogers*, 157 Or App 147, 153 (1998); *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). The dispositive date is the date the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. *SAIF v. Kelly*, 130 Or App 185, 188 (1994).

Claimant testified that she first experienced numbness in her arm while she was pregnant 23 years ago. (Tr. 11). After she gave birth, the numbness went away. (*Id.*)

A March 14, 1994 chart note indicated claimant had complained of [h]ands numb swollen & feet. (Ex. OA). Claimant was working for Protection One in March 1994. (Tr. 22, 27).

At hearing, claimant said she had some hand and wrist symptoms while working at Wells Fargo. (Tr. 12). In an October 8, 1998 statement, claimant indicated she sought medical treatment for her hand while she was working for Wells Fargo between 1994 and 1995. (Ex. 6). She sought treatment at Kaiser Permanente (Kaiser) and was given hand braces to wear at night. (Tr. 13). Her symptoms went away after about a month of wearing the braces. (*Id.*) She continued to wear the braces, however, except for a three month period. (Tr. 13, 17, 30). Claimant agreed that, except for that three month period, she had worn the braces every night from the time she received them at Kaiser until she had surgery. (Tr. 30).

On February 7, 1995, claimant sought treatment for "pain in legs, hands, arms, tingling in hands." (Ex. 1). She was diagnosed with obesity. (*Id.*) An undated chart note from Kaiser showed that claimant was diagnosed with CTS.[1] (Ex. OB).

Claimant said that her hands and wrists were fine when she began to work for SAIF's insured in April 1996. (Tr. 14). She testified that she began experiencing hand/wrist symptoms about two years ago. (Tr. 16). She eventually sought treatment from Dr. Henry, her primary care doctor, in approximately June 1998. (Tr. 18). Nerve conduction studies on July 24, 1998 indicated claimant had right CTS. (Ex. 2).

Dr. Henry was sent copies of the 1994 and 1995 chart notes from Kaiser Permanente that documented claimant's complaints of numbness and tingling in her hands. (Ex. 17). Dr. Henry agreed that it was medically probable that the condition treated on March 14, 1994 and February 7, 1995 was CTS. (*Id.*) Dr. Gardner, who examined claimant on behalf of SAIF, also agreed that it was medically probable that the condition treated on March 14, 1994 and February 7, 1995 was CTS. (Ex. 18).

Based on the reports from Drs. Henry and Gardner, we find that claimant was first treated for CTS on March 14, 1994. (Exs. 17, 18). A March 14, 1994 chart note indicated claimant had complained of [h]ands numb swollen & feet. (Ex. OA). Claimant was working for Protection One in March 1994. (Tr. 22, 27). Under these circumstances, we would ordinarily assign presumptive (initial) responsibility for claimant's CTS condition to Protection One. *See Timm v. Maley*, 125 Or App at 401; *SAIF v. Kelly*, 130 Or App at 188. However, Protection One was not a party to this proceeding. In a previous case, we held that responsibility cannot be assigned to a non-joined carrier. *See Kristin Montgomery*, 47 Van Natta 961 (1995).

Nevertheless, Wells Fargo and claimant argue that, even if initial responsibility is assigned to another employer, claimants CTS condition pathologically worsened during her employment with SAIFs insured and, therefore SAIF is responsible. On the other hand, SAIF contends that the medical evidence is not sufficient to establish a pathological worsening of claimants CTS.

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

Wells Fargo and claimant rely on Dr. Bretts opinion to establish a pathological worsening. SAIF contends that Dr. Brett's opinions are not persuasive because he had an inaccurate history of claimant's previous CTS symptoms.

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[1] The ALJ admitted that chart note in evidence for the sole purpose of establishing that claimant was diagnosed with CTS at Kaiser sometime before mid-1995. (Tr. 32, 33). Claimant testified that she had not been treated at Kaiser since mid-1995. (Tr. 30).

Dr. Brett first examined claimant on October 2, 1998. (Ex. 5). He indicated claimant had some right carpal tunnel complaints with pregnancy more than 10 years ago, but her symptoms had resolved completely. (Ex. 5-1). He reported that claimant had been working in accounts receivable for the past 12 years and she began to develop increasing complaints of pain two years ago. (*Id.*) He said her symptoms had persisted despite the use of wrist splinting and anti-inflammatories. (*Id.*) Dr. Brett diagnosed CTS, explaining:

> "I suspect that she does have some idiopathic smallness of the carpal tunnel and she did have some median nerve entrapment with her pregnancy and general body fluid gain and edema. However, these symptoms resolved completely and it is mainly her work activities over the last 12 years in accounts receivable that have resulted in additional pathologic worsening and now median nerve entrapment on the right with ongoing symptoms of right carpal tunnel syndrome despite conservative care." (Ex. 5-2).

On June 3, 1999, Dr. Brett wrote to claimant's attorney and reiterated his understanding of claimants previous symptoms:

> "Particularly noted in her history is that she did have similar symptoms when pregnant, more than ten years ago, but these symptoms resolved completely after delivery. It was two years prior to my seeing her that she developed recurrent right carpal tunnel symptoms while continuing to work in her occupation in accounts receivable. This job involved ten-key operation and repetitive and sustained exertion with both hands." (Ex. 15-1).

Dr. Brett felt that claimant likely had some congenital smallness of the carpal tunnel, but he concluded that the major contributing cause of claimants CTS and median nerve entrapment was her work activities over the last two years. (*Id.*) He said that claimants work activities were consistent with those that would precipitate swelling, erythema, edema, and entrapment of the median nerve with the carpal tunnel. (Ex. 15-2). Dr. Henry, claimants primary physician, concurred with Dr. Bretts June 3, 1999 report. (Ex. 16).

On August 7, 1999, Dr. Brett acknowledged that claimant had prior carpal tunnel complaints with her pregnancy and she likely had congenital smallness of the carpal tunnel that predisposed her to development of the CTS. (Ex. 20). He noted, however, that two years ago, claimant began to develop recurrence of classic right median nerve entrapment symptoms and typical carpal tunnel syndrome. (*Id.*) Dr. Brett felt that claimants median nerve entrapment was precipitated by the work activity and was the major contributing factor to her on-going nerve entrapment and need for surgery. (*Id.*) He concluded that claimants work exposure over the last two years was the major contributing factor to the development of her median nerve swelling, ongoing entrapment and CTS. (*Id.*)

In a subsequent letter, Dr. Brett said that claimants median entrapment and CTS was a result of her work exposure over the last two years. (Ex. 21). He explained:

> "She was previously symptomatic while pregnant some ten years ago, but this resolved spontaneously; and I suspect she has a congenital smallness of the carpal tunnel bilaterally. She did not have any symptoms of median nerve entrapment until two years ago, and these have now become unremitting and require treatment. However, I feel the major contributing factor to her current condition and need for treatment with her on-going median nerve entrapment is her work exposure over the last two years and not prior to that." (*Id.*)

Dr. Brett understood that claimant had some right CTS symptoms with her pregnancy more than 10 years ago, but those symptoms had resolved. (Exs. 5, 15, 21). It is clear from Dr. Brett's reports that he understood that claimant did not have CTS symptoms until two years ago, when she was working for SAIF's insured. (Exs. 5, 15, 20 , 21). In fact, Dr. Brett opined that claimant "did not have *any* symptoms of median nerve entrapment until two years ago[.]" (Ex. 21; emphasis supplied).

At hearing, claimant acknowledged that Dr. Brett did not have a complete history of her CTS symptoms, based on his understanding that she had no symptoms between her pregnancy many years ago and her last two years of employment at SAIF's insured. (Tr. 28-29). Claimant testified that she had symptoms while she was working at Wells Fargo and she acknowledged that a March 1994 chart note referred to her numb and swollen hands. (Tr. 29). Also, as we discussed earlier, Drs. Henry and

Gardner agreed that it was medically probable that the condition claimant was treated for on March 14, 1994 and February 7, 1995 was CTS. (Exs. 17, 18).

There is no evidence that Dr. Brett was aware of claimant's CTS symptoms in 1994 or 1995. Dr. Brett incorrectly understood that claimant had no CTS symptoms until two years ago, while working for SAIF's insured. Consequently, Dr. Brett's opinion that claimant's work at SAIF's insured was the major contributing factor to her current CTS condition and need for surgery 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, we find that Dr. Brett's opinion is not sufficient to establish that claimant's work at SAIF's insured contributed to the cause of, aggravated, or exacerbated the underlying disease. *See Bracke v. Baza'r*, 293 Or at 250. In Dr. Brett's October 2, 1998 report, he said that "it is mainly [claimant's] work activities over the last 12 years in accounts receivable that have resulted in *additional pathologic worsening* and now median nerve entrapment on the right with ongoing symptoms of right carpal tunnel syndrome despite conservative care. (Ex. 5-2; emphasis supplied). In the same report, however, Dr. Brett said that the major contributing factor to claimant's current condition and need for treatment was her work for SAIF's insured. (*Id.*) Dr. Brett's report is inconsistent. On the one hand, he indicated that claimant's 12 years in accounts receivable had resulted in "additional pathologic worsening." On the other hand, he focused on claimant's work for SAIF's insured as the major factor in her current condition and need for treatment.

In light of Dr. Brett's inaccurate history and inconsistent reports, we conclude that his opinion is not sufficient to establish that responsibility for claimant's CTS should shift to SAIF's insured. *See Bracke v. Baza'r*, 293 Or at 250 (1982) (a recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer); *Guy R. Strahon*, 51 Van Natta 1418 (1999). Dr. Brett's reports are not sufficient to establish that claimant's employment with SAIF's insured contributed to a worsening of the underlying disease. For the same reasons, we are not persuaded by Dr. Henry's concurrence with Dr. Brett's opinion.

There are no other medical opinions sufficient to shift responsibility to a later carrier, either SAIF's insured or Wells Fargo. Dr. Gardner did not believe claimants work for SAIF's insured had contributed to the overall pathogenesis of her CTS. (Ex. 9-5). At most, Dr. Gardner indicated that claimant's work at SAIFs insured may have comprised a minor contribution[.] (*Id.*) Dr. Gardner agreed that claimant's work exposure at Wells Fargo in 1994/1995 did not constitute the major contributing cause of claimant's CTS or her need for treatment. (Ex. 19). There is no medical evidence that claimant's work at Wells Fargo contributed to the cause of, aggravated, or exacerbated the underlying disease. *See Bracke v. Baza'r*, 293 Or at 250.

As we discussed above, we would ordinarily assign presumptive (initial) responsibility for claimant's CTS to Protection One, because claimant first sought medical treatment for her CTS condition while she was employed at Protection One. *See Timm v. Maley*, 125 Or App at 401; *SAIF v. Kelly*, 130 Or App at 188. However, because claimant has not chosen to pursue a claim against Protection One, it cannot be held responsible for claimant's CTS condition.[2]

We conclude that the medical evidence is insufficient to establish that claimant's work at Wells Fargo or at SAIF's insured contributed to the cause of, aggravated, or exacerbated the underlying disease. *See Bracke v. Baza'r*, 293 Or 239, 250 (1982); *Kristin Montgomery*, 47 Van Natta at 961 (responsibility for the claimant's condition could not be assigned to a non-joined carrier). Therefore, neither SAIF nor Wells Fargo is responsible for claimant's CTS condition.

ORDER

The ALJ's order dated September 9, 1999 is reversed in part and affirmed in part. SAIF's responsibility 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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[2] For purposes of our analysis, we emphasize that Protection One is only presumptively responsible for claimant's condition. Because claimant is only pursuing a claim against Wells Fargo and SAIF's insured, our review is limited to addressing whether either of those carriers is responsible for claimant's CTS condition.

In the Matter of the Compensation of
DARLENE CORTHELL, Claimant
WCB Case No. 99-05138
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillip Polich and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration that awarded claimant 17 percent (25.5 degrees) scheduled permanent disability for the loss of use or function of each forearm. On review, the issue is extent of scheduled permanent disability.

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

The employer contends that claimant is not entitled to an award for loss of strength identified by the medical arbiter, Dr. Van Allen, because Dr. Van Allen did not identify the strength loss as related to any specific nerve. The employer refers to OAR 436-035-0110(8), which provides: "Loss of strength in the arm, forearm or hand due to a peripheral nerve injury is rated based upon the specific peripheral nerve, which supplies (innervates) the weakened muscle(s). . ."

However, OAR 436-035-0110(8)(a) allows that "[v]alid loss of strength in the arm, forearm or hand, substantiated by clinical findings, shall be valued as if the peripheral nerve supplying (innervating) the weakened muscle(s) was impaired, pursuant to this section."

In a June 10, 1999 letter to the Department, Dr. Van Allen stated:

> "Clarifying strength and repetitive limitations, with carpal tunnel it is standard for patients to be weaker following a carpal tunnel release than they were postoperatively. This can occasionally result in a 4/5 graded measurement; however, this is more related to the release of the carpal tunnel than to any nerve injury or muscle injury * * *. I do feel that this strength limitation is due to the carpal tunnel release and is probably attributable to altered tendon dynamics within the carpal tunnel following release." (Ex. 209-3).

The employer interprets OAR 436-035-0110(8)(a) as allowing an award only where claimant proves damage to some nerve or muscle group. It argues that Dr. Van Allen did not attribute claimant's loss of strength to any nerve or muscle, but rather to "altered tendon dynamics." (Ex. 209-3).

We disagree. Applying the plain language of OAR 436-035-0110(8)(a), if a claimant proves a valid loss of strength, that loss shall be rated "as if" a specific nerve and muscle group were impaired. Dr. Van Allen expressly found claimant's loss of strength to be valid. (Ex. 205-3).

Interpreting a similar rule[1], the Court of Appeals held that a claimant is not required to prove damage to a particular nerve, muscle or tendon to qualify for an award for loss of strength. *Gevers v. Road Runner Construction*, 156 Or App 168 (1998).

The employer argues that the arbiter attributed claimant's loss of strength to "altered tendon dynamics," rather than to either a specific nerve or muscle group, and therefore OAR 436-035-0110(8)(a) does not apply as a "catch-all" provision to yield an award for loss of strength. However, in *Gevers*, the

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[1] Specifically, the court examined *former* OAR 436-35-350(3) and (5). *Former* OAR 436-35-350(3) provided, in part: "Injuries to a unilateral specific named peripheral nerve with resultant loss of strength shall be determined based upon a preponderance of medical opinion that reports loss of strength...and establishes which specific named peripheral nerve is involved."

Former OAR 436-35-350(5) provided: "Loss of strength due to muscle loss or disruption of the musculotendinous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired."

arbiter ascribed the claimant's loss of strength in his shoulder to "perijoint fibrosis,"[2] rather than to any specific nerve or muscle group. 156 Or App at 170. Consequently, we agree with the ALJ that claimant has proved a valid loss of strength meeting the standards for rating permanent impairment.

Finally, the employer contends that certain evidence, including surveillance videotapes of claimant, proves that she is not credible, and that any findings by the arbiter should be read with suspicion and found invalid. We disagree. Generally, the validity of physical testing must be determined by the medical examiner performing the tests. *Kathleen S. Schultz*, 48 Van Natta 2518, 2519 (1996). As noted above, Dr. Van Allen expressly found claimant's loss of strength to be valid. (Ex. 205-3).

Claimant is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the 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 October 12, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $800, to be paid by the self-insured employer.

[2] "Fibrosis" is "Formation of fibrous tissue as a reparative or reactive process, as opposed to formation of fibrous tissue as a normal constituent of an organ or tissue." Stedman's Electronic Medical Dictionary v. 4.0 (1998).

In the Matter of the Compensation of
CLAUDIA J. BROWN, Claimant
Own Motion No. 99-0256M
OWN MOTION ORDER
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable left hand condition. Claimant's aggravation rights on that claim expired on October 22, 1998.

SAIF denied the responsibility for claimant's current left thumb condition on June 28, 1999. Claimant timely appealed that denial. (WCB Case No. 99-05506). Thereafter, the Board received a request for consent to issues an order designating a paying agent pursuant to ORS 656.207. On September 8, 1999, the Board issues an Interim Own Motion Order Consenting to the Designation of Paying Agent under ORS 656.307, which also postponed action on the own motion matter pending resolution of that litigation.

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

Here, claimant did appeal the June 28, 1999 responsibility denial; however, she withdrew her request for hearing. An Order of Dismissal issued on December 1, 1999. That order has not been appealed. Thus, the current condition and ensuing surgery for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted claimant's current condition as its responsibility. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARILYN J. FLICKINGER, Claimant
WCB Case No. 99-00239
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) increased claimant's award of unscheduled permanent disability for a low back injury from 9 percent (28.8 degrees), as awarded by an Order on Reconsideration, to 10 percent (32 degrees); and (2) awarded claimant a $2,000 assessed attorney fee for services regarding SAIF's request for a reduction of permanent disability. On review, the issues are extent of unscheduled permanent disability and attorney fees.

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

The ALJ awarded claimant a $2,000 attorney fee pursuant to ORS 656.382(2) for prevailing over the SAIF's request for hearing that attempted to reduce the award of unscheduled permanent disability granted by the reconsideration order. SAIF contends that the fee is excessive, particularly considering the value of the interest involved. We disagree.

The value of the interest involved is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4). *See Ben E. Conradson*, 51 Van Natta 851 (1999). Following our *de novo* review of the record, and considering the factors set forth in OAR 438-015-0010(4), particularly the time devoted to the extent of disability issue (as represented by the record[1]), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated, we agree with the ALJ that $2,000 is a reasonable attorney fee in this matter.

In addition, claimant's counsel is entitled to an assessed fee for services on review with regard to extent of disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review with regard to the extent of disability issue is $750, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the extent of disability 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 expended in securing the attorney fee award. *See Amador Mendez*, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated July 1, 1999 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, to be paid by the SAIF Corporation.

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[1] 35 exhibits were admitted into evidence. SAIF submitted a 6 page written closing argument and a 1 page reply argument. Claimant submitted a 4 page responding argument.

In the Matter of the Compensation of
JAMES H. GLASS, Claimant
WCB Case No. 99-02561
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) declined to award temporary disability benefits after June 1, 1998; and (2) did not assess penalties or attorney fees pursuant to ORS 656.262(11)(a) and 656.382(1). On review, the issues are temporary disability benefits and penalties and attorney fees. We reverse in part.

FINDINGS OF FACT

Claimant injured his right shoulder at work on February 3, 1998. Claimant was released to modified work from February 9, to February 19, 1998 by Dr. Daluga. Claimant was released to regular work on February 19, 1998 by Dr. Daluga. However, on March 3, 1998, claimant was again released to modified work by Dr. Wilson.

The insurer accepted a disabling right shoulder strain on March 11, 1998. On April 29, 1998, claimant was seen by Dr. Davis, who continued him on modified work with no repetitive movements or gripping with the right hand and wrist and no pushing, pulling or lifting in excess of 10 pounds and no work at or above shoulder level. On May 6, 1998, Dr. Davis gave claimant a 20 pound lifting limit to waist level and no work with his arm away from his side.

On May 21, 1998, claimant accepted the employer's offer of modified work. The offer was for a job starting on May 26, 1998; however, claimant wrote that he would be able to begin work on May 27, 1998 because of a doctor's appointment on the 26th. On May 19, 1998, Dr. Davis approved the job offer which was consistent with his May 6, 1998 release to modified work.

Claimant was seen by Dr. Davis on May 26, 1998. According to Dr. Davis' chart note, claimant reported having returned to work for a few days at light duty and having to discontinue work because of pain caused by overhead lifting. Dr. Davis again released claimant to light duty as of June 1, 1998 to the same job approved on May 19, 1998. On June 29, 1998, claimant saw Dr. Davis who indicated that claimant's symptoms had progressed and that he would submit a surgery authorization request. The doctor stated that claimant would continue on light duty work with no gripping to the right hand and wrist and a 20 pound lifting limit.

On June 1, 1998, the employer sent the approved modified job offer to claimant with a starting date of June 3, 1998. Also on June 1, 1998, Dr. Davis' office completed a form 828 that listed claimant's limitations as "no work over shoulder level. No push/pull/lift over 10 lbs." (Ex. 27).

The employer terminated claimant after a warning to him for missing work from June 1, to June 5, 1998 without calling in. Claimant was examined on behalf of the insurer by Dr. Woodward. Dr. Davis requested surgery for right shoulder impingement syndrome and bicipital tendon instability. The insurer partially denied the claim on September 24, 1998. By a stipulation approved on January 4, 1999, the insurer accepted right shoulder impingement syndrome with bicipital tendon instability.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that Dr. Davis did not change claimant's restrictions on June 1, 1998 and that the employer was therefore not required to submit a new modified job offer within those restrictions in order to terminate claimant's temporary total disability benefits. The ALJ found that the June 1, 1998 form 828 that stated that claimant's lifting was limited to 10 pounds was a "mistake made by the nurse who misread the file." (O & O, p. 4). The ALJ reasoned that the June 1, 1998 form 828 was inconsistent with Dr. Davis' May 26, 1998 chart note that reinstated a 20 pound lifting limit with no work with claimant's arm away from his side and the June 29, 1998 restriction against lifting above 20 pounds and no gripping to the right hand and wrist.

On review, claimant argues that he is entitled to temporary disability on and after June 1, 1998 because Dr. Davis further restricted his modified work release on June 1, 1998 and no modified job offer within that new restriction was offered to claimant and approved by his physician.

ORS 656.325(5)(a) provides:

"(5) Notwithstanding ORS 656.268:

"(a) An 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 worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

Here, attempting to comply with ORS 656.325(5)(a), the employer had offered claimant a modified job within the limitations approved by Dr. Davis. However, prior to beginning the job, on June 1, 1998, the form 828 from Dr. Davis' office altered claimant's restrictions such that the job previously approved by Dr. Davis was no longer within the new restrictions. We also note that the May 29, 1998 modified release by Dr. Davis added the limitation of no gripping to the right hand and wrist. Claimant was subsequently terminated for violation of the employer's work rules (failing to call in to report absences).

Although the ALJ conjectured that the form 828 from Dr. Davis' office was a "mistake made by the nurse who misread the file," there is no evidence in the record supporting that conclusion. Based on the unrebutted evidence in this record, Dr. Davis changed claimant's limitations to a 10 pound lifting limit on June 1, 1998. Thus, the job previously approved by Dr. Davis exceeded the new limitations. Therefore, in order to properly terminate claimant's temporary total disability benefits after that date, the insurer/employer would have had to resort to ORS 656.325(5)(b). That statute provides:

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

On this record, we conclude that temporary total disability could not be terminated until the carrier complied with ORS 656.325(5)(b). Thus, claimant is entitled to temporary total disability benefits until termination is authorized under the law.

Claimant seeks a penalty pursuant to ORS 656.262(11)(a). Whether a carrier's actions are unreasonable is determined by whether it had a legitimate doubt, from a legal standpoint, about its liability. *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988).

Here, we find that the carrier attempted to comply with ORS 656.325(5)(a). The same day claimant was scheduled to begin the modified job, however, Dr. Davis altered claimant's restrictions. Claimant did not attempt to return to work on June 1, 1998, although Dr. Davis had approved the modified job. The new restriction imposed on June 1, 1998 was a change from the previous restrictions and (although we have concluded differently) the carrier could legitimately have believed that it had already complied with the statute and that claimant's failure to return to work was a refusal of the modified job offer. Under the circumstances presented here, we find that the insurer had a legitimate doubt concerning its continuing duty to pay temporary total disability benefits. Thus, we decline to assess a penalty or an attorney fee for unreasonable resistance to the payment of compensation.

ORDER

The ALJ's order dated September 3, 1999 is reversed in part and affirmed in part. That portion that declined to award temporary total disability benefits after June 1, 1998 is reversed. The insurer is directed to pay temporary total disability benefits beginning June 2, 1998 and continuing until termination is authorized by law. Claimant's attorney is awarded an attorney fee of 25 percent of the additional compensation awarded by this order not to exceed $3,800, payable out of claimant's compensation and directly to claimant's attorney. The remainder of the order (that does not award penalties or attorney fees for unreasonable claim processing) is affirmed.

In the Matter of the Compensation of
DOLORES M. GUILLEN, Claimant
WCB Case No. 98-04412
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Bostwick, et al, Defense Attorneys

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

The insurer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's right patella tendonitis, degenerative changes involving the lateral compartment (primarily the lateral tibia plateau and the intercondylar portion of the proximal tibia), tear of the lateral meniscus and grade II chondromalacia of the medial femoral condyle; and (2) set aside an Order on Reconsideration as prematurely closed. On review, the issues are compensability and premature closure. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the fifth paragraph on page 2, we change the second sentence to read: "Dr. North diagnosed a right knee medial meniscus tear, possible anterior cruciate or lateral meniscus tear, with degenerative joint disease, lateral compartment." On page 3, we do not adopt the last paragraph of the findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on August 17, 1993 when she fell at work and injured her right knee. On January 5, 1994, the insurer accepted a right knee contusion. (Ex. 8).

Claimant continued to have right knee problems. In August 1994, Dr. Eubanks recommended an MRI of claimants right knee, which showed tears of both menisci and the anterior cruciate ligament, degenerative changes in the lateral compartment and a probable fracture of the lateral tibial plateau. (Ex. 10). Claimant was referred to Dr. Wilson and was treated conservatively. (Exs. 11, 13).

In October 1995, claimant sought treatment from Dr. North, who diagnosed a right knee medial meniscus tear, possible anterior cruciate or lateral meniscus tear, with degenerative joint disease, lateral compartment. (Ex. 15-2). On November 8, 1995, Dr. North performed a right knee arthroscopic chondroplasty and medial femoral condyle and lateral meniscectomy. (Ex. 16). His post-operative diagnosis was right knee grade III chondromalacia medial femoral condyle and lateral meniscus tear. (*Id.*)

Claimant continued to have right knee problems. A December 9, 1996 right knee MRI showed degenerative changes involving the lateral compartments, primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia; extensive degenerative changes involving both the medial and lateral menisci with probable tears bilaterally; and moderate joint effusion. (Ex. 19). Dr. North recommended conservative treatment. (Exs. 20, 21, 22, 23).

On December 31, 1997, claimants attorney wrote to the insurer, requesting that they accept the conditions of right knee - status-post partial lateral meniscectomy and medial femoral condyle chondroplasty, patellar tendonitis, degenerative changes involving the lateral compartment primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia, extensive degenerative changes involving the medial and lateral menisci with probable tears bilaterally, moderate joint effusion, grade III chondromalacia of the medial femoral condyle, lateral meniscus tear; patellar tendonitis, left. (Ex. 24). On May 7, 1998, the insurer denied compensability of those conditions. (Ex. 27).

An Order on Reconsideration issued on August 31, 1998, which indicated that an Updated Notice of Acceptance at Claim Closure dated May 11, 1998 had listed the following accepted conditions: right knee contusion/strain, tears of the medial meniscus and anterior cruciate ligament, and fracture of the lateral tibial plateau. (Ex. 31).

Claimant requested a hearing on the insurers May 7, 1998 denial. She also requested a hearing concerning the August 31, 1998 Order on Reconsideration.

The ALJ found that the accepted fracture of the lateral tibial plateau was the major contributing cause of claimants lateral meniscus tear. The ALJ concluded that claimant's right patella tendonitis, degenerative changes involving the lateral compartment (primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia), tear of the lateral meniscus and grade II chondromalacia of the medial femoral condyle were compensable. The ALJ found no support in the record for the claim for left patella tendonitis.

The insurer argues that claimant has not established compensability of her claimed right knee conditions. The insurer acknowledges that it is the law of the case that claimant has a compensable fracture of the lateral tibial plateau. Nevertheless, the insurer contends that the ALJ abbreviated the analysis of the medical evidence under the mistaken belief that the "law of the case" doctrine led to discounting the opinions of Drs. Thompson and Fuller because they believed claimant never had a fracture of the lateral tibial plateau.

On the other hand, claimant relies on *Florence L. Scott*, 44 Van Natta 2454 (1992), and argues that the Board must reject the opinions of Drs. Wilson and Fuller because their opinions are based on the assertion that claimant did not have a fracture of the lateral tibial plateau. Claimant relies on the opinions of Drs. North and Gritzka to establish compensability of her right knee conditions.

For the following reasons, we find that it is not necessary to address the parties' "law of the case" arguments. In other words, whether or not we discount any medical opinions for being inconsistent with the "law of the case," *see Kuhn v. SAIF*, 73 Or App 768 (1985), we would reach the same result.[1]

Here, the insurer has accepted a right knee contusion/strain, tears of the medial meniscus and anterior cruciate ligament, and fracture of the lateral tibial plateau. (Ex. 31). Compensability of those conditions is not in dispute. Instead, claimant seeks to set aside the insurer's denial "in its entirety." The insurer had denied the claims for "right knee-status post partial lateral meniscectomy and medial femoral condyle chondroplasty, patellar tendonitis, degenerative changes involving the lateral compartment primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia, extensive degenerative changes involving the medial and lateral menisci with probable tears bilaterally, moderate joint effusion, grade III chondromalacia of the medial femoral condyle, lateral meniscus tear and left patellar tendonitis. (Ex. 27).

In light of the number of potential causes of claimant's aforementioned right knee conditions, 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).

Although claimant requested that the insurer accept the conditions of "right knee-status post partial lateral meniscectomy and medial femoral condyle chondroplasty" (Ex. 24), Dr. Fuller reported that those terms described medical procedures, rather than conditions. (Ex. 25-10). Those terms refer to Dr. North's November 8, 1995 surgical treatment, in which he performed a "[r]ight knee arthroscopic chondroplasty, medial femoral condyle and lateral meniscectomy." (Ex. 16). Under these circumstances, we agree with the ALJ that it is appropriate to address compensability only of claimant's diagnosed medical conditions.

Claimant relies on the opinions of Drs. Gritzka and North to establish compensability of her right knee conditions. Claimant contends that, as the treating surgeon, Dr. North's opinion is entitled to great weight. She also argues that Dr. Gritzka is a persuasive reviewing expert.

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[1] In *Kuhn v. SAIF*, 73 Or App at 768, one of the physicians opined that the claimant's low back condition was entirely due to her congenital abnormalities. The court reasoned:

> "Although [the physician] was entitled to reiterate his original conclusion, it conflicts with the law of the case, which is that permanent disability resulted from her industrial injury. As a legal matter, it is wrong. * * * Therefore, his conclusion must be discounted." 73 Or App at 772 (citations omitted.)

The insurer contends that the history relied upon by Drs. North and Gritzka was incorrect and, therefore, their opinions are not persuasive. Claimant's attorney submitted a list of several causation questions to Drs. North and Gritzka. Both physicians were provided with the following information:

> "Regarding conditions that pre-date the industrial injury, [claimant] likely had degeneration in her right knee prior to the industrial accident on or about 8/17/93, but no significant problems requiring ongoing treatment and disability with her right knee until the industrial injury other than those in the records. She has stated that she had no disability or ongoing treatment for problems with her knees (*other than the documented three week period in January/February 1993, diagnosed as suprapatellar bursitis, suprapatellar chondromalacia, tearing of the lateral meniscus, lax anterior cruciate ligament, chondromalacia patella - see Exs. 1, 2, 3*) prior to the 08/17/93 work injury. She may have had some degeneration in her knee(s) related to age, and her work activities over the years." (Exs. 30-3, 33-2, -7; italics in original).

Drs. Gritzka and North indicated that analysis was correct. (*Id.*)

Claimant sought medical treatment for a right knee condition in February 1993, six months before the August 17, 1993 injury. A right knee arthrogram on February 4, 1993 indicated that claimant's medial meniscus was normal, the anterior cruciate ligament was lax and the lateral meniscus was "slightly truncated in the mid-sector and slightly irregular along the undersurface of the mid-sector and anterior horn suspicious for degenerative tearing." (Ex. 2). On February 12, 1993, Dr. Wade felt that claimant had a chondromalacia of the right patella. (Ex. 3). Claimant was given a patellar strap and advised to take anti-inflammatories. (*Id.*)

Claimant's attorney's letters instructed Drs. North and Gritzka that claimant had no disability or ongoing treatment for problems with her knees, other than the documented three week period in January/February 1993. (Exs. 30-3, 33-2). At hearing, claimant was asked about the patellar strap given to her by Dr. Wade and she agreed that the strap enabled her to perform her job. (Tr. 16, 17). She wore the strap about six months. (Tr. 17). Claimant testified that she "used to wear [the strap] all the time" and she agreed that she needed to put the strap on every day to go to work. (Tr. 23). She said she also wore the strap after the August 1993 injury. (*Id.*)

There is no evidence that either Dr. North or Dr. Gritzka was aware that claimant needed ongoing treatment for her right knee between February 1993 and the August 17, 1993 injury. To the contrary, both physicians indicated their understanding was consistent with the history summarized by claimant's attorney, *i.e.*, that claimant had no disability or ongoing treatment for problems with her knees before the August 1993 work injury, other than the documented three week period in January/February 1993. We are not persuaded that Drs. North and Gritzka had an accurate understanding of claimant's right knee symptoms February 1993 and the August 17, 1993 injury. Consequently, we find that the causation opinions of Drs. North and Gritzka are 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. North had an accurate history of claimant's right knee symptoms, we are not persuaded by his opinion on causation. We generally give greater weight to the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, however, we find persuasive reasons not to defer to the opinion of claimant's treating surgeon, Dr. North.

Dr. North was asked several questions by claimant's attorney. Dr. North was asked if claimant's August 1993 work injury was "more likely than not the major contributing cause of the need for treatment you have provided (including surgery and your projected knee replacement), and/or disability of a combined right knee condition of 'right knee status post partial lateral meniscectomy and medial femoral condyle chondroplasty, patellar tendonitis, degenerative changes involving the lateral compartment primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia, extensive changes involving the lateral meniscus with probable tears, moderate joint effusion, grade II chondromalacia of the medial femoral condyle, lateral meniscus tear[.]" (Ex. 33-3; bold print omitted). Dr. North answered "no," without an explanation. (Ex. 33-3, -7).

In a later question, however, Dr. North was asked to assume that claimants August 1993 injury combined with a preexisting condition(s) and he agreed that the injury *was* the major contributing cause of the need for treatment or disability of these conditions: status post partial lateral meniscectomy and medial femoral condyle chondroplasty, patellar tendonitis, degenerative changes involving the lateral compartment - primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia, extensive degenerative changes involving the lateral meniscus with probable tears, moderate joint effusion, grade II chondromalacia of the medial femoral condyle and lateral meniscus tear. (Ex. 33-4, -7).

Because Dr. North's answers to those questions are inconsistent and lack any explanation, his opinion on causation is entitled to little weight. To confuse matters further, in answering another question, Dr. North indicated claimant's work injury was *not* a material and direct cause of the right knee conditions of degenerative changes involving the lateral compartment - primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia and grade II chondomalacia of the medial femoral condyle. (Ex. 33-3. -7). Also, although Dr. North agreed with "part" of the reports from Dr. Thompson and Dr. Gritzka, he did not explain which "part" he agreed with. (Ex. 33-4, -8). In addition to an inaccurate history, we find that Dr. North's opinion is inconsistent and lacks adequate explanation and, therefore, is not persuasive. We conclude that Dr. North's opinion is insufficient to establish compensability of claimant's right knee conditions.

The only other medical opinion that supports causation is from Dr. Gritzka. Dr. Gritzka reviewed claimant's medical records, but he had not examined claimant. As we discussed above, we are not persuaded that Dr. Gritzka had an accurate understanding of claimant's right knee symptoms February 1993 and the August 17, 1993 injury. Consequently, we find that Dr. Gritzka's opinion is entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App at 478.

Furthermore, we find that Dr. Gritzka's opinion is not persuasive because of material inconsistencies. Claimant's attorney asked Dr. Gritzka if the August 1993 work injury was "more likely than not the major contributing cause of the need for treatment (including surgery and the [sic] Dr. North's projected knee replacement), and/or disability of a combined right knee condition of 'right knee status post partial lateral meniscectomy and medial femoral condyle chondroplasty, patellar tendonitis, degenerative changes involving the lateral compartment primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia, extensive changes involving the lateral meniscus with probable tears, moderate joint effusion, grade II chondromalacia of the medial femoral condyle, lateral meniscus tear[.]" (Ex. 30-4; bold print omitted). Dr. Gritzka answered "yes" to that question. (Ex. 30-4, -27).

Although Dr. Gritzka had responded that claimant's work injury was the major contributing cause of her patellar tendonitis, he indicated in a later response that claimant's injury was *not* a material and direct cause or the major contributing cause of her patellar tendonitis. (Ex. 30-5, -9, -29, -30). Also, although Dr. Gritzka had responded that claimant's work injury was the major contributing cause of her grade II/III chondromalacia of the medial femoral condyle, he indicated in a later response that claimant's injury was *not* a material and direct cause or the major contributing cause of her grade II chondromalacia. (Ex. 30-7, -10, -30, -31). In addition to having an inaccurate history, we find that Dr. Gritzka's answers to the aforementioned questions are inconsistent with his previous response and, therefore, his opinion is not persuasive. We conclude that Dr. Gritzka's opinion on causation is not sufficient to establish compensability of claimant's claimed right knee conditions.

None of the other medical opinions support compensability. Dr. Wilson agreed that the "fall in 1993 was acute, self limited and would largely have resolved, though adding to the underlying degenerative changes in a minor and probably insignificant way." (Ex. 32; underline in original.) Dr. Thompson concluded that the degenerative changes involving the lateral compartment were a natural progression of the condition diagnosed in February 1993, prior to the August 1993 injury and he also believed that a lateral meniscus tear was probably present in February 1993. (Ex. 29-3, -4). Dr. Thompson said that moderate joint effusion was present as a result of degenerative changes and not the August 1993 injury. (Ex. 29-4). Dr. Fuller found that claimant's injury on August 17, 1993 was limited to a right knee contusion and strain and he concluded that claimant's August 1994 right knee symptoms related to the preexisting pathology described in the February 1993 arthrogram. (Ex. 25-9).

Premature Closure

Claimant acknowledged that her premature closure challenge to the August 31, 1998 Order on Reconsideration was based on compensability of the additional conditions. (Tr. 7-11). Because we have

determined that those conditions are not compensable, we reinstate and affirm the Order on Reconsideration.

ORDER

The ALJ's order dated July 15, 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 right patella tendonitis, degenerative changes involving the lateral compartment (primarily the lateral tibial plateau and the intercondylar portion of the proximal tibia), tear of the lateral meniscus and grade II chondromalacia of the medial femoral condyle is reversed. The insurer's denial of those conditions is reinstated and upheld. The portion of the ALJ's order setting aside the August 31, 1998 Order on Reconsideration is reversed. The Order on Reconsideration is reinstated. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich dissenting.

The majority mistakenly finds that it is not necessary to address the parties' "law of the case" arguments. Because I believe the "law of the case" is controlling, I respectfully dissent.

The insurer admits that the "law of the case" is that claimant has a compensable fracture of the lateral tibial plateau. The insurer's updated May 11, 1998 Updated Notice of Acceptance at Closure listed the following accepted conditions: right knee contusion/strain, tears of the medial meniscus and anterior cruciate ligament, and fracture of the lateral tibial plateau. (Ex. 31).

Despite the insurer's acceptance of the tibial plateau fracture, the insurer attacks Dr. Gritzka's opinion by arguing that claimant never had a fracture in the first place. Claimant properly relies on *Florence L. Scott*, 44 Van Natta 2454 (1992). In that case, the carrier had accepted the claimant's tendinitis and overuse conditions. We found that two physicians' subsequent contrary opinions were "irrelevant" with regard to the issue of compensability. Furthermore, because the two doctors' opinions were based upon their shared belief that the original conditions were not compensable, we concluded that the persuasiveness of their opinions was diminished.

I would reach a similar conclusion in this case. The opinions of Drs. Wilson and Fuller are based in part on their assertion that claimant had no fracture of the lateral tibial plateau. Because their opinions on causation are inconsistent with the "law of the case," those opinions must be rejected.

I agree with the ALJ that only Dr. Griztka offered an analysis based on the conditions already accepted. Dr. Gritzka properly relied on the presence of a lateral tibial plateau fracture to draw a causal connection regarding claimant's other conditions. He provided extensive analysis supporting his conclusion that the failure to see the fracture during the arthroscopy did not detract from its presence as revealed by the August 1994 MRI. Based on Dr. Gritzka's persuasive opinion, I agree with the ALJ that claimant has established compensability of her right patella tendonitis, degenerative changes involving the lateral compartment (primarily the lateral tibia plateau and the intercondylar portion of the proximal tibia), tear of the lateral meniscus and grade II chondromalacia of the medial femoral condyle.

In the Matter of the Compensation of
ROSE L. LANGLEY, Claimant
WCB Case No. 98-09539
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Phillip Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett'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, except for the next-to-last paragraph,[1] with the following supplementation.

Claimant performed manual labor for the employer for over 20 years before the onset of upper extremity problems. She did not lose work time for medical reasons (other than overtime) before hearing.

Claimant now works as a line attendant in the employer's packaging area and she has performed this job for 4 1/2 to 5 years.[2] In this position, she first works at the cleaning station for a half hour. Then she rips bags off 40 pound blocks of cheese (by hand) and places them on a belt line for initial cutting. Claimant processes 2 1/2 to 3 pallets of cheese in a half hour, or about 180 squares of cheese, in this manner.

After the cutter cuts the blocks into eight pieces each, claimant "take[s] each one and trim[s] it by hand--two pieces off each end, and put[s] it on a patch slicer, which cuts it down to the size you need ." (Tr. 9). After the "weighers" weigh the blocks, claimant moves to "chuck weigh-in, where she breaks the cut blocks apart by hand and feeds them "down the line." (Tr. 10). Some cheese, like sharp cheddar, is much harder to break apart than other types. (Tr. 22).

After that, claimant moves down to the "weigh-in position," where she picks up overweight and underweight pieces and cuts or patches them to size by hand. After the cheese is bagged, claimant watches two lines of cheese passing by simultaneously, 60 bags per minute each, reaching out and straightening the bags as they pass. She also watches for jamming and takes care of the cheese, stacking it by hand, when the bagger jams (or when the old boxing area machine broke down). Then she returns to the cleaning station and begins the half hour rotation process again.[3] She performs these activities 8 hours per day. Claimant used to work a lot of overtime on weekends before she "had too much trouble with the arms" to do it any more. (Tr. 12).

Claimant is right-handed, but she uses both arms all day every day at work. (Tr. 14, 25).

Claimant had trouble with her arms and "up [her] wrists" for about a year before she filed her claim on July 16, 1998. (Tr. 13). Although anti-inflammatories helped some, claimant's elbow pain never went away once it started. (Tr. 25-26).

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[1] We are not just "barely persuaded" by the treating doctors' conclusions and we do not find that Dr. Cunningham's analysis is "*no less likely* an explanation of the cause of claimant's condition than Dr. Radecki's explanation." Instead, we find that claimant has carried her burden of proof by a preponderance of the persuasive medical evidence.

[2] Before that, claimant "worked graveyard sanitation." She dragged hoses around to clean machinery, did a "lot of washing down things with [her] arms and hands," and dried the washed equipment with blown air. (Tr. 16). She also spent about two hours per shift loading dishes to be washed.

[3] Recently, some of the rotation was changed to 15 minute, rather half hour, intervals.

Drs. Nietling and Cunningham, treating physicians, opined that claimant's work activities are the major contributing cause of her bilateral upper extremity problems, which they diagnosed primarily as epicondylitis. (Exs. 14, 18.)[4]

Drs. Radecki and Fuller examined claimant on October 5, 1998 and opined that her upper extremity problems were due to "a combination of aging and other factors of a personal nature leading to a slight decrease in work tolerance with aging and the occasional aches and pains that accompany aging with vigorous but normal work." (Ex. 5-4; see Exs. 10, 15). We find the examiners' opinion unpersuasive for several reasons.

First, the only personal factor identified as contributory is claimant's age--58--and Dr. Cunningham explained that age was not the major cause of the onset of symptoms: Most 58-year-olds do not complain of upper extremity pain "unless they're doing something vigorous or repetitive." (Ex. 18-21-22). Dr. Cunningham implicitly acknowledged that claimant's age contributes to her problems, (*id.*), but the remainder of her opinion and the nature of claimant's work support a conclusion that age is not the primary contributor.

We also find Dr. Radecki's discounting of claimant's work inadequately explained in light of Dr. Cunningham's reasoning. On one hand, Dr. Radecki opined that claimant's age would decrease her "tolerance" for vigorous work and he acknowledged that claimant "could get epicondylitis from doing work activities." (Exs. 5-4, 15-32). On the other hand, Dr. Radecki opined that claimant could not have developed it "suddenly" only 15 days after his examination, when she had performed the putative work activities for over 20 years. (*See* Exs. 10-2, 15-21-22, 15-34). But Dr. Cunningham explained that claimant's condition was not easily diagnosed[5] and it did not develop suddenly. (*See* Ex. 18-21). Thus, in our view, Dr. Cunningham's reasoning is consistent with claimant's history and Dr. Radecki did not adequately explain why he discounted claimant's long repetitive work exposure involving both arms.[6]

Finally, Dr. Radecki opined that claimant's symptoms and findings are "normal" for her age.[7] But Dr. Cunningham explained that most 58-year-olds do not have problems like claimant's: The significant factors that distinguish claimant from other 58-year-olds are the nature and longevity of her work activities and constant upper extremity pain. Accordingly, because we find the treating doctors' opinions well-reasoned and consistent with claimant's history (and the contrary opinions unpersuasive), we agree with the ALJ that claimant has proven her claim under ORS 656.802.

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[4] Dr. Cunningham concurred with 2 examining physicians' opinions. However, she later retracted these concurrences insofar as they addressed causation, explaining that she had not read one concurrence letter "as carefully as [she] should have." (Ex. 18-8). She also explained that, although she agreed that claimant had the symptoms listed in the second report at the time, she would not, in retrospect, agree that with the examiners' causation conclusion. (Ex. 18-9-12; *see* Exs. 9-11). In this regard, Dr. Cunningham noted that claimant did have symptoms and findings of bilateral epicondylitis by the time of her October 22, 1998 examination; her problems were worse with work activities; the development of symptoms was consistent with progression of the condition and the work activities; claimant had no off-work contributory activities; and she had worked at the creamery for 20 years. (Ex. 18-8-21). We find the doctor's explanation for changing her opinion adequate and her ultimate opinion persuasive. We also note that Dr. Cunningham tested claimant and elicited elbow symptoms with hand grasping and resisted pronation and supination. (Ex. 18-24-25).

[5] Dr. Cunningham does not dispute that Dr. Radecki's exam was inconsistent with a firm diagnosis of epicondylitis at that time. (*See* Exs. 18-17, 18-23). But a specific diagnosis is not required to establish compensability; 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). (*See also* Tr. 3).

[6] We also note that Dr. Radecki's reliance on claimant's right hand dominance is unpersuasive because claimant used both arms all day at work every day. (*See* Ex. 15-45, Tr. 25).

[7] Dr. Radecki opined that claimant's degenerative findings were normal for her age and not causing her symptoms. He also stated that claimant has "aches and pains here and there, which is perfectly normal for her age." (Ex. 15-22; *see* Exs. 15-11-12, 15-15-17). Dr. Radecki did not believe that claimant was "making up" her symptoms. (Ex. 15-26).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 28, 1999 is affirmed. For services on review, claimant is awarded an $800 attorney fee payable by the insurer.

In the Matter of the Compensation of
KIMBERLY R. RICE, Claimant
WCB Case No. 99-00425
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board *en banc.*

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that awarded claimant an assessed attorney fee under ORS 656.386(1)(b)(B). In her respondent's brief, claimant seeks an increase in the ALJ's $1,500 attorney fee award. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, which we summarize as follows:

Claimant sustained a compensable injury on September 3, 1997. A "First Medical Report" and an 801 Form described claimant's condition as a "pulled [right] AC strain" and "shoulder strain." (Exs. 2, 3, and 4). The insurer issued a Notice of Acceptance on December 12, 1997 accepting a right shoulder strain. Claimant's attending physician, Dr. Wilson, diagnosed a "probable labral injury" on April 27, 1998.

On May 28, 1998, Dr. Hirsh interpreted a CT scan as apparently showing "thinning of the glenoid labrum anteriorly and superiorly," noting that it was "of uncertain significance" and "may be normal in this patient." Dr. Hirsh concluded that "a small labral tear cannot be definitely be excluded." (Ex. 9). On June 22, 1998, Dr. Wilson identified an anterior capsular laxity secondary to the original injury.

Dr. Wilson declared claimant stationary on August 24, 1998. On November 7, 1998, the insurer issued an Updated Notice of Acceptance at closure accepting only the right shoulder strain. The Notice of Closure was issued on November 11, 1998.

On November 20, 1998, claimant's attorney mailed an objection to the updated Notice of Acceptance at closure to the insurer. Specifically, claimant sought acceptance of her right shoulder labral tear and anterior capsular laxity conditions as "omitted" conditions under ORS 656.262(6)(d). Consistent with that statute, claimant's counsel anticipated a response within 30 days. (Ex. 17).

Claimant's counsel's letter was received by insurer on November 23, 1998. Claimant filed a Request for Hearing alleging a *de facto* denial of the right shoulder anterior labral tear and anterior capsular laxity on January 15, 1999. On February 18, 1999, the insurer issued a modified Notice of Acceptance which included the conditions of labral tear and capsular laxity with the originally accepted right shoulder strain. The hearing on the attorney fee issue was held on April 13, 1999.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's counsel's November 20, 1998 letter was a written objection to the updated Notice of Acceptance at closure pursuant to ORS 656.262(6)(d). Reasoning that the insurer had not responded to claimant's objection within 30 days, the ALJ found that claimant was entitled to an attorney fee pursuant to ORS 656.386(1)(b)(B) for prevailing over a "denied claim."

On review, the insurer argues that claimant's counsel's November 20, 1998 letter was a claim for new medical conditions pursuant to ORS 656.262(7)(a), and because the claim was processed and the conditions accepted within 90 days, no attorney fee may be awarded pursuant to ORS 656.386(1)(b)(B). More specifically, the insurer argues that the 30-day limitation in ORS 656.262(6)(d) is inapplicable because the labral tear and capsular laxity conditions were not diagnosed and in existence at the time of the initial Notice of Acceptance.

The ALJ reasoned that the holding of *Johansen v. SAIF*, 158 Or App 672 (1999), was not controlling. We agree. In *Johansen*, the court devised a three-part definition stating that a new medical condition: (1) arises after acceptance of an initial claim; (2) is related to an initial claim; and (3) involves a condition other than the condition initially accepted. *Id.* The court's decision, however, was in the context of distinguishing between an aggravation claim and a new medical condition. We do not consider that discussion to be controlling when considering the distinction between an objection to a Notice of Acceptance and a "new medical condition."

Here, the conditions of right shoulder anterior labral tear and anterior capsular laxity were not known at the time of the *initial* Notice of Acceptance, but came into existence prior to the *updated* Notice of Acceptance at closure. The issue is one of first impression: whether an objection to a Notice of Acceptance can be raised only in response to an *initial* Notice of Acceptance or whether it may only be raised in reference to an *updated* Notice of Acceptance at closure.

To determine their meanings, we examine the text of the statutes in context, turning to the legislative history only if we cannot discern the meaning of the statutes from that review. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993).

ORS 656.262(7)(c) states:

> "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." (Emphasis added.)

ORS 656.262(7)(c) places an obligation on the insurer to issue an updated Notice of Acceptance at closure. The statute further states that the procedure in ORS 656.262(6)(d) shall apply to the updated notice.

ORS 656.262(6)(d) states that:

> "An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, *first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice.* The insurer or self-insured employer has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. *A worker who fails to comply with the communication requirements of this paragraph may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer.* Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time." (Emphasis added.)

Thus, the statute provides that a worker who believes that the insurer has incorrectly "omitted" a condition from a Notice of Acceptance must submit a written objection to the carrier.

We analyzed ORS 656.262(6)(d) in *Mark A. Baker*, 50 Van Natta 2333 (1998). We stated:

> "ORS 656.262(6)(d) refers to a condition that has been incorrectly omitted from *a* notice of acceptance while ORS 656.262(7)(a) refers to claims for aggravation or new medical conditions after claim acceptance. The words "new," "omitted" and "after" are terms of common usage and should be given their "plain, natural, and ordinary meaning." The word "new" means having existed or having been made but a short time, having

originated or occurred lately, not early or long in being. "After" means following in time or place. "Omit" means to leave out or leave unmentioned." *Id.* at 2335. (Internal citations omitted.)

In the present case, claimant's right shoulder labral tear and anterior capsular laxity conditions were in existence at the time of the *updated* Notice of Acceptance at closure. Under such circumstances, we find that the conditions were omitted from the updated Notice of Acceptance pursuant to the requirements of ORS 656.262(7)(c) and 656.262(6)(d).

In *William B. Barrett*, 51 Van Natta 286 (1999), the claimant requested that the carrier accept new medical conditions after the updated Notice of Acceptance at closure pursuant to ORS 656.262(7)(a). After 30 days, but within 90 days, the carrier accepted the additional conditions. The claimant sought an assessed attorney fee pursuant to ORS 656.386(1)(b)(B), contending that the carrier neglected to timely respond to his objection to the updated Notice of Acceptance at closure. We declined the claimant's attorney fee request. In doing so, we noted that none of the claimed conditions were identified or diagnosed prior to the issuance of the *initial* Notice of Acceptance.

Today's decision is consistent with our holding in *Barrett*. In *Barrett*, the claimant did *not* file a written communication with the carrier objecting to the updated Notice of Acceptance at closure. Thus, the condition precedent for an attorney fee under ORS 656.386(1)(b)(B) (*i.e.*, a written objection under ORS 656.262(6)(d)) was not satisfied.[1] Here, in contrast, claimant filed a written communication with the insurer objecting to the updated Notice of Acceptance at closure. Because the record establishes that the alleged "omitted" conditions were in existence at the time of the *updated* Notice of Acceptance and that the insurer did not respond within 30 days, claimant is statutorily entitled to an insurer paid attorney fee as a result of the insurer's subsequent acceptance of the previously "omitted" conditions.[2]

Claimant's attorney is entitled to an assessed attorney fee because he was instrumental in obtaining a rescission of the *de facto* denial. *See* ORS 656.386(1)(b)(B). At hearing, claimant's counsel sought a $2,400 award for his eight hours of services. Considering the time spent, counsel's representation, complexity of this issue, value of the interest involved and the risk of going uncompensated, the ALJ awarded $1,500 to claimant's attorney. In her respondent's brief, claimant seeks an increased award.

On *de novo* review, we consider the amount of attorney fees by applying OAR 438-015-0010(4) to the circumstances of this case. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain why the factors it has considered lead to the conclusion that a specific fee is reasonable). Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

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[1] We acknowledge that we conducted a substantive review of the record in *Barrett* to determine whether the alleged "omitted" conditions were in existence at the time of the *initial* Notice of Acceptance. On further reflection, such an examination in *Barrett* was unnecessary because the claimant did not file a written objection to a Notice of Acceptance as required by ORS 656.262(6)(d). Moreover, had the claimant in *Barrett* filed such an objection, the proper analysis under today's decision would have been to determine whether the "omitted" conditions were in existence at the time of the *updated* Notice of Acceptance, rather than the *initial* Notice of Acceptance. In light of these circumstances, our discussion of the merits of the "existence" issue in *Barrett* was not only *dicta*, but unnecessary and erroneous under the analysis employed in this case.

[2] We note that ORS 656.262(6)(d) requires that, within 30 days, a carrier must either revise the notice of acceptance or "make other written clarification in response." In other words, the carrier is not obligated to issue a denial within the statute's 30-day period if it decides not to expand its notice of acceptance within that period. Instead, the statute prescribes that, in the absence of a revised notice of acceptance, a carrier must respond in writing providing clarification of its position. For example, if issued within the prescribed 30-day period, a written response explaining that the carrier was continuing its investigation of the claimant's objection would appear to satisfy the statute.

Furthermore, the claim processing requirements set forth in ORS 656.262(7)(a) for a "new medical condition" would only become effective if the worker had specifically requested formal written acceptance of a new medical condition and the medical evidence supported a conclusion that the subsequently accepted condition was, in fact, a "new medical condition." Conversely, if the medical evidence established that the "claimed" condition was actually a worsening of a previously accepted condition, the statutory procedures prescribed in ORS 656.273 and 656.278 would apply.

We have previously held that our mandate in determining the amount of an attorney fee for services regarding a rescinded denial is confined to a claimant's counsel's services prior to the rescission. *Ernest C. Richter*, 44 Van Natta 101 (1992), *on recon* 44 Van Natta 118 (1992). Thus, counsel's services pertaining to "post-rescission" (*i.e.*, following the insurer's February 18, 1999 acceptance) preparation for the hearing have not been considered.

Claimant's counsel stated that 8 hours of service were devoted to this case, which was not challenged by the insurer. The record shows that claimant's counsel prepared and delivered a written objection to the updated Notice of Acceptance at closure and prepared and filed a request for hearing prior to the insurer's rescinded denial.

The case involved issues of medical and legal complexity comparable to disputes generally presented to this forum. The interest involved and the benefit secured are likewise consistent with claims normally litigated before the Hearings Division. Because the insurer modified its acceptance 88 days after claimant's counsel's written communication, 34 days after claimant's hearing request and 54 days prior to the scheduled hearing, the nature of the proceedings were less complex with limited scope than those generally conducted. No frivolous issues or defenses were presented and the parties' positions were advocated in a professional manner. Finally, considering the insurer's reliance on the statutory scheme, there was a risk the claimant's counsel's efforts might have gone uncompensated.

The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4). *See Schoch v. Leupold & Stevens*, 144 Or App 259 (1996). Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. Rather, in accordance with OAR 438-015-0010(4)(g), the amount of time expended in litigating a claim is but one of many factors considered in determining a reasonable attorney fee award. *See Karen M. Stone*, 51 Van Natta 1560 (1999); *June E. Bronson*, 51 Van Natta 928, 931 n. 5 (1999).

We find that a reasonable fee for claimant's attorney's services in obtaining a pre-hearing rescission of the right shoulder labral tear and anterior capsular laxity conditions is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case prior to the rescission (as represented by the record), the complexity of the issue, the value of the interest involved, the nature of the proceedings, and the risk that counsel may go uncompensated. Accordingly, we affirm the ALJ's attorney fee award.

Claimant's counsel is not entitled to an attorney fee on review regarding his services when the sole issue is attorney fees. *See Dotson v. Bohemia*, 80 Or App 233 (1986).

ORDER

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

Board Members Phillips Polich and Biehl specially concurring.

While we agree with the outcome reached by the majority, we believe its rationale and legal reasoning are more burdensome than that required by statute. Therefore, we respectfully issue this special concurrence.

Previously, the Board has held that the award of an attorney fee is based upon a determination of whether the condition for which the claimant attempted to seek acceptance was actually an "omitted condition" or a "new medical condition." *See Mark A. Baker*, 50 Van Natta 2333 (1998) and its progeny. For the reasons set forth below, we would disavow the Board's previous analysis.

We begin our analysis with the text and context of the relevant statutes. *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993). To address the issues raised by the insurer, the provisions relating to "omitted" conditions and an updated Notice of Acceptance at closure are interrelated. An understanding of the procedure depends on an understanding of that relationship.

ORS 656.262(6)(d) states:

"An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice. The insurer or self-insured employer has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A claimant who fails to comply with the communication requirements of this paragraph may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time."

ORS 656.262(7)(c) states:

"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."

ORS 656.386(1) states, in relevant part:

"(a) *** In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed.

"(b) For purposes of this section, a "denied claim" is:

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

"(C) A claim for an aggravation or new medical condition, made pursuant to ORS 656.262(7)(a), with the insurer or self-insured employer does not respond to within 90 days."

Mark A. Baker and its progeny required a determination of whether the claimant's condition was actually an "omitted condition" or a "new medical condition" in order to determine entitlement to an attorney fee. To the contrary, Oregon Workers' Compensation Law does not require the adjudicator to make an actual distinction between an "omitted condition" and a "new medical condition" for the purposes of awarding attorney fees pursuant to ORS 656.386(1)(b)(B) or (C).

Reading the statutes as a whole, it is clear that a written communication requesting that an omitted condition be accepted begins the process. There is no ambiguity. ORS 656.262(7)(c) makes the process applicable to an updated Notice of Acceptance at closure. ORS 656.262(6)(d) requires that once the claimant has properly communicated an objection to *any* Notice of Acceptance,[1] the carrier has 30 days to respond. However, we do not find that the statute requires the carrier to accept or deny a condition within 30 days of an objection. Only that the carrier is obligated to revise or to "make other written clarification in response." *Id.*

Here, claimant's attorney provided the proper written communication to the insurer. The letter stated with particularity that claimant was requesting that "omitted" conditions be accepted and *specifically referenced ORS 656.262(6)(d).* Thus, the claim was clearly made under that statute and not under ORS 656.262(7)(c). The insurer did not provide any response prior to the expiration of the 30-day limitation set forth in ORS 656.262(6)(d).

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[1] We would interpret the term *any* to refer to, but not necessarily limited to, an initial Notice of Acceptance, any subsequent amended Notice of Acceptance, an updated Notice of Acceptance at closure, or any subsequent amended updated Notice of Acceptance at closure. An objection pursuant to ORS 656.262(6)(d) may be made at *any* time.

ORS 656.386(1)(b)(B) states that if the insurer fails to respond within 30 days to an objection, then it will be considered a *de facto* denial and the attorney is entitled to fees in the event the insurer later rescinds the denial. That is precisely what occurred here. The insurer failed to respond within 30 days and later accepted the conditions claimant's attorney had raised.

We would disavow *Mark A. Baker, supra,* and its progeny, to the extent that this prior case law incorrectly requires a distinction between an "omitted condition" and a "new medical condition claim." ORS 656.386(1)(b)(B) and (C) allow a claimant to specify which type of claim is being made. Once a claim is made and the statute is identified, it is then up to the carrier to respond to the claim within the appropriate time period. Contrary to *Baker,* the statute does not require the factfinder or carrier to look behind the request. As noted, claimant in this case made a claim under ORS 656.262(6)(d) and the carrier did not respond within the 30 day period allowed for that type of claim. Thus, ORS 656.386(1)(b)(B) provides a fee for a denied claim in that circumstance. The statutes do not require any more stringent examination of the claim or any other determination.

For substantive purposes, we believe the distinction of what actually constitutes an "omitted condition" or a "new medical condition" is properly determined by the majority opinion in this case and prior case law.

January 31, 2000 Cite as 52 Van Natta 143 (2000)

In the Matter of the Compensation of
VERNA F. THOMAS, Claimant
Own Motion No. 95-0456M
SECOND OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our July 22, 1999 Own Motion Order Reviewing Carrier Closure, as reconsidered on November 8, 1999. Our prior orders affirmed the insurer's March 18, 1999 Notice of Closure in its entirety. On December 6, 1999, we abated our prior orders to allow the insurer sufficient time to respond to claimant's motion. The time for a response having expired, we proceed with our reconsideration. On reconsideration, we adhere to our prior orders, as supplemented below.

In our prior orders, we based our findings on Dr. Nolan's February 25, 1999 medical report, which found claimant medically stationary on that date. We concluded that Dr. Nolan, an insurer-arranged medical examiner, offered the most well-reasoned and fact-based opinion.

In her request for reconsideration, claimant repeats her contention that the "improvement of range of motion from 55 to 70, or 75, degrees is not a minimal improvement," but rather an objective finding that her condition has materially improved. However, as stated above, we considered the record we had before us, which, in this case, necessarily included the range of motion findings. Therefore, when we concluded that the insurer's March 18, 1999 Notice of Closure was proper, we had taken the change in claimant's range of motion into consideration.

Claimant provides no new argument to dispute our findings in our July 22, 1999 Own Motion Order, as reconsidered on November 8, 1999. In those orders, we explained our reasoning supporting our conclusion that claimant was medically stationary when the insurer closed her claim. After further consideration, we have nothing to add to our analysis of the persuasiveness of the existing medical evidence or our determination that, on this record, claimant was medically stationary when the insurer closed her claim on March 18, 1999.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 22, 1999 order, as reconsidered on November 8, 1999, effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERI L. BERNLOEHR, Claimant
WCB Case Nos. 99-03995 & 98-09603
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Phillip Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld the self-insured employer's November 16, 1998 partial denial of her cervical strain condition; (2) declined to award interim compensation; and (3) declined to assess penalties and attorney fees for allegedly failing to process the cervical strain as a new injury claim. On review, the issues are compensability, interim compensation, penalties and attorney fees.

We adopt and affirm the order of the ALJ with the following supplementation addressing claimant's contention that the ALJ incorrectly found that claimant was not entitled to interim compensation. Specifically, claimant asserts that the employer had knowledge of a "new" claim, that claimant should have been paid interim compensation while the claim was in deferred status, and that the failure to do so entitles claimant to penalties and attorney fees.

A worker is entitled to interim compensation if she has suffered a loss of earnings as a result of a work-related injury. *RSG Forest Products v. Jansen,* 127 Or App 247 (1994); *Robert W. Fagin,* 50 Van Natta 1680 (1998). The first installment of temporary disability compensation shall be paid no later than the 14th day after the employer has notice or knowledge of the claim, *if* the attending physician authorized the payment of temporary disability compensation. ORS 656.262(4)(a). A worker's entitlement to interim compensation, therefore, is triggered by the attending physician's authorization relating the claimant's inability to work to the job-related injury. *Robert W. Fagin,* 50 Van Natta at 1681; *see also Rustee R. St. Jean,* 49 Van Natta 2161 (1997).

Here, claimant must not only show that the employer had knowledge of a claim but also, as noted by the ALJ, that the claim was represented by medical verification of an inability to work due to the "new" injury. For the following reasons, we agree with the ALJ that the record fails to establish the attending physician authorized claimant's inability to work due to a new injury.[1]

As noted by the ALJ, Dr. Moshofsky, who treated claimant the day after the cash register incident, assessed this incident as "persistent problems with the upper back musculature." (Ex. 13). Dr. Moshofsky's follow-up notes on June 19, 1998 stated that claimant suffered from an "exacerbation of an existing work injury" (referring to the April 2, 1998 right shoulder sprain.) (Ex. 14). Most importantly, Dr. Moshofsky's chart notes do not provide authorization for temporary disability due to the "new" injury.

Claimant's follow-up examination with Dr. Otten on July 2, 1998 resulted in his reaffirming his original diagnosis from April 23, 1998 without any notation as to temporary disability due to new or additional injuries. In fact, as noted by the ALJ, the first reference in claimant's medical history to limitations due to her neck are not until late August and the reference does not establish a connection between the noted limitations and the June 16, 1998 incident. (Ex. 25). In sum, as chronicled by the ALJ, claimant's medical records do not provide physician verification that she was entitled to temporary disability due to the June 16, 1998 incident. (Ex. 26; 29; 33; 34; 35; 36; 38; 40; 41; 45; 47; 48).

Accordingly, we agree with the ALJ that claimant did not establish medical verification of the inability to work related to the June 16, 1998 incident. Therefore, claimant did not establish an award of interim compensation is merited.

ORDER

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

[1] We do not reach the issue of whether claimant established the employer had knowledge of a new claim, because we find, in light of the absence of physician verification, the issue is not dispositive.

In the Matter of the Compensation of
ROBERT M. LIMA, Claimant
Own Motion No. 00-0023M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On January 19, 2000, we issued an Own Motion Order that authorized the reopening of claimant's claim for the provision of temporary disability compensation beginning November 4, 1999, the date claimant was hospitalized for surgery. Following our order, we received a letter from the SAIF Corporation indicating that claimant had requested that any temporary disability compensation awarded in this matter should begin January 1, 2000.

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.*

With its request for reconsideration, SAIF submitted a copy of a letter it received from claimant wherein he requests that "no time loss be issued for November 1999 and December 1999. Any time loss should start January 1, 2000." In its correspondence, SAIF asks that we "honor" claimant's request. We interpret SAIF's request as a concurrence with claimant that temporary disability compensation should be awarded to commence on January 1, 2000.

Under ORS 656.278(1), the Board *may*, upon its own motion, modify, change or terminate former findings, orders, or awards if in its opinion such action is justified. Here, inasmuch as the parties agree that temporary disability compensation should be awarded beginning January 1, 2000, rather than the date claimant underwent surgery on November 4, 1999, we conclude modification of our prior order is justified.[1]

Accordingly, we withdraw our January 19, 2000 order, which found that the commencement of claimant's temporary disability should begin November 4, 1999. Instead, on reconsideration, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning January 1, 2000. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.[2]

IT IS SO ORDERED.

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[1] Although we are modifying our prior order to grant claimant's request that his temporary total disability compensation start on January 1, 2000, we emphasize to claimant that he is legally entitled to have his temporary total disability compensation start on November 4, 1999, the date he underwent compensable surgery. ORS 656.278(1)(a).

If claimant needs advice regarding his rights are under his own motion claim, he may contact the Workers' Compensation Ombudsman. The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial party. Inasmuch as claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

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

[2] If claimant changes his mind and decides that he wants to have his temporary total disability begin on November 4, 1999, the date he underwent compensable surgery, he must request reconsideration of this order as soon as possible.

In the Matter of the Compensation of
NANCY L. PENDERGAST-LONG, Claimant
Own Motion No. 95-0408M
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 March 31, 1999 Notice of Closure which closed her claim with an award of temporary total disability compensation from September 22, 1995 through December 24, 1995, and temporary partial disability from December 25, 1995 through January 31, 1996. SAIF declared claimant medically stationary as of September 1, 1996. Claimant does not contend that SAIF's closure was premature. Rather, claimant contends that she is entitled to additional temporary disability benefits from September 22, 1995 through September 1, 1996, less time worked.

Claimant has the burden of proving by a preponderance of the evidence that she was entitled to temporary disability benefits for the time in question. *See* ORS 656.266. A claimant's substantive entitlement to temporary disability benefits is determined at claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992).

Furthermore, the temporary disability need not be total. Claimant may be entitled to temporary partial disability benefits when the disability becomes only partial. ORS 656.212. Thus, where the disability is partial, claimant is entitled, at least theoretically, to temporary partial disability benefits during the period she is partially disabled. ORS 656.212; *David L. Gooding*, 47 Van Natta 1468 (1995); *Ricardo Morales*, 47 Van Natta 1394 (1995). If modified work is paid at claimant's regular work wage; however, claimant's temporary disability rate would be zero.

In a handwritten February 6, 1996 physical therapy chart note, the therapist recorded that claimant was working full-time, "80 hrs/pay period." In a February 26, 1996 "Outpatient Physical Therapy Discharge Summary," the therapist noted that "[claimant] is continuing to work full-time."

In a March 14, 1996 medical report, Dr. Miller, claimant's attending physician, noted that claimant had returned to work full-time, albeit exceeding the "fairly strict restrictions" he placed on her work capacity. Claimant attended a follow-up examination with Dr. Miller on September 24, 1999. At that time, Dr. Miller noted that claimant had quit her previous employment and was currently employed, full-time, as a home health nurse. Finally, on March 12, 1999, in response to an inquiry from a SAIF representative, Dr. Miller declared claimant to be medically stationary as of September 1, 1996.

With her request for review, claimant submitted a May 17, 1999 affidavit wherein she attested that she had not returned to full-time work since the date of her surgery, *i.e.* September 22, 1995. The record does not support claimant's assertions. As noted above, the physical therapy chart notes and Dr. Miller's medical reports support a finding that claimant had returned to full-time work by February 1996, although Dr. Miller noted that she was exceeding her work restrictions. Additionally, there is no medical evidence that would indicate that claimant was disabled after she returned to full-time work in February 1996 and/or before she was found medically stationary on September 1, 1996.

On this record, we are persuaded that claimant was medically stationary on September 1, 1996 as SAIF declared. Further, based on the uncontroverted medical evidence, we are not persuaded that claimant has established that she was disabled due to her compensable injury until September 1, 1996, and, thus, entitled to temporary disability benefits until that time.

Accordingly, we affirm SAIF's March 31, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN P. SCHRIBER, Claimant
Own Motion No. 98-0490M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Westmoreland & Mundorff, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 1, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from April 7, 1998 through June 9, 1999. SAIF declared claimant medically stationary as of June 9, 1999. Claimant does not appear to contest his medically stationary status or the temporary disability compensation award. Instead, claimant contends that he is entitled to permanent total disability benefits. We disagree.

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). Effective January 1, 1988, the Board no longer has Own Motion authority to award permanent disability benefits. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990).

Here, claimant compensably injured his low back on June 21, 1983. This injury claim was first closed on July 23, 1984, and claimant's aggravation rights expired five years later, on July 23, 1989. ORS 656.273(4)(a). Thus, when claimant's condition worsened requiring surgery on April 7, 1998, claimant's claim was under our own motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on December 9, 1998, we issued our own motion order authorizing the payment of temporary disability compensation and ordering SAIF to close the claim pursuant to OAR 438-012-0055 when claimant's condition was medically stationary.

Because claimant's claim is in Own Motion status, we are without authority to award any further permanent disability benefits. *See Miltenberger v. Howard's Plumbing*, 93 Or App at 475; *Independent Paper Stock v. Wincer*, 100 Or App at 625. Accordingly, we are unable to grant claimant's request for an award of permanent total disability benefits. *See Charles H. Jones*, 47 Van Natta 1546 (1995); *David L. Grenbemer*, 48 Van Natta 195 (1996).

In addition, to the extent that claimant contends that his condition was not medically stationary at claim closure, that contention fails on this record.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 1, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

On June 9, 1999, Dr. Grewe, claimant's attending physician, noted that he "thinks [claimant's] condition is stationary." Dr. Grewe further opined that claimant did not require further neurosurgical treatment. This opinion is unrebutted. Furthermore, although Dr. Grewe indicates that claimant may need some pain management, 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. Grewe's unrebutted medical opinion, we find that claimant was medically stationary on the date his claim was closed. Therefore, he is not entitled to additional temporary disability beyond June 9, 1999. Accordingly, we affirm SAIF's July 1, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA M. DePAOLO, Claimant
Own Motion No. 98-0269M
OWN MOTION ORDER
Floyd H. Shebley, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer initially submitted claimant's request for temporary disability compensation for her compensable bilateral carpal tunnel injury. Claimant's aggravation rights on that claim expired on March 13, 1995.

On June 18, 1998, as amended on August 27, 1998, the insurer denied the compensability of and responsibility for claimant's current cervical spondylistic changes at C5-6, with canal stenosis and some thecal compression condition. Claimant requested a hearing. (WCB Case No. 98-04991). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated December 1, 1998, Administrative Law Judge (ALJ) Peterson, among other things, set aside the insurer's June 18, 1998 and August 27, 1998 denials, finding that the insurer remained responsible for claimant's current neck condition. The insurer did not request Board review of that portion of the ALJ's order. Thus, claimant's current cervical condition is compensable under the November 1984 injury.

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.

The Board's staff has made multiple inquiries regarding whether claimant's current cervical condition requires surgery or hospitalization. Claimant responded that she would decide whether or not to have surgery after seeing Dr. Slack, a spinal diagnostics physician to whom her attending physician, Dr. Long, had referred her. On November 12, 1999, Dr. Slack examined claimant and administered a cervical epidural steroid injection for both diagnostic and therapeutic purposes. Following the injection, Dr. Slack opined that further treatment would consist of more epidurals and facet joint injections.

Pursuant to ORS 656.278(1)(a), temporary disability benefits may be awarded only when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. We have previously interpreted "surgery" to be an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta 1538 (1990). In addition, epidural injections done on an outpatient basis do not qualify as surgery or hospitalization. *Victor Schunk*, 50 Van Natta 2049 (1998); *Carol Knodel*, 45 Van Natta 426 (1993).

The epidural that claimant underwent in November 1999 was an in-office procedure that did not require hospitalization. The chart note submitted demonstrates that epidural injection may have provided some relief of claimant's current cervical pain complaints; however, the injection does not qualify as "surgery" within the meaning of ORS 656.278(1)(a). Nor does this outpatient procedure qualify as "other treatment requiring hospitalization." *Tamera Frolander*, 45 Van Natta 968 (1993) (the claimant did not qualify for temporary disability compensation where her sympathetic nerve block injections did not rise to the level of surgery or hospitalization); *Victor Schunk*, 50 Van Natta at 2049; *Carol Knodel*, 45 Van Natta at 426.

Finally, Dr. Slack did not recommend surgery as future treatment. Rather, he opined that claimant's future treatment would involve additional epidural injections and facet joint injections. Thus, 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.[2]

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] In response to the Board's staff's multiple inquires regarding the parties' positions following the ALJ and Board orders, the insurer raised the possibility of a work force issue. However, inasmuch as we have concluded that we are without authority to grant claimant's request for own motion benefits on the basis of a lack of surgery or hospitalization, we need not address the insurer's contention regarding claimant's "work force" status.

[2] In the event that claimant disagrees with our decision, she may request reconsideration. However, because our authority to further consider this matter expires within 30 days of this order, she should submit her information as soon as possible.

In the Matter of the Compensation of
KIMBERLY K. PENN, Claimant
WCB Case No. 98-09414
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of claimant's injury claim for a neck and low back condition; and (2) assessed a penalty for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's order regarding compensability.

Penalties

On November 23, 1998, the insurer denied claimant's injury claim for neck and low back pain on the basis there were "no objective findings to substantiate your condition or a specific diagnosis." (Ex. 29). The ALJ found that the "827" form and the underlying chart note, as well as Dr. Halpert's September 4, 1998 chart note, clearly established the presence of objective findings. The ALJ found that the insurer's denial was unreasonable and assessed a penalty.

The insurer relies on Dr. Halpert's reports indicating there were no objective findings to argue that claimant is not entitled to a penalty.

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

At the time of the insurer's November 23, 1998 denial, it had Dr. Halpert's September 25, 1998 chart note that diagnosed "increasing complaints without obvious objective findings," as well as a "negative MRI." (Ex. 21). On October 26, 1998, Dr. Halpert indicated the physical therapist told him claimant had no objective findings and was exhibiting significant pain behavior. (Ex. 24). One day later, Dr. Halpert diagnosed "multiple complaints without objective findings." (Ex. 25). In an October 27, 1998 letter to Dr. Hudson, Dr. Halpert said claimant's MRI showed no objective findings and the physical therapist was concerned that claimant did not have anything objective. (Ex. 26).

We agree with the ALJ that claimant has established "objective findings" of an injury.[1] Nevertheless, based on the reports from Dr. Halpert, we find that the insurer had a legitimate doubt as to whether claimant's injury claim was compensable. Consequently, we conclude that the insurer's denial is not unreasonable and claimant is not entitled to a penalty.

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

ORDER

The ALJ's order dated August 17, 1999 is affirmed in part and reversed in part. That portion of the ALJ's order that assessed a penalty for the insurer's unreasonable denial is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

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

In the Matter of the Compensation of
ROBERT E. ANDERSON, Claimant
Own Motion No. 97-0438M
OWN MOTION ORDER
Willner, Wren, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

On October 28, 1998, we authorized reopening of claimant's claim for the payment of temporary disability compensation beginning the date he was hospitalized for the proposed surgery. Claimant requests enforcement of our October 28, 1998 order, contending that the insurer had unilaterally terminated his temporary disability benefits. Specifically, claimant requests reinstatement of his benefits, as well as penalties and attorney fees for unreasonable claim processing.

In response, the insurer contends that: (1) it perfected an objection to the current out-of-state physician on August 16, 1999, on which claimant filed an appeal with the Medical Director (MRU Case No. 2050); and (2) it has no records that claimant has sought treatment since July 6, 1999, and therefore is unable to "medically verify [claimant's] inability to work." For these reasons, the insurer contends that it properly suspended claimant's temporary disability benefits pending the outcome of the medical issues litigation. Based on the following reasoning, we disagree with the insurer's contentions

Entitlement to Temporary Disability Compensation

Temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-0055; (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(3)(a) through (c). *See* OAR 438-012-0035(4).[1]

Here, claimant's claim has not been closed nor has a claim disposition agreement been filed pursuant to ORS 656.236(1). Rather, it appears that the insurer terminated claimant's temporary disability compensation partially based on its assumption that claimant has failed to seek medical treatment. While the Department does have rules that allow such termination of benefits under ORS 656.268(3)(d) and ORS 656.262(4)(e), there are no similar provisions for termination of benefits in an Own Motion claim pursuant to ORS 656.278. *See Ronald P. Olson*, 51 Van Natta 354 (1999); *Brian K. Lutz*, 49 Van Natta 2009 (1997); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996); *Pamela Vinyard*, 48 Van Natta 1442 (1996). Rather, as noted, termination of temporary disability benefits in a claim reopened under ORS 656.278 can only occur when a claimant is medically stationary, or when a CDA extinguishes a claimant's right to further temporary disability compensation, or when termination of such benefits is authorized under ORS 656.268(3)(a) through (c). *See* OAR 438-012-0035(4).

Claimant's claim is in open status; therefore, the issue is claimant's procedural entitlement to temporary disability. In an open own motion claim, an insurer may unilaterally terminate a worker's temporary disability compensation when any of the criteria under ORS 656.268(3)(a) through (c) have been met.

ORS 656.268(3) provides, in relevant part:

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

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

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[1] OAR 438-012-0035(4) provides:

"Temporary disability compensation shall be paid until one of the following events 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)."

"(b) The attending physician advises the worker and documents in writing that the workers 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."

We have previously held that the requirements of ORS 656.268(3)(a) through (c) are clear, unambiguous and specific in what is required before an insurer may unilaterally terminate temporary disability benefits. *See generally Trevor E. Shaw*, 46 Van Natta 1821, *on recon* 46 Van Natta 2168 (1994). There is no evidence demonstrating that any of those requirements were met here.

Further, the insurer argues that, because there is litigation regarding its challenge of the status of claimant's current out-of-state physician, temporary disability compensation has been suspended pending the outcome of that litigation. However, the insurer offers no statutory, regulatory or case authority to support its suspension of claimant's temporary disability compensation pending the resolution of this issue before the Director.

OAR 438-012-0035(5)[2] provides that an own motion insurer may make a written request to the Board for suspension of temporary disability compensation, if the insurer believes that such compensation should be suspended for any reason. This rule also provides the procedures by which the insurer must notify the claimant of any such request and the procedures by which the parties may submit their respective positions. Importantly, this rule also declares that the insurer is *not* permitted to suspend compensation without prior written authorization by the Board. *Id.*

Here, the insurer did not make any written request to suspend claimant's benefits pursuant to OAR 438-012-0035(5). Instead, the insurer unilaterally terminated claimant's temporary disability benefits. Additionally, as explained above, we find that the necessary criteria to terminate temporary disability compensation pursuant to ORS 656.268(3)(a-c) have not been met. Therefore, claimant's temporary disability compensation should not have been terminated. Accordingly, we conclude that claimant is entitled to further temporary disability compensation beginning August 17, 1999, to continue until such benefits can be lawfully terminated.

Penalties and Attorney Fees

Claimant requests penalties and attorney fees for the insurer's allegedly unreasonable claims processing and failure to pay compensation. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount up to 25 percent of the amounts "then due." The insurer's refusal to pay compensation is not unreasonable if it has a legitimate doubt about its liability. *Castle & Cook, Inc. v. Porras*, 103 Or App 65 (1990). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier at the time of its refusal to pay compensation. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Here, our October 28, 1998 order authorized temporary disability to be paid until the insurer could lawfully terminate such benefits. The question becomes whether the circumstances on which the insurer based its termination of claimant's benefits provided it with a legitimate doubt regarding its continuing liability to pay such benefits.

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[2] OAR 438-012-0035(5) provides:

"If the own motion insurer believes that temporary disability compensation should be suspended for any reason, the insurer may make a written request for such suspension. Copies of the request shall be mailed to claimant and the claimant's attorney, if any, by certified or registered mail. Unless an extension is granted by the Board, claimant or claimant's attorney shall have 14 days to respond to the Board in writing to the request. Unless an extension is granted by the Board, the insurer shall have 14 days to reply in writing to claimant's response. The insurer shall not suspend compensation under this section without prior written authorization by the Board."

On this record, we are not persuaded that the insurer had a legitimate doubt regarding its continued obligation to pay compensation on claimant's own motion claim in accordance with our prior order. As previously noted, the insurer did not request suspension of claimant's temporary disability benefits nor did it receive our authorization to suspend such benefits. OAR 438-012-0035(5).

Furthermore, we have found that the insurer was not entitled to unilaterally terminate temporary disability compensation under ORS 656.268(3)(a) through (c). Given that the terms of the statute are clear, unambiguous and specific, outlining the specific criteria that must be satisfied before a carrier may unilaterally terminate temporary disability compensation, and that the record does not reveal that any of those criteria were satisfied prior to August 17, 1999, we conclude that the insurer's conduct in unilaterally terminating temporary disability compensation on August 17, 1999 was unreasonable.

Consequently, pursuant to ORS 656.262(11)(a), we find that claimant is entitled to a penalty of 25 percent of the amounts "then due" as a result of this order, payable in equal shares by the insurer to claimant and his attorney. *See John R. Woods*, 48 Van Natta 1016 (1996); *Jeffrey D. Dennis*, 43 Van Natta 857 (1991).

Accordingly, the insurer is directed to recommence temporary disability compensation beginning August 17, 1999, the date it terminated compensation, and continuing until the insurer can lawfully terminate such benefits. The penalty assessed by this order shall be based on the unpaid temporary disability compensation made payable by this order from August 17, 1999 through the date of this order (unless said compensation could be lawfully terminated under OAR 438-012-0035 prior to 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 insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH M. ENFIELD, Claimant
WCB Case No. 99-00403
SECOND ORDER OF DISMISSAL (REMANDING)
Sather, Byerly & Holloway, Defense Attorneys

On January 7, 2000, we dismissed claimant's request for Board review because we found that claimant had not provided notice of his "appeal" to all parties to the proceeding within 30 days of the Administrative Law Judge's (ALJ's) October 25, 1999 order. In response to our order, claimant has submitted a letter explaining that his initial letter (the document that was interpreted as a request for Board review) was actually an inquiry to the ALJ seeking information on his case (because claimant had not received a copy of the ALJ's order). We treat claimant's submission as a motion for reconsideration. Under these circumstances, we withdraw our Dismissal Order and remand the case to the ALJ with instructions to republish his order.

FINDINGS OF FACT

On October 25, 1999, the ALJ issued an Opinion and Order that upheld the employer's denial of claimant's right shoulder condition. Copies of that order were mailed to the employer, its claim processing agent and its attorney. Claimant's copy of the ALJ's order was mailed to 5405 Mack Road # 4, Sacramento, California. The hearings file and claimant's correspondence indicate that claimant's correct address is on that road, in that city and state, but at # *14*, rather than # 4.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order shall be mailed to all parties in interest. ORS 656.289(3). "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). If an ALJ's order is not mailed to all parties, the order is not final and is not subject to Board review. *Richard F. Taylor*, 40 Van Natta 384 (1988); *Martin N. Manning*, 40 Van Natta 374 (1988); *see Taylor v. Liberty Northwest Insurance Corporation*, 107 Or App 107, 110 (1991).

Here, the ALJ's order does not provide that a copy of the order was mailed to claimant's correct address. Because claimant was a party to the proceeding before the ALJ, the ALJ's order is not final and is not subject to our review. ORS 656.289(2), (3); *Taylor*, 40 Van Natta at 384; *Manning* 40 Van Natta at 374. Inasmuch as the ALJ's order is not final, any request for review would be premature.

Accordingly, insofar as claimant requested Board review, his request is dismissed. This matter is returned to ALJ Lipton for the issuance of a republished and final order bearing a new date of actual mailing with copies mailed to all parties to the proceeding at their correct addresses, as well as their respective representatives. The republished order should also include new appeal rights.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES P. ILSLEY, Claimant
WCB Case Nos. 99-03346 & 99-03344
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Cavanagh & Zipse, Defense Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Meyers.

Farmers Insurance Group (Farmers), on behalf of Paragon Refinishing Technologies, requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its denial of claimant's aggravation claim for his current low back condition; and (2) upheld the SAIF Corporation's denial, on behalf of Express Systems Northwest, of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except the third full paragraph on page 2 of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Claimant performed physical labor for both employers. He injured his low back while working for Farmers' insured on October 25, 1997. Dr. Grewe operated to remove L5-S1 disc fragments in November 1997 and Farmers accepted claimant's injury claim.

Claimant recovered slowly, but completely, after surgery. He returned to work as a self-employed painter in June 1998. In or around October 1998, claimant gave up his self employment and began working for SAIF's insured. His low back was asymptomatic until February 1999, when he suffered two injuries moving heavy desks at work. Claimant again sought treatment from Dr. Grewe. After the second (more serious) incident, claimant filed claims with both insurers. The claims were denied on responsibility grounds and an order issued under ORS 656.307(1).

Dr. Grewe operated on claimant's low back again on June 30, 1999. The surgery involved repair of 2 herniations, laminectomy decompression, interbody fusion with Ray cages at L5-S1, and removal of scar tissue from the previous surgery. Claimant requested a hearing from the denials.

The ALJ held that responsibility for claimant's condition did not shift from Farmers to SAIF, because Farmers failed to prove that claimant suffered a "new injury" while working for SAIF's insured. We reach the opposite result, as follows.

We agree with the ALJ's recitation of the applicable law and adopt his opinion in this regard, through the last full paragraph on page 4 of the Opinion and Order. In summary: To escape responsibility for claimant's current low back condition, Farmers must establish that claimant's injury

during SAIF's coverage was the major contributing cause of the current condition, or the disability or need for treatment therefore. *See SAIF v. Drews*, 318 Or 1 (1993) (In order to shift responsibility to a subsequent employer under ORS 656.308, the last employer with an accepted claim has the burden to show that the subsequent employment is the major contributing cause of the condition.).

The medical evidence concerning causation is provided by Dr. Grewe, treating physician, and Drs. Rosenbaum and Wilson, independent examiners. We generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. In this case, we find no such reasons.

Dr. Grewe treated claimant before and after the 1999 injuries. His second surgery findings confirmed his pre-surgery expectation that claimant had, not only scar tissue from his previous surgery, but also recurrent *and* new disc findings. (*See* Exs. 21-6-7, 29-2, 30-1). Dr. Grewe opined that claimant's disc herniations were the primary cause of his need for surgery. (*See* Ex. 28A). He reasoned that claimant had recovered from the first surgery, he was able to perform physical work for several months without problems, and he was asymptomatic until the sudden onset of severe symptoms in February 1998. (*See* Exs. 21-7, 29-3). We find Dr. Grewe's opinion persuasive because it is well-reasoned[1] and based on an accurate and complete history.

We find the contrary opinions of Drs. Rosenbaum and Wilson unpersuasive, because they are based on inaccurate information in two important respects. First, the examiners believed that claimant did not have a herniation in 1999. (*See* Exs. 23-3, 28-1, 28-6). This belief is rebutted by Dr. Grewe's surgical findings.[2] (Ex. 30). Second, the examiners relied on an inaccurate history that claimant's symptoms continued after his first surgery. (*See* Exs. 23-4-5, 28-5). Claimant's credible testimony and the remainder of the record establish that claimant was asymptomatic and able to perform physical labor after the 1997 surgery -- until the 1999 injuries during SAIF's coverage. (*See* Tr. 17, 21, 26). Under these circumstances, we do not rely on the examiners' opinions.

We rely on Dr. Grewe's opinion because we find no persuasive reason to discount it. Accordingly, based on that opinion, we conclude that claimant suffered a "new injury" while working for SAIF's insured and responsibility for claimant's current condition shifts from Farmers to SAIF. ORS 656.308.

ORDER

The ALJ's order dated August 11, 1999 is reversed. Farmers Insurance Group's denial is reinstated and upheld. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. The ALJ's attorney fee award is payable by SAIF rather than Farmers.[3]

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[1] The ALJ found Dr. Grewe's opinion inadequately reasoned for failure to weigh the relative contributions of claimant's preexisting scarring and the 1998 injuries. We do not find Dr. Grewe's reasoning defective. He consistently opined that the 1998 injuries were the primary cause of the recent need for surgery, noting that claimant was entirely asymptomatic for some time before the sudden onset of symptoms in early 1998. Dr. Grewe also observed claimant's condition firsthand and over time, before *and* after critical events. *See Kienow's Food Stores v. Lyster*, 79 Or App 416, 421 (1986) (greater weight accorded to physicians who observed the claimant's condition before and after the critical event). He repaired claimant's herniations and his preexisting scarring, without altering his causation conclusion. Dr. Grewe had an accurate and complete history, and his reasoning, findings, and conclusions are entirely consistent with that history. His conclusions are also consistent with the surgical discovery of a "new" disc herniation. Under these circumstances, we do not find that Dr. Grewe failed to weigh the preexisting condition or that his conclusion is based solely on a temporal relationship.

[2] Dr. Rosenbaum opined that claimant did not have a 1999 disc herniation even after Dr. Grewe's 1999 surgical report. (Ex. 31, *see* Ex. 30).

[3] We note that claimant's former counsel has submitted a "Notice of Attorney Fee Lien," asserting entitlement to a carrier-paid attorney fee for services rendered. It is well-settled that an attorney fee award is granted to the current attorney-of-record. *See Gabriel Zapata*, 46 Van Natta 403 (1994). The manner in which that fee should be shared between claimant's current and former counsel is a matter to be decided between them, not this forum. *Id.*

Board Member Meyers dissenting.

Because the persuasive medical evidence does not establish that claimant's 1999 work incident was the major contributing cause of his need for treatment or disability attributable to his combined L5-S1 herniated disc condition, I would find that claimant did not sustain a "new compensable injury" under ORS 656.308(1). Consequently, I respectfully dissent.

In reaching its conclusion, the majority relies on the opinion expressed by Dr. Grewe. As the treating surgeon for claimant's 1997 and 1999 surgeries, Dr. Grewe is in an advantageous position to offer an opinion. Nonetheless, for the reasons that follow, I find persuasive reasons to discount Dr. Grewe's opinion.

As noted by the majority, it is Dr. Grewe's opinion that the 1999 work incident was the major cause of claimant's additional disability and need for treatment. In making this determination, Dr. Grewe's "pre-1999 surgery" diagnosis was that claimant had experienced a "small recurrent disc" which was related to the 1999 employment episode. This diagnosis was partially confirmed during the 1999 surgery, from which Dr. Grewe observed a small recurrent disc and removed disc material.

Yet Dr. Grewe also noted that claimant's L5-S1 nerve root was "quite firmly adherent to the annulus scar tissue and a small recurrent disk at this level," to such a degree that he "had to take a small chisel and cut the scar tissue edges free so that the central portion could be mobilized." (Exhibit 30-3). This latter finding is consistent with conclusions reached by both Dr. Rosenbaum and Dr. Wilson that claimant's current disability and need for treatment was attributable to scar tissue from the 1997 surgery. This "scar tissue" finding further coincides with Dr. Rosenbaum's "post-1999 surgery" persuasive explanations that: (1) once a disc annulus has ruptured, additional disc material can escape at any time to cause nerve root compression; and (2) a recurrent disc herniation is more likely to occur closer in time to the original rupture (within one year of surgery not being uncommon), which is an indication that all of the free disc material was not removed during the first surgery.

Dr. Grewe acknowledged the contribution from scar tissue in describing claimant's condition as a "combined problem;" *i.e.*, a recurrent herniation and scar tissue combination. Nonetheless, in concluding that claimant's 1999 work injuries were 51 percent responsible for his need for further treatment, Dr. Grewe does not offer a persuasive rebuttal to Dr. Rosenbaum's opinion regarding the "scar tissue" impact. Instead, Dr. Grewe based his opinion on claimant's lack of symptoms and heavy work for several months after the 1997 surgery and before the 1999 work injuries. Such an opinion implies a "but for" or "precipitating cause" analysis. *Dietz v. Ramuda*, 130 Or App 397, *rev den* 321 Or 416 (1995).

When compared with Dr. Rosenbaum's persuasive "post-1999 surgery" opinion, I consider Dr. Grewe's conclusion to be insufficient to establish that claimant's 1999 work injuries were the major contributing cause of his need for treatment or disability for his combined L5-S1 disc herniation condition. Consequently, I agree with the ALJ's reasoning that, because the medical evidence does not establish that claimant suffered a "new compensable injury," responsibility for his L5-S1 herniated disc condition remains with Farmers.

In the Matter of the Compensation of
ROBERT A. RODGERS, Claimant
Own Motion No. 00-0031M
OWN MOTION ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On January 27, 2000, the Board received claimant's attorney's January 26, 2000 letter in which he requested that we amend our January 24, 2000 Own Motion Order. Specifically, claimant's attorney requests that we withdraw the attorney fee awarded him in our order.

Our January 24, 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 SAIF Corporation

directly to claimant's attorney. We took this action because SAIF 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 acknowledges that he did not participate in SAIF's investigation and recommendation which ultimately resulted in our issuance of our January 24, 2000 Own Motion Order. Thus, claimant's attorney contends that he is not entitled to an "out-of-compensation" attorney fee inasmuch as he was not "'instrumental in obtaining compensation' for my client." Claimant's attorney further asserts that SAIF does not oppose his motion to withdraw the awarded attorney fee.

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 unopposed contentions regarding his lack of participation in obtaining compensation for claimant, we conclude that it is appropriate to withdraw the "out-of-compensation" attorney fee awarded in this matter.

Accordingly, our January 24, 2000 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our January 24, 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
EDWARD A. SENZ, Claimant
WCB Case Nos. 99-06170, 99-04321 & 99-00308
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Thomas A. Andersen, Defense Attorney
Julie Masters (Saif), Defense Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the SAIF Corporation's compensability and responsibility denials of his current low back condition; (2) upheld the Employer's Insurance of Wausau's compensability and responsibility denials of the same condition; and (3) upheld Reliance Insurance Company's compensability and responsibility denials of the same condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following changes and supplementation. On page 3, we delete the first paragraph. In the second paragraph on page 4, we change the date in the sixth sentence to "1990."

We agree with the ALJ's reasoning and conclusion. We write only to address claimant's argument about the standard of proof regarding his 1990 injury claim and current low back condition.

Claimant compensably injured his back on February 15, 1990. (Exs. 2, 3). Employer's Insurance of Wausau (Wausau) accepted a nondisabling low back strain, soft tissue injury. (Ex. 3). Claimant argues that his ongoing low back problems are caused by his accepted injury of 1990. Citing ORS 656.245(1), he contends that, if the continuation of his low back problems is caused by his accepted low back injury, he need only prove that the 1990 low back injury continues to be a material contributing cause.

On the other hand, Wausau argues that ORS 656.308 does not apply to this case because the medical condition for which claimant seeks compensation (L5-S1 spondylolisthesis) is not an accepted medical condition of the 1990 claim. Wausau contends that a major contributing cause standard of proof applies.

Under ORS 656.308(1), Wausau remains "responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition." ORS 656.308(1) applies only when the new condition involves the same condition previously accepted. In *Multifoods Specialty Dist. v. McAtee,* 164 Or App 654 (1999), the court determined that the claimant's "new compensable injury" (a lumbar strain) did not involve the same condition that had been previously accepted by another carrier (a herniated disc and degenerative back condition). The court concluded that the claimant's new injury did not involve the same condition previously subject to an accepted claim and, therefore, ORS 656.308(1) was inapplicable.

We reach a similar conclusion here. The condition accepted by Wausau in 1990 was a low back strain. (Ex. 3). We agree with the ALJ that the medical evidence does not demonstrate claimant is being treated for a back strain. Rather, claimant's current low back condition has been diagnosed as L5-S1 spondylolisthesis. We find that claimant's L5-S1 spondylolisthesis does not involve the same condition (a low back strain) that was accepted by Wausau and, therefore, we agree with Wausau that ORS 656.308 does not apply to this case. We do not agree with claimant that he need only prove that the 1990 low back injury continues to be a material contributing cause of his current low back condition.

Penalties

Claimant argues that he is entitled to a penalty because there is no evidence that supports Wausaus denial of compensability. On review, we agree with the ALJ that claimant's current low back condition is not compensable. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food,* 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

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

February 3, 2000 Cite as 52 Van Natta 158 (2000)

In the Matter of the Compensation of
KENT W. CRISWELL, Claimant
WCB Case No. 98-09964
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's current "combined" low back condition. In his respondent's brief, claimant's counsel requests sanctions under ORS 656.390 for an allegedly frivolous request for review. On review, the issues are compensability and sanctions.

We decline to impose sanctions and adopt and affirm the ALJ's order with the following supplementation.

Claimant raises the additional issue of sanctions for a frivolous request for review. ORS 656.390. Because the insurer raised valid arguments on review based on the reports of Drs. Sacamano and Reimer, we do not find that the insurer's request for review was "initiated without reasonable prospect of prevailing." ORS 656.390(2). *Arlene J. Bond,* 50 Van Natta 2426 (1998). Therefore, claimant's request for sanctions is denied.

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

ORDER

The ALJ's order dated August 12, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

Board Member Haynes dissenting.

Because I do not believe that claimant's November 19, 1997 compensable injury continued to be the major contributing cause of his combined lower back condition after December, 1998, I respectfully dissent.

As early as December, 1997, just one month after claimant's initial injury, two separate x-rays revealed the presence of "severe" degenerative disc disease at L2-3 as well as "severe" scoliosis of the lumbar spine. (Exs. 5-3, 8). By his own admission, claimant, now 60, has been diagnosed with scoliosis since age 40. (Tr. 22). Claimant and his supervisor both testified that he has walked with a "weird limp" for a "long time," certainly since before the November 1997 injury. (Tr. 25, 56).

By Notices of Acceptance dated March 16, 1998 and October 23, 1998, the insurer accepted a cervical strain and lumbar strain with radicular symptoms. (Exs. 25, 60). Drs. Sacamano and Reimer, in their report of February 17, 1999, concluded that these accepted conditions were no longer the major contributing cause of claimant's disability and need for treatment. (Ex. 83-6). Drs. Sacamano and Reimer reasoned that claimant had sustained a muscoligamentous strain on November 19, 1997 that did not materially worsen his well-documented preexisting conditions of scoliosis and degenerative disease at L2-3. (*Id.*) They correctly observed that the fusion surgery performed by Dr. Treible was directed at treating the "advanced" degenerative disc disease at L2-3, as the operative report itself confirms. (Ex. 83-7, 64). Certainly, the surgery was not directed at treating the accepted lumbar strain condition. (Ex. 83-7).

Neurosurgeon Dr. Silver agreed with Drs. Sacamano and Reimer in this regard. (Ex. 82-1). Although Dr. Silver initially stated that the major contributing cause of claimant's lower back condition was the injury of November 19, 1997, (Ex. 77-2), he later corrected this opinion by clarifying that he believed that the injury was still the major contributing cause of claimant's disability and need for treatment only as of June 3, 1998, the date of his last examination of claimant. (Ex. 82). Any disability after that time, and definitely by the date of the November 19, 1998 surgery, was attributable to the preexisting L2-3 degenerative disc disease. (*Id.*).

Claimant's treating physician and surgeon Dr. Treible authored a report supportive of compensability, but only after initially concluding that claimant's low back pain was "a consequence of the advanced degenerative disc disease." (Ex. 56). For unexplained reasons, Dr. Treible then retracted this opinion and declared that the injury had "destabilized" the L2-3 disc, necessitating surgery. (Ex. 63). Nowhere did Dr. Treible reconcile these two opinions. Drs. Sacamano and Reimer unequivocally stated that there was no evidence of instability or neurologic deficit at any disc space. (Ex. 83-7).

Based on this evaluation of the medical evidence, I would have concluded that the compensable injury was no longer the major contributing cause of claimant's combined lower back condition. I would uphold the insurer's denial.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
DEBORAH M. JOHNSON, Claimant
Own Motion No. 99-0085M
OWN MOTION ORDER
Glen J. Lasken, Claimant Attorney

The self-insured employer submitted a request for temporary disability compensation for claimant's compensable right ankle condition. Claimant's aggravation rights on that claim expired on January 28, 1997.

The employer recommended that claimant's claim be reopened. However, although agreeing that the surgery is reasonable and necessary, it answered in the negative regarding the compensability of and responsibility for claimant's current ankle condition. The employer explained that claimant's right ankle requires three types of surgery: (1) sinus tarsi debridement; (2) subtalar joint reconstruction; and (3) medial exostectomy. The employer agrees that the medial exostectomy is compensably related to claimant's 1985 work injury, and does not oppose reopening the claim for that portion of the surgery. But it contends that the other two surgeries are the responsibility of a 1997 off-work subtalar sprain injury. The employer denied that 1997 injury claim, and the denial has become final by operation of law. In support of its contentions, the employer relies on a February 15, 1999 medical report from Dr. Holmboe, claimant's attending physician.

In response to the employer's contentions, claimant submits an April 27, 1999 concurrence report and a December 14, 1999 medical report from Dr. Holmboe, as well as a copy of the December 10, 1999 operative report. Claimant contends that those reports support her position that the entire surgery is compensably related to her 1985 injury and, therefore, her claim should be reopened for the payment of temporary disability compensation.

Claimant's 1985 claim was first closed on January 28, 1992, and her aggravation rights expired on January 28, 1997. ORS 656.273(4)(a). Thus, when claimant's condition worsened requiring surgery on December 10, 1999, claimant's claim was under our own motion jurisdiction. Inasmuch as we have exclusive own motion jurisdiction over the claimant's 1985 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 December 10, 1999, claimant underwent the recommended surgery as outlined above. The employer disputes the compensability of two parts of the surgery, as they relate to claimant's compensable 1985 injury. As noted above, this "compensability" dispute is not within our jurisdiction to decide. Should a party wish to seek resolution of this "compensability" dispute, that party must request a hearing before the Hearings Division under ORS 656.283(1).

However, the parties agree, and the medical evidence supports, that a portion of the surgical procedure that claimant underwent (*i.e.* excision of exostosis from the medial malleolus) is a compensable component of her 1985 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 1985 injury claim to provide temporary disability compensation beginning December 10, 1999, the date claimant was hospitalized for the medial exostectomy. When claimant's condition related to the medial exostectomy is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

February 3, 2000 Cite as 52 Van Natta 161 (2000)

In the Matter of the Compensation of
TERRY W. MARTIN, Claimant
WCB Case No. 98-00466
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
David L. Jorling, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that (1) declined to admit Exhibit 84, a post-hearing medical report offered by claimant, and (2) upheld the self-insured employer's denial of his occupational disease claim for a respiratory condition. On review, the issues are evidence and compensability.

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

Claimant contends that the ALJ should have admitted Exhibit 84, a May 17, 1999 concurrence report from Dr. Browning. We review the ALJ's decision for abuse of discretion. *Josephine Kreuger*, 51 Van Natta 1407 (1999). Having reviewed the exhibit, we conclude that claimant would not have met his burden of proving the compensability of his respiratory condition even if the document had been admitted. For that reason, we decline to hold that the ALJ abused his discretion in excluding Exhibit 84.

ORDER

The ALJ's order dated September 14, 1999 is affirmed.

In the Matter of the Compensation of
RONALD M. DAVIS, Claimant
Own Motion No. 99-0299M
OWN MOTION ORDER

The self-insured employer submitted its own motion recommendation form which recommended reopening of claimant's 1990 claim for temporary disability compensation. However, the employer contended that claimant was retired at the time of the current worsening. Claimant's aggravation rights on that claim expired on August 5, 1996.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization.[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).

Under the Board's own motion jurisdiction,[2] the "date of disability," for the purpose of determining whether claimant is in the work force 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, claimant underwent surgery in August 1999. Therefore, the relevant time period for which claimant must establish he was in the work force is the time prior to the August 1999 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).

The employer contended that claimant was retired at the time of the current disability and therefore not in the work force. The employer further contended that claimant is not seeking temporary disability compensation. It asserted that claimant's "main concern is to make sure that his surgery and medical treatment is paid for under his workers' compensation claim." The employer further asserted that all medical costs "associated with the August 1999 surgery will be paid for until [claimant] is declared medically stationary."

In response to the employer's submission and the Board's staff's inquiry, claimant agreed that he retired when he was 63 years old.[3] He contended that he retired due to pain he was suffering as a result of the worsening of his compensable condition. Claimant indicated that he would have worked until he was 65 years old, but could not "stand the pain, it was horrible."

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[1] Claimant apparently underwent surgery in August 1999. (Employer's letter dated October 12, 1999). In any event, because claimant's compensable injury occurred after December 31, 1965, the Board has no authority over any medical issues regarding that claim. ORS 656.278(1)(b). Medical issues regarding post-1965 work injuries are handled in the same manner whether the aggravation rights have expired on the claim or not. ORS 656.245. In other words, the Board has no authority to authorize surgery regarding this post-1965 injury claim. Rather, it is up to the employer to authorize surgery. Here, the employer apparently has authorized the surgery. Specifically, the employer agrees that the proposed surgery is reasonable and necessary and causally related to the compensable injury. In fact, the employer states that "[a]ll medical costs associated with the August, 1999 surgery will be paid for until [claimant] is declared medically stationary." (Employer's letter dated October 12, 1999). Thus, the Board's decision regarding whether claimant's claim should be reopened for temporary disability benefits does not affect claimant's entitlement to medical services.

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

[3] In a July 7, 1999 medical report, Dr. Franks, claimant's attending physician, noted that claimant was 65 years old at the time of that report.

According to this record, at the time claimant's compensable condition worsened requiring surgery in August 1999, he was 65 years old and had retired. Furthermore, claimant stated that he intended to retire at 65 years old, but pain from the work injury caused him to retire at 63 years old. There is no evidence in the record that claimant intended on working beyond his stated goal of retiring at age 65. Although retirement is not necessarily a permanent condition, that is, a worker can retire and subsequently return to the work force, claimant offers no evidence that he was willing to work at the time of his worsening, nor does he offer any medical evidence that any reasonable work search would have been futile at the time of his worsening due to the compensable condition.

Thus, the information submitted to us to date does not demonstrate claimant's presence in the work force at the relevant time. While payment of medical benefits is not in dispute, claimant's request for temporary disability compensation is nevertheless denied.[4] We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

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[4] It would appear that claimant is not clear as to what his rights are under his own motion claim. The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial party. Inasmuch as claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

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

February 4, 2000 Cite as 52 Van Natta 163 (2000)

In the Matter of the Compensation of
BAU T. ANDERSON, Claimant
WCB Case Nos. 98-08148 & 98-04524
ORDER OF DISMISSAL
Starr & Vinson, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

The self-insured employer requested review of that portion of Administrative Law Judge (ALJ) Martha Brown's order that set aside its denial of claimants occupational disease claim for bilateral carpal tunnel syndrome. Claimant cross-requested review of that portion of the order that upheld the employer's denial of claimant's cervical condition. The parties have submitted two Stipulation[s] and Order[s] of Settlement Pursuant to ORS 656.289(4) (Disputed Claim Settlement[s]) and a Stipulation and Order of Settlement to resolve their disputes.

Pursuant to the Disputed Claim Settlements, claimant agrees that she will not further contest the employers denials and that her appeal shall be dismissed with prejudice as to all issues raised or raisable therein. According to the stipulation, the parties hereby agree that [the employer] shall accept a claim for nondisabling, bilateral wrist strain.

We approve the parties' settlements and stipulation,[1] thereby fully and finally resolving these matters, in lieu of the ALJ's order. Finally, this date we have also approved the parties' Claim

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[1] The stipulation was signed by an Administrative Law Judge. Because the agreement, however, pertains to the resolution of a dispute that is pending Board review, the stipulation requires Board approval. *See* OAR 438-009-0015(5). Our signatures on this order constitute our approval of the parties' stipulation.

Disposition Agreements (one of which includes a provision that all issues pending in WCB Case No. 98-08148 (claimant's wrist claim) are dismissed with prejudice). Accordingly, these matters are dismissed with prejudice.

In the Matter of the Compensation of
CHRISTOPHER H. HOWARD, Claimant
WCB Case No. 98-02728
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of his injury claim for a 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 second full paragraph on page 4, we change the citations after the first sentence to read: "(Exs. 85, 86)." On page 5, we delete the last paragraph of the findings of fact and replace it with the following: "The parties deposed Drs. Poulson and Collada. (Exs. 94, 96)." We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant was compensably injured at work on July 23, 1997. The insurer accepted a disabling right elbow contusion and left shoulder strain. (Ex. 73). Claimant contends that the July 23, 1997 injury was the major contributing cause of his need for treatment of his cervical condition. *See SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998).

We agree with the insurer that claimant had a preexisting degenerative condition in his cervical spine before the July 23, 1997 injury. The opinions of Drs. Poulson and Collada establish that the July 1997 injury combined with claimant's preexisting degenerative cervical condition to cause or prolong his disability or need for treatment. (Exs. 94-20, 96-18). Therefore, claimant must prove that the July 23, 1997 work injury was 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. *See* ORS 656.005(7)(a)(B).

Because of the multiple possible causes of claimant's disability or need for treatment, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983).

Claimant relies on the opinions of Drs. Collada and Poulson, his treating physicians, to establish compensability. On September 8, 1998, Dr. Collada, neurosurgeon, performed claimant's cervical surgery at C5-6 and C6-7. (Ex. 93). We first address the insurer's argument that Dr. Collada's opinion is not persuasive because he relied on an inaccurate history of claimant's symptoms.

Although Dr. Collada's initial history of claimant's symptoms was not entirely accurate, he was subsequently informed about the medical reports documenting claimant's symptoms shortly after the injury. In his initial report, Dr. Collada said that claimant's injury occurred when he "hit his elbow on a concrete wall, jarred his neck he feels with activity, and from then has had left neck pain and left arm discomfort." (Ex. 77-1). In a deposition, Dr. Collada agreed that his history was not entirely consistent with records of claimant's medical treatment after the July 23, 1997 injury. (Ex. 96-35).

Nevertheless, at the deposition Dr. Collada had the opportunity to review records concerning claimant's medical treatment shortly after the July 1997 injury. On July 23, 1997, Dr. Dover had reported that claimant hit his right elbow on a concrete wall and was having "discomfort over his right elbow, but also having some left shoulder and arm discomfort." (Ex. 68). The nurse's note on July 23, 1997 indicated that claimant had complained of left shoulder and left arm pain, as well as right arm pain. (*Id.*) Dr. Collada testified that claimant's elbow pain and pain going into the arms raised the suspicion of some nerve root problems. (Ex. 96-11,-12).

Dr. Collada reviewed Dr. Dover's July 28, 1997[1] chart note that indicated claimant's right elbow contusion and left shoulder strain symptoms had resolved and his examination was within normal limits. (Exs. 70, 96-30). Dr. Collada was informed that the first specific documentation of neck pain was on August 19, 1997, when Dr. Fitzgerald reported that claimant complained of left shoulder and neck pain. (Exs. 71, 96-30, -31). Dr. Collada testified that the fact claimant may have had some hiatus of no symptoms did not "necessarily rule out definitively that he doesn't have a significant spine pathology[.]" (Ex. 96-32). Dr. Collada was also aware that claimant had some neck symptoms after his 1995 cervical surgery. (Ex. 96-14, -36, -37, -38, -39).

After reviewing and discussing claimant's medical reports, Dr. Collada testified that his opinion on causation was based on the fact claimant had a symptom complex that was consistent with nerve irritation, which was well-explained by the large C5-6 disk pathology. (Ex. 96-51, -52). His opinion was based on claimant's entire clinical picture. (Ex. 96-52, -53, -54). Dr. Collada concluded that the July 1997 injury was the major cause of claimant's need for surgical treatment. (Exs. 85, 86, 96-7, -18, -24). At the deposition, Dr. Collada understood that claimant's medical reports shortly after the July 1997 injury did not document the immediate onset of neck pain, but he said that did not change his opinion on causation. (Ex. 96-55).

We are persuaded by Dr. Collada's opinion because it is well-reasoned and based on an accurate history. Moreover, we find that Dr. Collada weighed and considered the potential contributing factors in determining causation. *See Dietz v. Ramuda,* 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

Dr. Collada's opinion is supported by the opinions of Drs. Poulson and Dover. Dr. Poulson, orthopedic surgeon, examined claimant in June 1998 and obtained a history that claimant had immediate pain in the elbow, shoulder and neck area after the July 23, 1997 injury. (Ex. 90). He had previously treated claimant for neck pain in 1982. (Ex. A). Dr. Poulson believed that the July 23, 1997 injury was the major contributing cause of claimant's current cervical problems and continued need for medical treatment. (Ex. 90-3).

In a deposition, Dr. Poulson reviewed the medical reports prepared shortly after claimant's July 1997 injury and he was aware there were no specific references to neck pain in the July 23, 1997 or July 28, 1997 chart notes. (Exs. 94-16, -17). He testified, however, that the July 23, 1997 reference to symptoms down both arms was "usually what you see with radiculopathy or an irritated nerve that goes out of the neck and into the upper extremity." (Ex. 94-19). He felt those chart notes indicated claimant had swelling around nerve roots from the trauma. (*Id.*) Dr. Poulson agreed that the mechanism of claimant's injury, hitting his elbow against a concrete wall, was enough trauma to cause disruption to the C5-6 disk. (Ex. 94-20). Claimant testified at hearing that he initially thought he had broken his elbow. (Tr. II-16).

Dr. Poulson explained that "[i]t's pretty hard to separate the neck from the shoulder at times, especially when you're talking about the trapezius area." (Ex. 94-20). He felt that the initial pain in claimant's left shoulder, which was diagnosed as a strain, was probably early radiculopathy. (Ex. 94-21, -25). He was aware that the first mention of specific neck pain relative to the July 1997 incident occurred on August 19, 1997. (Ex. 94-21). Nevertheless, Dr. Poulson felt that was reasonable and he said that did not change his opinion on causation. (Ex. 94-21, -22). Dr. Poulson agreed that, by September 16, 1997, the medical reports referred to radiation in the arm and he felt it was reasonable to attribute that radiculopathy to the July 23, 1997 injury. (Ex. 94-22).

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[1] We agree with the ALJ's conclusion that, although the chart note is dated July 23, 1997, the surrounding documents and other references in the record indicate that the correct date of this chart note is July 28, 1997. (Ex. 70).

After reviewing additional medical reports, including the MRI films, Dr. Poulson testified that claimant's July 1997 injury was the major contributing cause of the C5-6 disk pathology. (Ex. 94-23, -24). He explained that claimant's work injury had weakened the disk so that as time went by, it became extruded or protruded. (Ex. 94-27). He felt that the herniation was developing during this time to the point it became disabling. (*Id.*) We are persuaded by Dr. Poulson's well-reasoned opinion.

The opinions of Drs. Collada and Poulson are also supported by Dr. Dover's opinion. Dr. Dover examined claimant on July 23, 1997 and treated him on a few occasions thereafter. (Exs. 68, 70, 72, 79, 81). He believed that claimant's current cervical problems were secondary to the July 23, 1997 injury. (Ex. 87-1). He explained that, when claimant struck his left arm, it caused a tenuous situation and his neck became worse. (*Id.*)

The insurer argues that the opinion of Drs. Fuller and Reimer is the most persuasive. Drs. Fuller and Reimer found there was "no connection" between claimant's neck pathology and the July 1997 injury. (Ex. 91-8). They believed that claimant's shoulder discomfort in July 1997 was "simply an expression of his pre-existing condition." (Ex. 91-9). Drs. Fuller and Reimer reported that the "morphology of the discopathies in 1994 is identical to those noted on the 09/24/97 MRI." (Ex. 91-8). They explained there was "no change" in the morphology of claimant's C5-6 and C6-7 discopathies. (Ex. 91-10).

Dr. Collada disagreed with Dr. Fuller's and Reimer's report that found "no change" in the morphology of claimant's discopathies at C5-6 and C6-7. (Ex. 96-17). Dr. Collada had reviewed the MRI films and not just the reports. (Ex. 96-8). He had previously reported that claimant's large C5-6 disc changes were indisputable. (Ex. 96-10, depo ex. 1). In his deposition, Dr. Collada explained that "there was a substantially larger protrusion at C5-6 between the films that were done earlier and the ones that were done after the injury." (Ex. 96-17). He said there was a "substantial increase" in the protrusion and the C5-6 disk was a "lot larger" after claimant's injury. (Ex. 96-17, -44). Similarly, Dr. Poulson disagreed with Drs. Fuller and Reimer, testifying that "[t]here was a definite change at the C5-6 level" since the July 1997 injury. (Ex. 94-23). Dr. Poulson testified that the later MRI "showed a definite herniation." (Ex. 94-29).

We are most persuaded by the opinions of claimant's treating physicians, Drs. Collada and Poulson. In particular, we are not persuaded by the opinion of Drs. Fuller and Reimer, who found "no change" in the morphology of claimant's discopathies at C5-6 and C6-7. As the treating surgeon, Dr. Collada had the opportunity to examine claimant's cervical pathology during surgery and, thus, had the most complete information upon which to base his opinion. *See Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988). Based on Dr. Collada's well-reasoned opinion, as supported by the opinions of Drs. Poulson and Dover, we conclude that the July 23, 1997 injury was the major contributing cause of the need for treatment of claimant's cervical condition.

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 $8,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, claimant's counsel's statement of services, and the insurer's objections[2]), the complexity of the issue, the value of the interest involved, the nature of the proceedings (two hearings-one in which no testimony was taken-lasting less than two hours total; two depositions), and the risk that counsel may go uncompensated. Claimant is not entitled to an attorney fee for services expended in securing the attorney fee award. *See Amador Mendez*, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated June 11, 1999 is reversed. The insurer's denial is set aside and the claim remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $8,500, payable by the insurer.

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[2] Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Nonetheless, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4). *See Ben E. Conradson*, 51 Van Natta 851 (1999).

In the Matter of the Compensation of
GWENDOLYN A. MOOTZ, Claimant
WCB Case No. 99-04695
ORDER ON REVIEW
Bischoff, Strooband & Ousey, 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) Stephen Brown's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

On review, SAIF contends that the ALJ erred in weighing the medical evidence regarding causation. We disagree.

Where compensability involves a complex medical question, we must rely on expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985). The expert medical opinion must evaluate the relative contribution of each cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). Where there is a division of experts, we rely on those opinions that are the most well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Here, there is no dispute that claimant suffered from CTS. (Exs. 12, 13, 15, 16, 20, 23, 25, 29, 30). Therefore, the only remaining question is whether claimant's work activities were the cause of her CTS. Claimant's two treating physicians, Dr. Appleby and Dr. Grant, give contradictory opinions regarding this causation issue. Dr. Appleby concurs with the opinion of Dr. Arbeene, an insurer-arranged medical examiner, that the cause of claimant's CTS was idiopathic, while Dr. Grant opined that claimant's work activities were the major contributing cause.

SAIF argues that the ALJ erred by not giving deference to Dr. Appleby's opinion. We disagree for the following reasons.

Dr. Appleby, claimant's surgeon, first indicated that it was difficult to determine the cause of claimant's CTS due to her other conditions. (Exs. 13-4, 28-2). Additionally, Dr. Appleby indicated that claimant's torticollis and increased muscle tone due to her benign tremor played a role in the development of her CTS. (Ex. 28-2). Ultimately, Dr. Appleby concurred with the opinion of Dr. Arbeene that claimant's CTS was idiopathic due to her age and gender and that neither her increased muscle tone nor her torticollis played a role in its development.

However, Dr. Appleby did not provide an explanation as to why he changed his opinion. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (an unexplained change of opinion is given little probative weight). Further, while Dr. Appleby expressed the opinion that age and gender played a role in claimant's development of CTS, he offered no explanation for this opinion other than acknowledging that the cause of CTS is commonly idiopathic in individuals of claimant's age and gender. (Exs. 28-2, 29). Lastly, Dr. Appleby did not fully consider the relative contribution of claimant's work activities on her CTS. Instead, Dr. Appleby briefly mentioned that it was possible claimant's CTS became more symptomatic due to her work duties, but he did not discuss the impact these duties might have on claimant's current need for treatment. (*Id.*) Therefore, we find that Dr. Appleby's opinion is not persuasive.

In contrast, Dr. Grant provided a well-reasoned and complete opinion. Both Dr. Appleby and Dr. Arbeene concurred in Dr. Grant's diagnosis of claimant's CTS. Additionally, Dr. Grant's opinion as to causation of the CTS was based on a complete medical history of claimant as well as thorough consideration and explanation of all relevant factors. *See Dietz v. Ramuda*, 130 Or App at 401. Finally, for the reasons expressed by the ALJ, we do not consider Dr. Grant's opinion to have been biased.

Accordingly, we agree with the ALJ that claimant met her burden of proof that her work activities were the major contributing cause of her CTS. Consequently, the claim is compensable.

Claimant's attorney is entitled to an assessed fee for services on review. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and 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 October 7, 1999 is affirmed. For services on Board review, claimant's counsel is awarded $1,200, to be paid by SAIF.

In the Matter of the Compensation of
BYRON K. OLDS, Claimant
WCB Case No. 99-03869
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of claimant's neck injury claim. On review, the issue is compensability.

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

On review, claimant contends that the insurer's denial concedes that it accepted the preexisting degenerative neck condition because it states that the 1989 work injury is no longer the major contributing cause of the combined condition. In support, claimant cites *Croman Corporation v. Serrano*, 163 Or App 136 (1999).

Serrano addressed the application of ORS 656.262(7)(b) and, specifically, whether the carrier's denial was procedurally invalid because the carrier had not accepted a combined condition and it issued the denial before claim closure. Here, there is no contention that the insurer's denial was procedurally invalid and should be analyzed under ORS 656.262(7)(b).[1] Thus, we find that *Serrano* has no relevance to this case.

Furthermore, we agree with the ALJ's assessment of the medical evidence and his conclusion that the opinion of claimants treating surgeon, Dr. Purtzer, was not sufficiently persuasive to carry claimant's burden of proof under ORS 656.005(7)(a)(B). Along with the reasons cited by the ALJ, we find that Dr. Purtzer provided inconsistent opinions. In this regard, Dr. Purtzer first concurring with the report from examining physician, Dr. Williams, stating that claimant's symptoms were the result of preexisting degenerative changes and any pathological worsening of such condition was due to natural aging and not the 1989 work injury. (Ex. 29-6, 29-7).

Dr. Purtzer then indicated that claimant's abnormality at C3-4 was either directly caused by the 1989 injury or had degenerated as a result of the subsequent surgery. (Ex. 33A). Finally, Dr. Purtzer reported that the worsening of the C3-4 disc was due to a combining of the passage of time and the 1989 injury. (Ex. 36-2).

Thus, Dr. Purtzer indicated an agreement that claimant's neck condition was not related to the 1989 injury, stated that the 1989 injury, or subsequent surgery, caused the condition, and that the condition was due to a combination of time and the 1989 injury. Based on such inconsistency, we find persuasive reasons not to defer to Dr. Purtzer's opinion. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Because the remaining opinions do not relate claimants current neck condition to the 1989 injury, claimant did not carry his burden of proving compensability.

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[1] In fact, the claim was closed when the insurer issued its denial of claimant's current neck condition.

ORDER

The ALJ's order dated September 20, 1999 is affirmed.

In the Matter of the Compensation of
GLADYS J. REYNOLDS, Claimant
WCB Case No. 99-01194
ORDER DENYING MOTION TO DISMISS
Reinisch, et al, Defense Attorneys

Claimant, *pro se*, has requested Board review of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's denial of claimant's occupational disease claim for a right carpal tunnel syndrome condition. Contending that notice of the appeal was untimely provided to the other parties, the insurer has moved the Board for an order dismissing claimant's request for review. We deny the motion.

FINDINGS OF FACT

The ALJ's order issued on December 20, 1999. The order recited that copies had been mailed to claimant, the employer, the insurer, and their attorney.

On January 19, 2000, the Board received claimant's January 7, 2000 request for review of the ALJ's order. The request, which was contained in an envelope bearing a postmark date of January 14, 2000, indicated that copies had been sent to the employer, the insurer, and their attorney.

On January 21, 2000, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for review. Receipt of this acknowledgment was apparently the insurer's counsel's first notice of claimant's appeal.

CONCLUSION OF LAW

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

The failure to timely file and serve all parties with a request for Board review requires dismissal. *Mosley v. Sacred Heart Hospital*, 13 Or App 234 (1992). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." *Robert Casperson*, 38 Van Natta 420, 421 (1986).

Here, the 30th day after the ALJ's December 20, 1999 was January 19, 2000. The Board received claimant's request for review on January 19, 2000. Consequently, the request was timely filed. ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(a); *David S. Livesay*, 48 Van Natta 1732 (1996).

We turn to the insurer's attorney's contention that claimant neglected to provide timely notice of her appeal to the other parties to the proceeding. Although the insurer's counsel did not receive a copy of claimant's appeal, an attorney is not a "party." Moreover, no contention has been made that the employer or its insurer (the "parties" to the proceeding) were not provided with timely notice of claimant's appeal. In light of such circumstances, the present record does not rebut claimant's representation in her January 7, 2000 request for review that copies of her request were mailed to the other parties to the proceeding (*i.e.*., the insurer and the employer). *See Yekaterina Drevenchuk*, 49 Van Natta 1016 (1997); *David S. Livesay*, 48 Van Natta at 1732; *Harold E. Smith*, 47 Van Natta 703 (1995). Under such circumstances, we are persuaded that claimant provided timely notice of her appeal to the other parties to this proceeding. *See* ORS 656.295(2).

Accordingly, we deny the motion to dismiss. Enclosed with claimant's and the insurer's counsel's copy of this order are copies of the hearing transcript. The following briefing schedule has also been implemented. Claimant's appellant's brief (her written argument explaining why she disagrees with the ALJ's decision and what action she wants the Board to take) must be filed within 21 days from the date of this order. (A copy of her brief should also be mailed to the employer'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 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.

February 7, 2000 Cite as 52 Van Natta 170 (2000)

In the Matter of the Compensation of
JOAN L. BASZLER, Claimant
WCB Case No. 97-09089
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's combined right shoulder condition; and (2) awarded a $9,000 employer-paid attorney fee pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

The employer contends that claimant failed to meet her burden of proving the compensability of her right shoulder impingement syndrome condition because Dr. Morrison, her attending physician and surgeon, did not properly weigh the effect of claimant's preexisting shoulder conditions. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed*, 321 Or 416 (1995). We disagree.

The ALJ properly analyzed this claim as one for a combined condition. Claimant must prove that her August 15, 1996 compensable injury is the major contributing cause of her combined shoulder condition. ORS 656.005(7)(a)(B). Dr. Morrison examined and treated claimant over an extended period of time. He also performed a surgery on claimant's right shoulder on August 31, 1998. (Ex. 52-25). Therefore, Dr. Morrison was in the best position to render an opinion on causation. *Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988); *Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Schilperoort, who performed an employer-arranged medical examination, recognized and deferred to Dr. Morrison's unique position in this regard. (Ex. 50-45). Specifically, Dr. Schilperoort referred to Dr. Morrison as a "good surgeon," and stated that he would "bow to the fact" that Dr. Morrison was there (at surgery), whereas he was not. (*Id.*)

Moreover, Dr. Morrison properly weighed the contribution of claimant's preexisting conditions in her right shoulder and neck. Dr. Morrison acknowledged that claimant likely had cervical degenerative disc disease as well as an asymptomatic impingement syndrome in her right shoulder, before her August 15, 1996 injury. *See* Exs. 23, 34, 51. Dr. Morrison explained that claimant's August 15, 1996 compensable injury caused an instability and muscle imbalance in claimant's right shoulder, which in turn caused a symptomatic right shoulder impingement syndrome. (Ex. 51).

The parties deposed Dr. Morrison twice, once before and once after his August 31, 1998 surgery. (Exs. 45, 52). At the latter deposition, and in a January 5, 1999 letter to counsel, Dr. Morrison adequately defended his reasoning behind his opinion in reference to several findings at surgery. (Exs. 51, 52-8, 20-21). Contrary to the employer's contention, Dr. Morrison's opinion did not turn on whether the osteophytes were "inferior" as opposed to "posterior" in location. After observing several "inferior" osteophytes during surgery, Dr. Morrison explained that claimant's preexisting arthritis in her right acromioclavicular joint had caused these osteophytes to develop, but that the osteophytes were not causative of claimant's impingement syndrome because of their small size. (Ex. 51-2).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,500, 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 and uncontested attorney fee request), the complexity of the issue, and the value of the interest involved. 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 (1986).

ORDER

The ALJ's order dated August 20, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
KIM K. CRAWLEY, Claimant
WCB Case No. 98-10029
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se,* requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the insurer's denial of claimant's medical conditions of L5-S1 herniated disk with radiculopathy, depression and sacroilitis be included as part of claimant's 1991 accepted low back injury claim; and (2) declined to assess penalties for allegedly unreasonable claim processing. Following his request for review, claimant submitted copies of a physical therapy prescription and records, as well as a "post-ALJ's order" letter from a physician.[1] We treat such submissions as a motion to remand to the ALJ for the taking of additional evidence. On review, the issues are remand, compensability and penalties.

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

Claimant has provided this additional medical documentation in support of his claim that his 1991 accepted low back injury is the major contributing cause of his current conditions. To the extent that these records were not presented as evidence at the hearing, we treat these submissions as a request for remand for the admission of additional evidence. *Judy A. Britton,* 37 Van Natta 1262 (1985).

Our review is limited to the record developed by the ALJ. 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). However, to merit remand for consideration of additional evidence it must be clearly shown that relevant, material evidence was not obtainable with due diligence at the time of the hearing. *Compton v. Weyerhaeuser Co.,* 301 Or 641 (1986).

The first submission of additional evidence by claimant is the prescription from Dr. Flanagan and his physical therapy records from Dr. Fagg. The physical therapy records recount claimant's progress and complaints of pain over the course of his two months in physical therapy in 1991.

In addition, clamant has presented a December 22, 1999 letter from Dr. Walker in connection with claimant's application for social security disability benefits. Dr. Walker gives a brief synopsis of claimant's current symptoms and conditions as well as provides his opinion on claimant's ability to do functional activities (which Dr. Walker apparently attributes to claimant's 1991 accepted low back injury).

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[1] Claimant submitted three pages of his physical therapy records with Dr. Fagg. The first page of these records was already admitted into evidence and is marked as Exhibit 3.

Because it is unclear whether the insurer was sent copies of the prescription, the additional pages of claimant's physical therapy record, and the December 22, 1999 letter we are attaching copies of them to the insurer's attorney's copy of this order.

We are not convinced that these submissions were not obtainable with due diligence at the time of hearing. In other words, the record does not provide a persuasive reason why claimant could not have obtained his complete physical therapy records or a similar letter from Dr. Walker before the hearing and submitted the documents at that time.

In addition, even if we considered these documents, they would not change the result. In this regard, part of claimant's physical therapy records were already admitted into evidence. Additionally, Dr. Flanagan's records, the physician that prescribed the physical therapy, were admitted into evidence. The documents already admitted into evidence provide an accurate picture of claimant's condition during the time period covered by these newly submitted records. Therefore, these records do not provide any new material evidence.

The December 22, 1999 letter in which Dr. Walker states his opinion regarding causation of claimant's current condition is conclusory in nature. Additionally, the letter offers no new material evidence by Dr. Walker regarding claimant's current condition that has not already been admitted into the record. As addressed by the ALJ, under the facts of this case, deference is given to the medical opinions that are the most well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Therefore, even if we were to consider the December 22, 1999 letter, it would not change the result.

For all of these reasons, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Accordingly, we deny claimant's motion for remand.

ORDER

The ALJ's order dated September 13, 1999 is affirmed.

February 7, 2000 Cite as 52 Van Natta 172 (2000)

In the Matter of the Compensation of
ANGLEE MINOR, Claimant
WCB Case No. 99-02403
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Lundeen, 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 left groin injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW

The ALJ set aside the insurer's denial of claimant's left groin condition to the extent that it denied diagnostic medical services for claimant's alleged lifting injury. Reasoning that claimant experienced symptoms of acute pain upon heavy lifting, for which Drs. Harper and Standage provided medical services, the ALJ concluded that the lifting was directly causative of claimant seeking medical services. Thus, the ALJ concluded that claimant had proved that he sustained a compensable injury.

On review, the insurer contends that the ALJ erred in finding that claimant proved a compensable injury, citing *Brown v. SAIF*, 79 Or App 205, *rev den* 301 Or 666 (1986), and *Daniel L. Hakes*, 45 Van Natta 2351 (1993). We agree with the insurer's contention.

In *Hakes,* the ALJ set aside the employer's denial of a claim for blood exposure. There, the claimant, a pilot for an air ambulance company, had got blood on his hands while unloading a trauma patient. The claimant sought medical treatment for a variety of complaints, which his physician reported were unrelated to his blood exposure. We reversed the ALJ's order and reinstated the employer's denial, reasoning that while the claimant was exposed to blood, there was no evidence that he had been injured by his exposure or had a disease.

The facts of this case are similar. Here, on December 16, 1998, claimant experienced nausea and an acute onset of pain in his left groin area while lifting heavy aluminum T-bars. (Tr. 6). Upon self-inspection, claimant noticed a bulge in his left groin. (Ex. 1). This prompted claimant to seek emergency medical services. Both Dr. Harper and Dr. Standage treated patient under the assumption he was suffering from a hernia. (Exs. 1, 2). However, subsequent surgery revealed claimant did not have an indirect or direct hernia but suffered from a non-communicating hydrocele. (Exs. 2, 7-4, 7-15). Dr. Standage and Dr. Braun, who reviewed claimant's medical history at the request of the insurer, both agreed that the hydrocele was not caused by any acute trauma and significantly predated December 16, 1998. (Exs. 4, 6, 7-5 to 7-9). Thus, the medical evidence establishes that the non-communicating hydrocele was a preexisting and noncompensable condition.

Claimant argues, however, that he did suffer some type of injury, possibly a groin pull/strain, when lifting the T-bar and that injury was the major cause of his need for treatment and not his preexisting condition. For support, claimant relies on the findings and opinion of Dr. Standage. However, Dr. Standages opinion only stated that heavy lifting can cause a groin strain and that one possibility is that claimant suffered from a hydrocele and then suffered a groin strain. (Ex. 7-11). Significantly, Dr. Standage also stated that his only objective finding at the time of surgery was the hydrocele. (*Id. at* 12).

As was the case in *Hakes,* there is no medical evidence, to a degree of medical probability, that the symptoms claimant experienced after heavy lifting were related to the heavy lifting and not to his preexisting condition. (*Id. at* 11 to 13). Although claimant suffered an acute onset of pain upon heavy lifting, there is no evidence that claimant was injured as a result of the lifting. (*Id.*). The only condition Dr. Standage diagnosed, non-communicating hydrocele, is not related to the lifting, according to both Dr. Standage and Dr. Baum. (Exs. 4, 6, 7-5 to 7-9).

Therefore, while claimant did experience an acute onset of pain while performing heavy lifting at work, he has not established that he was injured or sustained physical damage as a result of the lifting. Therefore, we do not find that he sustained a compensable injury. *See Finch v. Stayton Canning Co.,* 93 Or App 168 (1988). Thus, we reverse the ALJ's order and reinstate the insurer's denial in its entirety.

ORDER

The ALJ's order dated October 15, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's insurer-paid attorney fee award is also reversed.

In the Matter of the Compensation of
BRIAN L. VANDERPOOL, Claimant
WCB Case No. 99-02032
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of that portion of Administrative Law Judge Mills' (ALJ's) order that upheld the SAIF Corporation's partial denial of claimant's injury claim for an L4-5 disc condition. SAIF cross-requests review of those portions of the order that: (1) directed it to pay temporary disability from February 20, 1999[1] through April 1, 1999; and (2) assessed a penalty for its allegedly unreasonable failure to pay that compensation. On review, the issues are compensability, temporary disability, and penalties. 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 claimant was on modified work release when he was laid off on January 20, 1999. And we do not find that claimant was fired on February 6, 1999 for reasons related to his work injury. We make the following findings instead.

After his June 19, 1998 back and groin injuries, and his October and November 1998 exacerbations, Dr. Breen placed claimant on modified work duty, then released him to regular work as of December 31, 1998. (Exs. 11A-2, 12). Claimant continued to work during this time. On January 20, 1999, the employer laid claimant off due to lack of work. Claimant apparently lost no wages before the lay-off.

On February 5, 1999, Dr. Breen (claimant's attending physician for his low back condition) authorized modified duty from that day until March 7, 1999. (Ex. 14D-3, *see* Ex. 19A). On February 6, 1999, the employer fired claimant for alleged violation of work rules.

On February 18, 1999, Dr. Pardoe (claimant's attending physician for his hernia condition) authorized time loss for the period beginning that day (when claimant had hernia surgery), until April 1, 1999. (Exs. 19C-1, 19C-3). Claimant was released to regular work as of April 1, 1999. (Tr. 30).

SAIF sent claimant one time loss check sometime after his lay-off. (*Id.*).

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant suffered a compensable hernia and a compensable lumbar strain on June 19, 1998. The issue is whether claimant's L4-5 disc condition is due in material part to the same injury. ORS 656.005(7)(a).

Claimant has worked in the heating, venting, and air conditioning industry for about 15 years. He began performing very heavy work for the insured in March 1997.

On June 19, 1998, claimant and three co-workers removed a heavy old electric water boiler from the basement of a customer's house. They cut the boiler into pieces and struggled to haul the pieces up 15 or 20 stair steps. Claimant and another man were above the boiler, bending toward it and pulling it up the stairs. It was the "heaviest thing [claimant had] ever lifted." (Tr. 12). About three-quarters of the way up the stairs claimant felt his "back just pull and it hurt like heck." (Tr. 13).

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[1] The order portion of the Opinion and Order refers to the time period "from May 20, 1999 through April 1, 1999." Based on the ALJ's prior statement of issues and the parties' agreement, we find that the time period in question is from February 20, 1999 until April 1, 1999.

Claimant's back pain began with the June 1998 lifting incident and it worsened progressively thereafter. On July 8, 1998, he sought treatment from a physician (who advised that his groin and back pain might subside), then a chiropractor.

Claimant continued to perform heavy work after his injury, though he tried to avoid heavy lifting. In early September, claimant agreed to remove a hot tub from a co-worker's house in exchange for the tub. Claimant's back was hurting too much to move the tub, so he hired a co-worker to do it for him. Claimant did not hurt his back moving the hot tub. (Tr. 17-22).

Claimant sought treatment again for his groin and low back on October 9, 1998. He performed heavy lifting at work on October 28, 1998 and his back pain worsened. It worsened again, toward the end of November, when he worked in a crawl space, then dragged and carried heavy equipment up a hill.

Dr. Breen examined claimant and placed him on modified work duty. Nonetheless, claimant dragged a heavy furnace across a customer's yard on December 4, 1998 and his back continued to hurt. Dr. Breen diagnosed claimant's L4-5 disc herniation based on a December 7, 1998 CT scan. (Ex. 9).

The employer laid claimant off, then terminated him, on January 20 and February 6, 1999, respectively. Claimant had hernia surgery on February 18, 1999. SAIF issued a partial denial of claimant's L4-5 disc condition on February 24, 1999.

The ALJ found claimant credible, based on his demeanor and manner while testifying. We agree that claimant is credible, based on his testimony and the consistency between his testimony and the remainder of the record.

The parties agree that the central issue is legal causation --whether the June 19, 1998 work injury was a material cause of claimant's later-discovered herniated disc.[2]

As a preliminary matter, we note that SAIF does not contend that claimant injured his L4-5 disc while moving the hot tub off work in September 1998, only that he *could* have done so -- based on Dr. Breen's opinion to that effect. But claimant's credible testimony establishes that his symptoms worsened progressively beginning with the June 1998 injury, more notably after heavy lifting at work, but *not* after the September hot tub event. Also, claimant did not move the tub himself, he hired help to do that. On these facts, although claimant could have herniated his L4-5 disc moving the hot tub, we find that he probably did not injure his back that day.

The medical evidence is provided by Dr. Breen, treating physician, and Dr. Schilperoort, who examined claimant on SAIF's behalf. We generally rely on the treating physician's opinion, absent persuasive reasons to do otherwise. In this case, we find no such reasons.

Dr. Breen initially opined that the June 19, 1999 work injury was the major cause of claimant's herniated disc, based on his examination, the CT scan, claimant's straightforward presentation and his lack of prior back problems. (Ex. 10). Then, after SAIF informed him that claimant had no radicular symptoms until they were first recorded on October 19, 1998 (after moving the hot tub), Dr. Breen expressed doubt. (Exs. 18, 27-32-33; *see* Ex. 17).

During a later deposition, Dr. Breen first explained that a lateral herniated disc would be expected to cause radicular symptoms because it would impinge on nerves which exit laterally from the spine. But a *central* herniated disc--like claimant's--would be expected to cause only mechanical back pain, not radicular symptoms--unless it was quite large. (Ex. 27- 10-12). Therefore, although the lack of earlier radicular findings in claimant's case makes it "less likely" that the herniation occurred as of the June injury, claimant's central herniation would not necessarily be inconsistent with his late-appearing findings. (*See* Ex. 27-32-33).

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[2] There is no persuasive evidence that a preexisting condition contributed to claimant's herniated disc or that any such condition combined with his injury to cause the disc condition. (*See* Exs. 13, 18; *c.f.* Ex. 16).

In addition, based on a facts presented by claimant's attorney, Dr. Breen stated that, if claimant's work injury was his most significant injury, it probably caused the herniation. He described which medical and case-related facts would, if true, lead him to relate claimant's herniation to the work injury. (Ex. 27-13-14, 27-16-20, 27-30-32). These are the facts of the case. Accordingly, we find that Dr. Breen's opinion supports a conclusion that claimant's herniated disc is at least materially related to his June 1998 work injury.[3]

Dr. Schilperoort offers the only contrary opinion. He suspected that claimant had contributory degenerative disc disease. (Ex. 24-5). Based on claimant's history and examination findings that did not suggest a herniation until months after the June 1998 injury, Dr. Schilperoort concluded that claimant's herniation was probably not a consequence of the work injury. (Ex. 24-6-7). We find Dr. Schilperoort's opinion unpersuasive for the following reasons.

First, Dr. Breen explained that claimant does not have degenerative disease, based on his CT scan, which showed that his stenosis was due to disc material, not bony material. (Ex. 18). Second, we note again that Dr. Breen explained that claimant's *central* disc herniation would not be expected to cause neurological findings unless (or, presumably, until) it was large enough to encroach on a nerve root.[4] We find Dr. Breen's reasoning more persuasive because it is more specific to claimant's particular circumstances and more consistent with his findings. Accordingly, based on Dr. Breen's opinion, we conclude that claimant has carried his burden of proving that his June 19, 1998 work injury was a material cause of his L4-5 disc herniation.

Temporary Disability/Penalty

The ALJ found that SAIF improperly terminated claimant's time loss benefits because the employer did not fire claimant for a violation of work rules or other disciplinary reasons under ORS 656.325(5)(b). Therefore, the ALJ directed SAIF to pay temporary disability benefits for the period from February 20, 1999 through April 1, 1999. We find claimant entitled to those benefits on different grounds.

The pivotal facts are these: Claimant was released to his regular work as of December 31, 1998. Dr. Breen imposed the next work restriction on February 5, 1999, the day before claimant was fired. Then, on February 18, 1999, Dr. Pardoe released claimant from work from that day until April 1, 1999, for hernia surgery and recovery.

We need not address the reason claimant was fired because the result would be the same whether he was fired for disciplinary reasons or for injury-related reasons: Even if claimant was fired for disciplinary reasons (and not entitled to temporary disability benefits at that time), he would be entitled to temporary disability benefits as of the subsequent time loss authorization.[5] Dr. Pardoe provided that authorization. (Ex. 19C-3, *see* Ex. 19C-1). Moreover, because the time loss dispute is limited to periods after the authorization and claimant was otherwise in the work force[6] when he

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[3] To the extent that Dr. Breen's doubts arise from a "hot tub injury," they are unfounded, because, as we have explained, claimant did not injure his back moving the hot tub. (*See* Ex. 27-26-28). We also note that claimant's potentially contributory "post injury" heavy work activities would not weigh against his current claim. (*See* Ex. 27-18-20).

[4] By the time claimant's herniation was discovered, he had radicular findings, and a loss of vertical height of the thecal sac of about 40 percent of the disc. (Ex. 27-9).

[5] *See Gray v. SAIF*, 70 Or App 313 (1984) (The claimant's entitlement to temporary disability for periods after she stopped working, for reasons unrelated to her compensable condition, depends upon whether she was subsequently disabled due to the compensable injury); *Lisa R. Angstadt*, 47 Van Natta 981 (1995) (where the claimant had diminished earning capacity after being fired, she became entitled to interim compensation as of the date of her subsequent injury-related diminished earning capacity).

[6] *Compare Lino Villa-Acosta*, 51 Van Natta 211, 214 (1999) (where the claimant was unable to work legally in the country because he was an illegal alien, he was not entitled to temporary disability because he was not "in the work force" when he became disabled).

became disabled due to his surgery, his prior work restrictions are not determinative.[7] Accordingly, because time loss was properly authorized for the period in question, we conclude that claimant had injury-related lost wages from February 20, 1999 through April 1, 1999.

The ALJ assessed a penalty based on SAIF's failure to pay the disputed temporary disability. He stated that SAIF's conduct constituted unreasonable resistance to the payment of compensation, without further explanation.

SAIF argues that claimant is not entitled to time loss because he was fired for disciplinary reasons and therefore the ALJ's penalty was unjustified. But SAIF does not contend that it lacked notice of claimant's compensable hernia surgery or Dr. Pardoe's related time loss authorization. SAIF knew, or should have known, that temporary disability was due based on Dr. Pardoe's authorization. Under these circumstances, we find that SAIF's failure to pay temporary disability benefits for the period from February 21, 1999 until April 1, 1999 was unreasonable. *See Joseph E. Bridwell, on recon*, 49 Van Natta 1452, 1453 (1997); *Lisa R. Angstadt*, 47 Van Natta 981, 983 (1995). Consequently, we agree with the ALJ that a penalty for unreasonable resistance to pay that compensation is appropriate.

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

Claimant's attorney is also entitled to an assessed fee for services related to SAIF's challenge to the ALJ's temporary disability award. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability issue is $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 August 3, 1999 is reversed in part, modified in part, and affirmed in part. That portion of the order that upheld the SAIF Corporation's partial denial of claimant's L4-5 disc condition is reversed. The denial is set aside and the claim is remanded to SAIF for processing according to law. That portion of the order that awarded time loss benefits for the period from May 20, 1999 [sic] through April 1, 1999 is modified. Claimant is awarded time loss for the period from February 20, 1999 until April 1, 1999. The ALJ's "out-of-compensation" attorney fee award is modified to include this increase. The remainder of the order is affirmed. For services on review, claimant is awarded a $4,000 attorney fee under ORS 656.386(1) and a $500 attorney fee under ORS 656.382(2), both to be paid by SAIF.

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[7] Absent entitlement to temporary disability when payments ceased, ORS 656.325(5)(b) does not apply. *Ricardo Chavez*, 50 Van Natta 90, 91 (1998). Here, Dr. Breen imposed work restrictions on February 5, 1999, the day before claimant was fired. Claimant testified that he received one temporary disability payment, but the record does not indicate when payments ceased. We surmise that payment was made sometime *after* the February 5 work restrictions, because claimant was previously released to regular work; and payment probably "ceased" before February 20, 1999, because that is when the disputed time period begins. In any event, there is no issue regarding temporary disability benefits before February 20, 1999. And claimant had lost wages *due to his compensable hernia injury* as of Dr. Pardoe's February 18, 1999 time loss authorization. Under these circumstances, claimant's prior "fired status" is not determinative.

In the Matter of the Compensation of
TAMMY L. FOSTER, Claimant
WCB Case No. 98-08327
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the self-insured employer's denial of her occupational disease claim for a left shoulder condition. On review, the issue is compensability.

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

The ALJ upheld the employer's denial of claimant's left shoulder occupational disease claim, finding that the medical evidence did not establish that claimant's work activities were the major contributing of the occupational disease, calcific tendonitis. *See* ORS 656.802(2)(a).

On review, claimant notes that her calcific tendonitis is a "combined condition" resulting from the combination of her work activities and a preexisting calcium deposit and, further, that ORS 656.802(2)(c) provides that occupational disease claims are subject to the same limitations and exclusions as accidental injuries under ORS 656.005(7).

Citing *Brown v. A-Dec, Inc.*, 154 Or App 244 (1998), claimant contends that she need only establish that work activities are the major contributing cause of the disability or need for treatment of the combined condition in order to establish a compensable occupational disease claim. *See* ORS 656.005(7)(a)(B). Claimant argues that the medical evidence satisfies her burden of proof under this standard. For the following reasons, we disagree with claimant's contentions.

At the outset, we agree with the ALJ that claimant's theory of compensability is not based on a worsening of a preexisting condition. Thus, ORS 656.802(2)(b) does not apply.[1] *See Ron L. Merwin*, 49 Van Natta 1801 (1997) (ORS 656.802(2)(b) not applicable where the claimant's theory of compensability was not based on a worsening of the preexisting condition). Therefore, pursuant to ORS 656.802(2)(a), claimant must prove that her work activities are the major contributing cause of the disease itself, not just the disability or treatment associated with it. *See Margo E. McMurrin*, 50 Van Natta 1167 (1989) (in a case involving a "combined condition," where the claimant's theory of compensability was not based on a worsening of a preexisting condition, compensability established under ORS 656.802(2)(a)). Moreover, while ORS 656.802(2)(c) provides that occupational diseases are "subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7)," we agree with the employer that this statute imposes additional requirements for compensability and does not eliminate the necessity of proof that work activities are the major contributing cause of the disease.

Brown does not require a different result. There, the court held that an age-related degenerative cervical condition qualified as a "preexisting condition," despite the claimant's contention that, because the degenerative condition was caused by the natural process of aging, it was not a disease. The court reasoned that there was no indication that ORS 656.005(24) was intended to exclude naturally occurring diseases. In addition, the court noted that the physicians in the case had characterized the degenerative process in the claimant's back as a "disease" and that there was no question that the condition contributed or predisposed the claimant to her need for treatment. 154 Or App at 248.

While the *Brown* court indicated that ORS 656.005(7)(a)(B) may apply to occupational disease claims, it did not eliminate the requirement of ORS 656.802(2)(a) that employment conditions be the major contributing cause of the "disease." *Id.* at 247. Indeed, at no point did the court hold, as

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[1] That statute provides:

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

claimant proposes in this case, that a claimant may prove the compensability of an occupational disease claim merely by proving that work activity is the major contributing cause of disability or a need for treatment.[2]

Accordingly, because we agree with the ALJ that claimant failed to prove that work activities were the major contributing cause of her calcific tendonitis, we conclude that claimant's occupational disease claim is not compensable. Thus, we affirm.

ORDER

The ALJ's order dated April 26, 1999, as reconsidered on July 8, 1999, is affirmed.

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[2] The dissent asserts, based on the *Brown* court's reference to ORS 656.005(7)(a)(B), that the issue in this case is whether the employment conditions are the major contributing cause of the disability or need for treatment of the calcific tendonitis condition. The dissent's analysis gives insufficient consideration to ORS 656.802(2)(a), which explicitly requires that employment conditions be the major contributing cause of the disease at issue. Moreover, subsection (2)(c) of ORS 656.802 provides that occupational diseases are subject to the same limitations and exclusions as accidental injuries under ORS 656.005(7). This subsection is a clear indication of the legislature's intention to place additional restrictions on the compensability of occupational disease claims. Yet, to strictly follow the dissent's argument would *expand* the compensability standard for an occupational disease in violation of this subsection. Moreover, the dissent's position is inconsistent with subsection (2)(a) that requires employment conditions be the major contributing cause of the disease itself. *See* ORS 174.010; *Joseph A. Gerber*, 51 Van Natta 278, 280 (1999) (avoid statutory construction that creates conflict between statutes or renders a statute ineffective).

Board Members Phillips Polich and Biehl dissenting.

The majority affirms the ALJ's finding that claimant failed to prove that work activities are the major contributing cause of her calcific tendonitis and, thus, that her occupational disease claim is not compensable. In affirming the ALJ's order, the majority rejects claimant's contention that she need only establish that work activities are the major contributing cause of the disability or need for treatment of a "combined condition." Because we agree with claimant's interpretation of the occupational disease statute, we must dissent.

The majority does not dispute that claimant's calcific tendonitis represents a "combined condition." ORS 656.802(2)(c) provides that an occupational disease claim is subject to the same limitations and exclusions as accidental injuries under ORS 656.005(7)(a). ORS 656.005(7)(a)(B) specifically applies to "combined conditions" and clearly sets forth the compensability standard that work activities must be the major contributing cause *of the disability or need for treatment* of the combined condition. That this subsection is germane to occupational disease claims was recently made clear by the Court of Appeals. *See Brown v. A-Dec.*, 154 Or App 244, 247 (1998).[1]

Despite the existence of statutory and case law authority authorizing application of ORS 656.005(7)(a)(B), the majority holds that claimant must prove that employment conditions are the major contributing cause of the calcific tendonitis condition itself. Such a holding is untenable in light of the above authority. Because of this, and the fact that claimant has proved that her employment activity is the major contributing cause of the disability or need for treatment of the calcific tendonitis condition, we would find that claimant has proved a compensable occupational disease claim. Because the majority concludes otherwise, we respectfully dissent.

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[1] The majority contends that the statutory interpretation does not sufficiently consider ORS 656.802(2)(a). We would argue, however, that the majority's analysis does not adequately consider ORS 656.802(2)(c), which indicates that, in cases concerning "combined conditons," the compensability standards for an occupational disease have been modified to create an exception to the general occupational disease standard in ORS 656.802(2)(a). To the extent that there is a conflict between the statutes, we would find the more specific statutory provisions in ORS 656.802(2)(c) controlling. *See, e.g. South Benton Educ. Ass'n v. Monroe Union High School Dist. No. 1*, 83 Or App 425, 431 *rev den* 303 Or 331 (1987).

In the Matter of the Compensation of
DENNIS MAXFIELD, Claimant
WCB Case No. 99-01500
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) upheld the insurer's denial of his injury claim for a spleen condition; and (2) declined to assess penalties for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant worked for the employer's logging company as a chaser between July 1998 and September 28, 1998. (Tr. 9-10). Claimant explained that his job duties were to unhook the chokers off logs, cut the limbs off and cut the logs to size. (Tr. 9). Two other individuals worked with claimant: Mr. Ragsdale was the shovel operator and Mr. Wallis was the yarder operator. (Tr. 21, 40, 48).

During his employment with the employer, claimant recalled two unusual incidents. In one incident, a log hit the opposite end of the log that claimant was standing on, which caused him to be thrown up in the air. (Tr. 10, 11). He said the incident "knocked the wind" out of him. (Tr. 10). Claimant's coworker stopped and asked if he was all right. (*Id.*) The coworker, Mr. Ragsdale, testified he had seen claimant "flipped up in the air" during that occasion. (Tr. 41). Claimant did not seek medical treatment after that incident, nor did he report an on-the-job injury. (Tr. 11).

A second incident occurred approximately four to five days before claimant was hospitalized on September 30, 1998. Claimant testified that he was attempting to unhook a choker when a log hit him in the rib cage. (Tr. 12-14, 26-28). Claimant said it knocked the air out of him and he started feeling weak. (Tr. 14).

On September 28, 1998, claimant was fired by the employer for using alcohol and marijuana in a company vehicle. (Tr. 16, 32, 37).

Claimant sought emergency treatment on September 30, 1998 because he was in bad pain and his stomach was bloated. (Tr. 17; Ex. 3). Claimant testified that he had pain into his shoulders and his sister insisted he should go to the hospital. (Tr. 18).

Claimant was examined by Dr. Shipsey in the emergency room. (Ex. 3). Dr. Shipsey reported that claimant had sustained a possible blunt abdominal trauma and had a "one day history of progressively severe left upper quadrant abdominal pain, intermittent nausea, diaphoresis with severe pain, occasional radiation of pain up to his left shoulder." (*Id.*) Claimant's skin was "definitely bronze-tinted or possibly jaundiced." (*Id.*) An abdominal CT scan showed a splenic rupture with associated hemorrhage. (Ex. 4).

On September 30, 1998, Dr. Cassim, the treating surgeon, reported the following history:

> "[Claimant] tells me that he was working for a logging company on Monday, 2 days ago and he had blunt abdominal trauma with one of the logs. It was aimed at the left upper quadrant. He mentioned it to his working partner because he felt a little light headed and a little bit of pain, but did not think much about it. By the end of the day, the pain was still there and being a 'macho guy' he was not too concerned about it and went home. Tuesday, the next day, he did not go to work, because his boss told him to stay home. (I do not know exactly why). He was still in pain, but again, did not think too much about it. He told me that day he did not have much of an appetite and he was feeling weak. On Wednesday, which is the 9/30/98, by 11:00 A.M., he had sudden onset of abdominal pain and he became very dizzy and light headed. He still would not seek medical help until his sister came in to see him. She looked at him and he looked pale and pasty by the evening. She brought him to the ER." (Ex. 5).

Dr. Cassim performed a splenectomy on September 30, 1998. (Ex. 6).

Dr. Braun performed a records review on behalf of the insurer. (Ex. 17).

The insurer denied the claim on the basis that claimant's injury did not arise out of or in the course and scope of his employment with the employer. (Ex. 13). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that, based on demeanor, Mr. Lamprecht and Mr. Ragsdale were credible witnesses. The ALJ concluded that there were too many inconsistencies in the record for claimant to meet his burden of proof regarding legal causation. The ALJ also found that claimant had failed to prove medical causation. The ALJ concluded that claimant was not a reliable witness and, therefore, she did not rely on the medical opinions that were based on his description of a work-related traumatic injury to his abdomen.

On review, claimant argues that he has established legal and medical causation. For the following reasons, we agree with claimant.

Although the ALJ did not find claimant to be a reliable witness, she made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). On *de novo* review, we are persuaded by claimant's testimony and by reviewing the record as a whole, that his ruptured spleen was the result of an accidental injury at work.

Claimant testified that he was injured at work while he was attempting to unhook a choker and a log hit him in the rib cage. (Tr. 12-14, 26-28). Claimant said it knocked the air out of him and he started feeling weak. (Tr. 14). He testified that the incident occurred about four or five days before he was hospitalized on September 30, 1998. (Tr. 12-13).

Dr. Shipsey examined claimant in the emergency room and reported that claimant had sustained a possible blunt abdominal trauma on September 28, 1998. (Ex. 3). On September 30, 1998, Dr. Cassim, the treating surgeon, reported that claimant had been working for a logging company two days ago and had blunt abdominal trauma with one of the logs that was aimed at the left upper quadrant. (Ex. 5).

The employer argues that claimant is not credible. The employer contends that claimant's testimony at hearing that he was injured four days before he sought medical treatment is inconsistent with his statements to medical providers that he had been injured two days before. The medical records indicate that, by the time claimant sought medical treatment, he was in very serious condition with a splenic rupture and hemorrhaging. (Exs. 3, 4, 5, 6). Dr. Cassim testified that when he initially examined claimant on September 30, 1998, claimant was "not really in a very normal coherent manner" and was not able to give a very detailed account. (Ex. 18-11). Based on Dr. Cassim's comments, we find that the discrepancies as to claimant's date of injury are understandable in light of the seriousness of his condition.

The insurer also contends that claimant was not credible because there were no eyewitnesses to the alleged blow to his abdomen at work. The insurer asserts that there were two coworkers present whose jobs required them to watch claimant "virtually every moment[.]" (Insurer's br. at 5).

The fact that claimant's coworkers did not recall the particular incident with a log is of minor importance because the record is clear that both coworkers were only able to see claimant a portion of the time. Mr. Ragsdale was a shovel operator during the time claimant worked for the employer. (Tr. 40). He did not recall seeing claimant hit by a log during the days shortly before he was terminated. (Tr. 44). Mr. Ragsdale estimated that he had visual contact with the chaser (claimant's job) about 50 percent of the time. (Tr. 46). Mr. Wallis was a yarder operator working with claimant and he did not recall seeing claimant hit by a log during that time period. (Tr. 48, 50). Mr. Wallis estimated that he was able to see the chaser about 95 percent of the time. (Tr. 49). Based on the testimony of Mr. Ragsdale and Mr. Wallis, we disagree with the insurer's assertion that claimant's coworkers were able to see him "every moment."

Furthermore, we note that, based on claimant's testimony regarding both incidents at work, he is not the type of person that would complain of pain or immediately seek medical treatment. Despite his severe pain, claimant's sister had to convince him to go to the hospital on September 30, 1998. (Tr. 18). Dr. Cassim reported that, although claimant had sudden onset of abdominal pain and became dizzy and light-headed, he did not seek medical treatment until his sister "dragged him" into the hospital. (Exs. 5,18-14).

Based on claimant's testimony and the record as a whole, we find that claimant sustained an abdominal injury at work approximately occurred four to five days before he sought medical treatment on September 30, 1998.

In addition to establishing legal causation, we find that claimant has established medical causation. Dr. Cassim performed claimant's splenectomy on September 30, 1998. (Ex. 6). On October 8, 1998, Dr. Cassim reported that claimant had an acute hemorrhage from the spleen that had resulted from a blunt trauma sustained while working as a logger. (Ex. 8). He explained that claimant probably had a minor abdominal trauma that developed an intracapsular hematoma that subsequently resulted in massive bleeding. (*Id.*) In a later report, Dr. Cassim said that, based on claimant's history, the CT scan and the elevated bilirubin count, he believed claimant had a delayed rupture of the spleen from a minor blunt trauma at work. (Ex. 16-2).

Dr. Cassim was subsequently deposed. Dr. Cassim is certified in general surgery and works as a trauma surgeon. (Ex. 18-8). Based on claimant's history and his clinical findings, Dr. Cassim concluded that claimant's ruptured spleen was related to his work. (Ex. 18-9). He believed claimant had some type of blow in the left upper quarter. (Ex. 18-10). He understood that a log had hit claimant in the left upper quarter approximately two days before he went to the emergency ward. (Ex. 18-11). Dr. Cassim was asked whether it mattered to his opinion on causation that claimant had not reported the injury to his coworkers or his employer. (Ex. 18-13). He responded:

> "No, because [claimant] probably did not appreciate the magnitude of his injury, what was going to happen to him later on. And being a macho man, he just ignored it. The reason I say that is [claimant] did not want to come to the hospital. He was dying, but he didn't want to come to the hospital. His sister dragged him into the hospital knowing that her brother was acutely ill." (Ex. 18-13, -14).

The fact that claimant did not have any apparent bruises did not affect Dr. Cassim's opinion on causation. Dr. Cassim explained that he had seen many trauma patients with significant internal injuries who did not have any contusions. (Ex. 18-15, -16). Dr. Cassim also said that if claimant's incident with the log had occurred four to five days before he went to the emergency room, that history would still be compatible with the delayed hemorrhage. (Ex. 18-20). Dr. Cassim indicated that, at the time he initially treated him, claimant was very ill and was not able to give a detailed account of the injury. (Ex. 18-11, -12). Dr. Cassim explained that the spleen initially ruptured, but did not bleed sufficiently to produce clinical signs at that time. (Ex. 18-20). The secondary hemorrhage occurred later. (*Id.*)

The only other medical opinion on causation is from Dr. Braun, who reviewed claimant's medical records. He opined that the interval of splenic rupture could have been anywhere from four weeks to several days. (Ex. 17). He noted there was no evidence of a contusion or abrasion of the abdomen or flank, which he said would be likely if the injury had occurred two to three days before the bleeding episode. (*Id.*)

We generally give greater weight to the opinion of a claimant's treating surgeon, absent persuasive reasons not to do so. *Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988); *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, there is no persuasive reason not to defer to Dr. Cassim, who performed claimant's spleen surgery. Dr. Cassim persuasively rebutted Dr. Braun's opinion and provided a well-reasoned explanation of why claimant's spleen condition was causally related to his employment. In sum, we conclude that claimant has sustained his burden of proving a compensable injury.

Penalties

Claimant argues that he is entitled to penalties and attorney fees for the insurer's allegedly unreasonable denial. He contends that the insurer did not have any medical records in its possession to reasonably conclude that the claim was not compensable prior to issuing its denial. The insurer

responds that the evidence in the record is "more than adequate" to find that the insurer's denial was reasonable.

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

On December 23, 1998, the insurer denied the claim on the basis that claimant's injury did not arise out of or in the course and scope of his employment with the employer. (Ex. 13). Drs. Shipsey and Cassim reported that claimant had sustained a possible blunt abdominal trauma on September 28, 1998. (Exs. 3, 5). Although claimant asserted he was injured at work, there were no eyewitnesses to the injury, despite the fact that he worked closely with two people who were required to watch him. Claimant did not seek medical treatment until September 30, 1998. Mr. Lamprecht, the owner of the logging company, testified that he was not informed that claimant had any work-related injuries until September 30, 1998. (Tr. 38). In his September 30, 1998 chart note, Dr. Cassim said that claimant had not gone to work on September 29, 1998 because his boss told him to stay home. (Ex. 5-1). On September 28, 1998, however, claimant had been fired by the employer for using alcohol and marijuana in a company vehicle. (Tr. 16, 32, 37).

We find that the insurer had a "legitimate doubt" regarding its liability for claimant's injury based on the delay in seeking medical treatment, the lack of eyewitnesses to the injury and the fact that claimant had been terminated on the same day that he reported he was injured. Therefore, we do not assess a penalty against the insurer for an unreasonable denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the 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. 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).

ORDER

The ALJ's order dated August 13, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the insurer's denial is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded $4,200, payable by the insurer.

Board Member Meyers dissenting.

The alleged injury in this case was unwitnessed and the claim is uncorroborated. Because I find claimant's testimony concerning the alleged work incident to be unreliable and, therefore, the medical opinions that depend on claimant's reported history to be unpersuasive, I conclude that claimant has failed to sustain his burden of proof. For these reasons, I respectfully dissent.

The outcome of this case turns on claimant's credibility. The ALJ found that, based on demeanor, Mr. Lamprecht and Mr. Ragsdale were credible witnesses. Since the ALJ's credibility finding was based in part on the observation of demeanor, I would defer to that determination. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990). In contrast, the ALJ found that claimant was not a reliable witness and there were too many inconsistencies in the record for claimant to meet his burden of proof regarding legal caustion. After considering the record as a whole, I agree with the ALJ that claimant was not a reliable historian.

Claimant began working for the employer in July 1998. He was fired on September 28, 1998 for using alcohol and marijuana in a company vehicle. (Tr. 16, 32, 37). Claimant testified that an incident at work occurred approximately four to five days before he was hospitalized on September 30, 1998. (Tr. 12). He said the carriage was not working correctly and he was attempting to unhook a choker

when a log hit him in the rib cage. (Tr. 12-14). Claimant said it knocked the air out of him and he started feeling weak. (Tr. 14). He testified that he told "Brian," a coworker, about the injury. (Tr. 15, 30, 31).

In contrast, claimant's medical reports indicate that he was injured on September 28, 1998, the same day he was fired. (Exs. 2, 3, 5). Claimant's "827" form also referred to the date of injury as September 28, 1998. (Ex. 9). The majority brushes aside this inconsistency on the basis of claimant's very serious medical condition. Although claimant was in a great deal of pain, he was coherent enough to give many details to his physicians, including the day of the alleged injury (Monday), the cause (abdominal trauma) and the fact that a carriage had slipped. (Exs. 2, 3, 5). In addition, claimant told Dr. Cassim that he had mentioned the injury to his "working partner." (Ex. 5-1). Although claimant insisted at the hearing that he had told "Brian" about the injury, no one named Brian testified at the hearing. Claimant did not report the incident to his employer until after he went to the emergency room. (Tr. 38). The inconsistencies regarding the date of claimant's alleged injury are not explained based on the circumstances of his emergency room visit.

Furthermore, claimant's testimony is not persuasive based on the lack of any eyewitnesses to the alleged "log blow" to claimant's abdomen. Claimant, the chaser, testified that he worked with Mr. Ragsdale, who operated the shovel, and Mr. Wallis, who was the yarder operator. (Tr. 21). Claimant agreed it was important to stay in visual contact with them to avoid injuries. (Tr. 22, 23). Mr. Lamprecht, the owner of the logging company, and Mr. Wallis testified that the yarder operator cannot proceed until he knows the chaser is out of the way. (Tr. 36, 49). Mr. Wallis said that he was able to see the chaser 95 percent of the time. (Tr. 49). The shovel operator also had to stay in visual contact with the chaser. (Tr. 36, 46). Mr. Ragsdale testified that, between the shovel operator and the yarder operator, the chaser would be in sight 95 to 98 percent of the time. (Tr. 47).

Despite the fact that claimant would have been in view of either Mr. Wallis or Mr. Ragsdale almost all the time, neither of them witnessed claimant's alleged incident at work shortly before he was terminated. (Tr. 44, 50). In light of claimant's testimony that the carriage was not working correctly on that day, I find it hard to believe that neither Mr. Ragsdale nor Mr. Wallis would have witnessed the alleged injury. Moreover, although claimant said he told "Brian" about the injury, he never mentioned it to his coworker, Mr. Wallis, despite the fact that they rode back and forth to work and worked together 12 to 14 hours a day. (Tr. 51, 52).

In addition, there are other troubling aspects of claimant's alleged injury. Dr. Braun reviewed the medical records and noted there was no evidence of a contusion or abrasion on claimant's abdomen, which he said would be likely if the injury were as recent as two or three days before the bleeding episode. (Ex. 17). Claimant testified that he did not have a contusion or abrasion on his abdomen after the alleged injury. (Tr. 27).

Finally, my conclusion that claimant was not credible is also based on his testimony about an earlier work incident. Claimant testified that another incident at work occurred two or three weeks before he was fired. (Tr. 12, 24). He asserted that a log hit the opposite end of the log he was standing on, which caused him to be thrown up in the air. (Tr. 10, 11). He said he was "knocked out." (Tr. 11, 19).

Mr. Ragsdale confirmed that such an incident occurred, but he said it occurred two and one-half to three months before claimant was terminated from work. (Tr. 43, 45). He testified that claimant was not knocked out, but "jumped right back up." (Tr. 45). The ALJ expressly found that Mr. Ragsdale was a credible witness, based on demeanor. I would defer to the ALJ's finding and conclude that claimant was not credible.

My doubts about this claim are further compounded because the only expert evidence supporting the claim is based on claimant's history regarding his injury. Dr. Cassim agreed that his opinion on causation was based predominately on the history given to him by claimant. (Ex. 18-9). I fail to see how such evidence could be persuasive considering the inconsistencies in claimant's reporting and the utter lack of corroboration of any sort. I agree with the ALJ that claimant is not a reliable historian and the medical evidence based on his reporting is not persuasive. Under these circumstances, I must respectfully dissent.

In the Matter of the Compensation of
CARL F. PLUMLEE, Claimant
WCB Case No. 98-07275
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

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

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's current low back condition/aggravation claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on November 11, 1994, accepted as a disabling lumbar strain. Before this injury, however, claimant experienced low back pain in the early 1990's. Specifically, claimant sought treatment on July 1, 1992 from Dr. Byerly for low back pain of more than 2 years duration. (Ex. 2-1). Dr. Byerly diagnosed probable degenerative disc disease with osteoarthritis of the spine.

Dr. Roach began treating claimant on July 21, 1992. Among his diagnoses was "sciatica." (Ex. 3-1). Dr. Roach continued to provide care for claimant for a variety of problems, which included low back pain, into early 1994. (Ex. 8).

Dr. Roach also provided treatment for claimant after the compensable 1994 injury. Dr. Roach's last treatment for this injury occurred on February 15, 1995, at which time the diagnosis was lumbosacral strain and degenerative joint disease. (Ex. 17). On March 15, 1995, in response to an inquiry from SAIF, Dr. Roach agreed that claimant's November 1994 injury had resolved to pre-injury status and that this injury had caused no permanent impairment. (Ex. 18). Dr. Roach further agreed that the compensable injury had combined with preexisting degenerative disc disease and an L3-4 disc bulge/protrusion and that the preexisting conditions "remain[ed]" the cause of claimant's need for treatment and/or disability. *Id.*

A March 21, 1995 Notice of Closure then closed the claim with an award of temporary disability only. (Ex. 19).

In November 1997, Dr. Herring, a neurologist, saw claimant on referral from Dr. Willey for an evaluation of low back and right hip pain. (Ex. 20). Dr. Herring opined that claimant had symptoms consistent with lumbar radiculopathy, as well as right leg sensory and motor symptoms. After obtaining a lumbar MRI scan, which revealed degenerative disc disease with annular bulging but no focal disc herniation, Dr. Herring recommended a neurosurgical evaluation. (Ex. 22).

A neurosurgeon, Dr. Van Pett, evaluated claimant's low back condition on February 13, 1998. Dr. Van Pett was uncertain of the source of claimant's pain, but opined that claimant seemed to suffer from sciatica originating outside the spinal canal. However, Dr. Van Pett emphasized that, until the etiology of claimant's condition was clarified, she could not say that the 1994 injury was the major contributing cause of claimant's need for treatment. (Ex. 25-4).

On April 28, 1998, Dr. Van Pett reported claimant had been in a motor vehicle accident while driving a truck. This caused a significant exacerbation of low back and hip pain, but Dr. Van Pett noted that the pain was in the same distribution and of the same quality as before. (Ex. 27).

In May 1998, Dr. Gripekoven, an examining physician, attributed claimant's low back condition in major part to degenerative disc disease. (Ex. 30). Dr. Van Pett opined, however, on July 9, 1998, that she had "worked up" claimant exhaustively and could not correlate claimant's symptoms with degenerative changes or disc problems. Conceding that sciatic nerve compression outside the spinal canal is difficult to diagnose, Dr. Van Pett, nevertheless, stated that her evaluation with selective nerve blocking procedures had clearly identified the problem. Dr. Van Pett recommended surgical decompression, which was performed in August 1998. (Ex. 37).

On August 6, 1998, Dr. Van Pett filed a formal notice of an aggravation claim. (Ex. 39). SAIF denied the aggravation/current condition claim on September 30, 1998, on the ground that the 1994 injury was not the major contributing cause of claimant's lumbar condition. (Ex. 40). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial, finding that Dr. Van Pett's opinion established the compensability of claimant's current condition and aggravation claim.[1] On review, SAIF contends that the ALJ should not have found Dr. Van Pett's opinion persuasive because it was not well-reasoned or based on an accurate history. Instead, SAIF asserts that the opinion of examining physicians, Drs. Gripekoven and Rosenbaum, are more persuasive and establish that claimant's current condition is not related to the compensable 1994 injury. For the following reasons, we agree with SAIF.

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

We begin our analysis with a determination of whether claimant's current condition is a compensable condition. As a result of the compensable November 1994 injury, SAIF accepted a low back strain. Dr. Van Pett has diagnosed claimant's current condition as a sciatic nerve compression. This is not an accepted condition. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the sciatic nerve compression condition is a compensable condition. *See Gloria T. Olson*, 47 Van Natta at 2350.

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 not to give greater weight to the opinion of Dr. Van Pett, claimant's current attending physician.[2]

Dr. Van Pett did not become the attending physician until February 1998, over 3 years after the compensable November 1994 injury. Under these circumstances, we cannot say that Dr. Van Pett is in a more advantageous position as attending physician to render an opinion regarding the relationship between the November 1994 injury and the low 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).

In addition, Dr. Van Pett concedes that her diagnosis of sciatic nerve compression is rare but, through her evaluation of claimant's current condition, she is convinced that this diagnosis explains claimant's current condition. Even assuming that this admittedly rare diagnosis explains claimant's current condition, Dr. Van Pett does not explain how the 1994 injury caused this condition.

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[1] The ALJ also held that claimant was entitled to interim compensation from August 6, 1998 through the date of the September 30, 1998 denial and 25 percent penalty for SAIF's allegedly unreasonable failure to pay interim compensation. SAIF does not contest those portions of the ALJ's order.

[2] Because we do not find that claimant's sciatic nerve condition is a compensable condition and, thus, that the aggravation claim is not compensable, we need not address whether there was an "actual worsening" or whether claimant extablished a diminished earning capacity.

On October 26, 1998, Dr. Van Pett stated that the 1994 injury caused the sciatic nerve condition, but did not offer an explanation except to say that this opinion was based on her review of literature and claimant's history. (Ex. 42). In two other reports, Dr. Van Pett reiterated that the 1994 injury resulted in the sciatic nerve compression outside the spinal canal. (Exs. 44, 47). But Dr. Van Pett again provided no explanation of how the compensable injury caused the diagnosed condition.

We find the lack of reasoning particularly significant in this case because of the opinion of Dr. Roach, who treated claimant both before and after the compensable 1994 injury, and who opined in 1995 that the compensable injury had resolved to pre-injury status. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 421 (1986). Moreover, there is a substantial gap in medical treatment of nearly three years between February 1995 and November 1997.

Finally, Dr. Van Pett noted that claimant's symptoms began with the 1994 injury. However, to the extent that Dr. Van Pett is relying on a temporal relationship to establish causation, we are not persuaded in light of claimant's similar low back and lower extremity symptoms experienced prior to the 1994 injury.

In summary, we find persuasive reasons not to give greater weight to Dr. Van Pett's opinion. In addition, we find the medical opinions of Dr. Gripekoven and Dr. Rosenbaum more persuasive.

Dr. Gripekoven had an accurate history of claimant's medical condition and reviewed MRI studies done in 1982 and 1997. (Ex. 45-8). His conclusion that claimant's degenerative disc disease is the major factor in claimant's back and right leg symptoms is well-reasoned and convincing in light of the medical record, including claimant's pre-1994 back condition. Dr. Rosenbaum specifically noted claimant's previous symptoms in 1992 and 1993 and concluded that, regardless of the appropriate diagnosis, there was not an industrial relationship to the 1994 injury. (Ex. 43-7, 8). We also find Dr. Rosenbaum's opinion well-reasoned in light of the entire medical record.

Accordingly, we disagree with the ALJ's evaluation of the medical evidence and conclude that claimant's current condition is not compensably related to the 1994 injury. Therefore, we conclude that the aggravation claim is not compensable.

ORDER

The ALJ's order dated August 17, 1999 is reversed in part and affirmed in part. That portion of the order that set aside SAIF's September 30, 1998 denial is reversed. The denial is reinstated and upheld. The ALJ's insurer-paid attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich dissenting.

The majority concludes that claimant's current condition/aggravation claim is not compensable, finding the opinion of the attending physician, Dr. Van Pett, unpersuasive. Because I find no persuasive reason to depart from our usual practice of giving greater weight to the treating doctor's opinion, I must part company with the majority and dissent. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983) (absent persuasive reasons to do otherwise, Board will 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).

To begin, I acknowledge Dr. Van Pett did not examine claimant in close temporal proximity to the compensable 1994 injury, but that fact does not significantly detract from the persuasiveness of her opinion. To the contrary, Dr. Van Pett's opinion is persuasive because she arrived at her diagnosis of sciatic nerve compression after careful and exhaustive evaluation. Significantly, as a result of this evaluation, Dr. Van Pett was unable to correlate claimant's symptoms with any degenerative condition. (Ex. 34). She specifically noted that claimant's relief from pain after steroid injections and surgery indicated that the sciatic nerve compression condition was separate from degenerative changes. (Ex. 44). This persuasively rebuts the medical opinions of Drs. Gripekoven and Rosenbaum, on whom the majority relies and who attributed claimant's current condition to degenerative disc disease. Claimant's response to treatment also supports Dr. Van Pett's conclusion that the compensable injury, not degenerative disc disease, is the major contributing cause of claimant's sciatic nerve condition. (Ex. 47).

Because it is well-reasoned and the product of exhaustive work-up and considerable familiarity with claimant's condition, Dr. Van Pett's is the most persuasive opinion in this record. For this reason, I would defer to her opinion and find the aggravation claim compensable. Thus, I would affirm the ALJ's order. Because the majority concludes otherwise, I dissent.

February 8, 2000 Cite as 52 Van Natta 188 (2000)

In the Matter of the Compensation of
ELLEN M. SMITH, Claimant
WCB Case No. 99-03606
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside the insurer's denial of claimant's new medical condition claim for a low back injury; and (2) assessed penalties for allegedly unreasonable claim processing. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

Claimant, who worked as a respiratory therapist for a hospital, compensably injured her low back and left hip when she leaned over to retrieve a piece of respiratory equipment from the floor on July 25, 1996. The insurer accepted a disabling left lumbar/hip strain.

On September 3, 1996, claimant returned to her doctor after a physical therapy session with complaints of lumbar pain radiating into the left leg to the ankle. A lumbar CT scan revealed degenerative changes and a disc bulge at L4-5 and mild facet hypertrophic changes at L4-5 and L5-S1. Claimant's condition improved by September 6, 1996, although she complained of pain in the right lumbar area if she attempted to pick up something or drive.

On September 26, 1996, Dr. Jansen declared her medically stationary and a February 21, 1997 Determination Order closed the claim with temporary but no permanent disability.

On July 26, 1997, after being without symptoms for six months, claimant sought treatment for central lumbar pain and intermittent bilateral leg pain, right greater than left, that arose after she got up out of a chair. Dr. Schepergerdes prescribed physical therapy. By November 3, 1997, Schepergerdes reported that claimant had only very occasional twinges of low back pain not involving the legs and that she had returned to her regular work.

On August 31, 1998, claimant experienced immediate pain in the right lumbosacral region radiating through the buttock and thigh after light use of a shovel. Dr. Schepergerdes diagnosed acute on chronic lumbar strain, with history of a mild L4-5 disc bulge on CT scan. He suspected that the bulge had become a herniation with right greater than left L5 versus S1 radiculitis. A lumbar MRI revealed disc space dessication and a central bulge at L5-S1. Dr. Schepergerdes filed an aggravation form on September 10, 1998.[1]

Claimant's low back pain did not improve, so she was referred to Dr. Dunn for evaluation. He assessed recurrent radiculitis with MRI evidence of a disc bulge and discogenic type referred pain without significant radiculitis. He performed an epidural steroid injection that helped somewhat. However, claimant was unable to resume her work schedule without an increase in symptoms, so Dr. Schepergerdes referred her to Dr. Gallo for surgical evaluation.

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[1] The aggravation claim is not at issue on review.

Dr. Gallo reported pain along the midline lumbar spine with bilateral involvement of buttocks and legs. Gallo assessed mechanical back pain and radicular leg pain as a result of the central L5-S1 disc herniation. In February 1999, Gallo performed an interbody fusion at L5-S1 that relieved claimant's symptoms.

On January 29, 1999, claimant was examined for the insurer by Drs. Arbeene, orthopedist, and Denekas, neurologist. They diagnosed degenerative disc disease at L5-S1, history of a lumbosacral strain and left hip strain in 1996, and history of a lumbar strain in August 1998, "non-work related." (Ex. 23).

On April 26, 1999, the insurer partially denied claimant's central L5-S1 herniated disc on the basis that the condition was not compensably related to the accepted injury or work activity.

On June 10, 1999, Drs. Williams, neurologist, and James, orthopedist, examined claimant for the insurer. They diagnosed an acute lumbosacral strain in July 1996, work related, with a history of transient left lower extremity pain with no objective neurological deficit; and acute lumbosacral strain on August 31, 1998, non-work related.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Gallo's opinion to conclude that claimant's 1996 work injury was the major contributing cause of her herniated disc and set aside the insurer's denial. The ALJ also assessed a penalty for the insurer's allegedly unreasonable denial. On review, the insurer contends that Dr. Gallo's opinion is insufficient to establish compensability, and that the penalty should be reversed because it had reasonable doubt as to its liability. We agree.

Compensability

Claimant's L5-S1 herniated disc has three possible causes: the 1996 work injury, the 1998 lifting incident, or the preexisting degenerative disc disease.[2] For claimant to meet her burden of proof, she must show that the 1996 work injury was the major contributing cause of her disk herniation and need for treatment. ORS 656.005(7)(a)(B).

Because of the multiple possible causes of claimant's herniated disc and the passage of time since the 1996 work injury, this case presents a complex medical question that depends on expert medical analysis for its resolution. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (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). In addition, a persuasive opinion must also adequately consider and weigh the relative contribution of various potentially contributory factors. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 426 (1995).

Claimant relies on the opinion of Dr. Gallo, her treating neurosurgeon, in support of her claim. We generally defer to the conclusions of the attending physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 10 (1983). Here, we find persuasive reasons to do otherwise.

In her first report, Dr. Gallo based her opinion that claimant's L5-S1 herniated disc was caused by the 1996 injury on the theory that claimant most likely had some early disc fissuring prior to her 1996 injury and that the work injury caused the fissure to extend into a bulge with pressure on the annular pain fibers, thus causing the subsequent symptoms and exacerbations with trivial activities. (Ex. 26). However, there is no contemporary medical evidence to establish that claimant experienced a disc bulge at L5-S1 as a direct result of the 1996 injury. Rather, the 1996 CT scan (which Dr. Gallo could not remember seeing) establishes that claimant had facet changes and a mild disc bulge at L4-5 and facet changes at L5-S1. Dr. Gallo does not explain this discrepancy, nor does she discuss the relative contribution of the degenerative changes at L4-5 and L5-S1, as required under *Dietz v. Ramuda*.

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[2] Dr. Gallo, upon whom claimant relies, posited a fissure at L5-S1 that probably preexisted her 1996 injury and that the 1996 injury caused the fissure to extend into a bulge. (Ex. 29). Drs. Williams and James remarked that the facet changes at L4-5 and L5-S1 in the 1996 MRI were indicative of a preexisting condition. (Ex. 28-4).

Moreover, in a subsequent report, Dr. Gallo stated that claimant's 1996 injury caused a *fissure* in her L5-S1 disc with resultant pressure on the pain fibers in the annulus causing her symptoms. (Ex. 29). Again, Dr. Gallo offers no explanation for her confusing opinions (did the 1996 injury cause a bulge or a fissure), nor, as noted above, is there any contemporary medical evidence that would support her conclusions. Moreover, even assuming the validity of the fissure theory, Dr. Gallo provides no explanation as to how a fissure in 1996 is now the major contributing cause of claimant's current disc herniation.

Dr. Gallo also reported that claimant had never been pain free since the 1996 injury. (Exs. 22, 29). But the contemporary medical records show otherwise. After a significant lapse in treatment, claimant reported to her physical therapist in July 1997 that she had had no pain for the prior six months.[3] (Ex. 11). And in November 1997, Dr. Schepergerdes reported that claimant had only "very occasional twinges of low back pain not involving the legs," and that claimant had returned to her regular 12-hour a day shift work. (Exs. 12, 13). Claimant continued to perform regular work until the 1998 lifting incident.

Dr. Gallo also based her opinion on the fact that claimant was asymptomatic prior to the 1996 injury, that her symptoms waxed and waned after that time, and that her subsequent flare-ups were associated with minimal activity. (Exs. 22, 29). Not only does Dr. Gallo base her opinion on a temporal relationship to establish compensability, but she failed to offer any explanation of why claimant's symptoms had apparently resolved for lengthy periods of time after the 1996 and 1997 incidents, but had become unrelenting after the 1998 lifting incident.

The other medical experts who examined claimant attributed her L5-S1 herniated disc to her preexisting degenerative condition. Drs. Arbeene and Denekas diagnosed degenerative disc disease at L5-S1. Although they found that the 1998 MRI did not suggest the presence of significant degenerative disc disease at L4-5, they noted that the 1996 CT scan did suggest degenerative disc disease at this level. Based on this medical evidence, they opined that claimant's current symptoms related to her degenerative disc disease. (Ex. 23-6).

Likewise, Drs. Williams and James compared the 1996 CT scan to the 1998 MRI. (Ex. 28). Although they noted that the 1996 study was inadequate to establish a disc bulge at L5-S1, they stated that what they did see in relation to both the L4-5 and L5-S1 levels was not clinically significant. (Ex. 28-4). They also agreed that the facet changes at L4-5 and L5-S1 were indicative of a preexisting degenerative condition and that the degenerative condition at L5-S1 was likely the source of claimant's chronic back pain. (Ex. 28-4, -5). In support of their opinion, they noted that claimant was asymptomatic from late 1996 until July 1997 and from after the 1997 episode until August 1998. They accordingly concluded that there was no permanent impairment associated with the 1996 injury, and that the major cause of claimant's preoperative back pain was from degenerative changes at L5-S1 and not the July 1996 work injury.[4]

On this record, we find Drs. Williams and James' opinion more persuasive than Dr. Gallo's, as it is better-reasoned and based on an accurate medical history.

Penalties

In light of our conclusion that claimant's L5-S1 disc is not compensable, there are no amounts then due on which to assess a penalty, and there has been no unreasonable resistance to the payment of compensation giving rise to an attorney fee. ORS 656.262(11)(a) and 656.382(1). For this reason, we reverse the ALJ's decision that claimant is entitled to a penalty for the insurer's allegedly unreasonable denial.

ORDER

The ALJ's order dated September 9, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] We find the contemporary medical records to be more persuasive than claimant's testimony that she had continuing low back pain over the years. (Tr. 11).

[4] They also eliminated claimant's 1998 shoveling activity as a sufficient mechanism to cause the disc bulge in claimant's low back.

In the Matter of the Compensation of
LORINDA L. ZABUSKA, Claimant
WCB Case No. 99-00781
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's right hip treatment. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In December 1995, claimant sustained a compensable low back injury. The ALJ concluded that this incident was the major contributing cause of claimant's need for treatment of the right hip. SAIF challenges the ALJ's order, first asserting that the claim is for "right hip pain," which is not a medical condition and, thus, does not require acceptance under ORS 656.262(7)(a). SAIF further argues that its acceptance of central disc protrusion at L5-S1 includes the right hip pain because it is "a result of the specific accepted condition[.]" According to SAIF, it was not required to specifically accept the right hip because its acceptance of a central disc protrusion at L5-S1 "reasonably apprises claimant and her medical providers of the nature of the compensable conditions."

Dr. Keenen, orthopedic surgeon, examined claimant at SAIF's request. After noting claimant's symptoms in her right hip, Dr. Keenen provided "[l]umbar degenerative disc disease, status post discectomy and arthrodesis" as his "impression." (Ex. 54-3). Dr. Keenen stated that claimant "continues to have pain secondary to her lumbar degenerative disc disease" and that her December 1995 injury "was the major contributing cause to the preexisting condition, with the injury being the primary factor for her current need for treatment and limitations." (*Id.*) Finally, Dr. Keenen indicated that claimant's "current back, right groin and buttocks symptoms are the direct result of her December 4, 1995 injury[.]" (*Id.* at 4).

Although Dr. Keenen discussed and referred to symptoms in different parts of claimant's body, including her low back, the hips and the buttocks, he provided only one "impression": "Lumbar degenerative disc disease." Thus, we understand his report as indicating that such symptoms were the result of lumbar degenerative disc disease. Consequently, based on Dr. Keenen's report, we disagree with SAIF that the claim is for right hip pain for a previously accepted L5-S1 central disc protrusion; instead, we conclude that claimant needs treatment for her right hip attributable to a combination of claimant's work injury and her lumbar degenerative disc disease.

We also disagree with SAIF that the scope of its acceptance of central disc protrusion includes this lumbar degenerative disc condition. In the absence of medical evidence that lumbar degenerative disc disease is the same condition, or a symptom of, the accepted central disc protrusion, we find that SAIF's acceptance does not reasonably apprise claimant and her medical providers of the nature of the compensable conditions as required by ORS 656.262(7)(a). *Compare Terrance W. Heurung*, 51 Van Natta 1272 (1999) (acceptance included "cold intolerance" based on medical evidence that such condition was a symptom of the accepted condition).

Finally, because SAIF argues that claimant's right hip symptoms resulted from the accepted condition, we do not construe its contentions on review as challenging that part of the ALJ's order concluding that claimant proved that her need for right hip treatment was in major part caused by the industrial injury. In any case, we agree with the ALJ that, based on Dr. Keenen's persuasive opinion, she carried her burden of proof. That is, claimant demonstrated that the December 1995 injury combined with her degenerative disc condition and was the major contributing cause of her need for treatment of the right hip.

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 September 2, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
BILLIE W. GALE, Claimant
WCB Case No. 99-03944
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

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

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

Claimant argues that the ALJ failed to review all of the reports from Dr. Coe, attending physician, and Dr. Buchholz, consulting physician, that when read together provide the necessary analysis to establish compensability of her occupation disease claim. We disagree.

Dr. Buchholz screened claimant for any inflammatory conditions, thyroid dysfunction, and diabetes and opined that, if those tests were normal, claimant may need carpal tunnel release on the left. (Ex. 4-3). The record does not contain the results of those tests, although Dr. Coe noted that claimant had no history of diabetes or thyroid disease. (Exs. 1, 4, 7). Dr. Buchholz' entire causation opinion consisted of the following statement: "Bilateral carpal tunnel syndrome presumably related to overuse. No obvious risk factors otherwise." (Ex. 4-2). It is well-established law, however, that probability, not possibility, is the requisite standard of proof. *Gormley v. SAIF*, 52 Or App at 1059-60. Furthermore, a worker cannot prove compensability "merely by disproving other possible explanations of how the injury or disease occurred." ORS 656.266.

In addition, we agree with the ALJ that Dr. Coe offers no reasoning to support his statement that work related activities at the employer are the major contributing cause of her CTS condition. Contrary to claimant's argument, the fact that Dr. Coe was aware of her work activities at the employer and noted that she had no history of diabetes or thyroid disease does not provide persuasive reasoning establishing that claimant's work activities were the major contributing cause of her CTS condition. ORS 656.266.

ORDER

The ALJ's order dated September 2, 1999 is affirmed.

In the Matter of the Compensation of
SANDY J. LOMMEL, Claimant
WCB Case No. 99-01983
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's left shoulder impingement syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt and affirm the ALJ's findings of fact with the following changes. On page 4, we replace the first full paragraph with the following: The parties deposed Dr. Chamberlain. (Ex. 39). We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

In July 1997, claimant filed a claim for bilateral tendinitis in her upper extremities following long periods of typing for the employer. (Ex. 3). On October 9, 1997, the insurer initially accepted bilateral bicipital tendinitis, wrists. (Ex. 8). Claimant's right upper extremity symptoms continued. On March 9, 1998, the insurer accepted medial/lateral epicondylitis right elbow and right biceps tendinitis. (Ex. 17). The insurer's October 26, 1998 updated notice of acceptance at closure accepted medial/lateral epicondylitis right elbow, tendonitis right bicep, calcific tendinitis right shoulder, wrists. (Ex. 27).

In March 1998, Dr. Chamberlain diagnosed impingement syndrome of the right shoulder. (Ex. 18). On June 11, 1998, Dr. Chamberlain performed a right shoulder arthroscopy and subacromial decompression. (Ex. 23).

On July 29, 1998, Dr. Chamberlain reported that claimant's right shoulder was making progress, but she was complaining of some left shoulder difficulties. (Ex. 24-1). On December 9, 1998, Dr. Chamberlain diagnosed impingement syndrome of the left shoulder. (Ex. 30-1).

On January 14, 1999, claimant's attorney wrote to the insurer and requested amendment to the notice of acceptance to include impingement syndrome of the left shoulder. (Ex. 32A).

The insurer denied claimant's left shoulder claim on the grounds that her current condition was unrelated to her July 9, 1997 injury and that the original injury did not contribute to her disability or need for medical treatment. (Ex. 35). Claimant requested a hearing.

The ALJ found that, during the period of treatment for claimant's right arm, she used her left arm to a significantly greater degree than her right arm and her left arm symptoms worsened in the latter part of 1998. The ALJ determined that there was no persuasive evidence that claimant's Type II acromion was a "preexisting condition" that must be factored into an evaluation of major contributing cause under ORS 656.005(7)(a)(B). Based on Dr. Chamberlain's opinion, the ALJ concluded that claimant's left shoulder impingement syndrome was a consequential condition of her accepted right arm and shoulder conditions.

The insurer contends that Dr. Chamberlain's opinion is not sufficient to establish compensability of claimant's left shoulder impingement syndrome. The insurer argues that the ALJ erred when he concluded that claimant's Type II acromion was not a preexisting condition.

We need not determine whether claimant's Type II acromion constitutes a preexisting condition because we find that the claim is not compensable in any event. For the following reasons, we conclude that claimant has failed to prove that her left shoulder impingement syndrome is compensable.

As the ALJ noted, Dr. Chamberlain has offered the only medical opinion as to the cause of claimant's left shoulder impingement syndrome. In evaluating the persuasiveness of medical evidence, we generally defer to the opinion of the treating physician, absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to rely on Dr. Chamberlain's opinion.

Dr. Chamberlain first examined claimant on February 18, 1998, several months after her July 1997 injury. (Ex. 12). He performed a right shoulder arthroscopy and subacromial decompression on June 11, 1998. (Ex. 23).

On July 29, 1998, Dr. Chamberlain reported that claimant was complaining of some left shoulder difficulties. (Ex. 24-1). On December 9, 1998, Dr. Chamberlain reported that claimant had increasing complaints of left shoulder pain and he diagnosed impingement syndrome of the left shoulder. (Ex. 30-1). He explained:

> "Over the past year or so she has occasionally had left shoulder complaints. As she was undergoing her right shoulder work and her surgery she would more than likely overuse the left shoulder as she only had one arm to use. We discussed this over time, not officially." (*Id.*)

In a May 5, 1999 letter to the insurer, Dr. Chamberlain reported that claimant had left shoulder impingement syndrome, which was supported by objective evidence. (Ex. 38). His first documentation of left shoulder pain was on July 29, 1998. Dr. Chamberlain explained:

> "As to the causality of the left shoulder problem, the patient feels that she has had long-standing shoulder difficulty which stems from July 1997. I personally have no record of this in my chart and, therefore, cannot determine whether it would be related to this injury. It was not mentioned to me for at least one year's time and, therefore, based on my direct knowledge at this time, I would be unable to say that it is related to the July 9, 1997 industrial claim." (*Id.*)

In a deposition, Dr. Chamberlain testified that he had never actually assessed claimant's left shoulder until the December 1998 examination. (Ex. 39-6). Before that time, all of the focus of treatment was on claimant's right shoulder and elbow. (Ex. 39-7). He acknowledged it was possible that claimant had relatively overused her left arm. (Ex. 39-8, -10, -11). Dr. Chamberlain agreed that the shape of a person's acromion plays a part in developing impingement syndrome. (Ex. 39-17). He explained that a Type II has a hook, which can be congenital, idiopathic or the result of chronic irritation. (Ex. 39-18).

The insurer's attorney asked Dr. Chamberlain about his May 5, 1999 letter:

> "Q: Okay. Final question. You had indicated you are unable to make a probable relationship between the July 97 industrial injury and her left-shoulder impingement syndrome in your letter to me. Does that remain your opinion?
>
> "A: Because I don't have enough data her July -- is it July 97 original injury?
>
> "Q: Yes.
>
> "A: I did not see her for the right-shoulder problem for quite some time, so there was no treatment and history that occurred prior to that. And then I can't state absolutely for sure what her activities were." (Ex. 39-20, -21).

Although Dr. Chamberlain had restricted claimant's right shoulder activities, he did not quantify what activities claimant was actually doing. (Ex. 39-22). He testified: "And I never quantified or looked at her left shoulder, so I have a very difficult time knowing how much she ever did with her left shoulder." (*Id.*)

Claimant's attorney asked Dr. Chamberlain:

> "Q: And was one of the causes of her problems with her left arm, if not the major cause one of them, the material causes of that medical treatment probably the restriction of the right arm and shoulder?
>
> "A: That I don't know." (Ex. 39-30).

Dr. Chamberlain agreed that he did not know whether claimant restricted her right arm. (*Id.*) He said that, since he did not document how much claimant did or did not use her left arm, he could not answer the question very well. (Ex. 39-31). He explained:

"If you are asking me if she had to prove that she had to do things and use her left arm because her right arm didn't work, one could say it was relative overuse. But I don't know what her base level of use was, so it's an impossible question for me to answer." (*Id.*)

Dr. Chamberlain agreed that one of the causes for the relative nature of overuse in the left arm would be the restrictions in the right injured arm. (Ex. 39-32). However, when asked whether that was based on a "degree of probability," Dr. Chamberlain said "I guess so." (*Id.*) He explained that not every person who has an impingement or surgery on one arm develops problems with the other shoulder. (*Id.*)

Dr. Chamberlain's opinion does not support the conclusion that claimant's left shoulder impingement syndrome arose directly from the 1997 compensable injury. Dr. Chamberlain said the first mention of left shoulder pain was on July 29, 1998 and he explained that he could not determine whether claimant's left shoulder impingement syndrome was related to her July 1997 claim. (Exs. 38, 39-20, -21).

ORS 656.005(7)(a)(A) 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). We agree with claimant that medical certainty is not required. *Robinson v. SAIF*, 147 Or App 157, 160 (1997). Instead, a preponderance of evidence may be shown by medical probability. *Gormley v. SAIF*, 52 Or App 1055, 1060 (1981).

In light of the equivocal nature of Dr. Chamberlain's reports and testimony, we find that his opinion is insufficient to establish that claimant's compensable injury was the major contributing cause of her left shoulder impingement syndrome. In his May 5, 1999 report, Dr. Chamberlain said he was unable to relate claimant's left shoulder problem to the July 1997 claim. (Ex. 38). Dr. Chamberlain stated that he had not even evaluated claimant's left shoulder until the December 1998 examination and he had no idea of what activities she was performing with her left arm. (Exs. 39-6, -20, -21, -22, -31). He testified that he did not know what claimant's base level of use was, so it was impossible for him to decide whether the left arm had been relatively overused. (Ex. 39-31). When asked if a material cause of claimant's left shoulder problems was the restriction of her right arm and shoulder, Dr. Chamberlain responded that he did not know. (Ex. 39-30). In his later testimony, Dr. Chamberlain agreed that the restrictive right arm use was one of the causes for the relative nature of overuse in the left arm, but when he was asked whether that was based on a "degree of probability," Dr. Chamberlain said "I guess so." (Ex. 39-32). We find that Dr. Chamberlain's opinion is insufficient to sustain claimant's burden because it was couched in terms of possibility rather than probability. *See Gormley v. SAIF*, 52 Or App at 1055 (claimant must prove more than just the possibility of causal connection).

Furthermore, we do not agree with the ALJ's conclusion that Dr. Chamberlain's opinion that "one of the causes" of claimant's relative overuse of her left arm was her right arm restrictions should be interpreted as an opinion that the restrictive use of the right arm was the "only cause." Dr. Chamberlain agreed that a Type II acromion plays a part in developing impingement syndrome. (Ex. 39-17). He explained that a Type II acromion is believed to decrease the available space in the shoulder and therefore it becomes symptomatic more quickly. (Ex. 39-33, -34). Thus, whether or not claimant's Type II acromion was "preexisting," Dr. Chamberlain indicated that it was a factor in developing impingement syndrome. Dr. Chamberlain also explained that not every person who has an impingement or surgery on one arm develops problems with the other shoulder. (Ex. 39-32). In addition, he had no history of what claimant did with her left shoulder in her off-work activities. (Ex. 39-22). Contrary to the ALJ's finding, Dr. Chamberlain's opinion indicates that claimant's relative overuse of her left arm was not the only cause of her left shoulder impingement syndrome.

For all of these reasons, we find that Dr. Chamberlain's reports and testimony are not sufficient to establish, by a preponderance of the evidence, that claimant's compensable injury is the major contributing cause of her left shoulder impingement syndrome.

ORDER

The ALJ's order dated September 30, 1999 is reversed. The insurer's denial of claimant's left shoulder impingement syndrome is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
RANDY L. LUEKER, Claimant
WCB Case No. 98-04287
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
John E. Snarskis, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of his occupational disease/injury claim for a right shoulder condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of claimant's right shoulder condition that developed while he was employed as dry belt veneer grader. That position required claimant to grasp thin sheets of veneer and pull or flip them onto one of four carts located at his side. Claimant testified he could pull up to 8,000 pieces of veneer in a day.

In upholding the denial, the ALJ determined that there was a preexisting right shoulder condition and that the claim was appropriately characterized as one for accidental injury rather occupational disease. In concluding that the claim was for an accidental injury, the ALJ found that claimant's symptoms arose on one particular day. The ALJ then concluded that claimant failed to present persuasive medical evidence that work activity was the major contributing cause of his need for treatment under ORS 656.005(7)(a)(B).

On review, claimant asserts that ALJ incorrectly determined that there was a preexisting right shoulder condition, but that, if there was, he sustained his burden of proof under ORS 656.005(7)(a)(B). The insurer argues that, while the ALJ properly upheld its denial, the claim should have been analyzed as an occupational disease.[1] For the following reasons, we agree with the insurer.

An occupational disease occurs when symptoms are gradual in onset, not attributable to a specific event, and are due to an ongoing condition or state of the body. *James v. SAIF*, 290 Or 343 (1981); *Valtinson v. SAIF*, 56 Or App 184 (1982); *O'Neal v. Sisters of Providence*, 22 Or App 9, 16 (1975). Cases have treated a condition as an injury when symptoms occur over a discrete, identifiable period of time and are due to a specific activity or event. *Id. See also Mathel v. Josephine County*, 319 Or 235, 240 (1994) (an "injury" is an event and a "disease" is an ongoing condition or state of the body or mind).

Here, we conclude that claimant's right shoulder condition is properly analyzed as an occupational disease under ORS 656.802. When claimant first sought treatment for his right shoulder condition on March 2, 1998, he reported a history of right shoulder pain for several weeks with "no history of trauma." (Ex. 2-2). On March 14, 1998, it was reported that claimant had pain for a month, but that it was worse over the past few weeks. (Ex. 4-2). Again, no specific incident of injury or trauma was reported. We acknowledge, however, that on March 24, 1998, claimant reported to Dr. Wenner that, over the course of one day, he developed increasing pain in the shoulder. (Ex. 7-1). Nevertheless, claimant's testimony did not establish that his condition arose during a discrete period.

Claimant testified in response to a question about what time of day the pain arose, that the pain "was always there, I think." (Tr. 13). Claimant further testified that his shoulder pain was gradual in onset without specific inciting event. (Tr. 21-22). Claimant's counsel specifically asked claimant whether the right shoulder condition came on during one day. Claimant replied that it did not, testifying that it "gradually got worse and worse and worse." (Trs. 33-34).

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[1] Claimant contends that the insurer is prohibited from challenging the ALJ's characterization of the claim as an accidental injury because it failed to cross-appeal the ALJ's order. We disagree. It is well-settled that a party may contest any portion of an ALJ's order in the absence of a timely cross-appeal, provided that the other party which requested review does not withdraw its request for review. *See Brenda Foil*, 51 Van Natta 345 (1999); *Pamela G. Frank*, 50 Van Natta 219 (1998).

Considering the record as whole, we are persuaded that claimant's symptoms were related to repetitive trauma and that his condition developed gradually over an extended period, rather than as a result of a event or work activities during a discrete period of time. Thus, we find that claimant's claim is properly analyzed as an occupational disease.[2]

Therefore, under ORS 656.802(2)(a), claimant must establish that his employment conditions were the major contributing cause of his right shoulder condition. Moreover, if the occupational disease claim is based on the worsening of a preexisting condition or disease, 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).

Three physicians provided opinions regarding the causation issue: Drs. Wenner, Dinneen and Thompson. However, none of them opined that claimant's work activity was the major contributing cause of the right biceps tendonitis itself or, assuming the existence of a preexisting condition (Type III acromion), that those activities were the major contributing cause of the "combined condition" or a pathological worsening of the combined condition. (Exs. 12, 15-17, 16). Therefore, we find that the medical evidence does not establish the compensability of the occupational disease claim. Accordingly, we affirm the ALJ's decision to uphold the insurer's denial.

ORDER

The ALJ's order dated August 6, 1999 is affirmed.

[2] Given the repetitive nature of claimant's employment duties that he asserts led to the development of his right shoulder condition, we agree with the insurer that the claim is more in the nature of a series of traumatic events or occurrences that allegedly required medical services or disability. *See* ORS 656.802(1)(a)(C).

February 9, 2000 Cite as 52 Van Natta 197 (2000)

In the Matter of the Compensation of
JOE R. DALE, Claimant
WCB Case No. C000201
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff, Strooband & Ousey, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

On January 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 for the compensable injury. For the following reasons, we approve the proposed disposition.

On February 2, 2000, the Board wrote the parties requesting the extent of the workers' vocational training as required by OAR 438-009-0022(4)(e). After further considering this matter, we withdraw our request for an addendum. Although the CDA does not specifically provide the extent of claimant's vocational training, it provides that his highest grade level completed is dental school and that claimant has been employed at the occupation of dentist. Based on this provision, we find that the CDA includes a statement describing the extent of claimant's vocational training.

Thus, we find that the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CAMILLA S. KOSMOSKI, Claimant
Own Motion No. 99-0414M
OWN MOTION ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our November 24, 1999 Own Motion Order that declined to reopen her claim for the payment of temporary disability compensation because the record did not establish that she requires surgery or hospitalization. On December 23, 1999, we abated our order in order to allow sufficient time to consider the motion for reconsideration and to allow the SAIF Corporation the opportunity to respond to claimant's motion. Having received SAIF's response, we proceed with our reconsideration.

With her request for reconsideration, claimant submitted a copy of SAIF's October 8, 1999 modified notice of acceptance, which: (1) noted that claimant's claim was previously accepted for "left shoulder strain and right elbow strain;" and (2) accepted the following new medical conditions: "left shoulder impingement syndrome; tendonitis, left shoulder; bicipital tenosynovitis, left shoulder and adhesive capsulitis, left shoulder." Based on this modified acceptance, claimant requests that, pursuant to ORS 656.262(7)(c), the Board order SAIF to reopen her claim regarding these new medical conditions and issue the appropriate closure. Claimant cites *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), in support of her request. SAIF responds that jurisdiction in this matter rests with the Board in its own motion jurisdiction, and claimant's claim does not qualify for reopening under own motion because her condition does not require surgery or hospitalization.

Claimant's aggravation rights expired on her compensable injury claim on August 20, 1999. Therefore, this claim is within our own motion jurisdiction. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). The legislature has provided strict limitations on the Board's own motion authority. ORS 656.278(1).[1] Regarding additional monetary benefits, the Board, in its Own Motion jurisdiction, may authorize temporary disability benefits from the time a worker is actually hospitalized or undergoes surgery for a worsening of a compensable injury until the worker becomes medically stationary. ORS 656.278(1)(a). Thus, by statute, undergoing surgery or hospitalization is a *prerequisite* to the Board's authority to authorize temporary disability benefits. In addition, the Board, in its own motion jurisdiction, has no authority to award either permanent partial or permanent total disability compensation. *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).

Here, claimant's compensable condition, including the recently accepted new medical conditions relating to the left shoulder, does *not* require surgery or hospitalization. Therefore, claimant does not meet the statutory prerequisite that would enable the Board in its own motion capacity to authorize reopening the claim under ORS 656.278(1)(a). Consequently, the Board does not currently have the authority to authorize reopening the claim under ORS 656.278(1)(a). Furthermore, the Board is without authority in our own motion capacity to direct a carrier to process a claim under ORS 656.262(7)(c).[2] *See Craig J. Prince*, 52 Van Natta 108 (2000).

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[1] ORS 656.278 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; or

"(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

[2] If claimant disagrees with SAIF's processing of the claim under ORS 656.262(7)(c), she may wish to request a hearing regarding that "matter concerning a claim." ORS 656.283; *Prince*, 52 Van Natta at 108.

Accordingly, as supplemented herein, we adhere to and republish our November 24, 1999 Own Motion Order, effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

February 9, 2000 Cite as 52 Van Natta 199 (2000)

In the Matter of the Compensation of
JOHN E. McARDLE, Claimant
WCB Case No. C993098
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Member Haynes and Phillips Polich.

On December 29, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, for payment of a stated sum, claimant released rights to future workers' compensation benefits for the compensable injury. For the following reasons, we approve the proposed disposition.

As an addendum to the proposed agreement, the parties submitted a document entitled a "Qualified Assignment and Release," which provided that the insurer had assigned duties and obligations to make future periodic payments under the agreement to a designated "Assignee." According to the document, the "Assignee" was substituted for the "Assignor" (the insurer) with respect to the obligation to make periodic payments under the agreement. The document specifically provided that the Assignor/insurer's obligation to make periodic payments was discharged and released.

In addition, while the CDA reserved claimant's rights to medical services, the addendum also provided that claimant completely released and forever discharged the employer and the insurer from any and all past, present or future claims under Workers' Compensation Law arising out of or related to claims and conditions subject to the CDA.

On January 7, 2000, the Board wrote the parties seeking a signed addendum, addressing the "Qualified Assignment and Release." We noted that such a provision by which the insurer was fully and unconditionally released from further obligations or payments under the CDA was inconsistent with the statutory scheme. We also sought clarification that claimant's rights to future medical services were retained.

Thereafter, we received a January 26, 2000 letter from claimants attorney, stating that the Qualified Assignment and Release had been inadvertently submitted with the agreement and that it may be discarded. Moreover, the letter reiterated that the parties had specifically preserved claimant's medical rights in the CDA, as well as his ability to enforce them.

In light of the above, we conclude that claimant's rights to medical services are not released by the CDA and that the parties addendum only pertains to "non-medical" benefits. Thus, we find that the agreement, as clarified by the January 26, 2000 letter and this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARA S. VINSON, Claimant
WCB Case No. 98-08506
ORDER ON REVIEW
Linda Attridge, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's occupational disease claim for a right wrist condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In 1992, claimant sought treatment for a number of musculoskeletal complaints. She experienced a vascular disturbance that affected her left hand and wrist. She was diagnosed with a non-specific musculoskeletal-neurologic syndrome. (Exs. 1 through 7). In January 1996, claimant sought treatment for a swollen right wrist. She was diagnosed with right wrist tendinitis affecting the extensor retinaculum. (Ex. 8). In March 1996, she sought treatment for left wrist, elbow and shoulder pain in addition to her right wrist complaints. (Ex. 8A). She was referred to Dr. Sultany, rheumatologist, who diagnosed inflammatory arthritis. (Ex. 10).

In September 1997, claimant, who is right hand dominant, began working for the employer as a bookkeeper. The majority of her workday involved data entry, which required repetitive keyboarding with both hands and additional right hand use doing ten-key entry.

About two weeks after going to work for the employer, claimant began to wear an Ace bandage on her left hand to control shaking in that hand, an ongoing problem associated with the 1992 vascular disturbance. In about November 1997, claimant began wearing a brace for the left hand and, a few weeks later, a brace for the right hand. These braces were not prescribed by a physician. (Tr. 24 through 27).

On April 16, 1998, claimant sought treatment for swelling and pain over the back of her right wrist that she had experienced for about a week. (Ex. 11). She reported a prior history of stroke, possible lupus, possible multiple sclerosis. (*Id.*; Exs. 1 through 7, 17). She was diagnosed with tenosynovitis of the right wrist and was treated with a splint and anti-inflammatories. (Ex. 11).

On May 11, 1998, claimant left work at the employer.

On May 16, 1998, she treated for the same right hand/wrist complaints, stating that her condition had not improved. Dr. Schuler noted edema and tenderness of the dorsal carpal bones, which had the appearance of a convoluted ganglion cyst. X-rays revealed no fracture, dislocation or arthritic changes. (Exs. 12, 14). Claimant's right wrist was evaluated on May 27, 1998 by Dr. Gordon, who noted no swelling but found tenderness among the carpal bones. He suspected a work injury. (Ex. 15).

On June 18, 1998, claimant's right wrist was evaluated by Dr. Peacock, who became her attending physician. Peacock diagnosed tenosynovitis of the right wrist, probably work-related. He prescribed therapy and splinting. (Ex. 19). By July 1, 1998, claimant's condition had improved. (Ex. 22). But by July 15, 1998, claimant's symptoms returned. Dr. Peacock referred her to Dr. Tilson, orthopedist and occupational medicine specialist, for evaluation. (Ex. 23).

On July 28, 1998, Dr. Mass, neurologist, examined claimant for the insurer. (Ex. 25). Dr. Mass opined that claimant's symptoms were "related to an overuse syndrome which may be the result of her industrial injury." Dr. Peacock concurred. (Ex. 30).

On July 30, 1998, Dr. Tilson examined claimant and reviewed her medical history. Tilson noted that claimant had been diagnosed with multiple sclerosis, which she reported was in remission. Tilson concluded that claimant's condition was not an overuse syndrome and, after testing, recommended a rheumatology consultation. (Ex. 27).

On September 2 and again on September 16, 1998, Dr. Peacock noted that claimant had been off work and that her condition was improving. (Ex. 31, 33). On October 7, 1998, claimant returned to work with a different employer and her wrist symptoms flared. (Ex. 35). By October 28, 1998, claimant returned "nearly asymptomatic." Dr. Peacock found that claimant's tenosynovitis and ganglion cyst of the right hand and wrist had resolved. (*Id.*)

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of claimant's attending physician, Dr. Peacock, and claimant's credible testimony, the ALJ found that claimant proved compensability of her right wrist tendonitis condition. On review, the insurer argues that claimant failed to meet her burden of proof because she was not credible and Dr. Peacock relied on her history to support his opinion. We agree with the insurer that claimant failed to meet her burden of proof, but for the following reasons.

To establish a compensable occupational disease claim for her right wrist condition, claimant must prove that employment conditions were the major contributing cause of the disease or, if the claim is based on the worsening of a preexisting disease, the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(a) and (b). "Major contributing cause" means that the work activity or exposure contributed more to causation than all other causative agents combined. *See Dietz v. Ramuda*, 130 Or App 387 (1994); *McGarrah v. SAIF*, 296 Or 145, 166 (1983). Pursuant to ORS 656.802(2)(e), "[p]reexisting conditions shall be deemed causes in determining the major contributing cause."[1]

Claimant has the burden of proving compensability of her occupational disease claim for a right wrist condition. ORS 656.266. As noted above, in order to prove a compensable occupational disease claim, claimant must establish several factors. *See* ORS 656.802. Failure to establish any one of those factors results in the failure of claimant's occupational disease claim.

Claimant worked as a bookkeeper for the employer from September 1997 to May 11, 1998. This work involved repetitive use of the wrists, with greater use of the right wrist doing 10-key data entry. In 1992, claimant experienced a vascular incident that permanently affected her left wrist. She has also been diagnosed with a systemic condition, variously diagnosed as arthritis or a non-specified rheumatological disorder. Claimant also had a problem with both wrists in 1996, which was diagnosed as tendonitis affecting the extensor retinaculum. Dr. Sultany, a rheumatologist, thought that she had inflammatory arthritis, a systemic condition. Sometime in 1997 or 1998, she was diagnosed with multiple sclerosis. Finally, she was diagnosed with a ganglion cyst affecting the carpal bone area of her right wrist.

Given the multiple possible causes of claimant's right wrist condition, the causation issue presents a complex medical question. Accordingly, claimant's lay testimony is "probative but not dispositive." *See Moe v. Ceiling Systems*, 44 Or App 429, 433 (1980).[2] Resolution of the issue, therefore, turns primarily on expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). In evaluating the persuasiveness of medical evidence, we generally defer to the opinion of the treating physician, absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Peacock's opinion.

Two physicians rendered opinions regarding the cause of claimant's right wrist condition. Dr. Tilson, orthopedist and occupational medicine specialist, evaluated claimant on referral from Dr. Peacock. Based on tests performed by Dr. Sultany in 1996, Dr. Tilson believed that claimant had a

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

[2] In reaching this conclusion, we do not reject or disregard the ALJ's determination that claimant testified in a credible manner. Rather, because of the medical complexities presented in evaluating the compensability of claimant's condition, we have directed our attention to the medical opinions in resolving this dispute.

preexisting rheumatological disorder that combined with her work activities and contributed to claimant's disability and need for treatment. (Exs. 27, 41, 44, 46, 50). Based on Dr. Tilson's opinion, we find that the claim for right wrist tenosynovitis is based on the worsening of a preexisting disease or condition and, therefore, ORS 656.802(2)(b) applies. Accordingly, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.

Dr. Tilson opined that claimant's work activities were not the major contributing cause of claimant's right wrist condition. Instead, he believed that claimant's preexisting systemic disorder was the major contributing cause of her condition, explaining that tenosynovitis has multiple causes, including rheumatologic disorders. He explained that his opinion was supported by tests and his physical examination of claimant's wrist. (Ex. 50-8, -9, -10). Moreover, based on Dr. Sultany's 1996 tests and the 1998 tests he himself ordered, Tilson reasoned that claimant's preexisting condition had waxed and waned but had not pathologically worsened. At most, Tilson believed that claimant's work activities contributed to her symptomatology, need for medical treatment and disability. (Exs. 41, 50). Thus, Dr. Tilson's opinion does not support compensability.

Dr. Peacock initially concluded that claimant's work activities were the major contributing cause of her right wrist tenosynovitis, based on her history and clinical presentation. In his deposition, he stated that tenosynovitis is usually caused by repetitive use and is not a rheumatological disease, in contrast to Tilson's explanation that there are many factors that can cause tendonitis. (Ex. 51-8). But after claimant's condition failed to improve and Dr. Peacock became aware of her preexisting rheumatological disease, he modified his opinion. He continued to believe that claimant's work activities were the initial reason for treatment (Tr. 51-16, -24), but also believed that by about two to four weeks after she lost her job (*i.e.*, by June 11, 1998, prior to her seeing Dr. Tilson), the major contributing cause of her right wrist condition had become the preexisting condition (Ex. 51-28). Dr. Peacock also stated that he was unable to say whether claimant's preexisting condition had pathologically worsened, unless he relied on a worsening of claimant's symptoms. (Ex. 51-30). Finally, Dr. Peacock averred that he deferred to Tilson's opinion.

After *de novo* review of the record, including claimant's credible lay testimony, we nevertheless find Dr. Tilson's complete and well-reasoned opinion more persuasive than that of Dr. Peacock. Although Dr. Peacock initially opined that the major contributing cause claimant's right wrist condition during the period she was working was her work activities, he did not evaluate the relative contribution of claimant's work activities and her preexisting condition and explain why claimant's work exposure contributed more to her right wrist condition than all other causes or exposures combined during that period. *Dietz*, 130 Or app at 401. Moreover, claimant's reliance on Dr. Peacock's opinion is insufficient to establish that her combined condition pathologically worsened. Finally, the opinion is internally inconsistent, in that Dr. Peacock both defers to Dr. Tilson's opinion and offers an opinion that differs in substantive ways. Because we are not more persuaded by the opinion of Dr. Peacock, we conclude that claimant did not carry her burden of proving compensability.

ORDER

The ALJ's order dated July 20, 1999 is reversed. The insurer's denials are reinstated and upheld. The ALJ's award of an assessed attorney fee is reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not prove compensability. Instead, I would affirm the ALJ's order concluding that claimant carried her burden to prove that her occupational disease claim for her right wrist condition is compensable.

In particular, I would agree with the ALJ's conclusion that attending physician Dr. Peacock's opinion was more persuasive than that of Dr. Tilson. The ALJ explained that, since beginning to treat claimant, Dr. Peacock has related claimant's condition to her work activities. The ALJ recognized that Dr. Peacock had come to believe that claimant's condition was also impacted by her preexisting

condition. But the ALJ also recognized that, although Dr. Peacock would generally defer to Dr. Tilson's opinion as an orthopedist, he has not adopted Tilson's opinion outright. Rather, Dr. Peacock accepts Dr. Tilson's conclusion that, by the time claimant saw Tilson for treatment, her condition was probably caused in major part by the preexisting condition, since so much time had passed since claimant had engaged in the work activities. Nevertheless, Dr. Peacock was convinced that, during his initial period of treatment, claimant's work activities were the major contributing cause of claimant's condition. Moreover, Dr. Peacock concluded that there was a pathological change and worsening of the underlying condition because claimant's symptoms changed in terms of swelling and pain.

Finally, the ALJ found that claimant credibly testified, based upon her demeanor and manner while testifying. As discussed by the ALJ, claimant established that she wore a brace initially to control shaking in her left arm, and then wore a brace on the right arm, but for a different condition than that which developed in April 1998. The ALJ also found that claimant's witness credibly testified that claimant did not bowl regularly.

The majority, however, reverses the ALJ's finding that claimant met her burden of proof establishing compensability by focusing on the medical evidence and discounting the role of lay testimony. As can be discerned from the ALJ's Opinion and Order, the majority position in this order, and this dissent, the medical evidence can be interpreted to support opposing outcomes. Therefore, I find that this case turns on lay testimony.

The ALJ made explicit demeanor-based credibility findings regarding claimant and her witnesses. He found them credible. Well-established case law supports deference to an ALJ's demeanor-based credibility findings, unless we find that a witness is not credible based on the substance of his or her testimony. *Erck v. Brown Oldsmobile*, 311 Or 519, 528 (1991); *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). In this case, resolution of the compensability question is determined by whether or not claimant's testimony was credible. A reversal of the ALJ's determination implies that the majority did not find claimant to be credible despite their assertion otherwise.

The foundation of the workers' compensation system is the hearing. What is the purpose of the hearing if we continually discount the significance of lay testimony and resolve cases on medical evidence alone? The ALJ is the only person in a position to look all the parties in the eye and evaluate all evidence in light of those assessments. If compensability claims can be resolved solely by assessment of the medical evidence, why do we have a hearing at all? Why allow claimants or other lay witnesses to testify? I believe that the Board consistently discounts the importance of lay testimony in its review function.

In this case, the ALJ found that the most persuasive medical evidence was provided by claimant's attending physician *and* claimant's credible testimony. Like the ALJ, I would defer to claimant's attending physician, *Weiland v. SAIF*, 64 Or App 810 (1983), as he actually treated claimant and his opinion was based on an accurate history, as established by claimant's and the witnesses' credible testimony.

In sum, I would find that claimant has established the compensability of her occupational disease claim for her right wrist. Because the majority comes to a different conclusion, I respectfully dissent.

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

Reviewed by Board Members Biehl, Bock, and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) increased claimant's unscheduled permanent disability award for a left shoulder condition from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 36 percent (115.2 degrees); (2) assessed a 25 percent penalty under ORS 656.268(4)(g); and (3) directed the insurer to recalculate claimant's temporary total disability rate based on an average weekly wage of $710.56. On review, the issues are extent of unscheduled permanent disability, penalties and temporary total disability rate. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

Claimant has been employed as a truck driver for the employer since 1995. (Ex. 10-2). On February 3, 1997, claimant sought medical treatment from Dr. Morgan for severe arm pain that he had been having for three to four weeks. (Ex. 2). Dr. Morgan diagnosed tendinitis and muscle spasms. (*Id.*) On April 2, 1997, claimant was treated by Dr. Galt, who reported that the left shoulder pain had begun two months ago, without a prior injury. (Ex. 6-1). Dr. Galt diagnosed impingement syndrome, left shoulder. (Ex. 6-2). Claimant was treated conservatively with medication and physical therapy. (Exs. 6, 7, 14).

Claimant signed an "801" form on April 4, 1997, indicating he was injured on February 21, 1997. (Ex. 8). He said he was injured while "lifting and pushing - throwing pallets." (*Id.*) On June 25, 1997, the insurer accepted a disabling injury claim for left rotator cuff tendonitis and left adhesive capsulitis. (Ex. 18).

On August 4, 1997, Dr. Galt performed a closed manipulation of the left shoulder, as well as a subacromial injection. (Ex. 20). On October 15, 1997, Dr. Galt performed arthroscopic subacromial decompression and resection of the coracoacromial ligament. (Ex. 21). Seven months after surgery, claimant had persistent lateral discomfort. (Ex. 26). Claimant continued with physical therapy. (Exs. 27, 28). On July 15, 1998, Dr. Galt reported that claimant's strength was improving gradually. (Ex. 28).

A Physical Capacity Evaluation (PCE) was performed on July 27, 1998. (Exs. 29, 30). Claimant's residual functional capacity was "light." (Ex. 29). Claimant's left shoulder flexion was rated as 4/5. (Ex. 30-2).

Dr. Galt performed a closing exam on August 25, 1998. (Ex. 32). He reported that claimant was medically stationary. (Ex. 32-1). Dr. Galt noted that he had reviewed the PCE and concurred with the recommendations. (Exs. 32-3, 34). Among other things, he indicated that claimant's strength testing was normal. (*Id.*)

A Notice of Closure issued on September 24, 1998, awarding 22 percent unscheduled permanent disability for claimant's left shoulder, as well as temporary disability benefits. (Ex. 36). Claimant's permanent disability award was based on a 1 percent impairment value for reduced shoulder range of motion and a 5 percent impairment value for his acromial resection. (Ex. 36-2). Claimant's base functional capacity was shown as "medium" and his residual functional capacity was "sedentary/light." (*Id.*)

Claimant requested reconsideration, raising several issues and reserving the time loss rate issue due to incomplete information. (Ex. 41). Claimant subsequently detailed his concerns regarding the time loss rate. (Ex. 44).

A February 4, 1999 Order on Reconsideration increased claimant's unscheduled permanent disability for the shoulder condition to 24 percent and directed the insurer to recalculate temporary disability. (Ex. 49). The Order on Reconsideration indicated claimant's 52-week earnings were $33,887.20 and his average weekly wage was $651.68. (Ex. 49-2). Both parties initially requested a hearing, but the insurer withdrew its request for hearing.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The ALJ relied on the PCE findings, which had determined that claimant's flexion strength was 4/5. The ALJ found that claimant's impairment for loss of strength was 4.2 percent. The ALJ rejected Dr. Galt's range of motion findings because there was no indication Dr. Galt had used the Director's rules or bulletins for measuring range of motion. The ALJ also found no evidence Dr. Galt had used a goniometer. The ALJ concluded that Dr. Galt's range of motion findings were "incompetent."

Disability standards adopted by the Director that are in effect at the time of claim closure are used in determining claimant's permanent disability. ORS 656.283(7); ORS 656.726(3)(f)(A). Claimant's claim was closed by a Notice of Closure on September 24, 1998. Therefore, his claim is properly rated under WCD Admin. Order 98-055. OAR 436-035-0003(2) and (3).

Claimant has the burden of proving the nature and extent of any disability resulting from the compensable injury. ORS 656.266. Claimant expressly waived his right to a medical arbiter examination. (Ex. 41). Under OAR 436-035-0007(14), impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0280, except where a preponderance of medical opinion establishes a different level of impairment pursuant to ORS 656.726(3)(f)(B). We rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993). In addition, 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).

Claimant's attending physician was Dr. Galt, who began treating claimant in April 1997 and performed two surgical procedures, including a subacromial decompression. There is no dispute that claimant is entitled to 5 percent impairment for the subacromial decompression. *See* OAR 436-035-0330(13). The parties dispute claimant's awards for reduced range of motion and loss of strength.

Range of Motion

The September 24, 1998 Notice of Closure awarded claimant 1 percent for reduced range of motion, based on Dr. Galt's August 25, 1998 report. (Ex. 36-2). The Order on Reconsideration relied instead on the PCE findings and awarded 2.8 percent, rounded to 3 percent, for reduced range of motion. (Ex. 49-3). The ALJ affirmed the Order on Reconsideration award for reduced range of motion.

The insurer argues that claimant's award for range of motion should be reduced to 1 percent, based on Dr. Galt's August 25, 1998 report. We disagree.

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). Here, there was no medical arbiter examination. After reviewing the record, we find that Dr. Galt's September 8, 1998 concurrence with the PCE provides the most accurate assessment of claimant's shoulder range of motion. We acknowledge that the PCE was performed on July 27, 1998, before claimant was declared medically stationary. Nevertheless, Dr. Galt concurred with the PCE *after* he had declared claimant medically stationary. (Ex. 34). Under these circumstances, we rely on the PCE findings to determine claimant's shoulder ranges of motion.

Where, as here, there is no history of injury or disease in the contralateral joint, loss of range of motion of the injured joint is compared to and valued proportionately to the contralateral joint. OAR 436-035-0007(23).

The PCE measured claimant's shoulder ranges of motion (left/right) of flexion (145/145), extension (55/55), abduction (138/145), adduction (30/30), internal rotation (45/60), external rotation (38/90). (Ex. 30-2). The ranges of motion for abduction, internal rotation and external rotation results in

ratings of .8 percent, 1 percent, and 1 percent, respectively. OAR 436-035-0330(5), (9), (11). These values are added and rounded up for an impairment value due to lost range of motion of 3 percent. OAR 436- 035-0007(15). Based on the PCE findings, we agree with the ALJ that claimant is entitled to 3 percent impairment for reduced range of motion.

Loss of Strength

The insurer contends that claimant is not entitled to an impairment value for loss of strength based on Dr. Galt's August 25, 1998 report. In contrast, claimant relies on the July 27, 1998 PCE and argues that he is entitled to 8 percent impairment for loss of strength.

To determine impairment due to loss of strength, a physician reports the worker's strength by using a 0 to 5 grading system, which is converted into a percentage value under OAR 436-035-0007(19)(a). The record establishes that Dr. Galt had been consistently testing claimant's shoulder strength, using a 0 to 5 grading system, since he began treating claimant in April 1997. (Exs. 6, 14, 17, 19, 22, 26, 28, 32). On July 15, 1998, Dr. Galt reported that claimant's strength was improving gradually. (Ex. 28). On that date, he noted some problems with internal rotation. (Ex. 28-1). Dr. Galt's August 25, 1998 closing exam, however, did not refer to any problems with claimant's strength testing. (Ex. 32-1). Dr. Galt concluded that claimant was medically stationary. (*Id.*)

A physical capacity evaluation (PCE) was performed on July 27, 1998 and the evaluators reported claimant's left shoulder strength as 4/5 flexion, 5-/5 abduction, 4-/5 internal rotation and 5-/5 external rotation. (Exs. 29, 30-2). On September 8, 1998, Dr. Galt concurred with the PCE. (Ex. 34).

As we discussed above, 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. Here, there was no medical arbiter examination. After reviewing the record, we find that Dr. Galt's September 8, 1998 concurrence with the PCE provides the most accurate assessment of claimant's loss of strength. We acknowledge that the PCE was performed on July 27, 1998, before claimant was declared medically stationary. Nevertheless, Dr. Galt concurred with the PCE *after* he had declared claimant medically stationary. (Ex. 34). Under these circumstances, we rely on the 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) 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."

Thus, under OAR 436-035-0330(17), loss of strength in the shoulder is based on a preponderance of medical opinion that reports loss of strength and establishes which specific named peripheral nerve is involved. On this record, however, there is no medical opinion that establishes which specific named peripheral nerve is involved in claimant's loss of shoulder strength.

Under OAR 436-035-0007(19)(b), 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. On the other hand, our findings regarding a claimant's impairment must be based on medical evidence in the record. In *SAIF v. Calder*, 157 Or App 224, 227 (1998), the court held that the Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge. *Id.*

In this case, 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 conclude that claimant is not entitled to an award for loss of shoulder strength.

Adaptability

Claimant's adaptability is measured by comparing his Base Functional Capacity (BFC) to his maximum Residual Functional Capacity (RFC). OAR 436-035-0310(2).

The ALJ found that claimant's primary job was trailer truck driver, Dictionary of Occupational Titles (DOT) 904.383-010, which has a strength of "medium." The ALJ found that claimant used a pallet jack and a forklift to load and unload his trailer and he reasoned that the additional duty was properly classified as a truck driver helper, DOT 905.687-010, which has a strength of "heavy." The ALJ concluded that claimant's BFC was "heavy."

The insurer argues that the ALJ erred by assigning a different DOT code when that issue had not been raised by claimant. The insurer contends that the ALJ incorrectly found that claimant's BFC was "heavy."

Under OAR 436-035-0310(4)(a), a worker's BFC is determined by the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five years prior to determination. When a combination of DOT codes most accurately describes a worker's duties, the highest strength category for a combination of codes applies. *Id.* In *Donald L. Odell*, 49 Van Natta 1872 (1997), we found that a combination of DOT codes most accurately described the claimant's duties. *See id.* (Member Bock, concurring) (appropriate to take administrative notice of DOT Code not cited by the parties in determining which DOT Code most closely fit the claimant's job duties). For the following reasons, we do not agree with the insurer that the ALJ incorrectly found that claimant's BFC was "heavy."

The most physically demanding job that claimant performed in the five years prior to determination was his at-injury job as a truck driver. The dispute arises as to whether the duties of claimant's at-injury job more closely fit within the DOT description of a tractor-trailer-truck driver (DOT 904.383-010) or a truck-driver helper (DOT 905.687-010).

Claimant's duties as a truck driver included lifting pallets and using forklifts. (Ex. 10-2). He indicated that lifting pallets had caused pain. (*Id.*) On his "801" form, claimant indicated his symptoms occurred while "lifting and pushing - throwing pallets." (Ex. 8). Claimant reported to the physical therapist that he was employed as a truck driver, but his jobs include pushing pallets and moving some equipment, as well as driving." (Ex. 7-1). A May 7, 1998 report indicated claimant's job duties included driving a truck, maintaining log books and following appropriate federal and state laws and regulations. (Ex. 25-2).

The DOT description for tractor-trailer truck driver (DOT 904.383-010) includes driving a truck, inspecting the truck for defects, maintaining driver logs and indicates the person "[m]ay assist workers in loading and unloading truck." The DOT description for a truck-driver helper (DOT 905.687-010) provides:

> "Assists TRUCK DRIVER, HEAVY (any industry) by performing any combination of following tasks: Loads and unloads vehicles by hand or by use of handtruck or dolly. Pads, stacks, and secures items in position on truck to prevent damage during shipment. Delivers and stacks merchandise on customer's premies and collects payment or obtains receipt for goods. Performs other duties as described under HELPER (any industry) Master Title."

After reviewing the record, including the job duties and physical demands of the relevant job, we find that many of claimant's duties overlap and are included in the DOT descriptions of both the tractor-trailer-truck driver and truck-driver helper. Under these circumstances, we conclude that the combination of the DOT codes for both the tractor-trailer-truck driver and truck-driver helper most accurately describes claimant's job duties. Under OAR 436-035-0310(4)(a), when a combination of DOT codes most accurately describes a worker's duties, the highest strength category for a combination of codes applies. Therefore, we conclude that claimant's BFC is "heavy," the strength requirement of the truck-driver helper.

The insurer contends that claimant's RFC is "sedentary/light." On the other hand, claimant asserts that he has a limit of carrying 10 pounds, which is a sedentary rating. Claimant argues that he has restrictions on overhead lifting and forward reaching that would leave him in "sedentary restricted" RFC.

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. Where a worker fails to cooperate or use maximal effort in the evaluation, the medical opinion of the evaluator may establish the worker's likely RFC had the worker cooperated and used maximal effort."

Dr. Galt was claimant's attending physician. In Dr. Galt's August 25, 1998 closing examination, he did not expressly refer to claimant's formal job restrictions. (Ex. 32). Dr. Galt noted, however, that he had reviewed the PCE and concurred with their recommendations. (*Id.*) The July 27, 1998 PCE found that claimant's RFC was "light," with "restrictions in reaching with left upper extremity, crawling and bending." (Ex. 29). In this situation, there are no inconsistencies between Dr. Galt's concurrence and his other reports. Based on the PCE, we find that claimant's RFC was "light" with restrictions, which puts claimant in the sedentary/light category. *See* OAR 436-035-0310(3)(e).

Comparing claimant's BFC of "heavy" with his RFC of "sedentary/light" results in an adaptability factor of 6. OAR 436-035-0310(6). The parties do not dispute the age value (1). OAR 436-035-0290(2). He is not entitled to a value for education. OAR 436-035-0300(2)(a).

Claimant's Specific Vocational Preparation (SVP) value is the highest SVP of any job he has met in the five years prior to determination. OAR 436-035-0300(3)(b). The job title with the highest SVP number during the 5 years prior to determination was DOT 904.383-010, tractor-trailer-truck driver, which assigns an SVP value of 4. Therefore, claimant is entitled to a skills value of 3. OAR 436-035-0300(4).

The total value of claimant's age (1), education (0) and skills (3) is (4). That value is multiplied by the adaptability value of (6) for a total of 24. OAR 436-035-0280(6). When this value is added to the value for impairment (8), the result is 32. OAR 436-035-0280(7). Therefore, claimant's unscheduled permanent disability is 32 percent (102.4 degrees). Consequently, we modify the ALJ's order to reduce claimant's unscheduled permanent disability award from 36 percent to 32 percent. In other words, we increase claimant's unscheduled permanent disability award for a left shoulder condition from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 32 percent (102.4 degrees).

Penalties

The ALJ increased claimant's unscheduled permanent disability award for a left shoulder condition from 24 percent to 36 percent and concluded that claimant was entitled to a 25 percent penalty under ORS 656.268(4)(g).

The insurer argues that claimant is not entitled to a penalty under ORS 656.268(4)(g) when an award in an Order on Reconsideration is modified by an Administrative Law Judge. The insurer contends that, based on the express language of the statute, entitlement to a penalty depends on a determination by the *department* to increase an award by 25 percent or more. We agree with the insurer.

ORS 656.268(4)(g) provides:

"If, upon reconsideration of a claim closed by an insurer or self-insured employer, *the department orders an increase by 25 percent or more* of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the penalty shall not be assessed." (Emphasis supplied).

In construing ORS 656.268(4)(g), our task is to discern legislative intent. ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. *Id.* at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *Id.*

We agree with the insurer that the terms of ORS 656.268(4)(g) provide that a claimant is entitled to a penalty if, upon reconsideration of a claim closed by an insurer or self-insured employer, the *department* orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability. Thus, the statute only applies if the *department* has ordered an increase in scheduled or unscheduled permanent disability. *See Frederick W. Van Horn*, 48 Van Natta 956 (1996) (penalty under ORS 656.268(4)(g) must be based on compensation determined to be then due by reconsideration order.)

Our interpretation of the statute is consistent with the rules promulgated by the Department of Business and Consumer Services (the Department) to implement ORS 656.268(4)(g). OAR 436-030-0175(2) provides, in part:

> "If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer shall be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation."

Under OAR 436-030-0005(7), "[r]econsideration" is defined as "the review of a claim determination by an insurer Notice of Closure or a Determination Order by the department." Thus, claimant is entitled to a penalty if the *department* has reviewed a carrier's Notice of Closure. In the present case, the department has not ordered an increase in unscheduled permanent disability. Rather, the ALJ ordered an increase and while we have modified the ALJ's order, we find that claimant is still entitled to increased unscheduled permanent disability. Nevertheless, because the department has not ordered an an increase in unscheduled permanent disability, we conclude that claimant is not entitled to a penalty.

Temporary Total Disability Rate

Claimant requested reconsideration of the September 24, 1998 Notice of Closure, contending, among other things, that he was reserving the time loss rate question due to incomplete information. (Ex. 41). On November 29, 1998, claimant's attorney wrote to the Department, explaining there were two issues concerning the time loss rate: the inclusion of vacation pay and calculating claimant's wages for the 52 weeks from the date of injury. (Ex. 44).

The February 4, 1999 Order on Reconsideration indicated that claimant's average weekly wage was determined in accordance with OAR 436-060-0025(5). (Ex. 49-2). The Order on Reconsideration found that claimant's 52 week earnings were $33,887.20, which provided an average weekly wage of $651.68. (*Id.*) The Order on Reconsideration directed the insurer to recalculate the temporary disability rate.

At hearing, claimant argued that the data was insufficient to accurately determine the rate and he urged that the matter be remanded to the carrier to compile the correct information. According to claimant, based on the evidence in the record, the average weekly wage was $684.44, which would provide a TTD rate of $455.84 per week.

The ALJ found there were two wage records in evidence, both purportedly from the employer, which were inconsistent. The ALJ found that it was the employer's obligation to compile the correct information and the ALJ construed any inconsistencies against the employer. The ALJ concluded that claimant's first date of disability was February 3, 1997 and he found that during the 48 weeks before that date, claimant had earned $34,106.76. The ALJ determined that claimant's average weekly wage was $710.56.

On review, the insurer argues that the ALJ erred in finding that claimant's condition arose before the date identified by claimant. The insurer asserts that claimant filed his claim with a date of onset of February 21, 1997. The insurer contends that the ALJ erred by modifying the date of the claim on his own initiative. The insurer also argues that claimant has not met his burden of establishing that the rate calculated by the Department was incorrect.

We disagree with the insurer's argument that claimant has not met his burden of establishing that the rate calculated by the Department was incorrect. The Order on Reconsideration said that claimant's 52 week earnings were $33,887.20, which provided an average weekly wage of $651.68. (Ex. 49-2). After reviewing the record, we are unable to verify that claimant's 52 week earnings were $33,887.20. As we will explain further, we conclude that the temporary disability rate calculated by the Department is incorrect.

Alternatively, the insurer asserts that, if the Board determines that the TTD rate calculated by the Department is incorrect, the calculation should be based on 52 weeks preceding the onset of disability, rather than the date of injury. The insurer argues this is "clearly" a claim for occupational disease, rather than an accidental injury.

Claimant's "801" form signed on April 4, 1997 indicated he was injured on February 21, 1997 at 9:00 a.m. (Ex. 8). The "801" form said claimant was "lifting and pushing - throwing pallets" and he thought he had pulled a muscle, which worsened over time. (*Id.*) On the other hand, Dr. Morgan's February 3, 1997 chart note indicated claimant had been having severe arm pain for three to four weeks, with no known injury. (Ex. 2). Dr. Galt's April 2, 1997 report indicated claimant's onset of pain began two months ago, with no prior injury. (Ex. 6).

The insurer's "1502" form dated April 29, 1997 referred to the claim as a disabling injury, with a "date of injury" as March 29, 1997. (Ex. 12). On May 8, 1997, the insurer changed the date of injury to February 21, 1997. (Ex. 13). On June 25, 1997, the insurer accepted left rotator cuff tendonitis, left adhesive capsulitis, referring to an "original injury" with a "date of injury" as February 21, 1997. (Ex. 18). On October 12, 1998, the insurer issued a "1502" form, again referring to a disabling injury, with a date of injury as February 21, 1997. (Ex. 39).

Despite the fact that the insurer accepted the claim as an injury and consistently classified the claim as an injury, the insurer now argues that "this is clearly a claim for occupational disease, rather than an accidental injury." (Insurer's br. at 7). On the other hand, claimant contends that the insurer may not raise an issue regarding claim classification because it was not raised previously on reconsideration. Claimant argues this is not an issue that "arises out" of the reconsideration process. *See* ORS 656.268(8).

After reviewing the record and considering the "totality of circumstances," we find that the insurer accepted claimant's claim as an accidental injury and has waived its right to argue that the claim was an occupational disease. *See Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 688 (1995). We find it is appropriate to treat the claim as an accidental injury, with an injury date of February 21, 1997, which was described in claimant's "801" form and referenced by the insurer as the "date of injury." (Exs. 8, 13, 18, 39).

The rate of temporary disability benefits is based on a worker's wage at the time of injury. ORS 656.210(1), 656.210(2)(b)(A). Claimant's shifts as a truck driver varied. (Ex. 9). For workers whose remuneration is not based solely on daily or weekly wages, the Director of the Department of Consumer and Business Services (Director) may prescribe rules for establishing the worker's weekly wage. ORS 656.210(2)(c).

At the time of claimant's injury on February 21, 1997, OAR 436-060-0025(5) (WCD Admin. Order 96-070) applied to determine the average weekly wage for workers, like claimant, who were employed on other than a daily or weekly basis. OAR 436-060-0025(5) provides, in part:

> "The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *
>
> "(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:
>
> "(A) Insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks

> or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker. For the purpose of this section, the wage earning agreement may be either oral or in written form."

There is no dispute that claimant had 52 weeks of earnings with the employer before the injury. The problem is that the insurer's evidence of claimant's earnings contains inconsistencies and discrepancies. As we discussed above, claimant requested reconsideration of the September 24, 1998 Notice of Closure, noting that he was reserving the time loss rate question due to incomplete information. (Ex. 41).

On November 29, 1998, claimant's attorney wrote to the Department, indicating there were two issues concerning the time loss rate. (Ex. 44). Claimant's attorney said claimant was paid vacation pay after he was required to leave work, which should be included in the calculation. (*Id.*) Claimant's attorney also said:

> "[The insurer] originally requested wage information for 52 weeks. This was originally done from the date he left work, rather than the date of injury. This was discovered by [the insurer] during an audit of the claim. [The insurer] then reduced the wages for those weeks from the averaging. While we do not dispute that this is correct, they should have gone back to the employer for the wages for the 52 weeks from the DOI. Specifically the wages paid in February and March 1996." (*Id.*)

On December 14, 1998, the Department advised claimant's attorney that it had requested the 52 week wage information from the employer. (Ex. 46). The Department apparently forwarded a copy of that information to claimant's attorney on January 6, 1999 and indicated it would be recalculating claimant's average weekly wage and TTD rate. (Ex. 47).

The evidence of claimant's wage earnings in the record on review is in Exhibit 1. Pages 1 and 2 of Exhibit 1 pertain to the period from February 18, 1996 through March 8, 1997. (Ex. 1-1, -2). Pages 3 and 4 pertain to the period from April 7, 1996 through March 29, 1997. (Ex. 1-3, -4). After reviewing the records, we find that it is appropriate to use pages 1 and 2 of Exhibit 1, with adjustments for missing records. For example, pages 1 and 2 of Exhibit 1 do not include claimant's wages for the week of May 19, 1996 or the week of February 2, 1997. Therefore, we use the figures for those weeks from pages 3 and 4 of Exhibit 1, *i.e.*, the week of May 19, 1996 was $424.06 and the week of February 2, 1997 was $732.85. (Exs. 1-3, -4). Also, the parties have stipulated that the correct wage for November 24, 1996 to November 30, 1996 is $291.71. With these three adjustments, we find that claimant's wages for the 52 weeks before the February 21, 1997 injury were $36,827.48. Therefore, claimant's average weekly wage was $708.22. On review, the insurer is directed to recalculate claimant's temporary disability benefits using an average weekly wage of $708.22.[1]

ORDER

The ALJ's order dated June 18, 1999 is reversed in part, modified in part and affirmed in part. That portion of the ALJ's order that assessed a 25 percent penalty under ORS 656.268(4)(g) is reversed. In lieu of the ALJ's permanent disability award, claimant's unscheduled permanent disability award for a left shoulder condition is increased from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 32 percent (102.4 degrees). In lieu of the ALJ's temporary disability award, the insurer is directed to recalculate claimant's temporary disability benefits using an average weekly wage of $708.22. Claimant's counsel's out-of-compensation attorney fee, as awarded by the ALJ, shall be modified accordingly. The remainder of the ALJ's order is affirmed.

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[1] In light of our findings, we disagree with claimant's argument that this matter should be returned to the insurer with instructions to obtain the correct information.

Board Member Haynes concurring in part and dissenting in part.

I agree with the portions of the majority opinion concerning penalties and the temporary total disability rate. For the following reasons, however, I disagree with the majority's conclusion that claimant is entitled to a 3 percent impairment value for reduced range of motion.

The majority relies on Dr. Galt's September 8, 1998 concurrence with the PCE in awarding a 3 percent impairment value for reduced range of motion. The majority acknowledges that the PCE was performed on July 27, 1998, before claimant was declared medically stationary. Nevertheless, the majority reasons that Dr. Galt concurred with the PCE after he had declared claimant medically stationary. (Ex. 34).

I do not agree that we should rely on the PCE, which was performed *before* claimant was medically stationary. Instead, I am persuaded by Dr. Galt's August 25, 1998 report and find that it provided the most accurate evaluation of claimant's permanent impairment. In previous cases, we have held that a medical report may be more probative regarding impairment when it is dated closer in time to the reconsideration order. *See, e.g., Ronald L. Tipton*, 48 Van Natta 2521 (1996). Here, I find that to be an important factor. The PCE was performed on July 27, 1998, almost a month before claimant was declared medically stationary. Although Dr. Galt concurred with the PCE on September 8, 1998, he did not refer to or explain the "timing" differences. In other words, Dr. Galt may have been concurring that the PCE findings on July 27, 1998 were accurate at that time. Under these circumstances, Dr. Galt's August 25, 1998 report provides a more thorough analysis and explanation because he had deemed claimant to be medically stationary at that time.

Based on Dr. Galt's August 25, 1998 report, I would conclude that claimant is entitled to an impairment value of 1 percent for reduced range of motion. The record indicates that Dr. Galt had been consistently testing claimant's range of motion since he began treating him in April 1997. (Exs. 6, 14, 17, 19, 22, 26, 28, 32). On August 25, 1998, Dr. Galt reported that claimant's range of motion findings (right/left): flexion (170/170), abduction (170/150), external rotation (80/70) and internal rotation (90/90). (Ex. 32-1). Based on these findings, I would conclude that claimant is entitled to a 1 percent award for loss of abduction. *See* OAR 436-035-0330(5). Although Dr. Galt apparently did not measure adduction and extension, I note that the PCE findings for adduction and extension were normal. (Ex. 30-2).

Finally, although I agree with the majority that claimant is not entitled to an award for loss of shoulder strength, I disagree with its reasoning. Instead of relying on Dr. Galt's September 8, 1998 concurrence with the PCE, I would find, as noted above, that Dr. Galt's August 25, 1998 report provided a more thorough analysis and explanation because he had deemed claimant to be medically stationary at that time. The record establishes that Dr. Galt had been consistently testing claimant's shoulder strength, using a 0 to 5 grading system, since he began treating claimant in April 1997. (Exs. 6, 14, 17, 19, 22, 26, 28, 32). On July 15, 1998, Dr. Galt reported that claimant's strength was improving gradually. (Ex. 28). On that date, he noted some problems with internal rotation. (Ex. 28-1). Dr. Galt's August 25, 1998 closing exam, however, did not refer to any problems with claimant's strength. (Ex. 32-1). Although I agree with the majority that claimant is not entitled to an award for loss of shoulder strength, I would rely instead on Dr. Galt's August 25, 1998 report to reach that conclusion.

In the Matter of the Compensation of
LORETTA K. FOUNTAIN, Claimant
WCB Case No. 98-05293
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

On September 14, 1999, we adopted and affirmed Administrative Law Judge (ALJ) Tenenbaum's order that upheld the SAIF Corporation's partial denial of a right rotator cuff tear injury claim. Claimant subsequently requested reconsideration of our order, requesting that we: (1) abate our September 14, 1999 order; (2) consolidate this case with claimant's appeal from ALJ Marshall's September 30, 1999 order, WCB Case No. 99-03369;[1] and (3) reconsider the present case during our review of WCB Case No. 99-03369.

On October 12, 1999, we withdrew our September 14, 1999 order in order to further consider claimant's request and to allow SAIF the opportunity to respond. Having received SAIF's response, we proceed with our reconsideration.[2]

After reconsideration, we continue to adopt and affirm ALJ Tenenbaum's order that concluded that claimant failed to establish that her right rotator cuff tear condition is compensably related to her work injury.

There is some controversy as to whether claimant raised, should have raised, or could have raised the issue of compensability of her right rotator cuff tear condition as an occupational disease claim at the time of the hearing before ALJ Tenenbaum. We need not address this issue, however, because, even if claimant raised the issue of compensability as an occupational disease claim, the medical record in WCB Case No. 98-05293 does not establish compensability under that theory.

To establish an occupational disease, claimant must prove that her employment conditions were the major contributing cause of her right rotator cuff tear condition. ORS 656.802(2)(a). In addition, if the occupational disease claim is based on the worsening of a preexisting disease or condition[3] pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition *and* pathological worsening of the disease. ORS 656.802(2)(b). Determining the "major contributing cause" of claimant's right rotator cuff tear condition involves evaluating the relative contribution of different causes of the disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *review dismissed* 321 Or 416 (1995). The fact that work activities or injury may have precipitated the worker's disability or need for treatment does not necessarily mean that the work injury is the major cause. *Id.* Indeed, "major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *McGarrah v. SAIF*, 296 Or 145, 166 (1983).

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[1] Following ALJ Tenenbaum's February 19, 1999 order, claimant filed an occupational disease claim for her right rotator cuff tear condition. In his September 30, 1999 order, ALJ Marshall determined that claimant was precluded by the doctrine of claim preclusion from raising the compensability of her right rotator cuff tear condition under an occupational disease theory. Consequently, ALJ Marshall upheld SAIF's denial of claimant's occupational disease claim. Claimant has requested Board review of ALJ Marshall's order. WCB Case No. 99-03369.

[2] This matter has been consolidated for review with WCB Case No. 99-03369. 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.

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

Due to the multiple possible causes of claimant's right rotator cuff tear condition, including her preexisting grade II acromion condition, the cause of claimant's right rotator cuff tear involves complex medical questions that must be resolved with expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Uris v. Compensation Department*, 247 Or 420 (1967). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

The medical evidence in WCB Case No. 98-05293 regarding causation is provided by four physicians: (1) Dr. Vessely, an orthopedist who reviewed claimant's medical records on behalf of SAIF; (2) Dr. Jones, examining orthopedist; (3) Dr. Benz, claimant's treating orthopedist who repaired her right rotator cuff tear; and (4) Dr. Dickinson, consulting orthopedist. (Exs. 14, 16, 19, 23, 25, 25A, 28, 29, 30).

Dr. Vessely explained that claimant had preexisting morphological changes of her right acromion, consisting of a Grade II acromion. (Ex. 19-4). He opined that this Grade II acromion condition was developmental and not related to work. He found that claimant was not performing activities that would continually, repetitively overload her shoulder. (*Id.*). He opined that the Grade II acromion subjected claimant to repetitive irritation of the rotator cuff, which caused atrophy of the insertional area of the supraspinatus and resulted in a rotator cuff tear. In other words, he explained, claimant's shoulder pain began as an impingement syndrome and progressively developed into an atrophic rotator cuff tear from the chronic impingement of the Grade II acromion with the anterior spur. (Ex. 19-4-5). Although Dr. Vessely found that repetitive use of an arm that has impingement would set up a symptom complex, he concluded that the major contributing cause of claimant's shoulder problem was the preexisting abnormality of the subacromial area. (Exs. 19-5, 23).

Dr. Jones also found that claimant had a preexisting Grade II acromion condition, which predisposed her to degenerative changes in the rotator cuff complex. (Ex. 25-7). In addition, he noted that an ultrasound showed fluid in the opposite, nonsymptomatic shoulder, which he opined supported the possibility of constitutional factors causing degenerative changes, wear and inflammation in claimant's shoulders. (*Id.*). Dr. Jones agreed with Dr. Vessely that claimant's job was not heavily physical so that it would cause a rotator cuff tear. (Ex. 25-6). Dr. Jones opined that the cause of claimant's current right shoulder condition was due to the degenerative nature of her subacromial impingement and progression to a rotator cuff tear in an appropriate age group individual, and that was the major cause of her need for treatment. (*Id.*). He also found that claimant's preexisting right shoulder condition was not pathologically worsened by her work activities. Instead, he explained that claimant has a continuation of her preexisting condition, whose natural course was to eventually have a rotator cuff tear. (*Id.*).

After reviewing the opinions of Drs. Vessely and Jones, Dr. Benz acknowledged that claimant has an anatomic habitus that predisposes her to a rotator cuff tear, although he distinguished it as a "correlation, but not a causation." (Ex. 28-1). Dr. Benz also explained that "it requires an additional factor to produce the rotator cuff tear, and in this situation it is [claimant's] work activity." (*Id.*) He concluded, however, that "ultimately there is a combination of the two which resulted in the need for treatment." (Ex. 28-2).

Finally, Dr. Dickinson stated that claimant's rotator cuff tear was work related, stating that, while there were clear degenerative changes, claimant's condition was "markedly accelerated by the type of work she has done and therefore, would qualify as an occupational illness." (Exs. 25A-1, 30-1). He also stated that claimant's work activities, when compared to any preexisting condition, were the major contributing cause of "her condition, her disability and her need for medical care and treatment for her right rotator cuff tear." (Ex. 30-1).

Thus, the opinions of Drs. Vessely, Benz, and Dickinson establish that claimant's preexisting Grade II acromion condition combined with her work activities to cause her rotator cuff tear condition.[4] Therefore, claimant must prove that employment conditions were the major contributing cause of the combined condition *and* pathological worsening of the preexisting condition. ORS 656.802(2)(b). On this record, claimant fails to meet that burden of proof.

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[4] Dr. Jones does not explicitly address the issue of whether claimant's preexisting condition combined with her work activities. He opines, however, that claimant's preexisting condition is the major contributing cause of her right rotator cuff tear. (*Id.*). Thus, his opinion does not support compensability.

No physician opines that claimant's work activities pathologically worsened her preexisting right shoulder condition. To the contrary, the only physician who specifically addressed this issue, Dr. Jones, opined that claimant's work did *not* worsen her preexisting condition. (Ex. 25-7). Furthermore, while only the opinions of Drs. Benz and Dickinson might be read to support compensability of an occupational disease claim, neither of those opinions address whether claimant's work activities were the major contributing cause of a pathological worsening of claimant's preexisting right Grade II acromion condition. ORS 656.802(2)(b). Accordingly, if we were to find that claimant raised the issue of compensability of her right rotator cuff tear condition as an occupational disease claim in the hearing before ALJ Tenenbaum, we would conclude that she failed to meet her burden of proving compensability of such a claim.

Accordingly, on reconsideration of WCB Case No. 98-05293, as supplemented herein, we republish our September 14, 1999 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORETTA K. FOUNTAIN, Claimant
WCB Case No. 99-03369
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a right shoulder rotator cuff tear condition; and (2) declined to assess penalties for an allegedly unreasonable denial. On review, the issues are claim preclusion, compensability and penalties.[1] We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

By order dated February 19, 1999, ALJ Tenenbaum upheld the SAIF Corporation's partial denial of a right shoulder rotator cuff tear injury claim. WCB Case No. 98-05293. Following ALJ Tenenbaum's order, claimant filed an occupational disease claim for the same right shoulder rotator cuff tear condition. WCB Case No. 99-03369.

On September 14, 1999, we adopted and affirmed ALJ Tenenbaum's February 19, 1999 order. WCB Case No. 98-05293. On October 6, 1999, claimant requested reconsideration of our September 14, 1999 order.

Meanwhile, by order dated September 30, 1999, ALJ Marshall determined that claimant was precluded by the doctrine of claim preclusion from raising the compensability of her right rotator cuff tear condition under an occupational disease theory. WCB Case No. 99-03369. Consequently, ALJ Marshall upheld SAIF's denial of claimant's occupational disease claim and declined to access penalties for an allegedly unreasonable denial. Claimant requested Board review of ALJ Marshall's order.

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[1] This matter has been consolidated for review with WCB Case No. 98-05293. 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 case currently before us, claimant contends that her occupational disease claim is not barred by the doctrine of claim preclusion because there must be a *final* order in a prior judicial proceeding in order for claim preclusion to apply. *Drews v. EBI Companies*, 310 Or 134, 140 (1990); *North Clackamas School District v. White*, 305 Or 48, 53 (1988). Claimant argues that, because she timely appealed ALJ Tenenbaum's February 19, 1999 order and timely requested reconsideration of our September 14, 1999 order that adopted and affirmed ALJ Tenenbaum's order, there was no *final* order upon which to base the doctrine of claim preclusion. SAIF responds that, notwithstanding the lack of finality regarding the first determination, claim preclusion applies to bar claimant's current occupational disease claim.

We need not resolve this dispute because, even if the current occupational disease claim is not barred by claim preclusion, claimant failed to establish a compensable occupational disease claim on this record.

On today's date, we issued an Order on Reconsideration regarding WCB Case No. 98-05293. In that order, we concluded that we need not address the issue of whether claimant raised, should have raised, or could have raised the issue of compensability of her right rotator cuff tear condition as an occupational disease claim at the time of the hearing before ALJ Tenenbaum because, even if claimant had raised that issue, the medical record did not establish compensability under that theory.

Specifically, we determined that the medical evidence in WCB Case No. 98-05293 established that claimant's occupational disease claim was based on a worsening of her preexisting type II acromion condition and, therefore, under ORS 656.802(2)(b),[2] claimant must prove that employment conditions were the major contributing cause of the combined condition *and* pathological worsening of the disease. After reviewing the medical evidence, we concluded that claimant failed to meet her burden of proving this second factor, *i.e.*, that her work activities were the major contributing cause of a pathological worsening of her preexisting type II acromion condition.

We incorporate into the present order our reasoning and conclusions as explained in our Order on Reconsideration regarding claimant's failure to prove a compensable occupational disease claim on the merits.[3] Specifically, claimant failed to prove that work activities pathologically worsened her preexisting right type II acromion condition. ORS 656.802(2)(b). The same reasoning (based on the same evidence) applies in WCB Case No. 99-03369 to determine that, up to the receipt of the final reports from Drs. Dickinson and Benz (Exs. 27, 28), and the report from Dr. Schilperoort (Ex. 24), claimant failed to prove that work activities pathologically worsened her preexisting right type II acromion condition. (Exs. 13A, 15, 17, 11, 18, 19, 11A, 17A, 19A). The only question is whether the new reports from Drs. Dickinson, Benz, and Schilperoort meet claimant's burden of proving that work activities pathologically worsened her preexisting right type II acromion condition. (Exs. 24, 27, 28). After reviewing those reports, we find that they do not.

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[2] ORS 656.802(2)(b) provides:

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

[3] We find that such incorporation is appropriate because most of the medical evidence in the record of the case now before us is identical to the record in WCB Case No. 98-05293, although the exhibit numbers for identical medical reports differ. In this regard, in WCB Case No. 98-05293, the medical evidence regarding causation of claimant's right shoulder torn rotator cuff condition is provided by four physicians: (1) Dr. Vessely, an orthopedist who reviewed claimant's medical records on behalf of SAIF; (2) Dr. Jones, examining orthopedist; (3) Dr. Benz, claimant's treating orthopedist who repaired her right rotator cuff tear; and (4) Dr. Dickinson, consulting orthopedist. The same reports from the same four physicians are admitted into the record in WCB Case No. 99-03369. Compare Exhibits 19, 23, 25, 14, 28, 29, 16, 25A, 30 in WCB Case No. 98-05293 to Exhibits 13A, 15, 17, 11, 18, 19, 11A, 17A, 19A in WCB Case No. 99-03369. Three additional medical records regarding causation were admitted in WCB Case No. 99-03369: (1) an April 16, 1999 report from Dr. Schilperoort, examining orthopedist (Ex. 24); (2) a June 14, 1999 report from Dr. Dickinson (Ex. 27); and (3) a July 23, 1999 report from Dr. Benz (Ex. 28).

Dr. Schilperoort explained the evolution of subacromial impingement syndrome, noting that there are three possible major contributors: (1) AC joint degenerative joint disease with inferiorly directed osteophyte; (2) type II or III acromion abnormalities with chronic impingement; or (3) superior migration of the humeral head in the glenoid. (Ex. 24-5). He considered that only the third situation may be post-traumatic or work related. (Ex. 24-6). But he ultimately concluded that claimant's preexisting type II acromion was the major contributing cause not only of her subacromial impingement but also the rotator cuff tear. (Ex. 24-6-7). He offered no opinion as to whether claimant's work activities pathologically worsened her preexisting right type II acromion condition. In any event, his opinion does not support compensability.

Moreover, although Drs. Dickinson and Benz both opined that claimant's work activities were the major contributing factor to her right rotator cuff tear condition, they offered no opinion as to whether work activities pathologically worsened her preexisting right type II acromion condition. (Exs. 27, 28).

Accordingly, based on the record before us, we find that claimant failed to meet her burden of proving a compensable occupational disease claim under ORS 656.802(2)(b).

Finally, we adopt ALJ Marshall's reasoning and conclusions regarding the penalty issue.

ORDER

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

Board Member Phillips Polich dissenting.

Although I agree that claimant has not established a compensable injury claim regarding her right rotator cuff tear condition, I would find that she has established a compensable occupational disease claim for that condition. Specifically, I disagree with the majority's application of ORS 656.802(2)(b) to the facts of this case. Therefore, I respectfully dissent.

ORS 656.802(2)(b) provides:

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

Claimant has a preexisting type II acromion. What the majority loses sight of is the fact that the right rotator cuff tear is the condition at issue, not the type II acromion. As Dr. Benz explains, a type II acromion is an "anatomic habitus." (Ex. 18-2). Claimant's type II acromion exists, but it does not "worsen." Therefore, the basis of the present occupational disease claim is not a "worsening" of the preexisting "anatomic habitus" or type II acromion. Instead, it is based on the cause of the right rotator cuff tear under ORS 656.802(2)(a), which provides that "[t]he worker must prove that employment conditions were the major contributing cause of the disease." Furthermore, I would find that the treating and consulting physicians' opinions establish that the major contributing cause of the right rotator cuff tear is claimant's work activities. (Exs. 18, 27, 28).

In the Matter of the Compensation of
LLANCE A. PETERSON, Claimant
Own Motion No. 99-0376M
OWN MOTION ORDER
Carney, et al, Claimant Attorneys

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable asthma injury/occupational disease. Claimant's aggravation rights expired on May 9, 1994. 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.*

From October 11, 1999 to October 13, 1999, claimant was hospitalized for treatment due to a worsening of his compensable asthma condition. Thus, we conclude that claimant's compensable condition worsened requiring 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).

For the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction,[1] the "date of disability" is the date he is hospitalized due to a worsening of his compensable condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Thus, the relevant time period for which claimant must establish he was in the work force is the time prior to his October 11, 1999 hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *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).

SAIF contends that claimant was not in the work force at the time of the current disability. In response to SAIF's contentions, claimant has submitted a January 24, 2000 affidavit, with attachments.

Claimant contends that he satisfies the third *Dawkins* criterion. As explained above, in order to satisfy that criterion, claimant must establish both that: (1) although not working, he is willing to work; and (2) he is not seeking work because his work-related injury has made any reasonable work search efforts futile. *Dawkins*, 308 Or at 258. Failing to prove either factor results in a finding that claimant is not considered a member of the work force, and thus, is not entitled to temporary disability compensation.

Based on claimant's January 24, 2000 affidavit, we find that he is willing to seek employment. Specifically, claimant stated that:

> "I have always hoped that I would be able to return to being an active member of the workforce [sic], but the unpredictability associated with my symptoms and overall health has made that impossible. * * * It is still one of my single greatest hopes and desires that my physical health will improve enough in the future to allow me to once again become an active participant in the work force."

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

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

In support of his position, claimant submitted a copy of an October 28, 1994 prescription slip from Dr. Keppel, his attending physician, stating that claimant is "not able to work due to pulmonary disability." However, as explained above, the relevant time period for the purpose of determining whether claimant was in the work force is the time prior to his October 1999 hospitalization. Dr. Keppel's 1994 note does not address claimant's ability to work and/or seek work at the relevant time, *i.e.*, the time prior to the October 1999 hospitalization.

Further, in his January 24, 2000 affidavit, claimant references our August 23, 1995 and September 24, 1998 Own Motion Orders that found that he was in the work force during hospitalizations occurring in 1995 and 1998. The first of these orders was unpublished and determined that claimant remained in the work force at the time of an April 1995 hospitalization based on the above-referenced October 28, 1994 note from Dr. Keppel, claimant's efforts at self-employment, and claimant's sworn statements regarding his willingness to work. Own Motion No. 95-0135M. The second order determined that claimant remained in the work force at the time of a May 1998 hospitalization based, in part, on a September 11, 1998 report from Dr. Keppel, stating that claimant was continually unable to work due to the compensable injury since he had taken claimant off work on October 28, 1994, and any work search would have been futile. *Llance A. Peterson*, 50 Van Natta 1808 (1998).

Although probative, our previous findings regarding the "futility" issue concerning claimant's 1995 and 1998 claims are not determinative. A prior finding does not irrevocably commit a claimant to a certain work force status for the purposes of workers' compensation benefits. Rather, claimant must show that he was in the work force at the time of his current worsening. *See Dean L. Watkins*, 45 Van Natta 1599 (1993); *Morris*, 103 Or App at 273.

Here, claimant contends that, since the time of the above orders, his condition has worsened, he has remained unable to work since 1994 due to the effects of his compensable condition, and any work search would have been futile due to his compensable condition. But the record before us contains no medical evidence that would support claimant's contentions. Consequently, we find that claimant has failed to meet his burden of proof regarding the futility standard of the third *Dawkins* criterion. Therefore, we conclude claimant was not in the work force at the time of the October 1999 worsening of his compensable condition.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
STUART C. YEKEL, Claimant
WCB Case No. 98-05313
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's injury claim for a cervical condition; and (2) awarded a $6,000 assessed attorney fee. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability of Cervical Condition

SAIF argues that Dr. Moore's opinion is not persuasive for two reasons. First, SAIF contends that the doctor stated that claimant's injury was a mere "possible" cause of his herniated cervical disc. Second, SAIF argues that Dr. Moore based her opinion on nothing more than the temporal relationship between claimant's fall at work and his subsequent radicular symptoms. We disagree.

Dr. Moore opined:

> "I do believe that it is medically probable that the C5-6 herniated disc is due in the major part to the accident with a slip on the ladder described on November 21, 1997. The history, physical, and scan all correlate well with the patient's injury. With a slip and fall and grabbing of a rung of the ladder to keep himself from falling it is quite easy to sustain a twisting and distraction type injury. This can cause a herniated disc of the cervical spine.
>
> "With the patient not having symptomatology of this sort with radicular symptoms prior to his injury[,] I do not think that any predisposing conditions have caused this injury, but it was due to his work related injury." (Ex. 17).

Dr. Moore thus explained that claimant's history, examination, and scan findings were consistent with the mechanism of his work injury. She also relied on claimant's lack of "pre-injury" radicular symptoms to conclude that November 21, 1997 fall at work caused claimant's cervical disc condition. (*Id*). In our view, Dr. Moore's causation opinion is not based solely on a temporal relationship -- it is also based on the consistency between claimant's injury and his findings. In addition, because Dr. Moore related claimant's condition to his injury on a "medically probable" basis, we do not find that her opinion indicates the mere possibility of a work relationship. Because Dr. Moore's opinion is also well-reasoned, based on an accurate and complete history, and consistent with that history, we agree with the ALJ that it is persuasive.

Attorney Fees

The ALJ awarded a $6,000 assessed attorney fee, noting that, as a result of claimant's counsel's services, claimant now has a compensable left hand injury and C5-6 disc and carpal tunnel syndrome conditions. The ALJ reasoned that the case presented factual questions of greater than average complexity; legal issues of average complexity; and the value of the interest and benefit secured was of greater than average significance. The ALJ found that both attorneys are experienced in the workers'

compensation field and defense counsel is a "skilled and worthy adversary." The ALJ also noted that claimant's attorney (actually, 2 attorneys) spent a total of 24.5 hours on the case.[1] Under these circumstances, and considering the risk that claimant's attorney might go uncompensated,[2] the ALJ assessed a $6,000 fee.

SAIF argues that the ALJ's attorney fee award was excessive, contending that a reasonable fee should be no more than $2,000. Claimant responds that the ALJ's $6,000 fee is reasonable. We agree with SAIF that the ALJ's award should be reduced, but not to the extent that SAIF requests.

Claimant is entitled to a fee for services devoted to overcoming SAIF's denial of his cervical claim and for obtaining SAIF's pre-hearing acceptance of his left hand injury claim, including acceptance of his carpal tunnel condition. Claimant's counsel spent 24.5 hours on the case. However, time devoted to the case is but one factor we consider in determining a reasonable attorney fee. Moreover, a reasonable attorney fee is not based solely on a strict mathematical 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 efforts may go uncompensated. *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 correctly notes that, contrary to the ALJ's understanding, claimant's counsel did not travel to Burns for a deposition, but rather participated by phone. In addition, while the ALJ noted that claimant submitted 16 exhibits, SAIF[3] correctly observes that claimant's counsel only generated 3 of those exhibits. Moreover, while the record includes about 256 pages of medical evidence, some of that evidence pertains to claimant's bilateral knee conditions. Claimant did not contest SAIF's denials of those conditions. Only two witnesses (including claimant) testified at the hearing, which generated 42 pages of transcript.

When compared to compensability disputes generally presented to this forum, the value of the claim and the benefits secured are somewhat above average. On the other hand, the factual and legal issues presented are comparable to those generally litigated in the Hearings Division. The parties' respective counsels presented their positions in a thorough and professional manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $4,500 is a reasonable attorney fee for services at the hearings level in this case. We reach this conclusion because of factors such as the time devoted to the case, the value of the interest involved, the complexity of the issues, and the risk that claimant's counsel might go uncompensated.[4] Accordingly, we modify the ALJ's attorney fee award in view of the factors in OAR 438-015-0010(4).

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[1] The ALJ further noted that claimant retained his attorney 11 months before the hearing; claimant and a co-worker testified at the hearing on claimant's behalf; the record consists of 45 exhibits, of which claimant offered 16; and there were 3 depositions in one day that began in Burns at 8 AM and ended after 5 PM in Bend, as well as a 4th deposition at a later date.

[2] The ALJ identified the risk of going uncompensated, "[c]onsidering the shifting medical opinions and the standard of proof."

[3] We recognize that claimant's counsel reviewed the exhibits although he did not generate them. The effort to review is considered in our analysis.

[4] In reducing the ALJ's award, we particularly rely on the following reasons: (1) claimant's attorney is not entitled to an attorney fee award for services devoted to the noncompensable knee conditions and the penalty issue; (2) claimant's counsel did not travel to Burns for a deposition as erroneously assumed by the ALJ; (3) the average complexity of the medical and legal issues; and (4) claimant's counsel generated three of the 16 exhibits claimant offered.

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

ORDER

The ALJ's order dated June 28, 1999 is modified in part and affirmed in part. That portion of the order that awarded a $6,000 assessed fee is modified. In lieu of the ALJ's award, claimant is awarded an assessed fee of $4,500, to be paid by the SAIF Corporation. For services on review regarding the compensability issue, claimant is awarded a $1,000 attorney fee, payable by SAIF.

February 11, 2000 Cite as 52 Van Natta 222 (2000)

In the Matter of the Compensation of
ROBERT W. COBURN, Maimant
WCB Case No. 96-10496
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Coburn*, 159 Or App 413 (1999). The court has reversed our prior order, *Robert W. Coburn*, 49 Van Natta 1778 (1997), that held that, because claimant's previous permanent disability award had become final, it was improper to reevaluate his unscheduled permanent disability following his completion of an authorized training program (ATP). Relying on ORS 656.268(9), the court determined there must be a reevaluation of claimant's extent of permanent disability upon his completion of the ATP. Moreover, reasoning that the prior award was correct when it was made, the court concluded that the SAIF Corporation's payment of that award did not result in an overpayment (despite the "post-ATP" reduction of claimant's permanent disability award). Consequently, the court remanded for reinstatement of the ALJ's order (that affirmed the "post-ATP" Determination Order that reduced claimant's unscheduled permanent disability award from 42 percent (134.4 degrees) to 19 percent (60.8 degrees) and declined to grant SAIF's offset request for an alleged "overpayment") and an attorney fee award under ORS 656.382(2) for claimant's counsel's services on Board review in successfully defending the ALJ's decision to reject SAIF's request for an offset.

Consistent with the court's opinion, we reinstate the ALJ's order. In accordance with the court's directive, we now proceed to a determination of a reasonable attorney fee for claimant's counsel's services on Board review regarding the "overpayment/offset" 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 Board review concerning the "overpayment/offset" 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.[1]

Accordingly, on remand, the ALJ's order dated March 14, 1997 as reconsidered on April 17, 1997, is reinstated and affirmed.

IT IS SO ORDERED.

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[1] We do not award a fee for that portion of claimant's respondent's brief devoted to claimant's unsuccessful attempt to have the prior 42 percent unscheduled permanent disability award reinstated.

In the Matter of the Compensation of
SAMUEL H. ROCKWELL, Claimant
WCB Case No. 98-08331
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Reinisch, et al, Defense Attorneys

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

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that awarded a $4,000 attorney fee. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer denied claimant's right wrist injury claim. Claimant requested a hearing. The ALJ found the claim compensable and, after considering the factors set forth in OAR 438-015-0010(4), particularly the complexity of the case, the time involved, the risk that claimant's counsel would go uncompensated, and the benefit to claimant, awarded a $4,000 assessed attorney fee under ORS 656.386(1).

The insurer requested review of the ALJ's attorney fee award, challenging each of the aforementioned factors, in particular the factors of time, effort, skill and risk. The insurer requests that we reduce the fee to $2,000. We agree that the fee should be reduced for the following reasons.

The insurer argues that the case took little time to develop or prosecute, that claimant's attorney generated only two of the exhibits, that the hearing was brief, lasting under one hour, and that the deposition took only one-half hour, and, because it was the insurer's deposition, the insurer did almost all of the questioning. The insurer also argues that the case presented no complex legal or medical issues, but involved only one lay issue involving whether claimant's wrist condition was actually related to a work incident or activities. The insurer further argues that the testimony was brief and the medical evidence cursory, and that claimant's counsel was not required to prepare witnesses other than claimant nor to cross-examine any insurer witnesses.

The insurer also contends that the case was of minimal value because claimant prevailed on a nondisabling wrist strain. The insurer further contends that, even though claimant's counsel has considerable skills, those skills were not tested by this case. The insurer further contends that the hearing was not complicated and the burden of proof was conventional.

Finally, the insurer contends that the issues raised in its denial do not ordinarily support compensability defenses, and lack of cooperation defenses are subject to validation through Department procedures that were not invoked. The insurer states that it was, therefore, clear at hearing that the only significant issue was whether the failure to comply with the MCO enrollment or with discovery requests prevented the record from containing sufficient medical evidence to support the existence of the work-related condition, which required the insurer to challenge the sufficiency of the unrebutted medical opinion. Accordingly, the insurer contends that there was only a limited risk of a decision upholding the denial.

Claimant contends that the insurer's statement regarding the number of documents generated by claimant's counsel is incorrect. Claimant also points out that, although the deposition was requested by the insurer, it was arranged for by claimant's counsel (including attendance of the court reporter) and required preparation, cross-examination and travel time. Claimant also notes that the ALJ requested written closing arguments, which took time and effort to prepare. As for complexity, claimant argues that the insurer complicated resolution of the case by issuing a denial on one ground and litigating the case on another theory.

Claimant also argues that the insurer has provided no evidence to establish that the value of the case or the benefits at risk were of minimal value. Claimant further notes that he was also required to prepare claimant's doctor and to rehabilitate him through questioning after cross-examination by the

insurer. Finally, claimant argues that, in light of the insurer's shifting theories of denial, and its actual litigation of whether there was a variance in the medical history provided by claimant to his attending physician, it was difficult to anticipate the thrust of what the insurer actually intended to litigate.

Having considered the parties' arguments, and after *de novo* review of the record, we turn to an application of the factors set forth in OAR 436-015-010(4) to the circumstances of this case[1] to establish a reasonable fee for claimant's counsel's services at the hearings level. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issue at hearing was compensability of claimant's right wrist injury. The insurer issued its denial of claimant's claim based on alleged noncooperation and nonparticipation in the MCO by claimant and his attending physician. At hearing, the parties also addressed the merits of the claim. Claimant prevailed on the compensability issue. The hearing lasted approximately one hour and generated 39 pages of transcript. Claimant testified on his own behalf. The insurer presented no witnesses. The record contains 28 exhibits, of which claimant's attorney provided nine, including several medical reports and the attending physician's deposition upon which the ALJ relied in finding the claim compensable. There was one post-hearing deposition of claimant's attending physician, which was requested by the insurer. The deposition was arranged for by claimant's counsel. (Tr. 3, 4). This deposition, taken at the physician's office, generated 24 pages of transcript, of which 8 pages were reexamination by claimant's counsel. Claimant's counsel prepared a five-page written closing argument and a four-page written reply argument, both of which discussed the factual, medical and legal issues presented for resolution in the case.

Based on compensability disputes generally litigated before this forum, we find that the issue at hearing was of average complexity regarding the legal, medical and factual issues involved. Because claimant's right upper extremity injury was found compensable, claimant is entitled to workers' compensation benefits. The value of the interest involved and the benefit secured for claimant is comparable to claims normally presented to the Hearings Division. The parties' counselors, both experienced attorneys, presented their respective positions in a skillful and thorough manner. No frivolous issues or defenses were presented. Finally, considering the noncooperation challenge to claimant's claim and the insurer's vigorous defense, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our consideration of each of the previously enumerated factors and the parties' arguments[2], we find that a reasonable fee for claimant's attorney's services at hearing is $3,200, payable by the insurer.[3] In reaching this conclusion, we have particularly considered the time devoted to the

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[1] The insurer cites *Jarrin L. Hickman*, 51 Van Natta 1022 (1999), as support for its request for reduction of the attorney fee on the basis of the length of the hearing and the number of exhibits submitted by claimant's counsel. The insurer'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).

[2] In his reply brief, claimant discussed the manner in which the factors set forth in OAR 438-015-0010(4) specifically apply to the case. In support of his contentions, claimant's counsel attached an Affidavit of Counsel that included Exhibits A through D. The insurer objects to consideration of the affidavit or arguments based upon it, contending that we are not empowered to admit new evidence on appeal under ORS 656.295(5). Alternatively, the insurer contends that claimant's counsel waived presentation of such an affidavit because he failed to present it to the ALJ. We reject the insurer's contentions and have considered claimant's submission on review. OAR 438-015-0029(1) permits a claimant's attorney to file a request for an attorney fee for services at the hearing level and/or for services on Board review. *See William F. Davis*, 51 Van Natta 257 (1999).

[3] Accepting claimant's counsel's sworn representations regarding the amount of time he spent on the case, the dissent would affirm the ALJ's $4,000 attorney fee for claimant's services at hearing. However, in considering claimant's attorney's affidavit, that affidavit would only substantiate a reasonable fee of approximately $3,200, based on the hours expended and the hourly rate for the compensability issue (which is presumably based on all the relevant factors set forth in OAR 438-015-0010(4)). Services expended after the ALJ's order and following the insurer's appeal are attributable to the attorney fee issue and, as such, are not a basis for an attorney fee award regarding the compensability issue.

case (as represented by the hearing record and claimant's counsel's request), the complexity of the issue, the value of the interest involved, the benefits secured, the nature of the proceedings (including a deposition), and the risk that counsel may go uncompensated. Finally, claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated July 14, 1999 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award for claimant's counsel's services at hearing, claimant's attorney is awarded $3,200, to be paid by the insurer. The remainder of the order is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's reduction of claimant's attorney fee for services at hearing to less than the $4,000 awarded by the ALJ. Instead, I would affirm the ALJ's order, particularly in light of his application of the factors under OAR 438-015-0010. I reason as follows.

Because the scope of our *de novo* review encompasses all issues considered by the ALJ, *Destael v. Nicolai*, 80 Or App 723 (1986), and OAR 438-006-0031, we have the authority to award a reasonable attorney fee for claimant's counsel's services at hearing and on review. *See Billy J. McAdams*, 41 Van Natta 2019 (1989).[1]

Unlike the majority, I find that the record and claimant's counsel's affidavit do not support the insurer's allegations that the fee should be reduced to $2,000. Claimant's counsel's itemized statement of time spent on the case establishes that he spent 21.8 hours through the date he submitted his reply brief on review. He also establishes that his current hourly fee for civil and administrative matters in state and federal court is $175 per hour.[2] He further establishes that he has been licensed to practice law in Oregon and before the United States District Court. He also establishes that he has practiced in Oregon for 21 years and that his practice is devoted to representing individuals in workers' compensation, employment discrimination, and personal injury cases.

Based on claimant's counsel's sworn and undisputed representations, I conclude that he is a skilled and experienced attorney. I also find that he spent a total of 18.5 hours on the case through the date the Opinion and Order issued.[3] Absent any evidence to the contrary,[4] I would conclude that this is a reasonable number of hours for a skilled and experienced attorney to spend on this case.[5] I also conclude that the fee of $175.00 per hour is reasonable.

The insurer also contends that the case was of minimal value because claimant prevailed on a nondisabling wrist strain. But the insurer has provided no evidence (argument is not evidence) to establish that the value of the case or the benefits at risk were minimal. Claimant prevailed over a right upper extremity injury denial. This entitles claimant to workers' compensation benefits. Thus, the value of the interest involved and the benefits secured for claimant is comparable to denied claims normally presented to the Hearings Division.

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[1] I consider claimant's affidavit as part of his respondent's brief because no question was raised regarding his fee at hearing and, because the insurer can properly raise an objection to the fee for the first time on review, *see Hays v. Tillamook County General Hospital*, 160 Or App 55 (1999), then claimant's counsel must be able to respond by providing us information to aid us in assessing the reasonableness of the fee.

[2] I note that the insurer does not challenge claimant's fee rate of $175 per hour.

[3] I calculate this amount of time by subtracting the 3.3 hours spent on the attorney fee issue after the Opinion and Order issued from the 21.8 hours documented by claimant's counsel.

[4] The insurer has provided argument regarding the factors of time, effort, skill and risk. However, the insurer has not provided evidence that claimant's attorney spent less time on the case, that he is less skilled, nor that his fee is different from those items documented in his affidavit.

[5] The time devoted to the case, here 18.5 hours of cognizable services, is but one of the factors considered in determining a reasonable attorney fee. *Danny G. Luehrs*, 45 Van Natta 889, 890 (1993).

Finally, the insurer specifically contends that the risk that claimant's attorney would go uncompensated was limited because the issues it raised in its denial do not ordinarily support compensability defenses, and lack of cooperation defenses are subject to validation through Department procedures that were not invoked. Therefore, the insurer contends that it was clear at hearing that the only significant issue was whether the failure to comply with the MCO enrollment or with discovery requests prevented the record from containing sufficient medical evidence to support the existence of the work-related condition.

The denial issued by the insurer had nothing to do with any supposed variance in medical history given to the doctor. The insurer denied claimant's right wrist claim for the reason that "there has been a lack of cooperation on the part of the employee being seen within the required MCO and a lack of information provided by an attending physician to this file." The denial did not raise the issues of whether claimant's condition arose out of and in the course and scope of his employment, and whether there had been objective evidence of an injury.[6] Nevertheless, the insurer did not withdraw the "lack of cooperation" issue at hearing, and, in fact, proceeded to cross-examine claimant on his willingness to cooperate, full well knowing that it had issued its original denial on an unsupportable basis.[7] Consequently, the insurer, in effect, raised a "red herring" while actually litigating whether there was supposedly a variance in the medical history given to his treating doctor by claimant. As a result of the lack of clarity of what was actually at issue at hearing, I conclude that there was a decided risk that claimant's attorney might have gone uncompensated.[8] For the same reason, expenditure of substantial time was required to secure claimant's benefits. But, as discussed above, I do not find the amount of time claimant's counsel worked on this case to be unreasonable, considering the nature and complexity of the work he performed.

After considering the factors under OAR 438-015-0010(4), I conclude that $4,000 is a reasonable assessed attorney fee for claimant's counsel's services regarding the insurer's denial of claimant's right wrist injury. In particular, I have considered the time devoted to the issue (as represented by the record and claimant's counsel's itemized statement of time spent on the case), the complexity of the issue, the nature of the proceedings, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Unlike the majority, I would find that the record and claimant's affidavit does not support the insurer's allegations regarding minimal time spent, minimal effort, claimant's attorney's failure to use his acknowledged skills, and virtual lack of risk that he might go uncompensated.

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[6] This alternative theory was not raised until the insurer responded to claimant's hearing request.

[7] *See* ORS 656.262(14), which authorizes a "noncooperation" denial only after a worker has failed to cooperate for 30 days after the Director's notice to the worker. There is no evidence in the file that the insurer notified the Director of claimant's alleged noncooperation, a statutory prerequisite for issuance of such a denial.

[8] In reaching this conclusion, I reiterate that I would not apply a contingency factor in a strict mathematical sense. *See Lois J. Schoch*, 49 Van Natta 170, 173 n.1 (1997). Instead, in conjunction with the other relevant factors discussed above, including the time devoted to the case, the risk that claimant's counsel might go uncompensated for services rendered in this proceeding has been considered in the ultimate determination of a reasonable attorney fee.

In the Matter of the Compensation of
TERRY G. LOGSDON, Claimant
WCB Case No. 99-00431
ORDER ON REVIEW
Max Rae, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) declined to continue the hearing to allow claimant to depose two physicians; (2) found that claimant's claim had not been prematurely closed by an August 19, 1998 Notice of Closure; (3) declined to award claimant additional temporary disability benefits; and (4) declined to increase claimant's award of scheduled permanent disability for loss of use or function of the right leg beyond the 37 percent (55.5 degrees)

awarded by an Order on Reconsideration. On review, the issues are continuance, premature closure, temporary disability, and scheduled permanent disability.

We adopt and affirm the ALJ's order.

ORDER

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

February 14, 2000 Cite as 52 Van Natta 227 (2000)

In the Matter of the Compensation of
TODD E. COLE, Claimant
WCB Case No. 99-00333
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

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

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's claim for a low back injury that allegedly occurred on October 9, 1998 when the overhead trolley system claimant was pulling on locked up.

The ALJ determined that it was more probable than not that the alleged trolley system lock-up incident had occurred and that the unrebutted opinions of claimant's attending physicians (Drs. Puziss and Saalfeld) established that claimant's alleged injury was the major contributing cause of the need for treatment of a "combined condition" consisting of the alleged injury and the preexisting low back condition.

On review, the employer contends that the questionable circumstances surrounding the alleged injury raise serious doubts about whether an incident or injury actually occurred or, if it did, whether claimant's intervening deck-building activity was responsible for claimant's low back symptoms. Moreover, the employer asserts that, even if the alleged incident at work occurred, claimant failed to prove that it was the major contributing cause of claimant's need for treatment in light of the significant preexisting low back condition. For the following reasons, we find the employer's arguments persuasive.

We first address the employer's arguments regarding the existence of the alleged incident of injury on October 9, 1998. Having reviewed the record the record *de novo*, we have serious questions as to whether the alleged incident of injury actually occurred.

First, claimant did not report the injury when it occurred, but rather waited several days. In fact, the incident was only mentioned in passing when claimant sought treatment on October 13, 1998 for a puncture related to intervening deck building activity. (Ex. 45aaa-1). Second, claimant alleged that a co-worker named "Chris" had witnessed the incident of injury, yet claimant, who has the burden of proof, never produced the alleged witness to corroborate the October 9, 1998 incident. (Ex. 46B-3). Given the testimony of the employer's witness (Sabolish), which raised doubts about whether the trolley system malfunctioned, we construe the failure to call the alleged witness against claimant. *See Rickey A. Stevens*, 49 Van Natta 1444 (1997) (failure to produce corroborating witness construed against the claimant where the employer provided countervailing testimony).

Even if the incident of injury occurred as claimant alleges, we agree with the employer that claimant failed to prove medical causation under ORS 656.005(7)(a)(B). At the outset, we note that the parties do not contest, and we find, that the above statute is applicable because the medical evidence establishes that, if the alleged injury occurred, it combined with the preexisting low back condition to cause a need for treatment. (Ex. 53-1). Thus, claimant has the burden of proving that the October 1998 injury was the major contributing cause of the need for treatment of the combined condition.

Given the existence of a significant preexisting low back condition, as well the delay in reporting the injury and in seeking medical treatment, we find that this case involves complex medical questions regarding the cause of claimant's low back condition. Thus, expert medical evidence is required. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). It is well-settled, however, that even the uncontradicted medical opinion of a physician is not binding on the trier of fact. *Randy L. Carter*, 48 Van Natta 1271, 1272 (1996); *William K. Young*, 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive). In this case, we find the medical opinons of Drs. Puziss and Saalfeld unpersuasive, even though the record does not contain contrary medical evidence on the medical causation issue.

Dr. Puziss concluded that, despite the existence of a preexisting low back condition that had caused continuing pain prior to the alleged injury of October 9, 1998, the alleged injury was the major contributing cause of the combined condition necessitating resumption of treatment. (Ex. 53). Nevertheless, we do not find this opinion well-reasoned in light of Dr. Puziss' concession that he continued essentially the same work restrictions after the October 1998 incident that were in place when he last treated claimant for the 1997 injury in August 1998. *Id.* Moreover, Dr. Puziss termed the October 1998 incident as a "temporary" aggravation of the preexisting condition. *Id.* Finally, claimant's diagnoses of chronic or recurrent lumbar strain and facet syndrome remained the same both before and after the October 1998 incident. (Exs. 34, 48, 52, 55a).

Dr. Saalfeld also described the October 9, 1998 incident as an "aggravation" of the preexisting low back condition. (Ex. 52A). Although characterizing the "aggravation" as "51% of [claimant's] problems," Dr. Saalfeld provided little or no explanation of this opinion. Under these circumstances, we do not find Dr. Saalfeld's opinion persuasive, given that he had provided nearly 70 treatments for claimant's back condition prior to the alleged October 1998 injury. Moreover, Dr. Saalfeld's conclusory opinion is not persuasive in light of the similarity of claimant's current condition to his "pre-October 9, 1998" condition.

Accordingly, on this record, we agree with the employer that claimant's current low back condition is more a continuation of claimant's preexisting low back condition, rather than a distinct new injury of which the alleged trolley system malfunctioning incident was the major cause. Therefore, we reverse.

ORDER

The ALJ's order dated September 14, 1999 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

Board Member Phillips-Polich dissenting.

The majority concludes that claimant failed to prove that he sustained a compensable injury on October 9, 1998, finding that claimant's current low back condition is merely a continuation of a preexisting condition. Because I would rely on the unrebutted medical opinions of Drs. Saalfeld and Puziss and affirm the ALJ's order, I must dissent.

The majority questions whether the alleged injury ever occurred. Having reviewed the record, I find no compelling reason to question claimant's account of the injury. Claimant's testimony that he hoped for his low back problems would go away and that he had difficulty in getting an appointment with Dr. Puziss explain why he delayed reporting the injury and seeking medical treatment. (Trs. 21, 32). The majority faults claimant for not calling his coworker to corroborate his story. However, this was not necessary given that the employer's witness (Sabolish) did not directly rebut claimant's testimony that he injured himself, but rather questioned whether the trolley system malfunctioned. The employer's witness conceded that there was a report of a malfunction that coincided with claimant's injury. (Tr. 49). In short, I find no reason to seriously question whether an incident of injury occurred.

As to medical causation, the majority is on very weak ground. The opinions of Drs. Saalfeld and Puziss were uncontradicted. Because they treated claimant before and after the October 9, 1998 incident, they were in a perfect position to assess the impact of this injury on claimant's preexisting condition. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 421 (1986). Their well-reasoned opinions (based on a complete and accurate history) clearly prove that the October 1998 injury is the major contributing cause of the need for treatment of the combined condition. The majority criticizes the Saalfeld/Puzisss opinions, but overlooks the fact there is no contrary opinion. If the employer truly believed that claimant's current low back condition was the result of the preexisting low back condition, it could have produced some medical evidence to support that position. But the employer did not. Therefore, even assuming that there are faults in the opinions of Drs. Saalfeld and Puziss (a point I do not concede), this is not a case in which the medical evidence is divided. Thus, there is no satisfactory reason not to defer to the attending physicians.

The majority's position is not supported by substantial evidence. The ALJ's well-reasoned order should be affirmed.

February 14, 2000 Cite as 52 Van Natta 229 (2000)

In the Matter of the Compensation of
MARK FOWLER, Claimant
WCB Case No. C000218
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Ray Myers (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

On January 31, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement in exchange for payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injuries. For the following reasons, we approve the proposed disposition.

The "summary page" of the agreement provides that claimant shall receive $3,125, with claimant's attorney receiving $9,375. The body of the agreement also provides for the above mentioned distribution. After reviewing the summary page and the body of the documents, we conclude, however, that the attorney fee and the amount payable to claimant have been inadvertently transposed.[1] Thus, we find that the parties' intent is for the disposition proceeds to be distributed as follows:

$3,125 Total Due Attorney
$9,375 Total Due Claimant

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

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[1] We note that a $3,125 attorney fee is consistent with OAR 438-015-0052(1).

In the Matter of the Compensation of
WILLIAM C. TONEY, Claimant
WCB Case Nos. 98-07540 & 98-07539
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of his current cervical and lumbar conditions. The employer cross-requests review of that portion of the ALJ's order that set aside its backup denial of claimant's herniated C6-7disc. In its brief, the employer contends that the ALJ abused his discretion by refusing to admit a supplemental medical report into evidence. On review, the issues are evidence, compensability of claimant's current condition, and backup denial.

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

On review, the employer contends that the ALJ abused his discretion by declining to admit a supplemental report from Dr. Schilperoort into the record. At hearing, claimant's treating doctor, Dr. Amstutz, testified regarding causation of claimant's cervical condition and his interpretation of claimant's MRI. Following the hearing on February 11, 1999, but prior to the submission of written closing argument, counsel for the employer submitted an April 30, 1999 motion to reopen the record for a report from Dr. Schilperoort that would respond to Dr. Amstutz' interpretation of claimant's films. The ALJ denied the motion.

The employer argues that, in *SAIF v. Kurcin*, 160 Or App 489 (1999), the court held that a need for continuance can be established where the request to continue the record to obtain rebuttal evidence is based on a party's surprise by a change in the expert's testimony. The employer contends that Dr. Amstutz' testimony regarding his interpretation of the films was new and different from his previous reports, and that Dr. Amstutz took advantage of the fact that another medical expert was not at the hearing who could rebut his comments.

The disputed exhibit, an April 5, 1999 report from Dr. Schilperoort, is contained in the file for purposes of review. After considering the report, we conclude that it is not necessary to decide whether the ALJ abused his discretion in declining to reopen the record. Specifically, we conclude that, even if the report is considered, we would continue to affirm the ALJ's opinion on the issue.

Dr. Schilperoort's April 5, 1999 report reiterates his disagreement with Dr. Amstutz' interpretation of claimant's films. For example, Dr. Schilperoort reported that the films discussed at hearing were representative of the films that were available at the time of the independent medical exam performed on July 20, 1998. In the report following the exam, Dr. Schilperoort expressed his disagreement with Dr. Amstutz regarding the films. (Ex. 26-6). The ALJ acknowledged the difference of opinion and discounted the examiners' opinion for several reasons. (Opinion and Order, pg. 7). Because we find that the April 5, 1999 essentially repeats Dr. Schilperoort's earlier opinion, and we agree with the ALJ that the prior opinion is not persuasive, we do not find that the report would change the outcome in this case.

Claimant's counsel is entitled to an assessed attorney fee for services on review concerning the employer's cross-request of review on the issue of backup denial. 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 on the issue of backup denial is $1,200, 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 appellate brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 12, 1999, as reconsidered August 10, 1999, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the employer.

Board Member Meyers dissenting in part.

For the following reasons, I do not agree with the majority that the employer failed to meet its burden of proof with regard to the issue of the backup denial of claimant's C6-7 herniated disc. The majority affirms the ALJ's reasoning that, based on Dr. Amstutz' opinion, claimant most likely has a C6-7 disc herniation and there is no medical evidence that the disc is unrelated to claimant's work.

I do not find that Dr. Amstutz' opinion is persuasive. Dr. Amstutz is the only doctor in the record that has diagnosed a cervical disc herniation. None of the independent medical examiners agreed with Dr. Amstutz with respect to the diagnosis of a disc herniation.

Moreover, I do not find that Dr. Amstutz' opinion establishes that claimant's condition is causally connected to his work. Drs. Schilperoort and Williams reviewed claimant's films and reported that claimant did not have a clinically significant disc bulge. Additionally, the examiners reported that claimant's symptoms were due to degenerative disc disease. Drs. Dineen and Melson have essentially agreed with that conclusion as they believe that claimant's findings were due to disc degeneration that preexisted the 1996 filing of the claim.

On the other hand, Dr. Amstutz has conceded that he could not say that the diagnosed disc injury was acute, as opposed to degenerative in origin. Additionally, Dr. Amstutz stated that claimant had the spinal film findings of a 30 year old (although claimant was 52 years old at the time of hearing) and it could not be established that his work for the employer had caused significant spinal degeneration. Therefore, Dr. Amstutz has basically concluded that, because claimant had neck symptoms while doing strenuous work, his work must have caused the disc damage. Because such an opinion is based on a temporal relationship, it is not persuasive.

Accordingly, because I find that the opinions of the independent medical examiners are accurate and well-reasoned, as opposed to the opinion of Dr. Amstutz, I would conclude that the employer has met its burden of proof in this matter. Therefore, I dissent from the portion of the majority's opinion that affirms the ALJ's order which set aside the employer's backup denial of claimant's cervical condition.

February 15, 2000 Cite as 52 Van Natta 231 (2000)

In the Matter of the Compensation of
CHRISTOPHER S. ANDERSEN, Claimant
WCB Case No. 99-02676
ORDER ON RECONSIDERATION
John M. Hoadley, Claimant Attorney
Bostwick, et al, Defense Attorneys

Claimant requests reconsideration of our January 25, 2000 Order on Review, contending that we failed to award an assessed attorney fee for his attorney's services at hearing and on review for defending against the self-insured employer's request for hearing that sought reduction of claimant's permanent disability award.

ORS 656.382(2) provides for an assessed attorney fee award if a carrier requests a hearing and it is found that the compensation awarded to claimant should not be disallowed or reduced. *See Kordon v. Mercer Industries*, 308 Or 290 (1989).

Here, the employer requested a hearing seeking reduction of the Order on Reconsideration's 5 percent unscheduled permanent disability award for claimant's mid and low back conditions. The ALJ reversed the Order on Reconsideration, reducing claimant's permanent disability award to zero. Therefore, no attorney fee was awarded under ORS 656.382(2).

Our order reversed the ALJ's order and reinstated and affirmed the Order on Reconsideration. Although our order awarded an "out-of-compensation" attorney fee, we neglected to grant an attorney fee under ORS 656.382(2) for claimant's services at hearing for defending against the employer's request for hearing from the Order on Reconsideration. Therefore, inasmuch as the employer requested a hearing and claimant's compensation was ultimately not disallowed or reduced, claimant is entitled to an attorney fee pursuant to ORS 656.382(2). However, that carrier-paid attorney fee award is limited to

claimant's attorney's services at the hearings level. *See Donald D. Davis*, 49 Van Natta 2100, 2102 (1997), *aff'd mem* 190 Or App 289 (1999); *Patricia L. McVay*, 48 Van Natta 317 (1996).

In determining a reasonable fee for claimant's attorney's services rendered at the hearing level, we consider the factors set forth in OAR 438-015-0010(4). Those factors include: (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 benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After consideration of the aforementioned factors and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the extent of disability issue (as represented by the record), the complexity of the issue, the value of the interest involved, the nature of the proceeding, and the risk that claimant's counsel might have gone uncompensated. Finally, we have not considered claimant's counsel's services rendered on Board review.

Accordingly, we withdraw our order. On reconsideration, as supplemented herein, we adhere to and republish our January 25, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

February 15, 2000 Cite as 52 Van Natta 232 (2000)

In the Matter of the Compensation of
ERNEST W. MERCER, Claimant
Own Motion No. 96-0253M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Cummins, Goodman, et al, Defense Attorneys

The insurer requested reconsideration of our December 16, 1998 Own Motion Order Reviewing Carrier Closure that set aside the insurer's June 15, 1998 Notice of Closure as premature and remanded the claim to the insurer for further processing in accordance with law. *Ernest W. Mercer*, 50 Van Natta 2354 (1998). On January 13, 1999, we withdrew our December 16, 1998 order and granted the parties the opportunity to submit their written positions and supporting documentation. In response, the insurer submitted a copy of its February 2, 1999 compensability denial of claimant's current left foot condition. Claimant filed a request for hearing with the Hearings Division. (WCB Case No. 99-02511).

Inasmuch as the compensability of claimant's current left foot condition might have affected our reconsideration of the insurer's closure, on April 29, 1999, we postponed action pending resolution of that litigation.

Here, although claimant appealed the February 2, 1999 denial, he failed to appear at the scheduled hearing. The Administrative Law Judge (ALJ) issued an Order to Show Cause, allowing claimant the opportunity to provide a written explanation as to why he failed to appear at the scheduled hearing. On September 9, 1999, after claimant failed to provide any written explanation, the ALJ issued an Order of Dismissal, dismissing the matter with prejudice. (WCB Case No. 99-02511). That order was not appealed and has become final by operation of law. Consequently, the insurer's February 2, 1999 denial of claimant's current left foot condition has also become final by operation of law.

In light of such circumstances, we proceed with our reconsideration. After reconsideration, we replace our December 16, 1998 Own Motion Order Reviewing Carrier Closure with the following order.

FINDINGS OF FACT

On March 31, 1986, claimant sustained a compensable left ankle fracture injury. His aggravation rights on that claim expired on September 29, 1992.

On June 18, 1996, we issued our Own Motion Order which authorized the payment of temporary disability compensation beginning May 29, 1996, the date claimant underwent surgery for his compensable left ankle condition. Due to complications, claimant underwent a second compensable surgery on November 15, 1996.

On June 19, 1997, Dr. Coughlin, claimant's former surgeon and attending physician, formally requested authorization to proceed with surgery to realign claimant's left hindfoot/forefoot, *i.e.*, a transverse tarsal arthrodesis and first metatarsal osteotomy. The insurer authorized the surgical procedure, which was scheduled for August 20, 1997. However, on August 8, 1997, Dr. Coughlin canceled the surgery because of an increased chance of infection due to claimant's contracting scabies.

Surgery was rescheduled for October 15, 1997. However, claimant failed to show up for surgery. Although releasing claimant from his care, Dr. Coughlin reported that further care was needed, including the recommended left foot surgery, and referred him to Dr. Waters.

Dr. Waters began treating claimant on January 2, 1998. Although concluding that claimant needed the recommended left foot surgery, Dr. Waters noted that claimant had declined surgery to pursue conservative management.

On June 2, 1998, claimant attended an insurer-arranged medical examination performed by Dr. Knoebel, orthopedist. Regarding claimant's left ankle, Dr. Knoebel concluded that: (1) claimant was medically stationary, with the ankle stabilized in a good position; and (2) no further medical treatment, including surgery, was necessary.

On June 9, 1998, Dr. Waters concurred with Dr. Knoebel's June 2, 1998 report. On June 15, 1998, the insurer issued a Notice of Closure, closing the claim and declaring claimant medically stationary as of June 2, 1998.

On September 8, 1998, the insurer submitted another own motion recommendation form, which the Board treated as a separate request to reopen claimant's claim for own motion relief. (Own Motion No. 98-0327M).[1] With its recommendation, the insurer submitted an August 25, 1998 medical report from Dr. Waters, who continued to recommend surgery for claimant's left foot condition. In its recommendation, the insurer asserted that it was not contesting the compensability of and/or responsibility for claimant's current left foot condition. It further agreed that claimant's required surgery, a mid-foot osteotomy, was reasonable and necessary. Although the insurer recommended reopening, it contended that claimant was not in the work force at the time of the current worsening.

On December 16, 1998, we issued an Own Motion Order Reviewing Carrier Closure that found claimant's claim prematurely closed based on Dr. Waters' continued recommendation of surgery for claimant's left foot condition. However, following the insurer's request for reconsideration, we withdrew our December 16, 1998 order.

On February 2, 1999, the insurer issued a denial denying compensability of claimant's current left foot condition. Claimant filed a request for hearing with the Hearings Division. (WCB Case No. 99-02511). We abated our reconsideration of our December 16, 1998 order pending resolution of this litigation.

On September 9, 1999, after claimant failed to appear at the scheduled hearing and failed to provide a reason for failing to appear, the ALJ issued an Order of Dismissal and dismissed the matter with prejudice. That order has become final by operation of law.

CONCLUSIONS OF LAW

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the June 15, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694

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[1] By a separate order issued today's date, we declined to authorize reopening claimant's left ankle injury claim for own motion relief. Own Motion No. 98-0327M.

(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, the accepted condition is a left *ankle* fracture injury. Dr. Knoebel, examining orthopedist, opined that claimant's left ankle condition was medically stationary as of June 2, 1998, the date he examined claimant. Specifically, Dr. Knoebel stated that:

> "[Claimant] has reached medical stationary status in regard to his left ankle at this time. His ankle is stabilized in a good position and it is painless. [Claimant's] ankle condition is not likely to improve with any further active medical treatment or surgical intervention, nor is his degree of impairment likely to change in the upcoming years." (*See* Dr. Knoebel's June 2, 1998 report, page 9).

Dr. Waters, claimant's current attending physician, concurred with Dr. Knoebel's June 2, 1998 report. No medical evidence contradicts these opinions that claimant's left ankle condition was medically stationary as of June 2, 1998.

We acknowledge that Dr. Waters and Dr. Coughlin, claimant's former surgeon and attending physician, opine that claimant requires surgery to treat his left *foot* condition. Specifically, claimant needs surgery to realign his left hindfoot/forefoot. However, the insurer's February 2, 1999 denial of claimant's current left *foot* condition is final by operation of law. Therefore, the left foot condition for which claimant requires surgery is not compensable. Thus, any need for surgery regarding that condition is not relevant to claimant's medically stationary status regarding his compensable left *ankle* condition.

Consequently, on this record, we find that claimant has not met his burden of proving that his compensable left ankle condition 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 June 15, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
ERNEST W. MERCER, Claimant
Own Motion No. 98-0372M
OWN MOTION ORDER ON RECONSIDERATION
Cummins, Goodman, et al, Defense Attorneys

The insurer requested reconsideration of our December 16, 1998 Own Motion Order in which we dismissed claimant's current request for reopening because we found that our order setting aside the insurer's closure rendered his request moot. *See Ernest W. Mercer*, 50 Van Natta 2354 (1998) (set aside the insurer's June 15, 1998 Notice of Closure as premature). On January 13, 1999, we withdrew our December 16, 1998 order and granted the parties the opportunity to submit their written positions and supporting documentation. In response, the insurer submitted a copy of its February 2, 1999 compensability denial of claimant's current left foot condition. Claimant requested a hearing regarding that denial. (WCB Case No. 99-02511).

Inasmuch as the compensability of claimant's current left foot condition might have affected our reconsideration of our dismissal and the current request for reopening, on April 29, 1999, we postponed action pending resolution of that litigation.

Here, although claimant appealed the February 2, 1999 denial, he failed to appear at the scheduled hearing. The Administrative Law Judge (ALJ) issued an Order to Show Cause, allowing claimant the opportunity to provide a written explanation as to why he failed to appear at the scheduled hearing. On September 9, 1999, after claimant failed to provide any written explanation, the ALJ issued an Order of Dismissal, dismissing the matter with prejudice. (WCB Case No. 99-02511). That order was not appealed and has become final by operation of law. Consequently, the insurer's February 2, 1999

denial of claimant's current left foot condition has also become final by operation of law. In light of such circumstances, we proceed with our reconsideration.

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

On September 8, 1998, the insurer submitted a request for temporary disability compensation for claimant's left ankle condition. Claimant's aggravation rights regarding that claim expired on September 29, 1992. Although the insurer initially did not contest the compensability of and responsibility for claimant's current left foot condition and recommended reopening, it noted that claimant had withdrawn from the work force.

On December 16, 1998, we issued two orders. The first order set aside the insurer's June 15, 1998 Notice of Closure as premature. *Ernest W. Mercer*, 50 Van Natta at 2356. The second order (the order at issue here) dismissed claimant's request to reopen the claim following the June 1998 closure, finding that claimant's claim remained in open status as a result of our order setting aside the insurer's June 1998 closure.

Following our December 16, 1998 orders, the insurer denied the compensability of claimant's current left foot condition. We abated our orders pending resolution of the compensability litigation. As noted above, because of claimant's failure to appear at the scheduled hearing, the ALJ dismissed the matter. Thus, the current left foot condition for which claimant requested own motion relief remains in denied status. Consequently, we are not currently authorized to reopen claimant's claim at this time as the insurer has not accepted claimant's current condition as compensable.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT WEST, Claimant
WCB Case No. 99-00951
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the insurer's denial of claimant's left knee condition claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant's left knee first dislocated at work in October 1974. Claimant's left knee again dislocated in November 1974 and February 1975. (Ex. 1). In March 1975, claimant underwent surgery for "recurrent dislocation of the left patella." (Ex. 7).

CONCLUSIONS OF LAW AND OPINION

Claimant contends that he proved that his October 1974 injury was the major contributing cause of his current left knee condition. *See* ORS 656.005(7)(a)(B). In support, claimant relies on the opinion from his treating physician, Dr. Buehler.

Dr. Buehler first concurred with a report stating that claimant's current left knee condition of "end stage osteoarthritis" was the "1974 injury and subsequent surgery in 1975." (Ex. 91-2).

In a deposition, Dr. Buehler explained that, it "would be very difficult" to determine which of the three dislocations was the major contributing cause of the current left knee condition.[1] In reference to his prior report, Dr. Buehler further stated that it was not necessarily the 1975 surgery that caused the current condition but such condition was the result of one or all of the three knee dislocations claimant sustained before the surgery. (*Id.* at 15-16). Dr. Buehler discounted any other factor in claimant's condition. (*Id.* at 20-22).

As framed by the parties, claimant's "compensable injury" is the October 1974 left knee dislocation. Dr. Buehler, however, could not state that this injury was the major contributing cause of claimant's current condition. In particular, Dr. Buehler could not apportion the major contributing cause between the three dislocations sustained before the March 1975 surgery.

Thus, we agree with the ALJ that claimant did not carry his burden of proof under ORS 656.005(7)(a)(B).[2]

ORDER

The ALJ's order dated September 14, 1999 is affirmed.

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[1] Although Dr. Buehler understood that claimant had sustained three left patella dislocations, he thought that two of those dislocations had been prior to the October 1974 work injury. The record shows that claimant sustained a dislocation at work in October 1974 and then had subsequent dislocations in November 1974 and February 1975. We find it more important that Dr. Buehler based his opinion on claimant sustaining three dislocations prior to the March 1975 surgery, and find his opinion persuasive even though he did not correctly understand the sequence of the dislocations.

[2] Because the denial is not overturned, we need not address the insurer's objection to claimant's attorney fee request.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not carry his burden of proving the compensability of her left knee condition. Thus, I dissent.

On October 16, 1974, claimant compensably injured his left knee when it gave way at work as he stepped off an edger. Claimants treating physician, Dr. Gambee, diagnosed a dislocated patella. Prior to this injury, claimant had experienced no left knee problems or sought medical treatment for his left knee. Claimant testified at hearing that there were two additional occasions after the October 1974 incident when he felt like his knee was about to give way.

On November 8, 1974, claimant saw Dr. Gambee and was diagnosed with a second acute dislocation. On February 24, 1974, Dr. Gambee reported that claimant was again subluxing his knee cap and has subluxed this thing to a point where I think he ought to have a repair. (Ex. 1-2). In March 1975, claimant underwent surgery of the knee and the claim was closed. X-rays taken at that time indicated no bony or soft tissue abnormalities, although Dr. Gambee noted presumed degenerative process operative in the patella femoral joint. (Ex. 7A).

I agree with claimant that the medical opinions from Dr. Mahoney and Dr. Buehler show that the osteoarthritis from claimant's left patellofemoral joint is compensably related to the October 1974 injury. In the April 1999 report, Dr. Buehler indicated that the major contributing cause of claimant's left knee condition was the 1974 injury. Dr. Buehler based this conclusion on Dr. Gambees surgical note showing that the current need for treatment involved the same compartment; thus, Dr. Buehler concluded that the condition was a natural progression of the 1974 injury.

During a subsequent deposition, Dr. Buehler was asked about numerous contributing factors to the need for treatment, including an intercondylar notch; the back knee; bilateral knee arthritis; weight; gout; prior surgeries; age; and prior dislocations. Dr. Buehler identified only two contributory factors: age and the prior dislocations. (Ex. 92-20, 92-11). As the medical record shows, and claimant testified, claimant had two recurrent left knee dislocations *after* the October 1974 industrial injury and before the surgery. Dr. Buehler stated that one, or all three cumulatively, were the major contributing force of claimant's patella femoral joint arthritis. (*Id.* at 16).

I disagree with the majority's analysis isolating the October 1974 incident from the other dislocations. Because the record shows that all of these dislocations resulted in the surgery (which no one disputes was part of the claim), I would consider all the dislocations as part of the originally accepted claim. Based on Dr. Buehlers opinion, I think that claimant satisfies his burden by showing that the series of dislocations, or only one of them, was the major contributing cause of his current arthritic condition.

Because the majority comes to another conclusion, I dissent.

February 16, 2000 Cite as 52 Van Natta 237 (2000)

In the Matter of the Compensation of
ROBIN B. BERDAHL, Claimant
WCB Case No. 98-04216
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimants right arm condition 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

In December 1997, claimant worked for the employer, a temporary employment agency, and, while assigned to work at Mitsubishi Silicon, experienced left arm symptoms. After last working on December 11, 1997, claimant began working on January 5, 1998, at the Oregon Public Employees Union (OPEU).

Claimant worked for three days at OPEU collating various pieces of mail and stuffing the mail into envelopes. On the first or second day of work, claimant felt increased left arm pain and the initial onset of right arm pain.

The insurer accepted a claim for left arm injury but denied the claim for the right arm. The ALJ set aside the denial, finding that the medical evidence carried claimants burden of proving that a combination of work activities at Mitsubishi and OPEU were the major contributing cause of her condition. In reaching this conclusion, the ALJ relied on the opinion of Dr. Puziss.

The insurer asserts that the ALJ's interpretation of Dr. Puziss' opinion is not accurate and that, at best, Dr. Puziss indicated only that claimant's work "could" have been the major cause of the left arm condition. Thus, according to the insurer, Dr. Puziss' opinion is not sufficient to carry claimants burden of proof. We agree with the insurer.

As noted by the ALJ, as an occupational disease claim, claimant must show that her work activities were the major contributing cause of her right arm condition. *See* ORS 656.802(2).

Dr. Puziss first reported that, although there must be some underlying condition that combines with her work activities, claimant's work activities of January 1998 constitute the major cause of her right arm condition. (Ex. 25). Dr. Puziss, however, then provided a report stating that, because the work exposure appeared to be quite trivial, he thought it equally likely that activities of daily living could have caused her problems. (Ex. 26-2).

Dr. Puziss was then deposed and, after discussing claimant's work activities at Mitsubishi and OPEU, Dr. Puziss stated that the major contributing cause of claimant's right arm condition was a combination of her work at Mitsubishi and OPEU. (Ex. 27-15).

Dr. Puziss was then asked about causation in light of the fact that she did not work for approximately three weeks between the assignments at Mitsubishi and OPEU and had onset of right arm pain after working light duty for a short period of time. (*Id.* at 41). Dr. Puziss responded that he wasn't aware that there was a whole month between the job assignments and that he would have a hard time explaining why she would develop such pains on the right during those three days of collation given that she hadn't worked for nearly three weeks before that. (*Id.* at 41-42). Dr. Puziss then stated that it would appear that the underlying tendency would be the major cause and not the work activities of January 1998. (*Id.* at 43).

When asked to consider causation under the circumstances that claimant increased her right arm use at OPEU because her left arm was hurting, Dr. Puziss stated that work could be considered the major cause. (*Id.* at 45). When asked whether work activities were the major cause to a reasonable degree of medical probability, Dr. Puziss responded that [i]t's as reasonable interpretation as any. (*Id.*)

Claimant must prove more than just the possibility of causal connection and, in particular, the medical evidence must establish with reasonable certainty that claimant's right arm condition was in major part caused by her work activities. possibility. *See Gormley v. SAIF*, 52 Or App 1055 (1981). Here, although Dr. Puziss initially supported causation during the deposition, when informed about the length of time claimant did not work between assignments, Dr. Puziss indicated that work activities were not the major contributing cause. Unlike the ALJ, we do not consider his subsequent statements as a reversal of that opinion. Rather, Dr. Puziss indicated that work activities *could* be considered the major cause and that such a theory was as reasonable as any. Because we find that such statements constitute only a possible causal connection, we agree with the insurer that Dr. Puziss' opinion is not sufficient to carry claimant's burden of proof.

ORDER

The ALJ's October 7, 1999 order is reversed in part and affirmed in part. That portion finding claimant's occupational disease claim compensable is reversed. The insurer's denial of the right arm condition is reinstated and upheld. The ALJ's attorney fee award for prevailing over the denial is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
J. PETER LOHONYAY, Claimant
WCB Case No. 98-03510
ORDER ON REVIEW
Walsh & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's right shoulder injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW

The ALJ found that claimant credibly testified regarding the onset of his symptoms as well as his belief as to their cause. The ALJ also found Dr. Butdorf's opinion persuasive, reasoning that it was based on a sufficiently accurate and complete history. In doing so, the ALJ concluded that Dr. Butdorf's opinion was not dependent on the exact date of the onset of symptoms, a complete history of claimant's activities outside of work on the date of injury, or knowledge of claimant's prior shoulder pain.

On review, the insurer contends that the ALJ incorrectly found that claimant proved he suffered a compensable injury. Specifically, the insurer contends that the ALJ incorrectly relied on Dr. Butdorf's medical opinion in that it was based on inaccurate and/or incomplete history.

A compensable injury is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability. ORS 656.005(7)(a). The burden of proving that an injury is compensable and of proving the nature and extent of any resulting disability is upon claimant. ORS 656.266.

Additionally, where compensability involves a complex medical question, we must rely on expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967). To determine if a complex medical question exists requiring expert medical opinions as to causation we consider: (1) whether the situation is complicated; (2) whether symptoms appeared immediately; (3) whether the worker promptly reported the occurrence to a supervisor; (4) whether the worker was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

In this case, the situation is complicated due to confusion over the date of the onset of symptoms and the contemporaneousness of the onset of the shoulder condition with claimant's dismissal by the employer.[1] (Ex. 1, 2, 3, 9, 10, and Tr. p. 28, 32). Further, this case involves a delayed onset of symptoms as well as a delay in reporting of the symptoms to claimant's supervisor. (Tr. p. 28, 32). Lastly, there is an issue that claimant experienced shoulder pain prior to this current shoulder condition. (Tr. pp. 20-22). As shown from this analysis, we must rely on expert medical opinions.

The expert medical opinion must evaluate the relative contribution of each cause. *Dietz v. Ramuda*, 130 Or App 397 (1994) *rev dismissed* 321 Or 416 (1995). Additionally, we rely on those expert medical opinions that are the most well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986).

Claimant has the burden to establish through expert medical evidence that his work activities were a material contributing cause of his need for treatment or disability for his right shoulder condition. For support, claimant submits Dr. Butdorf's, his treating physician's, opinion that, based upon a reasonable medical probability, the major contributing cause of claimant's right shoulder condition was his work activity. (Ex. 9-2). There are no other medical opinions either supporting, or contrary to, Dr. Butdorf's opinion.

We generally give deference to claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983); *Kima L. Langston*, 52 Van Natta 15 (2000). Here, we find persuasive reasons to do otherwise.

Dr. Butdorf's opinion is based on an inaccurate and/or incomplete history. First, while Dr. Butdorf knew claimant was employed part-time as a high school wrestling coach, the record does not show that Dr. Butdorf knew what activities that occupation entailed. Most importantly, Dr. Butdorf was not aware of claimant's activities on the night of February 13, 1998, in which he stabilized the broken leg of one of his students by "clamping down" on the leg with both hands and holding it immobile for approximately 45 minutes while waiting for the paramedics. (Tr. 10-11). While claimant testified that this incident did not put extra stress on his shoulders, the issue before us is medically complex; therefore, claimant's testimony alone is not sufficient. *Hugh J. O'Donnell*, 51 Van Natta 1394 (1999).

Next, Dr. Butdorf's opinion is based in part on his understanding that claimant was symptom-free prior to February 1998. (Ex. 9-2). However, claimant admitted that he had previously experienced minor shoulder pain. (Tr. pp. 20-21).

Lastly, Dr. Butdorf's opinion is based on an incorrect date for the onset of symptoms. Dr. Butdorf was aware that claimant's last two days on the job, February 12th and 13th, 1998, involved

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[1] Claimant's last day of work with his employer was on February 13, 1998. Dr. Butdorf's chart notes, as well as claimant's 801 form and 827 form, state that the onset of symptoms occurred on February 12, 1998. However, claimant's adamant testimony at hearing was that the onset of symptoms occurred on February 14, 1998.

installing a heavy cast iron sink. Dr. Butdorf's chart notes indicate that claimant experienced an onset of symptoms on February 12, 1998. (Ex. 10-2). Therefore, Dr. Butdorf's opinion is based on an immediate, not delayed, onset of symptoms.[2]

While these discrepancies may or may not have made a difference to Dr. Butdorf's final opinion, in order for us to give deference to the opinion, Dr. Butdorf needed to address all possible causes of claimant's shoulder condition as well as to base the opinion on a correct history of claimant's symptoms. Because this case presents a complex medical question, as such we must rely on expert medical opinions. To hold otherwise would require us to substitute our judgment for that of a medical expert. Here, for example, we would need to determine whether Dr. Butdorf would find claimant's prior shoulder pain, his after work activities on February 13th and the delayed onset of symptoms to be inconsequential in determining whether claimant's work activities were a material contributing cause of claimant's shoulder condition. We decline to substitute our judgment for that of the medical expert.

Accordingly, inasmuch as Dr. Butdorf's opinion is based on an inaccurate and incomplete history, we do not find it persuasive. Thus, we conclude that claimant failed to establish that his work activities were a material contributing cause of his need for treatment or disability for his right shoulder condition.

ORDER

The ALJ's order dated October 4, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's insurer-paid attorney fee award is also reversed.

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[2] We acknowledge the ALJ's credibility determination concerning claimant's testimony. We generally defer to such findings. *Erck v. Brown Oldsmobile,* 311 Or 519 (1991). However, where the critical issue is dependent on the persuasive weight to be accorded to the medical opinions addressing claimant's shoulder condition and its relationship to claimant's work activities, as well as the accuracy and completeness of the histories provided by those medical experts, we do not consider the ALJ's credibility finding to be determinative.

In the Matter of the Compensation of
CORINNE BIRRER, Claimant
Own Motion No. 98-0279M
OWN MOTION ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Argonaut Ins. Co., Insurance Carrier

Claimant requests reconsideration of our January 18, 2000 Own Motion Order, that affirmed the insurer's September 13, 1999 Notice of Closure in its entirety.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MELODY R. WARD, Claimant
WCB Case No. 98-09972
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) remanded the claim to the Director with instructions to obtain a clarifying report from the medical arbiter; (2) admitted Exhibit 39 in evidence; and (3) reduced claimant's scheduled permanent disability award for loss of use or function of her right leg from 18 percent (27 degrees), as awarded by an Order on Reconsideration, to 11 percent (16.5 degrees). On review, the issues are the ALJ's authority to remand to the Director, evidence and extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant, a sales associate at a convenience store, was compensably injured on October 18, 1997 when she twisted her right knee. (Exs. 2, 3). She sought emergency medical treatment the following day. (Ex. 1). On October 22, 1997, Dr. Thomas diagnosed a possible medial meniscus tear and recommended an MRI. (Ex. 5). The MRI showed that claimant's ACL was torn. (Exs. 6, 8). Dr. Thomas recommended conservative treatment. (Ex. 9-11).

On March 3, 1998, Dr. Berney became claimant's attending physician. (Ex. 17). He recommended further conservative treatment. (Ex. 18). On April 21, 1998, Dr. Berney reported that claimant's ACL injury was starting to resolve, but she had some quadriceps atrophy. (Ex. 21). He recommended strengthening exercises and released claimant to full duty. (*Id.*)

On May 21, 1998, Dr. Berney performed a closing examination. (Ex. 23). He reported that claimant was doing well and was working 32 hours a week, not using her knee brace. (*Id.*) Claimant felt she was back to baseline. (*Id.*) Dr. Berney reported that claimant's "[a]ngle of motion" was up to 160 compared to 165 of the contralateral knee and he said there was "good strength" in the knee. (*Id.*) He provided an unrestricted release for regular work. (*Id.*)

The insurer initially accepted a disabling right knee strain on June 26, 1998. (Ex. 14). A Notice of Closure issued on June 29, 1998, awarding only temporary disability benefits. (Ex. 26). Claimant requested reconsideration. (Ex. 27).

On August 17, 1998, the insurer's acceptance was modified to include a disabling right knee anterior cruciate ligament tear and right knee medial collateral ligament strain. (Ex. 28). A Notice of Closure issued on August 19, 1998, awarding only temporary disability benefits. (Ex. 29). Claimant again requested reconsideration. (Ex. 32).

On October 29, 1998, Dr. Ho performed a medical arbiter examination. (Ex. 34). He reported that claimant's knee muscle strength for flexion at the right knee was "4/5" and extension at the right knee was "4/4." (Ex. 34-1). He concluded that claimant was significantly limited in her ability to repetitively use her right knee due to a chronic and permanent condition. (*Id.*) Dr. Ho said the findings were due to the accepted condition and none of the findings were considered invalid. (Ex. 34-2).

On November 25, 1998, an Order on Reconsideration issued concerning the June 29, 1998 Notice of Closure. (Ex. 36). Based on Dr. Ho's findings, the Appellate Reviewer concluded that manual muscle testing revealed 4/5 strength on flexion and extension of the right knee. (Ex. 36-3). The award for loss of strength of the right leg was 14 percent. Claimant was also awarded 5 percent scheduled chronic condition impairment for the right leg, for a combined total of 18 percent (27 degrees) scheduled permanent disability for loss of use or function of her right leg. (Ex. 36-3).

Also on November 25, 1998, an Order on Reconsideration issued regarding the August 19, 1998 Notice of Closure. (Ex. 35). Based on Dr. Ho's findings, the Appellate Reviewer again concluded that manual muscle testing revealed 4/5 strength on flexion and extension of the right knee. (Ex. 35-3). The Order on Reconsideration did not award additional compensation, however, because claimant was not entitled to be doubly compensated for the same loss. (*Id.*) The insurer appealed.

CONCLUSIONS OF LAW AND OPINION

In lieu of a hearing on February 19, 1999, the parties submitted the matter to the ALJ based on the record and written closing arguments. The insurer sought a reduction of claimant's permanent disability award to zero. The ALJ found that the medical arbiter's report was inadequate to support an award for loss of strength and concluded that claimant had been "effectively deprived of her requested medical arbiter's examination." (Interim Order at 3). The ALJ explained:

> "The medical arbiter's exam is solely within the control of the ARU [Appellate Review Unit]. It selects the arbiter, provides the background material to be reviewed, provides the questions to be answered and decides whether or not to rely on the medical arbiter's report in issuing the Order on Reconsideration (OOR). The parties do not see the report until the OOR issues and do not have an opportunity to correct or clarify the report at any stage in the proceedings." (*Id.*)

The ALJ found that the Appellate Review Unit relied on a medical arbiter's report that was inadequate for rating purposes and, therefore, claimant had not been provided a medical arbiter's exam and the reconsideration process was incomplete. The ALJ then remanded to the Director to obtain a "clarifying report from the medical arbiter complying with OAR 436-035-0230(9)(a) and (10) by identifying the nerves and muscles involved and correcting any typographical errors." (*Id.*)

After remand, an Appellate Reviewer sent a letter to Dr. Ho with the following questions:

> "Question 1. You reported the worker had grade 4/5 in right knee flexion. Please identify the involved muscle(s) and corresponding nerves.
>
> "Question 2. You reported the worker had strength grade 4/4 in right knee extension. This appears to be a typo, and could mean 4/5 or 5/5. Please indicate the correct grade. If grade 4/5, please identify the involved muscle(s) and corresponding nerves." (Ex. 38).

On May 4, 1999, Dr. Ho responded:

> "1. Muscle strength as 4/5 in right knee flexion was a measure of relative weakness in the quadriceps femoris muscle innervated by nerve roots L2, L3, and L4.
>
> "2. You are quite correct that muscle strength in right knee extension written as 4/4 was a typographical error and should have been 4/5." (Ex. 39).

After remand to the Director, the ALJ received supplemental written arguments. The insurer continued to object to the ALJ's remand to the Director. The ALJ reasoned as follows:

> "Consequently, I come to the conclusion that when a medical arbiter's examination is requested, the reconsideration record is not complete until a medical arbiter's opinion that is valid for rating purposes is received. Under circumstances as presented in this case, when a significant ruling renders a previously authored medical arbiter's opinion invalid for rating purposes and where the medical arbiter's opinion can be corrected simply, it would be a travesty not to do so. If because of the statutory time constraints under which the Appellate Review Unit operates can not timely obtain a clarification of the arbiter's opinion, it should not, as happened here, rely upon what it believes the medical arbiter meant but instead issue the Order on Reconsideration and seek a clarifying report to be admitted at hearing. ORS 656.268(6)(f). Where that is not done, the ALJ or the Board should direct the Appellate Review Unit to do so." (O & O at 3).

The ALJ concluded that as a result of the compensable injury, claimant suffered a loss of strength in right knee extension attributable to the quadriceps femoris muscle that is innervated by the femoral nerve. The ALJ awarded claimant 6 percent for loss of strength and 5 percent for chronic condition impairment, for a total 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of the right leg.

Remand to the Director

The insurer first argues that the ALJ had no authority to remand to the Director with instructions to obtain a clarifying report from the medical arbiter. The insurer contends that neither party requested remand or an additional arbiter report and the Director had no jurisdiction to request an additional report because the Orders on Reconsideration had been appealed by the insurer. In addition, the insurer contends that Dr. Ho's May 4, 1999 report (Exhibit 39) was not admissible under ORS 656.268(6)(f). The insurer argues that the ALJ's actions violated ORS 656.268(7)(g) and ORS 656.283(7).

Claimant asserts that the Department is permitted to request clarification of medical arbiter reports and, "[l]ogically, this would include the Administrative Law Judges in the Department's Hearings Division." (Claimant's br. at 3). She relies on *Tinh Xuan Pham Auto v. Bourgo*, 143 Or App 73, 78 n.5 (1996); *Jason O. Olson*, 47 Van Natta 2192 (1995); and *Larry A. Thorpe*, 48 Van Natta 2608 (1996), to support her argument. Claimant acknowledges, however, that parties are not permitted to request clarification of medical arbiter reports.

We find that claimant's reliance on *Bourgo*, *Olson* and *Thorpe* is misplaced. None of those cases establish that the Hearings Division has the authority to remand to the Director to request "clarification" of a medical arbiter report. At most, those cases refer to an exception to the general rule that a supplemental or clarifying arbiter report is not admissible unless the "medical arbiter's report is incomplete (as represented by the arbiter or the Department)[.]" *Olson*, 47 Van Natta at 2194; *see also Tinh Xuan Pham Auto v. Bourgo*, 143 Or App at 78 n.5 ("[t]he Board has held that there are some circumstances where a supplemental or clarifying medical arbiters' report would be admissible, for example, if the initial report itself indicates that it is not complete or when the Department requests the clarification"). Even if we assume, without deciding, that Dr. Ho's first medical arbiter report was "incomplete" (a conclusion that neither the Department nor Dr. Ho reached), those cases support only the idea that Dr. Ho's supplemental report may be admissible. Those cases do not support the conclusion that the ALJ has the authority to remand to the Director for a "supplemental" or "clarifying" report.

Claimant cites ORS 656.268(6)(f)[1] and *Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993), to argue that the Hearings Division may consider a medical arbiter report even if was completed after issuance of an Order on Reconsideration. Claimant's argument misses the mark. Before we decide whether Dr. Ho's supplemental May 4, 1999 report is admissible, we must first decide whether the ALJ had the authority to remand to the Director. Thus, the question of the ALJ's authority is a threshold issue. In any event, the court's decision in *Pacheco-Gonzalez*, 123 Or App at 312, does not support claimant's argument. In *Pacheco-Gonzalez*, one of the claimant's arguments was that the Board erred by failing to remand her claim to the Department of Insurance and Finance (now the Department of Consumer and Business Services - DCBS). The court rejected the claimant's argument, finding that *former* ORS 656.283(7) did not include a provision for remanding the claim to the department. *Id.* at 316-17.

Claimant also relies on *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538 (1993), and argues that the process of remanding a claim to the Director to obtain a temporary rule is "similar" to the process used by the ALJ in this case. In *Gallino*, the court held that the Board has authority to remand a claim to the Director for promulgation of a temporary rule when a disability is not addressed by the existing standards. *Id.* at 541-42. *See also Gevers v. Roadrunner Construction*, 156 Or App 168 (1998) (ORS 656.726(3)(f)(C) requires the Board to remand the case to the Director for adoption of a temporary rule if the claimant's disability is not addressed by the standards). Those cases have no application here because there has been no finding that claimant's disability is not addressed by the standards.

In previous cases, we have rejected requests from claimants to remand claims to the Director with instructions to obtain supplemental information from the medical arbiter. *See, e.g., Randal W. Piper*, 49 Van Natta 543 (1997); *Steven K. Rule*, 47 Van Natta 83 (1995); *see also Corinne L. Birrer*, 51 Van Natta 163 (1999) (reversing the ALJ's decision to remand to the Director for another medical arbiter examination). In *Rule*, the claimant requested remand to the Director for another arbiter's examination to obtain valid measurements of his impairment. We noted that, although we had the authority to remand to the Director for the adoption of temporary rules to address permanent impairment not

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[1] ORS 656.268(6)(f) provides that "[a]ny medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding."

covered by the disability standards, the claimant did not contend that the standards did not adequately address his permanent impairment. In addition, we noted that the Department had accepted and relied on the medical arbiter's report, did not find the report incomplete, and did not direct the arbiter to perform a supplemental examination. Under such circumstances, we found no basis to remand. *Rule*, 47 Van Natta at 84.

We reach the same conclusion in this case. Furthermore, we find that the statutory scheme does *not* provide the Hearings Division or the Board with the authority to remand to the Director to obtain a "supplemental" or "clarifying" report from a medical arbiter.

ORS 656.268(4)(e) provides that if a worker objects to a notice of closure, the worker first must request reconsideration by DCBS. If the basis for objection to a notice of closure 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. ORS 656.268(7)(a). The findings of the medical arbiter or panel of medical arbiters are submitted to the department for reconsideration of the notice of closure. ORS 656.268(7)(f).

Here, claimant requested reconsideration of both Notices of Closure. (Exs. 27, 32). Claimant requested a medical arbiter examination. (*Id.*) ORS 656.268(6)(b) provides:

> "If necessary, the *department* 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."[2] (Emphasis supplied).

See also ORS 656.268(7)(a) ("if the *director* determines that sufficient medical information is not available to estimate disability, the director shall refer the claim to a medical arbiter")[3] (emphasis supplied). Similarly, OAR 436-030-0145(3)(b) (WCD Admin. Order 97-065) provides:

> "Upon review of the record the *department* may request, in accordance with ORS 656.268(6)(b), any additional information deemed necessary for the reconsideration and set appropriate time frames for response." (Emphasis supplied).

In the present case, despite Dr. Ho's ambiguous reference to claimant's knee muscle strength for extension as "4/4" in the October 29, 1998 report, the Director did not request any additional information that it deemed necessary for reconsideration. ORS 656.268(6)(b) and OAR 436-030-0145(3)(b) clearly provide that the "department" has the authority to request additional medical or other information. Furthermore, OAR 436-030-0155(4) provides that "[r]esponses of the parties to the medical arbiter report shall be included in the record if received prior to completion of the reconsideration proceeding." Here, Dr. Ho's first report was dated October 29, 1998 and the record indicates that a copy of that report was sent to claimant's attorney on November 9, 1998. (Ex. 34-2). The Orders on Reconsideration were issued on November 25, 1998. (Exs. 35, 36). Thus, it appears that claimant had an opportunity to respond to Dr. Ho's October 29, 1998 report, but she did not do so.

We find no statutory authority for the ALJ to remand to the Director to request a "supplemental" or "clarifying" report from Dr. Ho.[4] *See Randal W. Piper*, 49 Van Natta at 543; *Steven K. Rule*, 47 Van Natta at 83. We agree with the insurer that the ALJ should have evaluated claimant's disability based

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[2] Under ORS 656.005(9), "department" means the Department of Consumer and Business Services (DCBS).

[3] Under ORS 656.005(11), "director" means the Director of DCBS.

[4] We note that this case is distinguishable from *Dennis R. Loucks*, 50 Van Natta 1779 (1998). In *Loucks*, the Department concluded that the claimant's request for reconsideration was untimely and, therefore, it did not schedule a medical arbiter examination. The ALJ subsequently determined that the request for reconsideration was timely. We reasoned that the claimant was statutorily entitled to a medical arbiter report and we fashioned a remedy to accomodate that right. We remanded the case to the ALJ for deferral of issues concerning the closure notice pending receipt of a medical arbiter's report, and we noted that the parties were responsible for contacting the Director to make arrangements for the appointment of a medical arbiter. Here, unlike in *Loucks*, claimant has already received a medical arbiter report.

on the reconsideration record. Our conclusion is consistent with ORS 656.268(7)(g), which provides: "[a]fter reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the department, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure." Likewise, ORS 656.283(7) provides, in part: "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing[.]" In light of our conclusion, we need not address whether Exhibit 39, Dr. Ho's May 4, 1999 report, is admissible. We proceed to address the extent of claimant's scheduled disability based on the reconsideration record, Exhibits 1 through 37.

Extent of Scheduled Permanent Disability

Loss of Strength

There are two Notices of Closure, dated June 29, 1998 and August 19, 1998. (Exs. 26, 29). Therefore, we apply the rules for rating permanent disability contained in WCD Admin. Order 96-072 and 98-055. *See* OAR 436-035-0003(2), (3). To determine impairment due to loss of strength, the physician reports the worker's strength using a 0 to 5 grading system, which is converted into a percentage value pursuant to OAR 436-035-0007(19)(a) (WCD Admin. Order 98-055).[5] Loss of strength in the leg or foot due to peripheral nerve injury is determined according to the specific peripheral nerve supplying (innervating) the weakened muscle(s). OAR 436-035-0230(9).

Under OAR 436-035-0007(14) (WCD Admin. Order 98-055), 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." 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).

After reviewing the record, we conclude that the medical reports from claimant's treating physician, Dr. Berney, are not sufficient to establish that claimant is entitled to a permanent disability award for loss of strength. Dr. Berney performed a closing examination on May 21, 1998. (Ex. 23). He reported that claimant was working 32 hours a week and was not using her knee brace. (*Id.*) Claimant felt she was "back to baseline." (*Id.*) Dr. Berney explained that claimant had "good strength in the knee." (*Id.*) He released claimant to full duty and provided an unrestricted release for her regular job. (*Id.*) Dr. Berney's statement that claimant had "good strength in the knee" is not sufficient to establish that she had any impairment.

Similarly, we find that Dr. Ho's report is not sufficient to establish that claimant is entitled to a permanent disability award for loss of strength. On October 29, 1998, Dr. Ho reported that the flexion at claimant's right knee was "4/5" and extension at her right knee was "4/4." (Ex. 34-1). Dr. Ho's reference to extension as "4/4" is ambiguous and he did not report claimant's loss of strength under the appropriate grading system as required by OAR 436-035-0007(19). *See Terrance L. Moore*, 49 Van Natta 1787 (1997) (physician did not measure the loss of strength in terms of the 0 to 5 grading system). Therefore, we conclude that claimant is not entitled to an award for loss of extension strength.

Although Dr. Ho reported that flexion at claimant's right knee was "4/5," he did not explain whether the loss of flexion was due to loss of muscle, nerve damage, disruption of the musculotendinous unit, range of motion loss, or some other reason. The "Medical Arbiter Questions" from the Appellate Review Unit regarding claimant's case provided, in part:

> "Described any MUSCLE STRENGTH loss, due to the accepted condition(s), graded on a scale of 0-5/5 (see table). Identify the specific body part and include a comment on whether the loss of strength is due to loss of muscle, nerve damage, disruption of the musculotendinous unit, range of motion loss, or other. If other, explain the etiology in detail." (Ex. 33-2; underline in original).

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[5] This rule was previously numbered OAR 436-035-0007(18)(a) in WCD Admin. Order 96-072.

Dr. Ho did not explain the etiology of claimant's loss of flexion strength. Our findings must be based on medical evidence in the record. *See SAIF v. Calder*, 157 Or App 224 (1998) (Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge; rather, the findings must be based on medical evidence). Because there are no other medical reports indicating that claimant has a loss of strength in right knee flexion, we conclude that the record is inadequate to support an award for loss of strength in right knee flexion. In sum, we conclude that claimant is not entitled to a scheduled permanent disability for loss of strength in right knee extension or flexion.

Chronic Condition

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:
>
> "(a) Lower leg (below knee/foot/ankle);
>
> "(b) Upper leg (knee and above) * * *."

The reports from Dr. Berney, claimant's treating physician, do not support the conclusion that claimant is entitled to an impairment value for a chronic condition. He began treating claimant on March 3, 1998 and released claimant to modified work on April 7, 1998. (Exs. 16, 17, 20). On April 21, 1998, Dr. Berney reported that claimant's ACL injury was "starting to resolve with some quadriceps atrophy." (Ex. 21). He recommended strengthening exercises. (*Id.*) On May 5, 1998, Dr. Berney reported that claimant was working four 8-hour days without problems. (Ex. 22). He released claimant to full duty. (*Id.*) Dr. Berney performed a closing examination on May 21, 1998. (Ex. 23). He reported that claimant was working 32 hours a week and was not using her knee brace. (*Id.*) Claimant felt she was "back to baseline." (*Id.*) Dr. Berney explained, in part:

> "She has much better range of motion of the right knee than she had even two weeks ago. Angle of motion is up to 160 compared to 165 of the contralateral knee. There is good strength in the knee. Evaluation of leg girth at mid thigh 16-1/2 inches on the left, 16-1/4 on the right. Mid calf 13-1/4 on the left, 13 inches on the right." (*Id.*)

Dr. Berney released claimant to full duty and provided an unrestricted release for her regular job. (*Id.*) We conclude that Dr. Berney's reports do not establish that claimant is significantly limited in the repetitive use of her right leg.

Dr. Ho performed a medical arbiter examination on October 29, 1998. Ex. 34). He concluded that claimant was significantly limited in her ability to repetitively use her right knee due to a chronic and permanent condition arising from her right knee strain. (*Id.*) Dr. Ho explained:

> "This limitation is manifested by the fact that after standing for 4 or more hours she experiences significant discomfort at the right knee; walking up or down 10 or more stairs is uncomfortable; exposure to coolness or dampness increases discomfort; whereas she could bike for 5 miles consecutively in the past she is now limited to 3 miles." (*Id.*)

Dr. Ho said that claimant's findings were due to the accepted condition and none of her findings were invalid. (Ex. 34-2).

In reviewing the medical evidence concerning claimant's right knee impairment, we note that Dr. Berney's closing examination was performed on May 21, 1998, six months before the November 25, 1998 Orders on Reconsideration. In contrast, Dr. Ho's findings regarding claimant's limitations were rendered shortly before the Orders on Reconsideration issued. The fact that the arbiter examination is performed closer in time to the reconsideration order is not always decisive. *See, e.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). In this case, however, given the six month gap between Dr. Berney's closing examination (which provided an unrestricted work release) and Dr. Ho's arbiter examination, we consider Dr. Ho's findings to be more reflective of claimant's permanent impairment at the time of the November 25, 1998 Orders on Reconsideration. Consequently, on this record, we are persuaded by a

preponderance of the evidence that claimant is significantly restricted in the repetitive use of her right knee due to a chronic and permanent medical condition arising out of her compensable injury. We agree with the ALJ that claimant is entitled to an impairment value of 5 percent scheduled permanent disability for the loss of use and function of the right knee.

ORDER

The ALJ's order dated June 18, 1999 is modified. In lieu of the ALJ's award and in lieu of the Order on Reconsideration's scheduled permanent disability award of 18 percent (27 degrees), claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of her right leg.

Board Chair Bock concurring.

I agree with the analysis and conclusions of the majority opinion. I write separately to respond to some of the concerns expressed by the dissent.

To begin, I want to emphasize that the Workers' Compensation Board, as an administrative agency, is a creature of statute and does not have the powers of a court of equity. Rather, administrative agencies are limited to the authority conferred on them by statute. *See Oregon Occupational Safety v. Don Whitaker Logging*, 123 Or App 498 (1993), *rev den* 318 Or 326 (1994). Furthermore, the Board is constrained by the court's interpretations of the statutes. The dissent apparently assumes that, because claimant may have a loss of strength, she is automatically entitled to an award of permanent disability. In this case, I agree with the majority that we do not have statutory authority to remand to the Director for a supplemental report from the medical arbiter. The dissent's assertions that we must fashion a remedy for this claimant are inconsistent with the statutes and court cases.

In addition, I do not agree with the dissent's assertion that Dr. Ho's October 29, 1998 report was "incomplete." In *Jason O. Olson*, 47 Van Natta 2192 (1995), we said that "unless a medical arbiter's report is incomplete (as represented by the arbiter or the Department), a medical arbiter's 'supplemental' or 'clarifying' report is not admissible under *former* ORS 656.268(7)." In this case, neither Dr. Ho nor the Department found that the October 29, 1998 report was "incomplete."

The dissent asserts that claimant's disability was not adequately addressed by the standards and, therefore, we should remand for adoption of a temporary rule. The essential problem with the dissent's argument is that Dr. Ho's October 29, 1998 report is not sufficient to establish that claimant is entitled to a permanent disability award for loss of strength. Consequently, there is no persuasive evidence that claimant has a "disability" related to loss of strength. Under ORS 656.726(3)(f)(C), there must first be a finding that the worker has a disability not addressed by the standards before the "temporary rule" provisions apply. Because Dr. Ho's report is not sufficient to establish that claimant has a disability related to loss of strength, it is not necessary to determine whether that disability was adequately addressed by the standards. The "temporary rule" cases are inapposite.

Finally, I strongly disagree with the dissent's assertion that Dr. Ho's finding that claimant's right knee extension was "4/4" is a "scrivener's error." According to the dissent, there is no doubt that Dr. Ho intended to write "4/5" instead. To the contrary, it is entirely possible that Dr. Ho intended to write "5/5." At most, we can reach a conclusion that Dr. Ho's finding of "4/4" strength is ambiguous. This is not a situation in which any ambiguity should be construed against the carrier.

Moreover, the dissent's reliance on *Georgia E. Wilson*, 47 Van Natta 387, *on recon* 47 Van Natta 627 (1995), is misplaced. In finding a scrivener's error in *Wilson*, we relied on the claimant's history showing that her symptoms were limited to her left elbow, the arbiter panel's own reference to symptoms only in the left elbow and the claimant's testimony that, during the arbiter exam, her right arm flexed better than her left arm. Unlike *Wilson*, there is nothing in the record of this case to support the dissent's conclusion that Dr. Ho intended to write "4/5" instead of "4/4." In *SAIF v. Calder*, 157 Or App 224 (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. Instead, our findings must be based on medical evidence in the record and the reasonable inferences that could be drawn from the medical evidence. *Id.* In this case, the inference drawn by the dissent regarding a scrivener's error in Dr. Ho's report is unreasonable.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with the majority that claimant is entitled to a 5 percent "chronic condition" scheduled permanent disability award. I disagree, however, with the majority's conclusion that we have no authority to remand for a clarification report from the medical arbiter. For the following reasons, I respectfully dissent.

OAR 436-035-0007(1) (WCD Admin. Order 98-055) provides that a worker is entitled to a value for those findings of impairment that are permanent and were caused by the accepted compensable condition. OAR 436-035-0007(2)(d) provides that workers with an irreversible finding of impairment due to the compensable condition "shall receive the full value awarded in this rules for the irreversible finding." Here, claimant has an irreversible finding of loss of strength due to her accepted condition and she is entitled to a permanent disability award for loss of strength in her right knee. The majority errs when it reduces claimant's scheduled permanent disability award.

In *Dennis R. Loucks*, 50 Van Natta 1779 (1998), the Department concluded that the claimant's request for reconsideration was untimely and, therefore, it did not schedule a medical arbiter examination. The ALJ subsequently determined that the request for reconsideration was timely. On review, we reasoned that the claimant was statutorily entitled to a medical arbiter report because he timely disagreed with the impairment findings used to rate his disability. *See* ORS 656.268(7)(a). Therefore, we fashioned a remedy to accomodate the claimant's right to a medical arbiter report. We remanded the case to the ALJ for deferral of issues concerning the closure notice pending receipt of a medical arbiter's report, and we noted that the parties were responsible for contacting the Director to make arrangements for the appointment of a medical arbiter.

Here, I agree with the ALJ's conclusion that, although claimant has received a medical arbiter report, that report was not valid for rating purposes. I agree with the ALJ that when a medical arbiter's examination is requested, the reconsideration is not complete until a medical arbiter's opinion, which is valid for rating purposes, is received. Although in this case the ALJ remanded to the Director to obtain a clarification report from the medical arbiter, I would instead fashion a remedy similar to the *Loucks* case. I would conclude that the "best remedy" is to remand to the ALJ for deferral of issues concerning permanent disability, pending receipt of a clarification of the medical arbiter's report. The parties would be responsible for contacting the Director to obtain a clarification report from the medical arbiter. Once the parties have obtained that report, they would proceed to hearing.

At hearing, the "clarification" report would be admissible in light of the exception discussed in *Tinh Xuan Pham Auto v. Bourgo*, 143 Or App 73 (1996). In that case, after quoting the Board's order, the court noted:

> "The Board has held that there are some circumstances where a supplemental or clarifying medical arbiters' report would be admissible, for example, *if the initial report itself indicates that it is not complete* or when the Department requests the clarification. *See Jason O. Olson*, 47 Van Natta 2192 (1995). That question is not before us because here the report does not indicate that it was incomplete, and the request for clarification was made by the employer." 143 Or App at 78 n.5. (Emphasis supplied).

Here, it is clear that the medical arbiter report from Dr. Ho was expressly incomplete and was not valid for rating purposes. Thus, the "clarification" report would be admissible at hearing.

Alternatively, I would conclude that ORS 656.726(3)(f)(C) applies to this case and we should remand to the Director for adoption of a temporary rule under which to address claimant's disability. ORS 656.726(3)(f)(C) provides that when "it is found that the worker's disability is not addressed by the standards," the Director must stay the proceeding and "adopt temporary rules amending the standards to accommodate the worker's impairment." The Board may remand a claim to the Director for promulgation of a temporary rule when a disability is not addressed by the existing standards, even if the claimant has not requested such relief. *Gevers v. Roadrunner Construction*, 156 Or App 168 (1998); *Gallino v. Pontiac-Buick-GMC*, 124 Or App 538, 541-42 (1993).

Because Dr. Ho's medical arbiter report is incomplete, I would find that claimant's disability is not adequately addressed by the standards and, therefore, we should remand to the Director for adoption of a temporary rule. *See, e.g., Peter Gevers*, 51 Van Natta 32 (1999) (remanding for a temporary rule because we could not rate the claimant's "perijoint fibrosis" under the current standards).

In any event, even if Dr. Ho's "clarification" report is not admissible, I would find that claimant is entitled to a permanent disability award for loss of strength. It is quite apparent that Dr. Ho's finding that extension at claimant's right knee was "4/4" is a scrivener's error. (Ex. 34-1).

In *Georgia E. Wilson*, 47 Van Natta 387, *on recon* 47 Van Natta 627 (1995), the claimant had an accepted claim for tennis elbow in her left arm. The medical arbiter panel reported that the claimant's elbows "flexed to 145 degrees on the right and 150 degrees on the left." We found that the medical arbiter panel's reference to "right" arm constituted a scrivener's error and we corrected the Order on Reconsideration to award the claimant 2 percent scheduled permanent disability for her left arm rather than her right arm. In reaching this decision, we relied on the claimant's medical history showing that her symptoms were limited to her left elbow, the arbiter panel's own reference to symptoms only in the left elbow and the claimant's testimony that, during the arbiter's examination, her right arm flexed better than her left arm. *See also Rosario Felix*, 45 Van Natta 1179 (1993) (awards for the forearm, rather than the arm, constituted a scrivener's error that was corrected by the Board on review).

I would reach a similar conclusion in this case. In determining impairment due to loss of strength, the physician reports the worker's strength using a 0 to 5 grading system, which is converted into a percentage value pursuant to OAR 436-035-0007(19)(a) (WCD Admin. Order 98-055). Here, Dr. Ho reported claimant's muscle strength concerning flexion at the right knee was "4/5" and extension at the right knee as "4/4." (Ex. 34-1). The Appellate Reviewer examined Dr. Ho's report and determined that claimant had 4/5 strength on flexion and 4/5 strength extension of the right knee. (Ex. 36-3). It is clear that Dr. Ho's reference to "4/4" is a scrivener's error, which should have been written as "4/5." Dr. Ho's error was properly corrected by the Appellate Unit on reconsideration.

Furthermore, the Appellate Unit properly determined that claimant's 4/5 strength on knee flexion constituted a 20 percent loss in the sciatic nerve distribution and her 4/5 strength on knee extension constituted a 20 percent loss in the femoral nerve distribution, which translated into a combined total of 14 percent for loss of strength in the right leg. (Ex. 36-3). I would affirm the Order on Reconsideration, which awarded a total of 18 percent scheduled permanent disability for loss of use or function of the right leg.

In the Matter of the Compensation of
KENNETH P. BUNDY, Claimant
WCB Case No. 95-07510
ORDER ON REMAND
Strooband & Ousey, Claimant Attorneys
Craig A. Staples, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999), *rev den* 329 Or 503 (1999). The court has reversed our prior order, *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), that had awarded claimant additional temporary disability based on his attending physician's "retroactive" authorization. Reasoning that the statutory limitation under *former* ORS 656.262(4)(f) (now subsection (g)) that limits an attending physician's "retroactive" time loss authorization to 14 days applied only to claimant's "procedural/pre-closure" entitlement to temporary disability, we had found that the requirement was inapplicable to claimant's "substantive/post-closure" entitlement to such benefits. Determining that the statutory limitation was applicable regardless of whether the claim was open or pending closure, the court held that claimant's attending physician was without authority to authorize temporary disability benefits retroactively for more than 14 days. Concluding that we erred in ruling that claimant was entitled to substantive temporary disability from May 11, 1993 through April 24, 1995, the court has remanded for reconsideration.

Here, the record contains no contemporaneous temporary disability authorization from an attending physician for the time period from May 11, 1993 through April 24, 1995. The only reference to claimant's work status during this period is contained in a May 24, 1995 report from Dr. Wenner, claimant's treating orthopedic surgeon, who stated that claimant was unable to perform his regular work from November 29, 1992 through April 1995 because of his compensable carpal tunnel syndrome. Because *former* ORS 656.262(4)(f) limited a retroactive award of temporary disability to 14 days, it follows that Dr. Wenner's May 24, 1995 report is insufficient to authorize temporary disability during the

disputed period. Therefore, claimant has not established entitlement to temporary disability benefits between May 11, 1993 through April 24, 1995. In light of such circumstances, the employer's failure to pay such benefits was not unreasonable.

Accordingly, on reconsideration, the ALJ's "substantive" award of temporary disability from May 11, 1993 through April 24, 1995 is reversed. The award of temporary disability in the August 16, 1995 Notice of Closure (as affirmed by the November 17, 1995 Order on Reconsideration) is affirmed. Inasmuch as claimant's compensation has not been increased, the ALJ's "out-of-compensation" attorney fee award is also reversed.[1] Finally, the ALJ's penalty assessment is reversed.

IT IS SO ORDERED.

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[1] Because claimant's award of temporary disability has ultimately been reduced as a result of the employer's cross-request for review, we rescind the $1,500 attorney fee awarded in our prior order pursuant to ORS 656.382(2).

In the Matter of the Compensation of
RICHARD P. CALLAHAN, Claimant
Own Motion No. 99-0429M
OWN MOTION ORDER ON RECONSIDERATION

Claimant requests reconsideration of our December 30, 1999 Own Motion Order in which we declined to authorize the reopening of claimant's claim to provide temporary total disability compensation because claimant had not provided proof that he was in the work force at the time of disability. Specifically, on reconsideration, claimant contends that he was in the work force at the time of disability, but it is futile for him to seek work due to his compensable condition.

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

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).

Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question. *See Ben L. Davis*, 47 Van Natta 2001 (1995); *Earl J. Prettyman*, 46 Van Natta 1137 (1994).

On reconsideration, claimant contends that he has been unable to work and/or seek work due to his compensable condition. Thus, claimant contends that he remained in the work force under the third *Dawkins* criteria. 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.

In response to our Own Motion Order of Abatement, the insurer submits a copy of a 1987 "Stipulation, Disputed Claim Settlement and Order of Dismissal," wherein claimant agreed that he had

"retired from the labor market." The insurer contends that the Stipulation supports its position that claimant has retired and, therefore, is not in the work force at the time of the current disability. We have previously found that a prior finding that a claimant has retired does not irrevocably commit the claimant to retirement for purposes of workers' compensation benefits. In other words, a claimant may retire and subsequently reenter the work force. However, in order to prove that he is in the work force under the third *Dawkins* factor, claimant must show that he is presently willing to seek work and that it is presently futile to seek work due to the work injury.

Here, in the absence of evidence establishing that claimant reentered the work force between the date of the 1987 Stipulation and his current disability, we are not persuaded that he is entitled to temporary disability benefits. *See Dean L. Watkins*, 45 Van Natta 1599 (1993); *see also Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990).

In addition, as late as November 9, 1999, claimant reported that he was retired. In this regard, claimant underwent an insurer-arranged medical examination (IME) on that date and reported that he has not worked since the date of the injury in 1983. Claimant also reported that he is retired and receiving Social Security benefits.

Furthermore, 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. Accordingly, claimant has not established that he was a member of the work force at the time of the current disability. Therefore, we deny his request for temporary disability compensation.

Finally, in his request for reconsideration, claimant states that "[i]t is my understanding that my claim could never be closed." Claimant is mistaken. By law, once a claimant's condition has become medically stationary, the carrier is required to close the claim. ORS 656.278 (1)(a); OAR 438-012-0055.

On the other hand, perhaps claimant has confused claim closure with entitlement to medical services. Pursuant to ORS 656.245, claimant is entitled to lifetime medical services regarding his compensable 1983 work injury. The current own motion order does not affect claimant's entitlement to medical services under ORS 656.245. This order only deals with claimant's entitlement to temporary disability compensation.

Claimant's statement that his claim "could never be closed," might also be interpreted as a request for additional permanent disability benefits. By law, we are unable to grant that request. Claimant's 1983 claim was first closed on July 31, 1986. Therefore, his aggravation rights expired five years later, on July 31, 1991. ORS 656.273(4)(a). Because claimant's aggravation rights have expired, his claim is in own motion status. That means that, although he is entitled to lifetime medical benefits related to his compensable injury, his only entitlement to future monetary compensation is restricted to time loss benefits under the limited circumstances discussed above, that is, when his condition requires surgery or hospitalization and he is in the work force at the time of the current worsening. ORS 656.278(1)(a). Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990). Thus, we cannot award claimant more permanent disability in this claim.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.[1]

IT IS SO ORDERED.

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[1] It appears from claimant's request for reconsideration that he may not understand his rights and benefits under the Workers' Compensation Law. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot give legal advice to either party. However, since claimant does not have an attorney, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street NE
Salem, OR 97310
Telephone: 1-800-927-1271

In the Matter of the Compensation of
CAROLYN M. CRAIG, Claimant
Own Motion No. 00-0058M
INTERIM OWN MOTION ORDER CONSENTING TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Glen J. Lasken, Claimant Attorney
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 1993 injury claim with the SAIF Corporation expired on April 22, 1998. 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 1993 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
PAUL D. JOHANSEN, Claimant
WCB Case No. 96-05209
ORDER ON REMAND
Carney, et al, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579 (1999), *rev den* 329 Or 528 (1999). The court has reversed our prior order, *Paul D. Johansen*, 49 Van Natta 2013 (1997), that declined to award temporary disability when the SAIF Corporation accepted claimant's "new medical condition" claim for a herniated disc condition more than one year after his accepted nondisabling back strain injury. Concluding that the limitations of ORS 656.277 and ORS 656.273 were not applicable to claimant's "new medical condition" claim, the court has remanded for an award of benefits for temporary disability.

Consistent with the court's opinion, we find that claimant is entitled to temporary total disability benefits arising from his "new medical condition" claim. Consequently, the ALJ's temporary disability award is affirmed.

Claimant is entitled to an attorney fee for his counsel's services before every prior forum because he has finally prevailed before the Board after remand from the court. *See* ORS 656.388(1). As a result of his hearing request, claimant was awarded temporary disability benefits. Pursuant to *former* OAR 438-015-0045 and claimant's executed retainer agreement, claimant's counsel was awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation, not to exceed $1,050. SAIF requested Board review, which initially resulted in the elimination of claimant's compensation and attorney fee awards. Thereafter, claimant petitioned for judicial review of our order, and the court reversed our decision and remanded for reconsideration. On remand, we have reinstated claimant's temporary disability award and affirmed the ALJ's order.

Consequently, claimant's counsel is entitled to an approved attorney fee under ORS 656.386(2) for services at hearing and before the court equal to 25 percent of the increased compensation created by the Board's order, not to exceed $1,050,[1] payable directly to claimant's counsel.[2]

Finally, ORS 656.382(2) does apply for claimant's counsel's services before the Board in defense of the ALJ's order. On reconsideration, we have not disallowed or reduced claimant's compensation as awarded by the ALJ's order. Consequently, because SAIF requested Board review of the ALJ's order, claimant's counsel is entitled to an assessed attorney fee under ORS 656.382(2) for services before the Board.

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

Accordingly, as modified and supplemented herein, the ALJ's order dated September 23, 1996 is affirmed.

IT IS SO ORDERED.

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[1] We note that the retainer agreement between claimant and his attorney limits "out-of-compensation" attorney fees from temporary disability compensation to $1,050.

[2] Claimant's attorney fee award for the court level is an "out-of-compensation" attorney fee under ORS 656.386(2). In reaching this conclusion, we note that neither carrier-paid attorney fee statute (ORS 656.386(1) nor ORS 656.382(2)) are applicable because this case does not involve a "denied claim" under ORS 656.386(1) and review by the court was not requested by the carrier (which is a condition precedent for application of ORS 656.382(2)).

In the Matter of the Compensation of
HERBERT K. SHINN, Claimant
Own Motion No. 66-0117M
OWN MOTION ORDER
Willard E. Fox, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request to reopen his August 5, 1955 industrial injury claim for temporary disability benefits and medical benefits related to an acute fracture/dislocation of the right hip arthroplasty. SAIF recommends against reopening the claim for the requested benefits, contending that the worsening is not compensable. Claimant responds that the current worsening is compensable. Based on the following reasoning, we agree with claimant.

FINDINGS OF FACT

On August 5, 1955, claimant sustained a compensable injury to his left tibia, fibula, and humerus and his right pelvis. The left leg injury eventually resulted in an "above-the-knee" amputation. In addition, claimant underwent a compensable right total hip arthroplasty. Claimant's aggravation rights on the 1955 injury claim expired on October 10, 1961.

Dr. McCullough, claimant's attending physician, first treated claimant in September 1979, and performed his right total hip arthroplasty in June 1983.

On October 9, 1990 and February 5, 1991, we reopened claimant's claim for payment of prosthetic repairs and injury-related medical services. On January 10, 1992, we authorized payment for a new prosthesis. On October 1, 1992, we again reopened the claim for payment of prosthetic services for a modified socket.

On June 9, 1993 and July 8, 1993, we issued orders denying payment for medical services related to claimant's right hip dislocation which occurred during a January 1993 snow skiing accident. Finding that claimant's compensable 1955 work injury was not the major contributing cause of his 1993 right hip dislocation, we denied authorization for payment of medical services. *Herbert K. Shinn*, 45 Van Natta 1446 (1993). Claimant did not request reconsideration or appeal this decision, which became final by operation of law.

Subsequently, we reopened claimant's claim for medical services related to a February 13, 1997 right hip dislocation. In doing so, we relied on the medical opinion provided by Dr. McCullough to find that claimant's February 1997 right hip dislocation was caused in major part by the compensable 1955 work injury. *Herbert K. Shinn*, 50 Van Natta 243 (1998).

On June 14, 1999, we reopened claimant's claim to provide medical services in the form of the purchase and maintenance of a new prosthetic leg.

On July 31, 1999, claimant was water skiing in calm, smooth water when his right hip replacement "fell apart," causing him to fall. (Claimant's affidavit dated November 3, 1999). Nothing of a traumatic nature occurred immediately before the hip replacement broke. (*Id.*). Claimant's right hip did not dislocate or "fall apart" as a result of a fall into the water. (*Id.*). Claimant began to have pain in his right hip several months prior to the water-skiing episode. (*Id.*).

On August 3, 1999, claimant underwent surgery performed by Dr. McCullough. The surgery consisted of a revision of the failed acetabular component of the right total hip replacement with an allograft. (August 3, 1999 operative report). As a result of the failed right total hip prosthesis, claimant remained in the hospital from July 31, 1999 until August 8, 1999. (August 8, 1999 discharge summary).

On August 9, 1999, Dr. McCullough rendered a causation opinion. On September 3, 1999, based on Dr. McCullough's opinion, SAIF submitted a Carrier's Own Motion Recommendation form, recommending against reopening claimant's claim for own motion relief.

On November 4, 1999, Dr. McCullough rendered a second causation opinion.

CONCLUSIONS OF LAW AND OPINION

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). In addition, where there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization, 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. ORS 656.278(1)(a).

The issue of the contribution of claimant's compensable injury to his current right hip dislocation condition is a complex medical question, the resolution of which requires medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985), *rev den* 300 Or 546 (1986).

SAIF agrees that: (1) claimant's current right hip condition required surgery and that surgery was reasonable and necessary; (2) the current condition is causally related to the accepted condition; and (3) claimant is in the work force. SAIF contends, however, that it is not responsible for claimant's current right hip condition. Specifically, SAIF argues that the worsening occurred as a result of the July 31, 1999 water-skiing incident and, pursuant to ORS 656.273(1),[1] if the major contributing cause of the worsening of a compensable condition occurs outside of the course and scope of employment, the worsening is not compensable.

ORS 656.273 deals with aggravation claims, *i.e.*, claims for worsened conditions resulting from the original injury for which aggravation rights have not yet expired. Here, claimant's aggravation rights have expired on his original injury claim. Therefore, his claim is within our own motion jurisdiction under ORS 656.278.[2] *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988) (Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights). Although ORS 656.278 provides for limitations in other aspects, *e.g.*, limited benefits are available to claimants whose claims are in own motion status, ORS 656.278 does not explicitly provide for the limitation that SAIF relies on under ORS 656.273.

Nonetheless, on this record, we need not determine whether the compensable 1955 injury is a material contributing cause or the major contributing cause of his July 1999 fracture/dislocation of the right hip arthroplasty because we find that Dr. McCullough's unrebutted opinion satisfies claimant's burden of proof under either standard.

Dr. McCullough performed claimant's total right hip arthroplasty in 1983 and performed the August 1999 revision to that hip arthroplasty. On August 9, 1999, Dr. McCullough stated that the July

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[1] ORS 656.273(1) provides in relevant part:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

[2] ORS 656.278(1) 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; or

"(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

31, 1999 dislocation of the acetabular component "was probably acute, although there was new pain evidently experienced for several months prior to that episode." He also stated that the dislocation of the acetabular component "resulted at least acutely from the water skiing episode. It was not possible to identify specifically whether that component was loose prior to this injury." However, he also noted that he did not "have specific information was [sic] to whether or not [claimant] fell as a result of the dislocation, or the dislocation occurred as a result of the fall." Finally, he stated that water skiing would not produce excessive stress on the right hip prosthesis, as evidenced by the fact that claimant had been doing it for many years.

On November 4, 1999, Dr. McCullough provided a second causation opinion, after being provided with a copy of claimant's affidavit describing the July 31, 1999 water skiing incident. This description included claimant water skiing in calm, smooth water when his hip replacement "fell apart," with nothing of a traumatic nature occurring before his hip replacement "fell apart," and no dislocation or damage to the hip replacement as a result of a fall into the water. Considering this description, and responding to a question as to whether the 1955 work injury was the major contributing cause of claimant's worsened condition on July 31, 1999, Dr. McCullough stated:

> "Assuming the above as stated, I would certainly conclude that the hip failed as a result of deterioration at the cement bone interface. It should be noted that I did not see [claimant] immediately following the injury and did not take an accurate history as to the factors related to the fall while he was water skiing. The condition at the prosthesis/bone interface was such as to be considered consistent with the failure as [claimant] describes it. Therefore, it is my opinion that the on the [job] injury of August 5, 1955, was the major contributing cause of [claimant's] worsened condition and need for treatment on July 31, 1999."

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) (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). Here, there is no persuasive reason not to defer to the opinion of Dr. McCullough, who is claimant's long-term treating physician and performed both the initial right hip replacement surgery and the August 1999 revision of that hip replacement.

Although Dr. McCullough initially opined that the dislocation of the acetabular component resulted "at least acutely from the water skiing episode," he acknowledged at the time of that opinion that he did not have specific information as to the water skiing episode itself. After receiving that information, and considering his findings at surgery, he opined that the work injury was the major contributing cause of claimant's worsened condition. Thus, Dr. McCullough persuasively explained the reason for his change of opinion. *Compare Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

Based on Dr. McCullough's opinion as a whole, we find that claimant has established that the requested medical services are compensable. Therefore, we authorize reimbursement for those medical services. *See* OAR 438-012-0037. In addition, because claimant underwent hospitalization and surgery for this compensable right hip replacement condition, he is entitled to temporary disability benefits beginning July 31, 1999, the date he was hospitalized, until his condition becomes medically stationary. ORS 656.278(1)(a).

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.

Finally, we note that, claimant's claim remains open pursuant to our October 1, 1992 and June 14, 1999, orders to provide medical services to maintain and monitor the status of his prosthetic device for his left above-the-knee amputation. Authorization for those medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstance. After those medical services are provided and claimant is medically stationary regarding his right hip replacement condition, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA ANDREW, Claimant
WCB Case No. 98-10122
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Reinisch, et al, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) awarded an attorney fee for obtaining acceptance of an "omitted condition"; and (2) assessed a penalty based on the employer's allegedly unreasonable failure to timely accept the condition. On review, the issues are attorney fees and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

First, we grant the employer's motion to strike claimant's "Respondent's Reply Brief." *See* OAR 438-011-0020 (allowing for consideration of an *appellant's* reply brief or a *cross-appellant's* cross-reply brief).

Attorney Fees

In February 1997, the employer accepted a lumbar strain and then, on August 3, 1998, issued an amended acceptance to also include a cervical strain. The employer also denied a right shoulder strain and certain cervical bulges/herniations. In August 1998, the parties went to hearing before ALJ Marshall to litigate the denied conditions. The parties also agreed to "preserve" the issues concerning a right shoulder rotator cuff tendonitis condition.

On November 23, 1998, claimant's attorney asked the employer to accept the right shoulder rotator cuff tendonitis condition and then filed a hearing request on December 28, 1998 after receiving no response. Meanwhile, on December 18, 1998, ALJ Marshall issued an Opinion and Order. On January 21, 1999, the employer accepted right shoulder rotator cuff tendonitis.

On review, the employer continues to argue that, based on the agreement at the first hearing to "preserve" the right rotator cuff tendonitis condition, all claim processing concerning that condition was "deferred" until ALJ Marshall issued his order. Thus, according to the employer, it had 30 days from the issuance of ALJ Marshall's order to respond to claimant's request for acceptance of the rotator cuff tendonitis condition. Although finding that "neither party understood what they were agreeing to by reserving issues" at the first hearing, the ALJ here found "nothing in this record to suggest that [the employer's] duty to respond to the claim was stayed pending the Opinion and Order."

We agree with the ALJ. Whatever the agreement at the first hearing, the employer has a *statutory* duty to process a claim under ORS 656.262(6)(d) or 656.262(7)(a). In other words, if those statutes apply, the carrier must satisfy its obligations notwithstanding its contrary understanding under an oral agreement. We find no authority, and the employer provides no cite, for determining otherwise, whether based on statutory language or caselaw.

We further agree with the ALJ that ORS 656.262(6)(d) applies in this case with regard to the right rotator cuff tendonitis condition. *See Kimberly A. Rice*, 52 Van Natta 138 (2000). As in *Rice*, here, the rotator cuff tendonitis condition was in existence before the August 3, 1998 amended acceptance and claimant asked for acceptance of that condition following the amended acceptance. Under such circumstances, ORS 656.262(6)(d) applies, providing the employer with 30 days "to revise the notice or to make other written clarification in response." *Id.* at 140. Because the employer did not accept the condition until January 21, 1999 (more than 30 days after claimant's November 23, 1998 notice of objection), its response was late, and claimant's attorney is entitled to an attorney fee under ORS 656.386(1)(b)(B) for prevailing over a "denied claim." *Id.* at 141.

Penalties

The employer also objects to the ALJ's imposition of a penalty, arguing that its failure to comply with ORS 656.262(6)(d) was not "unreasonable" under ORS 656.262(11)(a) based on its understanding at the first hearing that it had no duty to process the claim until ALJ Marshall issued his order.

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of its denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

As discussed above, ORS 656.262(6)(d) is the applicable statute in this case. At the time of claimant's request for acceptance, however, there was no caselaw addressing the carrier's processing duties when the disputed condition is in existence after the initial notice of acceptance but before an amended or updated acceptance. Although we have decided differently, under the terms of ORS 656.262(7)(a), the carrier was not unreasonable in considering the right shoulder tendonitis condition as a "new medical condition," giving it 90 days to process claimant's request. Thus, we find that the employer had "legitimate doubt" of the application of ORS 656.262(6)(d) and, because it accepted the condition within 90 days in compliance with ORS 656.262(7)(a), its conduct was not "unreasonable."

Finally, claimant is not entitled to an attorney fee for services on review because the issues concerned penalties and attorney fees. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated May 24, 1999 is reversed in part and affirmed in part. That portion assessing a penalty is reversed. The remainder of the order is affirmed.

Board Member Phillips Polich dissenting in part.

I disagree with the majority that a penalty should not be assessed for the employer's late denial. I agree that, at the time the employer issued its denial, we had not explicitly addressed the specific situation presented here--that is, which statute applies when a "new condition" comes into existence after an initial acceptance but is not included in a subsequent, amended, acceptance.

Our caselaw interpreting ORS 656.262(6)(d), however, clearly provided that a condition that was incorrectly omitted from a Notice of Acceptance is one that was in existence at the time of the notice, but is not mentioned in the notice or is left out. *See, e.g., Mark A. Baker*, 50 Van Natta 2333 (1998).

Based on the holding in *Mark A. Baker*, because the rotator cuff tendonitis condition was diagnosed before the August 3, 1998 amended acceptance, I would find that the employer lacked "legitimate doubt" of the application of ORS 656.262(6)(d) and, in particular, that it had 30 days to respond to the request for acceptance. Thus, I agree with the ALJ that the employer's conduct was "unreasonable."

In the Matter of the Compensation of
GARY F. BLASKE, Claimant
WCB Case No. 99-00738
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's lumbar strain injury claim; and (2) set aside its denial of claimant's current low back condition. On review, the issues are compensability and claim processing. We affirm.

FINDINGS OF FACT

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

On March 27, 1998, claimant underwent decompression and spinal fusion surgery at L4-5. Claimant had also been diagnosed with degenerative disease at L2-3 and L3-4. By July 24, 1998, Dr. Rinehart noted that claimant's low back pain was "doing well at this time," although he continued to prescribe pain medication.

On September 24, 1998, claimant was working for the employer on a cement pour for an overpass project. An 80-foot steel catwalk fell on claimant, knocking him onto some concrete forms. Claimant was able to get out from under the catwalk and assist coworkers to lift it off another worker. After the accident, claimant was taken to an emergency room where he was seen by Dr. Mickel. Dr. Mickel diagnosed contusions of the lower back and left lower leg with low back strain. (Exs. 55, 56).

On October 1, 1998, claimant saw Dr. Rinehart, who noted abrasions and swelling over claimant's surgical wound. Dr. Rinehart found marked tenderness and limited range of motion over the lumbosacral region. Dr. Rinehart assessed blunt trauma to the lumbar spine with exacerbation from the lifting injury. (Ex. 58).

Because claimant was driving about 80 miles to see Dr. Rinehart, he changed to Dr. Denker, a physician closer to home. On November 5, 1998, Dr. Denker noted that claimant had tight lumbar muscles bilaterally with tenderness. He diagnosed an acute lumbar strain and recent laminectomy. (Exs. 64, 64A). On November 24, 1998, Dr. Denker prescribed physical therapy.

On December 10, 1998, claimant was examined for the insurer by Drs. Fuller and Gardner. They opined that claimant had recovered from the effects of the contusion within two to four weeks after the accident and that the major cause of claimant's current need for treatment was the preexisting degenerative disease and surgery. (Ex. 68). Dr. Denker did not concur with this report. (Ex. 70D).

On December 23, 1998, the insurer accepted disabling contusions of the lumbar spine and left leg. (Ex. 70). On January 12, 1999, claimant requested formal acceptance of a lumbar strain.

On January 22, 1999, the insurer denied the lumbar strain claim on the basis that there was insufficient evidence to establish that that condition arose from the September 1998 claim and denied claimant's current condition and need for treatment on the basis that they were not compensably related to the September 1998 claim. (Ex. 71). On the same date, the insurer amended its acceptance to accept the low back and left leg contusions as a combined condition. (Ex. 72).

On January 26, 1999, the insurer issued a Notice of Closure that awarded temporary but no permanent disability. (Ex. 73). On the same day, the insurer issued an Updated Notice of Acceptance at Claim Closure that stated that the accepted conditions were contusion to lumbar spine and left leg. (Ex. 74).

On March 2, 1999, Dr. Dinneen performed a chart review. (Ex. 75).

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ concluded that claimant suffered a compensable lumbar strain in the September 29, 1998 catwalk incident in addition to the accepted low back and left leg contusions. On review, the insurer contends that claimant did not experience a lumbar strain as a result of the September 1998 injury. We disagree.

Dr. Mickel, the emergency room physician, diagnosed a lumbar strain as well as the low back and left leg contusions immediately after the injury. (Ex. 56). Although Dr. Rinehart did not provide a diagnosis, when he examined claimant on October 1, 1998, he found that claimant's lumbar range of motion (ROM) was markedly limited and found marked tenderness to palpation over the entire lumbosacral region. And when claimant first treated with Dr. Becker on November 5, 1998, Becker found tight and tender lumbar muscles bilaterally. Becker diagnosed claimant's condition as a recent lumbar strain and post lumbar laminectomy and residuals. (Exs. 64, 64A).

When Drs. Fuller and Gardner examined claimant on December 10, 1998, they diagnosed claimant with multi-level degenerative disc disease, an interbody fusion at L4-5, and a lumbar contusion/abrasion resulting from the September 1998 work incident. Most importantly, they concluded that claimant had had only a minor scrape on September 29, 1998, which caused only some bruising and abrasion with subsequent muscle stiffness. They noted that subsequent investigation revealed that the fusion continued to be in good shape and that there was no new discopathy. They concluded that claimant's preexisting degenerative condition and fusion had combined with the fairly minor contusion to cause an episode of back pain. Finally, they opined that the contusion was the major contributing cause of claimant's need for treatment for the first two to four weeks from the date of injury, and that the contusion had resolved. (Ex. 68).

In response to the Fuller and Gardner report, Dr. Denker agreed that claimant had multilevel degenerative disc disease, an interbody fusion at L4-5, and an acute contusion as a result of the injury. But he also concluded that claimant suffered a lumbar strain as a result of the injury, and, as a result, would take a longer period to heal than the two to four weeks the examiners proposed in regard to the contusion.

Dr. Denker also agreed with the examiners that a great deal of claimant's problem was the result of his preexisting degenerative disc disease, which significantly impaired claimant's ability to heal. Dr. Denker proposed a healing period of six months, opining that claimant should be medically stationary by March 19, 1999. Moreover, when asked what was the major contributing cause of claimant's symptoms and need for medical treatment for that period, Dr. Denker stated that it was the lumbar strain that claimant sustained in the September 29, 1998 injury.

We are more persuaded by the opinion of Dr. Denker than by that of the examining physicians. Although Dr. Mickel, the emergency room physician, diagnosed a lumbar strain, the examiners' opinion ignores that diagnosis and focuses solely on the contusion. Dr. Denker, on the other hand, recognized that claimant was examined and treated for a lumbar strain immediately after the injury. Moreover, the mechanism of injury, where claimant was struck in the back and pinned by an 80-foot steel catwalk, from which he struggled to extricate himself, does not comport with the minor "scrape" suggested by the examiners.

In commenting on the examining physicians' report, Dr. Denker reinterviewed claimant. Dr. Denker stated that this interview reaffirmed his opinion that, in addition to suffering a contusion of the back, claimant also suffered a strain injury, and that Dr. Mickel's evaluation of contusion and low back strain was correct. Dr. Denker also agreed that a lumbar contusion should resolve within one month. Finally, Dr. Denker noted that the majority of claimant's symptoms had resolved within six months, further confirming his opinion that claimant had suffered a lumbar strain.

In formulating his causation analysis, Dr. Denker considered the mechanism of injury and the course of claimant's symptoms, and evaluated the relative contribution of all causative factors, including claimant's degenerative condition and surgical residuals. Dr. Denker is also the attending physician and thus his opinion is entitled to greater weight unless there are persuasive reasons not to do so. *Weiland*

v. SAIF, 64 Or App 810 (1983). We find no such persuasive reasons in this record. Therefore, we conclude that Dr. Denker's opinion satisfies claimant's burden to prove that the September 1998 injury was the major contributing cause of his low back strain by a preponderance of the evidence. ORS 656.266; *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev den* 321 Or 416 (1995) (to be persuasive expert opinion, a doctor must consider or evaluate the relative contribution of all causative factors, including any preexisting conditions, in forming his causation opinion).

Premature Denial

The ALJ concluded that, because the lumbar strain was compensable, the insurer's current condition denial was premature. On review, the insurer contends that, pursuant to ORS 656.005(7)(a)(B) and 656.262(6)(c),[1] an insurer may issue a current condition denial when the compensable injury ceases to be the major contributing cause of the need for treatment. We agree that the denial was procedurally valid.

Here, on December 23, 1998, the insurer initially accepted a low back and left leg contusion. (Ex. 70). On January 12, 1999, claimant requested that the insurer accept a lumbar strain.[2] On January 22, 1999, prior to claim closure, the insurer denied claimant's claim for a lumbar strain and denied claimant's current condition on the basis that it was not compensably related to the September 1998 injury. (Ex. 71). On the same date, the insurer amended its acceptance to accept the low back and left leg contusion as a combined condition, based on Dr. Fuller's opinion that the September 1998 work injury combined with claimant's preexisting surgery and degenerative condition. (Exs. 68, 72). Based on Dr. Fuller's opinion that the major cause for claimant's current need for treatment and disability was the preexisting conditions and that the contusion had resolved by four weeks after the injury, the insurer closed the claim by a January 26, 1998 Notice of Closure. (Ex. 73).

ORS 656.262(6)(c) allows a carrier to deny the claim when the compensable injury ceases to be the major contributing cause of the combined condition and is premised on the carrier's acceptance of a combined or consequential condition under ORS 656.005(7). Moreover, ORS 656.262(7)(b), permits a "pre-closure" denial when the denial is based on the injury no longer being the major contributing cause of the combined condition under ORS 656.005(7)(a)(B).

Consequently, based upon the medical information at the time of the current condition denial, it would appear that the denial was procedurally valid. Nonetheless, we need not conclusively resolve this question because we set the denial aside on substantive grounds. Based on the reasoning previously expressed regarding the compensability of claimant's low back strain condition, we are persuaded that his work injury was and remained the major contributing cause of his need for medical treatment and disability for his current combined condition. Accordingly, we set aside the insurer's current combined condition denial and remand the claim to the insurer for further processing in accordance with law.

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[1] 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."

ORS 656.262(7)(b) provides:

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

[2] Once there is an acceptance, a claimant may object to the notice of acceptance and seek to have any omitted conditions included. ORS 656.262(6)(d); *Johansen v. SAIF*, 158 Or App 672, 678 (1999).

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

ORDER

The ALJ's order dated July 29, 1999 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,500, to be paid by the insurer.

February 17, 2000 Cite as 52 Van Natta 262 (2000)

In the Matter of the Compensation of
JAMES M. KING, Claimant
Own Motion No. 99-0248M
SECOND OWN MOTION ORDER ON ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our September 24, 1999 Own Motion Order, as reconsidered on October 21, 1999, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability. We abated our prior orders to allow the parties an opportunity to present their positions. Having received the parties' responses, we proceed with our reconsideration.

In our prior orders we found that the medical documentation contained in the record did not satisfy claimant's burden of proof regarding the "futility standard" of the third criterion expressed in *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989). *James M. King*, 51 Van Natta 1534 (1999), *on recon* 51 Van Natta 1794 (1999). On reconsideration, we continue to adhere to our previous findings.

Claimant submits a "check-the-box" report from Dr. Goldberg, his attending physician, in support of his contention that he was in the work force at the time of his current disability. Claimant's attorney sought Dr. Goldberg's concurrence that claimant's was unable to work prior to his May 9, 1999 surgery and that it was futile for him to seek work due to his compensable condition. Dr. Goldberg did not concur that claimant was unable to work prior to his surgery nor that it was futile for him to seek work. Rather, Dr. Goldberg explains that "[claimant] apparently worked * * * for 2-3 mo[nths] in Spring of [19]99 (selling photo supplies developer). He then did part time work as a temp. (inventory work)."

We do not find that Dr. Goldberg's statements support claimant's position. In the first place, the record shows that claimant left work on February 11, 1999, but did not undergo surgery until May 9, 1999. Contrary to Dr. Goldberg's understanding, there is no evidence in the record that claimant worked part-time after he left work. Finally, Dr. Goldberg specifically *disagreed* that claimant was unable to work or seek work prior to his May 9, 1999 surgery due to his compensable injury. Therefore, claimant does not satisfy the third *Dawkins* criteria, *i.e.*, he did not prove it was futile for him to work or seek work due to the compensable injury prior to undergoing surgery. Thus, we continue to find that the record does not establish that claimant was in the work force at the time of disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 24, 1999 and October 21, 1999 orders effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY R. BRADY, Claimant
WCB Case Nos. 98-07478 & 98-05377
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Reliance National Indemnity Company (Reliance), on behalf of Imperial Manufacturing, requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) found that its acceptance of a lumbar strain and disc bulges at L1-2 and L4-5 included claimant's underlying degenerative process; and (2) set aside its compensability and responsibility denial of claimant's current low back condition. On review, the issues are scope of acceptance, compensability and, if the claim is compensable, responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Reliance accepted claimant's injury claim for a September 11, 1992 lumbar strain and disc bulges at L1-2 and L4-5. Claimant injured his low back again at work in early 1998 while working for Farmers Insurance Company's (Farmer's) insured.

Dr. Chambers performed a decompressive lumbar laminectomy for spinal stenosis at L3-4 and L4-5 in September 1998.

Farmers denied claimant's injury claim on May 8, 1998 and Reliance denied compensability and responsibility on August 21, 1998. Claimant requested a hearing.

The ALJ found that Reliance's 1992 acceptance of claimant's lumbar strain and L1-2 and L4-5 disc bulges included claimant's underlying degenerative condition. Reasoning that claimant's disc bulges were a symptom of his then-existing degenerative condition, the ALJ concluded that Reliance necessarily accepted claimant's degeneration when it accepted his bulging discs. We disagree, based on the following reasoning.[1]

If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. *Georgia Pacific v. Piwowar*, 305 Or 494, 501-02 (1988). 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.

However, if a carrier accepts a separate condition (not just symptoms), the rule of *Piwowar* does not apply. *See Boise Cascade Corp. v. Katzenbach*, 104 Or App 732, 735 (1990), *rev den* 311 Or 261 (1991); *Jacqueline J. Griffin*, 51 Van Natta 1806 (1999). In *Katzenbach*, the court accepted the Board's finding that the claimant's wrist strain and avascular necrosis were separate conditions. Under those circumstances, the court found that the rule of *Piwowar* did not apply and it concluded that the carrier's acceptance of the strain was not an acceptance of a claim for avascular necrosis. *Id.* Acceptance of a specific, particular condition does not necessarily include the cause of that condition. *Granner v. Fairview Center*, 147 Or App 406, 410 (1997) (Stating that the "cause of the original injury does not determine the scope of the employer's acceptance" and that the "scope of the acceptance corresponds to the condition specified in the acceptance notice").

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[1] We do not reach the potential responsibility issue, because we find that claimant's current condition is not compensable.

In this case, Reliance accepted specific conditions: a lumbosacral strain and L1-2 and L4-5 disc bulges.[2] There is no evidence that these specific conditions were "symptoms," rather than conditions. *See Douglas Sherman*, 51 Van Natta 1213 (1999).[3] Moreover, as we explain below, the medical evidence establishes that claimant's 1998 surgery was not for the same condition that Reliance accepted. *See Granner*, 147 Or App at 411 (where no medical evidence described the accepted condition as a symptom or as the sole cause of the accepted condition, Board could (and did) find that carrier specifically accepted a separate condition, not the claimant's preexisting conditions). Thus, because Reliance accepted specific conditions (that did not contribute to his need for treatment in 1998), the rule in *Piwowar* does not apply. *See Griffin*, 51 Van Natta at 1807; *Sherman*, 51 Van Natta at 1214. Accordingly, we proceed to consider the merits of the denials.

The medical evidence uniformly relates claimant's current low back condition (and his recent need for low back surgery) to stenosis that is unrelated to either work injury. (*See* Exs. 34, 36-4, 42-6, 47, 48-18-20, 49, 50-10-15, -20-21). Under these circumstances, we conclude that claimant's condition is not compensable and we uphold both carriers' denials.[4]

ORDER

The ALJ's order dated October 8, 1999 is reversed in part and affirmed in part. That portion of the order that set aside Reliance National Indemnity Company's denial 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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[2] *Compare Fred L. Dobbs*, 50 Van Natta 2293, 2295 (1998) (when the carrier *does not* identify the specific condition accepted, we look to the contemporaneous medical records to determine what condition was accepted); *Kim D. Wood*, 48 Van Natta 482, 484 (because there was a specific acceptance, it was not necessary to examine the contemporaneous medical evidence to determine what condition was accepted), *aff'd mem* 144 Or App 496 (1996).

[3] *Compare Janet R. Christensen*, 50 Van Natta 396 (1998), *aff'd Freightliner Corporation v. Christensen*, 163 Or App 191 (1999) (the carrier accepted "low back pain r/o HNP;" the "low back pain" was caused in part by spinal stenosis and degenerative disc disease and, therefore, the carrier's acceptance included those conditions).

[4] Assuming, without deciding, that Reliance accepted a combined condition in 1992 (because claimant's then-existing disc conditions were due to preexisting degeneration), we would uphold its 1998 current condition denial on causation grounds. *See Multifoods Specialty v. McAtee*, 164 Or App 654, 661-662 (1999) (acceptance of combined condition "not an outright acceptance of the earlier condition itself * * * Rather, it is the 'combined condition' that is accepted, and only to the extent that the work injury was the major contributing cause of disability of the need for treatment of the combined condition").

In the Matter of the Compensation of
JAMES P. ILSLEY, Claimant
WCB Case Nos. 99-03346 & 99-03344
ORDER ON RECONSIDERATION
Allison Tyler, Claimant Attorney
Cavanagh & Zipse, Defense Attorneys
Julie Masters (Saif), Defense Attorney

Claimant has requested reconsideration our February 1, 2000 order that held that the SAIF Corporation, rather than Farmer's Insurance Group, is responsible for claimant's current low back condition. Specifically, claimant requests an attorney fee for services on review under ORS 656.307.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees may not be awarded. *Stephenson v. Meyer*, 150 Or App 300, 303 (1997); *SAIF v. Allen*, 320 Or 192, 200 (1994); *Forney v. Western States Plywood*, 297 Or 628 (1984).

Here, claimant is not entitled to an attorney fee for services on Board review under ORS 656.307. *See* ORS 656.307(5); *Lynda C. Prociw*, 46 Van Natta 1875 (1994).

Accordingly, our February 1, 2000 order is withdrawn. On reconsideration, as supplemented herein, our February 1, 2000 order is republished. 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
LARRY R. GARDNER, Claimant
WCB Case No. 99-01714
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) determined that the SAIF Corporation's denial was procedurally valid; and (2) upheld the denial of her L5-S1 and current low back conditions. On review, the issues are the procedural validity of the denial and compensability.

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

The ALJ upheld the procedural validity of SAIF's denial, which issued the same day as the claim was closed, rejecting claimant's contention that the denial was an invalid "pre-closure" denial. In so doing, the ALJ reasoned that, because the denial was issued the same day that the claim was closed, it was not issued "pre-closure."

On review, citing *David E. Horton*, 50 Van Natta 514, *on recon* 50 Van Natta 795, *aff'd mem EBI Companies v. Horton*, 157 Or App 297 (1998), claimant contends that a denial issued the same day as claim closure is a "pre-closure" denial and that such a denial in this case is procedurally invalid. For the following reasons, we find *Horton* distinguishable and conclude that SAIF's denial did not precede claim closure.

Like this case, in *Horton*, the claim was closed on the same date it was denied. The worksheet attached to the Notice of Closure in *Horton*, however, indicated that the claim was denied. Based on the worksheet, we found that the denial preceded the closure. We further noted that the worksheet attached to the Notice of Closure gave no medically stationary date. We observed that, normally, a worker must be medically stationary prior to claim closure. Based on the record in *Horton*, we were persuaded that the claim was closed following issuance of a pre-closure denial pursuant to ORS 656.268(1)(a). 50 Van Natta at 795.

Moreover, in *Horton*, we found the case cited by the carrier, *Chaffee v. Nolt*, 94 Or App 83 (1988), distinguishable. In *Chaffee*, the employer issued a claim denial three days before claim closure. The *Chaffee* court held that, in view of the employer's prompt closure of the claim immediately after the issuance of the denial, it did not appear that the employer's conduct was intended to shortcut the ordinary process of claim closure or was otherwise unreasonable. *Chaffee*, 94 Or App at 85. Thus, although the denial was considered to be an improper prospective denial, the court concluded that the Board had not erred in addressing the merits of the denial. In contrast to *Chaffee*, we were persuaded in *Horton* that the carrier's conduct in issuing its denial prior to its Notice of Closure did shortcut the claim closure process.

Unlike *Horton*, where the worksheet attached to the closure notice indicated that the claim had been denied and did not provide a medically stationary date, the closure notice's worksheet here does not indicate that the claim had been denied. (Ex.65-2). Moreover, the worksheet does contain a medically stationary date. *Id.*

Accordingly, we conclude that the denial in this case did not precede claim closure and, further, was not intended to shortcut the claim closure process. Thus, we conclude that the evidence here does not establish that SAIF's denial was an invalid "pre-closure" denial. Finally, we agree with the ALJ's reasons for approving the denial on the merits. Therefore, we affirm.

ORDER

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

February 18, 2000 Cite as 52 Van Natta 266 (2000)

In the Matter of the Compensation of
KAREN K. HAYWARD, Claimant
WCB Case No. 99-02656
ORDER ON REVIEW
Randy Rice, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial of claimant's occupational disease claim for a left carpal tunnel syndrome (CTS) condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer as a canteen operator and driver for 9 1/2 years. She works from about 6 a.m. to 3 p.m., presently making about 40 stops per day. The longest drive between stop is 12 minutes, the others are 3-7 minutes apart. She drives with both hands. At each stop she opens the canteen doors, allows customers to select food, beverage and/or tobacco items, replenishes product, receives payment and makes change, as necessary. She also replenishes the coin change device (changer) when she is not otherwise occupied. She wears the changer on a belt on her left side and a cash pouch on her right side.

Claimant holds a stack of paper money in her right hand and uses a pinching motion with her left thumb and fingers to remove bills from the stack or replace them. She operates the changer with her left hand, using her thumb to push the lever down to release coins and pressing against the bottom of the changer, usually with all four fingers, at the same time. She catches the coins that fall from the changer with her left hand. She also uses a pinching motion with her left thumb and index finger to replace coins through the top of the changer.

Claimant serves 350 to 400 customers per day. Serving customers is generally very fast paced, because the people she serves are on short work breaks. Some customers charge, some provide exact change, but most get change from claimant. A single transaction takes 10-15 seconds. Claimant's busiest time was during the summer of 1998, when she served as many as 100-150 customers and sold $500-$600 worth of product in 25-30 minutes.

Claimant first experienced left hand numbness and tingling in August or September 1998. Her symptoms worsened progressively and she sought treatment in November 1998. Claimant has positive right nerve conduction studies but no right hand symptoms. She filed a claim for left CTS only, which the insurer denied.

The ALJ upheld the insurer's denial of claimant's claim because he found Dr. Button's opinion questioning causation more persuasive than Drs. Long and Wiebe's opinions relating claimant's left CTS to her work activities. We disagree.

Dr. Long had an accurate and complete understanding of claimant's medical history and work activities.[1] (*See* Ex. 11-2). He found claimant's left-sided symptomatic CTS "quite unusual" because claimant is right-handed. (Ex. 11-4). However, he noted that left CTS used to be "fairly common" among right-handed grocery checkers, probably because they handled products unilaterally with their nondominant left hands--before scanners made the job bilateral. Now--with scanners, it is "quite rare to see unilateral left sided carpal tunnel syndrome in right handed grocery checkers." (*Id*). Similarly, based on claimant's detailed history and her change-making demonstration for him, Dr. Long related claimant's (nondominant) left CTS to her repetitive hand intensive work activities. He was impressed that claimant operated the changer with her left wrist flexed, noting that making change involved "almost constant left hand activity, with all fingers actively involved in operating the change machine." (Ex. 11-5). Dr. Long explained that claimant's left wrist flexion caused increased intercarpal pressure and the constant hand activity "means that the flexor tendons are under almost continuous mild tension, a factor that also raises intercarpal pressure." (*Id*). He also noted that it was not unusual for claimant to do transactions for 20 minutes continuously. (*Id*).

Dr. Long reasoned that claimant's left CTS is work related,

> "in view of the unilateral nature of her carpal tunnel syndrome, the fact that her symptoms are in the nondominant hand, but [] she uses the nondominant hand in a relatively intensive way to make change, and that she has done this on a full-time basis for almost 10 years[.]" (*Id*).

We find Dr. Long's opinion persuasive because it is well-reasoned and based on an accurate and complete history.[2] And we find Dr. Button's opinion unpersuasive because it is based on a materially inaccurate history and Dr. Long persuasively rebuts Dr. Button's reasoning.

Based on *his own* operation of a coin changer, Dr. Button mistakenly believed that claimant used only her left thumb, not her fingers, to make change. (Ex. 12A). Because the flexor tendon to the thumb is extrinsic to the carpal tunnel (and he does not believe that wrist flexion causes intracarpal tunnel pressure), Dr. Button concluded that claimant's use of the changer did not cause her CTS. (*Id.*). But Dr. Button also acknowledged that the carpal tunnel does contain the 9 flexor tendons for the digits (as well as the median nerve). And claimant testified that she pressed upward against the bottom of the changer with all 4 left-hand fingers all the time, to operate the device. She explained that she had to do that to keep the changer from moving about.[3] (Tr. 12-13, 15, 17-19, 48-49).

We have no reason to doubt claimant's description of her work and use of the changer. Her description is consistent with her demonstration at hearing and Dr. Long's history, but it is significantly inconsistent with Dr. Button's belief that she did not use her fingers at all operating the changer. Accordingly, because Dr. Button's opinion is based on a materially inaccurate history, his causation opinion is unpersuasive.

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[1] At one point, Dr. Long mistakenly stated that claimant served customers at the rate of about 600 per hour. (Ex. 11-5). Claimant later corrected this misunderstanding and informed the doctor that she had never served 600 customers in an hour, but she had had $600 in *sales* at the Port of Portland stop when it was busy. (*See* Tr. 47-48; Tr. 57). She explained that, on a few occasions -- at her busiest, she had served about 150 at one stop; now her busiest stop has a maximum of 50-100 customers. (Ex. 13-1; *see id.*). This corrected history did not affect Dr. Long's causation opinion. And the record does not suggest that claimant's condition is any less likely work-related because, at her busiest, she sold $600 worth of product at one stop without waiting on 600 people.

[2] We find Dr. Wiebe's concurrence with Dr. Long's opinion persuasive for the same reasons, noting that the *form* of the opinion does not impact its persuasive force. (*See* Ex. 14). *See Roseburg Forest Products v. Glenn*, 155 Or App 318, 321 (1998) ("An opinion that lacks explanation or foundation may be discounted, but not for the reason that it is expressed as an adoption or concurrence.").

[3] She probably operates the changer in this manner, with hand movement and finger pressure, thousands of times per day. (Tr. 19). She often makes change for the second or third customer in line while she is completing the transaction with the first customer in line. (Ex. 11-2). When claimant looks at the bottom of the underside of her wrist while operating the changer, she can see "[s]omething going in and out." (Tr. 21).

Dr. Long, on the other hand, observed claimant's use of the changer and correctly understood that all her fingers were actively involved. Considering claimant's ergonomics of change-making, Dr. Long concluded that her years of repetitive left hand use at work increased pressure inside her carpal tunnel and caused her CTS. We find his reasoning and conclusions persuasive.

Dr. Button also discounted claimant's work as a cause of her condition because claimant is right-handed and she did not have CTS problems until recently, even though she performed the same work for many years. He opined:

> "As her work routine has been the same for 9 1/2 years and the onset of symptomatology [was] only in the latter part of [the] 1998, I would not attribute the carpal tunnel syndrome to her work." (Ex. 6-4).

But Dr. Button's reasoning in this regard does not take into account that the late summer before the onset of claimant's symptoms was her busiest work time during the 9 1/2 year employment. And Dr. Long explained that it is

> "quite common for median neuropathy to develop silently for months and often years. [Claimant] has consistently done a job that requires her to use the nondominant left hand in a flexed and relatively hand intensive manner for a significant portion of the workday." (Ex. 13-2).

Thus, because claimant's left CTS developed gradually, and claimant had a long work exposure, Dr. Long persuasively rebutted Dr. Button's reasoning that claimant's symptoms appeared too late for her condition to be work related.

Before Dr. Button knew that claimant has positive nerve conduction findings in her asymptomatic *right* wrist, Dr. Button noted that claimant had fractured her *right* wrist 1 1/2 years previously and opined that CTS "frequently can occur after fractures." (Ex. 6-4, *see* 6-2). He also opined that the expectation for "garden-variety, ideopathic" CTS would be a "bilateral process and of even greater degree on the right [presumably, because claimant is right-handed]" -- but claimant's CTS is neither. (Ex. 6-4). Then, upon discovering that claimant has abnormal nerve conduction findings on her asymptomatic right side, he opined that claimant "fits into the ideopathic category" because her condition is bilateral. (Ex. 12A-2). We do not find Dr. Button's eventual conclusion persuasive because it ignores his own prior observation[4] that wrist fractures are "frequently" followed by carpal tunnel and claimant had a right wrist fracture about 1 1/2 years ago.

In summary, we do not rely on Dr. Button's opinion primarily because it based on an inaccurate history regarding the biomechanics of claimant's change-making work. Moreover, Dr. Button's observations about the anatomy of the carpal tunnel support, rather than refute, Dr. Long's explanation for the mechanism of disease in claimant's case. Accordingly, based on Dr. Long's persuasive opinion, we conclude that claimant has carried her burden under ORS 656.802.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $8,000, 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 fee request, the record, and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[4] Button found that claimant had no potential risk factors relative to body habitus or medical conditions. He stated that claimant had no prior CTS symptoms, no identifiable preexisting conditions or off-work factors that would theoretically cause or contribute to her CTS, and no family history of CTS. (Ex. 6-5). But he also stated that he viewed claimant's "employment conditions as simply exacerbating symptomatology[.]" (*Id*). And later, Dr. Long described claimant's left CTS symptoms as a worsening "of a pre-existing underlying condition[.]" (Ex. 12A-2). We find the latter conclusions at least potentially inconsistent with each other and the doctor's prior findings (that claimant did not have a preexisting condition). In any event, there is no persuasive evidence that claimant had a contributory preexisting condition.

ORDER

The ALJ's order dated August 30, 1999 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded an $8,000 attorney fee, payable by the insurer.

February 18, 2000 Cite as 52 Van Natta 269 (2000)

In the Matter of the Compensation of
JACK R. HUNTINGTON, Claimant
Own Motion No. 00-0057M
OWN MOTION ORDER
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable recurrent *right* inguinal hernia condition. Claimant's aggravation rights expired on September 27, 1998. SAIF recommends that we authorize the payment of temporary disability compensation. Inasmuch as claimant required *bilateral* hernia repair, SAIF advises that claimant has an accepted 1996 *left* inguinal hernia claim with another insurer and requests that the Board issue a "pro-rata order" to "split any time loss owed between these two claims."

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 the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

SAIF requests that the Board issue an order prorating claimant's temporary disability compensation between his 1993 claim with SAIF and a 1996 claim with another insurer. An injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den*, 296 Or 350 (1984). Therefore, if any concurrent temporary disability compensation is due claimant as a result of this order, SAIF may petition the Workers' Compensation Division of the Department of Consumer and Business Services for a pro rata distribution of payments. OAR 436-060-0020(8) and (9); *Michael C. Johnstone*, 48 van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

Finally, claimant's attorney is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve such a fee unless claimant's attorney files a current retainer agreement. *See* OAR 438-015-0010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
KAREN M. JOHNSON, Claimant
WCB Case No. 98-06528
ORDER ON REVIEW
Randy Rice, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Otto's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim of lumbar and thoracic conditions; (2) upheld the employer's denial of claimant's temporomandibular joint dysfunction (TMJ) and other current conditions; and (3) declined to assess penalties for allegedly unreasonable claim processing. On review, the issues are aggravation, compensability, and penalties.

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

The ALJ upheld the employer's denials of claimant's aggravation claim and her claim for various other conditions, including TMJ. On review, claimant asserts that the ALJ's findings were in error and that she established the compensability of her aggravation claim and of the disputed conditions. We disagree.

In order to prove a compensable aggravation, claimant must establish an "actual worsening" of the compensable conditions. ORS 656.273(1). In *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997), the court interpreted the "actual worsening" language in ORS 656.273(1) to require direct medical evidence that a condition has worsened. The court held that proof of a pathological worsening is required to prove an aggravation and that it is no longer permissible, as it was under the former law, to infer a worsened condition from evidence of increased symptoms alone. *Id.*

Here, we agree with the ALJ that the medical evidence does not establish that claimant suffered an "actual worsening" of her compensable conditions. Thus, claimant failed to prove a compensable aggravation claim.

Finally, to prove the compensability of disputed conditions that are allegedly directly related to her industrial accident, claimant must prove that her compensable work injury was a material contributing cause of those conditions. To prove the compensability of conditions that allegedly arose as a consequence of her compensable conditions, claimant must prove that the compensable injury is the major contributing cause of those consequential conditions. *See* ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (condition or need for treatment that is directly caused by an industrial accident is analyzed under a material contributing cause standard; condition or need for treatment that is caused in turn by a compensable condition is analyzed under the major contributing cause standard as a consequential condition).

We agree with the ALJ's reasoning that the medical evidence is insufficient to establish the compensability of the disputed conditions under either a material or major contributing cause standard. Therefore, we agree with the ALJ's decision to uphold the employer's denial of the disputed conditions.[1]

ORDER

The ALJ's order dated October 6, 1999 is affirmed.

[1] Claimant contends that the ALJ improperly refused to admit all documents she submitted. Having reviewed the record, we are persuaded that all appropriate non-duplicated documents were admitted into the record. Moreover, even if we considered the evidence claimant contends was improperly excluded from the record, we would reach the same result. That is, claimant failed to sustain her burden of proving the compensability of her various claims and conditions.

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
Own Motion No. 00-0051M
OWN MOTION ORDER
Schneider, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable bilateral knee conditions. Claimant's aggravation rights on that claim expired on May 21, 1997. SAIF opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his current disability.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In a December 29, 1999 medical report, Dr. Edelson, claimant's attending physician, recommended claimant undergo bilateral ACL reconstructions. 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 December 29, 1999, 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, SAIF contended that claimant's failure to provide proof of earnings demonstrated that he was not in the work force. In response to SAIF's contention, claimant has submitted copies of his paystubs for the period between July 1999 and February 2000 which demonstrates that he was in the work force during the time prior to his December 1999 worsening. Based on claimant's submission, we find that he was in the work force at the time of his current worsening which requires surgery.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVE E. PEWONKA, Claimant
WCB Case No. 98-08608
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of claimant's L4-5 facet joint annular tear/instability 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 improperly and incorrectly weighed the expert medical opinions. Specifically, claimant asserts that the ALJ incorrectly accorded more weight to the carrier-arranged medical examinations rather than giving deference to claimant's treating physician and neurosurgeon, Dr. Newby. We disagree.

To establish a compensable injury where it is shown that claimant suffers from a preexisting disease, the claimant must prove that his work exposure is the major contributing cause of his need for treatment or disability for his combined condition. *See* ORS 656.005(7)(a)(B); ORS 656.266. Where the causation issue involves complex medical questions, we necessarily rely on expert medical opinions. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). Where there is a division of experts we rely on those medical opinions that are the most well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Additionally, we generally give deference to claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983); *Kima L. Langston*, 52 Van Natta 15 (2000). Here, we find persuasive reasons to do otherwise.

There is no dispute that claimant suffers from preexisting dengerative low back disease with facet arthritis (DDD). (Exs. 13, 21,27, 31, 36, 38, 41, 43,48). Therefore, claimant must show that his compensable motor vehicle accident (MVA) on November 18, 1997 was the major contributing cause of his need for treatment or disability for his "combined" low back condition. ORS 656.005(7)(a)(B). Claimant relies on the medical opinion of Dr. Newby, his treating neurologist, for support.

Claimant argues that Dr. Newby's opinion was persuasive. We disagree. Dr. Newby opined that the compensable MVA was the major cause of claimant's need for treatment and his back condition. Specifically, Dr. Newby expressed the opinion that the MVA produced a annular tissue/capsular tear of the facet joints at L4-5 with subsequent micro-instability at that level. (Exs. 38, 49).

Importantly, Dr. Newby based his opinion on the fact that claimant was "totally asymptomatic" prior to the MVA. (*Id.*). However, Dr. Newby's opinion is founded on an inaccurate medical history. Claimant admitted a history of low back and anterolateral right leg pain prior to the MVA. (Ex. 13-1, 39, 40). Medical opinions that are not based on a complete and accurate history are not persuasive. *Miller v. Granite Construction*, 28 Or App 473, 476 (1977). Further, Dr. Newby did not begin to treat claimant until almost one year after the compensable MVA and has only examined claimant once. (Ex. 33). Therefore, he does not have any advantage regarding observation of claimant's condition over time.

Finally, the resolution of the causation issue in this case involves expert analysis rather than expert observation. *Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979). For the reasons set forth in the ALJ's order, we find the opinions of Dr. Davidson, Dr. Gambee, Dr. Gardner, Dr. Schilperoot, Dr. Williams to be persuasive.

Accordingly, we agree with the ALJ that claimant failed to prove that his November 1997 compensable MVA was the major contributing cause of his need for treatment or disability for his L4-5 facet joint annular tear/instability. Consequently, the condition is not compensable. *See* ORS 656.005(7)(a)(B).

ORDER

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

February 18, 2000 Cite as 52 Van Natta 273 (2000)

In the Matter of the Compensation of
GREG T. SMITH, Claimant
WCB Case No. 98-06651
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) denied its motion to dismiss claimant's request for hearing regarding the denial of claimant's low back injury claim based on claimant's alleged failure to attend carrier-scheduled medical examinations; and (2) set aside the employer's denial. In his respondent's brief, claimant challenges that portion of the ALJ's order that did not assess a penalty for an allegedly unreasonable denial. On review, the issues are dismissal, compensability and penalties.

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

At hearing, the ALJ denied the employer's motion to dismiss claimant's request for hearing for failure to attend two carrier-scheduled medical examinations. (Tr. 7). During an earlier telephone conference with the Assistant Presiding ALJ, that ALJ deferred ruling on the employer's November 11, 1998 "Motion to Postpone Hearings" (*sic*) (Ex. 21), subject to reconsideration if claimant failed to attend a properly scheduled third medical examination. (Respondent's Brief at 3, fn1). The employer does not dispute this characterization of the Assistant Presiding ALJ's ruling. (*see* Tr. 3, 4). There is no evidence in the record that the employer scheduled a third medical examination. Neither did the employer seek a continuance in order to schedule a third medical examination. Therefore, as far as this record reveals, there was no third medical examination with which claimant failed to cooperate. Dismissal for failure to prosecute the claim is therefore inappropriate. OAR 438-006-0071; *Ring v. Paper Distribution Services*, 90 Or App 148 (1988). The employer's motion to dismiss was properly denied.

The employer contends that claimant is not credible, and that his testimony regarding his July 7, 1998 injury therefore should not be relied on to establish compensability. We disagree. At best, the employer impeached claimant's credibility on collateral matters. *See Frank Sica*, 50 Van Natta 2092 (1998). Extrinsic evidence may not be used to impeach a witness on a collateral matter. *See John N. Sheagren, M.D., P.C. v. Albrecht*, 123 Or App 553, 556 (1993). Extrinsic evidence is generally considered collateral unless it is independently admissible for a reason other than to contradict the testimony of a witness. *Id.*

Several supervisors and coworkers testified that claimant had a reputation for stretching the truth, or for telling "untruths." (Tr. 97, 114, 122). However, there was no testimony directly disputing claimant's testimony that he was hurt on the job on July 7, 1998. Claimant reported his injury promptly to his employer, a temporary service agency, and to his onsite employer. (Tr. 34). Claimant's sister in law, Teresa Smith, confirmed that claimant told her he had injured his back at work while he was living at her home during the summer of 1998. (Tr. 13, 14).

Moreover, medical reports during the few weeks after July 7, 1998 provide a diagnosis of low back strain accompanied by objective findings of muscle spasm and positive straight leg raising tests. (Exs. 6, 10, 13). These contemporaneous medical reports also uniformly corroborate claimant's history of injuring his back while moving concrete blocks at work. (Exs. 3, 6, 10). Accordingly, we agree with the ALJ that claimant established the compensability of his July 7, 1998 injury claim by medical evidence supported by objective findings. ORS 656.005(7)(a). *See Westmoreland v. Iowa Beef Processors*, 70 Or App 642 (1984); *rev den* 298 Or 597 (1985); *Victor J. Cervantes*, 51 Van Natta 1343 (1999) (Even if a claimant lacks credibility with regard to certain matters, he can still meet his burden of proof where the remainder of the record supports his claim.)

Finally, claimant contends that the ALJ should have awarded penalties for an allegedly unreasonable denial. Whether a denial is unreasonable depends on whether the employer or insurer had a "legitimate doubt" as to its liability for the claim. *Brown v. Argonaut Insurance*, 93 Or App 588, 591 (1988); *Christopher F. Mangiofico*, 51 Van Natta 1881 (1999). If so, the refusal to pay is not unreasonable. The reasonableness of the employer's denial is assessed based on all information available to the carrier as of the date of the denial. *David A. Renno*, 51 Van Natta 1730 (1999).

Given the testimony at hearing from claimant's supervisors and coworkers regarding claimant's reputation for "untruthfulness" on various other matters, we find that the employer had a legitimate doubt as to its liability for the claim. This is so even though claimant proved the compensability of his claim by a preponderance of evidence at hearing.

Claimant's attorney is entitled to an assessed fee for services on review regarding the dismissal and compensability issues. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorneys services on review is $1,250, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated April 5, 1999 is affirmed. For services on review regarding the dismissal and compensability issues, claimant's attorney is awarded an assessed fee of $1,250, payable by the employer.

February 18, 2000 Cite as 52 Van Natta 274 (2000)

In the Matter of the Compensation of
CHARLES E. WARREN, Claimant
WCB Case No. 98-03210
ORDER ON REVIEW
Willner, Wren, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the insurer's denial of his occupational disease claim for his aspergilloma condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Conclusions and Opinion," with the following correction and supplementation. The ALJ found that one of the employer's witnesses was an employee of a car dealership, rather than one of the employer's own employees. As such, the ALJ suggested that the witness would have no reason to testify favorably for the employer. Opinion and Order, Pg. 4.

On Board review, claimant contends that the ALJ's conclusion was erroneous as the witness actually did work for the employer. The insurer concedes that claimant is correct in this regard. Respondent's Brief, Pg. 1. Accordingly, we correct that portion of the ALJ's order. We continue to agree with the ALJ's conclusion, however, that the evidence establishes that claimant wore a mask for much of his work for the employer.

Claimant also contends that the ALJ erred in concluding that claimant's treating doctor did not have an accurate history. The ALJ discounted the opinion of Dr. Bryant, in part, because he found that Dr. Bryant assumed that claimant was exposed to "a lot of bird nests or dead birds or the like." Opinion and Order, pg. 5. The ALJ concluded that the doctor's assumption was inaccurate, however, as claimant was only exposed on one occasion when a chimney was torn down and a few birds were found.

On review, claimant argues that there is no evidence in the record that any doctor assumed that claimant was exposed to numerous bird's nests or dead birds. We disagree.

Dr. Bryant stated that claimant was working in a dusty attic that was "littered" with dead birds. (Ex. 84-2). We agree with the ALJ that such a statement establishes that Dr. Bryant believed that claimant was exposed to numerous dead birds in a dusty attic. However, the record establishes that claimant was tearing down a chimney while wearing a mask and was actually exposed to several birds rather than an attic "littered" with dead birds.

Accordingly, we agree with the ALJ that claimant has not met his burden of proving a compensable occupational disease claim.

ORDER

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

February 18, 2000 Cite as 52 Van Natta 275 (2000)

In the Matter of the Compensation of
KAREN L. VERSCHOOR, Claimant
WCB Case No. 99-01890
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration that awarded 15 percent (28.8 degrees) scheduled permanent disability for the loss of use or function of the right arm and 15 percent (48 degrees) unscheduled permanent disability. On review, the issues are extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

We substitute the following for the second paragraph of finding of fact (4), with the exception of the last sentence:

The medical arbiter, Dr. Maukonen, found loss of sensation in the fingers of claimant's right hand consistent with a medial distribution in the right hand and decreased two-point discrimination loss of her thumb of 7 millimeters. (Exs. 59-9, -15). Maukonen stated that these findings were not due to unrelated causes or conditions. (Ex. 59-9). During his examination, Maukonen found no symptoms from thoracic outlet syndrome or reflex sympathetic dystrophy, noting that by history claimant experienced symptoms that were controlled by medication. (Ex. 59-7).

CONCLUSIONS OF LAW AND OPINION

Claimant has accepted claims for traumatic median neuropathy, right carpal tunnel syndrome, thoracic outlet syndrome, and reflex sympathetic dystrophy. A Notice of Closure awarded 9 percent scheduled permanent disability for the loss of use or function of the right arm. Based on the medical arbiter's findings, an Order on Reconsideration awarded 15 percent scheduled permanent disability for the right arm and 15 percent unscheduled permanent disability.

The ALJ affirmed the Order on Reconsideration. On review, claimant requests an increase in both the scheduled and unscheduled permanent disability awards.[1] She specifically contends that she

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[1] Claimant also notes that the Department erred in determining that she held a high school diploma or GED certificate at the time of claim closure. The insurer agrees that claimant's education value should be one (1), for a total of 12 for claimant's non-impairment factors. Based on the parties' agreement, we include the value of one (1) for education in our final calculations.

should receive increased scheduled permanent disability because she has reduced range of motion in the fingers of the right hand and increased loss of sensation in the thumb. The insurer, citing *David L. Couture*, 50 Van Natta 1181 (1998), contends that the ALJ correctly concluded that: (1) the evidence did not warrant an award for loss of range of motion in the right thumb and fingers because "nothing in [the arbiter's] exam indicates those findings are due to the injury;" and (2) the ALJ correctly concluded that claimant was not entitled to an increase in the impairment value for loss of sensation in the thumb under OAR 436-035-0110(1)(c).

As for unscheduled permanent disability, claimant contends that neither the ALJ nor the Department properly applied OAR 436-035-0320(5) when considering thoracic and cervical impairment and requests chronic condition values for each area. The insurer argues that there is no medical evidence to indicate that claimant's cervical and thoracic range of motion findings were due to the compensable injury.

ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." The determination of impairment is further explained in OAR 436-035-0007(14), which provides in material part that "[o]n 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."

Here, we agree with the ALJ that the medical arbiter, Dr. Maukonen, performed a more complete examination for the purpose of determining extent of permanent disability than Dr. Grant, claimant's treating physician. Although Dr. Grant examined claimant on July 15, 1998, Dr. Maukonen's measurements and tests are more complete and precise. (*Compare* Exs. 51, 52, 53 and 54 with Ex. 59). Furthermore, Dr. Maukonen examined claimant closer in time to the issuance of the Order on Reconsideration, the point at which we and the ALJ must evaluate claimant's disability. ORS 656.283(7); 656.295(5). Therefore, we conclude that Dr. Grant's report is less persuasive than Dr. Maukonen's medical arbiter report. Accordingly, because a preponderance of the evidence does not establish a different level of impairment, we rely on Dr. Maukonen's report to establish the extent of claimant's permanent disability.

Extent of Scheduled Permanent Disability

Range of Motion

Dr. Maukonen found reduced range of motion in claimant's right thumb and fingers. Relying on *David L. Couture*, 50 Van Natta at 1181, the ALJ concluded that the evidence did not warrant an award for loss of range of motion in the right thumb and fingers because "nothing in [the arbiter's] exam indicates those findings are due to the injury."

Claimant challenges the ALJ's order, asserting that the medical arbiter's impairment findings are consistent with claimant's compensable injury and the direct medical sequelae of that injury because her accepted conditions (traumatic median neuropathy, right carpel tunnel syndrome, thoracic outlet syndrome and reflex sympathetic dystrophy) immediately resulted in symptoms that affected the use of the fingers of her right hand and that the medical arbiter indicated that "no unrelated causes were found" when asked whether the findings were due to the accepted conditions or due to other unrelated causes. Thus, claimant argues that the medical arbiter's report and the medical record as a whole provide medical evidence that the range of motion loss in claimant's right digits is not only "consistent with" her accepted injuries under *SAIF v. Danboise*, 147 Or App 550 (1997), but also that the permanent loss of range of motion in the right fingers are "direct medical sequelae" of the accepted conditions. The insurer continues to argue that the ALJ correctly relied on *Couture*.

In *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997), the court held that when a treating doctor or medical arbiter makes impairment findings and describes those findings as consistent with a claimant's compensable injury and the medical record does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. 147 Or App at 553.

Here, claimant sustained multiple injuries when the nozzle of an air hose came off and she was hit in the chest and right arm by the flailing hose. The insurer accepted traumatic median neuropathy, right carpal tunnel syndrome, thoracic outlet syndrome and reflex sympathetic dystrophy. We agree with claimant that the medical record discloses no noncompensable factors that may have contributed to the impairment in claimant's fingers.

The arbiter found decreased range of motion in the fingers on the right hand and reported that claimant had "slight decreased range of motion in the right hand as compared to her left and does not make as tight a fist on the right as on the left." (Ex. 59-6). He also reported that claimant cannot use her right hand and arm for repetitive gripping, grasping, pushing or pulling. (Ex. 59-8). Finally, and most importantly, when asked to apportion his findings between the accepted conditions and unrelated causes, he reported that no unrelated causes were found. (Ex. 59-10). Under the circumstances, we conclude that, because the impairment findings are consistent with claimant's compensable injury and neither the medical record nor the arbiter has attributed claimant's impairment to other causes, the arbiter's report supports an award for lost range of motion of the right fingers.[2] We therefore proceed to rate the lost range of motion in claimant's right fingers.

There is no documented history of injury or disease of the contralateral joints (of the left fingers); therefore, pursuant to OAR 436-035-0007(23), a comparison of the contralateral joint is appropriate to determine impairment. If the motion of the contralateral joint exceeds the values for ranges of motion established under the rules, the values established under the rules shall be used to establish impairment. *See* OAR 436-035-0007(23)(a).

Thumb

The medical arbiter found reduced flexion at the interphalageal joint of the right thumb (58 right v. 60 left):

Right 58 Left 60 1% *See* OAR 436-035-0050(1).

The arbiter also found reduced carpometacarpal flexion (14 right v. 15 left) and extension (24 right v.26 left), which is considered part of the hand. *See* OAR 436-035-0020(3).

Loss of flexion at the carpometacarpal joint of the thumb:

Right 14 Left 15 0.4% *See* OAR 436-035-0050(8) and 436-035-0075(2).

Loss of extension at the carpometacarpal joint of the thumb:

Right 24 Left 26 0.6% *See* OAR 436-035-0075(5).

(Because these losses in the carpometacarpal joint are *hand* values, they are rated as part of the hand. *See* OAR 436-035-0075(1)).

Index Finger

The medical arbiter found right index finger asymmetrical values at the DIP joint (56 right v. 72 left); the PIP joint (76 right v. 102 left); and the MP joint (90 right v. 88 left).

Loss of flexion at the DIP joint of the index finger:

Right 56 Left 72 8.8% *See* OAR 436-035-0060(1)

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[2] We contrast the circumstances of this case with those in *David D. Couture*. In *Couture*, the claimant had an accepted claim for "lumbar strain." The arbiter rated range of motion in the cervical area. However, unlike in this case, in *Couture* there was no medical evidence that loss of *cervical* range of motion was "consistent with" the *low back* injury or that the claimant's cervical condition was a "direct medical sequelae" of the accepted lumbar strain condition.

Loss of flexion at the PIP joint of the index finger:

Right 76 Left 102 14.4% *See* OAR 436-035-0060(4)

Loss of flexion at the MP joint of the index finger:

Right 90 Left 88 0.0% *See* OAR 436-035-0060(7)

Middle Finger

The medical arbiter found right middle finger asymmetrical values at the DIP joint (60 right v. 80 left); the PIP joint (96 right v. 100 left); and the MP joint (88 right v. 88 left).

Loss of flexion at the DIP joint of the middle finger:

Right 60 Left 80 6.0% *See* OAR 436-035-0060(1)

Loss of flexion at the PIP joint of the middle finger:

Right 96 Left 100 2.4% *See* OAR 436-035-0060(4)

Loss of flexion at the MP joint of the middle finger:

Right 88 Left 88 0.0% *See* OAR 436-035-0060(7)

Ring Finger

The medical arbiter found right ring finger asymmetrical values at the DIP joint (60 right v. 74 left); the PIP joint (100 right v. 98 left); and the MP joint (82 right v. 78 left).

Loss of flexion at the DIP joint of the ring finger:

Right 60 Left 74 6.0% *See* OAR 436-035-0060(1)

Loss of flexion at the PIP joint of the ring finger:

Right 100 Left 98 0.0% *See* OAR 436-035-0060(4)

Loss of flexion at the MP joint of the ring finger:

Right 82 Left 78 0.0% *See* OAR 436-035-0060(7)

Little Finger

The medical arbiter found right little finger asymmetrical values at the DIP joint (62 right v. 66 left); the PIP joint (102 right v. 98 left); and the MP joint (82 right v. 84 left).

Loss of flexion at the DIP joint of the little finger:

Right 62 Left 66 6.6% *See* OAR 436-035-0060(1)

Loss of flexion at the PIP joint of the little finger:

Right 102 Left 98 0.0% *See* OAR 436-035-0060(4)

Loss of flexion at the MP joint of the little finger:

Right 82 Left 84 8.8% *See* OAR 436-035-0060(7)

Loss of Sensation

Loss of sensation in the thumb is rated according to the location and quality of the loss and is measured by the two point discrimination method. *See* OAR 436-035-0110(1). The arbiter found two point discrimination at 7 millimeters, which is graded as less than normal. The ALJ affirmed the Order on Reconsideration's award of 8 percent under the rule. Claimant argues that the loss of sensation affected the whole digit, which would allow an impairment value of 25 percent. The insurer contends that the Order on Reconsideration's award is correct because it is an accurate reflection of the medical arbiter's finding that claimant had loss of sensation for the "tip" of the thumb only.

The medical arbiter found decreased sensation over the thumb, index, middle and radial aspect of the ring finger on the right hand as compared to the left, which he attributed to residual numbness in the medial nerve distribution of the right hand. (Ex. 59-6, -7, -9). Even though he measured two-point discrimination at the "tips" of each of the fingers and thumbs, the arbiter stated that the loss was consistent with the median nerve distribution. His measurement of two-point discrimination of 7 millimeters of claimant's thumb is considered "less than normal."[3] Because the arbiter stated that claimant's loss of sensation was consistent with a median nerve distribution, and because claimant's thumb has been neither resected nor amputated, we agree with claimant that the loss of sensation in her thumb affects the whole digit. Therefore, the impairment value for loss of sensation of claimant's thumb is 25 percent.

The loss of use of two or more digits shall be converted to a value for loss in the hand. OAR 436-035-0070(1), (2). We first rate the total impairment value in each digit by combining the range of motion values for each joint for an overall loss of range of motion value, which is then combined with other impairment values. *See* OAR 436-035-0007(22)(b).

The range of motion value for the thumb is 1, which is combined with the value of 25 for loss of sensation for a value of 26. The total value for the index finger is 22; the middle finger is 8; the ring finger is 6; and the little finger is 15. *See* OAR 436-035-0070(2); 436-035-0007(22)(b).

We then convert the digit values to hand values. *See* OAR 436-035-0070(2). The thumb (26) converts to a value of 9 percent of the hand. The index finger (23.2) converts to an impairment value of 4 percent of the hand. The middle finger (8.4) converts to an impairment value of 2 percent of the hand. The ring finger (10.8) converts to an impairment value of 1 percent of the hand. And the little finger (0.8) converts to an impairment value of 1 percent of the hand. *See* OAR 436-035-0070(3). The hand values, including the 1 percent hand value for lost range of motion in the carpometacarpal joint, are then added (9 + 4 + 2 + 1 + 1 + 1) for a total of 18 percent of the hand.

The parties do not dispute the values of 1 percent for the right wrist and 5 percent for a chronic condition of the right hand. Thus, the total right hand impairment is found by combining (18, 5, 1), for a total of 24 percent. The right hand impairment of 24 percent is converted to 20 percent right arm impairment. *See* OAR 436-035-0090.

The 2 percent value for reduced range of motion for the right arm and the 5 percent value for a chronic condition restricting use of the right arm are also undisputed. We accordingly combine the right arm values of 20 percent, 5 percent and 2 percent for a total of 26 percent scheduled permanent disability for the loss of use and function of the right arm. OAR 436-035-0007(18).

Consequently, claimant's scheduled permanent disability award is increased from 15 percent, as awarded by the Order on Reconsideration and ALJ's order, to 26 percent.

Unscheduled Permanent Disability

Relying on the arbiter's report, the Order on Reconsideration found a total of 1 percent for lost range of motion in the thoracic spine and 4 percent for lost range of motion in the cervical spine, for a total of 5 percent unscheduled disability. The arbiter also opined that claimant was restricted in repetitive use of the right shoulder due to the accepted condition. But because claimant received

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[3] A loss of sensation measuring 6 millimeters or less is considered normal. *See* OAR 436-035-0110(1)(a).

5 percent impairment for reduced range of motion in the thoracic and cervical areas, the Order on Reconsideration declined to award a value for repetitive restrictions in the shoulder. The ALJ affirmed the Order on Reconsideration's unscheduled permanent disability award, reasoning that, because the insurer had failed to cross-appeal the order, claimant's permanent disability award could not be reduced.

On review, claimant contends that the ALJ erred in affirming the Order on Reconsideration's 5 percent award for the thoracic and cervical areas, because the order erroneously combined the unscheduled permanent disability findings involving claimant's thoracic and cervical spines for a single award of 5 percent unscheduled chronic condition impairment, rather than awarding 5 percent unscheduled chronic condition impairment for each body area.[4] The insurer concedes that claimant's condition merits a 5 percent award for chronic condition impairment for the shoulder, but not for a thoracic or cervical spine condition, as those findings were not due to the injury.[5] We agree.

The insurer contends that any losses recorded in claimant's neck and low back are unrelated to the accepted conditions. As noted above, the accepted conditions at the time of claim closure were traumatic median neuropathy, right thoracic outlet syndrome, right carpal tunnel syndrome and reflex sympathetic dystrophy.

Here, the record shows that Dr. Grant diagnosed claimant with chronic myofascial right neck, shoulder periscapular and upper extremity pain syndrome as early as October 10, 1994. Dr. Grant opined that this condition was related to her work injury. (Exs. 4-3, 26-2). Dr. Grant continued to diagnose this condition through the duration of his treatment, and, by the time of his July 15, 1998 closing examination, he found the chronic myofascial syndrome to be stable but still symptomatic. (Ex. 59-4). Based on this medical evidence, and the arbiter's statement that there were no unrelated causes for claimant's impairment findings, and because these findings are consistent with claimant's compensable injury, the arbiter's report supports an award for lost range of motion in the cervical and upper thoracic area.

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[4] Claimant misreads the Order on Reconsideration. The order found a total impairment value of 5 percent for lost of range of motion in the thoracic and cervical spines. Because claimant had ratable unscheduled impairment of 5 percent, she was not given a value for a chronic condition in the shoulder. *See* OAR 436-035-0320(5) ("Body area" means the cervical/upper thoracic spine (T1-T6)/shoulders area) and (5)(a) ([u]nscheduled chronic condition impairment is considered after all other unscheduled impairment within a body area, if any, has been rated and combined under these rules[; w]here the total unscheduled impairment within a body area is equal to or in excess of 5%, the worker is not entitled to any unscheduled chronic condition impairment).

[5] At hearing, the insurer argued that the Department erred in awarding claimant 5 percent chronic condition for the arm and that there was nothing in the record indicating that claimant's cervical and thoracic range of motion findings were due to the injury. The ALJ rejected the insurer's arguments on the basis that the insurer had failed to cross-appeal the order. The insurer did not object to the 5 percent chronic condition award on review.

We do not agree with the ALJ's reasoning for rejecting the insurer's argument. We reason as follows.

Although the insurer is barred from challenging the Notice of Closure's award of *scheduled* permanent disability for the right arm because it did not request reconsideration of that award, *see Christine M. Flaherty*, 51 Van Natta 1971 (1999), the Notice of Closure made no award for *unscheduled* permanent disability. (*See* Ex. 55). In her request for reconsideration, claimant raised the issue of entitlement to unscheduled permanent disability and the Department made such an award. Under such circumstances, we conclude that the insurer may contest the entire increased unscheduled award granted in the first instance by the Order on Reconsideration. *See Todd M. Brodigan*, 45 Van Natta 438, 439 (1993), *aff'd mem* 128 Or App 59 (1994), *rev dismissed* 321 Or 98 (1995) (where a claimant seeks reconsideration and the award is increased or a carrier seeks reconsideration and the award is decreased, the party who did not request reconsideration can contest the portion of the award altered by the reconsideration order).

Thus, although the insurer is barred from challenging the Notice of Closure's award because it did not seek reconsideration of the scheduled permanent disability award, we conclude that the insurer may challenge the portion of the award that was altered (here, the unscheduled permanent disability awarded in the first instance) by the Order on Reconsideration. Accoarding, we proceed to address the insurer's argument regarding claimant's cervical and thoracic impairments on review.

Based on the arbiter's report and OAR 436-035-0360(13), (14), (15), and (16), claimant has the following range of motion losses in the cervical spine:

flexion	56 degrees	= 0.4%
extension	48 degrees	= 2.16%
right lateral flexion	38 degrees	= 0.47%
left lateral flexion	40 degrees	= 0.33%
right rotation	78 degrees	= 0.10%
left rotation	78 degrees	= 0.10%

The impairment values for loss of range of motion in the cervical spine are added for a total impairment value of 3.56 percent, which is rounded up to 4 percent. *See* OAR 436-035-0007(15).

Based on the arbiter's report and OAR 436-035-0360(17) and (18), claimant has the following range of motion losses in the thoracic spine:

flexion	44 degrees	= 0.3%
right rotation	28 degrees	= 0.2%
left rotation	32 degrees	= 0.0%

The impairment values for loss of range of motion in the thoracic spine are added for a total impairment value of 0.5%, which is rounded to 1 percent. OAR 436-035-0007(15).

We combine the impairment values for lost range of motion in the cervical spine and thoracic areas for a total impairment value of 5 percent. The arbiter found that claimant is restricted in repetitive activities in the right shoulder due to the accepted condition. Because claimant has a 5 percent impairment value in the cervical/upper thoracic spine (T1-T6)/shoulders body area, claimant is not entitled to any unscheduled chronic condition impairment. OAR 436-035-0320(5)(a). Accordingly, the total unscheduled impairment is 5 percent.

We now assemble the factors for claimant's unscheduled permanent disability. The values of age (1) and education (1) are added for a total of 2. OAR 436-035-0280(4). The value for adaptability (2) is multiplied by the value for age/eduation (2) for a total of (4). OAR 436-035-0280(6). This value (4) is added to the impairment value (5) for a total of 9 percent unscheduled permanent disability.

Accordingly, claimant's unscheduled permanent disability award is reduced from 15 percent, as granted by the Order on Reconsideration and the ALJ's order, to 9 percent.

ORDER

The ALJ's order dated August 2, 1999 is modified. In addition to the Order on Reconsideration's and the ALJ's awards of 15 percent (28.8 degrees) scheduled permanent disability for loss of use and function of the right arm, claimant is awarded 11 percent (21.12 degrees) scheduled permanent disability, for a total of 26 percent (49.92 degrees) scheduled permanent disability. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's counsel. Claimant's 15 percent (48 degrees) unscheduled permanent disability award, as granted by the Order on Reconsideration and the ALJ's order, is reduced to 9 percent (28.8 degrees).

In the Matter of the Compensation of
ANNA B. MADRIZ, Claimant
WCB Case No. 98-03837
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's right lateral meniscus tear; and (2) awarded an assessed attorney fee. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to direct the employer to amend its acceptance of claimant's right knee tendinitis; and (2) declined to assess a penalty for an allegedly unreasonable resistance to the payment of compensation. On review, the issues are compensability, scope of acceptance and penalties 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 correction. We replace the second sentence of the first full paragraph of page three of the Opinion and Order with the following sentence: "Dr. Higgins did not think that the lateral meniscus tear was due to the injury."

CONCLUSIONS OF LAW AND OPINION

Compensability/Right Meniscus Tear

Claimant has a compensable right knee injury which was accepted by the employer as a medial collateral ligament sprain. Claimant contends that her subsequently diagnosed lateral meniscus tear is due to the work injury. Accordingly, claimant must establish that the work injury was a material contributing cause of her torn meniscus. ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

Here, two physicians have provided opinions regarding the causation of claimant's meniscus tear. Dr. Higgins, an orthopedic surgeon and claimant's treating doctor, did not believe that the tear was related to the work injury. Dr. Higgins agreed with the MRI finding of a small tear in the mid portion of the lateral meniscus. However, Dr. Higgins did not believe that the tear was related to the injury. Dr. Higgins based his conclusion on the fact that claimant's knee pain was not in the location of the tear. (Ex. 33-11). Dr. Higgins felt that there were inconsistencies upon examination and during each of claimant's visits she was tender in an area remote from where that tear was. (Ex. 33-17). Dr. Higgins' conclusion was based on both his objective physical examination of claimant and her symptoms and complaints of pain. (Ex. 33-26, 28).

Dr. Woodward, who examined claimant on behalf of the employer, reported that, while some of claimant's symptoms were consistent with a lateral meniscus tear, other symptoms that she reported were more than would be expected from such a tear. (Ex. 32A-6). Dr. Woodward stated that, on the basis of claimant's history it was "reasonable to presume that the injury of July 25, 1997, was the cause of the lateral meniscus tear." However, Dr. Woodward further stated that claimant's case was "confusing," and "it is difficult to provide certainty." Dr. Woodward stated that the "viability of her persistent symptoms requires further investigation by another MRI or arthroscopy" and "the patient's history is compatible with her sustaining a tear to the lateral meniscus at the time of her work injury." (Ex. 32A-7).

After reviewing the two expert medical opinions pertaining to causation, we find no persuasive reason to reject the opinion of claimant's treating doctor. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Dr. Higgins examined and treated claimant on numerous occasions over a period of approximately one year, while Dr. Woodward examined claimant on only one occasion. Dr. Higgins also explained that observation of claimant was important in a case involving inconsistencies, and for that reason, he believed that he was in a better position than Dr. Woodward to provide an opinion regarding causation. (Ex. 33-27). Consequently, we find Dr. Higgins' opinion that claimant's lateral meniscus tear was not related to the work injury to be persuasive.

Finally, we conclude that Dr. Woodward's opinion does not support compensability. Dr. Woodward conceded that claimant's case was difficult and he could not speak with certainty regarding causation. Dr. Woodward's opinion does not establish with reasonable certainty or probability that there is a causal connection between the injury and the tear. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (The court held that the treating doctor's opinion that it was medically reasonable to assume a causal connection and the mechanism could certainly have produced a herniation indicated that the doctor's opinion was based more on the history related by the claimant than on concrete medical evidence. Such an opinion was held not to establish more than just the possibility of causal connection.); *Wanda Taylor*, 44 Van Natta 2117 (1992) (The claimant's treating doctor reported that causation was difficult to establish with certainty but not beyond the realm of possibility. However, the Board held that such an opinion was not sufficient to establish compensability).

Moreover, as Dr. Higgins noted, Dr. Woodward's report containing claimant's objective findings included a finding of "giveway of all muscle groups of the right side." (Ex. 32A-3). Dr. Woodward also recorded claimant's symptoms magnification and functional overlay during her exam. (Ex. 32A-5). Accordingly, because Dr. Higgins testified that such findings "usually suggests pain behavior and usually tends to mitigate against the veracity of the findings," (Ex. 33-32), we conclude that, without further explanation, Dr. Woodward's opinion regarding causation is not persuasive.

Therefore, because there is no persuasive medical evidence establishing causation, the employer's denial of claimant's meniscus tear is upheld. The ALJ's order is reversed on that issue. The ALJ's assessed attorney fee of $3,000 is also reversed.

Scope of Acceptance/Penalties

We adopt the ALJ's Conclusions of Law and Opinion on these issues.

ORDER

The ALJ's order dated July 19, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the self-insured employer's denial of claimant's right lateral meniscus tear is reversed. The employer's denial is reinstated and upheld. The ALJ's assessed attorney fee of $3,000 is reversed. The remainder of the ALJ's order is affirmed.

February 23, 2000 Cite as 52 Van Natta 283 (2000)

In the Matter of the Compensation of
JAMES L. BATSON, SR., Claimant
WCB Case No. 99-01559
ORDER OF ABATEMENT
Alice M. Bartelt (Saif), Defense Attorney

Claimant, *pro se*, has requested reconsideration of our January 24, 2000 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that had awarded claimant unscheduled permanent disability for a neck condition of 31 percent (99.2 degrees) and affirmed an Order on Reconsideration that awarded 11 percent (35.2 degrees).

In order to consider this matter, we withdraw our January 24, 2000 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days of the date of this order. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
GORDEN L. ATKINS, Claimant
WCB Case No. 99-04079
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that affirmed the Order on Reconsideration award of 13 percent (24.96 degrees) scheduled permanent disability for loss of use or function of claimant's left arm. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his left arm on January 20, 1997. The employer initially accepted a nondisabling partial tear of extensor muscle, left forearm. (Ex. 6). The employer subsequently accepted claimant's aggravation claim for left lateral epicondylitis. (Ex. 32). On July 1, 1998, Dr. McWeeney performed left elbow surgery. (Ex. 33).

A January 27, 1999 Notice of Closure did not award any permanent disability. (Ex. 54). Claimant requested reconsideration. (Ex. 55A). Dr. Ho performed a medical arbiter examination on April 13, 1999. (Ex. 56). A May 3, 1999 Order on Reconsideration awarded 8 percent for loss of strength and 5 percent for chronic condition impairment, for a total of 13 percent scheduled permanent disability for loss of use of function of claimant's left arm. (Ex. 57). The employer requested a hearing.

The ALJ relied on Dr. Ho's report, despite the fact it was "exceedingly brief," and affirmed the Order on Reconsideration.

Loss of Strength

Citing OAR 436-035-0110(8)(a), the ALJ found that claimant had a "constructive" radial nerve injury and was entitled to an award for loss of left arm strength.

The employer argues that claimant is not entitled to impairment for loss of strength. The employer contends that a preponderance of evidence supports Dr. McWeeney's impairment findings and, in any event, Dr. Ho's findings regarding claimant's loss of strength were not permanent. The employer argues that the ALJ's award for a "constructive" radial nerve injury was erroneous.

To determine impairment due to loss of strength, the physician reports the worker's strength using a 0 to 5 grading system, which is converted into a percentage value pursuant to OAR 436-035-0007(19)(a) (WCD Admin. Order 98-055). Under OAR 436-035-0110(8)(a), valid loss of strength in the arm, forearm or hand is valued "as if the peripheral nerve supplying (innervating) the weakened muscle(s) was impaired[.]"

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. We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

The "Medical Arbiter Questions" from the Appellate Review Unit regarding claimant's case provided, in part:

"Described any **MUSCLE STRENGTH** loss, DUE TO THE ACCEPTED CONDITION(S), in the 0 - 5/5 method (see table). Identify the specific body part and applicable peripheral nerve, nerve root, or muscle. Include a comment on whether the loss of strength is **due to** loss of muscle, nerve damage, disruption of the musculotendinous unit, range of motion loss, or other. If other, explain the etiology in detail." (Ex. 55B-2; underline and bold in original).

Dr. Ho, the medical arbiter, issued a one-page report and discussed claimant's muscle strength as follows:

"Muscle strength was 5/5 at the right elbow and 4/5 at the left elbow associated with discomfort. The loss of strength is related to discomfort and the need for additional progressive resistance exercise and not due to muscle, nerve damage or disruption of the musculotendinous unit." (Ex. 56).

We find that Dr. Ho's opinion regarding claimant's loss of strength is not sufficient to establish permanent impairment. Dr. Ho attributed claimant's loss of muscle strength in his left elbow to "discomfort." (*Id.*) We acknowledge that OAR 436-035-0010(3) provides that "[p]ain is valued in these rules to the extent it results in objective measurable impairment." Nevertheless, OAR 436-035-0007(1) provides that a worker is entitled to a value under the rules "only for those findings of impairment that are permanent[.]" Although claimant relies on Dr. Ho's impairment findings, Dr. Ho reported that claimant's loss of left elbow muscle strength was "related to discomfort and the need for additional progressive resistance exercise[.]" (Ex. 56). Dr. Ho's comment that claimant needed additional progressive resistance exercise suggests that he will improve with further treatment and, therefore, his loss of strength is not permanent.

Moreover, Dr. Ho expressly found that claimant's loss of left elbow muscle strength was "not due to muscle, nerve damage or disruption of the musculotendinous unit." (Ex. 56). That comment also suggests that claimant's loss of strength is not permanent. Based on Dr. Ho's comments, we are not persuaded that claimant's loss of strength findings are permanent. *See generally Georgina F. Luby*, 49 Van Natta 1828 (1997) (rejecting impairment findings of medical arbiter who believed that the claimant was not medically stationary); *Phyllis G. Nease*, 49 Van Natta 195, *on recon* 49 Van Natta 301, *on recon* 49 Van Natta 494 (1997) (medical arbiter believed that the claimant was not medically stationary and was in need of further medical treatment).

Similarly, we find that Dr. McWeeney's report is not sufficient to establish that claimant is entitled to a permanent disability award for loss of strength. Dr. McWeeney, claimant's attending physician, had examined claimant on several occasions and performed his left elbow surgery on July 1, 1998. (Ex. 33). He released claimant to full and regular duty on December 4, 1998. (Ex. 49). On January 13, 1999, Dr. McWeeney reported that claimant was significantly improved and was medically stationary. (Ex. 51). He found that claimant had 5/5 strength in left elbow flexors, elbow extensors, wrist flexors and wrist extensors. (*Id.*) Dr. McWeeney noted, however, that claimant "has a slight deficit of weakness that I think is accurate." (Exs. 51, 52). Despite Dr. McWeeney's reference to a "slight deficit of weakness," he specifically reported that claimant had 5/5 strength. We find that Dr. McWeeney's comment is not sufficient to establish that claimant is entitled to an impairment value for loss of left elbow strength. *See Terrance L. Moore*, 49 Van Natta 1787 (1997) (physician did not measure the loss of strength in terms of the 0 to 5 grading system and did not attribute the loss in strength to an injury to a particular nerve).

Chronic Condition

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. Ho performed a medical arbiter examination on April 13, 1999. (Ex. 56). He reported that claimant was "significantly limited in his ability to repetitively use the left elbow because of left lateral epicondylitis arising out of the accepted condition." (*Id.*) Dr. Ho provided no explanation as to *why* claimant was significantly limited in the repetitive use of his left elbow. Dr. Ho's entire report consists of only one page. He provided only a cursory history of claimant's injury and did not discuss claimant's medical treatment or the fact that he was released to regular work without any limitations. We find that Dr. Ho's assessment of claimant's chronic condition is not persuasive because it lacks adequate explanation and is not well-reasoned.

The reports from Dr. McWeeney, claimant's attending physician, do not indicate claimant is significantly limited in the repetitive use of his left elbow. On July 1, 1998, Dr. McWeeney performed surgery on claimant's left elbow. (Ex. 33). Dr. McWeeney released claimant to full and regular duty at work on December 4, 1998. (Ex. 49). On January 13, 1999, Dr. McWeeney said that claimant was significantly improved. (Ex. 51). He reported: "[Claimant] does not feel as if he is perfect and sometimes if he is really going to do some heavy, heavy gripping work with it, he will use his right side to protect the left side." (*Id.*) Nevertheless, Dr. McWeeney released claimant to full regular duty at work, with no limitations. (*Id.*) Dr. McWeeney felt that claimant had a "slight deficit of weakness[.]" (*Id.*)

Although Dr. McWeeney indicated that claimant tried to protect his left upper extremity if he was performing heavy work, we have previously held 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, e.g., Rena L. Rose,* 49 Van Natta 2007 (1997). Similarly, Dr. McWeeney's comment that claimant had a "slight deficit of weakness" is not sufficient to establish that he has a chronic and permanent medical condition and is *significantly* limited in the repetitive use of his left elbow. *See* OAR 436-035-0010(5). Dr. McWeeney released claimant to regular duty without any limitations. Under these circumstances, we conclude that claimant has not established that he is entitled to a chronic condition award for his left elbow.

ORDER

The ALJ's order dated October 8, 1999 is reversed. In lieu of the May 3, 1999 Order on Reconsideration, the January 27, 1999 Notice of Closure is reinstated and affirmed. The ALJ's attorney fee award is reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority's conclusion that claimant is not entitled to a scheduled permanent disability award for a chronic condition or for loss of strength. Instead, I would affirm the ALJ's order, which affirmed the Order on Reconsideration award of 13 percent scheduled permanent disability for loss of use or function of claimant's left arm.

In particular, I agree with the ALJ's decision to rely on the opinion of Dr. Ho, the medical arbiter. 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. In this case, the ALJ correctly determined that the attending physician's reports did not preponderate over the medical arbiter's report. In any event, Dr. McWeeney's comments actually *support* Dr. Ho's findings concerning loss of strength. Dr. McWeeney found that claimant's "[g]rip strength on the left is 34/34/44 kilograms of force versus the right which is 53/48/51 kilograms of force." (Ex. 51). Dr. McWeeney concluded that claimant had a "slight deficit of weakness" that he believed was accurate. (Exs. 51, 52).

In sum, I believe that the majority is stretching to reverse the ALJ's order. I would instead affirm the determination by *both* the Order on Reconsideration and the ALJ that claimant is entitled to a scheduled permanent disability award of 13 percent.

In the Matter of the Compensation of
SHERI M. ASTORINO, Claimant
WCB Case No. 99-03124
ORDER ON REVIEW
Scott M. McNutt, Jr., Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's current low back condition; and (2) awarded claimant's counsel an assessed attorney fee. On review, the issues are compensability and attorney fees.

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

On review, the employer contends that the ALJ should not have relied on the opinion of Dr. Walker, claimant's treating physician. Dr. Walker reported that, prior to her compensable injury, claimant had never experienced back problems, but following the injury, claimant's pain and disability had been consistent in presentation. Based upon the results of his exams, claimant's response to treatment, and the history and consistency of the record, Dr. Walker reported that the compensable injury was the major contributing cause of claimant's current condition. (Ex. 15-2).

The employer argues that Dr. Walker's opinion is not sufficient to establish causation because, during his deposition, Dr. Walker conceded that claimant's case was "perplexing" and he did not have "the answer to [claimant's] problems." (Ex. 16-28). The employer contends that Dr. Walker's response during cross-examination establishes that his opinion is not based on a reasonable medical probability. *See e.g. Gormley v. SAIF*, 52 Or App 1055 (1981). We disagree.

When read in its entirety, Dr. Walker's opinion regarding causation is stated on a reasonable medical probability. (Ex. 15). Dr. Walker's responses during his deposition pertain to claimant's course of treatment and the lengthy duration of her problems. (Ex. 16-28). However, his concession that he was providing pain relief for claimant and could not state if or when her problems would completely resolve does not undermine his opinion that her current condition is due to the compensable injury. Accordingly, we affirm the order of the ALJ.

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 counsel's services on review is $1,200, 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 October 27, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the self-insured employer.

In the Matter of the Compensation of
DARLENE L. GAGE, Claimant
WCB Case No. 99-01974
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Lundeen, et al, Defense Attorneys

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

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of Finding of Fact No. 19, and with the following corrections:

At page 2 of the order, the ALJ's Finding of Fact Number 10 is corrected to read: "In *February*, 1991, claimant began treating with a psychiatrist, Dr. Henderson. . ."

On page 5 of the order, the ALJ's order is corrected to read "insurer accepted chemical dependency and cognitive dysfunction conditions," in lieu of "insurer accepted depression, chemical dependency and cognitive dysfunction conditions."

CONCLUSIONS OF LAW AND OPINION

Claimant currently suffers from psychological conditions diagnosed as major depression, substance abuse and somatoform pain disorder. (Ex. 16). Claimant's preexisting depression and substance abuse conditions have combined with her accepted low back, chemical dependency and related cognitive dysfunction conditions. (Exs. 38, 39).

The ALJ set aside the insurer's denial of claimant's current psychological condition. In reaching this conclusion, the ALJ relied on the opinion of claimant's treating psychiatrist Dr. Henderson. Based on the following reasoning, we disagree with the ALJ's conclusion.

To prove the compensability of her current psychological conditions, claimant must show that her accepted conditions remain the major contributing cause of her disability and need for treatment. ORS 656.005(7)(a)(B). When evaluating the medical evidence regarding causation, we rely on those opinions that are both well-reasoned and based on 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 claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to claimant's treating psychiatrist, Dr. Henderson.

As noted above, claimant never had an accepted depression condition. The insurer accepted "laminectomies at L 3-4 and L 4-5, chemical dependency to Morphine and Fentanyl, and related cognitive dysfunction." (Exs. 15, 26). Although claimant testified that she was never depressed before her 1985 injury, Dr. Davies concluded that claimant had a preexisting propensity to depression. (Ex. 39-6). Psychiatrist Dr. Klein did not specifically note a preexisting depression condition, but opined that claimant's current depression or dysthymia conditions were not related to any of her accepted conditions. (Ex. 31-12).

In December 1987, claimant entered into a Disputed Claim Settlement that provided that her low back degenerative disc disease was not compensable. (Ex. 9). Claimant also has had a substance abuse/chemical dependency problem that preexisted her 1985 compensable injury. (Ex. 38-9, Ex. 39-6). Dr. Klein, Dr. Farris and Dr. Davies concluded that these preexisting or noncompensable conditions were the major contributing cause of her current psychological conditions. For the following reasons, we find these opinions more persuasive than that of Dr. Henderson.

Dr. Henderson's opinion, first of all, is based on inaccurate information. His opinion is based on an assumption that claimant's "low back pain" is a compensable component of her claim. (Ex. 43). However, to the extent that claimant's low back pain relates to her denied degenerative disc disease condition, it cannot be considered in any equation that favors compensability. Furthermore, Dr. Farris concluded that claimant's degenerative disc disease is the major contributing cause of her low back pain. (Ex. 38-9).

Dr. Henderson's ultimate opinion is also inconsistent with his chart notes. In his chart notes, Dr. Henderson notes ongoing pain due to claimant's migraine headache and cervical conditions as a significant reason for claimant's seeking treatment and medications. Yet, he downplays the effect of these noncompensable conditions in his final opinion on causation. This apparent inconsistency is unexplained. Finally, Dr. Henderson initially concurred with Dr. Klein's July 15, 1998 report. (Exs. 31, 34). His later reversal of opinion is likewise never fully explained. We therefore find Dr. Henderson's opinion unpersuasive. *Kelso v. City of Salem,* 87 Or App 630 (1987).

Based on the foregoing reasoning, we find that claimant's psychological condition is not compensable. Consequently, we uphold the insurer's denial.

ORDER

The ALJ's order dated September 14, 1999 is reversed. The insurer's March 4, 1999 denial is reinstated and upheld. The ALJ's award of an assessed attorney fee is also reversed.

Board Member Phillips Polich dissenting.

Because I agree with the ALJ that claimant's current psychological condition remains compensably related to her accepted conditions, I respectfully dissent.

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); *Leonard M. Terrible,* 51 Van Natta 1377 (1999). Dr. Henderson has followed claimant over a significant period of time, since February 1991. (Ex. 43). Dr. Henderson authored a well-reasoned report concluding that claimant's 1985 compensable injury and its sequelae remain the major contributing cause of disability and need for treatment for her current psychological condition. (Ex. 43).

In reaching this opinion, Dr. Henderson thoroughly considered the effect of claimant's preexisting and noncompensable conditions. (Ex. 43). Dr. Henderson's report, when read in context, reveals a correct understanding of claimant's migraine headache and neck conditions. For example, Dr. Henderson recognized that claimant had a long-standing migraine condition, and stated only that each episode of migraines is "short-lived and resolves with treatment and time." (Ex. 43-1). This history is accurate and consistent with the record.

Moreover, importantly, Dr. Henderson was not under the misimpression that claimant had ever had an accepted depression condition. Significantly, claimant testified that she was never depressed before her compensable injury. (Tr. 15).

Dr. Henderson, in fact, correctly recited all of claimant's compensable conditions in his report. (Ex. 43-1). Contrary to the majority, therefore, I am satisfied that Dr. Henderson did not improperly consider claimant's denied low back degenerative disc disease condition.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
ALBERT E. KILLION, Claimant
WCB Case No. 99-02409
ORDER OF ABATEMENT
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant has requested abatement and reconsideration of our January 25, 2000 order that affirmed the order of the Administrative Law Judge (ALJ) that upheld the SAIF Corporation's "de facto" partial denial of right shoulder adhesive capsulitis and impingement syndrome. Specifically, claimant asserts that we did not sufficiently address his argument that ORS 656.262(7)(a) requires that future medical providers be reasonably apprised of the nature of the compensable injury. In addition, claimant asserts that it is SAIF's burden of proof to establish that future medical providers will be reasonably apprised of the nature of the compensable condition.

In order to allow sufficient time to consider claimant's motion, we withdraw our January 25, 2000 order. SAIF is granted an opportunity to respond to claimant's motion. To be considered, SAIF'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.

February 24, 2000 Cite as 52 Van Natta 290 (2000)

In the Matter of the Compensation of
BRYAN W. LUSK, Claimant
WCB Case Nos. 99-02559 & 98-09284
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that awarded a $3,000 assessed fee under ORS 656.382(1). On review, the issue is attorney fees.

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

The ALJ set aside the employer's "de facto" denial of claimant's current low back condition. The ALJ then determined claimant's entitlement to an assessed fee under various statutes. The ALJ first held that claimant was not entitled to an assessed fee under ORS 656.386(1), reasoning that the employer did not refuse to pay compensation on the express ground that the injury or condition for which compensation was claimed was not compensable or otherwise did not give rise to an entitlement to compensation. The ALJ, however, found that claimant was entitled to an assessed fee under ORS 656.382(1), concluding that the employer received a claim for compensation in November 1998, processed the claim through the investigation stage, but did not deny or accept the claim thereafter. Reasoning that medical services were provided for the compensable low back condition before a claim was filed with the employer and, thus, constituted compensation, the ALJ determined that the employer's conduct of inaction and delay constituted unreasonable resistance to the payment of compensation under ORS 656.382(1). Therefore, the ALJ awarded an assessed fee of $3,000 pursuant to that statute.

On review, the employer contends that, while the ALJ correctly concluded that a fee was not authorized under ORS 656.386(1), the ALJ improperly awarded one under ORS 656.382(1) because there was insufficient evidence that it unreasonably resisted the payment of compensation. We disagree.

ORS 656.382(1) provides that, if a carrier "unreasonably resists the payment of compensation," it shall be liable for a reasonable attorney fee. However, even if a carrier does not timely accept a claim, there is no unreasonable resistance to payment of compensation if it paid all compensation. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993).

Here, the basis for ALJ's conclusion that the employer unreasonably resisted payment of compensation was his finding that medical services were being provided for claimant's compensable condition before a claim was filed with the employer and that an examining physician found that such services were necessary treatment for the compensable low back condition. Inasmuch as the employer did not accept or deny the claim after a claim was filed, the ALJ reasoned that the employer's inaction and delay constituted unreasonable resistance to the payment of compensation.

We agree with the ALJ's reasoning. Moreover, even if as the employer contends, the record does not establish that it was ever presented with or asked to pay medical bills, the employer was aware that claimant was receiving medical treatment from Dr. Carr. (Ex. 52-3). Those medical services were unpaid. (Ex. A). Moreover, those services eventually became payable when the ALJ determined that

claimant's current low back condition was compensable and the responsibility of the employer. Accordingly, we find that the employer unreasonably resisted the payment of compensation within the meaning of ORS 656.382(1).[1] Therefore, we affirm.[2]

ORDER

The ALJ's order dated July 22, 1999 is affirmed.[3]

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[1] The employer cites *Mark A. Klouda*, 51 Van Natta 265, *on recon* 51 Van Natta 823 (1999). There, we concluded that, because there was no persuasive evidence that the carrier failed to pay compensation, including medical bills, there was no unreasonable resistance to payment of compensation. Therefore, we held there was no basis for an attorney fee under ORS 656.382(1). 51 Van Natta at 268. However, in *Klouda*, the focus was on untimely payment of medical bills in the context of an accepted claim. In contrast to *Klouda*, in this case, we have the employer's failure to respond by acceptance or denial to an initial claim, which has been determined to be compensable. The record supports a finding that there were unpaid medical bills. (Ex. A). Accordingly, we are persuaded that the employer in this case unreasonably failed to pay compensation through its inaction and delay when presented with a claim in November 1998. Thus, we find that the ALJ appropriately awarded an assessed fee under ORS 656.382(1)

[2] We also distinguish this case from *Condon*, because, unlike that case, all compensation in this case was not paid.

[3] We do not award an assessed fee for services on review regarding the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

February 24, 2000 Cite as 52 Van Natta 291 (2000)

In the Matter of the Compensation of
BRENT A. LASURE, Claimant
WCB Case No. 99-01779
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration that awarded 16 percent (1.6 degrees) scheduled permanent disability for loss of use or function of claimant's left ring finger. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order. *See* ORS 656.283(7) (evaluation of a worker's disability is as of the date of issuance of the reconsideration order).[1]

ORDER

The ALJ's order dated November 2, 1999 is affirmed.

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[1] The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. However, we have held that a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination. *See, e.g., James A. Hanson*, 50 Van Natta 23, 24 (1998) (arbiter most probative regarding the claimant's impairment, where the record established improvement between the time the claimant was declared medically stationary and the time of the medical arbiter examination several months later); *Maureen E. Bradley*, 49 Van Natta 2000, 2002 n.1 (1997) (arbiter's evaluation of claimant's grip strength more probative than treating doctor's, considering passage of time since treating doctor's last examination and claimant's improved strength as of reconsideration).

In the Matter of the Compensation of
KURT W. LUTHER, Claimant
WCB Case No. 99-02608
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's denial of his injury claim for left retinal irregularity. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following corrections and exceptions. Claimant saw ophthalmologist, Dr. Holland, on May 11, 1999. We do not adopt either the last sentence of the second to last paragraph of the ALJ's findings of fact or the findings of ultimate fact.

CONCLUSIONS OF LAW

The ALJ found that claimant did not establish that his work activities were a material contributing cause of his left eye condition or need for treatment. In reaching his conclusion, the ALJ focused on the expert medical testimony. Specifically, the ALJ found that the only physician who rendered an expert medical opinion as to the causation of claimant's left eye condition was inconsistent and unpersuasive.

On review, claimant challenges the ALJ's conclusion that he failed to establish that his work activities, *i.e.* the laser incident, were a material contributing cause of his left eye condition. Specifically, claimant disagrees with the ALJ's assessment of Dr. Holland's opinion as inconsistent and unpersuasive. The insurer contends, however, that the ALJ's order was correct and additionally, that claimant's testimony was not credible.

We first address the insurer's contention regarding claimant's credibility, specifically that claimant's history of the laser incident has been inconsistent. The ALJ made no express credibility findings and the issue of credibility concerns the substance of claimant's testimony, therefore, we are qualified to make our own determination of credibility. *Coast Farm Supply v. Hultberg,* 84 Or App 282 (1987).

We note there are some variations in claimant's medical history. Most significantly, there is a dispute as to whether claimant's right or his left eye was exposed to the laser. Chart notes from Dr. Pearson, (the emergency clinic physician) taken the same day as the incident, list the right eye as the one exposed. (Ex. 1). However, all other documents in the record as well as the testimony state that claimant's left eye was the one injured. (Exs. 1B, 2, 4, 5, 7; Tr. 11, 12, 13, 27). Most importantly, Troy Keough, one of claimant's co-worker's and a witness to the laser incident, testified that upon the laser being pointed in claimant's eye, claimant grabbed his *left* eye. (Tr. 27). Under such circumstances, we are persuaded that claimant's left eye was exposed to the laser.

Next, there is some dispute as to where the laser pointer was being aimed immediately prior to being pointed at claimant's eye. The insurer claims that Mr. Rich, the co-worker with the laser pointer, was seated behind claimant and that the laser could not have been pointed at claimant's chest. Claimant, on the other hand, argues that the laser was pointed on his chest immediately prior to striking him in the eye.

We find the testimony of Troy Keough to be most helpful. Mr. Keough was seated at the same table as Mr. Rich and had been watching Mr. Rich shine the laser pointer around the room. Mr. Keough drew a diagram of where he, Mr. Rich and claimant were seated at the time of the incident. (Ex. 6). After reviewing this diagram and Mr. Keough's and claimant's testimony, we find Mr. Rich was neither seated directly behind nor directly in front of claimant, but instead was at more of a 45 degree angle, to the left of and behind claimant. The evidence establishes that, from his position, Mr. Rich was able to shine the laser pointer on claimant's chest. Additionally, the record shows that if claimant were to turn his head to look at Mr. Rich, his left eye would be the eye most likely exposed to the laser.

Therefore, after reviewing the medical records and testimony regarding the circumstances of claimant's left eye injury, we do not find the variations in those descriptions to seriously undermine claimant's credibility or the histories on which the medical evidence was based. Accordingly, we find the substance of claimant's testimony regarding injury to his left eye and the circumstances surrounding that injury to be credible.

Next, we address claimant's contention that he sufficiently established that the on-the-job laser incident was a material contributing cause of his need for treatment or disability for his left eye condition.

Here, pursuant to the insured's instructions, claimant was at work at his designated location waiting for his specific job assignment for the day. While waiting, claimant's left eye was exposed to a laser beam. Claimant experienced immediate pain and promptly notified his supervisor. Claimant was released from work to seek emergency medical treatment that day.

Dr. Pearson assessed exposure of laser light but found no evidence of damage to either claimant's right or left corneas. However, Dr. Pearson explained that claimant would need to see an ophthalmologist for his retina to be checked for any possible damage. Claimant subsequently saw Dr. Holland, an ophthalmologist, to have a complete eye exam, including an examination of his retina. Dr. Holland diagnosed macular focal irregularity in the left eye and attributed claimant's on-the-job laser exposure as a material contributing cause to the irregularity.

A compensable injury is an accidental injury arising out of and in the course of employment requiring medical services or resulting in a disability, established by medical evidence supported by objective findings. ORS 656.005(7)(a). Where compensability involves a complex medical question, we must rely on expert medical opinion. *Uris v. Compensation Department,* 247 Or 420 (1967).

Here, it is undisputed that claimant was within the course and scope of his employment when the laser incident occurred. Claimant sought immediate medical treatment at an emergency clinic from Dr. Pearson and later sought medical treatment from Dr. Holland. Therefore, our focus rests on determining if the expert medical evidence establishes that the laser incident was a material cause of claimant's need for medical treatment or disability for his left eye condition.

The expert medical opinions must evaluate the relative contribution of each cause. *Dietz v. Ramuda,* 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). We rely on those expert medical opinions that are the most well-reasoned and based on complete information. *Somers v. SAIF,* 77 Or App 259 (1986). For support, claimant relies on Dr. Holland's opinion that he prove that, to a reasonable degree of medical probability, a material contributing cause of claimant's need for medical treatment for his left eye condition is the on-the-job laser incident. (Exs. 5, 7-12, 7-26). There are no other medical opinions, supporting or contrary to, Dr. Holland's opinion. However, the insurer contends that Dr. Holland's opinion is not persuasive because he found the laser incident only a possible, not probable, cause of claimant's macular focal irregularity.

We look at the expert medical opinion in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel,* 161 Or App 516 (1999). Here, we find that Dr. Holland provided a well-reasoned opinion based on a complete history. Dr. Holland explained that the laser pointer that caused damage to claimant's retina would not necessarily damage his cornea. (Ex. 7-33). Thus, Dr. Holland's opinion is consistent with Dr. Pearson's findings and suggestion that claimant see an ophthalmologist even though he did not find any signs of injury to the exterior portion of claimant's eyes.

Additionally, Dr. Holland's opinion did not vacillate back and forth, but discussed all possible causes for claimant's left eye condition and need for treatment. (Ex. 7-9, 7-11, 7-12, 7-26). While we acknowledge Dr. Holland did list the laser exposure as a *possible* cause, he did so in the context of outlining all possible causes for the irregularity. (Ex. 7-11, 7-12, 7-18, 7-21). However, and most importantly, Dr. Holland explained why the laser incident, out of all the possible causes, was the most probable cause. (Exs. 4, 7-12, 7-21, 7-22, 7-25, 7-26, 7-27). Dr. Holland's opinion consistently held that, given claimant's history and his objective findings, the laser incident was a material, more probable than not, cause of claimant's left eye condition and need for treatment. (*Id.*). Therefore, we find Dr. Holland's opinion taken as a whole, is consistent and persuasive.

In finding claimant's injury claim compensable, we distinguish this case from *Brown v. SAIF*, 79 Or App 205, *rev den* 301 Or 666 (1986); and *Daniel L. Hakes*, 45 Van Natta 2351 (1993). In *Brown*, the claimant had been exposed to asbestos at work and sought medical treatment when he became concerned that this exposure might have damaged his health. The doctors found that the claimant was healthy, but recommended regular testing. The court held that the claim was not compensable because the claimant failed to prove that he presently had a disease or had been injured.

Brown is distinguishable in that the claimant had not proven he had suffered any actual physical or mental harm. Here, however, an incident occurred at work and claimant received treatment as a result of the exposure to the laser. Additionally, claimant's ophthalmologist opined that the work incident was a material cause of his left eye condition and need for treatment.

In *Hakes*, the claimant was a pilot who was exposed to blood while transporting a patient. Although we found that the claimant had been exposed to blood, we further concluded that there was no evidence that the claimant had been injured by the exposure, or that he had HIV or any other disease. Here, however, as stated above, we conclude that claimant was injured. Specifically, based on Dr. Holland's opinion, claimant did sustain an injury to his retina.

Accordingly, we conclude that claimant has established a compensable injury claim. Therefore, the insurer's denial is set aside.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellant's brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 19, 1999 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on Board review, claimant's counsel is awarded $3,500 to be paid by the insurer.

February 24, 2000 Cite as 52 Van Natta 294 (2000)

In the Matter of the Compensation of
JOE M. MANN, Claimant
WCB Case No. 96-01194
ORDER ON REMAND
Floyd H. Shebley, Claimant Attorney
Gilroy Law Firm, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Labor Ready, Inc. v. Mann*, 158 Or App 666, *on recon* 160 Or App 576 (1999), *rev den* 329 Or 479 (1999). The court has reversed our prior order, *Joe E. Mann*, 50 Van Natta 62 (1998), that awarded claimant interim compensation based on his "new medical condition" beginning with the self-insured employer's telephone conversation with claimant's attending physician. Concluding that the conversation did not satisfy the filing requirements for a "new medical condition" claim under ORS 656.262(7)(a), the court rejected our holding that claimant's interim compensation commenced with the employer's telephone conversation with the attending physician. However, determining that claimant's attorney's September 26, 1996 letter satisfied the statutory requirements, the court has remanded for an award of interim compensation due from the date the employer received the September 26, 1996 letter.

Consistent with the court's opinion, we award interim compensation beginning the day the employer received claimant's attorney's September 26, 1996 letter. This compensation shall continue to run until such benefits may be terminated as authorized by law. Claimant's attorney is awarded an attorney fee equal to 25 percent of the compensation awarded by this order, not to exceed $3,800, payable directly to claimant's counsel. These awards are in lieu of those granted by our prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUDY L. MAGILL, Claimant
WCB Case Nos. 99-00277 & 98-07960
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

On December 15, 1999, we reversed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's aggravation claim for a current low back condition. Asserting that we erred in evaluating the evidence, the employer requested reconsideration.

On January 12, 2000, we abated our December 15, 1999 order to further consider the matter and allow claimant an opportunity to respond. Having received claimant's response, we now proceed with our reconsideration.

As a preliminary matter, we correct factual errors contained in our initial order. Note 1 of the order is replaced as follows: "A June 10, 1999 Board order *upheld* the January 8, *1998* claim closure." *Judy L. Magill*, 51 Van Natta 926 (1999). (*See* Ex. 89).

On reconsideration, the employer argues (as it did on review) that: (1) claimant's low back condition has not worsened pathologically; (2) any worsening that did occur was before the January 8, 1998 claim closure; and (3) even if claimant's condition worsened, she did not suffer diminished earning capacity. Therefore, the employer contends that claimant has not proven her aggravation claim.

The employer relies on evidence that claimant's condition (progressive low back degeneration, progressive loss of disc space at L5-S1, and L5 overriding the sacrum) existed before claim closure, her claim was not prematurely closed on January 8, 1998, and medical treatment before and after claim closure was purely palliative. This evidence does not persuade us that claimant's condition remained the same after claim closure. On the contrary, as we explained in our initial order, the record establishes that claimant's condition *worsened progressively* over time, and it continued to worsen "post closure."[1]

The employer also asserts that there is no "express" medical evidence establishing a pathological worsening and that claimant cannot prove her claim in any event because she has withdrawn from the workforce. We disagree with both contentions.

First, *direct*, not "express" medical evidence is required to prove an "actual worsening" (as opposed to mere symptomatic worsening) under ORS 656.273(1). *See SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997).[2] As we have explained, Dr. Grewe's description of claimant's progressively[3] worsened low back condition satisfies the statute's medical evidence requirement.

In addition, Dr. Grewe's June 29, 1998 opinion that claimant was unable to work because of her back condition (in light of her release to work at claim closure) persuades us that claimant's earning capacity diminished as a result of her worsened condition.[4] Moreover, although claimant's relationship

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[1] Dr. Grewe did not describe a mere symptomatic worsening; he specifically explained that claimant's *condition* worsened progressively at least until her October 22, 1998 surgery. (*See* Ex. 116). *Compare Rebecca M. Oakes*, 52 Van Natta 119 (2000) (claimant did not establish a pathological worsening where physician described only a symptomatic worsening).

[2] "ORS 656.273(1), as amended, requires that there be *direct* medical evidence that a condition has worsened." *Id.* (Emphasis added).

[3] Dr. Grewe described claimant's new symptoms and new findings over time and opined that her increase in symptoms was due to residuals from her prior lumbosacral disc removal, "which with the passage of time has resulted in *further* settling of the [disc] interspace[.]" (Ex. 116) (emphasis added). Thus, in our view, Dr. Grewe's opinion supports a conclusion that claimant's condition worsened progressively. *See also* note 1, *supra*.

[4] *See Jack W. Sizemore*, 46 Van Natta 1571, 1573 (1994) (diminished earning capacity established and aggravation claim proven, where the claimant was temporarily less able to work due to his worsening).

with the workforce may be material in a subsequent claim for temporary disability, we question its significance in determining whether she has proven a compensable worsening.[5] In any event, we need not answer the question because, even considering the "workforce" issue, we would not find that claimant has withdrawn from the workforce or that her nonworking status is voluntary (as opposed to injury-related). (*See* Tr. 18-19, 23-25, 29-30).

Accordingly, based on Dr. Grewe's observations and findings, and the consistency between his surgical findings, claimant's symptoms and her progressive disability, we continue to conclude that claimant's compensable condition pathologically worsened since the January 1998 Determination Order and her earning capacity diminished as a result of that worsening.

Claimant's attorney is entitled to an additional assessed fee under ORS 656.386(1) on reconsideration for services related to finally prevailing against the employer's denial. 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 $600, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case on reconsideration (as represented by claimant's counsel's fee request and claimant's response to the employer's request for reconsideration), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. This award is in addition to the attorney fee granted in our prior order.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our December 15, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[5] *See, e.g., Brian M. Eggman, on remand* 51 Van Natta 398, 400 (1999) (where the claimant was in the workforce at the time of his disability, he was entitled to temporary disability); *see also Roland L. Dawkins, second order on remand* 42 Van Natta 1 (1990) (entitlement to temporary disability established where the claimant had not withdrawn from the workforce when he became disabled under *reopened* aggravation claim).

February 29, 2000 Cite as 52 Van Natta 296 (2000)

In the Matter of the Compensation of
JACK R. HUNTINGTON, Claimant
Own Motion No. 00-0057M
OWN MOTION ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant seeks Board authorization of an approved fee for his attorney's services culminating in our February 18, 2000 Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amount of 25 percent of the increased temporary disability compensation is awarded under this order, not to exceed $1,050, payable by the carrier directly to claimant's attorney. *See* OAR 438-015-0080.

Accordingly, our February 18, 2000 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our February 18, 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
JEFFREY L. PROCIW, Claimant
WCB Case No. 98-08108
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) upheld the SAIF Corporation's *de facto* denial of his C5-6 disc injury; and (2) upheld SAIF's amended denial of a C5-6 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his neck, shoulders and low back in a motor vehicle accident (MVA) on April 15, 1997. (Ex. 1). A cervical MRI on April 24, 1997 showed "[m]inor posterior spondylitic spurring or mild midline disc bulge C5-6." (Ex. 2). On June 10, 1997, SAIF accepted a disabling cervical and thoracic strain. (Ex. 3).

Claimant's attorney requested that SAIF accept a C5-6 disc herniation that had been identified by Dr. Miller. (Ex. 4A). On December 30, 1997, SAIF indicated it was in the process of obtaining additional information regarding claimant's medical condition. (*Id.*) SAIF did not respond further to claimant's request.

Claimant did not respond to conservative treatment and Dr. Miller believed that claimant had a central disc herniation at C5-6 causing bilateral neck and shoulder pain without neurologic findings. (Ex. 5-1). In July 1997, Dr. Miller requested approval for a C5-6 nerve root block to be performed by Dr. Karasek. (Ex. 5-2).

A cervical myelogram/CT scan on May 20, 1998 showed a small, central disc bulge at C5-6 and a slight posterior bulge at C4-5. (Ex. 11). There was no evidence of canal stenosis or disc herniation. (*Id.*)

Claimant continued to have neck pain. On July 20, 1998, Dr. Butdorf reported that claimant had paresthesias, numbness and weakness of the upper extremities, as well as marked pain in the neck. (Ex. 14). He referred claimant to Dr. Keiper.

On August 27, 1998, Dr. Keiper reported that claimant had been having excruciating neck and right arm pain since the April 1997 MVA, and the pain was worsening. (Ex. 17-1). He diagnosed an injured disc at C5-6 causing radicular symptoms and neck pain and myofascial pain syndrome and recommended another MRI. (Ex. 17-4).

A cervical MRI on September 4, 1998 showed a small central disc protrusion at C5-6, minimally impressing the thecal sac, without cord or nerve root compression. (Ex. 18). The C4-5 disc was mildly degenerated without herniation. (*Id.*) Dr. Keiper reviewed the MRI and reported that the axial images reiterated the previous MRI findings of a "centrally herniated disc at C5-6 which pushes on the anterior surface of the spinal cord." (Ex. 21). On April 6, 1999, Dr. Keiper performed an anterior cervical discectomy and fusion at C5-6. (Ex. 27). His diagnosis was cervical spondylosis at C5-6. (*Id.*)

Claimant requested a hearing on SAIF's *de facto* denial.

CONCLUSIONS OF LAW AND OPINION

At hearing, SAIF orally denied claimant's C5-6 disc herniation on the ground that claimant did not suffer from that condition. The ALJ found there was no medical evidence as to whether SAIF's acceptance of a cervical and thoracic strain adequately apprised claimant and the physicians of the nature of the compensable condition. Because there was no expert opinion as to whether the acceptance apprised the parties that the cervical and thoracic strain encompassed the treatment for the C5-6 disc, the ALJ upheld SAIF's *de facto* denial.

With regard to SAIF's oral denial of a C5-6 disc herniation, the ALJ found no specific diagnosis of a disc herniation and no persuasive evidence that disc bulges and herniations were interchangeable terms. The ALJ upheld SAIF's oral denial on the ground that it was not a diagnosed condition. The ALJ specifically noted that he was not concluding that claimant did not have a compensable medical condition involving the C5-6 disc.

On review, claimant argues that the ALJ erroneously upheld SAIF's *de facto* denial and he contends he is entitled to an expanded acceptance to include his C5-6 disc condition.

On the other hand, SAIF relies on *Cynthia J. Thiesfeld*, 51 Van Natta 984, *on recon* 51 Van Natta 1264 (1999),[1] to argue that the ALJ properly upheld the *de facto* denial because there is no medical evidence that supports claimant's position that the acceptance failed to provide adequate notice of the accepted conditions.

Claimant relied on ORS 656.262(6)(d) in seeking acceptance of his C5-6 disc injury. Under ORS 656.262(6)(d), a claimant who believes a condition has been incorrectly omitted from the notice of acceptance may object to the notice in writing. *Johansen v. SAIF*, 158 Or App 672, 678, *adhered to on recon*, 160 Or App 579 (1999). The carrier then has 30 days to revise the notice or make another response. ORS 656.262(6)(d). In *Mark A. Baker*, 50 Van Natta 2333, 2336 (1998), we concluded that a condition that was incorrectly omitted from a Notice of Acceptance under ORS 656.262(6)(d) is a condition that was in existence at the time of the notice, but was not mentioned in the notice or was left out.

Here, claimant compensably injured his neck, shoulders and low back in an April 15, 1997 MVA. (Ex. 1). A cervical MRI on April 24, 1997 showed "[m]inor posterior spondylitic spurring or mild midline disc bulge C5-6." (Ex. 2). On June 10, 1997, SAIF accepted a disabling cervical and thoracic strain. (Ex. 3). We find that claimant's C5-6 disc condition was "in existence" at the time of the acceptance, but was omitted. Therefore, the next determination is whether claimant's C5-6 disc condition was incorrectly omitted from SAIF's acceptance pursuant to ORS 656.262(6)(d).

In reaching this determination, we note that the "reasonably apprises" language in ORS 656.262(7)(a) does not appear in ORS 656.262(6)(d).[2] In any event, even if we assume that the "reasonably apprises" language in ORS 656.262(7)(a) is applicable to this case, we do not agree with SAIF that its acceptance of a cervical and thoracic strain reasonably apprised claimant and medical providers that the acceptance encompassed the C5-6 disc condition. ORS 656.262(7)(a) provides, in part: "[t]he insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions."

The medical evidence establishes that claimant has received treatment for a C5-6 disc condition that was different and separate from the strain conditions accepted by the employer. The majority of the medical reports focus on the nature of claimant's C5-6 disc condition (a bulge versus a herniation) and whether surgery was reasonable and necessary. Only one medical report indicated that claimant was still having strain symptoms. Dr. Collada examined claimant in October 1997 and concluded that his symptoms were a sign of a significant cervical strain. (Exs. 5-2, 19-2).

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[1] In *Cynthia J. Thiesfeld*, the claimant requested that the insurer accept additional conditions pursuant to ORS 656.262(6)(d) and she also raised the argument that her claim for additional right shoulder conditions constituted "new medical condition" claims under ORS 656.262(7)(a). We relied on ORS 656.262(7)(a) and concluded that, based on a medical opinion that the diagnosis of right shoulder strain would encompass the other diagnosed right shoulder and right upper extremity conditions, the insurer's acceptance was sufficient to apprise the claimant and her medical providers of the nature of her compensable right shoulder condition.

[2] Inasmuch as SAIF continues to challenge the compensability of claimant's C5-6 disc herniation / bulge condition, we question whether the theory that the condition is reasonably encompassed within previously accepted strains has any application. In other words, the "reasonably apprises" analysis is premised on the acceptance of a claimed condition, whereas SAIF's position is that it is not liable for the claimed condition (C5-6 disc herniation / bulge condition); *i.e.*, the condition is not compensable. In any event, as we will explain further, because we have found that the disputed condition is compensable and that the prior "strain" acceptance did not reasonably apprise claimant or medical providers of acceptance of the disputed condition, we have assumed for the sake of argument that the "reasonably apprises" analysis of ORS 656.262(7)(a) was applicable.

In contrast, the other medical opinions focused on the nature of claimant's C5-6 disc problem and did not diagnose a cervical or thoracic strain. When claimant did not show improvement from his treatment for the cervical and thoracic strain, he was referred to Dr. Miller, neurosurgeon. (*Id.*) Dr. Miller diagnosed a C5-6 disc herniation and recommended a C5-6 anterior cervical discectomy and fusion. (Exs. 5, 6, 12, 19). Dr. Parsons felt that claimant had a midline central bulge at C5-6. (Ex. 6-1). Dr. Butdorf diagnosed chronic neck pain, which he believed was discogenic. (Ex. 14). Dr. Karasek reported that claimant's C5-6 disc was causing claimant's symptoms. (Exs. 19-2, 25). Dr. Keiper initially diagnosed an injured disc at C5-6 causing radicular symptoms and neck pain. (Ex. 17-4). After Dr. Keiper performed claimant's neck surgery, he diagnosed cervical spondylosis at C5-6. (Ex. 27).

Because Dr. Collada examined claimant on only one occasion in October 1997, we are not persuaded by his opinion that claimant continued to have strain symptoms. Unlike Dr. Collada, Drs. Miller and Keiper had an opportunity to treat claimant on several occasions. Based on the other medical opinions, particularly those of Drs. Miller and Keiper, we find that claimant's symptoms were caused by a C5-6 disc, not a strain. We conclude that claimant's C5-6 disc condition is a separate condition that was not encompassed within SAIF's acceptance of a cervical and thoracic strain. None of the medical opinions used the terms "strain" and C5-6 disc bulge/herniation/protrusion interchangeably. We do not agree with SAIF that its acceptance of a cervical and thoracic strain reasonably apprised claimant and medical providers of the acceptance of a C5-6 disc condition. *Compare Kris Henriksen*, 51 Van Natta 401 (1999) (the claimant's right arm findings did not constitute a distinct medical condition or diagnosis that must be formally accepted in addition to the acceptance of a right-sided herniated cervical disc at C5-6).

We proceed to analyze compensability of claimant's C5-6 disc condition. Our first task is to identify the appropriate legal standards to determine the compensability of the claim. *Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Dibrito v. SAIF*, 319 Or 244, 248 (1994)). Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

Claimant contends that his April 1997 MVA caused his C5-6 disc condition. The medical evidence does not establish that claimant's April 1997 injury "combined" with a preexisting condition to cause disability or a need for medical treatment. *See* ORS 656.005(7)(a)(B). Dr. Keiper, claimant's treating physician, reported that it was medically probable that claimant's "central disk herniation" was related to his work injury and that he did not have a preexisting condition. (Ex. 26). Dr. Keiper explained that claimant had reported no neck symptoms before his 1997 injury. (*Id.*) Dr. Parsons said it was impossible to know when the C5-6 disc bulging occurred, but he believed that it was medically probable that the bulge predated the April 15, 1997 injury. (Ex. 6-1). Although Dr. Parsons indicated claimant had a "preexisting condition," there is no persuasive medical evidence that claimant had a preexisting condition that combined with the April 1997 injury to cause or prolong his disability or need for treatment. Therefore, claimant need only establish that his 1997 work injury was a material contributing cause of his disability and need for treatment. *See* ORS 656.005(7)(a); *Beverly Enterprises v. Michl*, 150 Or App 357 (1997).

Claimant relies on the opinion of Dr. Keiper to establish compensability of his C5-6 disc condition. Claimant asserts that Dr. Keiper has used the terminology of disc herniation and spondylosis interchangeably in describing the injured disc.

On August 27, 1998, Dr. Keiper reported that claimant had been having excruciating neck and right arm pain since the April 1997 MVA, and the pain was worsening. (Ex. 17-1). He diagnosed an injured disc at C5-6 causing radicular symptoms and neck pain and myofascial pain syndrome and recommended another MRI. (Ex. 17-4).

On September 16, 1998, Dr. Keiper had reviewed the new MRI and reported that the axial images reiterated the previous MRI findings of a "centrally herniated disc at C5-6 which pushes on the anterior surface of the spinal cord." (Ex. 21). He recommended additional physical therapy. (*Id.*)

On December 10, 1998, Dr. Keiper reported that it was medically probable that claimant's "central disk herniation" was related to his work injury and that he did not have a preexisting condition. (Ex. 26). He explained that claimant had reported no neck symptoms before his 1997 injury. (*Id.*) Dr. Keiper said it was medically probable that the industrial injury was "the material cause" of the C5-6 disc herniation. (*Id.*)

On April 6, 1999, Dr. Keiper performed an anterior cervical discectomy and fusion at C5-6. (Ex. 27). His diagnosis was cervical spondylosis at C5-6. (*Id.*) In a later "check-the-box" letter from claimant's attorney, Dr. Keiper agreed that claimant's cervical spondylosis at C5-6 was caused by his April 15, 1997 MVA and that was the condition he and Dr. Miller had been treating. (Ex. 28-1). Dr. Keiper said that the "MVA injured the disc at C5-6 for which surgery was performed." (*Id.*) He agreed that, if the spondylosis preexisted the injury, it was medically probable that the "injury was the major cause of the need to treat that condition given the fact that [claimant] had no symptoms until the injury[.]" (Ex. 28-2). Dr. Keiper explained: "Spondylosis is a generic term applied to this case for lack of better terminology, *i.e.*, injured disc." (*Id.*)

In a subsequent letter from claimant's attorney, Dr. Keiper agreed that in his most recent correspondence he had used the term "cervical spondylosis" to indicate that claimant had a discal injury, for which he performed surgery. (Ex. 30). Dr. Keiper explained that the reports from Dr. Miller had referred to "C5-6" and therefore, he felt they were referring to the same condition. (*Id.*) In sum, Dr. Keiper believed that claimant's April 1997 MVA had caused claimant's C5-6 disc injury.

Unlike Dr. Keiper, Dr. Coutler concluded that, within reasonable medical probability, claimant's condition was "degenerative in origin and consistent with conditions seen frequently due to aging in the absence of trauma." (Ex. 29-2). Similarly, Dr. Parsons said it was impossible to know when claimant's C5-6 disc bulging occurred, but he concluded that it was medically probable that the bulge predated the April 15, 1997 injury and was not directly related to the injury. (Ex. 6-1). We find that the opinions of Drs. Coutler and Parsons are conclusory and lack adequate explanation.

In evaluating the medical evidence, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to rely on Dr. Keiper's opinion. Furthermore, as claimant's treating surgeon, we find no reasons not to rely on his opinion. *See Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988). We agree with claimant that Dr. Keiper has used the terminology of disc herniation and spondylosis interchangeably in describing claimant's injured disc at C5-6. Based on Dr. Keiper's opinion, we conclude that claimant C5-6 disc condition was caused by his April 15, 1997 MVA.

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

ORDER

The ALJ's order dated August 17, 1999 is reversed. SAIF's denials of claimant's C5-6 disc condition are set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded $4,500, payable by SAIF.

In the Matter of the Compensation of
GLENN S. REUTER, Claimant
WCB Case No. 98-0391M
SECOND OWN MOTION ORDER DENYING RECONSIDERATION

On December 21, 1999, we denied claimant's request for reconsideration of our August 31, 1999 Own Motion Order. Finding that more than 30 days had elapsed since the issuance of our August 31, 1999 Own Motion Order, we denied claimant's request for reconsideration as untimely. In addition, we determined that, even if we considered claimant's request for reconsideration, we would continue to find that his claim did not qualify for reopening because his compensable condition did not require surgery or hospitalization. In his most recent letter, claimant explains his reasons for his prior untimely filing of his request for reconsideration and requests that the surgery issue "be removed from this case." Based on the following reasoning, we reach the same conclusions as we did in our prior orders.

I. Claimant's request for reconsideration is denied because it is untimely.

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 (1986); *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

On December 21, 1999, we denied claimant's November 8, 1999 request for reconsideration of our August 31, 1999 Own Motion Order. In reaching our conclusion, we found that claimant's request for reconsideration was received by the Board well after the 30-day appeal period had expired, and we were without statutory authority to reconsider our prior decision. We further concluded that claimant had not established good cause for his failure to request reconsideration within 60 days of our August 31, 1999 Own Motion Order, nor had he established that extraordinary circumstances existed which prevented him from requesting reconsideration within 60 days of our final order.

In his most recent request, claimant asserts that he was very ill with an infection which prevented him from timely filing his first request for reconsideration. We have held that medical incapacity may establish good cause for failure to timely file a hearing request where the worker is sufficiently incapacitated during the relevant period following a denial to prevent him or her from seeking a timely hearing request. *See Patricia J. Mayo*, 44 Van Natta 2260 (1992); *Jerry M. McClung*, 42 Van Natta 400 (1990). In both *Mayo* and *McClung*, the claimants were essentially physically and/or mentally incapacitated due to medications, multiple surgeries, and hospitalizations until after the expiration of the appeal period.

However, the facts of this case do not rise to the level of medical incapacity that would satisfy the good cause standard. Although claimant asserts that he was ill with an infection, he does not provide medical documentation to support his position that as a result of the infection, he was unable to timely file his request for reconsideration. While we may empathize with claimant in that having an infection may be discomforting and debilitating, we do not find this constitutes good cause for failure to timely file his request for reconsideration. Claimant does not contend that he did not understand the appeal rights outlined in our August 31, 1999 Own Motion Order nor does he provide medical evidence supporting a conclusion that he was physically or mentally incapable of conducting his personal business affairs. Under these circumstances, we conclude that claimant's failure to timely file the request for reconsideration was due to his lack of diligence, which does not qualify as good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). Therefore, we conclude that claimant has not met his burden of proving "good cause," and continue to deny his request for reconsideration.

II. Even if we considered claimant's request for reconsideration, we would find that he has not met the legal requirements necessary to reopen his claim for temporary disability benefits.

Claimant repeats his assertion that his condition has worsened and that he is entitled to own motion relief. Even if we were to grant claimant's request for reconsideration, his claim for Own Motion relief still fails.

Claimant requests that the surgery issue "be removed from this case due to that surgery would make my condition worst [sic]." For the following reasons, we cannot grant claimant's request.

Our 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). Claimant's aggravation rights expired on March 5, 1987. Therefore, his claim is within our own motion authority.

In addition, as explained in our December 31, 1999 order, we are *limited by law* as to the type of benefits we may grant under our own motion authority to injured workers and under what conditions we may grant those limited benefits. Specifically, we may authorize, on our own motion, the payment of temporary disability compensation when there is a *worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.* ORS 656.278(1)(a). As long as claimant's condition has not worsened requiring surgery or hospitalization, we *cannot* reopen the claim for payment of temporary disability compensation. In other words, we are not able to change the legal requirements in order to grant claimant's request to reopen his claim for temporary disability compensation. The court has held that a claimant is entitled to benefits for temporary disability *only* if he/she meets the legal requirements for those benefits. *Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990).

Here, because claimant's compensable condition does not require surgery or hospitalization, he does not meet the legal requirements for own motion relief, that is, he does not qualify to have his claim reopened for payment of temporary disability compensation.[1] ORS 656.278(1)(a).

Accordingly, claimant's request for abatement and reconsideration is denied. The issuance of this order neither "stays" our prior orders nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986); *Fisher v. SAIF*, 76 Or App 656 (1985).

IT IS SO ORDERED.

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[1] In his most recent letter, claimant asserts that he "will keep on appealing this case for as long as I live or till [sic] you understand." As we explained above, although we understand claimant's position, we cannot grant him the benefits he requests. We again emphasize that, if claimant is unclear as to his rights and benefits under the Workers' Compensation Law, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to help injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97310
Telephone: 1-800-927-1271

In the Matter of the Compensation of
JOSE I. RIOS, Claimant
WCB Case No. 98-09859
ORDER ON REVIEW
Mark W. Potter, Claimant Attorney
Alice Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that awarded 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of the left hand, whereas an Order on Reconsideration had awarded no scheduled permanent disability. On review, the issue is the extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his left hand on December 8, 1997. The claim was accepted by the SAIF Corporation for a left hand laceration. It was closed by a Notice of Closure dated July 16, 1998 with no award of permanent disability benefits. Claimant requested reconsideration of the July 16, 1998 Notice of Closure and requested appointment of a medical arbiter.

On August, 28, 1998, claimant requested that SAIF amend its acceptance to include a wound infection and mild lymphangitis. SAIF accepted these additional conditions and issued another Notice of Closure on September 23, 1998 that awarded no permanent disability benefits.

An Order on Reconsideration issued on December 11, 1998 that affirmed the July 16, 1998 Notice of Closure regarding permanent disability. The medical arbiter report was not received until after the date of the Order on Reconsideration.

Claimant requested a hearing from the Order on Reconsideration. The medical arbiter report was admitted into the record. *See* ORS 656.268(6)(f). The medical arbiter found reduced ranges of motion in the left hand and reduced grip strength; however, the arbiter measured claimant's grip strength using the Jamar Hand Dynamometer instead of reporting the strength loss using the 0 to 5/5 rating method used by the standards. The medical arbiter also found a chronic condition limiting repetitive use of the left hand based on cold intolerance and loss of strength.

Based on the medical arbiter report, the ALJ awarded 7 percent scheduled permanent disability for lost range of motion in the left hand. Claimant also sought an award for loss of grip strength of the left hand and a chronic condition limiting repetitive use of the left hand. The ALJ held that the standards do not provide for conversion of measurements of grip strength that are not reported using the 0 - 5/5 muscle strength loss grading system.

We agree with the ALJ. In *Randal W. Piper*, 49 Van Natta 543 (1997),[1] the medical arbiter did not report the claimant's loss of strength in the manner required by the standards. We held that we lacked authority to remand the claim to the Director for a supplemental arbiter's report. Similarly, here, we are without authority to remand this matter to the Director to require the medical arbiter to supplement his report. Accordingly, because the disability is not reported in a manner required by the standards, we are unable to award impairment for loss of strength.

The ALJ also found that claimant's cold intolerance (due to the infection) was a direct medical sequelae to the original accepted laceration condition. However, the ALJ reasoned that since the later Notice of Closure specifically addressed the accepted infection (which resulted in the cold intolerance), the impairment from the later accepted conditions could not be rated in the appeal of the first Notice of Closure. We disagree.

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[1] Board Member Biehl directs the parties' attention to his specially concurring opinion in *Piper*.

OAR 436-035-0010(5)(c) provides that a worker is entitled to a 5 percent chronic condition impairment for the left hand 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 left forearm (hand). ORS 656.268(16) provides that 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.

Here, Dr. Potter, the medical arbiter, opined that the cold intolerance and weakness in the left hand will significantly limit claimant's ability to repetitively use the left hand. Based on the medical arbiter's report, the cold intolerance and weakness are direct medical sequelae of the original accepted laceration. Thus, we find that this impairment is rateable under the first Notice of Closure that closed the claim for the laceration.[2]

Because we find that ORS 656.268(16) permits rating of the cold intolerance, claimant is entitled to a 5 percent award for a chronic condition. Claimant's chronic condition impairment (5 percent) is combined with his impairment for lost range of motion (7 percent) to equal 12 percent scheduled permanent disability for the left hand. OAR 436-035-0007(22)(b).

ORDER

The ALJ's order dated May 24, 1999 is modified. Claimant is awarded an additional 5 percent (7.5 degrees) scheduled permanent disability for a total award to date of 12 percent (18 degrees) scheduled permanent disability for the loss of use or function of the left hand. Claimant's counsel is awarded an out-of-compensation attorney fee equal to 25 percent of this increase, payable directly to claimant's counsel. However, the total out-of-compensation attorney fee payable from the ALJ's order and this order shall not exceed $6,000.

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[2] To reach any other conclusion would preclude claimant from obtaining an award for permanent disability that is indisputably attributable to his original accepted condition even though he has timely and properly pursued his appeal of this Notice of Closure. Such a determination would be in direct contravention of ORS 656.268(16). Because the second Notice of Closure did not result in an award for claimant's permanent disability, there is no risk of double compensation for the same impairment. Nonetheless, even if the second Notice of Closure was still being contested, our decision would be unchanged because our award would be taken into consideration by any reviewing body evaluating that second Notice of Closure in determining claimant's permanent disability.

In the Matter of the Compensation of
DANNY R. SCHUSTER, Claimant
WCB Case No. 99-04182
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of his cervical injury claim. 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

The ALJ upheld the employer's denial of claimant's cervical injury claim, finding that claimant failed to prove that he suffered an injury to his neck during physical therapy for his compensable groin

injury. Moreover, the ALJ determined that the medical evidence from claimant's attending physician, Dr. Engstrom, was insufficient to sustain claimant's burden of proving that the compensable injury was the major contributing cause of a consequential neck condition. *See* ORS 656.005(7)(a)(A).[1]

On review, claimant contends that the record, viewed as a whole, establishes that he sustained a cervical injury during physical therapy on September 24, 1998, and that Dr. Engstrom's unrebutted opinion proves that the incident of injury is the major contributing cause of the consequential cervical condition. For the following reasons, we agree with claimant.

We begin by briefly summarizing the factual background of the case. Claimant sustained a compensable groin injury on July 31, 1998. Claimant had been previously treated for neck symptoms in the mid 1980's and in September 1994, when he was involved in a motor vehicle accident (MVA). Dr. Engstrom also provided treatment for the MVA.

As treatment for the compensable groin injury, Dr. Engstrom prescribed physical therapy. On September 24, 1998, claimant was performing a new exercise ("chopping") which required him to manipulate a small two pound ball. As he did so, claimant turned his neck in the opposite direction of the ball and allegedly heard or felt a popping in the right side of the neck, followed by a stinging sensation in the right shoulder and arm. (Tr. 9). Claimant, however, did not mention this incident to the physical therapist. (Ex. 33).

On September 28, 1998, claimant called Dr. Engstrom's office, where a nurse took a message that claimant had an episode "yesterday" of numbness in the right hand, arm and leg. (Ex. 36). Claimant again performed physical therapy on September 29, 1998, without complaint of neck or arm symptoms. (Ex. 33). On October 1, 1998, the physical therapy notes indicate that claimant complained of tingling and numbness in the right arm. (Ex. 33). Claimant sought treatment on October 5, 1998 from Dr. Engstrom, who reported that claimant one week previously had been carrying a "heavy" ball at physical therapy and felt a sudden "snap" in the neck and intermittent numbness in the right arm since then. (Ex. 36). On October 15, 1998, claimant advised the physical therapist that neck symptoms occurred the day after the "chopping" exercise was added to the exercise regimen. (Ex. 33). An MRI scan later revealed a small disc bulge at C5-6 and a larger one at C6-7.

The employer eventually denied the cervical claim on March 30, 1999. Claimant requested a hearing. In August 1999, Dr. Engstrom, the only physician to comment on causation, concluded that claimant's neck injury in 1994 had resolved and that the physical therapy incident was the major contributing cause of the cervical condition. (Ex. 59).

The ALJ described the essential issue as whether or not claimant injured his neck during physical therapy on or about September 24, 1998 and whether claimant proved medical causation.[2] The ALJ first found that claimant failed to sustain his burden of proving legal causation (*i.e.*, that an incident occurred in physical therapy) because of inconsistencies in the record as to the onset and nature of his symptoms. The ALJ also was troubled by the delayed report of the September 24, 1998 incident. The ALJ concluded that the conflicting testimony, combined with conflicting evidence in the record regarding the onset of symptoms, prevented a finding that claimant injured his neck during physical therapy.

Claimant argues, however, that the discrepancies in the record are not sufficient to defeat the claim, emphasizing that any preexisting neck condition had resolved well before the alleged September 24, 1998 injury and that no other injury is indicated in the record that can explain claimant's cervical complaints. We agree with claimant.

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[1] 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."

[2] No party contests the ALJ's determination that, if the injury during physical therapy occurred as claimant alleges, it took place during reasonable and necessary treatment for the compensable injury. Therefore, the cervical injury would be compensable if the treatment is the major contributing cause of the alleged injury. *See Barrett Business Services v. Hames*, 130 Or App 190, 196, *rev den* 320 Or 492 (1994) (where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)).

The record indicates that the prior cervical injury had resolved (Ex. 12-1), and we find insufficient evidence in the record of an off-the-job incident that is the cause of claimant's cervical complaints.[3] Moreover, while there are discrepancies in the record regarding the onset of the cervical symptoms, the bulk of the history provided to Dr. Engstrom is consistent with that provided to a consulting physician, Dr. Rosenbaum. (Exs. 40, 58). Accordingly, having reviewed this record *de novo*, we are persuaded that the alleged incident of injury did occur. This leaves the question of whether Dr. Engstrom's opinion establishes that the September 24, 1998 incident is the major contributing cause of claimant's cervical conditon. We find that it does.

In this regard, we first note that Dr. Engstrom's opinion is unrebutted. While we are not necessarily bound by the uncontradicted opinion of a medical expert, *see William K. Young*, 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive); *Edwin Bollinger*, 33 Van Natta 559 (1981) (uncontradicted medical opinion need not be followed), we find no persuasive reason to discount Dr. Engstrom's opinion. The ALJ was troubled by Dr. Engstrom's failure to explain why claimant improved with physical therapy if his symptoms resulted form a disc herniation and that, while claimant's attorney advised Dr. Engstrom that the physical therapy ball weighed two pounds, there was no evidence that Dr. Engstrom was aware of that. Finally, according to the ALJ, Dr. Engstrom did not explain how or why the "chopping" activity caused claimant's symptoms.

While Dr. Engstrom may have provided more explanation for his causation opinion, we find that it is reasonable to assume that he read the history provided in claimant's attorney's July 23, 1999 cover letter regarding the weight of the physical therapy ball. (Ex. 58-1). Moreover, we find the history contained in the letter sufficiently accurate so as to render Dr. Engstrom's unrebutted medical opinion persuasive. Accordingly, we conclude that Dr. Engstrom's uncontradicted opinion satisfies claimant's burden of proving medical causation.

Therefore, we find that claimant satisfied his burden of proving a compensable consequential cervical injury occurred on September 24, 1998. Thus, we reverse.

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

ORDER

The ALJ's order dated October 1, 1999 is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,500 to be paid by the employer.

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[3] There are references in the record to moving furniture and pushing a motorcycle up a hill, but the record does not establish that either incident caused cervical symptoms. (Exs. 29, 33).

In the Matter of the Compensation of
GARY A. TEBBETTS, Claimant
WCB Case No. 99-04294
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Gatti, Gatti, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's injury claim for an L4-5 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second paragraph on page 3, we change the last sentence to read: "At L5-S1 claimant also had posterior osteophytic ridging. (Ex. 9)." On page 3, in the second sentence of the third paragraph, we delete the work "cervical." In the fifth paragraph on page 4, which quotes from Dr. Schilperoort's report, we change the citations to "(Ex. 35-5)" and "(Ex. 35-6)."

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that claimant had a preexisting low back condition that combined with his December 9, 1998 injury and, therefore, ORS 656.005(7)(a)(B) applies to this case. The ALJ relied on Dr. Liu's opinion to determine that claimant had established compensability of his L4-5 disc herniation.

The insurer argues that Dr. Liu's opinion is not sufficient to sustain claimant's burden of proof because he did not have an accurate understanding of claimant's previous low back problems and furthermore, Dr. Liu's reports were inconsistent.

Claimant testified that he had been having back problems since approximately 1984, but his back problems were not disabling prior to the December 9, 1998 injury. (Tr. 13, 14). In August 1991, claimant sought medical treatment for left sacroiliac pain and Dr. Tihanyi reported that his pain "seems to occur about yearly, and lasts up to six weeks." (Ex. 1). X-rays on September 6, 1991 showed mild degenerative disc disease at L5-S1 with narrowing of disc space and osteophyte formation. (Ex. 2). Claimant was diagnosed with disc disease. (Ex. 3-1).

In March 1993, Dr. Tihanyi reported that claimant had left lower back pain, "which he suffers for about 1-2 months of every year." (Ex. 3-2). She noted that the pain was "shooting down into the left leg," which it had done in the past. (*Id.*) Dr. Tihanyi prescribed medication.

In November 1993, claimant was involved in a motor vehicle accident (MVA) and his symptoms included back pain. (Ex. 3-3, -4, -5). Dr. Tihanyi reported that claimant had decreased range of motion in the lower back, but she noted that "this is preexisting for some time." (Ex. 3-5). X-rays on January 26, 1994 showed increased disc space narrowing at the lumbosacral level. (Ex. 4). By the end of January, claimant felt that his back problem had resolved from the MVA and he was back to baseline, although he was still having problems. (Ex. 5-1).

In May 1995, Dr. Tihanyi reported that claimant had injured his back playing golf. (Ex. 5-2). At times, claimant had pain going down the left leg. (*Id.*) Dr. Tihanyi prescribed medication and diagnosed a muscle strain/sprain of the lumbar spine. (*Id.*)

On October 13, 1998, Dr. Tihanyi reported that claimant had injured his lower back while lifting a dresser and had pain with walking. (Ex. 5-6). Claimant's range of motion was "dramatically diminished" and his paralumbar muscles were tender, particularly on the left side. (*Id.*) Claimant testified that his back pain after that incident was in the "[s]ame area, same thing." (Tr. 18).

On December 9, 1998, claimant was taking a shower at the end of his work shift and as he bent over to pick up his clothing, he felt a "pop" in his lower left back. (Tr. 8, Ex. 6). Claimant experienced immediate back pain and pain shooting down his leg. (*Id.*) A chart note on December 10, 1998 said that claimant had called and "hurt back - already had lower back pain - twisted it yesterday." (Ex. 5-7). The next day, Dr. Tihanyi reported that claimant was very tender over the left perilumbar area and his range of motion was limited in all directions. (Ex. 5-8). A December 15, 1998 lumbar MRI showed a disc herniation at L4-5, as well as mild degenerative disc disease at that level and mild degenerative changes of the facet joints. (Ex. 9). Claimant also had severe degenerative disc disease with a Grade I retrolisthesis of L5 on S1 and a disc bulge at L3-4. (*Id.*) On December 18, 1998, Dr. Liu performed a left L4-5 lumbar microdiskectomy. (Ex. 11).

The medical evidence establishes that claimant has preexisting degenerative disk disease in his lumbar spine. (Exs. 2, 4, 9, 31-6, 31-7, 31A). Dr. Liu believed that claimant's December 9, 1998 work injury combined with his preexisting low back condition to cause his need for treatment. (Ex. 31A). Based on Dr. Liu'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 medical treatment of his combined condition.

Claimant relies on the opinions of Dr. Liu to establish compensability of his L4-5 disc herniation. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the following reasons, however, we are not persuaded by Dr. Liu's opinion.

Dr. Liu examined claimant on December 16, 1998 and described his previous low back problems as follows:

> "[Claimant] does have a history of prior chronic low back pain of over 10 years duration starting in 1985 with intermittent episodes of left lower extremity pain as well. He states that this pain, however, is much more intense than the prior episodes." (Ex. 10-1).

On June 17, 1999, Dr. Liu reported that claimant's December 9, 1998 injury had combined with his preexisting low back condition to cause his need for surgical treatment. (Ex. 31A). He explained:

> "Given the above combined condition, I believe that based upon a reasonable degree of medical probability the industrial accident on 12/9/98 is the major contributing cause for the need of treatment of the above combined condition. [Claimant] did not have exacerbation of his chronic back pain and radiculopathy secondary to a large disc herniation at L4-5 until the day of the accident on 12/9/98. Therefore, [claimant] became symptomatic after 12/9/98 requiring further surgical treatment." (*Id.*)

Dr. Liu subsequently reviewed Dr. Strum's June 17, 1999 report and concurred with his findings. (Ex. 32). Dr. Strum had reported that the major contributing cause and need for surgery was claimant's multiple-level degenerative disc disease that was "clearly present" at L4-5. (Ex. 31-6). Dr. Strum explained:

> "I do not consider the simple act of standing up from being in a bent-over position to constitute a mechanism of injury. This is an activity of daily living that does not result in forces being generated in the lumbar spine that are beyond the normal physiologic load levels, notwithstanding that the patient was slightly rotated and bending to the right. Once again, these are physiologic load levels, in my opinion. This is the natural history of the degenerative disk process, in that an atraumatic disc herniation is a frequent result, and this in turn not infrequently leads to clinical nerve root compromise, or radiculopathy." (*Id.*)

Claimant contends that Dr. Liu's concurrence with Dr. Strum's report is limited in scope because Dr. Liu was not directed to Dr. Strum's opinion concerning causation, but was expressly directed to Dr. Strum's "findings." Claimant argues that if the insurer had intended to obtain Dr. Liu's opinion concerning Dr. Strum's causation opinion, it should have asked him that particular question.

The insurer asked Dr. Liu to review Dr. Strum's June 17, 1999 report "in order to let us know whether you concur with Dr. Strum's findings." (Ex. 32). If Dr. Liu did not concur with the report, he was asked to provide a narrative report detailing "those areas" in which he disagreed. (*Id.*)

We decline to read Dr. Liu's concurrence letter as narrowly as claimant urges. We note that Dr. Strum's report did not include a specific section of his report referring to "Findings" and his clinical findings were in a section called "Physical Examination." We find no basis in Dr. Liu's concurrence letter to infer that he was only concurring with Dr. Strum's physical examination findings. Instead, we find it more likely that Dr. Liu was concurring with Dr. Strum's general "findings," which included his discussion regarding causation. Dr. Liu's concurrence with Dr. Strum's opinion does not support compensability and is inconsistent with Dr. Liu's June 17, 1999 report. At a minimum, Dr. Liu's final opinion is unclear and is therefore unpersuasive.

Moreover, even if we disregard Dr. Liu's concurrence with Dr. Strum's report, we find that Dr. Liu's report on causation is not sufficient to sustain claimant's burden of proving that his December 1998 work injury was the major contributing cause of his disability or need for treatment for the combined condition.

We are not persuaded that Dr. Liu had an accurate and complete history of claimant's low back problems prior to the December 1998 injury. Dr. Liu was aware that claimant had a history of chronic low back pain for over 10 years, with intermittent episodes of left lower extremity pain. (Ex. 10-1). In his causation opinion, Dr. Liu said that claimant "did not have exacerbation of his chronic back pain and radiculopathy secondary to a large disc herniation at L4-5" until December 9, 1998 and he became symptomatic after that date. (Ex. 31A).

There is no evidence that Dr. Liu was aware of the details of claimant's previous back treatment in August 1991, March 1993, or May 1995. In May 1995, for example, claimant injured his low back by playing golf and developed pain radiating to his left leg. (Ex. 5-2). In addition, there is no evidence that Dr. Liu was aware that claimant had injured his low back while lifting a dresser in October 1998, about eight weeks before the December 9, 1998 injury. On October 13, 1998, Dr. Tihanyi reported claimant's range of motion was "dramatically diminished" for flexion, extension and lateral motion and his paralumbar muscles were tender, particularly on the left side. (Ex. 5-6). After the December 9, 1998 injury, Dr. Tihanyi reported that claimant was very tender over the left perilumbar area and his range of motion was limited in all directions. (Ex. 5-8). The December 10, 1998 chart note indicated that claimant had called in with a "hurt back - already had lower back pain - twisted it yesterday." (Ex. 5-7).

Because Dr. Liu's causation opinion indicates that claimant only became symptomatic after the December 9, 1998 injury and did not have an "exacerbation" until that time, we are not persuaded that he had an accurate understanding of claimant's previous low back symptoms. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions based on an inaccurate history entitled to little or no weight).

Furthermore, Dr. Liu's opinion on causation is not persuasive because he did not adequately evaluate the relative contribution of other causal factors and explain why the work injury contributed more to claimant's condition than all other causes or exposures. 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). Dr. Liu merely explained that claimant became "symptomatic" after the December 9, 1998 incident and required surgical treatment. We find that Dr. Liu's explanation is no more than the "precipitating cause" analysis that was rejected in *Dietz v. Ramuda*, 130 Or App at 401.

Claimant also contends that Dr. Liu's opinion is persuasive because he had the opportunity to actually view the condition of the L4-5 disc during surgery. Because we find no evidence that Dr. Liu relied on his surgical findings in reaching his conclusion on causation, we find no reason to defer to Dr. Liu's opinion because he was the treating surgeon.

In sum, we conclude that the opinion of Dr. Liu is insufficient to establish that claimant's work injury was the major contributing cause of his disability and/or need for treatment. Similarly, the remaining medical opinions are not sufficient to establish compensability. As we discussed, Dr. Strum concluded that claimant's multiple-level degenerative disc disease was the major contributing cause of the need for surgery. (Ex. 31-6). Dr. Schilperoort concluded that claimant's L4-5 herniation was

"idiopathic" and was unrelated to the industrial injury. (Ex. 35-5, -6). Because there are no other medical opinions that support compensability of claimant's low back condition, we conclude that the L4-5 disc claim is not compensable.

Penalties

The ALJ found that the insurer's claims processing was unreasonable and assessed a penalty. On review, we have determined that claimant's L4-5 disc herniation is not compensable. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The ALJ's order dated October 1, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's penalty assessment and attorney fee award are also reversed.

Board Member Phillips Polich specially concurring.

I agree with the lead opinion that Dr. Liu's opinion is not persuasive and that claimant has failed to establish compensability of his L4-5 disc herniation. I write separately, however, to explain that I do not find Dr. Liu's opinion persuasive because his concurrence with Dr. Strum's opinion equates to an unexplained change of opinion. *Compare Kelso v. City of Salem*, 87 Or App 630 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive).

In the Matter of the Compensation of
EZRA J. TOLMAN, Claimant
WCB Case No. 99-02009
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's left shoulder impingement syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant, a dock worker for a motor freight company, compensably injured his left shoulder on December 3, 1997 after loading and unloading 30 to 70-pound boxes of freight. (Exs. A, B, C, D). On December 18, 1997, he was assessed by Dr. Vigeland, orthopedist, who diagnosed rotator cuff tendinitis-subacromial bursitis.

On January 8, 1998, the insurer accepted disabling "rotator cuff tendinitis, left shoulder." (Ex. H).

Therapy and medication did not improve claimant's condition, so Dr. Vigeland injected the subacromial area on January 8, 1998. Dr. Vigeland noted about 75 percent improvement by January 26, 1998 and ordered physical therapy to treat claimant's left shoulder impingement syndrome. (Exs. K, N). On February 26, 1998, Dr. Vigeland released claimant to regular work. (Ex. O). On March 13, 1998, the insurer issued a Notice of Closure that awarded temporary disability only. (Ex. Q).

From March to May 1998, claimant worked as a truck driver, making local pickups and deliveries without difficulty. (Ex. 7-2). Sometime in May, claimant's shoulder began to hurt. On July 13, 1998, he returned to Dr. Vigeland, who noted a two month increase in symptoms but no specific injury. Dr. Vigeland placed claimant on restricted duty and prescribed medication. (Exs. 1, R). Claimant's shoulder pain persisted; Dr. Vigeland attributed the shoulder symptoms to a waxing and waning of his underlying impingement disorder. Dr. Vigeland suggested that surgical intervention might be necessary if claimant did not respond to conservative treatment. (Exs. 2, 3).

From March to July 1998, claimant played basketball several times a week. (Tr. 17-20).

On August 13, 1998, claimant was evaluated by Dr. Berselli, orthopedist. (Exs. 4, 5). On September 15, 1998, after eliminating a torn rotator cuff, Dr. Berselli diagnosed rotator cuff impingement with tendonitis and, because of the duration of claimant's symptoms, requested authorization for arthroscopic acromioplasty of the shoulder. (Ex. 6).

On November 2, 1998, Dr. Gripekoven examined claimant for the insurer. (Ex. 7). In March 1999, the insurer denied claimant's current left shoulder condition.

In April 1999, Dr. Berselli performed the requested left shoulder surgery. Dr. Berselli found a frayed anterior labrum and rotator cuff tendonitis with impingement syndrome.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's current left shoulder impingement syndrome was compensable. On review, the insurer first contends that claimant's current condition is a combination of several pathologies, including impingement syndrome, frayed anterior labrum, and frayed subacromial bursa, none of which were expressly claimed as compensable conditions by claimant.

Insofar as the insurer is raising a procedural challenge to the claim, we decline to address it. The insurer's denial expressly denied claimant's claim for left shoulder impingement syndrome. The denial also denied claimant's "current condition" on the ground that it did not arise out of or in the course of employment. The insurer did not assert at hearing that claimant's failure to formally request acceptance of the unaccepted conditions barred the ALJ from considering compensability of claimant's current condition, whatever the diagnosis. Because the insurer has raised the procedural challenge for the first time on review, we are not inclined to consider it. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991). Moreover, because the insurer did not object at hearing to the characterization of the issues as aggravation and compensability of the current condition, and proceeded to litigate compensability on that basis,[1] *see* Tr. 8 and 9, the insurer has waived any potential procedural challenge to claimant's request for hearing. *Thomas v. SAIF*, 64 Or App 193 (1983). We now turn to the merits of the compensability issue.

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[1] In framing the issues at the outset of the hearing, the following colloquoy took place:

ALJ (regarding claimant left shoulder impingement syndrome): "You've denied it and you don't care what we call it and where it comes from as I understand it--"

Insurer: "Correct."

ALJ: "That's what you think they've done, right?"

Claimant: "I think they've denied a current condition as well as an aggravation, yes."

Insurer: "That's correct."

ALJ: "Okay. But he has a left rotator cuff tendinitis, which is accepted still--"

Insurer: "Correct. The permanent disability, we believe, resolved (phonetic)."

(Tr. 3, 4).

Relying on Dr. Berselli's opinion, the ALJ found that claimant's left shoulder impingement syndrome was compensable as a consequence of the December 1997 injury. The insurer contends that claimant has not proven the compensability of a fraying anterior labrum or a left shoulder impingement syndrome.

Claimant has the burden to prove that his December 1997 injury is the major contributing cause of his left shoulder impingement syndrome. ORS 656.005(7)(a)(A). Given the contrary causation opinions of the medical experts and the number of potential causes of claimant's current impingement syndrome, we conclude that the causation issue in this case involves complex medical issues that must be resolved by expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Special deference is generally given to the opinion of a treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Vigeland, who treated claimant at the time of the December 1997 injury, diagnosed left shoulder impingement syndrome, for which physical therapy was provided. (Ex. K). In July 1998, Dr. Vigeland noted recurrence of left shoulder pain that he diagnosed as left shoulder impingement syndrome. (Exs. R, 1, 2). Dr. Vigeland initially attributed claimant's current condition to the waxing and waning of his underlying impingement disorder. (Ex. 3).

Subsequently, however, Dr. Vigeland changed his opinion, concurring instead with Dr. Gripekoven's diagnosis of claimant's current condition as left shoulder sprain with rotator cuff tendonitis. Dr. Gripekoven noted that claimant's prior rotator cuff tendonitis had resolved in February 1998 and that claimant worked as a truck driver without difficulty from March to May. Because of the two-month hiatus, Dr. Gripekoven concluded that claimant's current rotator cuff tendonitis was unrelated to the December 1997 injury. (Exs. 7, 8). Dr. Vigeland himself now attributed claimant's current symptoms to an underlying tendonosis or a mechanical problem with the shoulder, rather than an impingement disorder. (Ex. 10).

In contrast, Dr. Berselli diagnosed claimant's current condition as a recurrence of rotator cuff impingement with tendinitis. (Exs. 4, 9, 16). After performing arthroscopic surgery on claimant's left shoulder, Dr. Berselli diagnosed a fraying anterior labrum, left shoulder; and rotator cuff tendinitis with impingement syndrome, left shoulder. (Ex. 16). Dr. Berselli opined that claimant had developed a rotator cuff tendonitis and, consequently, an impingement syndrome as a result of the December 1997 injury. (Ex. 19). Dr. Berselli's opinion is supported both by the 1997 medical records and his findings at surgery. Moreover, after fully considering all of the possible contributing factors, Dr. Berselli determined that the major contributing cause of claimant's current shoulder condition was the December 1997 injury.[2] (Ex. 19). Based on Dr. Berselli's persuasive opinion, we find that claimant has met his burden of proving the compensability of his current claim.[3]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,600, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 30, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,600, to be paid by the insurer.

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[2] Although claimant did not discuss playing basketball with Dr. Berselli, Berselli later opined that playing basketball would not have caused additional damage to his shoulder, although he may have experienced additional discomfort as a result. (Ex. 17). Moreover, Dr. Vigeland's report that references claimant's basketball activities does not implicate this activity as a factor contributing to claimant's condition. (Ex. 13).

[3] Because Dr. Vigeland's changed opinion is based on an unexplained change in his diagnosis of claimant's current condition, which is not borne out in the surgical report, we do not find his opinion persuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987); *see also Somers v. SAIF*, 77 Or App 259 (1986) (we give the most weight to opinions that are both well-reasoned and based on complete information).

In the Matter of the Compensation of
CARL G. VOORHEES, Claimant
WCB Case Nos. 99-01316 & 98-07822
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that upheld PAULA insurance's denials of claimant's "new injury" claim for a low back condition. On review, the issues are compensability and responsibility.

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

Claimant contends that Dr. Brett's opinion on causation was sufficient to meet his burden of proving that his June 23, 1998 injury while working for PAULA's insured, was the major contributing cause of his disability and need for treatment for his low back condition. We agree with claimant that Dr. Brett's opinion, standing alone, would meet his burden of proving major contributing cause. Nevertheless, we agree with the ALJ that the record as a whole supports upholding PAULA's denials.

If an injury combines with a preexisting condition, the injury is compensable only to the extent that it is the major contributing cause of claimant's disability and need for treatment for the combined condition. ORS 656.005(7)(a)(B). The ALJ analyzed Dr. Brett's opinion that claimant's June 23, 1998 work activities[1] for PAULA's insured "pathologically worsened" his preexisting degenerative disc disease as insufficient to meet his burden of proving major contributing cause. ORS 656.005(7)(a)(B); *SAIF v. Britton*, 145 Or App 288 (1996). We disagree with this analysis of Dr. Brett's opinion.

Dr. Brett was not claimant's attending physician. Dr. Brett, a neurosurgeon, examined claimant once on August 11, 1998. (Ex. 106). Claimant's attending physician was Dr. Oksenholt, who referred claimant to Dr. Brett for neurosurgical evaluation. (Ex. 105). Dr. Butler, another of claimant's treating physicians, did not offer an opinion on medical causation.

After reviewing claimant's relevant medical records, including those related to a March 6, 1991 low back injury with SAIF's insured, Dr. Brett concluded that: "[Claimant] did have some pre-existing degenerative change, but this then combined with his work activities on or about 6-23-98 and resulted in pathologic worsening with further annular tearing, nerve root impingement, and radiculitis. The major contributing factor to the development of his nerve impingement and disc herniation was his work activities of 6-23-98 in my opinion in all medical probability." (Ex. 113).

We agree with the ALJ that, if Dr. Brett had concluded merely that the injury of June 23, 1998 "pathologically worsened" the preexisting degenerative disc disease, his opinion would not meet the standard announced by the Court of Appeals in *Dietz v. Ramuda*, 130 Or App 397 (1994). *See SAIF v. Britton*, 145 Or App 288, 292-293 (1996). However, Dr. Brett's opinion went further - he compared the effect of claimant's preexisting condition with the effects of claimant's work activities to determine that the work activities were the "major contributing factor" for claimant's disability and need for treatment. (Ex. 113). Dr. Brett's failure to use "magic words" (*i.e.* major contributing *factor* vs. major contributing *cause*) is not fatal to his opinion. *McClendon v. Nabisco Brands*, 77 Or App 412 (1986); *Mary A. Crowley*, 51 Van Natta 1829 (1999).

Nevertheless, we agree with the ALJ's ultimate conclusion to uphold PAULA's denials. Dr. Brett's opinion is not persuasive in comparison to those of treating physician Dr. Oksenholt and Drs. Williams and Strum, who performed an examination at the request of PAULA. (Exs. 108, 111).

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[1] We agree with the ALJ that this claim is properly analyzed as an "injury" claim, because claimant's work activities over a discrete period of time gave rise to his claim for benefits. *See Valtinson v. SAIF*, 54 Or App 184 (1982).

Dr. Oksenholt, an osteopathic physician, treated claimant several times beginning June 23, 1998. (Ex. 91). At that time, claimant did not give a history of any specific injury to his back, only that he had been "having increasing pain over the last several weeks." (*Id.*) Dr. Oksenholt stated that, even assuming claimant suffered an "injury" to his low back, claimant's back condition was the result of a degenerative disc disease at L3-4 that developed independently of his work activities. (Ex. 111). Dr. Oksenholt concluded that, although claimant's work activity "could contribute," it is "probably not the major contributing cause of [claimant's] problem." (Exs. 111, 112).

Dr. Williams, a neurosurgeon, and Dr. Strum, an orthopedic specialist, examined claimant at the request of PAULA on September 24, 1998. (Ex. 108). These physicians diagnosed an acute herniation of the L3-4 disc, "associated with the work-related event of June 23, 1998." (Ex. 108-4). However, Drs. Williams and Strum ultimately reasoned that the major contributing cause of claimant's disc herniation was his preexisting degenerative disc disease at that level. (Ex. 108-5). In other words, if claimant had not had the degenerative disc disease, the work activity would not have caused a disc herniation. (*Id.*)

Therefore, although we have concluded that Dr. Brett's opinion, standing alone, would meet claimant's burden of proving major contributing cause, his opinion is conclusory and unpersuasive when compared to that of Drs. Oksenholt, Williams and Strum. (Exs. 108, 111).

ORDER

The ALJ's order dated September 24, 1999, as corrected September 27, 1999, is affirmed.

In the Matter of the Compensation of
LAURIE D. WILLIS, Claimant
WCB Case Nos. 99-05186 & 98-08828
ORDER ON REVIEW
Linda Attridge, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) upheld the self-insured employer's denial of claimant's August 12, 1998 occupational disease claim insofar as it pertained to her bilateral wrist condition; (2) upheld the employer's denial of her March 22, 1999 occupational disease claim for bilateral wrist and elbow conditions; and (3) declined to assess an attorney fee pursuant to ORS 656.382(1) for the employer's allegedly unreasonable processing of her March 22, 1999 claim. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, and Findings of Ultimate Fact, with the exception of the following correction:

On page 3 of the order (the ALJ's Ultimate Findings of Fact) the order is amended to read "claimant's March 22, *1999* bilateral elbow and bilateral wrist conditions."

CONCLUSIONS OF LAW AND OPINION

Compensability

With regard to the compensability of claimant's bilateral wrist and elbow conditions, we adopt and affirm the ALJ's order with the following supplementation.

We agree with the ALJ that claimant failed to meet her burden of proving a compensable condition supported by objective findings related to her August 12, 1998 work activity. ORS 656.005(7)(a); ORS 656.802(2)(d). Alternatively, we find that claimant did not meet her burden of proving that her work activity was either a material cause or the major contributing cause of her bilateral wrist condition.

In evaluating medical evidence on the issue of causation, we rely on those opinions that are both well-reasoned and based on 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 claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983).

The only medical opinion in favor of compensability comes from Dr. McDonald, who responded affirmatively to a Kaiser medical record boiler plate question: "Result of industrial exposure?" (Exs. 49-2, 51 and 53A). Dr. McDonald's opinion is not further explained. We therefore find Dr. McDonald's opinion conclusory and unpersuasive.

The balance of the medical opinions on causation from Drs. Lawlor, Battalia, and Nolan, all of which were fully explored in depositions, and from Dr. Thrall and Dr. Martin, weigh against compensability of a bilateral wrist condition as associated with claimant's August 12, 1998 work activity. These physicians all concluded that claimant's symptoms were caused by a vascular or respiratory condition. (*See* Exs. 34, 38, 39, 57, 59, 59A, 60).

For these reasons, we find that claimant has not met her burden of proving that her August 12, 1998 claim, whether characterized as an injury or occupational disease, is compensable.

Attorney Fee, ORS 656.382(1)

Claimant contends that her attorney is entitled to a separate employer-paid attorney fee for the employer's untimely denial of her March 22, 1999 claim. ORS 656.382(1).

However, after reviewing the record, we find that claimant did not raise the issue of entitlement to an attorney fee under ORS 656.382(1). At hearing, claimant's counsel raised the issue of a "penalty for a late denial and an unreasonable denial. . . " (Tr. 2). Like the ALJ, we interpret this statement to raise entitlement to a penalty pursuant to ORS 656.262(11). This is consistent with claimant's April 7, 1999 and June 29, 1999 Requests for Hearing, which included a cite to ORS 656.262(11), but not ORS 656.382(1). Consequently, because we do not consider issues raised for the first time on review, *see Lisa M. Smith*, 51 Van Natta 777 (1999), we need not address claimant's entitlement to an attorney fee pursuant to ORS 656.382(1).

ORDER

The ALJ's order dated October 6, 1999 is affirmed.

February 29, 2000 Cite as 52 Van Natta 315 (2000)

In the Matter of the Compensation of
LLANCE A. PETERSON, Claimant
Own Motion No. 99-0376M
OWN MOTION ORDER OF ABATEMENT
Carney, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our February 11, 2000 Own Motion Order, that declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CARL L. CHARLES, Claimant
WCB Case No. 97-07790
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's aggravation claim for an L4-5 disc disruption/tear. The employer also requests that we take "administrative notice" of a November 15, 1999 Opinion and Order from another ALJ, which it argues has a preclusive effect on this case. On review, the issues are administrative notice, issue preclusion and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.[1]

CONCLUSIONS OF LAW AND OPINION

Administrative Notice/Issue Preclusion

The employer has submitted a "Memorandum of Additional Authorities," requesting that we take "administrative notice" of a November 15, 1999 Opinion and Order from ALJ Johnson regarding the classification of claimant's May 1996 accepted low back strain. The November 15, 1999 Opinion and Order was issued after the ALJ's order in this case. The employer asserts that claimant did not request review of ALJ Johnson's order and it has become final. According to the employer, through application of issue preclusion, ALJ Johnson's findings bar claimant from contending that the May 1996 incident, rather than his preexisting degenerative pathology, was the major contributing cause of his current low back condition.

As a general rule, the Board may take administrative notice of a fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(2). In previous cases, we have taken administrative notice of agency orders involving the same claimant. *See, e.g., Janet R. Christensen*, 50 Van Natta 1152 (1998); *Brian M. Eggman*, 49 Van Natta 1835 (1997). We grant the employer's request to take administrative notice of ALJ Johnson's November 15, 1999 Opinion and Order.

Issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or 134, 139 (1990) (quoting *North Clackamas School Dist. v. White*, 305 Or 48, 53, *modified* 305 Or 468 (1988)). In *Washington Cty. Police Officers v. Washington Cty.*, 321 Or 430, 435 (1995), the Supreme Court explained that a decision in a prior proceeding may preclude relitigation of the issue in another proceeding if five requirements are met: (1) The issue in the two proceedings is identical; (2) the issue was actually litigated and was essential to a final decision on the merits in the prior proceeding; (3) the party sought to be precluded has had a full and fair opportunity to be heard on that issue; (4) the party sought to be precluded was a party or was in privity with a party to the prior proceeding; and (5) the prior proceeding was the type of proceeding to which this court will give preclusive effect.

Here, the issues in the two proceedings are not identical. In the present case before us on review, the issue is whether claimant has established compensability of his L4-5 disc disruption/tear and whether the accepted May 1996 injury claim should be reopened for an aggravation based on the L4-5 disc condition. The ALJ concluded that claimant has established that the May 1996 incident was the major contributing cause of his current need for treatment of the L4-5 disc. The ALJ also concluded that the L4-5 disc tear constituted a pathological worsening of the accepted injury.

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[1] We modify the ALJ's order to note that Exhibit 27 was withdrawn at hearing. (Tr. 3).

In contrast, the issue decided by ALJ Johnson was whether claimant's May 1996 accepted low back strain was properly classified as nondisabling. ALJ Johnson noted:

> "There are several other matters pending between claimant and employer. Those issues are all severable from the issue before me, and are respectively wending their way through the appropriate process. The effect of this Opinion and Order is strictly limited to the narrow issue before me." (11/15/99 Opinion and Order at 1).

ALJ Johnson did not address compensability of claimant's L4-5 disc condition or whether claimant had established a pathological worsening of the accepted low back strain. We find that the issue in the two proceedings was *not* identical and claimant's aggravation claim for a L4-5 disc condition was *not* "actually litigated and determined" in the proceeding before ALJ Johnson. *See Brian L. Schmitt*, 51 Van Natta 393 (issue preclusion did not apply where the issues in the two proceedings were different), *aff'd mem Schmitt v. Towne Center Tire*, 164 Or App 536 (1999). Thus, although the classification issue before ALJ Johnson was apparently a final decision, that order did not decide whether claimant's May 1996 claim should be reopened. Claimant is not precluded from contending that the May 1996 incident was the major contributing cause of his current L4-5 disc disruption/tear.

Aggravation

We adopt and affirm the ALJ's order with the following supplementation. After the first full paragraph on page 7, we add the following footnote:

> "In any event, even if no aggravation claim was proven, the employer would still be required to "reopen" and process the claim for claimant's L4-5 disc disruption/tear. ORS 656.262(7)(c); *see Marie L. Colombo*, 51 Van Natta 1872, 1873 n.2."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the 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 October 1, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the self-insured employer.

February 29, 2000 Cite as 52 Van Natta 317 (2000)

In the Matter of the Compensation of
CUONG V. LE, Claimant
WCB Case No. 99-04996
ORDER ON REVIEW
Swanson, Lathen, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of claimant's injury claim for a current low back condition. On review, the issue is compensability.

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

We do not adopt the "Findings of Ultimate Fact."

We acknowledge that Dr. Huun began treating claimant in 1996 and he performed claimant's low back surgery, while the examining physicians examined claimant only once. However, we find no indication that the treating doctors' causation conclusions were based on their opportunities to evaluate claimant's condition. Under these circumstances, we do not defer to the opinions of Drs. Liu and Huun based on the doctors' status as treating physicians.

ORDER

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

February 25, 2000 Cite as 52 Van Natta 318 (2000)

In the Matter of the Compensation of
FRED L. JONES, Claimant
WCB Case No. 99-04311
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's occupational disease claim for left carpal tunnel syndrome (CTS). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

> "Dr. Baum examined claimant on June 30, 1999 and diagnosed CTS, left greater than right, "related to work exposure during the year at [the employer]." (Ex. 13-2).

On page 2, we delete the fifth full paragraph.

CONCLUSIONS OF LAW AND OPINION

Claimant, a carpenter, began working for the employer in June 1998. (Tr. 5). He is right-handed and performed most of the hammering with his right hand, although he used his left hand to hold the item he was hammering. (Tr. 8, Ex. 8-5). He used other tools, such as a Skil saw, and estimated that he used his right hand 85 to 90 percent of the time. (Tr. 9). Claimant was laid off in March 1999. (Tr. 5). Approximately six months before he was laid off, claimant began experiencing numbness and tingling in his left hand. (Ex. 4, Tr. 6). Claimant sought treatment from Dr. Craven on March 25, 1999 and was diagnosed with left CTS. (Ex. 4). SAIF denied claimant's occupational disease claim for left CTS on the grounds that claimant's work was not the major contributing cause of the left CTS and his CTS did not arise out of and in the course of employment. (Ex. 12).

The ALJ relied on Dr. Baum's opinion to conclude that claimant had established a compensable occupational disease claim for left CTS. On review, SAIF argues that Dr. Baum's opinion is not sufficient to establish that claimant's work activities were the major contributing cause of his left CTS. For the following reasons, we agree with SAIF.

Under ORS 656.802(2)(a), claimant must establish that his employment conditions were the major contributing cause of his left CTS condition. Claimant, like the ALJ, relies on Dr. Baum's opinion to establish compensability. In evaluating medical opinions, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, because Dr. Baum examined claimant on only one occasion, his opinion is not entitled to any particular deference.

Dr. Baum understood that claimant had worked for the employer as a carpenter from March 1998 to March 1999 and had developed symptoms of numbness and tingling in both hands, with the left hand predominating. (Ex. 13-1). He noted that claimant's occupational disease claim had been denied and he explained:

> "My understanding of the denial is because it developed in the patient's non-dominant hand. As a carpenter he uses the right hand for striking blows with hammer and sawing; the left hand is used for power grasp and holding of objects. The vibration is transmitted through the left hand and could certainly precipitate carpal tunnel syndrome.

> The activities he does outside of work certainly are not near the level of physical demand of the upper extremities as a carpenter and therefore it is much more probable than not that the carpal tunnel syndrome occurred as a result of work exposure and not due to activities outside of work." (*Id.*)

Dr. Baum diagnosed CTS, left greater than right, "related to work exposure during the year" at the employer. (Ex. 13-2).

For the following reasons, we find that Dr. Baum's opinion is not sufficient to establish compensability of claimant's left CTS. To begin, we note that Dr. Baum had an inaccurate history of the time period claimant worked for the employer. Claimant began working for the employer in June 1998, not March 1998, as reported by Dr. Baum.

Moreover, Dr. Baum's opinion does not establish that claimant's work activities were the *major* contributing cause of his left CTS. 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. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Dr. Baum opined that claimant's CTS "occurred as a result of work exposure and not due to activities outside of work." (Ex. 13-1). At most, Dr. Baum's opinion establishes that claimant's CTS was "related" to his work activities, but does not establish that claimant's work exposure was the "major contributing cause" of his left CTS.

In addition, Dr. Baum's opinion establishes only that the work activity was the precipitating cause of claimant's left CTS. Such an opinion is insufficient to establish compensability. *Dietz v. Ramuda*, 130 Or App at 401 (fact that work activities precipitated a claimant's disease does not necessarily mean that work was the major contributing cause of the condition).

Dr. Baum attempted to explain why claimant's CTS was predominantly in his non-dominant left hand by noting that claimant's left hand was used for power grasp and holding of objects and the "vibration is transmitted through the left hand and *could certainly precipitate* carpal tunnel syndrome." (*Id.*; emphasis supplied). Dr. Baum's opinion about claimant's left hand use is couched in terms of possibility rather than probability, which is not legally sufficient nor persuasive. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). We conclude that Dr. Baum's opinion is insufficient to carry claimant's burden of proof.

The remaining medical opinions are not sufficient to establish compensability. Dr. Gardner examined claimant on behalf of SAIF and found no examples of claimant's work activities that seemed to require preferential, sustained use of his left hand. (Ex. 10-2). He noted that claimant's most repetitive activity with his left hand was simply holding things. (Ex. 10-3). Dr. Gardner concluded that claimant's CTS was idiopathic in origin. (Ex. 10-5). He felt that if claimant's work were primarily the cause of his CTS, he would expect the condition to be in claimant's right, more heavily-used hand. (Ex. 10-6).

Dr. Craven, claimant's treating physician, initially reported that claimant's left CTS was probably related to his work activities. (Ex. 4-2). After reviewing Dr. Gardner's report, however, Dr. Craven concurred with that report (Ex. 11), and explained:

> "I agree with the independent medical exam in that it is not definitely work related. I would rate it only as possibly, in other words, I agree with the IME that I do not think work is the major factor but work may be aggravating it." (Ex. 12A-1).

Dr. Craven's opinion establishes, at most, a possibility that claimant's left CTS was work-related. In sum, we conclude that the medical evidence is insufficient to establish that claimant's work activities were the major contributing cause of his left CTS.

ORDER

The ALJ's order dated September 22, 1999 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

In the Matter of the Compensation of
VERNON L. MINOR, Claimant
WCB Case No. 99-00420
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's claim for a low back injury; and (2) awarded a $5,000 attorney fee. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exceptions and modification. We modify the second and third paragraphs of the ALJ's findings of fact to provide:

> "Claimant testified that around August 11, 1998, he was receiving a load in the Medford area. He testified that, as he threw straps over the load to secure it, he felt the sudden onset of pain in his back and right hip down his right leg.
>
> "Claimant testified that he continued working with some difficulty. He reported that he was having back problems to his dispatcher and delivered his load and picked up another load in Nevada. Claimant then returned to Klamath Falls and told his employer that he was taking time off due to back pain. About two weeks later, claimant delivered one load for the employer, but otherwise has not worked since."

We do not adopt the last two sentences of the ALJ's findings.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant sustained a low back injury while working on August 11, 1998 and that the medical evidence was sufficient to establish compensability. SAIF argues that claimant has not established that his low back condition occurred at work or that the alleged work injury was the major contributing cause of his low back condition. In addition, SAIF argues that the amount of the ALJ's attorney fee award was excessive. Claimant argues that his testimony was credible and establishes that the injury occurred. Claimant further argues that SAIF did not argue at hearing or state in its denial that his injury was not compensable under the "major contributing cause" standard. On this basis, claimant argues that SAIF cannot argue on Board review that his injury was not the major contributing cause of his low back condition under ORS 656.005(7)(a)(B).

SAIF's denial provided, in relevant part, that: "We are unable to accept your claim for the following reasons: Your injury did not arise out of or occur within the course of your employment." 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. In reaching this conclusion, 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 this similarity in language, we construed the denial as asserting that the claimant did not sustain a "compensable injury." Consistent with *Phillips*, we find that SAIF's "course and scope" denial in this case encompasses the issue of medical causation.

Based on the following reasoning, we conclude that claimant has not met his burden to establish compensability.

Four medical experts address the cause of claimant's low back condition. After reviewing the medical opinions, we find that Dr. Schilperoort renders the most complete, thorough and well-reasoned opinion. *Somers v. SAIF*, 77 Or App 259 (1986) (in evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information).

Dr. Schilperoort examined claimant and believed that claimant's alleged work injury combined with a preexisting multi-level degenerative condition to cause his disability and need for treatment. Dr. Schilperoort could not identify the age of the disc herniation at L4-5, but believed that it likely preexisted the August 11, 1998 episode. Dr. Schilperoort was unable to establish that the major contributing cause of claimant's condition was his exposure at the employer. Dr. Schilperoort's opinion is consistent with that of claimant's chiropractor, who initially treated the low back condition and likewise could not connect claimant's low back condition to the alleged work incident.

Based on Dr. Schilperoort's persuasive opinion (Ex. 30), we find that ORS 656.005(7)(a)(B) applies to claimant's claim and that he has failed to establish that the alleged work incident was the major contributing cause of his disability or need for treatment. See *Daniel S. Field*, 47 Van Natta 1457 (1995) (as a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim).

Dr. Srch, a chiropractor who initially treated claimant for his low back problems, noted that claimant did not provide a specific history regarding the injury when first seen in August 1998. Instead, claimant told the doctor that "this had been going on for approximately two months." (Ex. 33). Because claimant's history indicated previous low back symptoms, Dr. Srch could not conclusively link claimant's injury to a work-related incident.

Dr. Balme was claimant's surgeon. He opined that claimant's condition was related to driving the truck and to the incident claimant described. (Ex. 20). We are not persuaded by the opinion of Dr. Balme because it is very conclusory and lacks any explanation or medical analysis. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (rejecting conclusory medical opinion). In particular, Dr. Balme did not address the significance, if any, of claimant's multi-level degenerative spine disease. We, thus, find persuasive reasons not to defer to Dr. Balme. *See Weiland v. SAIF*, 64 Or App 810 (1983) (we generally give greater weight to the opinion of the attending physician unless there are persuasive reasons not to do so).

Finally, we also find Dr. Coletti's opinion unpersuasive. Dr. Coletti opined that claimant did not have a preexisting condition and that the work incident described by claimant was the cause of the injury and need for treatment. Dr. Coletti performed only a record review and did not personally examine claimant as did the other medical experts. On this basis, we accord his opinion less weight.

Based on this record, we find that claimant has not met his burden to establish compensability. In light of our evaluation of the medical evidence, we need not address SAIF's argument that the record does not establish that any injury occurred at work on August 11, 1998.

ORDER

The ALJ's order dated September 8, 1999 is reversed. SAIF's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

In the Matter of the Compensation of
JON E. BALL, Claimant
WCB Case No. 98-06366
ORDER ON REVIEW
Dean Heiling & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

The self-insured employer 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 thoracic strain condition; and (2) awarded assessed attorney fees totaling $4,500 for claimant's counsel's efforts for prevailing over the employer's denials of claimant's current condition and thoracic strain condition. On review, the issues are compensability and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, 40 years old at the time of hearing, sustained an injury to his neck and back on April 9, 1998, while working in the employer's warehouse. (Ex. 50). On April 13, 1998, claimant sought treatment with Dr. Rose, D.C. (Ex. 48). Claimant had treated with Dr. Rose since October 26, 1989, for headaches, low back, thoracic and cervical problems. (Exs. 1-8). On April 13, 1998, claimant complained of neck pain extending down between the scapulae, headaches and low back pain. (Exs. 48, 51). Claimant informed the chiropractor's office that he would be filing a claim for workers' compensation benefits. *(Id.)*

On April 14, 1998, claimant saw Dr. Schrunk, D.O. (Ex. 49). Dr. Schrunk diagnosed cervical, trapezius and lumbosacral strains. (Ex. 53). X-Rays taken that day of claimant's cervical and lumbar spine were normal. (Ex. 54). Dr. Schrunk did not diagnose a thoracic strain condition.

On May 4, 1998, claimant sought treatment with Dr. Jura, a spine and rehabilitation specialist. (Ex. 63). Claimant described his pain as being between his shoulder blades and in his lower back. (Ex. 61A). Dr. Jura diagnosed a low back strain and a "mild thoracic back strain, also from the 4/9/98 injury. . ." (Ex. 63-2).

On June 2, 1998, Dr. Farris, orthopedic surgeon, examined claimant for the employer. (Ex. 120). Dr. Farris believed that claimant had probably sustained a thoracic strain on April 9, 1998, "by history." (Ex. 120-9). However, Dr. Farris concluded that claimant did not have objective findings to indicate any condition, either current or preexisting, in the thoracic spine. (Ex. 120-10).

On July 7, 1998, Dr. Fuller examined claimant on behalf of the employer. (Ex. 163). Dr. Fuller diagnosed cervical and lumbar strains by history, but could find no evidence of "true thoracic strain." (Ex. 163-6, 7).

On July 8, 1998, the employer accepted a claim for "disabling cervical strain and lumbosacral strain." (Ex. 167). On July 17, 1998, the employer issued a Notice of Closure with no award of permanent disability. (Ex. 183). On October 6, 1998, an Amended Notice of Closure issued, again awarding no permanent disability. (Ex. 189). Claimant's appeals of the closure notices were ultimately affirmed by the Board. (Exs. 197, 198).

On December 9, 1998, claimant requested formal written acceptance of a "thoracic sprain/strain." (Ex. 191). On January 20, 1999, Dr. Farris confirmed that he had diagnosed a thoracic strain only "by history," and that claimant's mid-back pain was likely referred pain from his cervical spine. (Ex. 194).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's thoracic strain condition was compensably related to claimant's work injury. Therefore, the ALJ set aside the employer's January 4, 1999 denial of that condition. On review, the employer contends that claimant did not prove the compensability of a thoracic strain condition by medical evidence supported by objective findings. We agree.

Claimant must prove that his April 9, 1998 work injury is at least a material contributing cause of his thoracic strain condition. ORS 656.005(7)(a). Claimant has the burden of proving the compensability of the thoracic strain condition. ORS 656.266.

In evaluating the medical evidence on causation, we rely on those opinions that are both well-reasoned and based on 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 claimant's attending physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinions of claimant's treating physicians.

The record does not persuasively establish a diagnosis of a thoracic strain condition supported by objective findings. The only treating physicians to diagnose a thoracic strain were Dr. Rose and Dr. Jura. Dr. Rose included a diagnosis of "thoracic sprain"[1] during his examination on April 17, 1998. (Ex. 56). Significantly, however, Dr. Schrunk, D.O., who examined claimant on April 14, 1998, just five days after the injury, did not diagnose a thoracic strain, but rather a "trapezius strain." (Ex. 53).

During his examination on July 7, 1999, Dr. Fuller found no evidence of a thoracic strain condition. (Ex. 163). Dr. Farris likewise found no objective evidence of a thoracic strain condition, either on examination or by reference to imaging studies. (Ex. 120-10). Although Dr. Farris had originally diagnosed a thoracic strain "by history," he later confirmed that claimant's pain in the mid-back was very likely referred pain from his cervical spine. (Ex. 194). We find Dr. Farris' analysis persuasive, particularly in reference to Dr. Rose's initial reports of pain radiating down from claimant's neck into his scapular area. (Ex. 51).

Finally, even if claimant had proved the existence of a thoracic strain condition supported by objective findings, the record does not persuasively establish a material relationship between claimant's original April 9, 1998 injury and a thoracic strain condition. In his June 2, 1998 report, Dr. Farris stated that, if claimant's history of the April 9, 1998 on-the-job injury was accurate, it was medically probable that he sustained a "musculoligamentous strain of the thoracic spine." (Ex. 120-10). However, Dr. Farris' physical examination of that same day revealed no objective evidence of a thoracic strain. (*Id.*) Moreover, on January 20, 1999, Dr. Farris altered his earlier opinion by stating that claimant's mid-back symptoms likely were referable to his cervical spine. (Ex. 194).

The only opinion on causation from claimant's treating physicians is from Dr. Jura, who assumed claimant's medical care on May 4, 1998. Dr. Jura's opinion that claimant had sustained a "mild thoracic back strain, also from the 4/9/98 injury," (Ex. 63-2) is conclusory and therefore unpersuasive.

For these reasons, we reverse the ALJ's order in regard to the compensability of claimant's thoracic strain condition. Inasmuch as we are upholding the employer's thoracic strain denial, we reverse the ALJ's $2,500 attorney fee award. We adopt and affirm that portion of the ALJ's order that set aside the employer's current condition denial and awarded a $2,000 attorney fee.[2]

ORDER

The ALJ's order dated October 18, 1999 is reversed in part and affirmed in part. Those portions of the ALJ's order that set aside the employer's January 4, 1999 denial of claimant's thoracic strain condition and awarded a $2,500 attorney fee are reversed. The employer's denial of that condition is reinstated and upheld. The remainder of the ALJ's order is affirmed.

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[1] The parties have stipulated that the terms "sprain" and "strain" are identical for purposes of this case. (*O&O* at 5).

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

Board Member Biehl dissenting.

Because I agree with the ALJ that claimant met his burden of proving the compensability of a thoracic strain condition, I respectfully dissent.

The employer does not contend that claimant has a "preexisting condition" in his thoracic spine which has in any way combined with his April 9, 1998 compensable injury. Therefore, claimant need only prove that the injury is a material contributing cause of his disability and need for treatment for his thoracic strain condition. *Albany General Hospital v. Gasperino*, 113 Or App 411, 414 (1992).

The record reveals ample support for the diagnosis of a work-related thoracic strain condition. Dr. Rose, who saw claimant closest in time to the date of injury, on April 13, 1998, diagnosed a thoracic strain. (Ex. 56). Dr. Rose noted "marked inflammation and swelling [at] T6-8," which are objective findings of injury in the thoracic spine. (*Id.*)

Dr. Jura, a spine and rehabilitation specialist who examined claimant multiple times beginning on May 4, 1998, similarly diagnosed a "mild thoracic back strain, also from the 4/9/98 work injury." (Ex. 63-2). Dr. Farris, who examined claimant for the employer on June 2, 1998, concluded that claimant had sustained a musculoligamentous strain of the thoracic spine on April 9, 1998 that had since resolved. (Ex. 120). The fact that claimant's thoracic strain may have resolved by June 2, 1998 does not make it any less compensable as an initial matter. Based on these doctors' reports, I would have affirmed the ALJ's order.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
MARJORIE M. SHORT, Claimant
WCB Case No. 99-05642
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that awarded 1 percent (1.35 degrees) scheduled permanent disability for loss of use or function of claimant's left foot (ankle), whereas an Order on Reconsideration had awarded 29 percent (39.15 degrees). On review, the issue is extent of scheduled permanent disability.

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

We agree with the ALJ that claimant is not entitled to an impairment rating under OAR 436-035-0200(4)(a) for serious injury "when objective medical evidence establishes the worker *cannot* walk and/or stand for a cumulative total of more than 2 hours in an 8 hour period." (Emphasis added). In this regard, the medical arbiter opined only that claimant "should be prevented" from standing or walking more than two hours out of 8 hours; he did not say that claimant "cannot" do that.[1] (Ex. 21-2).

We also agree with the ALJ that a preponderance of the medical evidence establishes that claimant is not entitled to an impairment rating for a left ankle "chronic condition" under OAR 436-035-0010(5), because no objective findings support a limitation on repetitive use of claimant's left ankle. (*See* Exs. 15-6, 16, 17, 21-2).[2]

Finally, we agree with the ALJ that claimant is not entitled to an impairment rating for left ankle laxity or instability because the medical arbiter did not identify lateral collateral or medial collateral ligament damage or find ankle joint stability with *additional* anterior and/or posterior instability. *See* OAR 436-035-0200(3)(a)-(c); *see also Vincent S. Roberts*, 48 Van Natta 15, 16 (1996). Under these circumstances, any left ankle laxity claimant has is not ratable under the standards.

ORDER

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

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[1] The arbiter also opined that any impairment claimant has "should be mild." (*Id*).

[2] *See* ORS 656.283(7); 656.295(5); 656.726(3)(f)(B); *Jill C. Van Horn*, 44 Van Natta 1523, 1524 (1992) (any finding of fact regarding a worker's impairment must be established by medical evidence supported by objective findings).

In the Matter of the Compensation of
JOHN D. BEARD, Claimant
WCB Case No. 98-05209
ORDER ON REVIEW
Daniel J. Denorch, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys
Schneider, et al, Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) upheld the self-insured employer's denial of claimant's injury claim for an L5-S1 herniated disc condition; and (2) did not address claims for low back strain or disc disorder conditions or an occupational disease claim for any condition. Claimant requests remand for a ruling on his request to preserve the occupational disease issue or, alternatively, to address the merits of that claim. The employer requests sanctions for an allegedly frivolous request for review. On review, the issues are compensability, remand, scope of the ALJ's review, and sanctions.

We adopt and affirm the ALJ's order with the following supplementation, beginning with a summary of the pertinent facts.

Claimant injured his low back in 1977 and he has had activity-related low back pain since that injury. He experienced a sudden onset of low back pain on March 13, 1998, when he bent over at work. Despite gradually worsened symptoms, claimant continued performing his regular work and first sought treatment on May 10, 1998. His condition was eventually diagnosed as an L5-S1 disc herniation and Dr. Doldevilla performed an L5-S1 hemilaminectomy and discectomy in October 1998.

Claimant filed an injury claim. The employer denied low back strain, lumbar disc disorder and/or crushed vertebra conditions. (Exs. 34, 44). Claimant requested a hearing.

At hearing, claimant's counsel agreed that the issue to be litigated was compensability of claimant's claim for a March 13, 1998 work injury, as denied by the employer. Counsel also stated that claimant was "neither raising nor waiving an argument that [claimant's] lumbar disc disorder constitutes an occupational disease." (Tr. 4). The ALJ declined to rule on the future effect of claimant's not raising an occupational disease claim at this hearing. (Tr. 5).

On review, claimant argues that the ALJ erred in failing to address whether claimant's low back strain and disc disorder conditions are compensable. Claimant also moves for remand for rulings on the merits of his claims for the latter conditions and indicating that the occupational disease issue is preserved (or, alternatively addressing the merits of claimant's condition as an occupational disease). We conclude that the ALJ did not err and we deny the motion to remand, for the following reasons.

First, the ALJ properly declined to address an occupational disease claim because claimant stated that no such claim was raised. Second, to the extent that claimant sought to avoid future preclusion of an occupational disease claim,[1] the issue was not ripe at this hearing (*i.e.*, there was no existing "preclusion issue") and the ALJ properly declined to give an advisory ruling on a future dispute. *See Marietta Z. Smith*, 51 Van Natta 324 (1999) (Board declined to issue advisory opinion regarding preclusive effect of ALJ's ruling because issue not ripe).

Finally, we deny the employer's motion for sanctions. The employer asserts that claimant's appeal is frivolous because there is no evidence supporting compensability. We disagree, because Dr. Pribnow initially opined that claimant's "lumbar disc disorder" was "probably" work-related. (Ex. 30). We also note Dr. Pribnow's comments that claimant's L5-S1 herniated disc with radiculopathy was "work-related in the sense that [claimant] had onset of the symptoms (by history) at work." (Ex. 28-2; *see* Ex. 47-16-17). Based on this evidence, we conclude that claimant made a colorable argument and sanctions are therefore not appropriate. *See* ORS 656.390; *Michael V. Lim*, 51 Van Natta 1777 (1999); *Denise L. Allen*, 50 Van Natta 2357 (1998).

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[1] We note that the employer objected to claimant's "at hearing" request for a ruling to "preserve" a future occupational disease claim and claimant did not request a continuance or postponement at this hearing. (*See* Tr. 4-12).

ORDER

The ALJ's order dated September 20, 1999 is affirmed.

March 1, 2000 Cite as 52 Van Natta 326 (2000)

In the Matter of the Compensation of
JASON A. JORDAN, Claimant
WCB Case No. 98-09888
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

On December 28, 1999, we abated our November 29, 1999 order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's current low back condition. Asserting that he has requested Board review of an ALJ's order in WCB Case No. 99-06305 that upheld SAIF's subsequent denial of his L3-4 and L4-5 disc bulge conditions, claimant seeks consolidation of this case with his pending appeal in WCB Case No. 99-06305. Having received SAIF's response to claimant's request, we now proceed with our reconsideration.

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). Here, although the two cases arise out of the same compensable injury, we do not find that consolidation would serve either interest.

While this matter involves the compensability of claimant's current low back condition, in WCB Case No. 99-06305, the issue is the compensability of disc bulges at L3-4 and L4-5. We agree with SAIF that these issues are separate and distinct from one another and that a decision in WCB No. 99-06305 is not dependent upon our or the ALJ's decision in this case. Thus, we do not find this to be a case where inconsistent results are a possibility. *See Gaspar Lopez*, 48 Van Natta 1774, 1775 (1996) (remanding case for consolidation to avoid the possibility of inconsistent results). In addition, we have completed our review of this case. Therefore, administrative efficiency would not be served by consolidated review. Accordingly, we conclude that there is no compelling reason to review the two cases together.[1]

On reconsideration, as supplemented herein, we adhere to and republish our November 29, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[1] Claimant cites *Dennis D. Hall*, 51 Van Natta 1537 (1999), in which we consolidated cases for review because the exhibits in both cases were contained in one record. SAIF correctly observes, however, that such circumstances do not exist in this case. Therefore, we do not find that *Hall* requires consolidation.

We recognize that we recently consolidated two matters in *Loretta K. Fountain*, 52 Van Natta 213 (2000) and 52 Van Natta 215 (2000), noting that consolidation would further judicial economy and avoid potentially inconsistent rulings. As previously discussed, neither judicial economy nor avoidance of potentially inconsistent results would be significantly furthered here. Therefore, unlike *Fountain*, we decline the consolidation request in this case.

In the Matter of the Compensation of
RUBEN R. MACIEL, Claimant
WCB Case No. 99-04833
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that reduced claimant's award of scheduled permanent disability for loss of use or function of his left foot (ankle) from 18 percent (24.3 degrees), as awarded by an Order on Reconsideration, to 17 percent (22.95 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant sustained a compensable left ankle injury on August 4, 1998. The insurer accepted the claim as a disabling "left achilles tendon tear." Claimant underwent surgical reconstruction of the left achilles tendon on August 28, 1998.

On January 18, 1999, Dr. Tsang, claimant's attending physician, released claimant for regular activities. Dr. Tsang later declared claimant's left ankle condition medically stationary on February 22, 1999. (Ex. 23). During the examination, claimant reported no significant discomfort and that he could jump, walk and perform activities without significant problems. After performing his examination, Dr. Tsang concluded that claimant had no evidence of restriction, range of motion or strength deficit. *Id.* Dr. Tsang released claimant for regular duty.

On March 4, 1999, the insurer closed the claim by Notice of Closure that awarded no permanent disability. (Ex. 25). Claimant requested reconsideration.

As part of the reconsideration proceeding, a panel of three medical arbiters (Drs. James, Schilperoort, and Brooks) evaluated claimant's left ankle condition. Claimant confirmed to the panel that his condition had been as described in Dr. Tsang's closing report. (Ex. 26-1). Claimant reported, however, that, after returning to work, he was getting into a trailer when his foot slipped. As a result of this, claimant had pain in the left achilles tendon area. (Ex. 26-2). Claimant stated that he saw Dr. Tsang once more after the closing examination and was told that the left ankle was swollen but probably not damaged or injured. According to claimant, in contrast to his condition at closure, he was experiencing significant symptoms, such as loss of strength and swelling. Claimant reported to the arbiters that he could not run, squat, hop or jump and was unable to walk on uneven surfaces. *Id.*

The panel did not comment on claimant's medically stationary status, but did document reduced range of motion, loss of strength and a limitation of repetitive use of the left foot and ankle. Opining that all findings were valid, the arbiter panel attributed 100 percent of the impairment to the accepted condition. (Ex. 26-3).

A June 3, 1999 Order on Reconsideration awarded 18 percent scheduled permanent disability, based on the arbiters' range of motion, strength and "chronic condition" findings. (Ex. 27). The insurer requested a hearing, contesting the permanent disability award.

CONCLUSIONS OF LAW AND OPINION

In analyzing the permanent disability issue, the ALJ rejected the insurer's contention that Dr. Tsang's closing report constituted a preponderance of evidence establishing a different level of impairment than that found by the medical arbiters. The ALJ thus determined that the reconsideration order properly relied on the arbiters' report in evaluating claimant's permanent impairment. Using the impairment findings contained in that report, the ALJ determined that the reconsideration order's calculation of claimant's permanent impairment was correct, with the exception of range of motion. With respect to that factor, the ALJ agreed with the insurer that claimant's impairment value was four instead of five, as determined by the reconsideration order. Thus, the ALJ reduced claimant's permanent disability from 18 to 17 percent.

On review, the insurer argues that the ALJ should have relied on Dr. Tsang's closing report in assessing claimant's permanent impairment because it was better reasoned and because a comparison of Dr. Tsang's closing report and the arbiter's report shows that claimant's condition had worsened after the closing examination. The insurer cites *Randy S. Lay*, 51 Van Natta 649 (1999), for its argument that, when a claimant's condition worsens after claim closure, impairment findings should be based on the closing examination.[1] *Cf. Lori L. Kowalewski*, 51 Van Natta 13 (1999) (rejecting the carrier's argument that the claimant's condition changed after the closing report such that the medical arbiter's findings were not reliable where there was no indication that the claimant's condition was no longer medically stationary or that the findings did not represent permanent residuals of the compensable injury).

For the following reasons, we conclude that Dr. Tsang provided the most persuasive evaluation of claimant's permanent impairment and, relying on his report, eliminate the permanent disability award. We reason as follows.

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 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 disagree with the ALJ's finding that the arbiter panel provided the most well-reasoned evaluation of claimant's impairment. As the insurer notes, the arbiter panel twice referred to the right ankle in evaluating claimant's left ankle condition. (Ex. 26-1, 2). Even assuming that these references were typographical errors, other aspects of the arbiter report were not well-reasoned. For instance, the arbiter panel confirmed that claimant's activities at closure were unrestricted and that claimant was not experiencing significant discomfort. (Ex. 26-1). The panel also reported, however, that, at the time of its examination, claimant was having significant symptoms and was unable to walk on uneven surfaces and could not run, jump, hop or jump. (Ex. 26-2). Despite having this information, the panel did not acknowledge the apparent worsened condition and did not comment on claimant's medically stationary status. No explanation was offered about why claimant's left ankle condition had apparently deteriorated, even though the panel was aware of a possible intervening injury. Under these circumstances, we are unable to conclude that the arbiter panel's report was well-reasoned.

In contrast, Dr. Tsang was claimant's attending physician throughout the course of the claim. He conducted a sufficiently thorough examination of claimant's condition at claim closure and concluded that claimant was capable of regular duty. Moreover, Dr. Tsang noted that claimant had no evidence of restrictions, range of motion deficit or strength loss. (Ex. 23). On this record, we are persuaded that Dr. Tsang provided the more thorough, complete and well-reasoned evaluation of claimant's permanent impairment.[2]

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[1] In *Lay*, we concluded, after comparing the attending physician's findings of no impairment at the time of claim closure to the medical arbiter's impairment findings four months later (after the claimant's condition had worsened), that the attending physician provided the most thorough, complete and well-reasoned evaluation of the claimant's permanent injury-related impairment. Under those circumstances, we declined to rate the claimant's permanent impairment based on the arbiter's findings. 51 Van Natta at 651.

[2] We acknowledge the insurer's argument that, under *Lay*, permanent impairment should not be evaluated using the arbiters' report because of the evidence that claimant's left ankle condition had worsened after claim closure. Moreover, we find that this case differs from *Kowalewski*, even though, like that case, there is no express statement in the arbiters' report that claimant's condition was not medically stationary. Given the significant deterioration in claimant's condition between Dr. Tsang's closing examination and the arbiters' examination, and the strong implication that claimant's condition was not medically stationary, we find that, unlike *Kowalewski*, the arbiters' findings in this case should not be relied upon in evaluating claimant's permanent impairment. However, we need not resolve this case on this basis because we find the arbiters' assessment of claimant's permanent impairment poorly reasoned.

Accordingly, based on Dr. Tsang's closing report, we find that claimant sustained no permanent impairment as a result of the compensable August 4, 1998 injury. Therefore, we conclude that the Order on Reconsideration incorrectly awarded permanent disability for claimant's left ankle injury. Thus, we eliminate the award of permanent disability in the reconsideration order.

ORDER

The ALJ's order dated September 23, 1999 is modified. In lieu of the ALJ's and the reconsideration order's permanent disability awards, the Notice of Closure is affirmed.

Board Member Phillips Polich dissenting.

The majority eliminates claimant's award of scheduled permanent disability in the June 3, 1999 Order on Reconsideration, finding that the medical arbiters' report, which supports an award of permanent disability, was not well-reasoned. Because I cannot accept the basis for the majority's conclusion, I dissent.

The majority concludes that claimant's condition worsened based on the medical arbiters' alleged history that claimant was unable at the time of their examination to walk on uneven surfaces, run, hop, squat or jump; whereas, at the time of the closing examination, claimant was able to perform activities without significant problems. I cannot accept this as a reliable basis to say that claimant's condition had worsened since claim closure.

First, claimant's history was given through an interpreter. Second, the panel noted some difficulty in obtaining history from claimant. (Ex. 26-2). Specifically, in noting claimant's history that sometime in February 1999, after Dr. Tsang's closing examination, his foot slipped and he had pain in the left Achilles tendon, the panel stated: "[claimant] was very indefinite, and also this was being done through an interpreter." *Id.* Under these circumstances, I would not rely on claimant's history in the medical arbiters' report to reduce his permanent disability award when claimant is prevented from testifying at a hearing and confirming that alleged history. Additionally, there is no medical record supporting the allegation that subsequent treatment was received. This record, when viewed as a whole, does not justify a reduction in claimant's benefits.

Accordingly, I do not agree with the majority's decision to eliminate claimant's permanent disability award. Therefore, I dissent.

March 1, 2000 Cite as 52 Van Natta 329 (2000)

In the Matter of the Compensation of
VICTOR L. BROWN, Claimant
WCB Case No. 98-09451
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's claim for a right shoulder condition. On review, the issue is compensability.

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

On review, claimant contends, for the first time, that the insurer's denial should be set aside as an invalid pre-closure denial. Relying on *Croman Corp. v. Serrano*, 163 Or App 136 (1999)(a decision issued subsequent to the hearing), claimant argues that it is permissible to challenge the procedural validity of the denial on Board review. We need not resolve these procedural questions because we agree with the ALJ that the insurer's denial should be set aside on the merits. In other words, regardless of whether claimant could raise the issue of whether the denial was procedurally invalid, we would reach the same result on substantive grounds.

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 August 19, 1999 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
THOMAS L. MATTSON, Claimant
WCB Case No. 98-09642
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's right knee anterior cruciate ligament (ACL) injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

About May 15, 1994, claimant injured his right knee when he slipped on scaffolding and landed on the floor below. (Tr. 20, 21). Two weeks later he treated with his family physician, Dr. Bailey, who diagnosed a right knee sprain. (Ex. 13). About a week and a half later, claimant returned to his regular sheetrocking work, which included climbing and kneeling. After this injury, claimant's knee was untrustworthy. It felt "sloppy" and loose and tended to buckle if he stepped wrong or on uneven ground. (Ex. 10; Tr. 21 through 25). Claimant also had to be careful with moving his knee side to side or twisting because he experienced pain under his kneecap when he made lateral outward movements with weight against his foot. (Ex. 2; Tr. 23 through 25).

On August 17, 1998, claimant injured his right knee at work. That evening, his knee was painful and slightly swollen. (Tr. 11). The next morning his knee was more painful, and, if he shifted his weight quickly, it wanted to buckle. He was able to walk if he was careful. (*Id.*) Even though his knee hurt, claimant returned to the job and finished up in about two hours of light work. (Tr. 12).

Later the same day, claimant rode his dirt bike to the top of his 108-acre property with a friend who rode a four-wheeler. (Tr. 15, 16). While using his right leg for balance, claimant's knee gave way twice and he fell over at least once. He returned to his house riding the four-wheeler. He then used crutches to walk. (Ex. 2; Tr. 16, 17, 18).

When claimant used his knee the next morning, he experienced significant pain and immediately sought emergency room treatment. (Exs. 1A, 1B). Dr. Crooks found a swollen right knee and a palpable hematoma on the superior medial aspect of the knee. Dr. Crooks diagnosed acute right knee pain, sprain, and referred him to an orthopedist. (Ex. 1B).

On September 14, 1998, Dr. Straub, orthopedist, assessed a chronic anterior cruciate deficient knee, some residual insufficiency of the medial collateral ligament (MCL), and a probable meniscal tear. Dr. Straub was unable to say whether the MCL and meniscal pathology were preexisting or were caused by the industrial injury. (Exs. 2, 15-5).

On September 15, 1998, claimant filed a claim for his right knee injury. (Ex. 4).

An October 19, 1998 MRI revealed an ACL tear, a medial meniscus tear, and a large area of interosseous edema and microfracture involving the proximal tibia, lateral tibial plateau and medial femoral condyle. (Ex. 7). Dr. Straub recommended right knee arthroscopy with ACL reconstruction and possible MCL repair. (Ex. 8).

On December 1, 1998, Dr. Baker examined claimant for the insurer. (Ex. 10).

On December 3, 1998, the insurer denied claimant's right knee ACL and MCL instability and torn medial meniscus as unrelated to his work at the employer. (Ex. 12).

On February 19, 1999, Dr. Straub agreed to the insurer's statements that whatever caused claimant's right knee swelling, that injury can be considered a right knee strain, which required examination and treatment, but was not the major contributing cause of his current need for ligament reconstruction to stabilize his right knee, and that the major contributing cause of claimant's need for ligament reconstruction was claimant's preexisting right knee condition. (Ex. 14).

Dr. Straub was deposed on April 5, 1999. (Ex. 15).

CONCLUSIONS OF LAW AND OPINION

Applying ORS 656.005(7)(a)(B), the ALJ concluded that claimant had established compensability of his ACL instability (tear).[1] The ALJ relied on claimant's testimony and Dr. Straub's deposition opinion. On review, the insurer contends that claimant has failed to prove compensability of his ACL instability because his testimony differed from the contemporary histories he provided to the treating and examining doctors, and that the hypotheticals provided to Dr. Straub were partially at odds with the record. We agree.

Claimant must prove that the work injury was the major contributing cause of the disability or the need for treatment of the combined condition by a preponderance of the evidence. ORS 656.266; 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309 (1997); *Gregory C. Noble*, 49 Van Natta 764, 767 (1997), *aff'd mem Liberty Northwest Insurance Corporation v. Noble*, 153 Or App 125 (1998). Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995); *Gregory C. Noble*, 49 Van Natta at 765-66.

Because of the number of possible causes of claimant's ACL instability (tear), this case presents a complex medical question that depends on expert medical analysis for its resolution. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, a persuasive opinion must also adequately consider and weigh the relative contribution of various potentially contributory factors. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 426 (1995).

Dr. Baker, examining physician, and Dr. Straub, treating orthopedist, each provided opinions regarding the cause of claimant's right knee condition.[2]

Claimant reported to Dr. Baker that since the 1994 injury, his knee had felt "sloppy," loose and untrustworthy, and buckled if he stepped wrong or on uneven ground. (Ex. 10-3, -4). Dr. Baker opined that claimant had both ACL and MCL instability prior to the August 17, 1998 injury and that, although the work injury caused an increase in claimant's symptoms, the preexisting instability was the major contributing cause of his current chronic knee instability and need for surgery.[3] (Ex. 10-7).

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[1] The ALJ upheld the insurer's denials of claimant's MCL and meniscus tears. Claimant does not dispute this holding on review.

[2] Dr. Bailey, claimant's family physician, also provided an opinion regarding causation. However, we agree with the ALJ's conclusion that his opinion is unpersuasive. *Somers v. SAIF*, 77 Or App 259 (1986); *Miller v. Granite Construction*, 28 Or App 473 (1997).

[3] Dr. Baker did not comment on the effect of the dirt-bike incident that occurred after the work injury. However, because Dr. Baker opined that the major contributing cause of claimant's right knee condition and need for treatment was the ligamentous instability that preexisted the work injury, we do not find that his lack of comment would have any effect on his ultimate opinion regarding the compensability issue.

When he first saw Dr. Straub, claimant reported that he had had to be careful moving his right knee side to side or twisting after his 1994 right knee injury. Claimant also reported that Dr. Bailey felt he had some degree of internal problems. (Ex. 2). After examining claimant, Dr. Straub concluded that claimant had a chronic ACL deficient knee. (*Id.*) In follow up with Dr. Straub, claimant again reported that his current right knee problems (frequent give way, especially when his leg was in the wrong position) were similar to those he had for the past four years. (Ex. 3). After the MRI, Dr. Straub stated that the ACL tear "looks to be chronic." (Ex. 8).

Dr. Straub initially concluded that the major contributing cause of claimant's need for ligament reconstruction was his preexisting, chronic right knee ACL instability. He based his opinion on claimant's history, supplemented by his review of Dr. Bailey's records, his clinical examination of claimant's right knee, his review of the October 1998 MRI, and Dr. Baker's evaluation. (Exs. 14, 15-32).

During his deposition, Dr. Straub offered testimony in support of the compensability of claimant's ACL tear. This testimony was premised on two hypotheticals (that, as claimant was riding his motorcycle the day after the work injury, he twice shifted his foot from the peg to the ground and when he felt a sharp pain in his knee it felt like it was going to buckle (Ex. 15-11, -13); and that after the 1994 injury, claimant had "mild discomfort" only with lateral movement of the leg (Ex. 15-14)). Thus, Dr. Straub's opinion requires supporting evidence in the record in accordance with the hypotheticals.

Claimant testified that, while turning his dirt-bike around, he put his foot down quickly to support himself and felt pain when his right knee buckled and *he fell over.* (Tr. 16, 18). He also testified that afterward, his knee did not feel right and was more sore than it had been before. (Tr. 18). Claimant then used his friend's four-wheeler (instead of his two-wheeler) to get back to his house, where he decided to use crutches. (Tr. 18, 19). Therefore, even though Dr. Straub concluded that the work injury was a much more traumatic injury than the episode of kneeling that he had described in his notes, we do not find his opinion that the work injury caused the ACL tear to be persuasive, as it is not based on an accurate history.

Moreover, as discussed above, claimant's contemporary reports to Dr. Baker and Dr. Straub indicate that claimant had experienced ongoing problems with his knee since 1994. Claimant's report to Dr. Baker stated that the ongoing problems involved a sense of the knee being "loose" and untrustworthy, and sometimes giving way if his leg was in the wrong position or if he walked wrong or over uneven ground.

When this contemporary medical information regarding claimant's 1994 injury and ongoing symptoms was reviewed with Dr. Straub during his deposition, he indicated that it was "highly suspicious of an anterior cruciate ligament injury." Dr. Straub also indicated that if claimant had an incident with little swelling and a lot of swelling after he reinjured the knee, he (Straub) would consider the second incident as the one contributing more to the knee swelling. Moreover, when asked if he would change his opinion that the injury was not the major contributing cause of claimant's need for ligament reconstruction if he were to rely on the history claimant provided to Dr. Baker and himself, Dr. Straub said no. Then, when asked about the relationship of claimant's preexisting problems and what probably occurred in claimant's knee, Dr. Straub said, "I think he probably had a subluxation of his knee related to his chronic anterior cruciate deficiency and it ended up with bruising of the bones that you can see on the MRI." Finally, when asked what the acute change was that was precipitated by the work injury, Dr. Straub stated: "I can't say for certain."

When Dr. Straub's medical opinion is read as a whole, we conclude that claimant has failed to establish that the August 17, 1998 work injury was the major contributing cause of his disability or need for medical treatment for his ACL instability (tear).

ORDER

The ALJ's order dated September 17, 1999 is reversed in part and affirmed in part. The insurer's denial of claimant's ACL instability in reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
NANCY A. NIELSEN, Claimant
WCB Case No. 98-05915
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to admit certain exhibits into the record; and (2) upheld the SAIF Corporation's denial of her occupational disease claim for a right shoulder, elbow and arm condition. On review, the issues are the ALJ's evidentiary ruling and compensability.

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

The hearing in this matter was originally scheduled for October 15, 1998, but was postponed over SAIF's objection because of incomplete case preparation. The case was rescheduled for hearing on February 5, 1999 before ALJ Hazelett.[1] That hearing was rescheduled when claimant's former attorney experienced severe migraine headaches that prevented him from presenting claimant's case. ALJ Hazelett "froze" the evidentiary record as of February 5, 1999.

On March 3, 1999, claimant's former counsel submitted additional documents (Exhibits 1A-1E, "new" Exhibit 5 and 9) for inclusion in the record. These records (with the exception of Exhibit 9, a January 29, 1999 report from Dr. Grewe to claimant's attorney) were apparently in SAIF's possession, but were not submitted by SAIF as exhibits for the February 5, 1999 hearing.[2] On March 25, 1999, claimant's former attorney wrote a letter to ALJ Hoguet, to whom the case had been reassigned, asserting that his headache condition was interfering with preparation for the case and that it would be unfair to exclude the submitted evidence. Claimant's former attorney also advised the ALJ that he would be resigning as counsel.

The rescheduled April 23, 1999 hearing was postponed when claimant retained her current counsel. The matter was reset for hearing on September 3, 1999. The issue at hearing, which ALJ Hazelett conducted, was the compensability of an occupational disease claim for a right shoulder, arm and elbow overuse condition.

The ALJ declined to admit the submitted "post-February 5, 1999" documents, but allowed them to remain in the record as an "offer of proof." In excluding the proposed exhibits, the ALJ rejected claimant's argument that SAIF had a duty under OAR 438-007-0018 to submit as exhibits all relevant and material records in its possession prior to the February 5, 1999 hearing. On the merits, the ALJ upheld SAIF's denial, noting that there was no persuasive medical evidence in the record that established that claimant's work activities were the major contributing cause of claimant's overuse condition.

On review, claimant contends that the ALJ erred in "freezing" the record at the February 5, 1999 hearing and, further, that SAIF had a duty under OAR 438-007-0018 to submit all relevant evidence to the ALJ for inclusion in the record. Claimant asserts that the case should be remanded to the ALJ for consideration of the excluded evidence. Finally, claimant agues that, even if we only considered the medical records admitted into evidence, the ALJ's decision to uphold the denial should be reversed.

We need not decide the evidentiary issues that claimant raises. That is, even if the excluded evidence is considered, we would still find that claimant failed to prove a compensable occupational disease claim.[3]

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[1] SAIF submitted five exhibits for inclusion in the record on September 4, 1998, four more exhibits on October 13, 1998 and one additional exhibit on December 15, 1998. Claimant's former attorney submitted no exhibits prior to the February 5, 1999 hearing.

[2] Claimant does not contend that these exhibits were not properly disclosed pursuant to OAR 438-007-0015(2).

[3] Because consideration of the excluded evidence is not reasonably likely to affect the outcome of the case, we also decline to remand the case to the ALJ. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

To establish compensability of her occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the right shoulder, arm and elbow overuse condition. ORS 656.802(2)(a); *Christine M. Stromer*, 51 Van Natta 1824 (1999). 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).

Dr. Harvey, an attending physician, opined that claimant's diagnosed right shoulder impingement syndrome and moderate medial and lateral epicondylitis were "related" to overuse syndrome at work. (Ex. 1E-5). Dr. Harvey also opined that these conditions were "work-related and due to an overuse syndrome." (Ex. 1E-12). While Dr. Harvey indicated that claimant's overuse condition was "related" to work, the applicable legal standard is "major contributing cause." Because Dr. Harvey did not opine that claimant's employment duties were the "major contributing cause" of the overuse condition, his opinion does not establish the compensability of the occupational disease claim.[4]

Dr. Grewe is the other attending physician whose opinion is among the excluded documents and who addresses the causation issue. (Ex. 9). He opined that the major cause of a condition "like lateral epicondylitis" is repetitive overuse. Dr. Grewe noted claimant's repetitive activities as a machine operator doing repetitive activities, but had no other specific details regarding her work. In responding to the question of whether claimant's employment was the major contributing cause of her present condition, Dr. Grewe stated that he could not comment on that without a specific job description. *Id.* Given Dr. Grewe's inability to address the major cause issue, we conclude that his January 29, 1999 report would also not establish medical causation.

Accordingly, having considered the medical evidence addressing the causation issue contained in the "offer of proof," we find that it would not establish that claimant's employment is the major contributing cause of her overuse condition. Inasmuch as the only medical opinion (Dr. Marble's) admitted into evidence that addresses causation does not support compensability, we find that claimant has not satisfied her burden of proof under ORS 656.802(2)(a), whether or not the excluded evidence is considered. Accordingly, we affirm the ALJ's decision upholding the denial.

ORDER

The ALJ's order dated October 4, 1999 is affirmed.

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[4] We recognize that "magic words" are not always required to establish compensability. *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986). But, in light of the complex nature of the medical question and the conflicting medical evidence from Dr. Marble, the lack of specificity in Dr. Harvey's opinions diminishes their persuasiveness.

In the Matter of the Compensation of
BRYCE A. SHERRICK, Claimant
WCB Case No. 99-03724
ORDER ON REVIEW
Sara L. Gabin, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent partial disability for his abdominal condition. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant argues that this matter should be remanded to the Director for promulgation of a rule that addresses claimant's injury.

The Director cited to OAR 436-035-0375 and found that any abdominal impairment was addressed by the standards. The Director also expressly found that claimant's impairment, if any, was addressed by the standards. (Ex. 15-2). Under the circumstances, we conclude that claimant has not met his burden of proving that his disability is not addressed by the standards. *See Terry J. Hockett*, 48 Van Natta 1297, 1298 (1996). Therefore, we affirm the ALJ's order.

ORDER

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

March 1, 2000 Cite as 52 Van Natta 335 (2000)

In the Matter of the Compensation of
NAZARIO N. SOLIS, Claimant
WCB Case No. 99-00410
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that: (1) awarded claimant a $1,000 assessed attorney fee under ORS 656.386(1) for a pre-hearing denial rescission; and (2) assessed a $250 penalty-related attorney fee under ORS 656.382(2) for the insurer's allegedly unreasonable denial. In addition, claimant cross-requested review, raising the issue of sanctions. On review, the issues are attorney fees and sanctions.

We adopt and affirm the ALJ's order with the following supplementation. Claimant, rather than his attorney, filed the request for hearing regarding the insurer's January 6, 1999 denial of his left hand laceration and contusion.

On review, the insurer states that, at hearing, the ALJ inquired as to what the insurer would consider to be a reasonable attorney fee if one were awarded, and the insurer's counsel responded that $750 to $1,000 would be a reasonable attorney fee. Appellant's Brief, page 2. The insurer argues that, after reviewing the ALJ's order and the record, no fee is warranted given the "total absence of any meaningful input by claimant's counsel in the carrier's decision to rescind its denial." *Id.* at 2-3. Claimant responds that the insurer cannot now raise this issue because the issue of his attorney's instrumentality in obtaining the pre-hearing denial rescission was not raised at hearing. We agree with claimant.

At hearing, the sole issue regarding claimant's entitlement to an assessed attorney fee pursuant to ORS 656.386(1)[1] was whether or not the denial was a legal nullity, thereby foreclosing the assessment of an attorney fee. (Tr. 4). Even after agreeing to this limitation regarding the attorney fee issue, the insurer could have raised at hearing the issue of claimant's attorney's instrumentality in setting aside the denial at hearing. In this regard, the Board's rules for the conduct of hearings and case law demonstrate a practice and policy of allowing issues to be raised during the hearing. OAR 438-006-0031. Where such a new issue is permitted, to afford due process, the responding party must be given an opportunity to respond to the new issues raised. OAR 438-006-0091(3). The appropriate way for that party to respond initially to a newly raised issue that he is not prepared to address is to request a continuance. *Id.*

Here, although the insurer's attorney posed some questions during the claims adjuster's testimony that touched on "instrumentality," the statement of the issues to be addressed at hearing was never altered. In other words, after agreeing to the above-stated limitation regarding the attorney fee issue, the insurer did not raise the issue of instrumentality of claimant's attorney at hearing. Instead, the insurer first raises the "instrumentality" issue on review. As a general rule, we do not consider

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[1] ORS 656.386(1) provides, in relevant part: "In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed."

issues that are raised for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *Gunther H. Jacobi*, 41 Van Natta 1031, 1032 (1989) (new issues or legal theories presented for the first time on review are not considered where prejudice would result to one of the parties); *see also Fister v. South Hills Health Care*, 149 Or App 214 (1997) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing); *compare Hays v. Tillamook County General Hospital*, 160 Or App 55 (1999) (in carrier's appeal of ALJ's compensability decision, Board is authorized to consider carrier's appeal of ALJ's attorney fee award even if carrier neglects to object to the claimant's counsel's attorney fee request at the hearings level). In this case, we find no reason to deviate from our general rule. Consequently, we decline to consider the "instrumentality" issue raised for the first time on review.

As for the penalty issue, the insurer argues that "there are no grounds for penalizing the carrier for maintaining that it thought claimant could withdraw his claim." Appellant's Brief, page 5. The insurer misses the point. As the ALJ found, the agreement purportedly entered into by claimant and the employer was void as a matter of law. Therefore, the claim was not withdrawn.

Claimant was injured at work, and the employer drove him to the Emergency Room for medical treatment. Thus, the employer had no doubt as to the compensability of the injury claim. Instead, the basis for the "withdrawal" of claimant's Workers' Compensation claim was the employer's agreement to pay the medical bills in exchange for claimant's withdrawing that claim.[2] (Tr. 10-11).

ORS 656.236 provides the means by which "parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, *except* for medical services." (Emphasis added). Such a disposition agreement, however, is subject to terms and conditions prescribed by the Board *and* must be approved by the Board. ORS 656.236(1)(a). The employer's attempt to *unilaterally* secure a withdrawal of the *entire* Workers' Compensation claim in exchange for a promise to pay medical bills is not permitted by law.

Moreover, the employer's knowledge of the work-relatedness of the injury and its conduct in attempting to unilaterally secure such a void agreement is legally imputable to its insurer. *See Nix v. SAIF*, 80 Or App 656 (1986), *rev den* 303 Or 158 (1987). Thus, the insurer's denial was unreasonable. *Linda M. Akins*, 44 Van Natta 108 (1992) (although the employer initially informed the carrier a work-related injury was not work-related, the carrier was imputed to have knowledge of the work-relatedness of the injury; therefore, the Board assessed a penalty against the carrier for its unreasonable denial).

Penalties and attorney fees are not "compensation" within the meaning of ORS 656.382(2). Therefore, claimant is not entitled to attorney fees for successfully defending those awards on Board review. *Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

Finally, although claimant raised the issue of "sanctions" in his cross-request for review, he presented no argument regarding that issue. In light of such circumstances, we are not inclined to address the issue because it has not been adequately developed. *See Ronald B. Olson*, 44 Van Natta 100,

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[2] The employer was under the mistaken belief that it was permissible to enter into such a private contract in lieu of filing a Workers' Compensation claim if the claim costs did not exceed $500. (Tr. 7).

ORS 656.262(5) provides:

"Payment of compensation under subsection (4) of this section or payment, in amounts not to exceed $500 per claim, for medical services for nondisabling claims, may be made by the subject employer if the employer so chooses. *The making of such payments does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits. If the employer chooses to make such payment, the employer shall report the injury to the insurer in the same manner that other injuries are reported.* However, an insurer shall not modify an employer's experience rating or otherwise make charges against the employer for any medical expenses paid by the employer pursuant to this subsection." (Emphasis added).

Thus, the law permits the employer to pay up to $500 for medical services for nondisabling claims. Furthermore, the insurer cannot modify the employer's experience rating or otherwise make charges against the employer as a result of any such payments. But the law also clearly requires the employer to report the injury and the insurer to process the claim in the usual manner. Thus, ORS 656.262(5) provides no basis for the parties' purported agreement to withdraw the Workers' Compensation claim in exchange for the employer's agreement to pay the medical bills.

101 (1992) (Board declined to address constitutional argument not adequately developed for review). In any event, based on the positions advanced by the insurer, we are persuaded that its appeal presented a colorable argument contesting the ALJ's order and, as such, sanctions for a frivolous appeal are not warranted. *See Bi-Mart Corporation v. Allen*, 164 Or App 288 (1999).

ORDER

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

March 2, 2000 Cite as 52 Van Natta 337 (2000)

In the Matter of the Compensation of
METIN BASMACI, Claimant
WCB Case No. 98-10143
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock, and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its denial of claimant's consequential condition claim for a low back strain; (2) awarded claimant additional temporary total disability benefits; and (3) assessed penalties and attorney fees for the employer's allegedly unreasonable claim processing. In his respondent's brief, claimant contests that portion of the ALJ's order that upheld the employer's denial of claimant's current bilateral plantar fasciitis condition. On review, the issues are compensability, temporary disability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the ALJ's "Findings of Ultimate Facts."

CONCLUSIONS OF LAW AND OPINION

Compensability of Current Plantar Fasciitis Condition

We adopt and affirm the ALJ's order regarding the compensability of claimant's current bilateral foot condition.

Compensability of the Low Back Condition

The ALJ set aside the employer's denial of claimant's consequential condition claim for a low back strain based on the opinions of Drs. Lazar and Hewitt. These physicians related claimant's low back condition to biomechanical changes created by orthotics that had been prescribed for his accepted bilateral plantar fasciitis condition. We agree with the employer that claimant has failed to establish the compensability of a low back condition.

The employer contends, as an initial matter, that claimant never properly perfected a claim for a "low back strain." We need not resolve this issue because we find that claimant did not meet his burden of proving the compensability of any low back condition.

The employer initially accepted claimant's claim for bilateral plantar fasciitis. (Ex. 7). Claimant contends that he developed a low back strain as a compensable consequence of wearing orthotics prescribed for his accepted plantar fasciitis condition. Accordingly, claimant must prove that the compensable condition is the major contributing cause of his low back strain. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

When evaluating medical evidence on the issue of causation, we rely on those opinions which are both well-reasoned and rely on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). Generally, we defer to the opinion of claimant's treating physicians, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to claimant's attending physicians Drs. Lazar and Hewitt.

Dr. Arbeene, an orthopedic surgeon, and Dr. Farris, a neurologist, performed an examination at the request of the employer. (Ex. 30). These doctors concluded that claimant did not have a specific diagnosis regarding his low back condition. (Ex. 30-7). Drs. Arbeene and Farris supported only the logical *possibility* that claimant's back symptoms result from biomechanical changes related to his use of orthotics for his bilateral foot condition. (Ex. 30-7). They also believed that it was possible that claimant's low back symptoms developed in relation to his athletic activities, *i.e.* soccer playing. (*Id.*) Drs. Arbeene and Farris ultimately reasoned that claimant's pes planus or "flat feet" condition was the most likely cause of his current bilateral foot condition. (*Id.*)

Drs. Fuller and Radecki, who performed another examination at the request of the employer, similarly failed to identify a specific diagnosis or objective findings in relation to claimant's low back. These doctors stated that claimant's presentation was "entirely subjective." (Ex. 36-12). Drs. Fuller and Radecki also noted the presence of psychological factors that contributed to both claimant's low back and bilateral foot conditions. (Ex. 36-13).

The employer initially accepted a bilateral planter fasciitis condition on January 7, 1998. (Ex. 7). Claimant has been prescribed orthotic devices for that accepted condition since October 24, 1997. (Ex. 3). However, the employer denied claimant's current bilateral foot condition on May 25, 1999. (Ex. 40). We agree with the employer that, because its denial of claimant's current bilateral plantar fasciitis (foot) condition has been upheld, the effect of the current bilateral foot condition cannot be weighed in favor of compensability of any low back condition.

Claimant's treating physicians relate his low back condition to his wearing orthotics, but the preponderance of evidence indicates that the orthotics are now related to his noncompensable bilateral foot condition. Because claimant's current bilateral foot condition is no longer compensable, the opinions of Drs. Lazar and Dr. Hewitt rest on an incorrect assumption, *i.e.* that claimant's orthotics are a compensable medical device for claimant's accepted bilateral plantar fasciitis condition that have caused postural changes in claimant's lower back.

Finally, unlike Drs. Arbeene and Farris, Drs. Lazar and Hewitt fail to consider any possible effects of claimant's off-work activities, most notably his soccer playing, on the development of his low back condition. To meet claimant's burden of proving major contributing cause, a physician's opinion must consider the relative contribution of all potential causes. *Dietz v. Ramuda*, 130 Or App 397, 402 (1994), *rev dismissed* 321 Or 416 (1995). For these reasons, we find the opinions of claimant's treating physicians unpersuasive.

Temporary Disability, Penalties and Attorney Fees

Inasmuch as we have upheld the employer's denial of claimant's low back condition, we also reverse the ALJ's award of temporary disability related to that condition. Similarly, we reverse the ALJ's awards of penalties and attorney fees because there are no amounts "then due" and no unreasonable resistance to compensation upon which to base such awards. ORS 656.262(11); ORS 656.382(1); *Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991).

ORDER

The ALJ's order dated July 6, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the employer's denial of claimant's low back condition is reversed. The employer's denial is reinstated and upheld. The ALJ's $3,000 attorney fee award is also reversed. That portion of the ALJ's order that awarded temporary disability and penalties and attorney fees for unreasonable claims processing is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Biehl dissenting.

Because I agree with the ALJ that claimant proved that his low back condition is compensably related to the orthotics prescribed for his accepted plantar fasciitis condition, I respectfully dissent from that portion of the majority's opinion.

Despite some inconsistencies, the record establishes, at a minimum, the diagnosis of a low back strain condition by Dr. Lazar. (*See* Exs. 14, 28). Moreover, for the following reasons, I am persuaded that claimant's low back strain condition is caused in major part by the orthotics prescribed for his then-accepted bilateral foot condition.

Claimant's treating physicians Drs. Lazar and Hewitt reasoned that claimant's low back condition arose from biomechanical, adaptive postural changes in his lumbosacral and hip areas. (Exs. 11, 12, 29A-2). As a result of this condition, claimant had documented muscle "hypertonicity," also called muscle spasms. (Ex. 29A). The opinions of claimant's treating physicians are well-reasoned and not based merely on a temporal connection between claimant's wearing the orthotics and the onset of his low back pain.

As the majority acknowledges, the employer initially accepted a bilateral planter fasciitis condition on January 7, 1998. (Ex. 7). Claimant has been prescribed orthotic devices for that accepted condition since October 24, 1997. (Ex. 3). The employer denied claimant's current bilateral foot condition on December 28, 1998. (Exs. 31, 32). The postural changes occasioned by claimant's wearing the orthotics, therefore, began more than a year before the employer issued a denial of his current bilateral foot condition.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
GEORGE H. GALE, Claimant
WCB Case No. 99-00743
ORDER ON REVIEW
Larson & Owen, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denials of his C3-4 disc herniation, C5-6 disc protrusion and his current cervical and lumbar conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

On October 16, 1996, Dr. Molloy diagnosed claimant with an acute upper lumbar strain, which was "resolving" by the following week. (Ex. A). Dr. Molloy noted that claimant had sustained two previous back injuries in the past 10 years. (Ex. A-1).

On March 12, 1998, claimant was working for the employer as a logger. On that day, his feet slipped as he was packing a very heavy block while stepping up on a log. (Ex. 6, Tr. 7). Claimant landed on his buttocks with the block on top of his shoulder. (Tr. 7). He sought medical treatment and medication was prescribed. (Ex. 1).

On March 16, 1998, Dr. Molloy reported that claimant's medication seemed to "improve things a bit and then while driving he twisted his neck, felt a pop, and things rapidly settled down to normal." (Ex. 1). He diagnosed "cervical strain, resolved" and "lumbar strain, resolved." (*Id.*) Dr. Molloy noted that claimant had come in that day primarily for a work release. (*Id.*)

On April 9, 1998, claimant sought treatment from Ms. Faber, nurse practitioner. Ms. Faber reported that claimant had been injured about four weeks ago, but had relief with medication. (Ex. 2). She said that about four days later he felt a "popping" sensation in his neck and his symptoms resolved until after being at work several more days. (*Id.*) Claimant's pain in his neck and low back had returned and had worsened significantly over the last three days. (*Id.*) Ms. Faber diagnosed a cervical and lumbar strain. (*Id.*)

Cervical x-rays on April 9, 1998 showed moderate degenerative spondylosis at C5-6 with moderate bilateral narrowing of the neuroforamina. (Ex. 3). There was probable bilateral narrowing of neuroforamina at C3-4 and mild to moderate narrowing of the right C4-5 neuroforamen. (*Id.*) A cervical MRI on April 17, 1998 showed mild to moderate stenosis of the spinal canal and neural foramina at C5-

6. (Ex. 4-2). The radiologist noted that "2-3 mm of right paracentral disc protrusion is also thought to be present at that level." (*Id.*) Claimant had neural foraminal stenosis at C3-4 and it was noted that there "may also be a small right-sided disc hernation at C3-C4." (*Id.*) Claimant was released from work by Ms. Faber on April 17, 1998. (Ex. 5).

Claimant signed an "801" form on April 27, 1998. (Ex. 6). On May 18, 1998, SAIF accepted disabling cervical strain and lumbar strain. (Ex. 8).

On June 12, 1998, claimant was examined by Dr. Collada, neurosurgeon. (Ex. 9). He said the cervical MRI showed mild stenosis at C5-6 and "some bulging disc at C3-4." (Ex. 9-2). He did not see any critical nerve compression and he did not believe claimant had a neurologic deficit that required surgery. (Ex. 9-2, -3). On September 11, 1998, Dr. Collada reported that claimant was medically stationary. (Ex. 11).

On October 15, 1998, Ms. Faber said claimant had been undergoing rehabilitation for the past three months. (Ex. 12). She did not believe he was ready to return to regular work. (*Id.*)

In early November 1998, claimant was examined by Dr. Fuller on behalf of SAIF. Dr. Fuller reviewed claimant's x-rays and cervical MRI. His diagnoses included moderately severe degenerative disc disease at C5-6, with foraminal bone spurs and narrowing, preexisting the date of injury, and "[c]ervical and lumbar strains, relating to the work incident of 03/12/98, resolved stationary without impairment." (Ex. 13-8). Dr. Fuller believed that claimant had preexisting degenerative disc disease at C5-6 and C3-4 that had slowed his recovery. (Ex. 13-9). He also felt claimant had a preexisting low back condition that was retarding his recovery. (*Id.*) Dr. Fuller concluded that claimant's ongoing aches and pains were caused, in major part, by the preexisting conditions. (*Id.*) Dr. Molloy concurred with Dr. Fuller's report. (Ex. 14).

A Notice of Closure issued on January 8, 1999 without an award of permanent disability. (Ex. 16). On the same date, SAIF issued a "current condition denial" on the basis that the March 12, 1998 injury was not the major contributing cause of claimant's current cervical and lumbar strain. (Ex. 17). SAIF amended the denial on February 11, 1999, stating that the medical evidence indicated that the accepted conditions had combined with preexisting degenerative disc disease of the cervical and lumbar spine. (Ex. 18). SAIF issued a "current condition denial" of claimant's disability and need for treatment on and after December 24, 1998, on the ground that his injury ceased to be the major cause of the combined condition, disability and need for treatment. (*Id.*)

On March 22, 1999, SAIF issued a partial denial, asserting that the March 12, 1998 injury was not the major contributing cause of claimant's C3-4 disc herniation and C5-6 disc protrusion. (Ex. 19).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that Dr. Molloy's opinion was not sufficient to sustain claimant's burden of proving compensability. The ALJ concluded that the claims for combined cervical and lumbar conditions and cervical disc abnormalities were not compensable.

Claimant relies on the opinion of Dr. Molloy to establish compensability of his current cervical condition, which involves a C3-4 disc herniation and C5-6 disc protrusion. He also relies on Dr. Molloy's opinion to establish compensability of his current lumbar condition.

C5-6 Disc Protrusion

Claimant relies on Dr. Molloy's opinion to establish compensability of his C5-6 disc protrusion. For the following reasons, we conclude that claimant has failed to establish compensability of the disc protrusion at C5-6.

Dr. Molloy examined claimant on March 16, 1998, four days after the March 12, 1998 injury. He reported that claimant had come in that day primarily for a work release. (Ex. 1). Dr. Molloy diagnosed "cervical strain, resolved" and "lumbar strain, resolved." (*Id.*)

The next report in the record from Dr. Molloy is a letter indicating he concurred in Dr. Fuller's November 2, 1998 report. (Ex. 14). Dr. Fuller reported that claimant's cervical x-rays showed moderate degenerative narrowing of the C5-6 disc space with mild anterior and posterior bone spurs, which produced moderate narrowing of the neural foramina at C5-6. (Ex. 13-4). Degeneration was also noted at C3-4 and C4-5. (*Id.*) After reviewing the cervical MRI, Dr. Fuller reported that there appeared to be a soft tissue bulge at C5-6, which was consistent with degenerative disc disease. (Ex. 13-6). His diagnoses included moderately severe degenerative disc disease at C5-6, with foraminal bone spurs and narrowing, preexisting the date of injury, and "[c]ervical and lumbar strains, relating to the work incident of 03/12/98, resolved stationary without impairment." (Ex. 13-8). Dr. Fuller concluded that claimant's ongoing aches and pains were caused, in major part, by the preexisting conditions. (Ex. 13-9).

Although Dr. Molloy had concurred with Dr. Fuller's report, Dr. Molloy subsequently reported that claimant's cervical findings of the studies in April 1998 "are due in major part to his work-related injury of March 1998." (Ex. 21). He referred to his March 16, 1998 report that had indicated that claimant's cervical and lumbar pain had resolved. (*Id.*) Dr. Molloy noted, however, that claimant returned on April 9, 1998 with complaints of increased neck and lumbar pain. (*Id.*) Dr. Molloy said that it was "discovered" that claimant "suffers from a moderate spinal canal stenosis and neural foramina narrowing at several levels in his neck" and he explained that there was evidence of degenerative disc disease and disc protrusion/herniation. (*Id.*)

We agree with the ALJ that Dr. Molloy's opinion was inconsistent. He initially concurred with Dr. Fuller's report, which said that claimant appeared to have a soft tissue bulge at C5-6 that was consistent with degenerative disc disease. (Exs. 13-6, 14). Dr. Fuller diagnosed claimant with "[m]oderately severe degenerative disc disease, C5-6, with foraminal bone spurs and narrowing, preexisting the date of injury." (Ex. 13-8). Dr. Molloy concurred with Dr. Fuller's report without comment. (Ex. 14).

In a later report, Dr. Molloy reported that claimant's cervical findings of the studies in April 1998 "are due in major part to his work-related injury of March 1998." (Ex. 21). Because Dr. Molloy provided no explanation for his change of opinion, his opinion is entitled to little weight. *See Kelso v. City of Salem*, 87 Or App 630 (1987). Furthermore, Dr. Molloy's opinion is not persuasive because he provided no explanation as to why claimant's work injury was the cause of claimant's C5-6 disc protrusion. We conclude that claimant has failed to establish compensability of the disc protrusion at C5-6.

C3-4 "Herniation"

Claimant argues that his C3-4 disc herniation is compensable based on the "uncontroverted" medical evidence from Dr. Molloy regarding this condition. SAIF argues that there is insufficient evidence that claimant has a disc herniation at C3-4. Dr. Post, radiologist, reviewed claimant's cervical MRI and explained, in part:

> "There is neural foraminal stenosis at C3-C4 that is moderate to severe on the right side and moderate on the left. There *may* also be a small right-sided disc herniation at C3-C4." (Ex. 4-2; emphasis supplied).

At most, Dr. Post's comment indicates only a possibility that claimant had a disc herniation at C3-4. *See Gormley v. SAIF*, 52 Or App 1055 (1981). There are no other medical opinions that establish that claimant had a disc herniation at C3-4. Dr. Collada felt that claimant had a "bulging disc" at C3-4, without any critical nerve compression. (Ex. 9-2). Dr. Fuller reported that claimant had mild degenerative findings at C3-4 that resulted in severe narrowing of the right C3-4 neural foramen. (Ex. 13-4). He had personally reviewed claimant's x-rays and cervical MRI (Ex. 13-6), but he did not refer to a disc herniation at C3-4. Dr. Fuller concluded that claimant's ongoing aches and pains were caused, in major part, by the preexisting conditions. (Ex. 13-9). Dr. Molloy concurred with Dr. Fuller's report without comment. (Ex. 14).

In a later report, Dr. Molloy said that claimant had a "disc protrusion/herniation," but he did not indicate whether it was a cervical or lumbar disc or what disc level was herniated. Moreover, even if we assume that Dr. Molloy believed claimant had a disc herniation at C3-4, he did not provide an explanation as to why claimant's work injury caused that condition. Dr. Molloy merely said that the

cervical findings from the studies in April 1998 "are due in major part to his work-related injury of March 1998." (Ex. 21). Moreover, as we discussed earlier, Dr. Molloy's opinion is entitled to little weight because he did not explain his change of opinion from his previous concurrence with Dr. Fuller's report. *See Kelso v. City of Salem*, 87 Or App 630 (1987). We conclude that claimant has failed to establish compensability of a disc herniation at C3-4.

Current Cervical and Lumbar Conditions

On May 18, 1998, SAIF accepted a cervical strain and lumbar strain. (Ex. 8). The claim was closed on January 8, 1999 without an award of permanent disability. (Ex. 16). On the same date, SAIF issued a "current condition denial" on the basis that the March 12, 1998 injury was not the major contributing cause of claimant's current cervical and lumbar strain. (Ex. 17). SAIF amended the denial on February 11, 1999, stating that the medical evidence indicated that the accepted conditions had "combined" with preexisting degenerative disc disease of the cervical and lumbar spine. (Ex. 18). SAIF issued a "current condition denial" of claimant's disability and need for treatment on and after December 24, 1998, on the ground that his injury ceased to be the major cause of the combined condition, disability and need for treatment. (*Id.*)

Claimant was injured on March 12, 1998, when his feet slipped as he was stepping up on a log. (Ex. 6, Tr. 7). On March 16, 1998, Dr. Molloy reported that claimant's medication seemed to "improve things a bit and then while driving he twisted his neck, felt a pop, and things rapidly settled down to normal. (Ex. 1). He diagnosed "cervical strain, resolved" and "lumbar strain, resolved." (*Id.*) Dr. Molloy noted that claimant had come in primarily for a work release. (*Id.*) Thus, Dr. Molloy felt that claimant's cervical strain and lumbar strain had resolved within four days after the injury.

Dr. Fuller examined claimant on November 2, 1998. He concluded that claimant's cervical and lumbar strains related to the March 12, 1998 work incident were "resolved stationary without impairment." (Ex. 13-8). Dr. Fuller noted that claimant's strains had resolved fairly rapidly following the work incident and he felt it was medically reasonable to attribute the current ongoing pains and aches to the preexisting conditions. (Ex. 13-9). Dr. Fuller's report indicated that claimant's current cervical and lumbar conditions were not related to the accepted cervical or lumbar strains. Dr. Molloy concurred with Dr. Fuller's report. (Ex. 14).

In a later April 20, 1999 report, Dr. Molloy discussed his March 16, 1998 chart note:

> "When [claimant] was subsequently seen on 3/16/98, the lumbar pain had apparently resolved and the cervical pain was also resolved and it was felt at that time that his neck pain was most consistent with a cervical strain. It is interestng that the pain resolved when he felt a pop after twisting his neck." (Ex. 21).

Dr. Molloy indicated that claimant returned on April 9, 1998 with complaints of increased neck pain and lumbar pain. (*Id.*) He explained:

> "It was discovered that this gentleman suffers from a moderate spinal canal stenosis and neural foramina narrowing at several levels in his neck. There is evidence of degenerative disc disease and disc protrusion/herniation. As to his lumbar condition, I think the major cause for his present lumbar pain is due to his work related injury of March 1998." (*Id.*)

Dr. Molloy also said that the cervical findings on the April 1998 x-ray and MRI were "due in major part" to claimant's March 1998 work injury. (*Id.*)

Although Dr. Molloy opined that claimant's current lumbar pain and neck problems were "due in major part" to the March 1998 work injury, there is no indication that Dr. Molloy believed that claimant was still suffering from a cervical or lumbar strain. To the contrary, he had previously reported on March 16, 1998 that both strains had resolved. In his April 1999 report, Dr. Molloy said that claimant was suffering from a "moderate spinal canal stenosis and neural foramina narrowing at several levels in his neck" and there was evidence of degenerative disc disease and disc protrusion/herniation. None of those conditions were accepted by SAIF. Dr. Molloy's report indicated that claimant's current cervical and lumbar conditions are not related to the accepted cervical or lumbar strains.

Based on the reports from Drs. Fuller and Molloy, we conclude that claimant's current cervical and lumbar condition is no longer related, in major or material part, to his accepted cervical or lumbar strains. Consequently, we uphold SAIF's denials.[1]

ORDER

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

[1] To the extent that SAIF's denial could be characterized as a pre-closure denial, it is procedurally valid as we have herein concluded that claimant's current cervical and lumbar strains are unrelated to the accepted cervical and lumbar strains. *See Connie L. Birrer*, 51 Van Natta 163, *on recon* 51 Van Natta 467 (1999); *Joey D. Smalling*, 50 Van Natta 1433 (1998); *Zora A. Ransom*, 46 Van Natta 1287 (1994).

March 6, 2000 Cite as 52 Van Natta 343 (2000)

In the Matter of the Compensation of
KENNETH L. GREEN, Claimant
WCB Case No. 97-02171
ORDER ON REMAND
Pozzi Wilson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *James River Corporation v. Green*, 164 Or App 649 (1999). The court has reversed our prior order, *Kenneth L. Green*, 50 Van Natta 132 (1998), that had affirmed an Administrative Law Judge's (ALJ's) order that awarded claimant 19.84 percent (38.09 degrees) scheduled permanent disability for a binaural hearing loss. In reaching this conclusion, we found the self-insured employer entirely responsible for claimant's permanent disability attributable to his hearing loss condition. Noting that it is undisputed that claimant's audiograms establish his hearing loss attributable to each of his employments with his two employers, the court has determined that OAR 436-035-0250 is applicable and will enable us to apportion responsibility for claimant's hearing loss in a manner in which he will receive benefits for permanent disability "due to" his industrial injury. Consequently, the court has remanded for reconsideration and apportionment of responsibility.

Consistent with the court's opinion, we find that claimant sustained a 5 percent rateable hearing loss in his right ear during his employment with the self-insured employer. Consequently, in lieu of the ALJ's order and our prior order, we reinstate and affirm the February 12, 1997 Order on Reconsideration that affirmed the January 8, 1997 Notice of Closure that awarded 5 percent (3 degrees) scheduled permanent disability for right ear hearing loss. In light of such circumstances, the attorney fee awards granted by the ALJ's order and our prior order are rescinded.

Accordingly, on reconsideration of our January 29, 1998 order, the ALJ's order dated August 4, 1997 is reversed. The February 12, 1997 Order on Reconsideration is reinstated and affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY L. DENNIS, Claimant
WCB Case No. 98-06329
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the insurer's partial denial of his occupational disease claim for a right elbow radial head fracture and intra-articular loose bodies; and (2) declined claimant's request for reclassification of his claim. On review, the issues are compensability and claim classification.

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

To establish a compensable occupational disease claim based on the worsening of a preexisting disease or condition, claimant must prove that his work activities were the major contributing cause of both the combined condition and the pathological worsening of the disease.[2] ORS 656.802(2)(b). The existence of the worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2)(d).

We first determine if claimant's work activities were the major contributing cause of his current combined condition. Because this determination involves a complex medical question, it must necessarily be determined by expert medical opinions. *Uris v. Compensation Department*, 247 Or 420 (1967). Claimant correctly notes that "magic words" are not required to meet a statutory burden of proof. *McClendon v. Nabisco*, 77 Or App 412 (1986).

Here, claimant relies on Dr. Walton, his treating orthopedist. While greater weight is generally accorded the opinion of an attending physician, *Weiland v. SAIF*, 64 Or App 810 (1983), Dr. Walton's does not support the conclusion that claimant's work activities were the major contributing cause of claimant's combined condition. Dr. Walton opined that, while claimant's work activities probably caused his preexisting condition to become symptomatic, they probably would not have caused claimant's current condition found during surgery. (Ex. 36-18, 36-19, 36-22). Additionally, Dr. Arbeene and Dr. Brooks, who conducted an insurer-arranged medical examination, were of the opinion that claimant's work activities were not the major contributing cause of claimant's current condition. (Ex. 28). Therefore, the preponderance of the medical evidence does not support the compensability of claimant's combined condition.[3]

Claimant argues, however, that he has satisfied his burden of proof under the first part of ORS 656.802(2)(b) by establishing his work activities were the major contributing cause of his current *need for treatment*. Claimant specifically requests that we disavow *Willard A. Hirsch*, 49 Van Natta 1311, n. 1 (1997) and acknowledge that ORS 656.005(7)(a)(B) and *SAIF v. Nehl*, 148 Or App 101 (1997), *recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998) are incorporated into ORS 656.802(2)(b).[4] (App. Br. 3). We decline to do so.

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[1] We do not, however, adopt the first sentence of finding of fact number 15.

[2] There was initially a dispute over whether claimant's occupational disease claim was properly analyzed under ORS 656.802(2)(a) or ORS 656.802(2)(b). Claimant concedes, however, that his work activities did combine with a preexisting condition or predisposition. (App. Br. 2). Thus, we analyze the compensability issue under ORS 656.802(2)(b).

[3] Because we have found that claimant's evidence failed to satisfy the first part of ORS 656.802(2)(b), we need not decide whether the evidence establishes a "pathological worsening."

[4] Claimant has also requested oral argument. We will not ordinarily entertain oral argument. OAR 438-011-0015(2). However, we may allow oral argument where the case presents an issue of first impression that could have a substantial impact on the workers' compensation system. See *Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994), *aff'd Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996); *Ruben G. Rothe*, 44 Van Natta 369 (1992). Here through their appellate briefs, the parties have addressed the impact of relevant Board and court decisions on the issues before us. Inasmuch as the parties' positions regarding these issues have been thoroughly defined and briefed, 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 Glen D. Roles*, 45 Van Natta 282, 283 n. 2 (1993).

ORS 656.802(2)(b) explicitly requires that employment conditions be the major contributing cause of 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 have held in *Tammy L. Foster*, 52 Van Natta 178 (2000), 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 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. For these reasons, we conclude that ORS 656.802(2)(b) is *not* satisfied by establishing that work activities are the major contributing cause of a need for medical treatment.

Accordingly, we agree with the ALJ that claimant's occupational disease claim for a right elbow radial head fracture and intra-articular loose bodies is not compensable.[5]

ORDER

The ALJ's order dated July 19, 1999, as reconsidered September 2, 1999, is affirmed.

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[5] In the event that the insurer's denial was set aside, claimant sought reclassification of his claim to disabling. Because the denial has been upheld, we agree with the ALJ's conclusion that the issue of claim classification is moot and need not be addressed.

Board Member Phillips Polich dissenting.

The majority found that since claimant's expert medical evidence only showed that his work activities were the major contributing cause of his *current need for treatment*, claimant did not satisfy the burden of proof required under ORS 656.802(2)(b) in that he did not show his work activities were the major contributing cause of his *combined condition*. I disagree with the majority's interpretation of the compensability requirements under 656.802(2)(b). Consequently, I must respectfully dissent.

As previously discussed in the dissent in *Tammy L. Foster*, 52 Van Natta 178 (2000), I believe the standards set forth in ORS 656.005(7)(a)(B) for combined conditions are incorporated by reference and apply to ORS 656.802. ORS 656.802(2)(c). Additionally, the Court of Appeals has held that the compensability standard of ORS 656.005(7)(a)(B) specifically applies to occupational disease claims. *See Brown v. A-Dec.*, 154 Or App 244, 247 (1998); *see also SAIF v. Cessnun*, 161 Or App 367, 371-372.

Under this interpretation of the compensability standards required by ORS 656.802, I would find the fact that claimant showed his work activities were the major contributing cause of his need for treatment sufficiently proved the compensability of his occupational disease claim. Because the majority holds otherwise, I respectfully dissent.

In the Matter of the Compensation of
JAMES A. HOYT, Claimant
WCB Case Nos. 99-03257 & 99-00400
CORRECTED ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

National Union Fire Insurance Co., through its processing agent, AIG Claim Services Inc. (AIG), requests review of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its compensability and responsibility denial of claimant's aggravation claim for a current L4-5 disc condition; (2) upheld Travelers Casualty & Surety Co.'s (Travelers) responsibility denial of claimant's "new injury" claim for the same condition; and (3) assessed penalties and attorney fees to be paid by AIG. Claimant argues that Travelers is responsible for his condition. On review, the issues are compensability, responsibility, penalties and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Claimant began working for the employer in 1987 as a dock worker/warehouseman. He injured his low back at work on July 31, 1991 and AIG accepted his claim for a disabling lumbosacral strain. (Ex. 5A). A May 22, 1992 Notice of Closure closed the claim with temporary, but not permanent, disability. (Ex. 35A). A second Notice of Closure awarded claimant 6 percent unscheduled permanent disability and an Order on Reconsideration affirmed that award on October 29, 1992. (Exs. 56A, 60A).

AIG accepted claimant's 1992 aggravation claim and paid medical and temporary disability benefits. (Exs. 50A, 66A). Dr. Gehling performed surgery to repair claimant's L4-5 disc condition on March 31, 1993. A July 13, 1993 Notice of Closure closed the aggravation claim with an additional award of 10 percent unscheduled permanent disability. (Ex. 96A).

Claimant's surgery was successful and he was released to return to his regular work by 1996. He worked full time as a dock worker, driving a forklift and lifting freight, from 1996 until September 1998.

On September 27, 1998, while Travelers was on the risk, claimant injured his low back at work when he bent over and picked up a pallet. Dr. Schneier performed an L4-5 diskectomy on January 14, 1999.

AIG denied claimant's current condition on compensability and responsibility grounds. (Ex. 117). Travelers denied responsibility only for claimant's current low back condition. (Ex. 116). Claimant requested a hearing.

Compensability

We agree with the ALJ that claimant's current L4-5 disc condition is compensable and we adopt his opinion on this issue.

Responsibility

The ALJ found that AIG accepted claimant's disc condition when it processed the 1992 aggravation claim. Further finding that claimant did not sustain a "new injury" under Travelers' coverage, the ALJ concluded that responsibility for the current condition did not shift from AIG to Travelers under ORS 656.308(1). We reverse, based on the following reasoning.

AIG accepted claimant's initial low back injury claim. Therefore, we first determine the nature of the accepted condition and the scope of the acceptance, then we address the responsibility issue.

As a general rule, whether an acceptance occurs is a question of fact. *SAIF v. Tull*, 113 Or App 449, 454 (1992). Acceptance is an act through which an insurer acknowledges responsibility for the claim

and obligates itself to provide the benefits due under the law. *See Richard L. Markum*, 48 Van Natta 2204 (1996); *Gene C. Dalton*, 43 Van Natta 1191 (1991). An acknowledgment that the claim is being "processed" under a prior claim number does not necessarily indicate that the claimed condition has been accepted. *See James K. Washington*, 50 Van Natta 223, 225 (1998).

Here, AIG specifically accepted claimant's 1991 disabling lumbosacral strain. AIG's acceptance and voluntary processing of claimant's subsequent aggravation claim does not mean that it obligated itself to provide benefits for anything other than the accepted strain. *See id.* Accordingly, based on the specific acceptance and absent evidence that AIG accepted any condition other than claimant's 1991 lumbosacral strain (by providing notice of responsibility and obligation to provide benefits), we conclude that AIG's acceptance is limited to the 1991 lumbosacral strain.[1] *See Eleanor I. Crockett*, 51 Van Natta 950 (1999).

We have determined that claimant's current L4-5 disc condition is compensable, so the next question is which carrier is responsible for it.

If ORS 656.308(1) applies to the responsibility determination, AIG remains responsible for future compensable medical services and disability relating to the accepted condition "unless the worker sustains a new compensable injury involving the same condition." If the statute does not apply, responsibility is assigned and ultimately determined under the last injury rule (because this is a successive injury case).

ORS 656.308 only applies if the later injury involves the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 181 (1996); *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371-72 (1993). In this context, a "new injury involves the same condition as the earlier accepted injury when it has the earlier compensable injury within or as part of itself." *MultiFoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999).

In this case, the accepted injury is a 1991 lumbosacral strain. The only evidence arguably indicating that the 1991 injury is "within" or "part of" the current L4-5 disc condition is Dr. Fisher's opinion that the 1991 injury is a material, and the major, contributing cause of claimant's L4-5 current condition, disability, and need for treatment. (*See* Exs. 116A-2, 122).

We do not find Dr. Fisher's opinion persuasive because it is entirely conclusory. Moreover, Dr. Fisher subsequently stated that he would defer to Dr. Schneier, treating surgeon, regarding the major contributing cause of claimant's 1999 need for surgery. (Exs. 123, 126). As we explain below, Dr. Schneier does not support a conclusion that claimant's current condition involves his 1991 strain injury. Because there is no persuasive evidence that the 1998 injury under Travelers' coverage involved the 1991 lumbosacral strain injury that AIG accepted, ORS 656.308(1) does not apply.[2] *See, e.g., Barrett Business Services v. Morrow*, 164 Or App 628, 632, n. 1 (1999) ("We do not understand how a 1991 strain and a 1994 strain are the same condition.").

Accordingly, because ORS 656.308(1) does not apply and the 1991 and 1998 injuries were "successive injuries" involving the same body part (*i.e.*, the low back), responsibility is determined under the "last injury rule." *See John J. Saint*, 46 Van Natta 2224, 2226 (1994).[3]

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[1] *Compare Fred L. Dobbs*, 50 Van Natta 2293, 2295 (1998) (when the carrier *does not* identify the specific condition accepted, we look to the contemporaneous medical records to determine what condition was accepted.) (emphasis added); *Kim D. Wood*, 48 Van Natta 482, 484 (specific acceptance, made it unnecessary to examine the contemporaneous medical evidence to determine what condition was accepted), *aff'd mem* 144 Or App 496 (1996).

[2] In any case, we would reach the same result under ORS 656.308(1), based on Dr. Schneier's persuasive opinion that the 1998 work injury is the major contributing cause of claimant's need for treatment for his compensable L4-5 disc condition. (*See* Ex. 118-2).

[3] In *Saint*, we stated:

> "Once the evidence establishes that the last incident is a work-related injury that could cause the subject condition, there is a rebuttable presumption that responsibility lies with the last employer/insurer at the time of the last work-related injury. *See Boise Cascade v. Starbuck*, 296 Or 238, 244 (1984). In a successive injury context, the last injurious exposure rule provides that, * * * if the second injury contributes independently to the disabling condition, the second insurer is solely liable. *Id.*" *Saint*, 46 Van Natta at 2226.

Specifically, in this successive injury case, we apply Larson's last injury rule:

> "The 'last injurious exposure' rule in successive injury cases places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability * * [I]f the second incident contributes independently to the injury, the second insurer is solely liable, even if the injury would have been much less severe in the absence of the prior condition, and even if the prior injury contributed the major part to the final condition."

Hensel Phelps Const. v. Mirich, 81 Or App 290, 293-94 (1986) (quoting *Smith v. Ed's Pancake House*, 27 Or App 361, 364-65 (1976) (quoting 4 Larson, *Workmen's Compensation Law* sec, 95.12 (1976))).[4]

Here, Dr. Schneier operated on claimant's L4-5 disc in 1998, visualized his low back pathology, and stated that claimant had a "new acute" herniation. (Ex. 118-1). Dr. Schneier opined: (1) that it was possible, given claimant's history, that the herniation was the result of the September 1998 work incident; and (2) the major contributing cause of claimant's current need for surgery and treatment was the new herniation "related to the September 1998 accident." (Ex. 118-2).[5] We find Dr. Schneier's opinion persuasive.[6] Based on that opinion, we conclude that claimant's 1998 injury during Travelers' coverage independently contributed to his current L4-5 disc condition.

Dr. Schneier's persuasive opinion that claimant's 1998 injury contributed to his current condition is sufficient to successfully invoke AIG's defensive use of the last injurious exposure rule. *See Safeco Ins. Co. v. Victoria*, 154 Or App 574, 577 (1998). Accordingly, we assign responsibility for claimant's current condition (under the rule) with the last potentially causal employment -- the employment under Traveler's coverage at the time of the 1998 injury.

Penalties and Attorney fees

The ALJ awarded a penalty payable by AIG for its unreasonable compensability denial. We agree with the ALJ's reasoning and conclusion and adopt his opinion on this issue, with the following clarification.

The penalty payable by AIG is based on the amount due, as a result of our order, on the claim with Travelers. *See SAIF v. Whitney*, 130 Or App 429 (1994) (penalty payable by "nonresponsible" carrier based on amounts due from responsible carrier); *Stuart C. Yekel*, 49 Van Natta 1448, 1451 (1997) (same).

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[4] "In successive injury cases, the first employer remains responsible if the second injury takes the form of a recurrence of the first and the second incident did not contribute to the causation of the disabling condition. If, on the other hand, the second incident independently contributed, however slightly, to the causation of the disabling condition, the second employer is solely responsible. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244, 675 P2d 1044 (1984); *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 294, 724 P2d 919 (1986)."

Mission Ins. Co. v. Dundon, 86 Or App 470, 472-73 (1987) (footnote omitted).

[5] Dr. Schneier *previously* described claimant's L4-5 disc as "degenerative" "with some enhancement consistent with scarring from the previous surgery," based on diagnostic studies. (Ex. 119). We do not find Dr. Schneier's pre-surgery descriptions inconsistent with his ultimate causation conclusions, because the later conclusions are based on firsthand surgical findings.

[6] We note that the ALJ stated at hearing that Exhibits 127 and 128 were received into evidence, but they were not listed as admitted in the Opinion and Order. (Tr. 2). We have considered them on review because they are included in the record and the parties and the ALJ refer to them. All the exhibits listed as intended to be received are included in the record as certified by the ALJ to us under ORS 656.295(3) and there are no evidentiary objections in the record. Accordingly, we conclude that the ALJ intended to admit, and implicitly did admit, all exhibits offered by the parties, including Exhibits 127 and 128. *See Nellie M. Ledbetter*, 43 Van Natta 570, 571 (1991). However, we find the (unsigned) report by Drs. Strum and Williams unpersuasive because it is based on a materially inaccurate history regarding the 1998 injury. (*See* Ex. 128). And we do not find Dr. Wayson's letter, (Ex. 127), helpful because it is inadequately explained.

AIG denied compensability and responsibility and Travelers denied responsibility only. Although we have found Travelers responsible, AIG is liable for the attorney fee awarded at hearing, as awarded by the ALJ, under ORS 656.386(1), because it denied compensability. *See Safeway Stores, Inc. v. Hayes*, 119 Or App 319 (1993). However, we modify that portion of the ALJ's order that awarded a $1,000 attorney fee under ORS 656.308(2) to be paid by AIG. Inasmuch as Traveler's responsibility denial has been set aside, it is responsible for the ALJ's $1,000 attorney fee award pursuant to ORS 656.308(2).

In addition, because the ALJ's order addressed the compensability of claimant's condition, claimant's attorney is also entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue which was potentially at risk by virtue of our *de novo* review of the ALJ's order. 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 AIG. In reaching this conclusion, we have particularly considered claimant's counsel's uncontested fee request, the nature of the proceeding, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252-53 (1992), *mod* 119 Or App 447 (1993).

ORDER

The ALJ's order dated August 27, 1999 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside AIG Claim Service, Inc.'s (AIG's) responsibility denial is reversed. AIG's responsibility denial is reinstated and upheld. That portion of the order that upheld Travelers Insurance Co.'s (Travelers) denial is reversed. Travelers' denial is set aside and the claim is remanded to it for processing according to law. That portion of the order that assessed a $1,000 attorney fee payable by AIG is modified. That fee is payable by Travelers, rather than AIG. That portion of the order that assessed a penalty payable by AIG is affirmed, except that the penalty is based on the compensation due under claimant's claim with Travelers. For services on review, claimant is awarded a $2,000 attorney fee, to be paid by AIG. The remainder of the ALJ's order is affirmed.

March 6, 2000 Cite as 52 Van Natta 349 (2000)

In the Matter of the Compensation of
SHERRIE J. JAMES, Claimant
WCB Case No. 99-04340
ORDER ON REVIEW
Ransom & Gilbertson, 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) Mills' order that reduced her award of unscheduled permanent disability for a head and back injury from 26 percent (83.2 degrees), as awarded by an Order on Reconsideration, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's conclusion that claimant is not entitled to an impairment value for brain impairment. For the following reasons, I would find that claimant is entitled to such an award.

Dr. Syna, the neurologist on the medical arbiter panel, opined that claimant had Class I brain impairment with episodic headaches. (Ex. 23). The sole purpose of Dr. Synas assessment was to determine whether claimant had brain impairment caused by the accepted concussion. In reaching this

conclusion, Dr. Syna stated, "[Claimant] did have difficulty with memory in the several months after [claimant's] initial injury, but now [claimant's] episodic memory lapses are a nuisance and consist of forgetting where [claimant] put her keys." (*Id.*).

Although the ALJ acknowledged that headaches could be disabling, the ALJ concluded that Dr. Syna's opinion was not sufficient evidence on which to base an award of permanent impairment because Dr. Syna did not explain how and whether the periodic headaches constitute an episodic neurological disorder rateable under the standard. (O&O at 3). Nothing in the statutes or administrative rules requires a medical arbiter to explain how and whether a disorder is rateable.[1] It seems redundant to require a medical arbiter to explain their findings beyond concluding that it is related to the accepted condition and is permanent. In this case, the ALJ merely substitutes his opinion for that of the medical arbiter.

While I believe that Dr. Syna's opinion, in and of itself, is sufficient to establish permanent brain impairment, this issue may have been resolved differently if claimant had been allowed to testify at hearing to clarify how her headaches were disabling and disruptive to her every day activities. However, the current statutory scheme does not permit such evidence at hearing. *See* ORS 656.283(7).

For these reasons, I respectfully dissent.

[1] Note that our administrative rules do required that when validity criterion are not met, but the physician determines the findings are valid, the physcian must explain their findings. See OAR 436-035-007(28).

March 6, 2000 Cite as 52 Van Natta 350 (2000)

In the Matter of the Compensation of
DONNA K. JARAMILLO, Claimant
WCB Case Nos. C000506, C000507 & C000508
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Daniel M. Spencer, Claimant Attorney
James Booth (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

On March 3, 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, three claims have been disposed of within one agreement. Two claims are being released for $100 each (less a $25 attorney fee), while a third is being released for $32,800 (less a $3,325 attorney fee). Thus, the total consideration for the three claims is $33,000 (less a $3,375 attorney fee). Yet, the total consideration on page 8 of the agreement recites $29,475 to claimant and $3,325 to claimants attorney (a total of $32,800).

After reviewing the three summary pages and the CDA as a whole, we conclude that the parties intent is for a total consideration of $33,000, the disposition proceeds to be distributed as follows:

$29,625 Total Due Claimant
$ 3,375 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 $3,375, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
GERALD D. MORRISON, Claimant
WCB Case No. 99-03424
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that awarded 43 percent (137.6 degrees) unscheduled permanent disability, whereas an Order on Reconsideration had awarded no unscheduled permanent disability benefits. On review, the issue is the extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Psychological Condition

The ALJ relied upon the findings of the medical arbiter, Dr. Bellville, to rate claimant's permanent disability due to his psychological condition. On the basis of Dr. Bellville's report, the ALJ awarded 35 percent impairment under OAR 436-035-0400(5)(b) (WCD Admin. Order 98-055). The insurer argues that the ALJ erred in relying on the findings of Dr. Bellville. Specifically, the insurer disagrees with the ALJ's conclusion that Dr. Davies' opinion (concurred in by the treating physician, Dr. Lazar) was unpersuasive because it was contrary to the law of the case. The insurer argues that, although Dr. Davies believed that claimant probably never truly suffered from post-traumatic stress disorder, he nonetheless would conclude that the post-traumatic stress disorder had resolved without permanent disability and that claimant's psychological problems stemmed from a preexisting, long-standing psychological condition.

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 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).

Based on our review of the reports of Dr. Bellville and Dr. Davies, we are more persuaded by the opinion of Dr. Davies. In this regard, we find Dr. Davies' opinion to be more thorough, well-reasoned and consistent with the other medical opinions in the record regarding claimant's psychological condition. Moreover, we disagree with the ALJ's conclusion that Dr. Davies' opinion is contrary to the law of the case. Although Dr. Davies suspected a preexisting psychological condition and questioned the diagnosis of post-traumatic stress disorder, he understood that this condition was compensable and that he was to rate claimant's permanent disability from the condition and to report his impairment findings. He believed that the compensable condition had resolved. Dr. Davies rated claimant's impairment due to the compensable psychological condition. Under such circumstances, we are persuaded by his opinion. Accordingly, we rely on Dr. Davies' opinion to rate claimant's permanent disability from the psychological condition. Based on his opinion, we conclude that claimant has no permanent impairment from his compensable psychological condition.

Low back and Cervical Conditions

Drs. Marble and Reimer examined claimant on January 4, 1999 and indicated that claimant had no permanent impairment due to his low back and cervical conditions. Dr. Lazar, claimant's attending physician, concurred with their report.

Claimant was examined regarding his low back and cervical conditions on April 2, 1999 by Dr. Schilperoort, medical arbiter. Dr. Schilperoort found reduced range of motion in the lumbar and cervical spines due to the compensable injury. Because Dr. Schilperoort's opinion is well-reasoned and based on complete information, and because his examination is closest in time to the Order on Reconsideration, we rely on it to rate claimant's impairment for his cervical and lumbar conditions. *See Matlack*, 46 Van Natta at 1632 (1994); ORS 656.283(7) (evaluation of worker's disability is as of the date of the reconsideration order). Based on Dr. Schilperoort's opinion, the ALJ found that claimant was entitled to a value of 7 percent for impairment to the cervical area and 5 percent for the lumbar area. The insurer does not contend that the ALJ's calculations based on Dr. Schilperoort's opinion were incorrect. Accordingly, we accept those values. When combined, the two values (7 and 5) equal 12 percent unscheduled permanent disability due to the cervical and lumbar injury.

ORDER

The ALJ's order dated August 31, 1999 is modified. In lieu of the ALJ's award of 43 percent (137.6 degrees) unscheduled permanent disability, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability benefits. The ALJ's "out-of-compensation" attorney fee award is modified accordingly.

Board Member Phillips Polich dissenting.

I would affirm the ALJ's well-reasoned order. In particular, I agree with the ALJ's reasoning that Dr. Davies' opinion should be accorded little weight because it is contrary to the law of the case. In this regard, we have previously found that claimant has a compensable post traumatic stress disorder condition and our order has become final. *Gerald D. Morrison*, 51 Van Natta 295 (1999). Dr. Davies states, in his report, that: "I seriously doubt he 'truly' suffers from post traumatic stress disorder, but if such was the case in the past, it has resolved." It is evident that Dr. Davies does not believe that claimant ever had a post-traumatic stress disorder. In light of this, his opinion is contrary to the law of the case.

In addition, Dr. Davies attributes claimant's current psychological symptoms and disability to preexisting, long-standing problems. In our February 16, 1999 order finding this claim compensable, we specifically stated: "We are not persuaded that claimant had a preexisting condition or that noncompensable factors contributed to his acute stress disorder condition." *Morrison*, 51 Van Natta 295, n. 1. Under such circumstances, I would find that Dr. Davies' opinion is contrary to the law of the case and is therefore unpersuasive. *See Kuhn v. SAIF*, 73 Or App 768 (1985).

Finally, the majority relies upon the attending physician to rate claimant's psychological condition, but switches to the medical arbiter to rate claimant's physical impairment. In my opinion, it is more consistent and makes more sense in this case to rely on the medical arbiters' opinions regarding claimant's impairment from both the psychological and physical conditions. Because I believe the ALJ's order is supportable and well-reasoned, I disagree with the majority opinion reducing claimant's unscheduled permanent disability award and would affirm the ALJ's order.

March 6, 2000 Cite as 52 Van Natta 352 (2000)

In the Matter of the Compensation of
BARRY E. PARKER, Claimant
WCB Case No. 99-03097
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's aggravation claim for a current right knee condition. On review, the issue is aggravation.

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

We do not adopt the last full paragraph on page 3, because we find that causation *was* at issue at hearing. (*See* Tr. 2-3).

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

ORDER

The ALJ's order dated September 15, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee to be paid by the self-insured employer.

[1] We would reach the same result even if the standard of proof was "major contributing cause," based on Dr. Weinman's opinion. (*See* Exs. 9, 19). *See Timothy O. Schrick*, 51 Van Natta 890, 891 (1999) (distinguishing *Marcum v. City of Hermiston*, 149 Or App 392 (1997)).

In the Matter of the Compensation of
HAZEL PECKHAM, Claimant
WCB Case No. 99-00531
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Bock and Meyers.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that awarded a $3,850 attorney fee for services at hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded an attorney fee of $3,850 for claimant's counsel's services in setting aside the insurer's denial of claimant's right knee injury claim. The ALJ noted that both attorneys were long experienced in workers' compensation cases. The ALJ found this was a case of average complexity and the benefits obtained were surgery, plus time loss and medical treatment. He noted that claimant had a preexisting condition, which required a higher burden of proof. The ALJ reasoned that the risk that the attorney's efforts will go uncompensated is high in contested cases. The ALJ noted that, due to the difficulty scheduling Dr. Singer, some extra attention was required after the hearing in the form of letters and a conference call.

On review, the insurer argues that the attorney fee award was excessive and it submits that a reasonable attorney fee should not exceed $2,500. The insurer contends there was no extraordinary risk that claimant's attorney's efforts would go uncompensated and it asserts that there was no conflicting medical evidence.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 38-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issue at hearing was compensability of claimant's right knee injury. The insurer denied the claim on the ground that there was insufficient evidence that claimant's medial meniscus tear was the result of either a work-related injury or disease. (Ex. 9). In its brief, the insurer acknowledges that it attempted to prove that no injury had occurred.

Nine exhibits were admitted at hearing, one of which was submitted by claimant's attorney. The transcript is 32 pages long. Claimant and her son testified on behalf of claimant and one witness testified on behalf of the insurer. There were no depositions. Claimant's counsel did not submit a statement of services or an affidavit describing counsel's time expenditures.

As compared to typical compensability cases, the issue here was of average complexity. Because claimant's right knee condition has been found compensable, she is entitled to workers' compensation benefits, and the interest involved and the benefit secured for claimant are valuable (*i.e.*, payment for her surgery, as well as time loss compensation). The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law and, in light of the insurer's denial, there was a risk that claimant's counsel might go uncompensated. No frivolous issues or defenses were presented at hearing.

After considering the factors set forth in OAR 438-015-0010(4), we conclude that $2,750 is a reasonable attorney fee for services at hearing regarding the compensability issue. In reaching this conclusion, we have particularly considered the value of the interest involved, the benefit secured for claimant, the skill of the attorneys, and the risk that claimant's counsel might go uncompensated. Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated October 29, 1999 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award, for services at hearing, claimant's attorney is awarded an assessed fee of $2,750, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
WAYNE RAMSEY, Claimant
WCB Case No. 99-05134
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its *de facto* denial of claimant's L4-5 stenosis with recurrent herniated disc and L5-S1 stenosis with stability. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes. In the sixth paragraph on page 2, we change the date in the second sentence to "November 17, 1998." In the first paragraph on page 3, we change the date to "January 1999."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,300, 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 October 28, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,300, payable by the self-insured employer.

Board Member Haynes dissenting.

By adopting and affirming the ALJ's order, the majority accepts the ALJ's conclusion that Dr. Copeland's opinion is sufficient to establish compensability of claimant's L4-5 stenosis with recurrent herniated disc and L5-S1 stenosis condition. For the following reasons, I respectfully dissent.

In this case, I believe we should rely on the reports actually authored by Dr. Copeland, rather than the concurrence report crafted by claimant's attorney. In a July 1, 1999 report, Dr. Copeland said:

> "The injury when hit with the 2000 lb pallet was the inciting factor and also considered major along with the pre-existing weakness of the disc. I would consider it *at least equal.*" (Ex. 35-2; emphasis supplied).

In a July 15, 1999 report, Dr. Copeland wrote:

> "The inciting cause of the acute episode was the work - driving the truck. He had *significant predisposing factors* as noted above." (Ex. 36-2; emphasis supplied).

I agree with the employer that Dr. Copeland's reports are not sufficient to sustain claimant's burden of proof. Moreover, Dr. Copeland's subsequent concurrence with the letter composed by claimant's attorney is not persuasive in light of his earlier hand-written statements. At best, the medical evidence is in equipoise and I would conclude that claimant has not carried his burden of proving compensability.

In the Matter of the Compensation of
JAMES E. SIMS, Claimant
WCB Case No. 99-04357
ORDER ON REVIEW
Cole, Cary, 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) Livesley's order that awarded 7 percent (22.4 degrees) unscheduled permanent disability for claimant's thoracic condition, whereas an Order on Reconsideration had awarded none. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a thoracic strain at work on July 28, 1998. He treated conservatively and Dr. Matteri became his attending physician in November 1998.

Claimant was medically stationary on January 29, 1999. A Notice of Closure closed his claim with temporary, but not permanent, disability on April 22, 1999. An Order on Reconsideration affirmed the Notice of Closure on May 17, 1999. Claimant requested a hearing and the parties submitted the matter to the ALJ on the record.

The ALJ awarded claimant 7 percent unscheduled permanent disability, including a 1 percent impairment rating for reduced thoracic range of motion (and the remainder based on social/vocational factors). The ALJ relied on range of motion measurements recorded in a Physical Capacities Evaluation conducted on February 9, 1999. (*See* Exs. 8, 10).

The threshold question is whether claimant has ratable impairment. *See* OAR 436-035-0270(2) ("If there is no measurable impairment under [the standards], no award of unscheduled permanent partial disability shall be allowed."). 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).[1]

No medical arbiter was appointed in this case. Dr. Matteri was claimant's attending physician at claim closure and he did not make impairment findings.[2] On March 19, 1999, Dr. Matteri indicated that he did *not* concur with Dr. Anderson's February 9, 1999 report discussing a Physical Capacities Evaluation that day.[3] (*See* Exs. 7, 8, 10). Thus, because there are no impairment findings by the treating physician at claim closure or a medical arbiter, there are no impairment findings that we may consider to rate claimant's permanent disability. Under these circumstances, claimant is not entitled to permanent disability under the standards. *See Jeffrey V. Collado*, 50 Van Natta 2075 (1998).

ORDER

The ALJ's order dated October 25, 1999 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee is reversed.

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[1] All disability ratings under the standards "shall be established on the basis of medical evidence that is supported by objective findings from the attending physician" or the medical arbiter. *See* OAR 436-035-0320(1).

[2] On January 19, 1999, three months before claim closure, Dr. Matteri commented on a Physical Capacities Evaluation that is not in the record. (*See* Ex. 4). This concurrence is not helpful in evaluating claimant's permanent impairment.

[3] Dr. Matteri specifically commented only on claimant's residual functional capacity.

March 6, 2000 Cite as 52 Van Natta 356 (2000)

In the Matter of the Compensation of
KENNETH L. SMITH, Claimant
WCB Case No. 98-06222
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Thye's order that awarded claimant permanent total disability (PTD), whereas an Order on Reconsideration awarded 37 percent (118.4 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of permanent disability, including permanent total disability.

We adopt and affirm the ALJ's order with the following supplementation. We agree that claimant is unable to regularly work, based on the vocational evidence and claimant's credible affidavit regarding the effect of his symptoms on his ability to work. (*See* Exs. 17A, 19-26-29, 20-13). *See* OAR 436-030-0115(3); *Earl W. Davis*, 51 Van Natta 1347 (1999) (the claimant's statements about his symptoms, the effect of his symptoms on his work activities, and the nature of a medical examination properly incorporated in the reconsideration record and considered in evaluating the medical evidence and the claimant's disability); *James D. Terry*, 44 Van Natta 1663, 1664 (1992) (PTD established absent persuasive evidence of available jobs appropriate to the claimant's limitations); *Blaine M. Jones*, 42 Van Natta 869 (1990) (job availability may not be based on speculation).

We also rely on Dr. Eiler's opinion that claimant is physically unable to work. Dr. Eiler's opinion in this regard is cognizable evidence on the PTD issue (even though Dr. Eiler was not claimant's

attending physician at the time of claim closure), because his "findings" are not "impairment findings" as described (and limited to the attending physician at claim closure) in ORS 656.245(2)(b)(B).[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 the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 18, 1999 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the insurer.

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[1] *See EBI Companies v. Hunt*, 132 Or App 128, 131 (1994) (discussing the same limitation, contained in *former* ORS 656.245(3)(b)(B)). We note that Dr. Eiler considered claimant's total condition, including the debilitating effect of claimant's activity-related symptoms on his functional capacity. *See id.*

In the Matter of the Compensation of
ENRIQUE TORRALBA, Claimant
WCB Case No. 99-05478
ORDER ON REVIEW (REMANDING)
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Lipton's order that dismissed his request for hearing for failure to appear at hearing. On review, the issue is the propriety of the ALJ's order. We remand.

FINDINGS OF FACT

On June 23, 1999, claimant's former attorney requested a hearing and one was scheduled for October 1, 1999. On July 14, 1999, however, claimant's attorney notified the Hearings Division that he was withdrawing from representing claimant.

On October 1, 1999, the ALJ convened a hearing; claimant did not appear. On October 6, 1999, the ALJ issued an Order of Dismissal stating that the Request for Hearing was dismissed as abandoned under OAR 438-006-0071(2).

On October 11, 1999, the Board received a letter from claimant addressed to the ALJ. It stated, in part, that claimant "had no notice before any paper until This one that you sent me" and to "please give me again the opportunity[.]"

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or his or her attorney fails to attend a scheduled hearing unless extraordinary circumstances justify a postponement or continuance of the hearing. OAR 438-006-0071(2). The ALJ, however, must consider a motion for postponement even if submitted after the ALJ issues an order of dismissal. *E.g., Olga G. Semeniuk*, 46 Van Natta 152 (1994). In those cases where the ALJ does not have the opportunity to rule on the motion to postpone, the Board remands the case to the ALJ for consideration of the motion. *Id.* The exception is when the motion to postpone contains no explanation concerning the claimant's failure to appear; in the absence of such discussion, we have found no compelling reason to remand. *E.g., James C. Crook, Sr.*, 49 Van Natta 65 (1997).

Here, we first find that claimant's letter following the Order of Dismissal constitutes a motion for postponement. In the letter, claimant attempts to explain his failure to appear and asks for another opportunity. Furthermore, because the letter alleges that claimant did not have notice of the hearing, we find that the motion contains an explanation for the failure to appear.

Consequently, we conclude that, because the ALJ did not have the opportunity to rule on the motion to postpone, the case should be remanded for the ALJ to decide if there are extraordinary circumstances preventing dismissal.[1] We emphasize that our order does not address the substance of claimant's allegations and it is up to the ALJ to evaluate the grounds of the motion.

Accordingly, the ALJ's October 8, 1999 order is vacated. This matter is remanded to ALJ Lipton to determine whether to postpone claimant's hearing request. The ALJ shall proceed in any manner that will achieve substantial justice. If the ALJ grants the motion to postpone, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ does not grant the motion to postpone, the ALJ shall dismiss the request for hearing.

IT IS SO ORDERED.

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[1] We note that the ALJ did not issue a "combined order" (*i.e.*, an order giving claimant a period of time to show "good cause" for his failure to appear, as well as 30 days to request Board review). *See Teresa Marion*, 50 Van Natta 1165 (1998); *Brent Harper*, 50 Van Natta 499, 500 n.2 (1998)). Had the ALJ done so and had claimant untimely responded to the "good cause" component of the "combined order," remand may not have been warrented.

In the Matter of the Compensation of
MIKE D. SMITH, Claimant
WCB Case No. 98-0107M
SECOND OWN MOTION ORDER DENYING RECONSIDERATION
Walsh & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our November 19, 1998 Own Motion Order Denying Reconsideration, contending that that order was mailed to an incorrect address and, thus, he was not notified that his prior request for reconsideration had been denied. In our November 19, 1998 order, we denied claimant's request for reconsideration of our April 2, 1998 Own Motion Order, which declined to authorize the reopening of claimant's claim for payment of temporary disability benefits because he failed to prove he remained in the work force at the time of disability. Although more than 60 days had elapsed since the issuance of our April 2, 1998 order by the time we received claimant's request for reconsideration on October 21, 1998, we found it unnecessary to resolve the procedural matter regarding whether that request for reconsideration was timely filed, finding that, even if we considered the request for reconsideration, we would continue to find that claimant's claim did not qualify for reopening because he did not provide persuasive evidence that he was in the work force at the time of his current disability.

In his most recent request, claimant explains his reasons for his prior untimely filing of his request for reconsideration and submits various affidavits and documents in support of his contention that he was in the work force at the time of his disability. Based on the following reasoning, we reach the same conclusions as we did in our prior orders.

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 (1986); *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).

Our April 2, 1998 order explained that, in order to be entitled to temporary disability compensation, claimant had to prove he was in the work force at the time of disability. It further explained what was required to meet that burden of proof and concluded that, by failing to provide any evidence on the work force issue, claimant failed to meet his burden of proof. Finally, our April 2, 1998

order provided appeal rights, stating that claimant could request reconsideration of our order within 30 days after the mailing date, or within 60 days after the mailing date if there was good cause for the failure to file a request within 30 days.

By affidavits dated January 12, 2000, both claimant and his wife attest that they received our April 2, 1998 Own Motion Order at their correct address, an address at which they have lived for seven years. However, they do not state when they received that order. In our November 19, 1998 order denying reconsideration, we noted that claimant submitted a copy of our April 2, 1998 order, stating that he was "responding to this letter [he] received [on] October 7, 1998." We interpreted from this statement that claimant meant that he first received a copy of our order on October 7, 1998 and, therefore, could not have sought reconsideration of our order within the 30 day appeal period.

We noted that claimant did not explain why he may not have received our order in a timely fashion. However, we also noted that the return address on the envelope containing his "reconsideration" request was different from the address to which our April 2, 1998 order was mailed. Assuming that the April 2, 1998 order had been mailed to an incorrect address, we determined that we might be inclined to find extraordinary circumstances to warrant our reconsideration under OAR 438-012-0065(2). However, we found that we did not need to resolve that procedural issue because, even if we considered claimant's belated submissions, the record still did not support a finding that he was in the work force at the time of his disability. We mailed our November 19, 1998 order denying reconsideration to the return address listed on claimant's envelope containing his "reconsideration" request.

From claimant's and his wife's current affidavits, this return address was incorrect and our April 2, 1998 order had been mailed to the correct address. This makes it even more unclear why claimant may not have received our initial order in a timely fashion. In light of such circumstances, we are not inclined to find extraordinary circumstances to warrant reconsideration of our April 2, 1998 order.

Nevertheless, we still need not conclusively resolve the procedural matter as to whether claimant meets "extraordinary circumstances" to warrant our reconsideration under OAR 438-012-0065(2) because, even considering claimant's most recent submissions, the record fails to support a conclusion that he was in the work force at the time of his disability.

In his most recent request for reconsideration, claimant repeats his assertion that when his condition worsened requiring surgery, he was in the work force. We disagree.

In our prior orders, we found that claimant had not met his burden of proof regarding the work force issue. Specifically, we concluded that the medical evidence contained in the record did not address his work force status and that he had not submitted documentation supporting his contention that he was willing to work and "seeking work through the State of Oregon OFSET Program." With his most recent request for reconsideration, claimant submitted an affidavit attesting to his willingness to work and copies of documents from the OFSET program and a former employer in support of his work force contentions. However, based on the following reasoning, we continue to find that claimant was not in the work force at the time of his disability.

The "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his March 13, 1998[2] hospitalization when his condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *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).

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

[2] Although the record does not contain a medical document which demonstrates that claimant underwent surgery on March 13, 1998, in his most recent request for reconsideration, claimant asserts that he underwent surgery on that date and SAIF does not dispute claimant's assertion.

Here, in his affidavit, claimant attests that prior to "needing shoulder surgery, I was working and in the process of looking for work." He outlines that "over the years" he has worked as a truck driver, for his mother and "undertaken various tasks for pay." However, claimant does not provide any documentation to support his assertions. His statement that he has sought work "over the years" is vague and broad and is insufficient to support his contention that he was in the work force *prior* to his March 1998 surgery. Although claimant attests that he underwent surgery to "improve [his] work capability," we are not persuaded that this assertion demonstrates his "willingness" to work *prior* to his date of disability.

Further, claimant submits copies of: (1) an undated letter to SAIF attesting that he was actively seeking employment through the State of Oregon OFSET program; (2) a June 26, 1997 completed "Requirements/Employment Development Plan" form from the OFSET program; (3) a blank Job Search Verification form with the only annotation indicating "Next Appt 7/30/97;" (4) a July 31, 1997 letter from OFSET noting that the July 30, 1997 appointment was missed without any attempt to reschedule; (5) a September 9, 1999 letter from an employer indicating that claimant had been employed with their firm for six months beginning in December 1996; and (6) a July 8, 1994 paycheck stub.

A review of these documents demonstrates that claimant may have been working until June 1997, and then sought work through the OFSET program. However, none of the documents address claimant's work force status just prior to his March 1998 surgery. There is no evidence that he continued his work search subsequent to his July 1997 OFSET appointment. In fact, the Job Search Verification form is blank and does not reflect any work search efforts. Thus, we are not persuaded that claimant was willing to work and seeking work prior to his date of disability. Consequently, claimant has failed to prove he was in the work force at the time of his current disability.

Accordingly, claimant's request for abatement and reconsideration is denied. The issuance of this order neither "stays" our prior orders nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986); *Fisher v. SAIF*, 76 Or App 656 (1985).

IT IS SO ORDERED.

March 7, 2000 Cite as 52 Van Natta 360 (2000)

In the Matter of the Compensation of
MICHAEL EASDALE, Claimant
WCB Case No. 99-04894
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration increasing claimant's award of scheduled permanent disability for loss of use or function of the right knee from 5 percent (7.5 degrees), as granted by a Notice of Closure, to 13 percent (19.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

The insurer contends that the ALJ incorrectly determined that claimant was entitled to 5 percent impairment for a "chronic condition." For the following reasons, we disagree.

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, he is significantly limited in the repetitive use of his right knee. OAR 436-035-0010(5).

The medical arbiter, Dr. Donovan, opined:

> "The worker reports that he is significantly limited in squatting with his right knee to provide appropriate body mechanics for lifting the tailgate or the rolling doors of trailers from loading dock level because of knee pain on the right. I think this does interfere with his ability to repetitively use the right knee in this fashion and arises out of the accepted condition." (Ex. 16-2).

The ALJ found that this statement established the presence of a "chronic condition," reasoning that the arbiter incorporated claimant's description of a significant limitation of his ability to repetitively use his right knee and that inability to squat was a significant limitation in and of itself. The ALJ further noted that the "chronic condition" rule does not require that a claimant be totally impaired from any repetitive use of the injured body part. We agree with the ALJ's reasoning.

The insurer argues, however, that Dr. Donovan's opinion was based solely on claimant's allegation that he was having difficulty squatting and, thus, cannot establish the presence of a "chronic condition." We disagree.

Dr. Donovan conducted a thorough examination of claimant's right knee condition and was aware that claimant had recently engaged in skiing. (Ex. 16-1). Given Dr. Donovan's awareness of claimant's recreational activity, and the fact that nothing in her examination or claimant's history caused her to question claimant's report of limitations in squatting, we do not find that Dr. Donovan's opinion was based solely on claimant's allegations.[1]

The insurer also asserts that the described limitation in squatting does not constitute a "significant" limitation on repetitive use. We disagree, considering that the limitation substantially interferes with claimant's ability to function.

The insurer also contends that the arbiter's opinion was not couched in terms of "medical probability." Once again, we do not concur. Having reviewed Dr. Donovan's report, we are persuaded that it establishes to a degree of medical probability that the limitation in squatting significantly interferes with claimant's ability to repetitively use his right knee and, thus, constitutes a "chronic condition."

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

ORDER

The ALJ's order dated November 3, 1999 is affirmed. For services on review, claimant's' attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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[1] The insurer cites *Marilyn S. Gabbard*, 47 Van Natta 1362 (1995), and *Kathleen L. Hofrichter*, 45 Van Natta 2368 (1993). In *Gabbard*, the claimant's treating physician stated: "[I]f claimant were to do some finite pulling of small objects with her hand, it might be quite difficult." We found this medical evidence insufficient to establish even a partial permanent loss of the claimant's ability to repetitively use her left hand.

In *Hofrichter*, a physician recommended that the claimant avoid repetitive motions of the back and work that required forward bending, in order to prevent an increase in symptoms. We also found this evidence was insufficient to establish a permanent and chronic impairment of the back.

In this case, unlike *Hofrichter*, Dr. Donovan's opinion was more than merely a recommendation to avoid repetitive use of the right knee in order to avoid a future increase in symptoms. Moreover, Dr. Donovan's opinion was made in stronger terms than the doctor's in *Gabbard*, who only opined that pulling of small objects "might" be quite difficult. In short, neither case causes us to conclude that the ALJ's reasoning was flawed.

In the Matter of the Compensation of
SUSAN LAUGHLIN, Claimant
Own Motion No. 97-0536M
OWN MOTION ORDER
Linerud Law Firm, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

On September 7, 1999, claimant informed the Board of her disagreement regarding the claims processing of her own motion claim. In particular, claimant raised the following issues: (1) incorrect calculation of her temporary disability compensation rate and resultant payment shortage; (2) unpaid prescription reimbursements; (3) unpaid mileage reimbursements; and (4) penalties for "withholding these monies entitled to me."

We requested the self-insured employer's position regarding claimant's contentions. Upon submission of the employer's response, claimant was allowed 14 days to submit additional materials. By letters dated December 7 and 14, 1999, the employer responded to claimant's contentions and submitted supporting documentation. Claimant has not responded to the employer's submissions. Therefore, we proceed with our review.

Entitlement to Prescription and Mileage Reimbursement

To begin with, we address claimant's reimbursement issues regarding her prescriptions and mileage. Pursuant to ORS 656.245, these medical issues are within the Director's jurisdiction. Thus, we are not authorized to address such matters. ORS 656.278. If claimant continues to dispute the employer's claims processing regarding these medical reimbursement issues, she may wish to refer her dispute to the Director.

Entitlement to Temporary Disability Compensation

On the other hand, because claimant's aggravation rights have expired on her compensable 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). Moreover, the Board's authority extends to enforcing its own motion orders. *See Larry P. Karr*, 48 Van Natta 2183 (1996); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996); *Thomas L. Abel*, 45 Van Natta 1768 (1993); *David L. Waasdorp*, 38 Van Natta 81 (1986).

Claimant contends that she was underpaid during the time her 1982 claim was reopened pursuant to our November 24, 1997 Own Motion Order for the provision of temporary disability compensation. Specifically, she contends that, after deduction of her attorney's fees, she was due time loss of $12,237.945 for the period from March 23, 1998 to October 12, 1998. She contends that the employer paid her $11,928.88 for that period, resulting in an underpayment of $309.065. She also contends that, in addition to this underpayment, her biweekly rate of compensation increased by a few dollars effective July 1998. Although she raised this issue directly with the employer, it did not adjust her temporary disability compensation rate.

By letter dated December 14, 1999, the employer stated that it had verified that claimant's allegation of a time loss shortage was correct and that her "time loss has been adjusted." On January 20, 2000, we requested claimant's position regarding the employer's statements. Claimant submitted no response to our request. Therefore, we find that claimant agrees that the employer has corrected its miscalculation of her temporary disability compensation rate and paid her the shortage. Thus, no enforcement issue remains regarding the temporary disability compensation rate issue.

Penalties

Therefore, the sole issue remaining is whether the employer unreasonably refused the payment of temporary disability compensation. Under ORS 656.262(11)(a), if the insurer "unreasonably delays or unreasonably refuses to pay compensation," it shall be liable for an additional amount up to 25 percent of the amounts "then due."

Here, the employer underpaid claimant's temporary disability, including improperly calculating claimant's temporary disability rate by not using the proper weekly wage. This miscalculation has resulted in a delay in payment of compensation. The employer has offered no explanation for its failure to ascertain and utilize the proper rate. Therefore, we find the employer's conduct unreasonable, and assess a 25 percent penalty on all of the temporary disability compensation not timely paid. *Vincente M. Taisacan*, 41 Van Natta 1005 (1989).

IT IS SO ORDERED.

March 8, 2000 Cite as 52 Van Natta 363 (2000)

In the Matter of the Compensation of
RAMIRO PELAYO, Claimant
WCB Case No. 99-01601
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Stoel, Rives LLP, Defense Attorneys

Reviewed by the Board *en banc*.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) declined to admit a medical arbiter report into the record; and (2) awarded 20 percent (35.2 degrees) unscheduled permanent disability for a low back injury whereas an Order on Reconsideration had awarded no unscheduled permanent disability. On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and summarize the relevant findings as follows.

Claimant has an accepted claim for a disabling lumbar strain. The acceptance was updated at claim closure to also accept L4-5 disc syndrome, left side. Claimant underwent an insurer-arranged medical examination with Drs. Staver and Englander who addressed claimant's permanent disability due to the injury. Claimant's attending physician, Dr. Matteri, concurred with the report.

The claim was closed by a Notice of Closure dated October 10, 1998 with an award of 11 percent unscheduled permanent disability. Claimant requested reconsideration, challenging only the age, education and adaptability figures used in rating his unscheduled disability. Claimant did not object to the impairment findings used at claim closure. The insurer requested a medical arbiter examination. Claimant objected to the insurer's request. Claimant was examined by Dr. Vessely, the medical arbiter, who issued a medical arbiter report.

A February 12, 1999 Order on Reconsideration reduced claimant's unscheduled award to zero.

CONCLUSIONS OF LAW AND OPINION

The ALJ noted that an insurer has no statutory right to request reconsideration of its own Notice of Closure. Relying on ORS 656.268(6)(a), the ALJ found that the insurer was without statutory authority to request appointment of a medical arbiter. On this basis, the ALJ struck the medical arbiter's report from the record. Finding that claimant's highest SVP in the past 5 years was 2, the ALJ amended the Order on Reconsideration to award 20 percent (64 degrees) unscheduled permanent disability.

On review, the insurer agrees that a carrier cannot request reconsideration of its own Notice of Closure, but argues that, once a claimant requests reconsideration, ORS 656.268(6)(e)(A) allows a carrier to "participate fully in the reconsideration proceeding."

The insurer argues that the statutory language allowing a carrier to "fully participate" in a reconsideration proceeding authorizes it to request a medical arbiter examination once a worker has initiated a challenge to a Notice of Closure. On the basis of this reasoning, the insurer argues that the ALJ erred in excluding the medical arbiter report. The insurer also argues that claimant is not entitled to

a chronic condition award and therefore has no measurable impairment on which to base an unscheduled award. Based on this reasoning, the insurer requests that we affirm the Order on Reconsideration. Alternatively, if we find that claimant has unscheduled impairment, the insurer challenges the SVP found by the ALJ and argues that the correct SVP value is 7, based upon the DOT for "cook."

The insurer also cites OAR 436-030-0115(5) in support of its position. The rule provides, in part, that

> "once the reconsideration proceeding is appropriately initiated by one party, the opposing party(ies) must use or lose this opportunity to introduce additional issues and evidence for review by the director or to file a cross-request for reconsideration * * *."

In response to the insurer's arguments, claimant cites ORS 656.268(4)(e), 656.268(6)(a) and OAR 436-030-0009(2) to argue that the insurer cannot request or cross-request review of its own Notice of Closure. Claimant argues that if the insurer cannot object to its own Notice of Closure, it likewise cannot request a medical arbiter examination under ORS 656.268(7). Finally, claimant argues that the ALJ's rating of claimant's unscheduled permanent disability award is correct and should be affirmed.

In order to determine their meaning, we examine the text of the statutes in context, turning to the legislative history only if we cannot discern the meaning of the statutes from that review. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). We, thus, examine the text of the statute in context to determine its meaning.

The relevant portions of ORS 656.268 provide:

> "(4)(a) When the worker's condition resulting from an accepted disabling injury has become medically stationary, and the worker has returned to work or the worker's attending physician releases the worker to return to regular or modified employment, or when the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7), the claim may be closed by the insurer or self-insured employer, without the issuance of a determination order by the Department of Consumer and Business Services.
>
> "(b) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the Department of Consumer and Business Services. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker and to the Department of Consumer and Business Services. The notice shall inform the parties, in boldfaced type, of the proper manner in which to proceed if they are dissatisfied with the terms of the notice. The notice must inform the worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the amount and duration of temporary total or temporary partial disability compensation; *of the right of the worker to request reconsideration* by the Department of Consumer and Business Services under this section within 60 days of the date of the notice of claim closure; of the aggravation rights; and of such other information as the Director of the Department of Consumer and Business Services may require.
>
> "* * * * *
>
> "(e) *If a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section.* The request for reconsideration must be made within 60 days of the date of the notice of closure.
>
> "* * * * *
>
> *"(5) * * * (b) If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order.* The request for reconsideration must be made within 60 days of the date of the determination order.

"(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each determination order or notice of closure. *However, following a request for reconsideration pursuant to subsection (5)(b) of this section by one party, the other party or parties may file a separate request.* At the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure.

"* * * * *

"(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection shall begin as follows:

"(A) *When a worker objects to a notice of closure pursuant to subsection (4)(e) of this section, the period begins upon receipt of the worker's request. The insurer may fully participate in the reconsideration proceeding.*

"(B) When any party objects to a determination order pursuant to subsection (5)(b) of this section, the period begins when the department receives a request for reconsideration from all parties or the nonrequesting party or parties waive, in writing, the right to file a separate request, but no later than the date following the expiration of the appeal period for the determination order. If a party elects not to file a separate request, the party does not waive any rights to fully participate in the reconsideration proceeding, including the right to proceed with the reconsideration if the initiating party withdraws its request.

"(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

"(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

"(7)(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.*

"* * * * *." (Emphasis added).

Based on the language of the statute and its context, there is no statutory procedure by which a carrier may challenge its own Notice of Closure. In this regard, ORS 656.268 contains a separate procedure for requesting reconsideration of Notices of Closure and Determination Orders. ORS 656.268(4)(e) provides that if the *worker* objects to the Notice of Closure, *the worker first must request reconsideration by the department.* Subsection (5)(b) pertains to requests for reconsideration from Determination Orders. It provides: "*If the worker, the insurer or self-insured employer* objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." According to the statute, the worker or the carrier may request reconsideration of a Determination Order. However, based on the language and context of ORS 656.268, only a worker may request reconsideration of a Notice of Closure, but any party may request reconsideration of a Determination Order.

This conclusion is supported by OAR 436-030-0009(2), which provides that an insurer may not request reconsideration of its own Notice of Closure. This conclusion is also strongly supported by ORS 656.268(6)(a), which provides:

"Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each determination order or notice of closure. *However, following a request for reconsideration pursuant to subsection (5)(b) of this section by one party, the other party or parties may file a separate request.* At the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure."

This statute allows the other party or parties to file a separate request for reconsideration *if* a request for reconsideration is submitted under *ORS 656.268(5)(b)*. ORS 656.268(5)(b) is the statute authorizing requests for reconsideration of *Determination Orders*. There is no reference to ORS 656.268(4)(e) that allows a *carrier* to cross-request reconsideration of a *Notice of Closure*. The language and context of ORS 656.268(6) persuades us that carrier requests or cross-requests from Notices of Closure are not contemplated or authorized.

Moreover, ORS 656.268(7)(a) provides for appointment of a medical arbiter if "the basis for the 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."[1] Because ORS 656.268 does not authorize a carrier to request reconsideration of its own Notice of Closure, it follows that a carrier cannot request a medical arbiter to challenge the Notice of Closure.

Although ORS 656.268(6)(e)(A) provides that an insurer may "fully participate" in the reconsideration proceeding, based on the language of the statute cited above, we conclude that the "fully participate" language means that an insurer/self-insured employer may participate in the reconsideration proceeding by defending the award made by its Notice of Closure, correcting any information or submitting any relevant medical evidence from the attending physician that should have been submitted at closure.[2]

In summary, we find that because a carrier has no statutory right to request reconsideration of its own Notice of Closure, it likewise has no statutory right to cross-request reconsideration of the Notice of Closure or to seek appointment of a medical arbiter. Thus, we conclude that the ALJ did not abuse his discretion by declining to admit the medical arbiter report into the record.[3] Moreover, even if the medical arbiter report were admitted into evidence, it would have little probative weight because a medical arbiter is not statutorily authorized under these circumstances.

We now turn to the extent of permanent disability. The Order on Reconsideration reduced claimant's unscheduled permanent disability award to zero. The ALJ increased the award to 20 percent. The insurer argues that the Order on Reconsideration should be affirmed and that claimant is not entitled to an award for a chronic condition and therefore has no ratable impairment. Claimant argues that because the insurer could not cross-request review of its own Notice of Closure, the award should not be reduced below that awarded by the Notice of Closure.

After considering this matter, we agree with claimant's argument that, because the insurer could not dispute its own Notice of Closure award, the only issue properly raised at reconsideration was the value for SVP. We adopt the ALJ's reasoning and conclusions regarding the SVP and the unscheduled permanent disability award.

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.

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[1] No contention has been made that the Director appointed a medical arbiter on his own initiative. Rather, it is undisputed that the appointment of the medical arbiter was solely based on the insurer's request for such an examination.

[2] ORS 656.268(6), including the "fully participate" language in ORS 656.268(6)(e)(A), was added to the statute in 1997 as part of SB 118, a bill introduced by the Workers' Compensation Division to clarify that only one reconsideration proceeding was allowed for each Determination Order or Notice of Closure. Thus, the main intent and purpose of the statute was apparently to clarify that only one reconsideration proceeding would be allowed and to make sure that each party had an opportunity to participate in the single reconsideration proceeding to the extent allowed by the statute. There is no indication, however, that there was any intent to allow a carrier to challenge its own Notice of Closure.

[3] 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).

ORDER

The ALJ's order dated June 29, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by the insurer.

March 8, 2000 Cite as 52 Van Natta 367 (2000)

In the Matter of the Compensation of
KENNETH F. PIERCE, Claimant
Own Motion No. 00-0048M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable left hand and left finger conditions. Claimant's aggravation rights expired on August 17, 1999. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

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

The insurer contends that claimant was not in the work force at the time of the current disability. However, the insurer notes, and does not dispute, that claimant was receiving unemployment benefits from the State of California. The receipt of unemployment benefits is prima facie evidence that claimant is willing to work and is making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991) (claimant's attending physician noted that she was receiving unemployment benefits and the insurer did not dispute the physician's contentions); *John T. Seiber*, 43 Van Natta 136 (1991). There is no rebuttal evidence. Therefore, we find claimant was in the work force at the time of his current disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN K. GADDIS, Claimant
WCB Case No. 99-00832
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that: (1) declined to award interim compensation; and (2) declined to assess a penalty for the insurer's failure to pay interim compensation. On review, the issues are interim compensation and penalties.

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

In an aggravation claim, the first installment of interim compensation shall be paid no later than the 14th day after the insurer had notice or knowledge of a medically verified inability to work in the form of a medical report that constitutes *prima facie* evidence of a compensable worsening under ORS 656.273(1). ORS 656.273(6); *Melba D. Moore*, 49 Van Natta 631 (1997).

Claimant contends that an aggravation form and accompanying chart note from Dr. Goodwin satisfied his burden of perfecting an aggravation claim which triggered the self-insured employer's obligation to pay interim compensation. ORS 656.273(6). We agree with the ALJ, that, even assuming Dr. Goodwin was claimant's treating physician, claimant has not met his burden of proving a *prima facie* case of an objective worsening of his accepted low back strain condition. ORS 656.273(1).

Specifically, Dr. Goodwin's report accompanying the July 13, 1998 aggravation form does not provide *prima facie* evidence of a pathological worsening of claimant's accepted low back strain condition. On June 16, 1998, the self-insured employer closed claimant's claim via a Notice of Closure awarding no permanent disability. (Ex. 22-2).[1] Dr. Goodwin's July 13, 1998 chart note does not provide any support for an objectively worsened condition since that date. (Ex. 25).

Claimant contends that Dr. Goodwin noted restrictions in claimant's range of motion on July 13, 1998 that were different from those found during a medical examination of April 10, 1998. (Exs. 11-5, 25-2). However, Dr. Goodwin never actually performed exact range of motion tests, noting only that claimant's forward flexion was "approximately 80% of normal." (Ex. 25-2). In the absence of a statement from Dr. Goodwin documenting that this less than normal range of motion finding constituted a worsening of claimant's condition since the June, 1998 claim closure, we consider such a finding to be insufficient to satisfy the *prima facie* component of an objective worsening under ORS 656.273(1).

Moreover, Dr. Goodwin attributed at least some of claimant's symptoms to a bilateral pars defect condition, which he stated was "likely congenital in nature." (Ex. 25-3). Finally, on June 21, 1999, Dr. Goodwin concurred with the statement that claimant's symptoms, to the extent they were even related to his accepted lumbar strain condition[2], represented a "waxing and waning" of symptoms as opposed to an objective worsening of the condition. (Ex. 46-2).

In conclusion, therefore, we find Dr. Goodwin's report accompanying the aggravation form inadequate to meet claimant's burden of proving a *prima facie* case of a compensable worsening of his low back strain condition sufficient to trigger the employer's obligation to pay interim compensation. ORS 656.273(6); *Moore*, 49 Van Natta at 632.

Because we agree with the ALJ that claimant is not entitled to interim compensation, there are no "amounts then due" upon which to base a penalty. ORS 656.262(11); *Patricia J. Petty*, 51 Van Natta 1688 (1999).

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[1] That Notice of Closure was affirmed by an Order on Reconsideration dated October 13, 1998. (Ex. 45AA).

[2] On June 17, 1998, the insurer issued a denial of claimant's "conjoined nerve root at L4-5" condition. (Ex. 23). Claimant withdrew his request for hearing from that denital. (Tr. 2).

ORDER

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

March 10, 2000 Cite as 52 Van Natta 369 (2000)

In the Matter of the Compensation of
JOHN ENTGELMEIER, Claimant
WCB Case No. 99-03769
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Howell's order that: (1) found that claimant timely notified the employer of his left shoulder injury claim; and (2) set aside its denial of that claim. On review, the issues are timeliness and compensability.

We adopt and affirm the ALJ's order. *See Colvin v. Industrial Indem.*, 301 Or 743, 747 (1986) ("any degree of authority that places a man in charge of even a small group of workers is enough to confer [] representative status" sufficient to impute that person's knowledge of an injury to the employer) *Richard W. Green*, 44 Van Natta 152, 153 (1993) (knowledge of injury imputed to employer where the claimant's son, president of the company, was aware of the event).

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 26, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
KEN KILLIAN, JR., Claimant
Own Motion No. 99-0443M
OWN MOTION ORDER ON RECONSIDERATION
Westmoreland & Mundorff, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our January 7, 2000 Own Motion Order in which we declined to reopen his 1993 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization.

On February 7, 2000, we abated our January 7, 2000 order, and allowed SAIF 14 days in which to file a response to the motion. Having received the parties' responses, we proceed with our review.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

With his request for reconsideration, claimant contends that he is a self-employed plumber and submitted copies of his 1998 tax return. In response, SAIF contends that the 1998 tax forms do not demonstrate that he was in the work force when his condition worsened requiring surgery on January 12, 2000.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Claimant's submission of his 1998 tax return demonstrates that he worked in 1998. However, claimant underwent surgery in January of 2000. In order to be considered in the work force at the time of his current disability, claimant must show he was in the workforce prior to his January 2000 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).

Accordingly, our January 7, 2000 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 7, 2000 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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

In the Matter of the Compensation of
BRIAN LUTZ, Claimant
Own Motion No. 94-0392M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Martin J. McKeown, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's August 5, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from May 6, 1994 through July 21, 1999. The insurer declared claimant medically stationary as of July 21, 1999. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Based on the following, we affirm the August 5, 1999 Notice of Closure.

FINDINGS OF FACT

Claimant sustained a compensable abdominal hernia condition that has required multiple surgeries over the years. On August 11, 1994, his claim was last reopened by an Own Motion Order that authorized payment of temporary disability benefits beginning May 6, 1994, the date of a surgery that repaired strangulated and incarcerated abdominal hernias and removed the mesh inserted during prior surgical repairs of the abdominal hernia condition. On May 13, 1994, claimant underwent a second surgery related to his abdominal hernia condition. Both surgeries were performed by Dr. Sheppard, an associate professor of general surgery at Oregon Health Sciences University (OHSU).

As a result of the multiple prior surgeries and the removal of the mesh involved in prior hernia repairs, claimant essentially has no abdominal fascia and has multiple, large abdominal hernias.

Dr. Sheppard referred claimant to Dr. Wheatley, an assistant professor of plastic surgery at OHSU, regarding the possibility of repairing claimant's hernia condition. On April 6, 1995, Dr. Wheatley examined claimant and described a surgical procedure that would "hopefully correct the majority or perhaps all of [claimant's] hernias." However, Dr. Wheatley found that claimant's weight was a complicating factor to a successful hernia repair and that any hernia repair at claimant's present weight was "almost guaranteed to be unsuccessful." He stated that, prior to any attempt at hernia closure, it was "mandatory" that claimant lose nearly 100 pounds. He opined that claimant probably only had one chance for correction of his hernias and it would be best not to proceed with surgery until his weight was optimized. (April 6, 1995 report from Dr. Wheatley to Dr. Sheppard). He instructed claimant that it was vital that he lose weight. (Dr. Wheatley's April 6, 1995 chart note).

On June 22, 1995, claimant returned to Dr. Wheatley and reported a 20 pound weight loss. Dr. Wheatley stated that claimant currently weighed 310 pounds and was progressing slowly with weight loss. He also stated that claimant would attempt to optimize his weight at approximately 220-230 pounds.

On October 18, 1995, Dr. Sheppard completed a "Supplemental Medical Report" in which he stated that he was no longer treating claimant, having last treated him on March 6, 1995. He also stated that claimant was to do no heavy lifting due to large abdominal wall hernias. He indicated that claimant was not medically stationary, stating that claimant was "currently losing weight so we can attempt to fix [the hernias]."

On May 6, 1997, the insurer issued a Notice of Closure closing claimant's claim, declaring claimant medically stationary as of May 5, 1997. By order dated November 18, 1997, we set aside the insurer's closure, finding that there was no evidence that claimant was medically stationary when the claim was closed. *Brian K. Lutz*, 49 Van Natta 2009 (1997). In making that determination, we relied on Dr. Sheppard's October 18, 1995 report, the most recent medical evidence in the record.

On April 21, 1997, Dr. Wheatley examined claimant, noting that he continued to have large abdominal hernias. Dr. Wheatley also noted that he had examined claimant ten months earlier and the plan at that time was that claimant would lose weight and undergo fascial reconstruction. Dr. Wheatley sent a copy of his chart note to Dr. Sheppard. (Dr. Wheatley's April 21, 1997 chart note). Dr. Wheatley stated that claimant had actually gained weight since his last visit. Finally, he scheduled a follow-up in September 1997, stating that, if claimant has lost weight, he would place him on the schedule for surgical correction of his hernias.

On January 16, 1998, claimant began treating with Dr. Phuntshog, primary care physician, who became his attending physician. At that time, claimant's abdomen was markedly distended, with hernias protruding across the entire lower abdomen. Dr. Phuntshog noted that the abdominal wall and musculature appeared very markedly decreased in thickness. He encouraged claimant to lose weight.

On March 26, 1998, claimant returned to Dr. Phuntshog, who noted that claimant had seen Dr. Sheppard "over the last week or so and was told to try to lose weight." (Dr. Phuntshog's March 26, 1998 chart note). Dr. Phuntshog stated that claimant weighed 289 pounds, the same weight as when last seen two months earlier. He noted that claimant had a hernia protruding across the entire circumference of his abdomen and advised him to try to lose weight to make surgery easier.

On April 17, 1998, claimant returned to Dr. Phuntshog, who noted that claimant had lost about five pounds since his last visit. Since his last visit with Dr. Phuntshog, claimant had seen Dr. Stanton, a physician in Eugene, for evaluation of the hernia condition. Claimant reported that Dr. Stanton felt that claimant's condition was too severe for him to attempt any kind of surgery. Dr. Phuntshog noted that claimant had almost no muscle in the abdominal wall and had significant bulging of the intestines, which put him at significant risk of rupture of the abdominal wall. He advised claimant against any strenuous activity, stating that claimant was essentially disabled secondary to this problem. He also advised claimant to continue his diet and weight loss.

On April 22, 1998, claimant was hospitalized for nonoperative treatment of an incarcerated incisional hernia. At that time, he weighed 285 pounds.

On July 15, 1999, Dr. Phuntshog reported that claimant had been evaluated by a surgeon at the Lichtenstein Hernia Repair Institute in California. That surgeon recommended that claimant lose weight before he would be considered for surgery. Dr. Phuntshog also reported that claimant had been undergoing physical therapy and had progressively been losing weight, with a weight loss of "over 20 pounds in the last six months." He recommended that claimant continue with physical therapy and stated that he would not consider claimant "medically stationary until he achieves a weight of about 225 pounds, at which time he can be considered for surgery."

By letter dated July 21, 1999, Dr. Sheppard responded to the insurer's inquiry about claimant's medically stationary status, opining that, until claimant was able to lose 40 to 50 pounds and/or undergo bariatric surgery in conjunction with his incisional hernia repair, "he would be considered medically stationary according to your criteria." He opined that surgical intervention was the "only modality which would lead to a significant and material improvement of [claimant's] condition."

On August 5, 1999, claimant underwent an insurer-arranged medical examination (IME) performed by Dr. Braun, urologist and surgeon, and Dr. Dordevich, rheumatologist. At that time, claimant weighed 253 pounds. They noted that claimant had been rejected by both the Lichtenstein Institute and OHSU for surgery, due to his obesity and asthma. While they considered surgery desirable, they found the likelihood of success small, and the possibility of serious consequences great. They doubted, even with claimant's current weight loss, that he would be accepted by either of those institutions. They did not think that surgery would currently be prudent, given the presence of the totally deteriorated abdominal wall. They recommended the use of an abdominal support. They also opined that claimant should be considered medically stationary at this time, since they believed that surgical intervention was in the distant future.

On August 5, 1999, the insurer closed claimant's claim with an award of temporary disability compensation from May 6, 1994 through July 21, 1999. The insurer declared claimant medically stationary as of July 21, 1999, the date of Dr. Sheppard's report.

CONCLUSIONS OF LAW AND OPINION

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

time of the August 5, 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 insurer contends that claimant's condition is medically stationary despite his attending physician's recommendation for further surgery. It relies on the August 5, 1999 IME report and Dr. Sheppard's July 21, 1999 report. Claimant relies on Dr. Phuntshog's July 15, 1999 opinion.

As recorded in the above findings of fact, since April 1995, multiple physicians have recommended that claimant lose a significant amount of weight to afford a reasonable chance of succeeding with a surgical repair of his multiple abdominal hernias. The record is not clear as to claimant's weight over the course of these various recommendations, but in April 1995, after a 20 pound loss, claimant weighed 310 pounds. The consensus of Drs. Wheatley and Phuntshog is that claimant must achieve a weight of about 225 pounds before he would be considered a candidate for surgery.

Prior to claim closure, claimant was following his doctor's recommendations in that he was attending physical therapy and progressively losing weight in preparation for surgery. On July 15, 1999, Dr. Phuntshog reported that claimant lost over 20 pounds in the last six months. Dr. Phuntshog opined that claimant was not medically stationary, stating that he would not consider claimant "medically stationary until he achieves a weight of about 225 pounds, at which time he can be considered for surgery." Although Dr. Phuntshog did not give claimant's current weight, claimant weighed 253 pounds during the IME performed on August 5, 1999.

On July 21, 1999, Dr. Sheppard opined that, until claimant lost 40 to 50 pounds and/or underwent bariatric surgery in conjunction with his hernia repair, he would be considered medically stationary "according to [the insurer's] criteria."[1] Although Dr. Sheppard opined that claimant still needed surgical intervention, stating that it was the only modality that would lead to a significant and material improvement of claimant's condition, he opined that claimant's condition was medically stationary pending the recommended weight loss.

Drs. Braun and Dordevich also found that surgery was "desirable," although not at claimant's present weight. Because they believed that surgical intervention was in the distant future, they opined that claimant was currently medically stationary.

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, two of claimant's treating physician's present opposing opinions as to his medically stationary status. Specifically, Dr. Sheppard, who performed claimant's 1994 surgeries and followed his care at least until March 1998, opines that claimant is medically stationary until he loses 40 to 50 pounds in preparation for surgery. In contrast, Dr. Phuntshog, a primary care physician who began treating claimant in January 1998, opines that claimant is not medically stationary until he achieves a weight of about 225 pounds and undergoes surgery. On this record, we find Dr. Sheppard's opinion more persuasive. Dr. Sheppard performed the surgeries related to the current reopening of claimant's claim. In addition, he has followed claimant's treatment over a greater period of time than has Dr. Phuntshog.

Moreover, the opinions of Drs. Braun and Dordevich support Dr. Sheppard's opinion. Given the opinions of Drs. Sheppard, Braun and Dordevich, we find that the preponderance of the medical evidence supports a finding that claimant's condition was medically stationary at claim closure.

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[1] By letter dated June 23, 1999, the insurer requested Dr. Sheppard's opinion regarding claimant's medically stationary status. In that letter, the insurer explained that, under Workers' Compensation Law, "medically stationary" meant that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." This is the definition provided in ORS 656.005(17). Therefore, we find that Dr. Sheppard had a correct understanding of the meaning of "medically stationary" when he rendered his opinion.

In addition, in cases where claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if claimant refuses the surgery. *E.g. Stephen L. Gilcher*, 43 Van Natta 319, 320 (1991); *Karen T. Mariels*, 44 Van Natta 2452, 2453 (1992). However, if postponement (as opposed to refusal) of surgery is beyond the claimant's control and the surgery is medically necessary for the compensable condition, we have held that the claim was closed prematurely since, at closure, there was still a reasonable expectation for material improvement based on the surgery recommendation. *See Bill H. Davis*, 47 Van Natta 219 (1995). On the other hand, where postponement of surgery is not beyond the claimant's control, even if the surgery is medically necessary for the compensable condition, we have found claim closure appropriate. *See Ronald L. Clark*, 50 Van Natta 2352 (1998), *on recon* 51 Van Natta 1365 (1999).

Here, we find our decision in *Clark* controlling. In *Clark*, the claimant's attending physician recommended that he undergo a significant weight reduction (50 pounds) before he could undergo surgery that reasonably could materially improve his compensable foot condition. After the claimant failed to follow his attending physician's instructions and did not lose any weight, the attending physician found him medically stationary until he was able to lose 50 pounds and could undergo the proposed surgery. Based on the attending physician's opinion, the carrier closed the claim. We affirmed the closure, finding that, although the claimant was advised on several occasions to lose weight, there was no medical evidence that he had complied with his doctor's recommendation. In addition, unlike *Davis*, there was no evidence that the postponement of the proposed surgery was due to circumstances outside of his control, *i.e.*, the claimant provided no evidence that he was unsuccessful in losing weight despite any attempts to do so and that his inability to lose weight was beyond his control. Based on this record, we found the claim closure proper. 50 Van Natta at 2353, 51 Van Natta at 1365.

Here, since April 1995, claimant has repeatedly been advised of the absolute necessity to lose a significant amount weight in order to afford a reasonable chance of successfully repairing his multiple abdominal hernias. Over the years since that initial recommendation, claimant's weight has fluctuated. Periodically, claimant has followed his physicians' advice and lost some weight. In this regard, in the six months before claim closure claimant lost about 20 pounds. Nevertheless, over the years, it is apparent that claimant did not consistently follow his doctors' orders to lose weight. Moreover, as in *Clark*, claimant presents no evidence that circumstances beyond his control were preventing him from losing the weight necessary to proceed with the recommended treatment. To the contrary, when claimant chose to follow his doctors' orders, he was able to lose weight. Thus, claimant's periodic weight loss shows that his weight loss was within his control. Under these circumstances, we find that by failing to lose the recommended weight over a period of more than four years, claimant effectively "refused" the recommended surgery.

Consequently, on this record, we find that claimant has not met his burden of proving that his compensable abdominal hernia condition was not medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's August 5, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

Board Member Biehl dissenting.

Although the majority correctly states the law regarding determination of a claimant's medically stationary status at claim closure, I disagree with its application of that law to the facts of this case. On these facts, I would find that claimant has met his burden of proving that he was not medically stationary at claim closure. Therefore, I respectfully dissent.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Furthermore, a claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); 656.278(1)(a); OAR 438-012-0055(1). Finally, the propriety of the closure turns on whether claimant was medically stationary at the time of the August 5, 1999 Notice of Closure, considering claimant's condition *at the time of closure*. *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 majority focuses on the fact that, since April 1995, multiple physicians have recommended that claimant lose a significant amount of weight to afford a reasonable chance of success in surgically repairing his compensable abdominal hernia condition. Because claimant had not accomplished this weight loss over a period of four years, the majority concludes that he effectively "refused" the recommended surgery. The majority's focus on prior events is misplaced, however. The issue before us is whether claimant's condition is medically stationary *at closure.* Events occurring prior to or subsequent to closure are not relevant to our inquiry.

Here, at closure, claimant was following his doctor's recommendations in that he was attending physical therapy and progressively losing weight in preparation for surgery. On July 15, 1999, Dr. Phuntshog reported that claimant lost over 20 pounds in the last six months. Dr. Phuntshog opined that claimant was not medically stationary, stating that he would not consider claimant "medically stationary until he achieves a weight of about 225 pounds, at which time he can be considered for surgery." As the majority finds, about the time of Dr. Phuntshog's opinion, claimant weighed 253 pounds. Thus, at closure, claimant was losing weight in preparation for surgery. In fact, he was within about 30 pounds of achieving the recommended weight to undergo surgery.

On July 21, 1999, Dr. Sheppard opined that, until claimant lost 40 to 50 pounds and/or underwent bariatric surgery in conjunction with his hernia repair, he would be considered medically stationary "according to [the insurer's] criteria." Nevertheless, Dr. Sheppard opined that claimant still needed surgical intervention, stating that it was the *only* modality that would lead to a significant and material improvement of claimant's condition. On this record, it appears that Dr. Sheppard last saw claimant in March 1998, at which time he weighed 289 pounds. (Dr. Phuntshog's March 26, 1998 chart note). It is not clear that Dr. Sheppard was aware of claimant's subsequent weight loss.

Drs. Braun and Dordevich also found that surgery was "desirable," although not at claimant's present weight. Because they believed that surgical intervention was in the distant future, they opined that claimant was currently medically stationary.

In cases where claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if claimant refuses the surgery. *E.g. Stephen L. Gilcher,* 43 Van Natta 319, 320 (1991); *Karen T. Mariels,* 44 Van Natta 2452, 2453 (1992). Here, however, claimant clearly did not refuse surgery. Instead, at closure, he was actively losing weight in preparation for the recommended surgery.

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF,* 64 Or App 810 (1983). In this case, I find no persuasive reason not to defer to the opinion of Dr. Phuntshog, claimant's long time treating physician. Dr. Phuntshog has treated claimant since January 1998, and has not altered his opinion that claimant requires surgery to repair the abdominal hernias before being considered medically stationary. He offers objective findings in the form of claimant's weight loss to substantiate claimant's adherence to his recommendation to lose weight in order to undergo the recommended surgery. In addition, although they found claimant's condition currently medically stationary due to his obesity, the remaining physicians also opined that the recommended surgery would materially improve claimant's abdominal hernia condition.

Under such circumstances, I find Dr. Phuntshog's opinion to be more persuasive. Multiple physicians have recommended surgery that could reasonably be expected to materially improve claimant's compensable condition. Dr. Phuntshog recommended that claimant lose weight before scheduling the surgery. He opined that claimant would not be medically stationary until he lost the recommended amount of weight and underwent the recommended surgery. The record demonstrates that claimant is complying with his doctor's recommendation to lose weight in preparation for this surgery.

In addition, I disagree with the majority's reliance on *Ronald L. Clark,* 50 Van Natta 2352 (1998), *on recon* 51 Van Natta 1365 (1999). I find *Clark* distinguishable. In contrast to *Clark,* where the claimant did not comply with his doctor's recommendation to lose weight prior to undergoing surgery recommended for his compensable condition, here, claimant is complying with his attending physician's recommendations to attend physical therapy and lose weight in preparation for the proposed surgery. In addition, considering that compliance, Dr. Phuntshog finds that claimant is not medically stationary

and continues to recommend the proposed surgery after claimant achieves a weight of about 225 pounds. Moreover, all the physicians agree that the proposed surgery will reasonably result in material improvement in claimant's condition, provided that claimant lose the necessary weight prior to undergoing that surgery. Under such circumstances, I conclude that claimant was not medically stationary at the time his claim was closed.

Finally, I address the insurer's argument that "[u]nder Own Motion a claim should not be held open indefinitely for the possibility of a future surgery." I understand the insurer's concern, especially where, as here, the same surgical treatment has been recommended since April 1995, provided that claimant lose a significant amount of weight. Nevertheless, under law, the claim cannot be closed until claimant is medically stationary. ORS 656.005(17); 656.268(1); 656.278(1)(a).

Although I would find on this record that claimant was not medically stationary at claim closure based, in part, on his current compliance with his attending physician's recommendation to lose weight in preparation for the proposed surgery, the insurer is not without a remedy if claimant should fail to continue to comply with those recommendations. In this regard, the insurer may request suspension of claimant's benefits under OAR 438-012-0035(5). In addition, if circumstances change, the insurer may again close the claim if the medical evidence supports a finding that claimant is medically stationary. *See Clark*, 50 Van Natta at 2353, 51 Van Natta at 1365.

Thus, the insurer is not without remedies if claimant should fail to continue to lose weight in preparation for the recommended surgery. Nevertheless, those remedies do not include closing the claim before claimant's compensable condition becomes medically stationary. ORS 656.005(17); 656.268(1); 656.278(1)(a).

March 8, 2000 Cite as 52 Van Natta 376 (2000)

In the Matter of the Compensation of
ANTHONY W. ABSHIRE, Claimant
WCB Case No. 99-01443
ORDER OF ABATEMENT
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 436-035-0007(19)(b), 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.

In order to further consider claimant's argument, we withdraw our February 11, 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 proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CRAIG B. MILLS, Claimant
Own Motion No. 98-0358M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's August 18, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from July 7, 1998 through August 4, 1999. SAIF declared claimant medically stationary as of August 5, 1999.

Claimant submitted his request for review on February 8, 2000, 174 days after the mailing of the Notice of Closure. To be considered, the request for review must be filed with the Board within 60 days from the date of mailing of the notice of closure, or within 180 days after the mailing date if claimant can establish good cause for the failure to file the request within 60 days. *See* OAR 438-012-0060(1).

Here, claimant contends that he was "compelled" to file his appeal beyond the 60 day appeal period because "only the passage of time would substantiate my disagreement with being considered 'medically stationary.'" However, we need not resolve whether claimant has established "good cause" for his untimely request. We reach this conclusion because, based on the record before us, we would reject claimant's contention that the closure of his claim was improper.

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 reasonable be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 18, 1999 Notice 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).

Here, SAIF submitted a July 19, 1999 chart note from Dr. Vigeland, claimant's attending physician and an August 5, 1999 "second opinion" medical report from Dr. Higgins in support of its of Closure. In his July 19, 1999 chart note, Dr. Vigeland opined that, although claimant may require yearly visits and possibly a knee revision "at some time," he was medically stationary "at this point." On August 5, 1999, Dr. Higgins concurred with Dr. Vigeland that claimant was medically stationary at that time. He further opined that it was unlikely that claimant would have any significant improvement "by virtue of further passage of time" and that no additional treatment was necessary. These medical opinions are unrebutted.

Claimant contends that he has "materially improved" with the passage of time as evinced by a reduction in the pain and swelling of his knee. As a result, he no longer needs the treatment modalities of ice packs and leg elevation. Claimant asserts that because he no longer requires treatment as a result of the passage of time, it demonstrates that he was not medically stationary when his claim was closed on August 18, 1999. However, as stated above, claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980). Claimant has not met his burden of proof by providing a *medical opinion* that would support his contention that he was not medically stationary when his claim was closed on August 18, 1999.

In conclusion, the record does not satisfy claimant's statutory burden of proof to establish that his condition was not "medically stationary" when SAIF closed his claim; *i.e.* no further material improvement of his condition would be reasonably expected from medical treatment or the passage of time. Accordingly, we deny claimant's challenge to SAIF's August 18, 1999 Notice of Closure.[1]

IT IS SO ORDERED.

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[1] Should claimant's compensable condition subsequently worsen to the extent that surgery and/or inpatient hospitalization is eventually required, he may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

In the Matter of the Compensation of
VICKEY L. RIDER, Claimant
WCB Case No. 98-08939
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
VavRosky, et al, Defense Attorneys

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

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its partial denial of claimant's cervical strain condition; and (2) set aside its *de facto* denials of claimant's C5-6/C6-7 disc bulge condition, low back condition, and left arm condition. On review, the issue is compensability. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

C5-6/C6-7 Disc Condition/Left Arm Condition

The ALJ found that the January 12, 1998 work injury was the major contributing cause of claimant's C5-6/C6-7 disc bulge condition and left arm condition. We disagree.

The medical evidence shows that claimant's degenerative cervical conditions are preexisting and combined with the January 12, 1998 work injury. (Exs. 68, 75, 76, 78, 79). Therefore, in order to establish compensability, claimant must proved that the work incident is the major contributing cause of her disability or need for treatment for the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101 *on recon* 149 Or App 309 (1997). A determination of major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994).

Dr. Calhoun, claimant's current treating physician, acknowledged that claimant had preexisting spondylosis at C5-6 and C6-7, but opined that the work incident was the major contributing cause of claimant's symptoms and need for surgery. (Ex. 76). Dr. Calhoun based his opinion on claimant's having no cervical or radicular symptoms prior to the work injury. (*Id.*).

In his deposition, Dr. Calhoun was provided with some of claimant's prior medical records. Dr. Calhoun agreed that the medical records were not consistent with the history that he had received from claimant. (Ex. 78-10). Dr. Calhoun also agreed that the surgery he was proposing was at the same cervical levels for which Dr. Silver proposed surgery in 1992. (Id.). Dr. Calhoun indicated that the fall in January 1998 had "something to do" with claimant reconsidering cervical surgery. (Ex. 78-12). Dr. Calhoun opined that the work incident may have made claimant more symptomatic, but agreed that it was difficult to quantify claimant's increased symptoms. (Ex. 78-14). On redirect examination, Dr. Calhoun opined that the work incident was the major cause of claimant's need for surgery because claimant was not seeking surgery until the work incident. (Ex.78-17).

We do not find Dr. Calhoun's opinion persuasive. His initial opinion was based on an inaccurate history regarding the lack of cervical and arms symptoms prior to the January 1998 work incident. When Dr. Calhoun was provided with claimant's medical records at deposition, he opined that the work injury was the major cause of the need for treatment since claimant was not seeking surgery until that time. However, decompression surgery at C6 and C7 had been proposed by Dr. Silver in 1992. (Exs. 25, 26). Consequently, we find the basis for Dr. Calhoun's opinion is not supported by the record.

Dr. Dolin also opined that the January 1998 work incident was the major cause of claimant's need for treatment. (Ex. 75). However, in his deposition, Dr. Dolin indicated that he could not quantify what role claimant's preexisting bone spurs played in claimant's need for surgery. (Ex. 79-24. Dr. Dolin ultimately agreed that he would defer to Dr. Calhoun's opinion. (Id.; Ex. 79-28). Because we are not persuaded by the opinion of Dr. Calhoun, it necessarily follows that Dr. Dolin's reliance on Dr. Calhoun's opinion is likewise not persuasive.

Inasmuch as we are not persuaded by the opinions of Drs. Calhoun and Dolin, and in light of the contrary opinions offered by Dr. Platt and Dr. Dineen, claimant has not established that the January 1998 work incident is the major contributing cause of her disability or need for treatment for the combined cervical condition. Accordingly, the employer's denial of claimant's cervical and left arm condition must be upheld.

Low Back Condition

We adopt the ALJ's conclusions and reasoning with regard to claimant's low back condition.

Claimant's attorney is entitled to an assessed fee for services on review concerning claimant's low back 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 $500, 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.

Finally, because we have herein reinstated and upheld the self-insured employer's denial of claimant's C5-6/C6-7 disc bulge and left arm condition, we modify the ALJ's assessed attorney fee award to reflect only those services rendered in connection with claimant's low back condition. 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 concerning claimant's low back condition is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 14, 1999 is reversed in part, modified in part, and affirmed in part. The self-insured employer's *de facto* denials and November 18, 1998 denial, to the extent that they deny claimant's C5-6/C6-7 disc bulge condition and left arm condition are reinstated and upheld. The assessed attorney fee awarded by the ALJ is also modified to award claimant $1,000 for services at hearing concerning the low back condition. The remainder of the order is affirmed. For services on review concerning the low back condition, claimant's counsel is awarded a reasonable assessed attorney fee of $500, payable by the self-insured employer.

Board Member Phillips Polich dissenting in part.

The majority concludes that claimant did not establish that her C5-6/C6-7 disc bulge condition and left arm condition are compensable. I disagree with that decision.

While it is true that the history initially given to Dr. Calhoun was inaccurate, he was provided with a complete history at the deposition. Like the ALJ, I am persuaded by Dr. Calhoun's opinion that claimant suffered physiologic changes to the cervical spine as a result of the work incident. (Ex. 78-20). Moreover, Dr. Calhoun explained that claimant's need for treatment was due to a combination of a combination of the preexisting disc bulges, bone spurs and this physiologic change. (Ex. 78-17). Dr. Calhoun then opined that the work incident was the major contributing cause of claimant's need for treatment. (Ex. 78-18). Although deferring to Dr. Calhoun, Dr. Dolin, claimant's long-time treating physician, also noted that claimant's cervical condition had significantly worsened following the work incident. (Ex. 79-23).

Based on the opinions of Drs. Calhoun and Dolin, I agree with the ALJ that claimant's cervical and left arm condition is compensable. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
CHAD H. STONIER, Claimant
WCB Case No. 99-00451
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Meyers, Bock, and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Houguet's order that set aside its denial of claimant's injury claim for an L5-S1 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW

The ALJ found, based on his observations and a review of the record, that claimant credibly testified he experienced periodic but nondisabling pain/discomfort in his low back and down his left leg to his foot from the time of his October 5, 1995 compensable injury through the beginning of April 1996 when his condition progressively worsened. The ALJ also found Dr. Rosenbaum's, a neurosurgeon's, opinion to be persuasive, reasoning that it was based on a sufficiently complete and correct medical history. In doing so, the ALJ concluded that the compensability of claimant's disc condition required expert analysis and, therefore, deference to claimant's attending physician, Dr. Ackerman, need not be shown.

On review, the insurer contends that the ALJ incorrectly found that claimant proved he suffered a compensable injury. Specifically, the insurer contends that the ALJ incorrectly relied on Dr. Rosenbaum's medical opinion in that it was based on an inaccurate and/or incomplete history.

To establish a compensable injury where it is shown that claimant suffers from a preexisting disease, the claimant must prove that his work exposure is the major contributing cause of his need for treatment or disability for his combined condition. *See* ORS 656.005(7)(a)(B); ORS 656.266. Where the causation issue involves complex medical questions, we necessarily rely on expert medical opinions. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnet v. SAIF*, 122 Or App 279 (1993).

In this case, claimant suffers from preexisting degenerative disc disease which combined with the work injury. (Exs. 10, 11, 12, 13, 16, 20, 21, 22, 23, 25, 28A). Claimant must, therefore, show that his compensable October 1995 fall was the major contributing cause of his need for treatment or disability for his L5-S1 disc herniation. ORS 656.005(7)(a)(B). Additionally, this case is complex due to the fact that claimant suffered three back injuries prior to the compensable October 1995 fall and several incidents after the October 1995 fall. (Exs. 1, 2, 3, 5, 16AA, 17, 18, 27). Further complicating the causation issue is the fact that claimant did not seek medical attention until over six months after the October 1995 fall. (Ex. 5). Therefore, we must rely on expert medical opinions as to causation of claimant's L5-S1 disc herniation.

The expert medical opinion must evaluate the relative contribution of each cause. *Dietz v. Ramuda*, 130 Or App 397 (1994) *rev dismissed* 321 Or 416 (1995). Additionally, where there is a division of experts we rely on those medical opinions that are the most well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Here, claimant was examined by several doctors, including three insurer- arranged medical examinations. However, only Dr. Ackerman, claimant's treating physician, Dr. Rosenbaum, a neurosurgeon who saw claimant once on referral from Dr. Ackerman, and Dr. Fuller, an orthopedic surgeon who conducted an insurer-arranged medical examination, were based on a substantially complete medical history of claimant. (Exs. 21, 22, 25, 24, 28, 28A). Claimant relies primarily on the medical opinion of Dr. Rosenbaum.

Dr. Rosenbaum's opinion, however, does not properly weigh the relative contribution of each cause. Dr. Rosenbaum did not evaluate several important issues, including the following: that claimant experienced low back pain radiating down into his left leg in 1993; that claimant's symptoms were noted to have resolved under Dr. Prideaux's care in July of 1996; that claimant's medical records note a reinjury to claimant's back in July 1996; that claimant's medical records did not show the lack of the left Achilles reflex until July 31, 1996; and that claimant suffered from dengerative disc disease at multiple levels of his spine including L5-S1. As noted above, Dr. Rosenbaum did have an accurate and substantially complete medical history of claimant, however, that alone does not provide adequate foundation for his opinion to be found persuasive.

Additionally, Dr. Rosenbaum provided only a qualified opinion based solely on claimant's subjective history. According to Dr. Rosenbaum, *if* claimant experienced the onset of immediate back pain at the time of the October 1995 incident and within three to six weeks developed radiating left leg pain, it was his opinion that claimant's October 1995 work injury was the primary cause of his L5-S1 disc herniation. However, Dr. Rosenbaum, admitted that he can not substantiate his opinion based on claimant's medical records and the history he received. Further problematic to reliance on Dr. Rosenbaum's qualified opinion is the fact that the record does not reflect an immediate onset of back pain, but rather that claimant believed he had injured his left leg with only minimal discomfort in his back and that the onset of his back pain was several days later. (Ex. 6; Tr. 33). Therefore, we find that Dr. Rosenbaum's opinion is not persuasive.

In contrast, Dr. Fuller provided a well-reasoned and complete opinion. Dr. Fuller reviewed claimant's prior medical records and, based on claimant's failure to seek medical attention until over six months after the October 1995 fall, the presence of a left ankle reflex until July 31, 1996, and the presence of degenerative disc disease at multiple levels of claimant's spine, opined that the October 1995 fall is not the major contributing cause of claimant's current L5-S1 disc herniation. (Ex. 28A-7 & 8). Dr. Fuller's opinion is further supported by the concurrence of Dr. Ackerman, claimant's treating physician.

Accordingly, inasmuch as Dr. Rosenbaum's qualified opinion did not address all of the relative causes of claimants L5-S1 disc herniation and is based solely on a subjective history which is not supportable based on the record, we do not find it persuasive. Thus we conclude that claimant has not met his burden of proving that his October 1995 compensable injury was the major contributing cause of his need for treatment or disability for his L5-S1 disc herniation.

ORDER

The ALJ's order dated September 15, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's insurer-paid attorney fee award is also reversed.

Board Member Biehl dissenting.

I disagree with the majority findings that claimant did not prove compensability of his L5-S1 disc herniation. Consequently, I must respectfully dissent.

First, the ALJ explicitly found claimant to be credible based on his "attitude, appearance, and demeanor." Because the ALJ had the opportunity to observe claimant's testimony, he is in the best position to assess credibility of claimant's testimony and, thus, the ALJ's determination is entitled to considerable weight. *See, e.g., Bragger v. Oregon Trail Savings,* 275 Or 219, 221 (1976). Here claimant testified he experienced periodic but nondisabling pain/discomfort in his low back and down his left leg to his foot from the time of his October 1995 compensable injury through the beginning of April 1996 when his condition progressively worsened.

In finding claimant a credible witness, I find that Dr. Rosenbaum's opinion was the most well reasoned and complete for the reasons set forth in the ALJ's order. Additionally, I do not believe deference should be given to the opinion of the treating physician, Dr. Ackerman, because the resolution of the causation issue in this case involves expert analysis rather than expert observation. *Allie v. SAIF,* 79 Or App 284 (1986); *Hammons v. Perini Corp.,* 43 Or App 299 (1979). Therefore, Dr. Ackerman is not in a more advantageous position to render an opinion as to causation than is Dr. Rosenbaum. *See Carl F. Plumlee,* 52 Van Natta 185 (2000).

Because Dr. Rosenbaum provided a well-reasoned opinion based on a claimant's complete medical history, I would defer to his opinion and find the injury claim compensable. Thus, I would affirm the ALJ's order. Because the majority holds otherwise, I dissent.

In the Matter of the Compensation of
TERESA A. TOMPOS, Claimant
WCB Case No. 99-01291
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant 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) Myzak's order that set aside its denial of claimant's current low back condition at L4-5. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On review, the insurer argues that the ALJ erred by relying on the opinions of Drs. Eckman and Newby, claimant's treating doctor and surgeon. The insurer also contends that the ALJ erred in finding that there was no evidence that claimant had a preexisting condition. After reviewing the expert medical opinions, we conclude that, even if claimant does have a preexisting condition at L4-5, she has established compensability of a combined condition.[1]

Pursuant to ORS 656.005(7)(a)(B), a combined condition is compensable only if, so long as, and to the extent that the compensable injury is the major contributing cause of the disability of the combined condition or the major cause of the need for treatment of the combined condition. Determining the "major contributing cause" of claimant's current condition involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994). The fact that the work injury may have precipitated the worker's disability or need for treatment does not necessarily mean that the work injury is the major cause. *Id.* Major contributing cause means that the work activity or exposure contributed more to causation than all other causative agents combined. *McGarrah v. SAIF*, 296 Or 145, 166 (1983).

After reviewing the opinions of Drs. Newby, Eckman, Strum and Bergquist, we agree with the ALJ's analysis that Drs. Newby and Eckman, claimant's treating surgeon and doctor, have provided the most persuasive expert medical opinion regarding causation. Dr. Newby acknowledged claimant's preexisting condition, yet described it as mild in nature. (Ex. 34). In this regard, Dr. Newby's opinion is consistent with the opinion of the radiologist who interpreted claimant's MRI. (Ex. 4). Dr. Strum, however, found that claimant's degenerative disc disease was more significant than the work injury in causing the disc herniation. (Ex. 33-3). Without further explanation regarding the minor findings on the MRI, we do not find Dr. Strum's opinion to be persuasive.

We conclude that Drs. Newby and Eckman had a complete and accurate history of claimant's prior back problems and of her work activities. (Exs. 5, 9, 13, 19, 34, Tr. 47). Moreover, Drs. Newby and Eckman have considered claimant's degenerative condition and have explained why claimant's work incident and activities are the major cause of her disability and need for treatment. (Exs. 31, 32, 34). Accordingly, we agree with the ALJ that claimant has established compensability of her combined condition.

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[1] The insurer alternatively contends that claimant's claim must be analyzed pursuant to ORS 656.802(2)(b). However, while claimant has a "combined" condition, her claim is not based on a worsening of a preexisting condition; therefore, ORS 656.802(2)(b) does not apply. *See Ron L. Merwin*, 49 Van Natta 1801 (1997).

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 attorney's services on review is $1,200, 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 October 13, 1999 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

March 13, 2000 Cite as 52 Van Natta 383 (2000)

In the Matter of the Compensation of
MICHAL A. FLEMING, Claimant
WCB Case No. 99-04637
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by the Board *en banc.*

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) declined to direct the SAIF Corporation to amend its acceptance of claimant's "Le Fort III fracture and nasal fracture" to include a comminuted ethmoid sinus (CES) fracture; and (2) declined to award penalties or attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are scope of acceptance, penalties and attorney fees.

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

Scope of Acceptance

The ALJ declined to order SAIF to amend its acceptance to include claimant's CES fracture. In so doing, the ALJ rejected claimant's argument that ORS 656.262(7)(a) required a specific acceptance of the CES fracture when claimant did not subjectively understand that the CES fracture was included among the compensable conditions. The ALJ reasoned that the statute required reasonable notice of the accepted conditions, but not necessarily that a claimant understand the notice. Finding that the medical evidence established that the accepted Le Fort III fracture referred to a pattern of fractures and encompassed the CES fracture, the ALJ determined that acceptance of the Le Fort III fracture "reasonably apprised" claimant and medical providers of the nature of the compensable conditions. Thus, according to the ALJ, SAIF was not required to amend its acceptance to include the CES fracture.

On review, claimant contends that the ALJ's decision was incorrect, asserting that the only evidence of what claimant was reasonably apprised is his uncontradicted testimony that he had no understanding that SAIF's acceptance included the CES fracture. (Tr. 10). Claimant asserts that the requirements of ORS 656.262(7)(a) are not satisfied when a claimant does not understand what conditions have been accepted and when there is no statement from any medical provider that he or she has been reasonably apprised of the nature of the compensable conditions.

ORS 656.262(7)(a) provides that "an insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions." In essence, claimant argues that the statute sets forth a subjective standard, conditioning compliance with the statute on claimant's and the medical providers' understanding of what conditions have been accepted. We disagree with that statutory interpretation.

ORS 656.262(7)(a) specifically states that acceptance of each and every diagnosis or medical condition is not required so long as the carrier's acceptance "reasonably apprises" claimant and medical providers of the "nature of the compensable conditions." We agree with the ALJ that the statute

requires only reasonable notice of the nature of the compensable conditions. Contrary to claimant's contentions, ORS 656.262(7)(a) sets forth an objective standard that does not require that, in every case, the claimant or medical providers subjectively understand what conditions are compensable. *See State v. Moyle*, 299 Or 691, 706 (1985) (statute prohibiting certain written or telephonic threats that "reasonably would be expected to cause alarm" imposed an objective standard). Moreover, accepting claimant's interpretation of the statute would vitiate that portion of ORS 656.262(7)(a) that provides that acceptance with particularity of each and every diagnosis or medical condition is not required.

In this case, the ALJ relied on medical evidence that establishes that the accepted Le Fort III fracture encompassed the CES fracture. (Ex. 22). This is the kind of evidence to which we have looked in previous cases to determine whether an acceptance notice reasonably apprises a claimant and medical providers of the nature of the compensable conditions. *See Cynthia J. Thiesfeld*, 51 Van Natta 984 (1999). The ALJ properly relied on such evidence here. Accordingly, we affirm the ALJ's holding that SAIF was not required to amend its acceptance to include the CES fracture.

Attorney Fee

Claimant contends that he is entitled to an assessed fee under ORS 656.386(1)(b)(B) because SAIF did not respond within 30 days to his request to include the CES fracture among the compensable conditions. *See also* ORS 656.262(6)(d). We disagree.

First, in light of our decision, claimant did not finally prevail against SAIF's alleged "de facto" denial of the CES condition. Thus, claimant is not entitled to an assessed fee under ORS 656.386(1).

Second, in his March 8, 1999 request that SAIF amend its acceptance to include the CES fracture condition, claimant specifically advised SAIF to consider the claim as one for a new medical condition under ORS 656.262(7)(a). (Ex. 17). Such claims allow a carrier 90 days to give written notice of acceptance or denial of a new medical condition. *Id.* In fact, claimant's counsel specifically stated that: "We look forward to [SAIF's] amended Notice of Acceptance within 90 days of the date of this letter." (Ex. 17). It was only at the hearing that claimant re-characterized the claim as one for an "omitted condition" under ORS 656.262(6)(d), which allows a carrier only 30 days to respond to an objection to a Notice of Acceptance. (Tr. 2).

Because SAIF responded to claimant's "new medical condition" claim on May 18, 1999, within 90 days of claimant's March 8, 1999 letter, we find that, under these circumstances, SAIF's claim processing was timely. Claimant's attorney is not entitled to an assessed attorney fee for an alleged "de facto" denial.

ORDER

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

Board Members Phillips Polich and Biehl concurring.

We acknowledge claimant's testimony that he did not understand that SAIF's Notice of Acceptance included the comminuted ethmoid sinus (CES) fracture. Nevertheless, based on the medical evidence *in this case*, we agree with the majority that SAIF's broad acceptance of "La Fort III fracture and nasal fracture" included the CES fracture. However, we disagree with the implication in the majority opinion that, in every case, medical evidence alone resolves the issue of whether an accpetance notice reasonably apprises a claimant or medical providers of the accepted conditions. To the contrary, we can envision instances in which a claimant's or a medical provider's understanding may be decisive. Nevertheless, because the medical evidence resolves the "reasonably apprised" issue in this case, we concur in this result.

In the Matter of the Compensation of
PAUL R. GRASHAM, Claimant
WCB Case No. 98-04820
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

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

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

We adopt and affirm the ALJ's order with the exception of the first full paragraph on page 5 (ALJ's analogy). We further supplement the ALJ's remaining analysis as follows.

The ALJ upheld the insurer's denial of a "combined" condition consisting of preexisting degenerative conditions (degenerative disc disease and spinal stenosis) and claimant's compensable February 26, 1998 injury, resulting in a diagnosed L4-5 nerve root syndrome. In so doing, the ALJ determined that the underlying degenerative conditions were the major contributing cause of claimant's need for treatment of the L4-5 nerve root syndrome. *See* ORS 656.005(7)(a)(B).

On review, claimant contends that the opinion of Dr. Zelaya, claimant's neurosurgeon, establishes that the compensable injury is the major contributing cause of the need for treatment of the L 4-5 nerve root syndrome. For the following reasons, we disagree.

Considering the presence of significant degenerative conditions in claimant's lumbar spine, the major contributing cause of the need for treatment of the L4-5 nerve root syndrome presents a complex medical question requiring expert medical analysis. *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Uris v. Compensation Department*, 247 Or 420, 424-26 (1965). Moreover, as the question before us requires expert medical analysis rather than expert observation, claimant's treating physician is entitled to no special deference. *See Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979). In evaluating expert medical opinion, we rely on those opinions that are both well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Several physicians have rendered opinions on the causation issue: Dr. Johnson, claimant's attending physician; Dr. Henderson, a consulting orthopedist; Dr. Church, an orthopedic surgeon who performed a records review; Dr. Zelaya, a neurosurgeon who performed surgery to relieve pressure on the L4-5 nerve root; and Dr. Young, a radiologist who also reviewed records. The opinions of Dr. Johnson, Dr. Henderson and Dr. Church are not particularly persuasive on the causation issue.

Dr. Johnson opined that, because of the "time sequence," claimant's present condition and physical findings were the result of the compensable injury. (Ex. 17A). We do not find Dr. Johnson's opinion persuasive, however, because it was based primarily on a temporal relationship between claimant's symptoms and the compensable injury. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone). Moreover, Dr. Johnson erroneously believed that claimant developed a disc herniation from the compensable injury, whereas Dr. Zelaya's surgery revealed no such herniation. (Ex. 18).

Dr. Henderson opined that the majority of claimant's symptoms were related to degenerative disc disease and spinal stenosis. (Ex. 12-4). However, Dr. Henderson provided little explanation for this opinion. Thus, we find Dr. Henderson's conclusory opinion of limited value in resolving the causation issue. *See Blakely v. SAIF*, 89 Or App 653, 656, *rev den* 305 Or 972 (1988) (physician's opinion lacked persuasive force because it was unexplained).

Dr. Church also attributed claimant's current low back condition to preexisting degenerative disc disease and spinal stenosis. (Ex. 19). Dr. Church's opinion, however, seems influenced by his belief that claimant must have had a long history of low back symptoms, given the extent of the preexisting conditions. (Ex. 19-8). The record, however, does not demonstrate any preexisting low back problems. Therefore, we conclude that claimant's preexisting degenerative conditions were asymptomatic before the compensable injury. In light of this, we do not find Dr. Church's opinion persuasive.

This leaves the opinions of Drs. Zelaya and Young. Dr. Zelaya opined in a report to claimant's attorney that the compensable injury was the major contributing cause of the L4-5 nerve root syndrome and claimant's need for treatment, including surgery. (Ex. 21-2). Dr. Zelaya later reiterated that opinion in a deposition. (Ex. 25-18). Dr. Zelaya, however, conceded that claimant's preexisting stenosis was "severe" and that claimant did not have a chance to recover from the blow delivered by claimant's injury to the L4-5 nerve root because of the stenosis. (Ex. 25-10). Moreover, Dr. Zelaya also testified that, given the degree of stenosis, almost anything could have triggered the L4-5 syndrome. (Ex. 25-11). Finally, while Dr. Zelaya emphasized that claimant's injury delivered "quite a significant force" to the nerve root (Ex. 25-19), he also agreed that, more likely than not, but for the existence of the preexisting stenosis, claimant's low back condition would have resolved. (Ex. 25-21).

It is, therefore, clear upon review of Dr. Zelaya's testimony that, while he adhered to his prior opinion regarding the major cause of claimant's need for treatment, the preexisting conditions were also very significant factors in the etiology of claimant's current low back condition. On balance, given the existence of a "severe" preexisting stenosis condition, we find more persuasive Dr. Young's opinion that preexisting conditions were the predominant factor in claimant's need for treatment. (Ex. 23).

Although Dr. Young did not examine claimant, as previously noted, this case involves expert analysis rather than expert observation. In addition, Dr. Young's opinion was based on a thorough review of imaging studies, including MRI studies that Dr. Zelaya believed were important in understanding claimant's condition. (Exs. 17, 23). Moreover, Dr. Young's opinion was also thoroughly tested at a deposition. (Ex. 24).

Accordingly, having reviewed the record *de novo*, we find that the preexisting degenerative conditions, rather than the compensable injury, are the major contributing cause of claimant's need for treatment for his current combined low back condition. Thus, we affirm the ALJ's decision to uphold the insurer's denials.

ORDER

The ALJ's order dated October 4, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority upholds the insurer's denial of claimant's L4-5 nerve root syndrome, preferring the opinion of a radiologist, Dr. Young, who never treated or examined claimant, over that of Dr. Zelaya, the treating neurosurgeon. Because I find no persuasive reason not to defer to the attending neurosurgeon's opinion, I respectfully dissent.

It is well-settled that the Board should give greater weight to the attending physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). This is especially true when the attending physician has also performed surgery to treat the disputed condition. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988) (treating surgeon's opinion found persuasive where he was able to observe the claimant's shoulder during surgery and indicated that there was no evidence that the claimant's condition was due to congenital defect); *Givens v. SAIF*, 61 Or App 490, 494 (1983) (treating surgeon's opinion found persuasive where he indicated that he saw no evidence during surgery that the claimant's thoracic outlet syndrome was the result of a congenital defect or a compressed artery).

Here, Dr. Zelaya's opinion that the compensable February 26, 1998 injury is the major factor in claimant's L4-5 nerve root condition is product of both the familiarity with claimant's condition that only an attending physician possesses and the unique perspective that an attending surgeon brings to the case. The majority greatly errs when it gives greater weight to the opinion of a physician, Dr. Young, who has not even examined, let alone treated, claimant.

The majority cites some examples in Dr. Zelaya's testimony that indicates that claimant's preexisting stenosis condition was severe. However, the majority gives insufficient consideration to the fact that, while Dr. Zelaya was candid regarding the severity of the preexisting condition, he also held firmly to his opinion that the compensable injury was the major contributing cause of claimant's need

for treatment. What the majority apparently views as a weakness (Dr. Zelaya's candor), I see as a strength. It is clear that Dr. Zelaya has thoroughly considered the effect of the preexisting stenosis condition in arriving at his well-reasoned causation opinion. *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).

Accordingly, I would find Dr. Zelaya's opinion satisfies claimant's burden of proof. Because the majority concludes otherwise, I must dissent.

In the Matter of the Compensation of
TERI HEFFLEY, Claimant
WCB Case Nos. 98-06550 & 98-03022
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that upheld CIGNA Insurance Company's (CIGNA's) compensability and responsibility denials of her current right ulnar neuropathy condition.[1] Business Insurance Company (BICO) cross-requests review of that portion of the ALJ's order that set aside its compensability and responsibility denials of claimant's current right lateral epicondylitis condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

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

Claimant broke her right forearm when she was a child. As a result, her elbow became chronically dislocated. In 1985, claimant suffered a compensable right elbow condition when working as a lumber grader at CIGNA's insured. CIGNA accepted the claim and claimant underwent right elbow and forearm surgery. The post-operative diagnosis was decompression of the radial sensory nerve, posterior interosseous nerve and the antebrachial cutaneous nerve of the forearm with resection of the radial head and exploration of the proximal forearm. The claim was closed in 1987 by a Determination Order that awarded 20 percent scheduled permanent disability. A stipulation awarded an additional 15 percent scheduled permanent disability.

In January 1990, claimant sought treatment for bilateral hand symptoms. She was diagnosed with tardy ulnar palsy.

In 1994, claimant began working for BICO's insured as a homemaker. In 1996, claimant's right elbow symptoms increased. She was diagnosed with lateral epicondylitis, which her physician attributed to her work at BICO's insured.

In 1997, claimant's right elbow symptoms recurred. In addition to the epicondylitis, her physician diagnosed ulnar compression neuropathy. In December 1997, claimant filed an aggravation claim with CIGNA. In February 1998, claimant filed a new injury claim with BICO. On March 16, 1998, CIGNA denied compensability of claimant's current condition.[2] On June 16, 1998, BICO denied compensability and responsibility for claimant's right ulnar neuropathy condition.

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[1] Claimant argues that her current right ulnar neuropathy is a compensable aggravation of her accepted 1985 right elbow claim with CIGNA. The CIGNA claim was closed by a January 29, 1987 Determination Order. Claimant's aggravation rights on her 1985 injury claim have expired, thus placing the claim in Own Motion status. ORS 656.273(4); ORS 656.278(1)(a).

[2] CIGNA subsequently denied responsibility as well.

CONCLUSIONS OF LAW AND OPINION

Right Ulnar Neuropathy

Based on Dr. Smith's opinion, the ALJ concluded that claimant's right ulnar nerve entrapment condition was not compensably related to her accepted 1985 claim and upheld CIGNA's compensability and responsibility denials. Claimant makes several arguments on review. She first asserts that, under *Georgia Pacific v. Piwowar*, 305 Or 494 (1998), and ORS 656.308(1), CIGNA accepted claimant's right elbow dislocation and surgery, which is the cause of her current right elbow ulnar neuropathy.

We conclude that *Piwowar* is inapplicable in this case. Under the rule of *Piwowar*, a carrier's acceptance of symptoms of an underlying condition is an acceptance of the disease causing the symptoms. The first question we must answer, then, is the scope of CIGNA's acceptance.

Here, there is no formal acceptance in the record.[3] But the parties stipulated that box 14 of the 801, which specifies the nature of the injury or disease, states "dislocation of elbow" and "strained wrist." These are conditions and not symptoms of conditions. Therefore, consistent with the Court's reasoning in *Piwowar*, we conclude that the employer did not unwittingly accept the separate condition of ulnar neuropathy by its acceptance of a wrist strain and a dislocated elbow. Therefore, claimant must prove that her 1985 injury is the major contributing cause of her ulnar neuropathy condition under ORS 656.005(7)(a)(A).

After *de novo* review of the record, we adopt the ALJ's opinion that claimant has failed to sustain her burden of proof, with the following supplementation.

Although Dr. James, claimant's treating physician, had the opportunity to evaluate claimant over time, there is no indication that this opportunity gave him any special knowledge regarding causation. Therefore, because this case requires expert evaluation, rather than expert observation, we give no special deference to the treating physician. *Allie v. SAIF*, 79 Or App 284, 287 (1996). In addition, we give more weight to those medical opinions which are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

The examination by Drs. Neumann and Melson revealed tardy ulnar nerve palsy, bilateral, right greater than left. Dr. James (who concurred in this report) admits that the examination suggested the condition was bilateral, but says no more about these findings. (Ex. 69). Nor does Dr. James address the number of other places in the medical record where doctors, including Dr. Murdock, reported claimant's left-sided symptoms. (Exs. 31D, 36-2, 60-1, 63-1). The failure of Dr. James and Dr. Murdock to discuss these findings makes their reports less persuasive than that of Dr. Smith, who addressed these findings and found them decisive in the formation of his opinion. Moreover, Dr. Smith's conclusion was not based solely on Drs. Neumann and Melson's report, as stated by claimant.

In addition, as discussed by the ALJ, Dr. James' opinions are inconsistent, attributing claimant's ulnar nerve problem to her recent work activities (Ex. 64-1) and to her old radial head injury (Ex. 64-3). But Dr. James offers no explanation for this apparent contradiction.

For these reasons, we agree with the ALJ that claimant has failed to prove, by a preponderance of the evidence, that her ulnar neuropathy is compensable.

Right Lateral Epicondylitis

The ALJ concluded that claimant's repetitive work activities with BICO's insured were the major contributing cause of her current lateral epicondylitis condition. On review, BICO makes three arguments. First, BICO contends that claimant did not have sufficient exposure at its insured to support a finding of sufficient repetitive use to give rise to an overuse-related lateral epicondylitis condition. Alternatively, BICO contends that claimant's lateral epicondylitis condition was due either to the residuals from her original noncompensable elbow fracture or to the effects of the CIGNA injury.

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[3] The date of acceptance is difficult to discern, but appears to have been the 26th of some month in 1985. (Ex. 1). Because the claim was not filed until September 16, 1985, the earliest this could have been is September 26, 1985.

We adopt the ALJ's opinion on this issue, with the following supplementation.

Dr. James attributed claimant's right lateral epicondylitis to overuse in her job at BICO's insured. (Ex. 32). Drs. Neumann and Melson opined that claimant's lateral epicondylitis was an independent injury and unrelated to her old right arm fracture and persistent dislocated radial head. (Ex. 44-5). They explained that the repeated use of the extensor wad musculature, associated with her scrubbing, polishing, dusting and similar activities, was the major contributing cause of the lateral epicondylitis. (*Id.*) Their analysis is congruent with that of Dr. Smith, who explained that, although close to where the radial head was, lateral epicondylitis involves the tendon attachment of the forearm muscles used in grasping and flexion of the wrist and fingers. (Ex. 68-7, -10, -11). Finally, Dr. Smith considered the contribution of the resected radial head and the ulnar nerve condition and concluded that the major contributing cause of the right lateral epicondylitis was claimant's work. (Ex. 68-11, -12).

Given this medical record, we agree with the ALJ that the effect of claimant's preexisting fracture and radial head resection surgery was minimal at most. Accordingly, claimant has proven that her work activities with BICO's insured is the major contributing cause of her current lateral epicondylitis condition.

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

ORDER

The ALJ's order dated May 6, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by BICO.

March 8, 2000 Cite as 52 Van Natta 389 (2000)

In the Matter of the Compensation of
ANGLEE MINOR, Claimant
WCB Case No. 99-02403
ORDER OF ABATEMENT
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

On February 7, 2000, we issued an Order on Review that upheld the insurer's denial of claimant's left groin injury claim. Asserting that the persuasive medical and lay evidence establishes the compensability of his condition, claimant seeks reconsideration of our decision and affirmance of the Administrative Law Judge's order that had set aside the insurer's denial.

In order to further consider claimant's contentions, we withdraw our February 7, 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
ALEXANDER HUIZAR, Claimant
WCB Case No. 98-08580
ORDER ON REVIEW
Zbinden & Curtis, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's claim for his low back condition; and (2) awarded an assessed attorney fee of $3,600. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that much of the evidence and arguments in the case pertained to when claimant's disc at L5-S1 became herniated and whether or not the herniation occurred as a result of his work for the employer. However, the ALJ concluded that it was not necessary to resolve the disc herniation questions which were not properly part of the compensability determination and were not before her in the case. We disagree.

On October 12, 1998, Dr. White examined claimant on behalf of the insurer and diagnosed claimant's condition as a herniated disc at L5-S1 and degenerative disc disease at L3-4 through L5-S1. On October 15, 1998, the insurer issued a denial of claimant's "current lower back condition, diagnosed as degenerative disc disease at L3-4 and L5-S1," on the ground that the condition was "due to preexisting age related degenerative factors that are not work related." (Ex. 7). Claimant's treating doctor, Dr. Silverman, subsequently agreed that claimant had a herniated disc. (Ex. 11). At hearing, claimant's counsel stated that the issue raised was the denial dated October 15, 1998. (Tr. 1). In recorded closing arguments, claimant's counsel stated that "[t]he medical records indicate he has a herniated disc, and there's no question that it would be an accepted claim." (Closing Arguments, Pg. 1). Accordingly, we conclude that the herniated disc was in issue and was properly before the ALJ.

The expert medical evidence in this case establishes that claimant's current low back condition consists of preexisting degenerative changes that have combined with a herniated disc at L5-S1. (Exs. 6-6, 11). Therefore, claimant must establish that the compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. *SAIF v. Nehl*, 148 Or App 101, *recon* 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 (1994), *rev dismissed* 320 Or 416 (1995).

Here, two expert opinions have been provided regarding causation. Dr. White, who examined claimant on behalf of the insurer, reported that claimant's MRI scan showed a herniated disc at L5-S1 and degenerative disc disease at L3-4 through L5-S1. Dr. White noted that claimant's condition had deteriorated since the exams performed on him shortly after the accident. Dr. White did not believe that claimant had "much of an injury at work" as he was moving very light pans of dough with some bending and turning to one side. Dr. White did not think that such activity would injure the lumbar spine. Dr. White noted that claimant's degenerative changes were older than his work exposure with the employer and he reported that the usual cause of disc herniations was degenerative disease in the lumbar spine. Consequently, Dr. White believed that claimant's herniated disc, his resulting condition, disability, and need for treatment, were due to the preexisting degenerative changes. (Ex. 6).

Dr. Silverman, claimant's treating doctor, believed that claimant injured himself at work on July 31, 1998. Dr. Silverman felt that claimant's injuries "were primarily spasm of the lower back with no clear indication of a herniated disc at that time." Following claimant's treatment in California and his exam by Dr. White, Dr. Silverman concluded that claimant had a herniated disc. Dr. Silverman agreed

with Dr. White that, generally, degenerative disc disease causes herniated discs; however, in claimant's situation, he felt that the July 1998 injury "accelerated" the development of the disc. (Ex. 11). Dr. Silverman subsequently checked a box indicating that he agreed that the July 31, 1998 disc injury was the major cause of the herniated disc at L5-S1. (Ex. 12).

In his final opinion regarding causation, Dr. Silverman agreed with counsel for the insurer that a straight-leg-raising test was the best clinical test for diagnosing a herniated disc. Dr. Silverman also agreed that on his first exam following the incident of July 31, claimant's straight-leg-raising test was negative, which indicated that there was no pressure on the nerves. (Ex. 13-7). Based on his examination, Dr. Silverman did not believe that there was a disc herniation at that time. (Ex. 13-8).

After being informed by the insurer that claimant worked for the employer for a period of approximately one week, Dr. Silverman concluded that he did not feel that "whatever happened in that one week of employment necessarily led to his having a herniated disc." Dr. Silverman stated that he was "not sure what the etiology is." (Ex. 13-16). Finally, because Dr. Silverman originally diagnosed claimant's condition as a back spasm and claimant was later diagnosed with a herniated disc, Dr. Silverman had a "supposition" that something happened in the interim (following claimant's employment at the bakery) to lead to the herniated disc. (Ex. 13-7). Dr. Silverman clarified that, if claimant had suffered a strain on July 30 or July 31, 1998, it had resolved by the time of the August 10, 1998 examination.

Dr. Silverman acknowledged in his deposition that he changed his opinion regarding causation. (Ex. 13-21). Dr. Silverman based his change of opinion on the fact that, after reviewing his records, he found that neither he nor his associate found that claimant had evidence of a herniated disc after the July 31 incident. (Ex. 13-24). Accordingly, because Dr. Silverman changed his opinion and his final statement indicates that he was unsure of the etiology of claimant's herniated disc, we conclude that his opinion does not support compensability. Moreover, there is no other expert medical opinion in the record that supports claimant's case. Accordingly, we conclude that claimant has failed to meet his burden of proof. ORS 656.005(7)(a)(B); ORS 656.266.

Because claimant has not proven compensability, we reverse the ALJ's order. We also reverse the ALJ's assessed attorney fee award.

ORDER

The ALJ's order dated November 12, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

March 10, 2000 Cite as 52 Van Natta 391 (2000)

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
Own Motion No. 00-0051M
OWN MOTION ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant seeks Board authorization of an approved fee for his attorney's services culminating in our February 18, 2000 Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amount of 25 percent of the increased temporary disability compensation is awarded under this order, not to exceed $1,500, payable by the carrier directly to claimant's attorney. *See* OAR 438-015-0080.

Accordingly, our February 18, 2000 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our February 18, 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
ALAN J. PARKER, Claimant
WCB Case No. 99-03784
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's current bilateral shoulder conditions. 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 primarily out of state from early February 1998 until early June 1998. His left shoulder problems worsened and he began having right shoulder problems during this time. (Tr. 22-26).

CONCLUSIONS OF LAW AND OPINION

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

Claimant objects to the employer's denials as procedurally improper under ORS 656.262(6)(c), citing *Croman Corp. v Serrano*, 163 or App 136 (1999) (the carrier must have accepted a combined condition in order for a pre-closure denial of a combined condition to be procedurally proper under ORS 656.262(6)(c) and 656.262(7)(b)). The employer responds that we should not address the propriety of the denial, because claimant did not raise the issue at hearing.

Our review of the record reveals that claimant did not argue that the employer's denial was procedurally defective at hearing. On the contrary, the parties agreed at the outset of the hearing that the issue to be litigated was the compensability of claimant's bilateral shoulder conditions. They also agreed that the outcome depends on the persuasive medical evidence. (*See* Tr. 5-13). Under these circumstances, we are not inclined to address claimant's procedural objection, because it is first raised on review.[1] *See Fred Meyer, Inc. v. Hofstetter*, 151 Or App 21, 24 (1997) ("It is generally recognized that the Board has discretion on whether to reach issues not raised before the ALJ."). In any event, we need not conclusively resolve this procedural challenge to the denial because we find the claim compensable on substantive grounds.

In other words, on the merits, we agree with the ALJ that the opinion of Dr. Puziss, treating surgeon, is persuasive. (*See* Exs. 28A-3, 31A, 31B-2, 41A-1, 44A, 47). Accordingly, based on Dr. Puziss' opinion, we conclude that claimant's shoulder conditions are compensable. *See* ORS 656.005(7)(a)(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 $2,100, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's uncontested statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[1] Parenthetically, we note that the employer apparently acknowledges that it *did* accept a combined condition when it accepted claimant's bilateral tendinitis. (Reply Brief, p. 2; *see* Ex. 39).

ORDER

The ALJ's order dated September 10, 1999 is affirmed. For services on review, claimant is awarded a $2,100 attorney fee, payable by the self-insured employer.

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

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 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 today's date, 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 condition and ensuing medical treatment for which claimant requests own motion relief, remains in denied status, and is the responsibility of a subsequent insurer. 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
RONALD W. WHITTED, Claimant
WCB Case No. 98-07685
ORDER ON REVIEW
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Livesley's order that dismissed his request for hearing. On review, the issue is the propriety of the dismissal order.

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

Claimant, through counsel, requested a hearing on September 24, 1998, challenging an August 14, 1998 denial of his occupational disease claim. A hearing was scheduled on December 23, 1998, but was postponed. The hearing was then rescheduled for March 23, 1999, but was again postponed so that claimant could find new counsel after his former attorney withdrew his representation.

The matter was rescheduled for hearing on September 29, 1999. On that date, claimant appeared without counsel and sought additional time to find legal representation. The ALJ granted a two-week postponement over the objection of the self-insured employer to allow claimant more time to find counsel. Claimant or his counsel was instructed to report to the ALJ within this time frame. If this did not occur, claimant was advised that the case would be dismissed. In an October 12, 1999 letter to claimant memorializing conversations at the September 29, 1999 hearing, the ALJ reiterated that claimant had been instructed to contact no fewer than four attorneys specializing in workers' compensation law.

After receiving no contact from either claimant or legal counsel, the ALJ then contacted claimant by telephone on October 19, 1999. Claimant advised the ALJ that he was unable to find an attorney to represent him or obtain a medical report supporting the claim. The ALJ informed claimant that he would be entering an order dismissing the claim. The ALJ issued an order dismissing the hearing request on November 23, 1999 for "want of prosecution."

In his brief to the Board, claimant explained that he had contacted attorneys and that he was told by one attorney that "it was too much work to get the case going" and that "he did not want to jump in the middle of the case."

Although claimant's "brief" once more states that he was unable to obtain counsel, the ALJ's October 12, 1999 letter, as well as his dismissal order, clearly state that claimant had two weeks from the date of the September 29, 1999 hearing to obtain a lawyer and that, if claimant or an attorney did not contact the ALJ, the matter would be dismissed. Claimant was also instructed to contact a minimum of four attorneys with experience in workers' compensation. Claimant did not comply with the ALJ's letter, nor does he provide on Board review the reasons for his noncompliance or a statement whether he contacted four attorneys as instructed. In light of this, we find that claimant has given no justification for his delay in retaining an attorney. Under such circumstances (and considering that the March 1999 hearing was postponed so that claimant could obtain counsel), we affirm the ALJ's dismissal order because claimant engaged in conduct that resulted in an unjustified delay in the hearing of more than 60 days.[1] *See* OAR 438-006-0071(1).[2]

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[1] We have interpreted a claimant's "post-hearing" correspondence after a hearing request has been dismissed for failure to appear as a motion for postponement of the scheduled hearing. In those cases, where the ALJ did not have an opportunity to rule on the motion, we have remanded to the ALJ for consideration of the motion. *See Randy L. Nott*, 48 Van Natta 1 (1996); *Olga G. Semeniuk*, 46 Van Natta 152 (1994).

Here, unlike other cases where we have remanded to ALJs to rule on a "post-dismissal order" request for postponement, claimant has not offered any reason not provided to the ALJ for his failure to retain an attorney in the time period detailed in the ALJ's October 12, 1999 letter. Under these circumstances, we find no compelling reason to remand to the ALJ for further proceedings. *See Glen A. Harbison*, 50 Van Natta 2157 (1998).

[2] OAR 438-006-0071(1) provides: "(1) A request for hearing may be dismissed if an Administrative Law Judge finds that the party that requested the hearing has abandoned the request for hearing or *has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days*. (Emphasis added).

ORDER

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

March 14, 2000 Cite as 52 Van Natta 395 (2000)

In the Matter of the Compensation of
LESLIE J. HART, Claimant
WCB Case No. 98-04496
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of claimant's injury claim for sternum fracture. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation. After our review of the record, we agree with the ALJ that the medical evidence is insufficient to establish compensability. Our reasoning is as follows.

Dr. Schilperoort, the insurer's examining physician, believed that the major contributing cause of claimant's sternal fracture was preexisting metabolic abnormalities created by claimant's eating disorder. Specifically, Dr. Schilperoort conjectures that the metabolic aberrancies caused by the eating disorders created sufficient osteoporosis in the sternum area to create a weakness. Claimant argues that Dr. Schilperoort's opinion is unpersuasive because the record does not support his conclusion that claimant had full blown osteoporosis. Rather, the record only establishes that claimant had osteopenia (low bone density).

While we agree that Dr. Schilperoort's opinion is not persuasive, the remainder of the medical evidence supporting compensability is also unpersuasive. Specifically, Dr. Cronin, an orthopedist who treated claimant, opined that there was no evidence of generalized bony disease and that claimant was simply of a frail build and was lifting heavily beyond her means and sustained a fracture of her sternum. In rendering his opinion, however, Dr. Cronin lacked the history that claimant had osteopenia, low bone mass. Because his opinion is based on an incomplete history, we do not find Dr. Cronin's opinion persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

Dr. Countiss' opinion is likewise insufficient to meet claimant's burden. Dr. Countiss opined that claimant's bone density study showed low bone mass (osteopenia) without actual osteoporosis. He indicated that this would contribute to, but not cause, a sternal fracture. We find Dr. Countiss' opinion unpersuasive because it acknowledges that the osteopenia contributes to the fracture, but does not evaluate the relative contributions of the bone condition and the work incident. As such, his opinion is not persuasive. *See Dietz v. Ramuda*, 130 Or App 387 (1994), *rev dismissed* 321 Or 416 (1995) (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). Accordingly, based on this record, we are not persuaded that claimant has established compensability.

ORDER

The ALJ's order dated August 13, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I respectfully dissent from the majority's opinion for the simple reason that when I review this record as a whole, I conclude that claimant has met her burden of proof to establish a compensable injury.

The majority opinion examines each medical opinion in isolation and finds flaws with each individual doctor. While it is true that none of the physicians' opinions in isolation meets claimant burden of proof, I believe that the medical opinions in combination persuasively establish compensability. Claimant's treating physicians, Drs. Cronin and Countiss, and the insurer's examining physician, Dr. Schilperoort, all have slightly differing information, opinions and ultimate conclusions. It is not necessary for one physician alone to render a flawless opinion that supports the compensability of a claim. Claimant can rely on a combination of medical opinions to establish compensability and does so in this case. When the medical evidence is read together in its entirety and in the context of this case, I am persuaded that claimant meets her burden of proof. For this reason, I respectfully dissent.

March 14, 2000 Cite as 52 Van Natta 396 (2000)

in the Matter of the Compensation of
JON E. BALL, Claimant
WCB Case No. 98-06366
ORDER ON RECONSIDERATION
Heiling & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our February 28, 2000 Order on Review which reversed in part the Administrative Law Judge's (ALJ's) order that had set aside the self-insured employer's denial of claimant's injury claim for a thoracic strain condition. The employer has responded to claimant's motion.

Claimant contends that we failed to defer to the opinions of his treating physicians, citing *Weiland v. SAIF*, 64 Or App 810 (1983). As we explained in our initial order, we find persuasive reasons not to defer to the opinions of claimant's treating physicians Drs. Rose and Jura. In particular, we found persuasive the fact that Dr. Schrunk, D.O., failed to diagnose a thoracic strain condition just five days after the April 9, 1998 injury. (Ex. 49). In diagnosing cervical and lumbar strains, Dr. Schrunk reported claimant's complaints of pain in his trapezius muscles that extended down from his neck. (*Id.*) These complaints were consistent with those reported to Dr. Rose the previous day. (Ex. 48).

Moreover, in our initial order, we found that claimant did not meet his burden of proving that his April 9, 1999 injury was a material contributing cause of an alleged thoracic strain. In this regard, we noted that the only supportive medical opinion for claimant came from Dr. Jura, whose opinion was conclusory and unexplained.

After reconsidering the record in light of claimant's motion and the employer's response, we continue to adhere to the conclusions reached in our prior decision.

Accordingly, our February 28, 2000 order is withdrawn. On reconsideration, as supplemented, we republish our February 28, 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
BARRY M. HENDRICKSON, Claimant
WCB Case No. 99-00923
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's injury claim for an L4-5 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, an auto mechanic, has worked for the employer since September 1991. (Tr. 7). On November 4, 1998, claimant had changed a water pump in a motor home and as he was stepping out of the motor home, he experienced a sudden, sharp twinge in his back. (Tr. 8-9). The step from the motor home to the ground was 24 inches. (Tr. 13).

Claimant sought medical treatment on November 12, 1998 and was initially diagnosed with a lumbosacral strain with sciatica. (Ex. 1). Lumbar spine x-rays in November 1998 showed bilateral L5 spondylolysis with grade 2-3 spondylolisthesis at L5-S1, moderately severe degenerative changes at L5-S1 and disk space narrowing with early degenerative changes at L3-4 and L4-5. (Ex. 2). A lumbar CT scan in November 1998 showed bilateral spondylolysis of L5 resulting in grade II spondylolisthesis with 50 percent anterolisthesis of L5 on S1 and a paracentral disk protrusion at L4-5. (Ex. 6). Dr. Jenkins diagnosed a herniated nucleus pulposus at L4-5 and he performed an L4-5 microdiskectomy on March 3, 1999. (Ex. 18).

Both parties agree that claimant has a preexisting back condition that combined with his November 4, 1998 work injury to cause or prolong his disability or need for treatment. Therefore, ORS 656.005(7)(a)(B) applies and claimant must prove that his November 1998 work injury was the major contributing cause of the disability or need for treatment of the combined condition. Claimant relies on the opinions of Drs. Jenkins and Ushman to establish compensability of his L4-5 disc herniation.

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). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). For the following reasons, we find persuasive reasons not to defer to the opinion of Dr. Jenkins or Dr. Ushman.

Dr. Jenkins first examined claimant on December 14, 1998. (Ex. 11). He explained that there were plain x-rays, lateral flexion x-rays and a CT scan of claimant's lumbar spine. (Ex. 11-2). Dr. Jenkins ordered new lateral flexion extension x-rays, which showed grade 3 L5-S1 spondylolisthesis and some retrolithesis at L4-5. (*Id.*) He noted that the CT scan showed a herniated left-sided disc at L4-5 and claimant also had a spina bifida occulta. (*Id.*) Dr. Jenkins reported that claimant had minimal symptoms in his spine prior to the disc herniation. (*Id.*) He believed this was a work-related injury and was not exacerbated by claimant's L5-S1 spondylolisthesis. (Ex. 11-3). Dr. Jenkins recommended a discectomy. (Ex. 11-2, -3).

On April 2, 1999, Dr. Jenkins responded to a letter from claimants attorney and stated that claimant had a herniated disk with radiculopathy at L4-5 and L5-S2 spondylolisthesis. (Ex. 20). Dr. Jenkins explained:

> "I believe that the industrial injury contributed to the herniated disk and did not contribute to the spondylolisthesis. I think the major cause for the herniated disk is the industrial injury that is greater than 51%. I do not think that the spondylolisthesis is directly related." (*Id.*)

In a later concurrence letter from claimant's attorney, Dr. Jenkins agreed that claimant's work injury was the major contributing cause of his herniated disc and need for surgery. (Ex. 24-1). Dr. Jenkins indicated that his opinion was based on several factors, including: (1) claimant had provided a cogent history that included an acute event, with subsequent radicular pain that was consistent with a diagnosis of a herniated disc; (2) claimant had a physical exam that was consistent with an acute onset of a herniated disc; and (3) claimant's extended posture and the hard, jarring step was sufficient to cause the protrusion. (*Id.*) Dr. Jenkins agreed that the L5-S1 spondylolisthesis was a separate diagnosis that was not the cause of claimants need for treatment. (Ex. 24-2). He did not treat or stabilize the spondylolisthesis in any way at the time of surgery. (*Id.*) Dr. Jenkins noted that the herniated disc was at L4-5, one vertebral level above the spondylolisthesis. (*Id.*) Finally, Dr. Jenkins agreed that his opinion on causation was bolstered by claimant's recovery after surgery. (*Id.*)

SAIF argues that Dr. Jenkins opinion is not persuasive because there is no evidence that he considered the relative contribution of claimant's preexisting degenerative disc disease in reaching his opinion on causation. SAIF acknowledges that Dr. Jenkins did discuss the fact that claimants L5-S1 spondylolisthesis was not the cause of the L4-5 herniation, but SAIF contends there is no evidence he considered the degenerative disc disease.

In his brief, claimant asserts that Dr. Jenkins had reviewed claimant's imaging studies and noted the L5-S1 spondylolisthesis, but did not comment on the minimal degenerative changes shown elsewhere in the lumbar spine. Claimant argues that Dr. Jenkins deemed these changes too insignificant to be factors in his causation analysis. (Claimants brief at 5).

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). 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).

Claimant's lumbar spine x-rays in November 1998 showed bilateral L5 spondylolysis with grade 2-3 spondylolisthesis at L5-S1, moderately severe degenerative changes at L5-S1 and disk space narrowing with early degenerative changes at L3-4 and L4-5. (Ex. 2). A CT scan in November 1998 showed, among other things, mild narrowing of the L3-4 and L4-5 intervertebral disk spaces with severe narrowing at L5-S1. (Ex. 6). Claimant had mild degenerative disease at the facets of L3-4 and mild degenerative change of the facet joints at L4-5. (*Id.*)

The medical evidence from Drs. Tesar and Weinstein focused on the importance of claimant's preexisting back conditions, including his degenerative disc disease. Dr. Weinstein noted that, among other things, claimant had narrowing of the L4-5 interspace. (Ex. 7). Dr. Tesar diagnosed several preexisting conditions, including degenerative disc disease at L3-4, L4-5 and L5-S1. (Ex. 12-5, -6). He felt that significant preexisting abnormalities in the back were the major contributing cause of claimant's current condition and need for treatment. (Ex. 12-7). Dr. Tesar said that [n]ormal disks do not herniate and he explained that the herniation never would have occurred when claimant stepped out of the motor home had it not been for the disk degeneration and weakening of the disk that enabled it to herniate with some minor episode. (*Id.*) Dr. Weinstein, who had treated claimant in January 1999, concurred with Dr. Tesar's report. (Ex. 19C).

In contrast, we find no evidence that Dr. Jenkins considered the possible contribution of claimant's preexisting degenerative disc disease in deciding causation. Furthermore, we find no evidence to support claimant's assertion that Dr. Jenkins deemed those changes to be insignificant. There is no indication that Dr. Jenkins had considered (and possibly rejected) Dr. Tesar's December 22, 1998 causation opinion.

In *SAIF v. Strubel*, 161 Or App at 521-22, the court held that a physician's opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. In this case, we find nothing in the context of Dr. Jenkins' opinion to support the conclusion that he properly evaluated the relative contribution of claimant's degenerative disc disease. Although claimant may be correct that Dr. Jenkins felt that claimant's degenerative changes were "too insignificant" to be a factor in the causation analysis, our findings must be based on the medical evidence and the reasonable inferences that can be drawn from the medical evidence. *See SAIF v. Calder*, 157 Or App 224, 227 (1998).

In the present case, we find that the reports from Dr. Jenkins are insufficient to allow us to infer that he took into account all contributing factors, including claimant's lumbar degenerative disc disease, in determining causation. We conclude that Dr. Jenkins' opinion is not persuasive because he did not properly evaluate the relative contribution of the preexisting conditions and the work exposure and explain why the work exposure contributes more to the claimed condition than all other causes combined. *See Dietz*, 130 Or App at 401.

Claimant also relies on Dr. Ushman's opinion to establish compensability. We note, however, that Dr. Ushman relied on Dr. Jenkins' opinion on causation. Dr. Ushman said that Dr. Jenkins was an "expert" in spondylolisthesis, who had stated that claimant's work exposure caused the disc herniation. (Ex. 22). Based on claimant's history and Dr. Jenkins' opinion, Dr. Ushman concluded that claimant's disk herniation was caused by his work exposure. (*Id.*)

Dr. Ushman did not provide any independent explanation of the causation of claimant's L4-5 disc herniation. Rather, his opinion was based primarily on Dr. Jenkins' causation opinion. For the reasons we discussed above, Dr. Jenkins' opinion is not sufficient to establish that claimant's November 1998 work incident was the major contributing cause of claimant's disability or need for treatment. Likewise, because Dr. Ushman relied on Dr. Jenkins' opinion, we are not persuaded by Dr. Ushman's opinion on causation. Furthermore, in an earlier report, Dr. Ushman noted that claimant had "preexisting significant instability in the lumbar spine" and said that he was "not at all sure" whether or not claimant's injury was work-related. (Ex. 17-2). We find that Dr. Ushman's opinion is not sufficient to establish that claimant's work injury was the major contributing cause of his L4-5 disc herniation.

The remaining medical opinions do not support compensability. As we discussed earlier, Dr. Tesar felt that the significant preexisting abnormalities in the back were the major contributing cause of claimants L4-5 herniation. (Ex. 12-7). Dr. Tesar explained that claimant's herniation never would have occurred when he stepped out of the motor home had it not been for the disk degeneration and weakening of the disk. (*Id.*) Dr. Weinstein concurred with Dr. Tesars report. (Ex. 19C). In sum, we conclude that the medical evidence is insufficient to establish compensability of claimant's L4-5 disc herniation.

ORDER

The ALJ's order dated October 6, 1999 is reversed. SAIF's denial of claimant's L4-5 disc herniation is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Biehl dissenting.

The majority concludes that claimant's L4-5 disc herniation is not compensable. Because I disagree with the majority's evaluation of the medical evidence, I respectfully dissent.

After reviewing the record, I agree with the ALJ that claimant's November 4, 1998 work incident was the major contributing cause of his L4-5 disc herniation. The ALJ properly relied on the opinions of Drs. Jenkins and Ushman. As claimant's treating surgeon, the opinion of Dr. Jenkins is entitled to deference. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988) (treating physician's opinion was given greater weight because of his first-hand exposure to and knowledge of the claimant's condition). Likewise, as claimant's attending physician, the opinion of Dr. Ushman is entitled to deference. *See Weiland v. SAIF*, 64 Or 810, 814 (1983).

The ALJ correctly determined that claimant's preexisting degenerative disease at L4-5 was not significant. I agree with the ALJ that, although Dr. Jenkins did not specifically discuss claimant's preexisting degenerative disc disease in his medical causation reports, the record as a whole indicates that he considered and weighed the preexisting degenerative condition before rendering his opinion on causation. I would adopt and affirm the ALJ's order.

In the Matter of the Compensation of
QUINCY J. INMON, Claimant
WCB Case No. 99-04546
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's injury claim for cervical-thoracic sprain and a C5-6 disc conditions. On review, the issue is compensability.

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

Claimant treated with Dr. Burton, chiropractor, for neck, back, and right shoulder conditions (but not for right arm symptoms) from March 1995 through September 10, 1996. (Exs. 15-5-8). He did not receive chiropractic treatment from Dr. Burton from September 10, 1996 until October 5, 1998. (Ex. 15-9).

In June 1998, claimant was involved in a motor vehicle accident (MVA). He treated with Dr. Burton for symptoms from the MVA, including neck, shoulder, and right arm pain (extending to the elbow), from October 5, 1998 through October 31, 1998. Claimant missed a day or two from work because of a stiff neck after the MVA and before October 31, 1998, but he continued working without additional chiropractic treatment (and only occasional neck and shoulder stiffness), until February 12, 1999.

On the evening of February 11, 1999, claimant spent several hours lifting 40 pound buckets at work. He experienced the onset of new and worse symptoms, notified his supervisor, and left work early. The next day, Dr. Burton treated claimant for neck pain, ongoing right arm pain, and new right hand and arm symptoms. (Exs. 15-14, -17; *see* Tr. 15). Dr. Burton noted that claimant's condition was definitely worse at that time. Claimant told Dr. Burton about his lifting work the previous night, but the doctor did not record it in his contemporaneous notes. (Ex. 15-12-13).

The medical evidence indicates that claimant's work activities on February 11, 1999 were probably the major contributing cause of his cervical-thoracic sprain and C5-6 disc conditions, based on claimant's history and clinical findings. (Exs. 11, 13-15). Based on claimant's credible testimony and the medical evidence (which is based on an accurate history regarding claimant's symptoms and activities), we agree with the ALJ that the claim is compensable. *See Deborah R. Smith*, 50 Van Natta 2443, 2444 (1998) (the claimant's failure to attribute her symptoms to the work injury not fatal (or detrimental) to her claim, because she was not charged with correctly identifying the cause of her problem).

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 November 9, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

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[1] The ALJ's findings are corrected to indicate that claimant was involved in a motor vehicle accident in July 1998, rather than October 1998.

In the Matter of the Compensation of
JOHN C. MELICK, Claimant
WCB Case No. 98-06356
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for his L4-5 and L5-S1 disc condition; (2) declined to award interim compensation; and (3) declined to assess penalties or attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability, aggravation, interim compensation, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.[1] We write only to address claimant's contention that he is entitled to interim compensation.

Specifically, claimant asserts that he was entitled to interim compensation from the time the employer had notice of his claim (May 18, 1998) until the claim was denied (September 11, 1998). (App.Br. 7; Reply Br. 6-7). The employer asserts that claimant waived his right to review of this issue because he neither referenced the issue in his closing argument nor sought reconsideration of the ALJ's order that declined to award interim compensation. (Resp.Br. 10-11).

We need not resolve the employer's waiver argument because, even if claimant did not waive the interim compensation issue, he would not be entitled to such an award. We base our conclusion on the following reasoning.

Claimant's entitlement to interim compensation depends on when the carrier received notice or knowledge of a medically verified inability to work in a medical report that satisfies the requirements of ORS 656.273(3). *See Russell D. Parker,* 49 Van Natta 83 (1997); *see also Ronda G. Prewitt,* 49 Van Natta 831 (1997). ORS 656.273(3) requires that the claim for aggravation be in writing in a form and format prescribed by the Director and signed by the worker or the worker's representative. The statute further requires that the aggravation claim "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.*" (Emphasis added).

Here, claimant was taken off work by his treating physician, Dr. Sedgewick, on May 12, 1998. (Ex. 18). On May 15, 1998, Dr. Sedgewick completed and filed a Notice of Claim for Aggravation and attached his chart notes to the form. (Ex. 16; 18; 19). The employer received the Notice of Claim for Aggravation form with attachments on May 18, 1998. (Ex. 19).

While the chart notes reported that claimant had some limitations with lateral bending and hyperextension and documented slight pain, those findings were not expressly related to claimant's 1996 accepted strain. (Ex. 16). Additionally, Dr. Sedgewick, under the heading "Impression," noted claimant suffered from degenerative disk disease at the L4-5 and L5-S1 level and further noted that a MRI was needed for final diagnosis. (Ex. 16). Therefore, although the attached chart notes provided medical verification of claimant's inability to work, the submitted materials did not provide prima facie evidence of a compensable worsening; *i.e.* the chart notes did not include a medical opinion/report that claimant's 1996 compensable strain condition had pathologically worsened.[2] Accordingly, we conclude that claimant was not entitled to interim compensation.

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[1] We note claimant does suffer from a preexisting degenerative disc disease. (Exs. 16; 21; 24; 25; 26; 27). Arguably, therefore, the major contributing cause standard applies under either a theory of a combined condition or a consequential condition. However, we do not need to decide this issue in that, even assuming the standard of material contributing cause does apply, we agree with the ALJ's conclusion that claimant did not meet even this lower burden of proof.

[2] We do not require the materials submitted by physicians to use legal terminology in order to establish prima facie evidence of a pathological worsening of a previously accepted condition. Rather we rely on the physician to provide documented medical evidence that gives some indication that claimant has experienced a worsening of a previous condition so that we may conclude by reviewing those materials that claimant has submitted prima facie evidence.

In light of our conclusions upholding the denials of claimant's claims for consequential condition, combined condition, aggravation and interim compensation there are no amounts then due on which to assess a penalty, and there has been no unreasonable resistance to the payment of compensation giving rise to an attorney fee. ORS 656.262(11); ORS 656.382(1). For this reason, we affirm the ALJ's decision that claimant is not entitled to penalties and/or attorney fees for the employer's allegedly unreasonable claims processing.

ORDER

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

Board Member Phillips Polich dissenting.

The majority found that since Dr. Sedgewick's notes did not provide evidence of a pathological worsening of claimant's accepted strain condition, the Notice of Aggravation did not trigger the employer's obligation to pay interim compensation. I disagree with the majority's opinion finding claimant not entitled to temporary disability benefits. Consequently, I must respectfully dissent.

Here, claimant was taken off work by his physician, Dr. Sedgewick, on May 12, 1998 and his employer received the Notice of Aggravation form with Dr. Sedgewick's notes attached on May 18, 1998. I recognize that Dr. Sedgewick's notes did not use the magic words "pathological worsening" or "actual worsening" in evaluating claimant's current condition. It is well settled, however, that magic words are not necessary provided the opinion otherwise meets the appropriate legal standard. *See Freightliner Corp. v. Arnold,* 142 Or App 98 (1996); *McClendon v. Nabisco Brands, Inc.,* 77 Or App 412 (1986).

Moreover, it is unreasonable to expect, or require, physicians to use workers' compensation legal terminology in order to determine whether claimant has provided *prima facie* evidence of an aggravation claim. Rather, it is the carrier's responsibility to assess the information provided by the physician and to determine if such evidence has been submitted. The absence of "magic words" does not support a conclusion that *prima facie* evidence has not been submitted. Consequently, I believe that Dr. Sedgewick's notes met the standard required for claimant's aggravation claim for his disc condition.

Therefore, the employer had notice of the aggravation claim on May 18, 1998. I believe that knowledge was sufficient to lead a reasonable employer to conclude that workers' compensation liability was a possibility. *See Argonaut Ins. v. Mock,* 95 Or App 1 (1989); *Arthur L. Ennis,* 43 Wan Natta 1477 (1991). Thus, I conclude the employer was obligated to begin payment of interim compensation within fourteen days of its receipt of the Notice of Aggravation until it issued its denial of the claim on September 11, 1998. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
TED B. MINTON, Claimant
WCB Case No. 99-03039
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the insurer's denial of claimant's aggravation claim for his current rectus abdominous strain condition; and (2) declined to award penalties for an allegedly unreasonable resistance to the payment of compensation. The insurer cross-requests review of that portion of the ALJ's order that found that the aggravation claim was not precluded by *res judicata.* On review, the issues are *res judicata,* aggravation, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Reasoning and Conclusions," with the exception of the partial paragraph set forth at the top of page 6 beginning with the words, "and it is my judgment..". We add the following supplementation.

On review, claimant contends that the ALJ substituted her own medical judgment for that of the experts in this case. However, the ALJ essentially found that the opinions of Dr. Rambousek, claimant's treating doctor and Dr. Davison, chiropractor, were not persuasive because they did not distinguish between symptoms related to the accepted rectus abdominous strain and symptoms related to the inguinal condition.[1] *See* Exs. 31A, 42A, 51, 55A.

Dr. Braun, a urologist who examined claimant on behalf of the insurer, found that claimant complained of pain from the "left groin, up along the left side of his abdomen, to the chest wall, and over to the right side of the abdomen and the upper abdomen." Dr. Braun noted that claimant's records contained a "discussion of left groin fascial disruption, which would be consistent with [claimant's] hernia repair." (Ex. 57-2). However, Dr. Braun was unable to identify any objective findings with regard to the rectus strain and he stated that there was no basis to conclude that claimant had a pathologic worsening of his abdominal musculature. (Ex. 57-4).

Dr. Puziss found that claimant's problems were in his left groin which dated to the 1994 injury. Although Dr. Puziss noted a defect seen in the rectus abdominous, his diagnosis listed: 1) history, left groin strain (1994); 2) scar tissue versus possible other soft tissue abnormality, left groin; 3) cannot rule out small, direct inguinal hernia, or femoral hernia; 4) tender, left spermatic cord. (Ex. 44F).

Accordingly, the opinions of Drs. Braun and Puziss attribute claimant's condition to findings other than a worsened abdominous condition. In light of their expert medical opinions, we are not persuaded by the opinions of Drs. Rambousek and Davison; we conclude that the experts relied on by claimant are not persuasive due to their failure to distinguish between symptoms due to the accepted condition and symptoms due to noncompensable factors. Therefore, we agree with the ALJ that claimant has not shown an "actual worsening," as required by ORS 656.273(1).[2]

ORDER

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

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[1] Claimant had a hernia repair at age 12 and has a left inguinal strain that occurred in 1993 and was accepted by another insurer.

[2] In light of our conclusion on the merits of this case, we need not address the insurer's *res judicata* argument, nor claimant's request for a penalty.

March 14, 2000 Cite as 52 Van Natta 403 (2000)

In the Matter of the Compensation of
DANIEL G. PUGH, Claimant
WCB Case No. 99-03946
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's injury claim for a cervical condition and left-sided radiculopathy. Claimant cross-requests review of that portion of the order that did not award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order with the following exception and supplementation concerning the penalty issue.

We do not find that claimant *provided* physicians with inconsistent histories about whether a particular work incident led to his worsened symptoms. Instead, we conclude that the insurer had a legitimate doubt about its liability for the claim, based on claimant's recent "pre-injury" neck problems and Dr. Brett's delayed recognition of the January 6, 1999 neck twisting incident.

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

ORDER

The ALJ's order dated September 17, 1999 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by the insurer.

In the Matter of the Compensation of
EUGENE I. BISCEGLIA, Claimant
WCB Case Nos. 98-08367 & 98-07329
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration finding that claimant's claim was prematurely closed. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

At the time of claim closure, the following condition was in accepted status: Medial collateral ligament tear. (Ex. 31). In order to establish that his claim was prematurely closed, claimant must carry the burden of proving by a preponderance of the evidence that the above-listed condition was not medically stationary on June 25, 1998, the date of claim closure. *See Berliner v. Weyerhaeuser Co.*, 54 Or App 624, 628 (1981). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). We conclude that claimant has not carried his burden of proof.

On May 13, 1998, Dr. Neitling, orthopedist, examined claimant at the self-insured employer's request. Dr. Neitling's clinical examination resulted in his conclusion that claimant had a partial tear of the anterior cruciate ligament and he opined that claimant's continuing symptoms resulted from that injury-related condition, with some of his pain possibly secondary to gradual degenerative changes in the medial compartment due to his varus deformity. (Ex. 27-5, -6). Dr. Neitling further opined that claimant was medically stationary. Dr. Neitling did not think that further active treatment would alter the course of natural progression of the right knee pain syndrome. (Ex. 27-7). Dr. Neitling did think that claimant's work-related impairment (diminished flexion of the right knee, weak quadriceps extension, and limitation on repetitive use) would improve. (*Id.*) Dr. Neitling also recommended a stabilizing brace to lessen the forces on the torn anterior cruciate ligament. (*Id.*)

Dr. Thomas concurred with Dr. Neitling's report, including his findings of a medial meniscal tear and a partial tear of his anterior cruciate ligament, and performed a closing examination on May 22, 1998. (Exs. 28, 29). Dr. Thomas found decreased right knee flexion and mild tenderness over the medial jointline. Dr. Thomas established a permanent 30-pound lifting restriction, with the expectation that claimant's symptoms would wax and wane. (Ex. 29).

On June 12, 1998, claimant sought treatment at an emergency room for recurrent right knee pain, for which he was treated with a brace and pain medication. (Ex. 30).

After reviewing the medical opinions in the record, we conclude that claimant has not carried his burden of proving that the accepted torn medial meniscus condition was not medically stationary at the time of claim closure. Both Dr. Neitling and Dr. Thomas found claimant medically stationary. Although both doctors attributed claimant's chronic right knee pain to the partially torn anterior cruciate ligament, that condition is not an accepted condition. As we held in *James L. Mack*, 50 Van Natta 338 (1998), 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.[1]

Because the medically stationary status of the non-accepted condition is irrelevant to the premature closure determination, claimant has not carried his burden of proving his claim was prematurely closed. Accordingly, we conclude that the June 25, 1998 Notice of Closure properly closed the claim.

Finally, we note that the parties stipulated at hearing that the claim had been reclosed by a March 5, 1999 Notice of Closure that reduced claimant's scheduled permanent disability award to 15 percent. (Tr. 2). The parties agreed that, if the claim was not prematurely closed, then the 17 percent scheduled permanent disability awarded by the June 25, 1998 Notice of Closure should be reduced to 15 percent. We accordingly modify the June 25, 1998 Notice of Closure to award 15 percent scheduled permanent disability for loss of use or function or the right leg (knee).

ORDER

The ALJ's order dated April 20, 1999 is reversed. The Order on Reconsideration is reversed, and the July 25, 1998 Notice of Closure is reinstated and modified to award 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee).

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[1] We further held in *Mack* that an evaluation of condition(s) accepted after claim closure must await the reopening and processing of the claim for the new condition(s). 50 Van Natta at 338. In reaching those conclusions, we relied primarily on ORS 656.262(7)(c), which states, in part, that "if a condition has been found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

In the Matter of the Compensation of
JOHN W. BLANKENSHIP, Claimant
WCB Case Nos. 98-07177, 98-07176, 98-03014, 98-06462, 98-06219 & 98-05949
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Steven T. Maher, Defense Attorney
Zimmerman & Nielsen, Defense Attorneys
John E. Snarskis, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation, on behalf of Knorr Steel Framing Systems (SAIF/Knorr), requests review of those portions of Administrative Law Judge (ALJ) Johnson's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for a bilateral hearing loss; (2) upheld Liberty Northwest Insurance Corporation's responsibility denial, on behalf of Praegitzer Industries, Inc. (Liberty/Praegitzer), for the same condition; (3) upheld EBI Insurance Company's responsibility denial, on behalf of Brookman Cast Industries (EBI/Brookman), for the same condition; (4) upheld SAIF's responsibility denial, on behalf of Pacific Safety Supply (SAIF/Pacific), for the same condition; (5) upheld Industrial Indemnity Co.'s responsibility denial, on behalf of Brown and Danton (Industrial/Brown), for the same condition; and (6) upheld SAIF's responsibility denial, on behalf of Terra Electric Construction (SAIF / Terra), for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

Claimant was employed from 1981 until August 19, 1994 at SAIF/Knorr. From 1981 to 1983, he operated extremely noisy 40-ton and a 20-ton pneumatic ram presses that punched holes in steel. He wore soft ear plugs only occasionally. After 1983, he began working as production manager. He did not wear ear protection when overseeing activities on the production floor.

Claimant did not work from August 19, 1994 until March 1, 1995.

From March 1, 1995 to June 6, 1995, claimant worked at SAIF/Terra as a purchasing agent, doing office work. No hearing protection was required or worn in this office environment. (Ex. 4A-2, -3).

From June 22, 1995 through September 12, 1995, claimant worked for SAIF/Brown, a temporary agency. For about three weeks during this period he worked in a very noisy environment at Hampton Lumber, where he always wore required hearing protection. Claimant was also assigned to the Boise Cascade container plant, where he drove a fork lift. He always wore required hearing protection at Boise. (Tr. 18, 19).

From September 1995 until March 1996, claimant worked for Pacific Safety Supply as a purchasing agent doing office work, inputting data into the computer and answering telephones. (Ex. 4A-3).

From March 1996 until September 1996, claimant worked for EBI/Brookman as a shipping clerk, working primarily near the loading dock. (Tr. 25). The environment was noisy, but he worked at the far end of the building away from the machinery and stood by an open bay door. (Ex. 4A-3). Claimant felt the noise traveled out the opening without affecting his hearing much. (*Id.*) On July 25, 1996, EBI/Brookman tested claimant's hearing. That test revealed that claimant had sustained high-frequency hearing loss in both ears, left greater than right.

On September 6, 1996, claimant began working for Kelly Temporary Employment Services, which assigned him to Praegitzer Industries in the print room. The environment was not noisy and no hearing protection was required. (Ex. 4A-3). Kelly Temporary Services is not a party to this proceeding.

On December 8, 1996, claimant was hired by Liberty/Praegitzer and worked there until April 16, 1998. In December 1997, claimant was transferred to the drill room. He operated a drilling machine that generated high levels of noise. (*Id.*) Claimant wore hearing protection (earplugs and earmuffs over them) as a driller. (*Id.*)

Claimant's hearing worsened between 1994 and 1998. He did not miss work or seek medical treatment. On February 12, 1998, he filed a hearing loss claim with SAIF/Knorr. (Ex. 2) On March 3, 1998, he underwent an audiologic evaluation that confirmed his hearing loss. (Ex. 4). On March 31, 1998, claimant's hearing was evaluated for SAIF by Dr. Ediger, audiologist. (Exs. 6, 7). On April 15, 1998, SAIF/Knorr denied compensability and responsibility. (Ex. 8).

On April 17, 1998, claimant began working for Vick West Steel at a desk job, where he was employed at the time of hearing. Vick West is not a party to this proceeding.

Industrial/Brown and EBI/Brookman each denied responsibility. (Exs. 13, 14a). Liberty/Praegitzer, SAIF/Pacific, and SAIF/Terra each denied compensability and responsibility. (Exs. 16, 18a, 18b).

Claimant's hearing stayed the same or improved between the July 1996 and March 1998 hearing tests.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's bilateral hearing loss was due in major part to his work activities over the past 18 years. The ALJ applied the last injurious exposure rule in assigning responsibility. The ALJ determined that Liberty/Praegitzer was initially responsible for claimant's bilateral hearing loss because claimant first sought treatment while working for that employer. *See Timm v. Maley*, 125 Or App 396, 401, *rev den* 319 Or 81 (1994) (if a claimant receives treatment for a compensable condition before experiencing time loss, the date the claimant received treatment for the compensable condition is considered the "onset of disability").

The ALJ further determined that there was no evidence that claimant's condition worsened subsequent to his work at Liberty/Praegitzer. The ALJ then found that, although the medical evidence failed to establish that it was impossible for claimant's work at Liberty/Praegitzer to have contributed to his hearing loss, it did establish that claimant's employment prior to that at Liberty/Praegitzer was the sole cause of the condition. Finally, the ALJ concluded that the medical evidence established that the actual cause of claimant's condition was his work at SAIF/Knorr. Accordingly, the ALJ assigned responsibility to SAIF/Knorr.

On review, SAIF/Knorr argues that the ALJ erred in his application of the last injurious exposure rule for two reasons: First, that Liberty/Praegitzer failed to prove that it was impossible for its working conditions to have contributed to claimant's hearing loss or that SAIF/Knorr was the sole cause of that condition. Second, SAIF/Knorr argues that, even if Liberty/Praegitzer proved either prong of the rule, thus escaping responsibility, the medical evidence indicates that claimant's work activities with other employers between SAIF/Knorr and Liberty/Brookman could have contributed to his hearing loss. Thus, SAIF/Knorr contends that it would not be responsible under the application of the rule. We disagree, for the following reasons.

A presumptively responsible insurer[1] may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused the disease in this particular case or (2) that the disease was caused solely by conditions at one or more previous employments. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997).

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[1] The ALJ correctly assigned initial responsibility to Liberty/Praegitzer, based on claimant's March 31, 1998 hearing loss evaluation by Dr. Ediger. *Bracke v. Baza'ar*, 293 Or 239, 248 (1984) (the "onset of disability" is the triggering date for determining which employment is the last potentially causal employment); *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994) (if the injured worker receives medical treatment before experiencing time loss due to the condition, then the date of first medical treatment is determinative for assigning initial responsibility for the claim).

The ALJ also correctly determined that Liberty/Praegitzer, as the presumptively responsible insurer, did not shift responsibility to the subsequent employer, Vick West Steel, because there was no medical evidence that claimant's condition had worsened at Vick West. *See Boise Cascade Corp. v. Starbuck*, 296 Or 238, 243 (1984); *Timm*, 134 Or App at 249; *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992) (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).

The cause of claimant's bilateral hearing loss condition is a complex medical question, the resolution of which requires expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967). Here, two experts rendered opinions concerning the cause of claimant's condition, Dr. Ediger, audiologist, and Dr. Hodgson, otolaryngologist.

Relying on claimant's history of noise exposures, Dr. Ediger concluded not only that the major contributing cause of claimant's bilateral hearing loss was the industrial noise exposure at SAIF/Knorr between 1981 and 1983, but that claimant's work at that employment through 1994 was the last noise exposure sufficient to have caused his hearing loss, because he was exposed to excessive noise every day and was not consistent in his use of hearing protection. (Exs. 7, 14). Dr. Ediger also determined that claimant's employments after 1994, including that at Liberty/Praegitzer, did not involve excessive noise exposure without the use of hearing protection and, for that reason, would not have caused claimant's hearing to worsen. (*Id.*)

When questioned by SAIF specifically in regard to employments between March 1995 and September 1996, Dr. Ediger stated that it was "not impossible" for any of these periods of employment to have contributed to claimant's hearing loss. (Ex. 20A). But after Dr. Ediger compared the 1996 and 1998 hearing tests that showed that claimant's hearing had improved after 1996, he stated that it was highly improbable that claimant's work at Liberty/Praegitzer could have contributed to his hearing loss. (Exs. 21, 22).

Like Dr. Ediger, and for the same reasons, Dr. Hodgson opined that the major contributing cause of claimant's hearing loss was his noise exposure at SAIF/Knorr. (Exs. 15, 20). Dr. Hodgson had also concluded that, on the basis of the decibel levels of the drilling machines at Liberty/Praegitzer, the noise exposure there was not injurious and did not contribute to a worsening, particularly because claimant performed that job for only a short time and wore personal noise protection. (Ex. 15).

When initially asked by SAIF about the contribution to claimant's hearing loss by his work exposure after leaving SAIF/Knorr, Dr. Hodgson admitted that he was unable to say that all employment subsequent to claimant's work exposure at SAIF/Knorr had "absolutely no contribution." (Ex. 20). To the contrary, the doctor agreed that subsequent employment "could have" contributed to claimant's hearing loss. (*Id.*) But, like Dr. Ediger, after Dr. Hodgson compared the 1996 and 1998 hearing tests and found that claimant showed a greater hearing loss in 1996 than in 1998, he concluded that claimant's hearing did not worsen during that time and that claimant's work at Liberty/Praegitzer did not contribute to a worsening of his hearing loss. (Ex. 20B).

Dr. Hodgson further explained that, in terms of medical probability, it was "highly unlikely" that claimant's work activity subsequent to SAIF/Knorr caused or contributed to any additional hearing loss, and that claimant's hearing loss had been stable since then. (Exs. 23; 24-26, -27). Finally, during his deposition, Dr. Hodgson agreed that it was impossible to say for certain that all of the hearing loss was caused before 1994, and admitted that, without audiogram evidence to establish that claimant's hearing did not worsen after leaving SAIF/Knorr in 1994, it was possible that claimant's hearing could have worsened between that time and the July 1996 test. (Ex. 24-22, -28).

Upon comparing the 1996 and 1998 hearing evaluations, which showed that claimant's hearing improved or stayed the same during that period, both Dr. Ediger and Dr. Hodgson determined that no hearing loss occurred while claimant was employed by Liberty/Praegitzer. *See SAIF v. Paxton*, 154 Or App 259, 265 (1998) (citing *Long*, the court found that, read as a whole, the medical record established that the claimant sustained no hearing loss while employed by a particular employer and, thus, that employer could not legally be the responsible employer on the claim); *on remand Conrid J. Paxton*, 50 Van Natta 1709 (1998). Instead, the sole work-related cause of claimant's hearing loss were his employments prior to July 25, 1996.

Consequently, responsibility shifts from Liberty/Praegitzer to insurers on the risk prior to July 25, 1996. Because both Dr. Ediger and Dr. Hodgson indicated that it was not impossible for claimant's employments between 1994 and the July 25, 1996 hearing test to have contributed to claimant's hearing loss, responsibility shifts to the next prior employer, EBI/Brookman.

Therefore, in order to shift responsibility to an earlier employer, EBI/Brookman must prove that a prior employment or employments were the sole cause of claimant's hearing loss. As discussed above, both Dr. Ediger and Dr. Hodgson identified SAIF/Knorr as the primary contributor to claimant's

condition. Claimant has consistently given a history of being exposed to excessive noise from 1981 through 1983 and lesser exposure thereafter, until 1994. Claimant has also consistently given a history that his subsequent employments after SAIF/Knorr did not involve excessive noise and that he wore hearing protection.

Dr. Ediger determined that claimant's employments after 1994 did not involve excessive noise exposure without the use of hearing protection and, for that reason, would not have caused claimant's hearing to worsen. Moreover, Dr. Hodgson thought it "highly unlikely" that claimant's work activity subsequent to SAIF/Knorr caused any additional hearing loss, concluding that claimant's hearing loss had been stable since then. In other words, both doctors opined that claimant's industrial hearing loss occurred prior to 1994. *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). Accordingly, we find that EBI/Brookman is not responsible for claimant's hearing loss because, based on Dr. Ediger's and Dr. Hodgson's medical opinions, it has established that the sole cause of claimant's hearing loss was employment prior to March 1996, when it assumed the risk. Therefore, responsibility shifts to employment prior to that date.

The same "sole cause" analysis and the same medical evidence is applicable to shift responsibility to each prior employer.[2] Therefore, because SAIF/Knorr cannot establish that prior employment was the sole cause of claimant's hearing loss or that it was impossible for claimant's employment while it was on the risk to have contributed to claimant's hearing loss condition, SAIF/Knorr is responsible for claimant's work-related hearing loss. *See Long*, 325 Or at 308.

Because both compensability and responsibility were decided by the ALJ, and by virtue of the Board's *de novo* review authority, compensability remained at risk on review as well. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 248, 252-53 (1992), *mod on recon*, 119 Or App 447 (1993); *Dilworth v. Weyerhaeuser Co.*, 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by SAIF. *See International Paper Co. v. Riggs*, 114 Or App 203 (1992); *Cigna Insurance Companies v. Crawford & Company*, 104 Or App 329 (1990); *Burton I. Thompson*, 48 Van Natta 866 (1996). Moreover, inasmuch as claimant has finally prevailed against SAIF/Knorr's responsibility denial and because the ALJ's order did not award an attorney fee for this issue, claimant's counsel is entitled to an attorney fee pursuant to ORS 656.308(2)(d).

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 $1,750 and $1,000 at hearing and on review for prevailing on the responsibility issue, both awards payable by SAIF/Knorr. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's uncontested statement of services, the record, and claimant's respondent's brief), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The ALJ's order dated July 9, 1999, as corrected July 13, 1999, is affirmed. For services on review, claimant's counsel is awarded a fee of $1,750, payable by the SAIF Corporation/Knorr. For services at hearing and on review regarding the responsibility issue, claimant's counsel is awarded $1,000, also payable by SAIF/Knorr.

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[2] *I.e.*, from EBI/Brookman to SAIF/Pacific (on the risk from September 1995 until March 1996); from SAIF/Pacific to SAIF/Brown (on the risk from June 22, 1995 through September 12, 1995); from SAIF/Brown to SAIF/Terra (on the risk from March 1995 to June 6, 1995); and, finally, from SAIF/Brown to SAIF/Knorr, on the risk from 1981 to 1994, during the period that Dr. Ediger and Dr. Hodgson stated that claimant's hearing loss occurred.

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

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its denial of claimant's claim for her right shoulder injury; and (2) awarded an assessed attorney fee of $4,500 for claimant's counsel's services at hearing. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact with the exception of the sentence in the second paragraph of the section stating that, "During the morning of January 6, 1999, claimant's right shoulder temporarily subluxated when she caught her hand as she was leaned over a table reaching to wipe spilled oil off a headboard." We also do not adopt the Findings of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had a compensable right shoulder injury that combined with her preexisting condition. The ALJ relied on the opinion of claimant's treating doctor, Dr. Hefele, and Dr. Irvine, a surgeon who performed claimant's right shoulder surgery. The ALJ found that the opinions of Drs. Hefele and Irvine established compensability. For the following reasons, we do not agree that claimant has met her burden of proof.

The record establishes that claimant has had prior incidents involving subluxation and "clicking" of her right shoulder. At hearing, claimant testified that, prior to the January 6, 1999 incident at work, she had not had any shoulder problems (other than "clicking") for approximately ten years. (Tr. 13). Two witnesses for the employer, however, testified that claimant informed them that she injured her shoulder at home prior to January 6, 1999. Specifically, Gary Michael, claimant's shop foreman, testified that claimant told him that she injured herself while oiling furniture at work. Claimant also told Mr. Michael that she injured herself "a couple days prior at home doing a similar operation--wiping something off, reaching out." (Tr. 29). Erik Swinney, the employer's manager, also testified that, on January 6, he noticed claimant applying towels to her shoulder and asked her why she was doing so. Claimant told Mr. Swinney that "she had injured her shoulder at home doing some reaching and scrubbing." (Tr. 37). Claimant denied that she told either Mr. Swinney or Mr. Michael that she injured herself at home two days prior to January 6. (Ex. 41).

After reviewing the testimony of the witnesses in this case, we do not find that it is possible to reconcile the conflicting statements of claimant and her supervisors.[1] *See, e.g., Charmaine A. Frazier*, 39 Van Natta 148 (1987) (The claimant failed to meet her burden of proof where her testimony could not be reconciled with the testimony of her supervisor). In this regard, we find no reason to reject the testimony of two different supervisors who both testified that claimant advised them of an injury just two days before she contended that she was injured at work. Therefore, based on the inconsistencies in the record, we find that claimant is not credible. Moreover, because there is no other evidence to corroborate claimant's contention that she injured herself at work on January 6, 1999, we do not find that she has met her burden of proof pursuant to ORS 656.266. *See Tabbatha G. Hubbs*, 51 Van Natta 1906 (1999) (where it is the claimant's burden to prove compensability of her claim by a preponderance of the evidence, corroboration of the circumstances of her injury is both material and relevant to the compensability issue, particularly in light of the employer's countervailing testimony).

Finally, because the expert medical evidence in this case is based on claimant's history and we have found that claimant is not credible, it follows that the medical evidence is not based on a complete or accurate history. *Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977). In addition to relying

[1] The ALJ made no credibility findings in this matter.

on claimant's history with regard to a January 6 injury, the doctors have not been informed of an injury occurring two days prior to that date. In light of claimant's preexisting subluxation condition, we find that such an omission is a further reason to reject the medical opinions as incomplete and inaccurate. Therefore, claimant has also failed to meet her burden of proving medical causation.

Accordingly, because claimant has failed to meet her burden of proof, we reverse the ALJ's order. The ALJ's attorney fee award is also reversed.

ORDER

The ALJ's order dated November 9, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

March 15, 2000 Cite as 52 Van Natta 411 (2000)

In the Matter of the Compensation of
LORENZO K. KIMBALL, Claimant
WCB Case No. 99-06601
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that reduced his scheduled permanent disability for loss of use or function of the right leg (knee) from 30 percent (45 degrees), as awarded by an Order on Reconsideration, to 17 percent (25.5 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant, an ironworker, compensably injured his right knee on April 15, 1998, when he slipped while moving a welder down a ramp. (Exs. 1, 3). Dr. Schwartz diagnosed a right medial meniscus tear and performed a partial medial meniscectomy on August 25, 1998. (Ex. 8). After surgery, Dr. Schwartz recommended physical therapy. (Ex. 13).

On November 18, 1998, Dr. Schwartz reported that physical therapy was helping, but claimant was still unable to do certain squatting, climbing and jumping activities. (Ex. 18). He prescribed further physical therapy.

On January 8, 1999, Dr. Duff examined claimant on behalf of the insurer. (Ex. 20). He opined that claimant was medically stationary and could return to regular work. (Ex. 20-3, -4). Dr. Duff reported that claimant had a very mild loss of right knee extension, but should be able to tolerate his normal work activities. (Ex. 20-4).

Dr. Schwartz reviewed Dr. Duff's report and agreed that claimant was medically stationary. (Exs. 23, 24). He did not agree, however, that claimant could return to regular work without restrictions. (*Id.*) Dr. Schwartz recommended a physical capacities evaluation (PCE). (*Id.*)

A PCE was performed on February 11, 1999. (Ex. 27). Among other things, the evaluator found that claimant performed in the "light" category. (Ex. 27-1). The evaluator found that claimant's examination was valid and reliable and he noted that there appeared to be a significant amount of pain in the right lower extremity with stance or weight-bearing activities. (*Id.*) Dr. Schwartz concurred with the PCE. (Ex. 28).

The insurer initially accepted a disabling right knee medial meniscus tear. (Exs. 10, 29). The claim was first closed by a March 30, 1999 Notice of Closure, which awarded 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of the right knee. (Ex. 30).

After the first closure, the insurer amended the acceptance to include patellofemoral and medial femoral chondromalacia. (Ex. 32). An April 30, 1999 Notice of Closure issued that did not provide any further permanent disability. (Ex. 33).

Claimant requested reconsideration of both Notices of Closure. (Ex. 34). On July 9, 1999, Drs. Colletti, Bald and Weller performed a medical arbiter examination. (Ex. 38).

On July 26, 1999, an Order on Reconsideration issued, reconsidering the March 30, 1999 Notice of Closure. (Ex. 39). Claimant was awarded an 8 percent impairment value for reduced range of motion and a 5 percent impairment value for the partial medial meniscectomy, for a 13 percent scheduled permanent disability award for loss of use or function of his right knee. (Ex. 39-2, -3).

On July 29, 1999, an Order on Reconsideration issued, reconsidering the April 30, 1999 Notice of Closure. (Ex. 39). The July 29, 1999 Order on Reconsideration awarded an additional 17 percent impairment value, for a total of 30 percent scheduled permanent disability award for loss of use or function of claimant's right knee. (Ex. 40-3). The award included an 8 percent impairment value for reduced right knee range of motion, a 5 percent impairment value for the partial medial meniscectomy, and a 15 percent impairment value because claimant was unable to walk/stand for greater than two hours in an eight-hour period. (Ex. 40-2, -3). The insurer requested a hearing on both the July 26, 1999 and July 29, 1999 Orders on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Standing/Walking Limitation

At hearing, the insurer objected, among other things, to the 15 percent impairment value for the inability to stand or walk more than two hours out of an eight-hour work day. The ALJ found that the PCE differed significantly from the medical arbiter panel's assessment regarding claimant's standing/walking impairment and she found that the PCE evaluator was in a better position to make an accurate assessment on this issue than the arbiter panel. The ALJ concluded that the evidence did not support an award for a chronic condition significantly limiting claimant's use of his leg *and* a separate award for a two-hour walking/standing limitation.

On review, claimant relies on the medical arbiter panel's report to argue that he is entitled to an additional 15 percent impairment value under OAR 436-035-0230(16).

On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14) (WCD Admin. Order 98-055). We rely on the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

OAR 436-035-0230(16) provides that when there is an injury to the knee/leg and objective medical evidence establishes the worker cannot walk and/or stand for a cumulative total of more than two hours in an 8-hour period, the award shall be 15 percent of the knee/leg.

A PCE was performed on February 11, 1999. (Ex. 27). Based on the findings of clinical consistency, increase in cardiac response and competitive test performances, the evaluator found that claimant's examination was valid and reliable. (Ex. 27-1). The evaluator noted that there appeared to be a significant amount of pain in the right lower extremity with stance or weight-bearing activities, along with a limitation in terminal knee extension. (*Id.*) In the section on "Postural Endurance (projected)," the evaluator provided the following information:

Activity	Observed	Hours at one time	Total hours in 8 hour day
Sitting	30	2	8
Walking	15	1	4
Standing stationary	15	1	4
Standing with movement	15	1	4

(Ex. 27-3).

In addition, the evaluator reported that claimant's "projected standing" and "projected walking" were each "[o]ccasional 1-33% of workday." (Ex. 27-4). The evaluator concluded that claimant performed in the "light" category. (Ex. 27-1, -7). Dr. Schwartz concurred with the PCE, noting that he was a "little surprised they came up with so much limitations." (Ex. 28).

Drs. Colletti, Bald and Weller performed a medical arbiter examination on July 9, 1999. (Ex. 38). They reported that claimant currently had knee pain, anteriorly and medially, aggravated by most activities. (Ex. 38-2). They explained that claimant's pain was aggravated by walking two to three blocks and he could be on his knee about 15 minutes before the pain developed. (*Id.*) There were no invalid findings. (Ex. 38-3). The arbiter panel explained:

> "[Claimant] is prevented from walking or from standing for more than two hours cumulative in an eight-hour period due to the accepted condition, due to the underlying chondromalacia and the pain associated with this posttraumatic chondromalacia related to the injury of April 15, 1998, documented as partial-thickness by surgical treatment." (*Id.*)

The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. *Charlene L. Vinci*, 47 Van Natta 1919 (1995). However, we have held that a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination. *See, e.g., Kelly J. Zanni*, 50 Van Natta 1188 (1998); *Ronald L. Tipton*, 48 Van Natta 2521, 2522 n. 5 (1996). Here, we find that the time gap between the PCE (February 11, 1999) and the medical arbiter panel examination on July 9, 1999 (*i.e.*, five months) was significant. We therefore conclude that the medical arbiter panel's report provided more probative evidence of claimant's disability as of July 26, 1999 and July 29, 1999, the issuance dates of the reconsideration orders. Furthermore, we find that the medical arbiter panel's report provides the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment.

Based on the medical arbiter panel report, we conclude that objective medical evidence establishes that claimant cannot walk and/or stand for a cumulative total of more than two hours in an 8-hour period. *See* OAR 436-035-0230(16). Consequently, claimant is entitled to an additional 15 percent impairment value.

Awards for Range of Motion, Surgery and Chronic Condition

The ALJ affirmed the 8 percent impairment value for reduced range of motion, the 5 percent impairment value for surgery and the 5 percent impairment value for a chronic condition. Because neither party requests review of those awards on review, we adopt and affirm those portions of ALJ's order. The July 29, 1999 Order on Reconsideration is reinstated and affirmed.

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 17 percent scheduled permanent disability granted by the ALJ's order and the 30 percent scheduled permanent disability granted by our order), not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055. In the event that compensation resulting from this order has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *aff'd on other grounds Volk v. America West Airlines*, 135 Or App 565 (1995), *rev den* 322 Or 645 (1996).

ORDER

The ALJ's order dated December 13, 1999 is modified. In lieu of the ALJ's award, the July 29, 1999 Order on Reconsideration award of 30 percent (45 degrees) scheduled permanent disability for loss of use or function of the right leg (knee) is reinstated and affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event that this compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane Volk*.

In the Matter of the Compensation of
STEVEN K. PULVER, Claimant
Own Motion No. 00-0071M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Jon C. Correll, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted its "Carrier's Own Motion Recommendation" form, recommending that claimant's current right knee condition claim be reopened under the Board's Own Motion jurisdiction. Claimant's aggravation rights expired on September 19, 1996. The insurer recommends that we authorize the payment of temporary disability compensation. Claimant objects to the processing of this claim under our Own Motion jurisdiction; instead, he contends that the claim should be processed as a new condition claim under ORS 656.262(7)(c). To that effect, claimant has requested a hearing with the Hearings Division raising that claims processing issue. WCB Case No. 00-01746. Based on the following reasoning, we find it appropriate to postpone action on the own motion matter pending resolution of the related litigation before the Hearings Division.

FINDINGS OF FACT

On September 19, 1991, claimant compensably injured his right knee. The insurer accepted the claim for a nondisabling right knee strain and processed it to closure. Claimant's aggravation rights expired on September 19, 1996.

Thereafter, claimant filed a claim for ACL laxity and loose body in the right knee, contending that this condition was a continuation of his accepted injury claim. On September 22, 1999, the insurer issued a partial denial of that claim.

On February 1, 2000, the parties entered into a Stipulation whereby the insurer "rescind[ed] its denial, agree[d] to accept responsibility for claimant's current right knee condition, and to process the claim according to law."

On February 18, 2000, claimant's treating physician sent the insurer a copy of his earlier March 1999 request for authorization to perform a right knee arthroscopy to repair claimant's ACL condition. On February 23, 2000, the insurer submitted a "Carrier's Own Motion Recommendation" form recommending that the claim be reopened under the Board's Own Motion jurisdiction.

On March 1, 2000, claimant requested a hearing with the Hearings Division, raising, *inter alia*, the issue of "failure to process as a new condition claim." WCB Case No. 00-01746.

CONCLUSIONS OF LAW AND OPINION

In *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), we held that a "new medical condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the original claim is in the Board's Own Motion jurisdiction. 51 Van Natta at 1745. Furthermore, in *Craig J. Prince*, 52 Van Natta 108 (2000), we determined that the Board, in its "Own Motion" capacity under ORS 656.278, does not have the authority to direct a carrier to process a claim under ORS 656.262(7)(c). In *Prince*, we explained that the issue of whether the claim should be processed under ORS 656.262(7)(c) is a "matter concerning a claim" and, under ORS 656.283, any party "may at any time request a hearing on any matter concerning a claim." 52 Van Natta at 111. Therefore, 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. *Id.*

Here, claimant has done just that. On March 1, 2000, claimant requested a hearing with the Hearings Division, raising, *inter alia*, the issue of "failure to process [his claim] as a new condition claim." WCB Case No. 00-01746. Consequently, pursuant to OAR 438-012-0050, we postpone action on the request for Own Motion relief pending resolution of this related litigation.

At the hearing, the Administrative Law Judge (ALJ) assigned to conduct the hearing shall resolve the claim processing issue raised by claimant (as well as any other issues properly raised by the parties). In addition, the assigned ALJ shall make findings of fact and conclusions of law and opinion regarding the effect of his or her decision on this claim processing matter on claimant's Own Motion claim.

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to this Own Motion matter and a copy of the appealable order issued in WCB Case No. 00-01746. In addition, if the matter is resolved by stipulation, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding Own Motion relief.

IT IS SO ORDERED.

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

On September 10, 1999, the SAIF Corporation submitted a request for medical services for claimant's compensable low back condition. Claimant's aggravation rights expired on November 21, 1955. SAIF opposes reopening of the claim on the grounds that the requested medical services are unrelated to his November 21, 1950 injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1)(b). 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 June 4, 1996, we reopened claimant's claim under our own motion jurisdiction to provide medical services related to his low back condition. We authorized provision of those medical services on an ongoing basis for an indefinite period of time, until there was a material change in treatment or other circumstances. After those services were provided, SAIF was to close the claim pursuant to OAR 438-012-0055. To date, SAIF has not closed the claim.

SAIF contends that claimant's current need for treatment is not related to his 1950 low back injury. Claimant responds that his current need for treatment is the same treatment and for the same condition for which his claim was reopened in June 1996. He further contends that since his claim remains in "open" status, he is entitled to the medical benefits authorized in 1996. In addition, claimant requests that SAIF be required to produce Dr. Goodwin, consulting neurosurgeon, for cross-examination regarding his June 10, 1999 report.

Claimant received conservative treatment regarding his low back condition in 1994 and 1995. This treatment was covered by our June 1996 order that reopened the claim for medical services. However, it is not clear what ongoing medical treatment claimant received for his low back condition following our June 1996 order. Although claimant has received ongoing medical treatment, that treatment has focused on various other health problems.

On the record before us, it appears that claimant again sought treatment for low back pain on May 28, 1998, at which time he was diagnosed with an exacerbation of chronic low back pain and given medication and instructions on back exercises and stretching. On July 21, 1998, claimant saw his current treating physician, Dr. Moser, for continuing low back pain that radiated into his legs. Dr. Moser prescribed medication and recommended a cortisone shot if the medication was not effective.

On January 19, 1999, claimant was examined by Physician's Assistant Leonard for complaints of right leg pain, which claimant reported began after he banged his leg on a chair in December 1998. On January 20, 1999, Dr. Moser examined claimant for low back and neck pain with paresthesias in his arms and legs. On March 26, 1999, Dr. Moser ordered MRIs of claimant's cervical and lumbar spine.

Dr. Kienzle read the April 6, 1999 MRI of the lumbar spine and compared it to a November 16, 1994 MRI, which had shown diffuse degenerative disc disease and neural foraminal stenosis at L4-5 on the right. He stated that the findings were essentially stable from the earlier MRI, noting that there was advanced multilevel disc space narrowing. He also noted that the findings suggest an element of arachnoiditis in the lumbar region, stating that arachnoiditis may be the main source of lumbar discomfort.

After reviewing the April 1999 MRI, Dr. Moser noted that it showed spinal stenosis with the possibility of arachnoiditis in the lumbar region. He diagnosed "cervical and lumbar spinal stenosis" and noted "consider lumbar arachnoiditis." (*See* Dr. Moser's chart note dated April 26, 1999). Subsequently, Dr. Moser referred claimant to Dr. Goodwin for a neurosurgery consultation.

On May 27, 1999, Dr. Goodwin examined claimant and reviewed the MRI scans of his neck and low back, noting that they showed severe degenerative disease at every level of the cervical and lumbar spine, but with no canal stenosis. He noted that claimant had significant neck and back pain that was not radiating. He did not feel that claimant's leg cramping was related to his back. He opined that claimant's neck and back pain were related to severe degenerative lumbar and cervical spondylosis. He did not feel surgery was appropriate and, instead, recommended physical therapy and conservative measures.

In response to an inquiry from SAIF, Dr. Goodwin stated:

> "I do not feel that [claimant's] low back injury sustained in November of 1950 is the major contributing cause of his current cervical or lumbar complaints. [Claimant] has degenerative disc disease at every level of his lumbar and cervical spine, and I cannot blame that on any single injury or even two or three injuries. In my opinion, this is the result of years of life as well as some degree of predisposition to osteoarthritic disease." Dr. Goodwin's letter dated June 10, 1999.

Based on the current record, we are unable to determine whether we should authorize payment of the requested medical services. First, contrary to claimant's contention, it is not clear that claimant is treating for the same condition that he was treating for at the time our June 1996 order reopened the claim for medical services. In this regard, there is some question as to whether claimant currently has arachnoiditis in the lumbar spine that could be causing problems. Also, claimant is currently treating for cervical pain. It is not clear, however, whether claimant contends the cervical treatment should be considered compensable.

Second, although Dr. Goodwin states that the 1950 work injury is not the major contributing cause of claimant's current cervical and lumbar complaints, that is not the standard of proof claimant must meet. As explained above, in order to establish that his current need for medical treatment is compensable, claimant must either demonstrate that the need for treatment is for his accepted condition or bears a *material* relationship to his 1950 compensable work injury. *Beck*, 124 Or App at 487.

Under these circumstances, we conclude that this is an appropriate matter for referral to the Hearings Division for an evidentiary hearing. OAR 438-012-0040.

Accordingly, this matter is referred to the Hearings Division with instructions to assign an Administrative Law Judge (ALJ) to perform the fact finding hearing. WCB Case No. 00-01846. At the hearing, the assigned ALJ shall take evidence on the issue of whether the work injury is a material cause of claimant's need for the requested medical treatment. The parties may present medical and lay evidence regarding this compensability issue.[1]

This hearing may be conducted in any manner that the ALJ determines will achieve substantial justice. ORS 656.283(7). Following the hearing, the ALJ shall issue a recommendation to the Board within 30 days. In that recommendation, the ALJ shall make findings of fact regarding this compensability issue. In addition, the ALJ shall address the effect, if any, our June 1996 order may have on the current medical services issue. Based on those findings, the ALJ shall recommend to the Board whether it should order the claim reopened under own motion jurisdiction for payment of medical services. Following the hearing and our receipt of the ALJ's recommendation, we shall implement a briefing schedule, and, upon its completion, proceed with our review and, eventually issue a final, appealable order.

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[1] In preparation for the hearing, or at the hearing itself, the parties may make arrangements for the "cross-examination" of Dr. Goodwin, as requested by claimant.

Finally, since further Board action will be required before resolution of this case, we emphasize that our action today constitutes an interim order.

IT IS SO ORDERED.

March 15, 2000 Cite as 52 Van Natta 417 (2000)

In the Matter of the Compensation of
HARRISON S. SAPUTO, Claimant
WCB Case No. 99-02630
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Thye's order that set aside a Determination Order and Order on Reconsideration as invalid. On review, the issues are whether the Determination Order and Order on Reconsideration are valid and, potentially, temporary disability and extent of unscheduled permanent disability. We vacate the ALJ's order, affirm in part and modify in part.

FINDINGS OF FACT

Claimant compensably injured his neck, low back and left foot on June 25, 1998 when he fell down some stairs at work. (Exs. 1, 4). The insurer accepted a disabling cervical/lumbar strain and left foot contusion. (Ex. 7). A September 22, 1998 Determination Order closed the claim with an award of temporary disability from June 25, 1998 through July 22, 1998, but no award of permanent disability. (Ex. 24).

A copy of the Determination Order was sent to claimant at an incorrect address. (Ex. 35). The Department of Consumer and Business Services (Department) did not send a copy of the Determination Order to claimant's attorney. (*Id.*)

On December 30, 1998, claimant's attorney received a facsimile copy of the September 22, 1998 Determination Order from the insurer. (Ex. 29). On December 31, 1998, claimant's attorney sent a request for reconsideration to the Department. (Ex. 30).

On January 5, 1999, the Department sent the insurer, claimant and claimant's attorney a "Notice and Acknowledgment of Reconsideration Proceeding." (Ex. 31). The notice indicated that the request for reconsideration had been "completed pursuant to ORS 656.268(6)(e)(B) with the expiration of the appeal period." (*Id.*) The notice said "[a]ny issues pertaining to the claim closure you want reviewed should be raised now so that they can be reconsidered." (*Id.*)

Dr. McKillop performed a medical arbiter examination on February 15, 1999. (Ex. 33). A March 25, 1999 Order on Reconsideration affirmed the Determination Order. (Ex. 34). Claimant requested a hearing on the Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

At hearing, the parties stipulated that the Department had not mailed a copy of the September 22, 1998 Determination Order to claimant's attorney. (Tr. 1-2). The insurer argued that the March 25, 1999 Order on Reconsideration was "void" because claimant had not appealed the September 22, 1998 Determination Order within the statutory 60 day period. The insurer acknowledged it had not raised this defense during the reconsideration process, but it asserted that it had not waived its right to contest the untimely appeal of the Determination Order because the issue "arose out of the reconsideration order itself."

On the other hand, claimant argued that the insurer waived the right to contest the untimely appeal of the Determination Order. Claimant asserted that although the insurer had received claimant's "late" request for reconsideration and was aware of the scheduling of the medical arbiter exam, the insurer did not object in any way.

The ALJ found that it was apparent before the commencement of the reconsideration proceeding that the request for reconsideration was not timely filed. The ALJ reasoned that the issue of the validity of the Order on Reconsideration arises out of the reconsideration order itself, not the Determination Order, because the issue was moot until the Order on Reconsideration had issued. The ALJ found that neither *Patti Hall*, 51 Van Natta 620 (1999), nor *Ed Long*, 51 Van Natta 748 (1999), were applicable to this case because those cases involved a Notice of Closure, rather than a Determination Order. The ALJ noted there was no statute requiring that Determination Orders be mailed to anyone, but OAR 436-030-0030(10) required that copies of Determination Orders were to be mailed to the insurer, employer, claimant and claimant's representative. The ALJ reasoned that, because the September 22, 1998 Determination Order did not comply with OAR 436-030-0030(10), it was invalid and, as a result, the March 25, 1999 Order on Reconsideration was also invalid.

On review, the insurer argues that the ALJ erred in setting aside the Determination Order merely because a copy had not been sent to claimant's counsel. The insurer contends that the Determination Order was final by operation of law and the Director did not have authority to issue the March 25, 1999 Order on Reconsideration. The insurer urges the Board to reinstate the Determination Order.

We first address claimant's argument that the insurer waived its right to contest the validity of the Order on Reconsideration because it was not raised during the reconsideration process. He contends that the validity of the Order on Reconsideration is an issue that does *not* "arise out of the reconsideration order itself." Claimant notes that, despite the Department's late receipt of his request for reconsideration, it nonetheless scheduled him to be evaluated by a medical arbiter. Claimant contends that, although the insurer was aware of the "late" request for reconsideration and the scheduling of the medical arbiter exam, the insurer did not object.

ORS 656.283(7) provides, in part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

In *Crowder v. Alumaflex*, 163 Or App 143 (1999), the court explained that ORS 656.283(7) refers to issues that must be raised or lost and the statute invokes common-law principles of claim preclusion and preservation. The court concluded that when the legislature referred in ORS 656.283(7) to issues that must be raised on reconsideration, it intended the reference to include only those issues that could have been raised at that point. *Id.* at 148.

Former ORS 656.268(8)[1] provides:

> "No hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing."

This provision bars a hearing on an issue that was not first raised at the Department's reconsideration proceeding, unless the issue "ar[ose] out of the reconsideration order."

In *Donald L. Halvorsen Jr.*, 50 Van Natta 284, *on recon* 50 Van Natta 480 (1998), the employer had requested reconsideration of a Determination Order and the claimant did not challenge the validity of that request during the reconsideration proceedings. An Order on Reconsideration stated that the employer had requested reconsideration more than 60 days after issuance of the Determination Order. The Order on Reconsideration increased the claimant's unscheduled permanent disability award, but eliminated the scheduled award. The claimant then requested a hearing from the reconsideration order, asserting that the employer's reconsideration request was untimely and that the reconsideration order was void.

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[1] We note that the 1999 legislature has amended ORS 656.268, but the revisions that went into effect on October 23, 1999 were not made retroactive and are therefore not applicable to this case. SB 220, 70th Leg., Reg. Sess., Sec. 1 (October 23, 1999). *See Robert E. Kelly*, 52 Van Natta 25, 26 (2000) (1999 amendments to ORS 656.277 were prospective).

In *Halvorsen*, we deterimined that the issue was whether the claimant's failure to raise the issue of the validity of the employer's reconsideration request in the reconsideration proceeding precluded him from raising it at hearing. Citing ORS 656.283(7), we said the answer depended on whether the issue "arises out of the reconsideration order itself." We concluded that the claimant's failure to contest the validity of the employer's reconsideration request before the Department did not preclude consideration of that issue at hearing. We reasoned as follows:

> "As previously noted, the employer's reconsideration request was dated January 3, 1997, which was within the 60-day period in which to request reconsideration of the November 5, 1996 Determination Order. If mailed on that date, the request would have been timely. *See* OAR 436-030-0115(1). There was no reason to question the timeliness of the reconsideration request (*i.e.*, whether the request was made within 60 days of the Determination Order) until the reconsideration order itself had issued. That is, until the reconsideration order issued stating that the employer's reconsideration request was made on January 7, 1997, one day late, there was no apparent issue with respect to the timeliness of the reconsideration request. Under such circumstances, we conclude that the timeliness issue 'arose out of the reconsideration order.'" 50 Van Natta at 285.

See also George L. Allenby, 50 Van Natta 1844, 1845 n.2 (1998) (because the validity of the Order on Reconsideration was a question that could not arise until issuance of the order, we found that the issue could be addressed at hearing because it arose out of the reconsideration order itself).

Here, unlike *Halvorsen*, we conclude that the issue regarding the timeliness of claimant's request for reconsideration of the September 22, 1998 Determination Order did not "arise" out of the reconsideration order.

Former ORS 656.268(5)(b) provides:

> "If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order. The request for reconsideration must be made within 60 days of the date of the determination order."

In this case, claimant's attorney's wrote a letter to the Department on December 31, 1998, enclosing claimant's December 30, 1998 request for reconsideration of the September 22, 1998 Determination Order. (Ex. 30). The letter to the Department indicated that a copy of request for reconsideration had been mailed to Ms. Johnson, an employee of the insurer who had been handling the claim. (*See* Exs. 6, 7, 8, 12, 18, 19, 20, 21, 26, 27). There is no dispute that the request for reconsideration was made more than 60 days after the date of the determination order. OAR 436-030-0115(1) (WCD Admin Order No. 97-065) provides that a request for reconsideration "must be mailed to the department within the statutory appeal period."

OAR 436-030-0135(1) provides that the party requesting reconsideration must provide copies of the completed request to the other interested parties. Upon receipt of a request for reconsideration on a Determination Order, OAR 436-030-0135(3) provides that "the department will advise all parties of the date the request was received and the options available to initiate the reconsideration proceeding, pursuant to OAR 436-030-0115." *Former* ORS 656.268(7) provides that if the basis for objection to a determination order is disagreement with the impairment used in the rating of the worker's disability, the director shall refer the claim to a medical arbiter.

Here, claimant's December 30, 1998 request for reconsideration referred to the September 22, 1998 Determination Order and raised issues including temporary disability, impairment findings and unscheduled permanent disability. (Ex. 30-2). On January 5, 1999, the Department issued a "Notice and Acknowledgment of Reconsideration Proceeding." (Ex. 31). The notice indicated that copies were sent to the insurer, claimant and claimant's attorney and the notice referred specifically to the September 22, 1998 Determination Order. (*Id.*) The notice said that the request for reconsideration had been "completed pursuant to ORS 656.268(6)(e)(B) with the expiration of the appeal period." (*Id.*) In addition, the notice said "[a]ny issues pertaining to the claim closure you want reviewed should be raised now so that they can be reconsidered." (*Id.*)

On January 28, 1999, the Department issued a "Notice of Postponement of Reconsideration Proceeding" that notified the parties that the Order on Reconsideration would be postponed for medical arbiter review. (Ex. 32). The January 28, 1999 notice referred to the September 22, 1998 closure and was addressed to the insurer. (*Id.*) The January 28, 1999 notice also indicated that copies were sent to claimant and his attorney. (*Id.*) On February 15, 1999, Dr. McKillop conducted a medical arbiter examination and issued a report. (Ex. 33). The report indicated that copies were sent to claimant, his attorney, and the insurer. (Ex. 33-11).

In *Donald L. Halvorsen Jr.*, 50 Van Natta at 285-86, we found that the employer's reconsideration request was dated January 3, 1997, which was within the 60-day period in which to request reconsideration of the November 5, 1996 Determination Order. We reasoned that there was no reason to question the timeliness of the reconsideration request until the reconsideration order itself had issued, which stated the employer's reconsideration request was made on January 7, 1997, one day late. Under those circumstances, we concluded that the timeliness issue "arose out of the reconsideration order."

Here, in contrast, it was apparent that claimant's December 31, 1998 submission of a request for reconsideration of the September 22, 1998 Determination Order exceeded the 60-day statutory period in *former* ORS 656.268(5)(b). The record indicates that the insurer was sent a copy of the Department's January 5, 1999 "Notice and Acknowledgment of Reconsideration Proceeding" (Ex. 31), a copy of the Department's January 28, 1999 "Notice of Postponement of Reconsideration Proceeding" (Ex. 32), and a copy of the February 15, 1999 medical arbiter's report. (Ex. 33). The insurer makes no argument that it did not receive any of these documents. Under these circumstances, we conclude that the issue concerning the timeliness of claimant's request for reconsideration of the September 22, 1998 Determination Order did *not* "arise[] out of the reconsideration order itself." Rather, the timeliness issue could have been raised on reconsideration. *Compare Crowder v. Alumaflex*, 163 Or App at 148-49 (the claimant was not required to raise the issue of the new rates of PPD at at time that the new rates did not exist).

Under ORS 656.283(7), issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. Similarly, ORS 656.268(8) provides that no hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. In the present case, because the issue concerning the timeliness of claimant's request for reconsideration did not "arise" out of the reconsideration order and was not raised before the Department on reconsideration, we conclude that the insurer is precluded from raising that issue at hearing or on review. We proceed to address claimant's request for hearing concerning the March 25, 1999 Order on Reconsideration.

Order on Reconsideration

The March 25, 1999 Order on Reconsideration affirmed the September 22, 1998 Determination Order in all respects. (Ex. 34). Claimant's request for hearing raised issues of premature closure, temporary disability, scheduled disability and unscheduled disability. At hearing, claimant withdrew the issues of premature closure and scheduled permanent disability. (Tr. 2).

The ALJ noted that Exhibits 17, 25, 28 and 35 were not included in the record on reconsideration. We agree with claimant that those exhibits should not be considered on review for purposes of addressing the merits of the March 25, 1999 Order on Reconsideration. *See* ORS 656.283(7) ("[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing").

Temporary Disability

The September 22, 1998 Determination Order awarded temporary disability from June 25, 1998 through July 22, 1998. (Ex. 24-1). The Order on Reconsideration found that the temporary disability dates were correctly established as authorized by the attending physician and prescribed by rule. (Ex. 34-2).

At hearing, claimant argued that he was entitled to temporary disability from June 25, 1998 through August 17, 1998. (Tr. 4). Claimant asserted that Dr. Nilaver took him off work completely until July 22, 1998 and he was then placed on modified duty. (*Id.*) According to claimant, the modified job offer, which was approved by Dr. Nilaver, did not begin until August 17, 1998. (*Id.*) Claimant contends that his temporary disability should have been extended from June 25, 1998 until he began the modified duty position on August 17, 1998. (Tr. 5).

On the other hand, the insurer argued at hearing that there was no authorization for time loss after July 22, 1998 and the Department properly limited the substantive time loss from June 25, 1998 through July 22, 1998. (Tr. 11-12).

In order for claimant to be entitled to additional temporary disability, the benefits must have been authorized by claimant's attending physician and the time off work must be due to the accepted injury. *See* ORS 656.245(2)(b)(B); ORS 656.262(4)(a), (g) & (h).

Claimant was injured on June 25, 1998 and sought emergency room treatment on that date. (Ex. 3). On June 30, 1998, Dr. Bajorek provided a two-week work release. (Ex. 5). On July 10, 1998, claimant was notified that Dr. Bajorek did not meet the requirements of an eligible medical provider. (Ex. 8). Dr. Bajorek examined claimant on July 14, 1998 and encouraged him to return to modified work. (Ex. 9). On the same date, the employer offered claimant modified work. (Ex. 10). On July 16, 1998, Dr. Nilaver provided a work release until July 22, 1998. (Exs. 13, 14). On August 7, 1998, Dr. Nilaver approved a modified work position. (Ex. 16).

We agree with the insurer that claimant is not entitled to additional temporary disability because there was no authorization for time loss from his attending physician after July 22, 1998. *See* ORS 656.262(4)(g).[2] Although claimant argued at hearing that his temporary disability should have been extended until he began the modified duty position on August 17, 1998 (Tr. 5), the record does not contain a contemporaneous time loss authorization for that time period. Thus, claimant has not established that he entitled to additional temporary disability benefits.

Extent of Unscheduled Permanent Disability

The September 22, 1998 Determination Order did not award any permanent disability. (Ex. 24-1). Dr. McKillop performed a medical arbiter examination on February 15, 1999. (Ex. 33). The March 25, 1999 Order on Reconsideration affirmed the Determination Order in all respects. (Ex. 34). Regarding claimant's unscheduled permanent disability, the Order on Reconsideration explained:

> "The worker's attorney raises issue with the rating of unscheduled disability and a review of the findings of impairment provided no ratable impairment. The medical arbiter reported decreased ranges of motion in the lumbar and cervical spine. However, Dr. McKillop opined such was related to pain in the absence of any other obvious findings of a pathological process. Therefore, no objective findings of unscheduled impairment are noted. Pursuant to OAR 436-035-0270(2), when there are no ratable impairment findings, no unscheduled award shall be allowed. Accordingly, we find the worker is not due an award for unscheduled permanent partial disability." (Ex. 34-2).

At hearing, claimant argued that this case involved a statutory closure so the only evidence of impairment was from the medical arbiter. (Tr. 6). Claimant argued that, based on Dr. McKillop's exam, he was entitled to a 16 percent award for unscheduled permanent disability based on 10 percent impairment for reduced cervical range of motion and 7 percent impairment for reduced lumbar range of motion. (Tr. 6-11).

The insurer argued at hearing that Dr. McKillop's findings were not sufficient to establish that claimant was entitled to an unscheduled permanent disability award. (Tr. 12-13).

On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14) (WCD Admin Order No. 98-055).

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[2] ORS 656.262(4)(g) provides:

> "Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance.

Claimant's attending physician at the time of claim closure was Dr. Nilaver. We agree with claimant that Dr. Nilaver did not provide a formal closing examination. The Order on Reconsideration said that claimant had not sought medical care for over 30 days and the claim statutorily qualified for claim closure. (Ex. 34-2). *See* ORS 656.268(1)(b). Under these circumstances, we refer to the medical arbiter examination in determining claimant's impairment.

As a result of the compensable injury, the insurer accepted a disabling cervical/lumbar strain and left foot contusion. (Ex. 7). On February 15, 1999, Dr. McKillop performed a medical arbiter exam and reported that, among other things, claimant continued to have pain in his neck and back and also had reduced function in both areas. (Ex. 33-2, -3). Dr. McKillop measured range of motion of claimant's cervical and lumbar spine. (Ex. 33-4). He noted that the findings were considered to be valid and there were no findings associated with an "unrelated cause." (Ex. 33-7, -8). Dr. McKillop explained:

> "I would state that the range of motion findings in the cervical and lumbar spine are largely related to pain. At the beginning of the examination, the patient was instructed that he should not over-stress himself or go beyond a reasonable amount of pain as his ranges of motion were measured. Thus, the amount of discomfort experienced has a lot to do with the ranges of motion measured. His ranges of motion were quite consistent throughout, and there was no giveway [sic] or other signs of nonorganic pain. The ranges of motion were simply somewhat less than one would expect considering the other findings. They seem to relate mainly to pain." (Ex. 33-8).

Dr. McKillop explained further that claimant's range of motion findings "seemed to be related mainly to pain in the absence of any other obvious findings of a pathologic process." (Ex. 33-9).

OAR 436-035-0320(3) provides that "[p]ain is considered in the impairment values in these rules to the extent it results in measurable impairment." If there is no measurable impairment, no award of unscheduled permanent partial disability shall be allowed.

Here, based on Dr. McKillop's report, we find that claimant's pain resulted in "measurable impairment" concerning his cervical and lumbar range of motion. Dr. McKillop specifically found that the findings were valid and there were no findings associated with an "unrelated" cause. (Ex. 33-7, -8). He explained that claimant's ranges of motion were "quite consistent throughout, and there was no giveway [sic] or other signs of nonorganic pain." (Ex. 33-8). Dr. McKillop noted that claimant's "physical examination shows very little in the way of objective findings, *other than the range of motion findings.*" (*Id.*; emphasis supplied). Dr. McKillop's comment indicates that he believed claimant's range of motion findings constituted "objective" findings. Based on Dr. McKillop's report, we find that claimant's cervical and lumbar range of motion findings were valid and were related to the compensable injury.

At hearing, the insurer relied on *Cheryl A. Boone*, 51 Van Natta 616 (1999), to argue that Dr. McKillop's findings were not sufficient to establish that claimant was entitled to an unscheduled permanent disability award. (Tr. 13). The insurer's reliance on that case is misplaced. In *Boone*, we found that, given the attending physician's varied comments regarding the claimant's range of motion measurements, a preponderance of the evidence did not support a finding that the claimant has valid losses of ranges of motion. Here, in contrast, Dr. McKillop found that claimant's range of motion findings were valid and he specifically noted there was no giveaway or other signs of nonorganic pain. (Ex. 33-7, -8). Therefore, we rely on Dr. McKillop's cervical and lumbar range of motion findings to determine claimant's impairment.

Dr. McKillop reported that claimant's lumbar flexion was 43 degrees, lumbar extension was 16 degrees, right lateral flexion was 26 degrees and left lateral flexion was 24 degrees. (Ex. 33-4). We find that claimant is entitled to a 7 percent impairment value for reduced lumbar range of motion. *See* OAR 436-035-0360(19), (20), (21).

Dr. McKillop reported that claimant's ranges of cervical motion (using dual inclinometers) were: flexion 40 degrees, extension 40 degrees, right lateral flexion 38 degrees, left lateral flexion 34 degrees, right rotation 40 degrees and left rotation 40 degrees. (Ex. 33-4). We find that claimant is entitled to a 10 percent impairment value for reduced cervical range of motion. *See* OAR 436-035-0360(13), (14),

(15), (16). The 7 percent and 10 percent impairment values are combined, for a final award of 16 percent unscheduled permanent disability.[3]

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 (16 percent unscheduled permanent disability) awarded by this order, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055.

ORDER

The ALJ's order dated September 21, 1999 is vacated. The Order on Reconsideration is affirmed in part and modified in part. Claimant is awarded 16 percent (51.2 degrees) unscheduled permanent disability for his back and neck conditions. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the Order on Reconsideration is affirmed.

[3] At hearing, the parties agreed that nonimpairment factors did not apply in rating claimant's unscheduled permanent disability. (Tr. 2).

March 15, 2000 Cite as 52 Van Natta 423 (2000)

In the Matter of the Compensation of
RALPH H. TEW, Claimant
Own Motion No. 66-0096M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On March 7, 2000, the SAIF Corporation submitted its request to reopen claimant's claim under our own motion jurisdiction to provide reimbursement for a diagnostic myelogram CT scan to determine the status of claimant's compensable January 21, 1958 injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

We have previous held that diagnostic medical services are compensable when the services are reasonable and necessary in order to establish a causal relationship between the compensable condition and the current condition. *Carl Hight*, 44 Van Natta 224 (1992) and *Cordy A. Brickey*, 44 Van Natta 220 (1992). In keeping with our holdings in *Hight, supra* and *Brickey, supra*, we find that the medical report generated as result of the diagnostic myelogram CT scan an integral part of a medical service provided to an injured worker. As such, we conclude the myelogram CT scan report qualifies as compensation under ORS 656.005(8) and ORS 656.625.

Accordingly, we find that the requested myelogram CT scan is reasonable and necessary and is justified by special circumstances. Therefore, we authorize SAIF's request for reimbursement for the costs of a diagnostic myelogram CT scan.

This order shall supplement our June 30, 1992, December 22, 1994 and April 14, 1999 orders that previously reopened claimant's 1958 claim for the payment of medical services pertaining to pain control, claimant's TENS unit and chiropractic treatment.

This authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
WAYNE R. SHERMAN, Claimant
Own Motion No. 00-0084M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable left knee condition. Claimant's aggravation rights on that claim expired on February 20, 1995. SAIF opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his current disability.

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

In a December 16, 1999 medical report, Dr. Singer, claimant's treating physician, recommended that claimant undergo an arthroscopic patellar chondroplasty. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

Here, SAIF contended that claimant was not in the work force at the time of his current disability because claimant failed to provide proof of earnings. However, on March 7, 2000, SAIF forwarded copies of wage information which claimant hand delivered to its office. That wage information includes copies of claimant's 1998 and 1999 W-2 forms, as well as a Form 1099G demonstrating unemployment benefits received in 1999. This documentation establishes that claimant was working and/or seeking work during those years. On this record, we conclude that claimant has established that he was working until the time of his current disability.[1]

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

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the 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 "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 (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)). *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 December 16, 1999, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *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).

In the Matter of the Compensation of
GARY S. FOX, Claimant
WCB Case No. 99-01031
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board *en banc*.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) directed SAIF to pay a 51 percent (163.2 degrees) unscheduled permanent disability granted by the a prior ALJ's "pre-ATP" order; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to pay that award. On review, the issues are claim processing and penalties. We reverse.

FINDINGS OF FACT

Claimant compensably injured his left lower back on February 27, 1995. A Determination Order closed his claim and awarded 38 percent unscheduled permanent disability. An Order on Reconsideration reduced the award to 13 percent. Claimant requested a hearing regarding the extent of his disability.

The claim was reopened while claimant was enrolled in an authorized training program (ATP) from May 30, 1997 through February 28, 1998. On August 19, 1997, while claimant was in the ATP, a prior ALJ increased claimant's "pre-ATP" award to 51 percent. The prior ALJ's order became final, but SAIF did not pay the award.

After claimant completed the ATP, a March 1, 1998 Notice of Closure re-closed the claim with a total award "to date" of 34 percent unscheduled permanent disability. An April 2, 1998 Order on Reconsideration affirmed the 34 percent award. Claimant requested a hearing challenging the Order on Reconsideration, but later withdrew his request. The 1998 Order on Reconsideration became final.

Claimant requested a hearing, raising the issue of SAIF's failure to pay the 1997 ALJ's 51 percent award. Another ALJ's April 9, 1998 Opinion and Order assessed SAIF a penalty for its unreasonable resistance to the payment of that compensation. A January 15, 1999 Board order reversed the 1998 ALJ's penalty assessment, holding that SAIF's nonpayment of the "pre-ATP" award was reasonable based on prior Board orders interpreting former statutes that provided for suspension of permanent disability payments during ATP.[1]

On February 8, 1999, claimant requested a hearing seeking enforcement of the 51 percent "pre-ATP" unscheduled permanent disability award and penalties for SAIF's allegedly unreasonable (continued) failure to pay that award.

CONCLUSIONS OF LAW AND OPINION

The ALJ directed SAIF to pay the 51 percent "pre-ATP" permanent disability awarded by a prior ALJ's August 17, 1997 order and a penalty based on SAIF's nonpayment of that award. The ALJ first reasoned that enforcement of the 1997 order was not precluded because the prior ALJ did not and could not address it. The ALJ then concluded that the prior ALJ's unappealed "pre-ATP" permanent disability award was enforceable, "finding no authority for failure to pay an unappealed Order." The ALJ cited *SAIF v. Coburn*, 159 Or App 413 (1999). We agree that the enforcement claim is not precluded, but we find that the "pre-ATP" award is not enforceable.

We have previously held that claimant was not entitled to a penalty for SAIF's nonpayment of the prior ALJ's 51 percent permanent disability award while claimant was in the ATP. *Gary S. Fox*, 51 Van Natta 60 (1999) (*Fox I*).

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[1] *See Minnie A Daniel*, 35 Van Natta 681 (1985), and *Charles C. Tackett*, 31 Van Natta 65 (1981). The Board later "took no position regarding the continued vitality of the *Tackett* and *Daniel* reasoning." *Gary S. Fox*, 51 Van Natta 60, 62 n. 2 (1999).

In *Fox I*, we stated:

> "When the hearing in this matter convened, claimant had completed the ATP program. Accordingly, payment of those previously suspended benefits [i.e., the 51 percent awarded by the August 17, 1997 order] is a moot issue, and the issue at hearing, as well as on review, is limited to claimant's request for a penalty for SAIF's allegedly unreasonable claim processing." 51 Van Natta at 60.

The Board's prior order became final without appeal. Consequently, it is the law of the case that payment of the 51 percent award was "a moot issue" at the time of *Fox I*.[2] Under these circumstances, we cannot say that claimant had an opportunity to litigate enforcement of the 51 percent award in the prior proceeding. Consequently, we agree with the ALJ that the current claim for enforcement of that award is not precluded.[3]

The ALJ stated that the issue on the merits is "whether a post ATP determination under ORS 656.268(9) supersedes and negates an unappealed Opinion and Order." We conclude that it does, based on the following reasoning.

In *Coburn*, the court stated that, pursuant to ORS 656.268(9),[4] there "*must* be a reevaluation of the worker's extent of disability upon completion of an ATP, even if the original award has become final." 159 Or App at 417 (emphasis in original). The court also stated that ORS 656.268(9) "does not condition the reevaluation of the claim on the existence of unpaid or suspended benefits[.]" *Id.* at 418 (citing *SAIF v. Sweeney*, 115 Or App 506, 511 (1992), *on recon* 121 Or App 142 (1993)).

Here, as in *Coburn*, at the time claimant enrolled in the ATP, no amounts were due under the "pre-ATP" award. In *Coburn*, no amounts were due because SAIF had paid the award in full. In this case, the prior ALJ's award was never enforceable, due to the timing of SAIF's "post-ATP" permanent disability payment.

OAR 436-060-0150(7)(d) provides that permanent disability benefits ordered paid by a litigation order shall be paid no later than the 30th day after the date any "litigation [order] authorizing permanent disability becomes final." ORS 656.268(9) provides that permanent disability payments due under a "pre-ATP" award are suspended during a "post-closure ATP" (and the claim is redetermined after the ATP is completed). *See also* OAR 436-060-0040(2) & (3).

Here, claimant's "pre-ATP" award did not become final until he was already in the ATP. Therefore, claimant's permanent disability payments were properly suspended until completion of the program on February 28, 1999. Then claimant's permanent disability was redetermined by a March 1, 1998 Notice of Closure and SAIF paid the unappealed "post-ATP" award within 30 days of the prior ALJ's order--*i.e.*, not counting the time suspension of payment was authorized under the statute. Simply put, claimant is not entitled to enforcement of the prior ALJ's 51 percent award, because it never

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[2] "The law of the case doctrine 'is a general principle of law and one well recognized in this state that when a ruling or decision has been once made in a particular case by an appellate court, while it may be overruled in other cases, it 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.' *State v. Pratt*, 316 Or. 561, 569, 853 P.2d 827, *cert. den.* 510 U.S. 969, 114 S. Ct. 452, 126 L.Ed.2d 384 (1993). (Citations omitted.)." *Blanchard v. Kaiser Foundation Health Plan of the Northwest*, 136 Or App 466, 470, *rev den* 322 Or 362 (1995).

[3] *See, e.g., Hewlett-Packard Co. v. Leonard*, 151 Or App 307, 311 (1997) (where the issue before the prior ALJ was limited to the claimant's 1993 medically stationary status, the claimant did not have an opportunity to litigate compensability of a later-diagnosed herniated disc condition at the prior hearing).

[4] ORS 656.268(9) provides in relevant part:

> "If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Consumer and Business Services shall redetermine the claim pursuant to this section if the worker is medically stationary[.]"

became due. In other words, SAIF's timely payment of the "post-ATP" award effectively excused it from paying the original award. *See SAIF v. Sweeney, on recon* 121 Or App at 145 (where the carrier issued its "post-ATP" notice of closure within 30 days of the original permanent disability award (not counting the time payment was lawfully suspended for ATP), issuance of the "post-ATP" notice of closure "effectively reduced the award and excused the carrier from payment under the original award.").

Moreover, even if the "pre-ATP" award became due before the "post-ATP" award was timely paid, we would conclude that the "pre-ATP" award is not enforceable, based on the following reasoning.

The dissent relies on the general rule that final litigation orders are enforceable. We do not dispute the general rule. But the dissent, claimant, and the ALJ confuse validity with enforceability. Here, the prior ALJ had authority (*i.e.*, subject matter jurisdiction) to address the extent of claimant's "pre-ATP" disability and his order was valid. But that does not necessarily mean that it is ultimately enforceable. On the contrary, ORS 656.268(9) creates an exception to the general enforceability of litigation orders, under very particular circumstances: When a "post-ATP" award follows a "pre-ATP" award, the former replaces the latter.[5] What that means here is that claimant is not entitled to payment of "pre-ATP" award.

The ALJ essentially construed ORS 656.268(9) to mean that permanent disability payments suspended under the statute are redetermined after an ATP if they were awarded by a Determination Order (or Notice of Closure), but not if they were awarded by an ALJ's order following a request for hearing from a Determination Order (or Notice of Closure). We read the statute differently, based on its text and context. *See PGE v. Bureau of Labor and Industries*, 317 Or 610-612 (1993).

The first level of statutory construction is to examine the text and context of the statute. *Id.* at 610. Further analysis is proper only if the meaning of the statute is ambiguous from its text and context. *Id.* at 611-612.

The operative text of ORS 656.268(9)[6] clearly provides that the Department "shall redetermine the claim" following post-closure ATP. In ordinary usage, "redetermine" means "fix again." *Webster's Third New Int'l Dictionary*, 1902 (unabridged ed 1993); *see Coburn*, 159 Or App at 417-419 (repeatedly equating redetermination under ORS 656.268(9) with "reevaluation").

The immediate context of mandatory "post-ATP" unscheduled permanent disability redetermination under ORS 656.268(9) includes the remainder of the subsection. The statute begins: "If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in [ATP] * * *." We read the opening phrase as descriptive, not restrictive. It sets the *timing* of "post closure/post-ATP" permanent disability redeterminations, it does

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[5] *See SAIF v. Sweeney, on recon* 121 Or App at 145; *Watkins v. Fred Meyer, Inc.*, 79 Or App 521, 524-25 (1986) (a claimant is entitled to a new permanent disability determination after completion of vocational rehabilitation, without regard to the previous award) (citing *former* ORS 656.268(5) and *Hanna v. SAIF*, 65 Or App 649, (1983)).

In *Leedy v. Knox*, 34 Or App 911, 919-20 (1978), the court stated:

> "A determination award made before the additional factor, vocational rehabilitation, can be assessed, is subject to modification upon completion or withdrawal from a program of vocational rehabilitation * * *. If a claimant is able to reduce the extent of his or her disability through participation in a rehabilitation program, provision has been made for reevaluation and reduction of the permanent award.")

Natalie M. Zambrano, 48 Van Natta 1812, 1815 (1996) (where the "post-ATP" Determination Order issued "before the insurer became obligated to continue the monthly payments of permanent partial disability, and the Determination Order reduced the award, the insurer was *effectively excused* from the remaining payments of the original permanent disability award." (emphasis added); *Mary E. Cordiero*, 48 Van Natta 1178 (1996) (the claimant's "post-ATP" permanent disability award remained the "final determination" of his disability to date, regardless of the extent of his "pre-ATP" disability); *Richard La France*, 48 Van Natta 427,431 ("post-ATP" "redetermination is made without regard to previous awards.")

[6] That text provides, "When the worker ceased to be enrolled and actively engaged in the training, the Department of Consumer and Business Services shall redetermine the claim pursuant to this section if the worker is medically stationary[.]" Later, the same subsection provides that only unscheduled permanent disability is redetermined after ATP.

not restrict redeterminations to unappealed closures. Thus, the subsection begins by simply limiting its application to "post closure/post-ATP" situations. Neither the text nor the immediate context of the operative sentence suggest that the legislature distinguished unscheduled permanent disability awarded at initial claim closure from that awarded later by an ALJ. In other words, there is no textual or contextual indication that the legislature intended to require redetermination of unscheduled permanent disability awarded by an initial closure order, but not that awarded by a subsequent ALJ's order on appeal of the same award.

The context of the statute also includes related statutory provisions. In this regard, we particularly note ORS 656.214 and 656.726(3)(f)(A), which provide that the basic criteria for rating unscheduled permanent partial disability shall be *permanent* loss of earning capacity *due to* the compensable injury. *See* ORS 656.214(2)-(5); ORS 656.726(3)(f)(A).

Here, if the "pre-ATP" and "post-ATP" awards are both enforced, a portion of claimant's total award would not be "due to" the compensable injury simply because it would be duplicative.[7] *See Schultz v. Springfield Forest Products*, 151 Or App 727, 732 (1992). (double recovery of permanent partial disability "would not be consistent with legislative policy.")

The dissent argues that a "post-ATP" award need not be duplicative, because previously compensated factors would be properly deducted during redetermination. But the effect of the dissent's "deduction method" would be that the "pre-ATP" award would be enforced and the "post-ATP" redetermination would be meaningless. In other words, claimant would be compensated as though his disability had not in fact been reduced through retraining. This is clearly contrary to the expectations of vocational rehabilitation and the purpose of statutory "post-ATP" unscheduled permanent disability redetermination. The dissent posits no reason for enforcing the "pre-ATP" award and essentially ignoring the "post-ATP" redetermination, except that this "pre-ATP" award happens to be by litigation order. Although we agree that litigation orders are generally enforceable, we conclude that *mandatory* redetermination under ORS 656.268(9) is an exception to the general rule (in circumstances like these, where there are "pre-ATP" and "post-ATP" unscheduled permanent disability determinations under the same claim).

For these reasons, we conclude that the context of ORS 656.268(9) indicates that the legislature did not intend the "pre-ATP" unscheduled disability award to be enforceable after "post-ATP" redetermination.[8] Accordingly, because the legislature's intent is clear from the text and context of ORS 656.268(9), further inquiry is unnecessary. *See PGE*, 317 Or at 610-612. The scope of the statute's application is clear: Mandatory "post ATP" redetermination is not limited to unappealed claim closures. Instead, all "pre-ATP" unscheduled permanent disability must be redetermined when the worker is medically stationary after retraining under ORS 656.268(9).

Finally, claimant is not entitled to a penalty for SAIF's allegedly unreasonable failure to pay the "pre-ATP" permanent disability award because there are no amounts due under the claim. Consequently, the ALJ's order must be reversed.

ORDER

The ALJ's order dated June 3, 1999 is reversed. The ALJ's permanent disability award and penalty assessment are reversed.

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[7] Moreover, if the "pre-ATP" award is enforced, it would not be for *permanent* loss of earning capacity, because claimant's earning capacity increased since ATP. Such results would contravene ORS 656.214 and 656.726(3)(f)(A). *See Vaughn v. Pacific Northwest Bell Telephone*, 289 Or 73, 83 (1980) (court will avoid a statutory construction which creates a conflict between statutes or renders one statute ineffective).

[8] Another aspect of the statute's context is its evolution--a comparison of the text of previous versions of the statute to its present version. *See Krieger v. Just*, 319 Or 328, 337 (1994) (context includes the text of a statute before it was amended). With this in mind, we note that the legislature has sometimes referred to what is now mandatory "post-closure/post-ATP" *redetermination* as a requirement to "*reconsider*" the claim under "post-closure/post-ATP" circumstances. *See* OR Laws 1991, ch 502, ° 1; Or Laws 1990, ch 2, section 16(8); *see also* Or Laws 1995, ch 332, section 30. In ordinary usage, "reconsider" means "to consider again" as "to think over * * * Esp. with a view to changing or reversing." *Webster's Third New Int'l Dictionary* at 1897. This definition of "reconsider" is consistent with our interpretation of "redetermine" and our conclusion that a "pre-ATP" unscheduled permanent disability award is not enforceable once it has been reconsidered/redetermined after ATP -- because the "post-ATP" award replaces the "pre-ATP" award.

Board Members Biehl and Phillips Polich dissenting.

In construing a statute, we are "not to insert what has been omitted, or to omit what has been inserted." ORS 174.010. But that is exactly what the majority does in this case.

ORS 656.268(9) provides that a worker's permanent disability is redetermined following ATP "after the determination made or notice of closure issued" only. It does not mention redetermination after an *ALJ's* permanent disability award. This critical omission from the statute should be determinative in the present case.

Moreover, in this case, SAIF *ignored* the prior ALJ's 51 percent permanent disability award even after it was unchallenged, due and payable. Yet the majority approves SAIF's conduct by essentially allowing it to collaterally attack the unappealed Opinion and Order. The majority's reasoning and result are contrary to well established judicial practice and the equally well established principle that an ALJ's final order *is* enforceable.

As the court explained in *SAIF v. Roles*, 111 Or App 597, *rev den* 314 Or 391 (1992), a final ALJ's order is enforceable (as long as the ALJ had subject matter jurisdiction) even if it is wrong. Here, there is no contention that the prior ALJ's "pre-ATP" permanent disability award was incorrect at the time. On the contrary, as in *SAIF v. Coburn*, 159 Or App 413, 419 (1999), the "pre-ATP" award was "correct when it was made." Because the prior ALJ had subject matter jurisdiction and her "pre-ATP" permanent disability award was correct, it follows that the "pre-ATP" award is enforceable.[1] *See Mischel v. Portland General Electric*, 89 Or App 140, 144 (1987) (Court's final order may not be unilaterally ignored, even though claim subsequently found not compensable); *Anthony N. Bard*, 47 Van Natta 2016 (1995) (Carrier obligated to pay benefits awarded by prior ALJ order even though underlying claim was ultimately determined not compensable); *Imre Kamasz*, 47 Van Natta 332 (1995); *Theodore W. Lincicum*, 40 Van Natta 1953, 1955 (1988) *aff'd mem, Astoria Oil Service v. Lincicum*, 100 Or App 100 (1990) (Prior order awarding compensation enforced even though prior order had been reversed).

Under these circumstances, we would find claimant entitled to the "pre-ATP" award (51 percent unscheduled permanent disability). In other words, under ORS 656.268(9) and the above-cited caselaw, a "pre-ATP" *final litigation order* is a "floor." And we would hold that a "post-ATP" redetermination may not reduce claimant's permanent disability below that "floor," precisely because it is based on a final litigation order.

The majority reasons that the legislature must have intended redetermination of unscheduled permanent disability in all cases, because "pre-ATP" and "post-ATP" awards would otherwise be duplicative. But the majority's concerns are unfounded because award duplication is unnecessary: Beginning with the "pre-ATP" award floor, we would compare the "post-ATP" redetermined award to the prior award, factor by factor, to evaluate whether claimant is entitled to additional "post-ATP" compensation (based on increased impairment or nonimpairment values "post-ATP"). Here, because claimant's "post-ATP" impairment and vocational factors are lower than his "pre-ATP" factors (and the "pre-ATP" award compensated him for all his current impairment and disability), we would conclude that claimant is not entitled to permanent disability compensation in addition to that awarded by the prior ALJ's final "pre-ATP" order.[2] Thus, claimant's ultimate permanent disability award would not be "duplicative," contrary to the majority's prediction.

Moreover, claimant's "pre-ATP" permanent disability was properly determined because claimant *was* medically stationary. Therefore, his disability *was* permanent as of the "pre-ATP" determination. Each statutory permanent disability determination must be evaluated on its own facts, *i.e.*, the facts establishing the worker's impairment and social/vocational factors *at that time*. *See* ORS 656.283(7). Under the statutory scheme, permanent disability is *not* determined by hindsight, contrary to the majority's understanding. Otherwise, we encourage collateral attacks on final orders and finality is but a mirage.

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[1] We do not believe that *Coburn* compels, or even invites the majority's reasoning. *Coburn* involved a notice of closure, not an ALJ's order; it does not suggest that an ALJ's final order may be ignored.

[2] Under ORS 656.268(9), the result would be different where the "pre-ATP" award is not also a final litigation product, *e.g.*, "post-ATP" redetermination of an unappealed determination order or notice of closure, as specifically provided in the statute. In that event, if the worker was less disabled after retraining, his or her unscheduled permanent disability would be reduced; if the worker was more disabled after retraining, his or her unscheduled permanent disability would be increased.

Finally, when claimant disagreed with the permanent disability awarded by the September 6, 1996 Determination Order, he had to request reconsideration within 60 days or be forever foreclosed from contesting the award.[3] *See* ORS 656.268(5)(b). And, when claimant disagreed with the Order on Reconsideration award, he had to request a hearing within 30 days of the reconsideration order (and 180 days of the Determination Order), or be similarly foreclosed. *See* ORS 656.268(6)(b)&(g). Thus, the statutory time limitations give the party challenging a permanent disability award no choice but to act affirmatively within a certain time period. *See Nelson v. SAIF*, 43 Or App 155 (1979).[4] Claimant's timely "pre-ATP" requests for reconsideration and hearing were specifically authorized by statute and necessary to protect his compensation under ORS Chapter 656.

SAIF, on the other hand, did *not* do what was statutorily required to contest the ALJ's order. *See* ORS 656.289(3). If SAIF was dissatisfied with the ALJ's "pre-ATP" award, its remedy was to timely appeal that award. It was *not* authorized to ignore the ALJ's order. *Mary J. McKenzie*, 48 Van Natta 473, 474 n. 3, *aff'd mem* 145 Or App 261 (1996) ("We decline to countenance a collateral attack on a previous order that issued in a separate hearing."); *Glen D. Roles, on remand*, 45 Van Natta 282, 284-85 (1993) (We decline to provide sanctuary for conduct which essentially defies the clear directive of a ALJ's order); *Oscar L. Drew*, 38 Van Natta 934, 936 (1986) (same).

Under these circumstances, we would hold that a carrier must respect the process and the forum: It must appeal an ALJ's permanent disability award to successfully overturn it. Accordingly, because we cannot condone the process or the result here, we must respectfully dissent.

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[3] in this case, both parties requested reconsideration. (*See* Ex. 2-3).

[4] "The benefits awarded under the workers' compensation law are purely statutory, and a claimant must strictly follow the prescribed procedures in order to recover under the law. *Gerber v. State Ind. Acc. Com.*, 164 Or 353, (1940). Time limitations prescribed by law are limitations upon the right to obtain compensation and are not subject to exceptions contained within the general statute of limitations. *Lough v. State Industrial Acc. Com.*, 104 Or 313 (1922).

Neither the Board nor the courts may waive these requirements. *Johnson v. Compensation Department*, 246 Or 449, (1967); *Rosell v. State Ind. Acc. Com.*, 164 Or 173 (1940)." *Id* at 159.

March 17, 2000 Cite as 52 Van Natta 430 (2000)

In the Matter of the Compensation of
LARRY D. ALLEN, Claimant
WCB Case No. C000606
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Daniel M. Spencer, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Member Biehl and Meyers.

On March 15, 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 agreement notes that claimant has received an award of permanent total disability through an Order on Reconsideration. (The insurer has requested a hearing from that order, which is pending before the Hearings Division.) In addition, the proposed CDA provides for a release of benefits payable under ORS 656.204(1) and ORS 656.208. Claimant's spouse has signed the CDA in acknowledgment of the compromise and release of these rights pursuant to the agreement

The Board has previously held that a claimant's spouse does not become a beneficiary until the claimant dies during the period of permanent total disability. Thus, a *spouse* may not release benefits to which he/she is not entitled through the claimant's CDA. *See Donald L. Pottorff*, 50 Van Natta 2247 (1998); *Ralph L. Witt*, 46 Van Natta 1902 (1994); *see also Robert K. Wilson*, 45 Van Natta 1747 (1993) (CDA assigning portion of proceeds to spouse prior to receipt is unreasonable as a matter of law). Because claimant has not died during a period of permanent total disability, pursuant to these cases, claimant's spouse is not a party to the CDA and cannot release benefits to which she is not yet entitled.

The present CDA is distinguishable from the aforementioned case precedent. In this regard, we note that claimants spouse here is not releasing her rights to spousal benefits, but rather, by her signature, is only acknowledging *claimant's* release of those benefits under ORS 656.204(1) and ORS 656.208 to which she was potentially entitled. Thus, we find the above cases distinguishable and conclude that the paragraph entitled "SPOUSAL BENEFITS" is not objectionable.

Accordingly, 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' CDA is approved. An attorney fee of $14,875, payable to claimant's counsel, is also approved. Should the parties disagree with our interpretation of the CDA, they may move for reconsideration by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035.

IT IS SO ORDERED.

March 17, 2000 Cite as 52 Van Natta 431 (2000)

In the Matter of the Compensation of
RICHARD A. LEE, Claimant
WCB Case No. 99-04640
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of claimant's consequential condition claim for a left foot condition. On review, the issue is compensability.

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

The ALJ noted that this matter arose out of claimant's request for hearing from SAIF's denial of his plantar fasciitis condition. The ALJ also stated that the parties had agreed that the compensability of claimant's bunion condition (hallux valgus) of the left toe was also denied. However, our review of the transcript indicates that claimant's attorney specifically stated that a claim for the bunion condition was *not* being asserted. (Tr. 1). Therefore, we find that the sole condition at issue is the left plantar fasciitis condition.

The ALJ upheld the denial of that condition, finding the opinion of claimant's attending podiatrist, Dr. Mozena, did not satisfy claimant's burden of proof. On review, claimant contends that the ALJ's assessment of the persuasiveness of Dr. Mozena's opinion was incorrect. For the following reasons, we disagree with that contention.

Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Although claimant relies on the opinion of his treating physician, Dr. Mozena, we find persuasive reasons not to give greater weight to his opinion.

Claimant had a left plantar fasciitis that preexisted his compensable May 19, 1998 left foot injury that occurred when a 36 pound steel rod struck his left foot. In concluding that this injury was the major contributing cause of claimant's post-injury plantar fasciitis condition, Dr. Mozena opined that the preexisting plantar fasciitis condition had "completely resolved" or had "healed." (Exs. 52-2, 53-1). Claimant, however, had treated with Dr. Mozena on March 19, 1998 for plantar fasciitis. (Ex. 7). While it is clear that claimant's plantar fasciitis condition was much improved, claimant was still symptomatic. In particular, although noting that orthotics had "much improved" claimant's pain in his arch, Dr. Mozena also indicated that claimant would most likely be cast for new orthotics at a future visit and that claimant was to use home physical therapy and anti-inflammatories as needed. Having reviewed this chart note, we agree with the ALJ that Dr. Mozena's assertion that the preexisting plantar fasciitis condition had "completely resolved" was incorrect.

Moreover, Dr. Mozena attributed claimant's post-injury plantar fasciitis to a May 1998 injury that allegedly caused him to alter his gait. 2(Exs. 52-2; 53-1, 2). Claimant testified, however, that he had limped since the 1970's. (Tr. 18). Thus, claimant had long demonstrated an altered gait before the compensable May 1998 left foot injury. We agree with the ALJ that Dr. Mozena does not sufficiently address how or why the post-injury gait pattern was different or more harmful than the pre-injury gait pattern.

Accordingly, we agree with the ALJ that Dr. Mozena's opinion is not sufficiently persuasive to establish medical causation. Because the opinions of the other physicians (Drs. Higgins and McKillop) do not support the compensability of claimant's left plantar fasciitis condition, we conclude that the ALJ properly upheld SAIF's denial.

ORDER

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

March 17, 2000 Cite as 52 Van Natta 432 (2000)

In the Matter of the Compensation of
ANTHONY W. PAPAJACK, Claimant
WCB Case No. 99-05618
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Hitt, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for an L4-5 disc condition.[1] On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The employer builds exhibits for trade shows. Claimant performed fairly strenuous manual labor for the employer for about nine years before March 1999. On March 22, 1999, he spent the morning moving aluminum panels from tables or dollies onto a table for sanding and painting. During this activity, claimant experienced the onset of low back and left leg pain and reported his symptoms to his supervisor. He sought medical treatment the next day.

A March 25, 1999 MRI revealed an L4-5 disc herniation and extruded fragment, as well as multilevel degeneration. Dr. O'Neill performed surgery at L4-5 and L5-S1 on April 2, 1999.

Claimant filed an injury claim which the insurer denied. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's injury claim for a "combined" L4-5 disc condition compensable under ORS 656.005(7)(a)(B). We reach the opposite result.

The medical evidence addressing causation is provided by Drs. O'Neill and Gerry. Dr. O'Neill noted that claimant "has had on and off back pain throughout his life, but nothing profound." (Ex. 8-1). Dr. O'Neill related claimant's history of recalling "a clear incident while lifting pieces of metal at work; a feeling of a pop in his back. . . .According to this history, and considering that [claimant] has a relatively-large soft disc herniation, the clinical symptoms of lumbar radiculopathy are indeed related to

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[1] In his brief, claimant argues that the ALJ erred in refusing to admit proposed Exhibit 23, a "post-hearing" medical report. We do not address the propriety of the ALJ's evidentiary ruling because the result would be the same even if the disputed report was admitted. *See Clifford L. Conradi*, 46 Van Natta 854, 857 (1994).

the work event." (Ex. 16). Dr. O'Neill also opined that claimant's preexisting multiple level of degeneration "unquestionably" combined with the work injury to cause the herniation. He concluded that the work injury was the major contributing cause of claimant's "need for treatment and time loss (i.e., radiculopathy)." (*Id*). Finally, Dr. O'Neill stated, "The basis of this opinion is obviously posing that the history of no prior evidence of back pain, radicular symptoms, and an event at work, are correct and accurate as reported." (*Id*).

Dr. O'Neill initially acknowledged that claimant had "on and off back pain throughout his life." But he also stated that his causation opinion was based in part on a "history of no prior evidence of back pain." Dr. O'Neill's opinion is also based on a belief that claimant had experienced "a clear incident" and work and a "feeling of a pop in his back." This history is not supported elsewhere in the record. (*See* Ex. 15, Tr. 20). Because Dr. O'Neill's conclusions are expressly based on a history that is inconsistent with his own reporting and the remainder of the record, we find his opinion unpersuasive.

We find Dr. Gerry's opinion similarly unpersuasive. He described claimant's "likely" underlying degenerative changes as "mild." But the record indicates that claimant has "extensive degenerative changes [] throughout the lumbar spine," including moderate spinal canal stenosis and moderately severe right and moderate left foraminal stenoses at L4-5. (Exs. 7, 8). Under these circumstances, we are not persuaded that Dr. Gerry relied on an accurate understanding regarding the extent of claimant's contributory preexisting degeneration.

We also find the opinions of Drs. Gerry and O'Neill unpersuasive because they are inadequately reasoned: The doctors do not explain why claimant's March 22, 1999 work activities contributed more to his disc herniation than did his preexisting condition. Accordingly, absent persuasive medical evidence indicating that claimant's work was the major contributing cause of his need for treatment or disability for his L4-5 disc condition, we conclude that the claim must fail. *See Randy L. Carter*, 48 Van Natta 1271, 1272 (1996) (even an uncontradicted medical opinion is not binding on the trier of fact); *William K. Young*, 47 Van Natta 740, 744 (1995).

ORDER

The ALJ's order dated November 10, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

March 17, 2000 Cite as 52 Van Natta 433 (2000)

In the Matter of the Compensation of
LLANCE A. PETERSON, Claimant
Own Motion No. 99-0376M
OWN MOTION ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorneys

On February 29, 2000, we withdrew our February 11, 2000 Own Motion Order which declined to reopen claimant's 1986 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization. Claimant requested reconsideration of our February 11, 2000 order and submitted additional medical documentation, which he contends support his contentions.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In order to satisfy the third *Dawkins* criterion, claimant must first establish that he was willing to work. Failing to demonstrate his willingness to work, a claimant would not be considered a member of the work force, and thus, not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996); *Arthur R. Morris*, 42 Van Natta 2820 (1990).

In our prior order we were persuaded that claimant had demonstrated his willingness to work. We based our conclusion on claimant's affidavit. On reconsideration, and based on the record before us, we continue to find that claimant was and is willing to work.[1]

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his October 11, 1999 hospitalization when his condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

On reconsideration, claimant submits a February 16, 2000 concurrence report from Dr. Keppel, his treating physician. Dr. Keppel agreed that claimant has been unable to work and/or seek work, due to his compensable condition, since "the time of my prior statement in that regard on September 11, 1998."[3] Although SAIF continues to contend that claimant has not met his burden of proof regarding his work force status, it does not provide an opposing medical opinion. Thus, Dr. Keppel's opinion is unrebutted. We are persuaded that claimant is willing to seek employment but unable to do so because of his compensable condition.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning October 11, 1999 the date he was admitted to the hospital. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] Based on claimant's January 24, 2000 affidavit, we found that he was willing to seek employment. Specifically, claimant stated that:

> "I have always hoped that I would be able to return to being an active member of the workforce [sic], but the unpredictability associated with my symptoms and overall health has made that impossible. * * * It is still one of my single greatest hopes and desires that my physical health will improve enough in the future to allow me to once again become an active participant in the work force."

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

[3] In a September 11, 1998 report, Dr. Keppel stated that claimant was continually unable to work due to the compensable injury since he had taken claimant off work on October 28, 1994, and any work search would have been futile. *Llance A. Peterson*, 50 Van Natta 1808 (1998).

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In the Matter of the Compensation of
RICK D. HEFFLEY, Claimant
WCB Case Nos. 98-09784 & 98-07583
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Liberty Northwest Insurance Corporation (Liberty) 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 current low back condition. On review, the issue is compensability.[1] We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Claimant injured his low back at work on July 11, 1986. A herniated disc was suspected, but not confirmed at the time.

Liberty accepted claimant's claim for a low back strain. The claim was closed on June 3, 1987 with a 5 percent unscheduled permanent disability award for a chronic low back condition. Claimant did not seek treatment for his low back after July 1989 until April 24, 1998. That day (while the SAIF Corporation was on the risk), claimant experienced a sudden onset of low back and right leg pain at work.

Dr. Louie performed an L5-S1 microdiscectomy with removal of a large calcified disc on June 18, 1998. SAIF denied compensability and Liberty denied compensability and responsibility. Claimant requested a hearing.

The ALJ found that claimant herniated his disc at the time of the 1986 injury and his 1998 symptoms and need for treatment were a "natural progression" of the 1986 herniation. Therefore, the ALJ concluded that Liberty "remains responsible for the original herniation." We disagree, based on the medical evidence.

The medical evidence concerning causation is provided by Drs. Louie, White, and Williams. Dr. Louie, treating surgeon, provides the only opinion relating claimant's current condition and need for surgery to the 1998 injury.

After removing claimant's calcified disc, Dr. Louie opined that claimant's "hard but large disk herniation most likely represent[ed] acute herniation of a chronic calcified annulus." (Ex. 54). After reviewing Dr. Williams' first report, Dr. Louie agreed that his surgical findings suggested "a herniation of a calcified disc or a worsening of a previous old disk herniation." (Ex. 58). Noting claimant's history to Dr. Williams of a prior work injury "consistent with right lumbar radiculopathy," Dr. Louie opined:

> "One could then conclude that it is possible that [claimant] had a disc herniation from his previous industrial injury, however, it was made more symptomatic by a more recent injury of 4-24-98[,] requiring surgical intervention." (*Id*).

Ultimately, Dr. Louie stated, "I believe that the April 24, 1998 injury is the major cause of the present need for treatment since the patient had no right leg pain in the past 10 to 11 years." (Ex. 62). We do not find Dr. Louie's causation opinion persuasive, because it is inadequately reasoned in light of Dr. White's rebuttal.

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[1] The issues at hearing were compensability and responsibility. We do not reach responsibility, because we find that claimant's current condition is not compensable.

Dr. White performed a file review and explained that claimant's calcified disc could not have suddenly caused his 1998 symptoms because it was "fixed to the tissues around it" and it had not changed in years.[2] (Ex. 66-9; *see* Exs. 66-8, -16-17). Dr. White reasoned that claimant's recent problems were "a natural progression" of the 1986 herniation, to the extent that claimant had developed additional spurring on the margin of the disc and arthritis-related enlargement of adjacent facet joints over the years since the 1986 injury. (Ex. 66-15-18). He also noted that Dr. Louie performed a foraminotomy to treat claimant's facet arthritis when he removed the calcified disc.[3] (Ex. 66-16, *see* Ex. 43). Considering the fixed nature of the old disc and the fact that Dr. Louie did not describe surgical findings of acute injury, Dr. White concluded that claimant's condition was not an "acute" disc herniation. (*See* Ex. 66-20). Dr. White's reasoning is consistent with claimant's undisputed diagnoses and findings.[4]

Dr. Louie, on the other hand, did not explain how claimant's calcified disc was [also] "acute" and causally related to the 1998 injury despite its hard, fixed nature and long existence. Consequently, we find his ultimate causation opinion inadequately reasoned. (*See also* Ex. 51-5). Accordingly, absent persuasive evidence relating claimant's current condition to the 1998 work incident, we agree with the ALJ that SAIF's denial is properly upheld.

The next question is whether claimant's current condition is compensably related to the 1986 injury.

Liberty accepted a low back strain in 1986. Claimant's current condition involves a chronic calcified disc at L5-S1 and facet arthritis.[5] Although Dr. Louie related claimant's current condition to the 1986 work injury, no physician indicates that it is *directly* related to that injury. Moreover, considering the undisputed evidence that claimant's disc took years to calcify and he has contributory degenerative arthritis, we find that claimant's current condition should be analyzed as an *indirect* (not a direct) consequence of the 1986 injury.[6] Therefore, claimant must prove that the 1986 injury was the major contributing cause of his current condition.[7] ORS 656.005(7)(a)(A). *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

The only evidence indicating that the 1986 injury is the major contributing cause of claimant's current condition is Dr. White's initial opinion. (Ex. 60). Dr. White disagreed with Dr. Louie's opinion that the 1998 injury caused claimant's 1998 condition, because the disc was long-standing, there were no surgical findings of recent injury, and the 1998 incident involved lifting only 5 pounds. (Ex. 60-3). In our view, Dr. White limited his opinion to a comparison of the two injuries. Later, Dr. White evaluated other causes and explained how the 1986 injury was but one of several contributors. (Exs. 64, 66). Based on his discussion of claimant's contributory obesity (at one point, claimant weighed 343 pounds) and facet arthritis, we conclude that Dr. White's ultimate well-reasoned opinion does not support a conclusion that the 1986 injury contributes more to claimant's current condition than all other causes combined. (Exs. 64, 66-13-14, -16-17). *See McGarrah v. SAIF*, 296 Or 145, 146 (1983). Under these circumstances, we conclude that claimant's current condition is not compensable.

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[2] He noted that Dr. Louie used bone instruments (curets, punches, a drill, and pituitary ronguers) to remove the hard disc. (Ex. 66-10; *see* Exs. 43, 51-5).

[3] Dr. Louie's operative report states, "A foraminotomy and medial facectomy was [sic] done to decompress the nerve completely." (Ex. 43).

[4] We acknowledge that Dr. White initially stated that the major contributing cause of claimant's current condition was the 1986 injury. (*See* Ex. 60-3). Later, he considered other contributing causes and concluded that the 1986 injury was but one of the contributing causes of claimant's current condition. We find his changed opinion and ultimate conclusion persuasive, as explained herein.

[5] Claimant argues that Liberty "implied" acceptance of claimant's disc condition when it denied claimant's aggravation claim without specifically denying the disc condition. We disagree, because Liberty accepted only a low back strain. *See Granner v. Fairview Center*, 147 Or App 406, 410 (1997) ("the scope of the acceptance corresponds to the condition specified in the acceptance notice"); *Richard L. Markum*, 48 Van Natta 2204 (1996) (acceptance is an act through which an insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law).

[6] We note that claimant did not seek treatment for his low back for over nine years after he recovered from the 1986 injury.

[7] Even if claimant herniated his disc in 1986, it does not necessarily follow that the 1986 injury is the major contributing cause of his current condition. (*See* Ex. 64).

ORDER

The ALJ's order dated November 12, 1999 is reversed in part and affirmed in part. That portion of the order that set aside Liberty Northwest Insurance Corporation's denial is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

March 17, 2000 Cite as 52 Van Natta 437 (2000)

In the Matter of the Compensation of
RICK D. HEFFLEY, Claimant
WCB Case No. 98-0479M
OWN MOTION ORDER
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The insurer initially submitted a request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights on that claim expired on June 3, 1992.

On November 19, 1998, the insurer denied the compensability of and the responsibility for claimant's current L5-S1 disc herniation condition. Claimant requested a hearing. (WCB Case No. 98-09784). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated November 12, 1999, Administrative Law Judge (ALJ) Stephen Brown set aside the insurer's November 19, 1998 denial, and remanded the claim back to the insurer for processing. The insurer requested Board review of ALJ Brown's order, and in an order issued on today's date, the Board reversed ALJ Brown's order and found that claimant's current condition was not compensable.

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
MICHAEL D. SEAMAN, Claimant
WCB Case Nos. 99-03985 & 98-10117
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) found that the SAIF Corporation did not deny compensability of claimant's current L4-5 disc condition: and (2) did not award an attorney fee under ORS 656.386(1). On review, the issues are scope of the denial and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last sentence and the "Ultimate Findings of Fact," with the following supplementation.

On March 18, 1999, SAIF sent claimant a letter with the caption "Disclaimer of Responsibility and Claim Denial." The letter stated that SAIF was

> "unable to pay for treatment or disability related to disc herniation at L4-5 because of the following reason(s):
>
> "The September 8, 1981 injury is not the major contributing cause of your disc herniation at L4-5.
>
> "The treatment and/or disability is not related to the accepted low back sprain/strain condition." (Ex. 96).

SAIF also informed claimant that it was disputing responsibility for claimant's condition, but had not requested a paying agent pursuant to ORS 656.307, and claimant should file claims against other potentially responsible parties. The letter stated, "This is a denial of your claim for benefits," and concluded by notifying claimant of his right to request a hearing. (*Id*).

CONCLUSIONS OF LAW AND OPINION

Claimant injured his low back (specifically, his L4-5 disc) on April 27, 1998. Employer's Insurance of Wausau and SAIF denied claimant's claims. Claimant requested a hearing, raising compensability and responsibility issues and requesting a penalty for SAIF's allegedly unreasonable compensability denial. At hearing, SAIF stated that it was denying responsibility only, not compensability.

The ALJ found Wausau responsible for claimant's current L4-5 disc condition. The ALJ also held that claimant was not entitled to a penalty based on SAIF's allegedly unreasonable denial. The ALJ reasoned that, although SAIF did not request designation of a paying agent under ORS 656.307, the heading of its denial did not indicate that SAIF had denied compensability of the claim and therefore claimant was not entitled to a penalty for an allegedly unreasonable compensability denial.

On review, claimant contends that SAIF did deny compensability and he argues entitlement to an attorney fee under ORS 656.386, payable by SAIF, for prevailing against the claim it denied.

ORS 656.386(1) allows an attorney fee in all cases involving denied claims where a claimant finally prevails against the denial. A "denied claim" is:

> "A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation[.]" ORS 656.386(1)(b)(A).

In this case, SAIF's denial specifically provided that it was a denial of claimant's claim for benefits and SAIF would not pay for treatment or disability under the claim because:

> "The September 8, 1981 injury is not the major contributing cause of [claimant's] disc herniation at L4-5.

"The treatment and/or disability is not related to the accepted low back sprain/strain condition." (Ex. 96).

The denial specifically stated that it was a denial of claimant's claim for benefits. In addition, it asserted that claimant's injury during its coverage did not cause claimant's condition. Therefore, we find that SAIF denied the claim on the express ground that claimant's disc condition was not compensable or otherwise did not give rise to entitlement to compensation. *See* ORS 656.386(1); *Frederick W. Hodgen*, 51 Van Natta 1490, 1493 (1999). Accordingly, based on the plain language in the denial, we find that SAIF denied compensability as well as responsibility.

SAIF argues that its denial does not say that the claim is not compensable. It acknowledges that the denial stated the accepted condition is not the major contributing cause of the current condition. However, because that assertion addresses the standard for shifting responsibility under ORS 656.308, SAIF contends that it denied responsibility only, not compensability.

But the denial stated that it *was* a denial of claimant's claim for benefits and it asserted that claimant's injury during its coverage was not the major contributing cause of the claimed condition and claimant's treatment and/or disability was not related to the condition SAIF had previously accepted. Moreover, SAIF's denial was captioned "Disclaimer of responsibility *and claim denial*" (emphasis added); it contained notice of hearing provisions consistent with a denial of compensation; and it specifically stated that a paying agent had not been requested.[1] Accordingly, on this evidence, we remain persuaded that SAIF denied compensability as well as responsibility. *See Douglas H. Brooks*, 48 Van Natta 736, 738-39 (1996); *Ronald L. Swan, Sr.*, 47 Van Natta 2412, 2415 (1995); *Howard L. Rose*, 47 Van Natta 345, 346 (1995); *Ancil R. Honeywell*, 46 Van Natta 2378 (1994). Because it is undisputed that the claim is compensable, claimant is entitled to an attorney fee for services at the hearing level for prevailing over the compensability portion of SAIF's denial.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the compensability issue is $3,000 payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Finally, claimant is not entitled to a fee for services at hearing regarding the penalty issue or on review regarding the attorney fee issue.

ORDER

The ALJ's order dated September 14, 1999 is reversed in part. The SAIF Corporation's compensability denial is set aside. For services at hearing, claimant is awarded a $3,000 attorney fee, payable by SAIF. The remainder of the order is affirmed.

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[1] We acknowledge SAIF's argument that OAR 436-060-0180 is invalid and claimant's response that we should not address this defense because SAIF first raised it on review. We do not address these arguments because we do not rely on the rule.

In the Matter of the Compensation of
WILLIAM C. TONEY, Claimant
WCB Case Nos. 98-07540 & 98-07539
CORRECTED ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

It has come to our attention that our recent Order on Review contains a clerical error. Specifically, in the body of the order, we awarded claimant's counsel an assessed attorney fee of $1,200, pursuant to ORS 656.382(2) and OAR 438-015-0010(4). However, the "Order" papagraph itself provides for an attorney fee of only $1,000. Accordingly, the "Order" papagraph is corrected to award an attorny fee of $1,200, to be paid to claimant's counsel by the self-insured employer.

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

IT IS SO ORDERED.

March 17, 2000 Cite as 52 Van Natta 440 (2000)

In the Matter of the Compensation of
MICHAEL D. SEAMAN, Claimant
Own Motion No. 99-0108M
OWN MOTION ORDER
Doblie & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable low back condition. Claimant's aggravation rights on that claim expired on June 22, 1987.

On March 18, 1999, SAIF issued a "Disclaimer of Responsibility and Claim Denial" of claimant's current low back condition. Claimant requested a hearing. (WCB Case No. 99-03985). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated September 14, 1999, Administrative Law Judge (ALJ) Otto upheld SAIF's March 18, 1999 denial and found a subsequent insurer responsible for claimant's current low back condition. Claimant requested Board review of those portions of ALJ Otto's order that: (1) found that SAIF did not deny compensability of claimant's current condition; and (2) did not award an attorney fee under ORS 656.286(1). By an order issued on today's date, we: (1) reversed that portion of the ALJ's order regarding whether SAIF had issued a compensability denial; (2) modified the ALJ's order and awarded a $3,000 attorney fee; and (3) did not disturb the ALJ's responsibility decision.

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 insurer. 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
JULIA (KLINGER) BJUR, Claimant
Own Motion No. 99-0462M
OWN MOTION ORDER

The insurer submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on January 7, 1992. The insurer opposed authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; (3) it is not responsible for claimant's current condition; and (4) surgery and/or hospitalization is not reasonable or necessary for claimant's current condition.

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

Claimant's 1983 claim was first closed on January 7, 1987, and her aggravation rights expired on January 7, 1992. ORS 656.273(4)(a). Thus, when claimant's condition worsened in November 1999, claimant's claim was under our own motion jurisdiction. Inasmuch as we have exclusive own motion jurisdiction over the claimant's 1983 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 February 8, 2000, the insurer submitted its recommendation to deny claimant's request for own motion relief. The insurer disputed the compensability of and responsibility for claimant's current condition. The insurer further contended that claimant's current condition did not require surgery and/or hospitalization and that any surgery or hospitalization is not reasonable or necessary for claimant's current condition. The Board wrote, on several occasions, to both the insurer and claimant requesting further clarification of the insurer's recommendation and requesting a copy of the denial if one had issued. To date, no response has been received from either party.

Thus, the issue of whether claimant's current condition is part of her accepted 1983 claim remains a compensability and a responsibility question which are undetermined at this time. As noted above, jurisdiction over matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization disputes rests either with the Hearings Division or with the Director.

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1983 injury claim for the payment of temporary disability benefits. *See* ORS 656.278(1)(a). Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES E. BOARD, Claimant
WCB Case No. 99-02118
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's injury claim for right wrist chondromalacia. 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 issue in this case involves claimant's injury claim for right wrist chondromalacia. Claimant signed an "801" form on March 5, 1998, stating that he had right wrist and thumb pain. (Ex. 8). The insurer accepted a right wrist sprain on November 6, 1998. (Ex. 30). On January 7, 1999, Dr. Lipp performed an arthroscopy on claimant's right wrist. (Ex. 35). Dr. Lipp's postoperative diagnosis was chondromalacia involving the lunate fossa of the distal right radius. (*Id.*) Dr. Lipp noted that the triangular fibrocartilage was completely intact. (Ex. 35-2).

On January 26, 1999, the insurer amended the acceptance to include a right triangular fibrocartilage tear. (Ex. 39). One day later, the insurer issued a partial denial of claimant's "chondromalacia involving the lunate fossa of the distal right radius." (Ex. 40). Claimant requested a hearing.

The ALJ noted there was an underlying acceptance resulting from the February 17, 1998 injury. Relying on *Boise Cascade Corp. v. Katzenbach*, 104 Or App 732 (1990), *rev den* 311 Or 261 (1991), the ALJ reasoned that, because the insurer accepted a claim arising from the February 17, 1998 work activities, the insurer had accepted the "cause." The ALJ found that claimant had been straightforward and honest throughout the claim. The ALJ relied on Dr. Lipp's opinion and concluded that claimant had established compensability of his right wrist chondromalacia.

We first address the insurer's argument that the ALJ's reliance on *Katzenbach* is misplaced. The insurer asserts that it is not denying what has been accepted; rather, it is denying a *separate* condition.

In *Katzenbach*, the carrier accepted the claimant's injury claim for a right wrist strain. Four months after the first report of injury, the claimant's condition was diagnosed as avascular necrosis and the carrier denied compensability of that condition. 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 *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), did not apply and it concluded that the carrier's acceptance of the strain was not an acceptance of a claim for avascular necrosis. *Id.* Acceptance of a particular condition does not necessarily include the cause of that condition. *Granner v. Fairview Center*, 147 Or App 406, 410 (1997).

Here, the insurer accepted a right wrist strain resulting from a February 1998 injury. (Ex. 30). Thus, the insurer has accepted a specific condition, not merely symptoms. The insurer is now denying the claim for chondromalacia. There are no medical opinions indicating that claimant's need for surgical treatment was related to the right wrist strain. Rather, the medical evidence establishes that the right wrist strain and chondromalacia are separate conditions. Therefore, the insurer's acceptance of a right wrist strain does not constitute an acceptance of chondromalacia. We conclude that the insurer is not barred from denying compensability of the chondromalacia condition.

Next, the insurer argues that claimant did not have a "jamming" injury involving his right wrist on February 17, 1998. The insurer contends that claimant's later history of an injury was embellished or fabricated and it argues that Dr. Lipp's causation opinion is not persuasive because it was based on claimant's later inaccurate history.

The ALJ found that claimant had been straightforward and honest throughout the claim. Although not statutorily required, the Board generally defers to the ALJ's credibility determination when it is based on the ALJ's opportunity to observe the witnesses. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

On *de novo* review, we agree with the ALJ that claimant was a credible witness. Claimant, an electric motor mechanic, testified that on or about February 17, 1998, he was using a pneumatic impact wrench to dismantle a mill motor. (Tr. 7-8). The bolts that claimant was attempting to remove were rusted in place. (Tr. 8). As he worked on the motor for most of eight hours, the tool "continually snapped" in his hand. (Tr. 8-9). He said that most of the time, his wrist was "jerked by the impact," instead of the bolts being turned. (Tr. 9). By the end of his shift, claimant's right wrist and thumb were so sore that he needed help putting his tools away. (Tr. 9-10).

Claimant initially sought medical treatment from Dr. Simons on February 23, 1998, complaining of right wrist and hand pain. (Ex. 7). He was referred to Dr. Lipp, who examined him on April 24, 1998. (Ex. 13). Dr. Lipp reported that claimant had injured his right wrist and thumb at work on February 17, 1998, and had been using a pneumatic tool when he noted some pain and popping in his wrist. (Ex. 14-1). Dr. Lipp diagnosed De Quervain's tendinitis of the right wrist and suspected a possible tear of triangular fibrocartilage of the right wrist. (Exs. 13, 14-2). In his February 18, 1999 chart note, Dr. Lipp explained that, at the time of the injury, claimant was loosening some bolts on an electric motor when the pneumatic device jumped and jammed his right wrist. (Ex. 44). After further diagnostic tests, Dr. Lipp performed an arthroscopy on claimant's right wrist on January 7, 1999. (Ex. 35). Dr. Lipp's postoperative diagnosis was chondromalacia involving the lunate fossa of the distal right radius. (*Id.*)

The insurer argues that claimant's revised history given to Dr. Lipp in February 1999 is not credible and it contends that Dr. Lipp's opinion on causation is not persuasive because it is based on an inaccurate history.

Dr. Lipp's April 29, 1998 report said that claimant had injured his right wrist and thumb at work on February 17, 1998, and had been using a pneumatic tool when he noted some pain and popping in his wrist. (Ex. 14-1). In his February 18, 1999 chart note, Dr. Lipp explained that, at the time of claimant's injury, he was loosening some bolts on an electric motor when the pneumatic device jumped and jammed his right wrist. (Ex. 44). Dr. Lipp's February 18, 1999 chart note is not inconsistent with his April 1998 report.

In a deposition, Dr. Lipp was asked about claimant's mechanism of injury. (Ex. 48A-7, -8). Dr. Lipp replied that claimant said he had been using a pneumatic tool when he injured his wrist. (*Id.*) Dr. Lipp explained that he had not gone into great detail at the time because it was not particularly pertinent for the purpose of treating claimant. (Ex. 48A-8, -9). He later asked claimant about the injury because of the discussions from different doctors and the debate about whether the injury was work-related. (*Id.*) Dr. Lipp said that claimant might have previously told him the February 1999 history, but he had not written it down. (Ex. 48A-9, -10). He explained that he would not necessarily have written that particular history in a previous chart note. (Ex. 48A-10). Dr. Lipp was asked whether he had to know the mechanism of injury in "great detail" for purposes of diagnosis and he replied:

> "No, I don't feel that you do. I don't think you need to know about it in any great detail; in other words, I think that my comment on April 29th that he injured himself when he was using this pneumatic tool, I think that's quite satisfactory." (Ex. 48A-10).

At hearing, claimant was asked why he told Dr. Lipp on February 18, 1999 that the pneumatic device had jumped and jammed his right wrist. (Tr. 15). Claimant replied: "Because he asked me again, and I told him again." (*Id.*) Based on claimant's testimony, we find that he sustained an injury on February 17, 1998 when the pneumatic tool he was using jumped and jammed his right wrist. Furthermore, based on claimant's testimony and Dr. Lipp's deposition testimony, we are not persuaded that claimant "changed" the history of injury that he gave to Dr. Lipp. We find that Dr. Lipp had an accurate understanding of claimant's February 17, 1998 work injury.

We agree with the ALJ that there is no medical evidence that claimant had a preexisting condition that combined with his work injury to cause or prolong his disability or need for treatment. Therefore, claimant need only establish that his work injury was a material contributing cause of his disability and/or need for treatment. 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).

Dr. Lipp is a board-certified orthopedic surgeon with a subspecialty in hand surgery. (Ex. 48A-65). Dr. Lipp believed that claimant had sustained a significant injury of the articular cartilage in the lunate fossa of his distal right radius due to the February 17, 1998 injury at work. (Ex. 47). He explained that, if the cartilage problem was due to a gradually developing degenerative arthritis of the wrist, he would have expected to see changes elsewhere in the wrist joint. (*Id.*) Dr. Lipp did not find such changes and he noted that the other areas of articular cartilage of the distal radius and proximal carpal row were normal. (*Id.*) In a deposition, Dr. Lipp adhered to his opinion on causation. (Ex. 48A-66). We find no persuasive reasons not to defer to Dr. Lipp's opinion. In particular, we give deference to Dr. Lipp because he has had the opportunity to observe claimant's right wrist condition during surgery. *Argonaut Insurance v. Mageske*, 93 Or App 689, 702 (1988).

The insurer relies on the opinions of Drs. Nye and Button to argue that claimant has not sustained his burden of proving compensability.

Dr. Nye examined the endoscopic pictures taken at the time of claimant's surgery and he agreed it was not possible to state the cause of the "purported" cartilage damage. (Ex. 51-1). He agreed that the cartilage disruption could be a degenerative problem or could have been caused by the arthroscopy itself. (*Id.*) We are more persuaded by the opinion of the treating surgeon, Dr. Lipp, who had the opportunity to examine claimant's right wrist pathology during surgery and who persuasively explained why he did not believe claimant's chondromalacia was degenerative in nature. *See Argonaut Insurance Co. v. Mageske*, 93 Or App at 702.

Similarly, for the following reasons, we are not persuaded by Dr. Button's reports. Dr. Button initially examined claimant on behalf of the insurer on July 29, 1998. (Ex. 18). Dr. Button could not arrive at any objective diagnosis and was doubtful there was any occult process within claimant's wrist joint that could account for his symptoms. (Ex. 18-5).

Dr. Button reevaluated claimant on May 19, 1999, after the arthroscopic surgery. (Ex. 48). He questioned Dr. Lipp's surgical findings, referring to the "supposed findings at surgery[.]" (Ex. 48-5). Dr. Button said that, if there were any loose cartilaginous fragments, he would have expected some abnormality to have been noted on the arthrogram. (*Id.*) He commented that the arthroscopy report referred to a problem with the articular surface of the radius, *i.e.*, chondromalacia, but he said that was a "very minor supposed abnormality and unlikely to be a cause of apparent refractory wrist and hand symptoms." (Ex. 48-2).

On the other hand, Dr. Lipp testified that he had taken a photograph of claimant's condition at the time of surgery and, during the deposition, he explained the portions that showed claimant's chondromalacia. (Ex. 48A-15, -16, -17, -68). In contrast to Dr. Button's report, Dr. Lipp said that loose cartilage or chondromalacia could not be seen on an arthrogram. (Ex. 48A-47, -48). He explained that claimant's cartilage was not totally loose, but it was pushing out from the surface. (Ex. 48A-48, -49). Dr. Lipp disagreed with Dr. Button's opinion that claimant had a "very minor supposed abnormality" and he explained that the chondromalacia on the surface of claimant's wrist had caused his pain and symptoms. (Ex. 48A-54). In light of Dr. Lipp's first-hand exposure to and knowledge of claimant's surgical condition, we are more persuaded by his opinion on causation and the need for surgical treatment. *See Argonaut Ins. v. Mageske*, 93 Or App at 702.

Furthermore, we are not persuaded by Dr. Button's comment that there is "secondary gain" involved in this case. (Ex. 48-3). In his first report, Dr. Button said that there were no obvious, nonanatomic findings and claimant came across as a "straightforward, motivated individual." (Ex. 18-6). As the ALJ noted, claimant lost little time from work as a result of the injury and he returned to his regular work. We find no evidence of "secondary gain" in this case.

Finally, we are not persuaded by Dr. Button's comments that claimant had "changed" his story long after the injury. (Exs. 48-5, 50). According to Dr. Button, claimant denied that he had been using a tool that suddenly jammed, causing a torquing injury. (Ex. 50). Dr. Button commented that the normal use of pneumatic tools was not likely to have caused chondromalacia. (*Id.*)

Claimant testified that when he was using the pneumatic tool on February 17, 1998, his wrist was "jerked" by the impact of the pneumatic tool, rather than the bolts being turned. (Tr. 9). As he worked on the motor for most of eight hours, the tool "continually snapped" in his hand and his wrist was constantly jerked by the impact. (Tr. 8-9). By the end of his shift, claimant's right wrist and thumb were so sore that he needed help putting his tools away. (Tr. 9-10). Claimant testified that he told Dr. Button that he did not have one specific incident. (Tr. 11-12). Rather, claimant told Dr. Button that his wrist had snapped back and forth while using the pneumatic tool. (Tr. 12-13).

We find claimant to be a credible witness and we are not persuaded that he provided inaccurate information to Dr. Button. To the extent that Dr. Button's history is inconsistent with Dr. Lipp's history, we are more persuaded by Dr. Lipp's understanding of claimant's injury. As we discussed earlier, we are persuaded that claimant did not "change" the history of injury that he gave to Dr. Lipp. Based on Dr. Lipp's well-reasoned opinion, we conclude that claimant has established compensability of his right wrist chondromalacia.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 21, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,750, payable by the insurer.

March 17, 2000 Cite as 52 Van Natta 445 (2000)

In the Matter of the Compensation of
MARGARET A. ANTHONY, Claimant
WCB Case No. 98-04017
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the insurers denial of claimants right arm injury claim. On review, the issue is compensability.

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

On review, claimant in part argues that the opinion of her treating surgeon, Dr. Stewart, is more persuasive because he performed surgery, allowing him to actually view the pathology in claimant's right arm and determine whether or not there was a fibrous union.

The problem with this argument is that Dr. Stewart did not rely on such a basis for his opinion. That is, Dr. Stewart did not base his opinion on anything he saw during surgery and, instead, relied upon claimant's history. For the reasons provided by the ALJ, we agree that Dr. Stewart relied on an inaccurate history and a diagnosis that is not confirmed by the record.

ORDER

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

In the Matter of the Compensation of
LORRAINE F. FORTADO, Claimant
WCB Case No. 99-02227
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that reduced her award of scheduled permanent disability for loss of use or function of the right ankle from 21 percent (28.35 degrees), as granted by an Order on Reconsideration, to 2 percent (2.7 degrees). On review, the issue is scheduled permanent disability.

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

Claimant sustained a compensable right ankle sprain on April 3, 1998. Dr. McMahon became claimant's attending physician and declared claimant's right ankle condition medically stationary on September 4, 1998 without permanent impairment. In his closing examination, Dr. McMahon noted claimant had full range of motion and that her right ankle was only occasionally bothersome. (Ex. 13).

The claim was closed by Notice of Closure on October 6, 1998. No permanent disability was awarded. Claimant requested reconsideration.

Dr. Tiley performed a medical arbiter's examination as part of the reconsideration proceedings. (Ex. 17). In his report, Dr. Tiley reported reduced range of motion and that claimant had "some limitation" of ability to repetitively use the right ankle that was "mild." (Ex. 17-4). Dr. Tiley also noted that claimant had difficulty with walking and standing for more than 2 hours cumulatively in an 8-hour period. *Id.*

Based on the arbiter's report, a February 17, 1999 Order on Reconsideration awarded 21 percent scheduled permanent disability. Two percent of the award was based on reduced range of motion, 5 percent was awarded for a "chronic" condition and 15 percent was awarded for inability to stand for more than 2 hours cumulatively in an 8-hour period. (Ex. 18-3). The insurer requested a hearing.

The ALJ reduced claimant's scheduled award to 2 percent, basing the award solely on the arbiter's range of motion findings. The ALJ determined that the arbiter's report did not establish claimant's entitlement to a 5 percent "chronic" condition award or to a 15 percent award based on an inability to stand or walk for a cumulative total of more than 2 hours in an 8-hour period.

On review, claimant contends that the ALJ should have affirmed the reconsideration order's scheduled permanent disability award. Claimant asserts that the arbiter's report establishes her entitlement to a "chronic" condition award, as well as one based on inability to walk or stand for more than 2 hours in an 8-hour period.

We agree, however, with the ALJ's reasoning that claimant is not entitled to the 15 percent impairment award for alleged inability to walk or stand for more than 2 hours in an 8-hour period. Moreover, we agree with the ALJ's "chronic" condition determination. We supplement the ALJ's order on the latter point.

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, she is *significantly* limited in the repetitive use of her right lower leg (below knee/foot/ankle). OAR 436-035-0010(5) (emphasis added). Dr. McMahon, the attending physician, did not expressly or impliedly identify any restriction on claimant's ability to use his right ankle in a repetitive manner. Accordingly, any "chronic" condition award must be based on Dr. Tiley's arbiter report.

In that regard, Dr. Tiley was directly asked whether claimant was "significantly" limited in her ability to repetitively use her right ankle due to a chronic and permanent medical condition. Dr. Tiley responded that there was "some limitation" of claimant's ability to repetitively use her ankle that was "mild" in nature. (Ex. 17-4). We conclude that this response does not establish claimant's entitlement to a chronic condition award.

In *Ronny G. Holland*, 50 Van Natta 2240 (1998), the medical arbiter also used the phrase "some limitation" in direct response to the Department's question asking for evidence of "significant limitation." We held that the arbiter's response indicated that the arbiter made a distinction between the two terms and, thus, that the claimant was not entitled to a "chronic" condition award. 50 Van Natta at 2241.

The result in this case should be the same. Dr. Tiley's response to the Department's inquiry also indicates that he was making a distinction between "significant" and "some" limitation. Therefore, we find that Dr. Tiley's response does not establish claimant's entitlement to a "chronic" condition award. Accordingly, we affirm.

ORDER

The ALJ's order dated October 14, 1999 is affirmed.

Board Member Biehl dissenting.

I agree with the majority's "chronic condition" analysis. However, I would not adopt, as the majority does, the ALJ's reasoning with respect to claimant's entitlement to a 15 percent impairment award for inability to walk or and for more than 2 hours in an 8-hour period. Instead, I would find that claimant qualifies for this impairment award. Accordingly, I dissent.

OAR 436-035-0200(4)(a) provides, in part:

> "When objective medical evidence establishes the worker cannot walk and/or stand for a cumulative total of more than two hours in an 8-hour period, the award shall be 15% of the foot/ankle * * * ".

The ALJ reasoned that claimant was not entitled to 15 percent impairment because there was no objective evidence of a severe injury that established that claimant could not walk and/or stand for more than 2 hours in an 8-hour period. Noting that it may be uncomfortable for claimant to walk and/or stand for more than 2 hours, the ALJ stated that the evidence did not persuade him that she could not do so. I respectfully disagree.

Dr. Tiley, the medical arbiter, was specifically asked whether claimant was prevented from walking or standing for more than 2 hours in an 8 hour period. (Ex. 17-4). Dr. Tiley did not respond in the negative and wrote that claimant "has difficulty" with that activity. I believe this response sufficiently establishes that claimant is prevented from walking or standing for the required period under the rule. The ALJ, therefore, erred in not granting the 15 percent impairment award. Thus, I dissent.

In the Matter of the Compensation of
ANNA B. MADRIZ, Claimant
WCB Case No. 98-03837
ORDER OF ABATEMENT
Hilda Galaviz, Claimant Attorney
Terrall & Terrall, Defense Attorneys

On February 18, 2000, we issued an 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 attorney fee award under ORS 656.386(1). Submitting a copy of a March 10, 2000 order involving a case before the Medical Review Unit for the Workers' Compensation Division (which held that a causation issue involving a diagnostic medical services claim must be resolved by the Board's Hearings Division under ORS 656.704(3)), claimant asks that we reconsider our decision and remand this matter to the Hearings Division for joinder with the WCD case.

In order to further consider claimant's motion, we withdraw our February 18, 2000 order. The 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 will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRADLEY P. FUSS, Claimant
WCB Case No. 99-00723
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporations denial of claimant's low back condition claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings with the supplement that, on September 11, 1999, examining physicians, Dr. Coletti and Dr. Green, saw claimant at SAIF's request. We also correct the ALJ's reference to October, 1999 in finding number 4 to October 1998.[1]

CONCLUSIONS OF LAW AND OPINION

Claimant has accepted claims of a 1986 low back strain and 1992 lumbar strain. In October 1998, claimant's attorney asked SAIF to accept the condition of chronic post-traumatic myofascial low back pain syndrome. SAIF denied the condition.

The ALJ upheld SAIF's denial after concluding that the preponderance of evidence did not show that the 1992 injury was the major contributing cause of the chronic post-traumatic myofascial low back pain syndrome. Continuing to rely the opinion of claimant's treating physiatrist, Dr. Grant, claimant asserts that he proved compensability, based either on the 1986 or 1992 injury. SAIF first responds that, because claimant did not argue that the 1986 injury was the major contributing cause, he is precluded from making such argument on review. SAIF also contends that the ALJ correctly determined that claimant did not prove that the 1992 injury was the major contributing cause.

Whether based on the 1986 injury or the 1992 injury, we agree that claimant did not carry his burden of proof.[2] The record contains numerous opinions concerning causation.

In February 1993, examining physicians, Dr. Rich and Dr. McKillop, found that the 1992 lifting strain was superimposed on preexisting chronic low back pain and that the major contributing cause of claimant's then current low back condition was progressive degenerative disc disease which is of unknown etiology. (Ex. 30-5).

Although Dr. Grant initially concurred with the report, (Ex. 31), he then stated that he did not agree with the panel's diagnosis or conclusions, (Ex. 36). According to Dr. Grant, claimant's chronic low back pain was not just related to degenerative disc disease and that his main problems are muscular/myofascial in nature. (Ex. 37). Dr. Grant also indicated that the muscular/myofascial problems are in major part due to his work injury of 6/11/92. (*Id.*)

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[1] We also correct the ALJ's statement in the opening paragraph that [f]ifty-one exhibits were admitted with the following. Exhibits 1 through 51 were admitted, including 20A, 35A, 37A-E, and 38A-L.

[2] Thus, we do not reach the issue of whether claimant is precluded on review from asserting compensability based on the 1986 injury.

Dr. Quarum, occupational medicine specialist, examined claimant at SAIF's request. Dr. Quarum found that a component of claimants symptoms were due to degenerative disc disease but thought most of his pain was of a soft tissue nature. (Ex. 42-5). Dr. Quarum disagreed with the diagnosis of chronic post-traumatic myofascial low back pain syndrome. (*Id.*)

Dr. Quarum also reported that he found no significant pre-existing condition or that the 1992 injury was the major contributing cause of the current need for treatment; instead, Dr. Quarum attributed claimant's complaints to deconditioning and lack of activity, rather than a specific disorder. (*Id.*)

Dr. Quarum provided a supplemental report after receiving additional medical reports. Based on chartnotes before the 1992 injury, Dr. Quarum concluded that the 1992 injury did not materially or pathologically change claimant's low back condition. (Ex. 45-2). Dr. Quarum also reversed his previous opinion and found that there was a preexisting degenerative disc disease condition and this condition was the major contributing cause of claimant's current need for treatment. (*Id.*)

Dr. Rothman, chiropractor, provided an opinion based on a review of the records. Dr. Rothman also thought that claimant's symptoms arose from soft tissues rather than degenerative disk changes. (Ex. 44-8). Dr. Rothman further reported that physical decompensation and emotional adjustment were strongly implicated as an underlying cause for claimant's continuing low back pain. (*Id.* at 8-9). Finally, Dr. Rothman indicated that claimant's current need for treatment was not related to the 1992 injury but to claimant's long history of low back pain, dating to 1980. (*Id.* at 9).

Dr. Grant then provided a report stating that he originally diagnosed claimant with chronic myofascial pain syndrome in September 1980 and that he continued to find that this condition was in major part caused by the 1992 injury. (Ex. 46-2). Dr. Grant also agreed that his current myofascial pain syndrome condition is the same condition that has been active all along[.] (*Id.*)

Dr. Grant further indicated that he disagreed with the reports from Dr. Quarum and Dr. Rothman; according to Dr. Grant, his extensive contact with claimant put him in the better position to accurately and appropriately diagnose his condition. (*Id.* at 3). Dr. Grant also noted that he had extensive training and lengthy experience in treating this condition. (*Id.*)

Finally, Drs. Coletti and Green diagnosed chronic degenerative disc disease with mechanical low back pain. (Ex. 51-4). According to the panel, this condition was the source of claimant's pain. (*Id.* at 5). The panel also thought that claimant's progressive symptoms was not consistent with a sprain but rather with an underlying spondyloarthropathy and/or degenerative disc disease. (*Id.* at 7). Finally, the panel found that claimant's 1992 sprain had resolved and was not the cause of his current condition. (*Id.*)

We generally defer to the treating physicians opinion, absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to defer to Dr. Grant's opinion that claimant's chronic post-traumatic myofascial low back pain syndrome is related to the 1992 injury.

First, Dr. Grant explains that claimant's current myofascial condition is the same one diagnosed in 1980. Dr. Grant, however, does not explain how, if it is the same condition, the subsequent 1992 injury is the major contributing cause of the current need for treatment. That is, we find it inconsistent to say that a condition has been the same since 1980 but is caused by a subsequent injury.

Furthermore, Dr. Grant does not respond to the opinion of Dr. Quarum and the Coletti/Green panel that the 1992 strain resolved, leaving only the preexisting condition as the major contributing cause. In fact, Dr. Grant provides *no* explanation or reasoning supporting his opinion; at most, he relies on the length of his treatment of claimant and expertise in the diagnosed condition. Although expertise and familiarity are important factors when assessing persuasiveness of medical opinion, an opinion also must be well-reasoned. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). We find the persuasiveness of Dr. Grant's opinion greatly undermined by the lack of explanation for why a condition (that was originally diagnosed in 1980) continues to be caused by the 1992 injury, especially when the record contains contrary conclusions.

In sum, we find Dr. Grant's opinion insufficient to carry claimant's burden of proof, whether based on the 1986 or 1992 injury. Thus, we conclude that claimant did not prove compensability. *See* ORS 656.005(7)(a)(B); 656.005(7)(a)(A).

ORDER

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

March 20, 2000 Cite as 52 Van Natta 450 (2000)

In the Matter of the Compensation of
CARMEN O. MACIAS, Claimant
WCB Case No. 99-02440
ORDER ON REVIEW (REMANDING)
Vick & Conroyd, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denial of claimant's new left shoulder conditions. Submitting documents pertaining to a post-hearing surgery, claimant seeks remand to the ALJ for the admission of additional evidence. On review, the issues are remand and compensability. We remand.

Claimant, who worked as a meat processor for the employer, compensably injured her left shoulder and upper back. The insurer accepted left shoulder and thoracic strains. Claimant continued to experience shoulder pain and reduced range of motion. By mid-December 1998, Dr. Neitling, treating surgeon, concluded that claimant had adhesive capsulitis (frozen shoulder) and possible anterior instability and, by mid-January 1999, proposed surgical decompression. The insurer denied compensability of her current left shoulder condition[1] and claimant requested a hearing, contending that her current left shoulder condition arose directly from the March 1998 injury.

As discussed below, the ALJ reviewed the medical evidence from Dr. Neitling, Dr. Switlyk, who evaluated claimant for Dr. Neitling, and the examining physicians. The ALJ concluded that claimant had failed to prove compensability.

Claimant asks that we remand the case to the ALJ for consideration of additional evidence generated after the hearing. In support of the motion, claimant provides reports showing that an MRI was performed on August 10, 1999 that revealed a rotator cuff tear, that Dr. Neitling scheduled claimant for left shoulder surgery, and that the surgery revealed adhesive capsulitis and a torn rotator cuff. Claimant contends that such evidence provides a compelling reason to remand.

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). 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 the hearing; and (3) is reasonably likely to affect the outcome. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, the evidence concerning claimant's MRI and surgery concerns claimant's disability. Because both the MRI and the surgery were performed after the hearing and revealed a new condition, these documents were not obtainable at the time of the hearing. Furthermore, we find that such evidence is reasonably likely to affect the outcome. *See Michelle T. Nagmay*, 47 Van Natta 1952 (1995).

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[1] Although the ALJ stated that claimant's diagnosis of adhesive capsulitis was not addressed in his order (O&O at 6), the parties agree on review that the insurer's denial encompassed all left shoulder diagnoses, with the exception of the accepted left shoulder strain.

The record developed at hearing contained three opinions concerning causation. Examining physicians Dr. Farris, neurologist and Dr. Bald, orthopedist, diagnosed claimant's left shoulder condition as myofascial pain without a specific orthopedic or neurologic diagnosis. They thought that the major contributing cause of claimant's left shoulder condition was unknown and unrelated to her March 1998 injury. Examining orthopedist Dr. Fuller diagnosed idiopathic adhesive capsulitis in the left shoulder, which he thought was not caused by her work injury. Dr. Neitling, claimant's treating physician, initially diagnosed impingement and associated left shoulder instability, but after claimant's shoulder failed to respond to injection, he changed his diagnosis to capsular strain. As discussed by the ALJ, neither Dr. Neitling nor Dr. Switlyk settled on a diagnosis for claimant's condition. All physicians, however, rendered their opinions before the MRI and surgery. Dr. Neitling's report submitted by claimant indicates that he considered the torn rotator cuff a direct result of the injury, and subsequently developed symptoms of impingement and stiffness as a result of the tear.

Inasmuch as no physician provided an opinion based on the existence of a torn rotator cuff that might have contributed to claimant's refractory left shoulder symptoms, we find that the evidence regarding the "post-hearing" surgery is reasonably likely to affect the outcome of the case. Thus, we grant claimant's motion for remand.

Accordingly, the ALJ's order dated August 27, 1999 is vacated. This matter is remanded to ALJ Davis for further proceedings consistent with this order. Following these further proceedings, ALJ Davis shall issue a final, appealable order.

IT IS SO ORDERED.

March 20, 2000 Cite as 52 Van Natta 451 (2000)

In the Matter of the Compensation of
DARRELL F. PARENT, Claimant
WCB Case No. 99-04289
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the SAIF Corporation's partial denial of a left knee condition (patello-femoral chondrosis). On review, the issue is compensability.

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

ORDER

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

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[1] In his appellant's reply brief, claimant raises the issue of SAIF's failure to provide two pieces of evidence referred to in the record. We infer that claimant is raising the issue of SAIF's alleged failure to comply with claimant's discovery request. Because claimant did not raise that issue at hearing, we decline to consider claimant's argument for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991).

In the Matter of the Compensation of
CHRISTY RIGGS, Claimant
WCB Case No. 00-0077
OWN MOTION ORDER

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable facial injury condition. Claimant's aggravation rights expired on March 13, 1989. The insurer opposes the reopening of the claim on the grounds that no surgery or hospitalization was required to treat claimant's condition.

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

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

Here, in January 2000, claimant began to have problems with cellulitis on the left side of her face. Her attending physician, Dr. Griffiths, obtained a CT scan to rule out any further problems and started claimant on intravenous antibiotics. Claimant received this intravenous treatment at home, with the assistance of a registered nurse. The treatment began on January 18, 2000, and continued until January 31, 2000.

On February 4, 2000, Dr. Griffiths reported:

> "[Claimant] was on home intravenous antibiotics for approximately 10 days and has significantly improved. Generally, this requires an in-patient hospitalization, but due to newer technology, she was able to be home on intravenous antibiotics, but, of course, not at work. [Claimant] has now improved significantly and I see no other specific signs of infection, but she does still run a good chance for getting infections in the future."

Claimant is entitled to benefits for temporary total disability only if she qualifies for those benefits under the relevant statutory provisions. *Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990). As noted above, by statute, the requirement of surgery or hospitalization is a prerequisite to obtaining temporary disability benefits after expiration of aggravation rights. Based on the following reasoning, we find that claimant does not meet that statutory prerequisite.

First, there is no evidence that claimant was hospitalized. *See Daniel P. Moore*, 46 Van Natta 2490 (1994); *Fred E. Smith*, 42 Van Natta at 1538. Although Dr. Griffiths stated that, generally, intravenous antibiotic treatment requires inpatient hospitalization, the fact remains that this treatment

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[1] ORS 656.278(1)(a) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

was provided to claimant without such hospitalization. ORS 656.278(1)(a) requires actual surgery or hospitalization.[2]

Furthermore, although the administration of intravenous antibiotics may have improved claimant's current condition, it does not qualify as "surgery" within the meaning of ORS 656.278(1)(a). *See Melvin L. Wall*, 51 Van Natta 23 (1999) (intravenous antibiotics provided without overnight hospital stay did not qualify as "surgery" or "hospitalization" under ORS 656.278(1)(a)); *John Denton*, 50 Van Natta 1073 (1998) (although the claimant was taken off work during part of epidural injection treatment provided on an outpatient basis, that treatment did not qualify as "surgery" or "hospitalization" under ORS 656.278(1)(a)); *Tamera Frolander*, 45 Van Natta 968 (1993) (although the claimant was taken off work for three weeks during sympathetic nerve block injection treatment provided on an outpatient basis, that treatment did not qualify as "surgery" or "hospitalization" under ORS 656.278(1)(a)).

Inasmuch as claimant was not hospitalized and the record fails to demonstrate that she required surgery, we are not authorized to grant her request to reopen her claim. Accordingly, we deny the request for own motion relief.

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

IT IS SO ORDERED.

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[2] In applying ORS 656.278(1)(a) to circumstances requiring pain center treatment, we have held that we have the authority to reopen a claim for pain center treatment requiring *inpatient* hospitalization. *Joseph Fisher*, 45 Van Natta 2112 (1993). We may also reopen a claim for pain center treatment on an outpatient basis where overnight accommodation away from home is necessary to obtain maximum benefits from the treatment. *Richard N. Uhing*, 50 Van Natta 1611 (1998). Under such circumstances, pain center treatment is treated as hospitalization. *Lenne Butcher*, 41 Van Natta 2084 (1989). Nevertheless, under the circumstances of this case, there is nothing equivalent to an overnight accommodation away from home that is necessary to obtain maximum benefits from treatment. Therefore, the at-home intravenous treatment that claimant underwent does not qualify as "hospitalization."

In the Matter of the Compensation of
JEFFREY L. PROCIW, Claimant
WCB Case No. 98-08108
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

On February 24, 2000, we issued an Order on Review 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. Announcing that the parties have resolved their dispute, SAIF seeks abatement of our order to enable us to retain jurisdiction to consider their forthcoming settlement.

Based on SAIF's unrebutted representation, we withdraw our February 24, 2000 order. On receipt of the parties' proposed settlement, we will proceed with our reconsideration. In the meantime, the parties are requested to keep us fully apprised of any future developments regarding this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES L. BATSON, SR., Claimant
WCB Case No. 99-01559
ORDER ON RECONSIDERATION
Alice M. Bartelt (Saif), Defense Attorney

On February 23, 2000, we withdrew our January 24, 2000 Order on Review that: (1) reversed an Administrative Law Judge's (ALJ's) order that had awarded claimant unscheduled permanent disability for a neck condition of 31 percent (99.2 degrees); and (2) affirmed an Order on Reconsideration that awarded 11 percent (35.2 degrees). We took this action to consider claimant's *pro se* request for reconsideration. With his brief, claimant has submitted documents not admitted into evidence at hearing. Having received the SAIF Corporation's response, we proceed with our reconsideration.

Our review is limited to the record developed at hearing. ORS 656.295(5). Therefore, we treat claimant's "post-hearing" submission as a motion for remand to the ALJ for further development of the hearings record. *Judy A. Britton*, 37 Van Natta 1262 (1985). However, we may 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); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

With his "brief," claimant submitted copies of letters querying Dr. Kadwell and Dr. Keenan regarding claimant's Social Security Disability claim. Each letter is dated after the hearing record closed on July 1, 1999, and after the January 26, 1999 Order on Reconsideration.[1]

Any evidence not submitted during the reconsideration process is inadmissible at a subsequent hearing, including the claimant's testimony. *Rogue Valley Medical Center v. McClearen*, 152 Or App 239 (1998). Because claimant's evidence was not submitted (and did not exist) during the reconsideration process, it is inadmissible at hearing. Therefore, because the evidence cannot be considered by the ALJ, we find that none of the submitted documents is reasonably likely to affect the outcome of this case. Consequently, for these reasons, we deny claimant's motion for remand.

Accordingly, on reconsideration, as supplemented herein, we adhere to our January 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] Dr. Kadwell signed and dated his response on September 17, 1999. Dr. Keenan signed and dated his response on September 28, 1999.

Member Phillips Polich concurring in part and dissenting in part.

I agree with the majority's decision that remand is not warranted. However, for the reasons expressed in my prior dissenting opinion, I continue to disagree with the majority's decision to reduce claimant's unscheduled permanent disability award from 31 percent to 11 percent.

In the Matter of the Compensation of
JUANITA C. ROSE, Claimant
Own Motion No. 00-0004M
OWN MOTION ORDER
Coughlin, Leuenberger & Moon, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable cervical condition. Claimant's aggravation rights on that claim expired on December 22, 1997. The insurer recommended that claimant's claim be denied on the grounds that: (1) claimant's current condition is not causally related to the compensable condition; (2) it is not responsible for the current condition; and (3) claimant is not in the work force.

In response to an inquiry from a Board staff member, the insurer explained that claimant's cervical condition requires surgery at two different levels, C5-6 and C6-7. The insurer agrees that the surgery at C5-6 is compensably related to claimant's 1988 work injury, and does not oppose reopening the claim for that portion of the surgery. But it contends that because it is still in the process of addressing the compensability of the current condition at C6-7, it is unknown whether that portion of the recommended surgery is part of claimant's 1988 claim. The insurer further contends that it is unknown whether claimant was in the work force at the time of disability.

Claimant has not responded to the insurer's recent submission. However, prior to the submission of the insurer's January 18, 2000 own motion recommendation, claimant requested own motion relief. With her request, claimant submitted various medical records including a September 29, 1999 medical report from Dr. Zimmerman, her treating physician. Dr Zimmerman recommended anterior cervical microdiscketomies at C5-6 and C6-7. Claimant contends that those reports support her position that the surgery is compensably related to her 1988 injury and, therefore, her claim should be reopened for the payment of temporary disability compensation.

Claimant's 1988 claim was first closed on December 22, 1992, and her aggravation rights expired on December 22, 1997. ORS 656.273(4)(a). Thus, when claimant's condition worsened requiring surgery on December 10, 1999, claimant's claim was under our own motion jurisdiction. Inasmuch as we have exclusive own motion jurisdiction over the claimant's 1988 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 September 29, 1999, Dr. Zimmerman recommended that claimant undergo surgery. The insurer notes that the compensability of the recommended surgery at C6-7, as it relates to claimant's compensable 1988 injury, is unknown. As noted above, this "compensability" dispute is not within our jurisdiction to decide. Should a party wish to seek resolution of this "compensability" dispute, that party must request a hearing 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.* microdiscketomy at C5-6) is a compensable component of her 1988 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)).

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

The insurer contends that it is not able to determine whether claimant was in the workforce at the time of the current disability. However, with its recommendation form, the insurer submitted a July 29, 1999 chart note from Dr. Warren, claimant's attending physician, reporting that claimant was working as a waitress and would "continue to work for the time being." In a September 1, 1999 consultation report from Dr. Zimmerman, he noted that claimant had been working as a waitress for the last four years and is presently "working as a waitress." In a September 29, 1999, in a letter to Dr. Warren, Dr. Zimmerman noted that claimant "continues to work as a waitress."

Based on these submissions, we conclude that claimant was in the workforce at the time of her current worsening.[1] Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] We 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 she enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish she was in the work force is the time prior to September 29, 1999 when her 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).

In the Matter of the Compensation of
GERALD C. ALM, Claimant
WCB Case No. 99-05869
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant[1] requests review of Administrative Law Judge (ALJ) Tenenbaum's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

On July 22, 1999, claimant signed a retainer agreement employing his attorney of record to represent him in connection with his workers' compensation claim. The retainer agreement provided that claimant retained the attorney to "act as my attorney for all issues and claims related to my Workers' Compensation injury" and authorized the attorney "to sign all settlements and any other documents on my behalf."

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[1] Although represented at the time of the hearing request and the withdrawal of that request, it is unclear whether claimant continues to be represented. By letter dated October 27, 1999 (addressed to claimant and copied to the ALJ and the insurer) claimant's attorney notified claimant that he had withdrawn claimant's request for hearing (pursuant to their telephone conversation the previous day). Counsel ended the letter, however, inviting claimant to contact him if he had any questions. We also have no record that claimant's attorney withdrew his representation or that claimant terminated his attorney.

FINDINGS OF FACT

On July 22, 1999, claimant, through his attorney, requested a hearing challenging the insurer's denial of claimant's claim and raising issues about claimant's proper time loss rate, the reasonableness of the denial, and attorney fees. A hearing was scheduled for October 26, 1999.

By letter dated October 27, 1999, claimant's attorney withdrew the hearing request. On November 1, 1999, the ALJ dismissed claimant's hearing request.

By letter dated November 26, 1999, postmarked and received by the Board on November 29, 1999, claimant requested review of the ALJ's dismissal order. Claimant expressed dissatisfaction with his attorney's action requesting dismissal of the scheduled hearing and stated that the attorney did not tell him that he was "withdrawing the case." Claimant also noted his understanding that legal representation would cost him nothing, but the attorney had billed him for "costs expended by his office." Claimant asks us to advise him regarding his options at this point.

CONCLUSIONS OF LAW AND OPINION

The ALJ dismissed claimant's hearing request. We treat claimant's November 26, 1999 letter as a request for review of that Order of Dismissal. In doing so, we emphasize that 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 was appropriate.

By letter dated November 27, 1997, claimant's attorney withdrew the hearing request. In addition, the retainer agreement between claimant and his attorney authorized claimant's attorney to act on claimant's behalf. Finally, although it is not clear whether claimant continues to be represented, claimant acknowledges that his attorney requested that claimant's hearing request be withdrawn.

We find that the record establishes that claimant, through his attorney, withdrew his request for hearing. Although claimant is dissatisfied with his attorney's action, he does not dispute his attorney's authority to act on his behalf, nor does he dispute the fact that the ALJ dismissed his request for hearing on this claim in response to his former attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the dismissal order.[2] *See Richard J. Rocha*, 49 Van Natta 1411 (1997); *William A. Martin*, 46 Van Natta 1704 (1994).

ORDER

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

[2] It appears that claimant disputes actions taken by his attorney on his behalf. We lack authority to address such issues. Claimant may wish to seek legal advice on these matters.

March 22, 2000 Cite as 52 Van Natta 457 (2000)

In the Matter of the Compensation of
ORVEL L. CHANEY, Claimant
Own Motion No. 99-0250M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Mark D. Sherman, Claimant Attorney

On November 2, 1999, we withdrew our July 16, 1999 Own Motion Order, as reconsidered on September 29, 1999. In those orders, we declined to reopen claimant's 1987 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery. Claimant requested reconsideration of our prior orders and submitted additional documentation, which he contends supports his contention that he was in the work force at the relevant time. Having considered the SAIF Corporation's response and the parties' respective positions, we proceed with our review.

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

On August 6, 1999, claimant underwent surgery for his compensable left knee condition; specifically, he underwent a revision of his left total knee arthroplasty. Thus, 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); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). The Court has repeatedly explained the importance of being a member of the work force in order to establish entitlement to temporary disability compensation. In this regard, in *Cutright v. Weyerhaeuser Company*, 299 Or 290, 302 (1985), the Court stated that "[a] claim for temporary total disability benefits in the absence of wage loss seeks a remedy where there is no damage. Non-workers can sustain medical expenses. They cannot lose earnings."

Furthermore, in *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989), the Court explained:

> "A claimant who is not employed, is not willing to be employed, or, although willing to be employed, is not making reasonable efforts to find employment (unless such efforts would be futile because of the work-related injury) has withdrawn from the work force. A claimant who, at the time of the aggravation of the work-related injury, has withdrawn from the work force is not entitled to temporary total disability."

Pursuant to the Court's reasoning in *Dawkins*, 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. *Id.*

Under the Board's own motion jurisdiction,[1] the "date of disability," for the purpose of determining whether claimant is in the work force is the date he undergoes outpatient surgery or the date he enters the hospital for curative treatment. *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 August 6, 1999, the date he was hospitalized for surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; Weyerhaeuser v. Kepford, 100 Or App at 414; *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997). Claimant has the burden of proof regarding the work force issue. ORS 656.266.

In his July 6, 1999 affidavit, claimant stated that: "I am always willing to work, but it is impossible (I tried it) my left knee is defective." In addition, in a June 3, 1999 letter to SAIF, claimant stated that: "I am not employed at the present time, and I haven't been for the past two years." With his current request for reconsideration, claimant and his wife submit separate affidavits dated January 20, 2000, which state, in part, that: (1) claimant has always been willing to work and continuously sought work from before the left total knee surgery, on March 3, 1997, until the present; (2) from the summer of 1998 until present, claimant performed a small amount of auto electric work in his garage for which he

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a). In his July 6, 1999 affidavit, claimant requested that we authorize temporary disability benefits beginning August 28, 1998, the date through which SAIF paid temporary disability benefits on his previously reopened claim. On September 28, 1998, SAIF closed that prior claim by a Notice of Closure that awarded temporary disability benefits from October 2, 1995 through August 28, 1998, and declared claimant medically stationary as of August 28, 1998. During the time claimant's claim was reopened pursuant to this earlier claim, he underwent a left total knee arthroplasty on March 3, 1997. The September 28, 1998 Notice of Closure provided claimant's appeal rights, stating that claimant could request review of the closure within 60 days or, with good cause, within 180 days, but that he would lose all rights to appeal after 180 days. Claimant did not appeal the closure; therefore, it became final by operation of law. To the extent that claimant's July 6, 1999 affidavit can be considered a request for review of the September 28, 1998 Notice of Closure, it was made more than 180 days after the date of closure; therefore, it is untimely.

In his July 6, 1999 affidavit, claimant argues that his prior treating surgeon, Dr. Schwartz, erred in declaring him medically stationary as of August 28, 1998. Therefore, claimant contends that his temporary disability benefits should "restart" as of August 28, 1998. [We note that, in his January 20, 2000 brief, claimant's attorney argues that we should award temporary disability benefits beginning in March 1997, the date of claimant's initial left total knee arthroplasty. However, as noted above, during the time claimant's claim was last reopened, he received time loss benefits from October 2, 1995 through August 28, 1998]. Because claimant did not timely appeal the September 28, 1998 Notice of Closure, it is final and not subject to collateral attack. Thus, the issue before us is claimant's entitlement to temporary disability benefits regarding his current request to reopen his claim for Own Motion relief relating to his August 6, 1999 surgery.

earned less than a few hundred dollars per month and for which he kept no records; and (3) during the summer of 1998, claimant inquired about a job at the Shasta Dam but it was not possible for him to accept employment due to the number of stairs he would have to climb each day.

In our prior orders, we found that claimant is willing to work based on his July 6, 1999 affidavit. We continue to find that claimant's sworn statements establish his willingness to work. However, in order to prove the work force issue, claimant must also establish that, during the time prior to the August 1999 surgery: (1) he was working; (2) seeking work; or (3) not seeking work because the work-related injury made such efforts futile. *Dawkins*, 308 Or at 258. Based on the following reasoning, we find that claimant has failed to establish any of these additional factors.

To the extent that claimant contends that the January 20, 2000 affidavits establish either that he was working or making a reasonable job search during the relevant period, we do not find such contentions persuasive. First, claimant provides no supporting documentation regarding the contentions made in these recent affidavits. In addition, these latest affidavits conflict with statements claimant made in his July 1999 affidavit and June 1999 letter to SAIF. Moreover, SAIF disputes these affidavits on the bases that they are unsupported and conflict with claimant's earlier statements. *See James M. Evans*, 51 Van Natta 1046 (1999) (challenged statement that the claimant was doing "odd jobs" for room and board insufficient to prove work force issue); *compare Michael D. Demagalski*, 51 Van Natta 1043 (1999) (unchallenged affidavit that the claimant was doing "odd jobs" for room and board sufficient to prove work force issue). Finally, to the extent that claimant made an inquiry about employment at the Shasta Dam during the summer of *1998*, such an inquiry is not relevant to the question before us, that is, whether claimant was in the work force prior to his surgery in *August 1999*.

Claimant also contends that, although he was willing to work, he could not do so because of the compensable left knee injury. Thus, claimant argues that he is in the work force under the third *Dawkins* criterion. In order to satisfy the third *Dawkins* criterion, in addition to proving that he is willing to work, claimant must also prove that a work search is futile because of the work-related injury. Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant. Rather, 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); *Janet F. Berhorst*, 50 Van Natta 1578 (1998) (same). 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. *Id.*

On reconsideration, claimant submits medical opinions from Drs. Schwartz and Edkin, his current treating orthopedist, regarding the "futility" factor of the third *Dawkins* criterion. Based on following reasoning, we find that neither opinion meets claimant's burden of proof.

When Dr. Schwartz declared claimant's condition medically stationary on August 28, 1998, he determined that claimant was capable of performing work in the sedentary to light range. However, on January 19, 2000, Dr. Schwartz stated that from March 3, 1997, when claimant underwent the left total knee replacement surgery, until August 6, 1999, when he underwent the revision of that surgery, "it is my opinion that [claimant] was unable to seek or accept employment." Dr. Schwartz does not explain his change of opinion. In light of Dr. Schwartz' unexplained change of opinion, we do not find his conclusions persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive).

In a letter dated October 26, 1999, Dr. Edkin noted that he had received a copy of our Own Motion Order on Reconsideration and understood that our work force decision was based on claimant's failure to prove the futility standard of the third *Dawkins* criterion. He noted that our decision was based at least in part "on a lack of evidence in the medical record that [claimant's] condition was significant enough to make attempts at working, or seeking work, futile."

Dr. Edkin noted that he first saw claimant on February 23, 1999, on referral from Dr. Schwartz for a second opinion regarding claimant's left knee condition. He outlined the history of claimant's medical treatment for his compensable left knee condition and stated:

> "Because an ongoing workup for difficulties directly related to his original industrial related injury was in process prior to [claimant] seeing me, it would seem that [claimant] had just cause for being off work prior to my initiation of evaluation and treatment.

> Certainly following the time of my initial evaluation attempts at engaging in or seeking work should be considered futile. Factors to consider in this regard are the preexisting positive bone scan and the ongoing difficulties which [claimant] experienced. We were actively engaged in evaluation of his painful knee and subsequently recommended that he undergo surgical management in the form of revision total knee arthroplasty. August 6, 1999, [claimant] underwent revision total knee arthroplasty and he was found to have a loose femoral component at that time." Dr. Edkin's October 26, 1999 letter.

On November 5, 1999, SAIF's claims adjuster spoke with Dr. Edkin, who agreed that it was his opinion that, aside from approximately two months from the date of the total knee replacement, claimant "has been medically able to work in a sedentary position. In other words, between August 28, 1998 to the present, it was not medically futile for claimant to seek work in the sedentary work range." Dr. Edkin added that claimant was not medically able to work for approximately two months following the August 1999 surgery.

Finally, in a November 30, 1999 progress report, Dr. Edkin again addressed the "futility" issue. At that time, he stated:

> "[Claimant] feels I have done a disservice by telling workman [sic] compensation that he could have been employed in a sedentary position during the period of work up to his most recent surgery. This again surrounds the issue of futility. That would be the futility standard of the third quote "Dawkins" criterion. It was explained to me by the claims manager with SAIF Corporation that if [claimant], for specific medical reasons, was 'unable' to perform 'any' work at the previously prescribed sedentary level, that his case would be considered futile. The question that arises is whether it was reasonable for [claimant] to be seeking work while on chronic narcotic pain medications and in the process of an ongoing medical workup to determine the need for further surgery. *It is my opinion that [claimant] could have performed some sedentary work during that period.* However, [claimant] had not returned to work as of my first encounter with him and I told him that he would likely require surgery as of the initial evaluation 2-23-99. We also outlined a plan for further evaluation. Approximately six months passed before [claimant] underwent eventual surgery. [Claimant] remained with chronic pain and on narcotics during that period. * * * *In general, I find it reasonable that [claimant] was off work for medical reasons during the period of 2-23-99 through his surgery August of 1999."* [Emphasis added].

In this last opinion, Dr. Edkin finds that claimant's condition remained unchanged from his initial examination on February 23, 1999, until he underwent surgery in August 1999. Specifically, claimant remained with chronic pain, on narcotics, and in the process of ongoing medical workup to determine the need for further surgery during this period. However, Dr. Edkin also opined that claimant could have performed some sedentary work in that condition. Nonetheless, Dr. Edkin also found it reasonable that claimant did not do so.

The "futility" factor in the third *Dawkins* criterion involves a medical question to be answered by persuasive medical opinion, *i.e.*, whether claimant's medical condition during the relevant period was such that it would be futile for him to work or seek work. It is clear from Dr. Edkin's opinions that he understood the medical question that the third *Dawkins* criterion presents. Read as a whole, Dr. Edkin's opinions conclude that claimant was *medically capable* of performing and/or seeking work in the sedentary range during the relevant period, *i.e.*, the time prior to the August 1999 surgery. The fact that Dr. Edkin also thought that it was reasonable that claimant did not seek sedentary work during that period is beside the point. Many factors may make it "reasonable" not to seek work that one is medically capable of performing, but that does not make one any less medically capable of performing and/or seeking work.

Accordingly, we continue to find that claimant failed to prove that he was in the work force at the time of disability. Therefore, we deny his request for temporary disability compensation.

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
JOHNNY R. RICHEY, Claimant
WCB Case No. 99-02426
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer 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. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW

The ALJ found claimant proved that his work activities were a material contributing cause of his low back strain/sprain condition. In doing so, the ALJ found that while claimant did suffer from degenerative disc disease and had numerous other back injuries, there was no medical evidence that these prior conditions combined with his work injury to cause claimant's current low back condition or need for treatment. Further, the ALJ found claimant's current attending physician, Dr. Grossman, to be persuasive.

On review, the employer contends that the ALJ incorrectly found Dr. Grossman's opinion persuasive in that it was based on an inaccurate/incomplete history, did not weigh the relative contribution of each cause or provide a well-reasoned, complete analysis. Based on the following reasoning, we agree with the employer's contention.

A compensable injury is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability. ORS 656.005(7)(a). The burden of proving that an injury is compensable and of proving the nature and extent of any resulting disability is upon claimant. ORS 656.266. To establish a compensable injury where it is shown that claimant suffers from a preexisting degenerative disc disease, the claimant must prove that his work exposure is the major contributing cause of his need for treatment or disability for his combined condition. *See* ORS 656.005(7)(a)(B).

In this case, claimant suffers from a preexisting degenerative disc disease and has had other back injuries. (Exs. 8,11, 17, 24, 25, 26). However, none of the physicians who treated claimant noted that claimant's degenerative disc disease or other injuries combined with his work injury to cause claimant's current back condition. Therefore, we agree with the ALJ that claimant need only show that his work injury was a material contributing cause of his need for treatment or disability for his low back sprain/strain.

Where the causation issue involves complex medical questions, we necessarily rely on expert medical opinions. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). This case is complex due to the fact that it involves a delay in the onset of symptoms, as well as a delay in reporting the injury to the employer and in seeking medical attention. Further complicating this issue is the fact that claimant has had numerous other unrelated back injuries. (Exs. AA-1, AA-3, 1, 6, 8, 11, 17A, 26). Therefore, we must rely on expert medical opinions as to causation of claimant's low back injury.

The expert medical opinion must evaluate the relative contribution of each cause. *Dietz v. Ramuda,* 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). Additionally, where there is a division of experts we rely on those medical opinions that are the most well-reasoned and based on accurate and complete information. *Somers v. SAIF,* 77 Or App 259 (1986).

Claimant has the burden to establish through expert medical evidence that his work activities were a material contributing cause of his need for treatment or disability for his low back injury. *See* ORS 656.266; ORS 656.005(7)(a); *Albany General Hospital v. Gaperino,* 113 Or App 411 (1992). Here, claimant was examined by several physicians and has had three different attending physicians. For support, claimant relies on the opinion of Dr. Grossman, his current attending physician.

We generally give deference to claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983); *Kima L. Langston*, 52 Van Natta 15 (2000). Here, we find persuasive reasons to do otherwise.

First, Dr. Grossman's opinion is based on an inaccurate and/or incomplete history. While Dr. Grossman did know that claimant had previously injured his back, he believed the last injury occurred over five years prior to claimant's work accident. (Ex. 24, 42A-22). However, claimant's medical records show claimant was treated for injury to his low back and right flank region 13 months before the current injury. (Ex. AA-1). Dr. Grossman also listed that claimant had been in two prior motor vehicle accidents, but that claimant's back was not injured in either accident. (Ex. 26-1). Additionally, Dr. Grossman did not obtain copies of or review any of claimant's medical records from his other physicians, including claimant's chiropractor, Dr. Jones, who was treating claimant for the same condition and at the same time as Dr. Grossman. (Ex. 42A-19, 42A-23 to 25, 42A-27). Lastly, Dr. Grossman neither took any x-rays or performed any other diagnostic studies nor reviewed any x-rays or diagnostic studies by claimant's other physicians. (Ex. 42-27).

Next, Dr. Grossman did not properly weigh the relative contribution of each cause. Dr. Grossman's opinion does not mention claimant's degenerative disc disease or discuss the effect or lack of effect of claimant's other back injuries. Dr. Grossman also did not address the inconsistencies in claimant's medical history or the issue of symptom magnification which was noted by all of claimant's prior physicians. Lastly, as noted above, Dr. Grossman did not review or discuss claimant's prior diagnostic studies. Dr. Grossman was presented with copies of claimant's medical records for the first time to review during his deposition, however, Dr. Grossman provided only a conclusory statement that they did not change his original opinion. (Ex. 42A-40). Additionally, while Dr. Grossman disagreed with the opinion of Dr. Tesar, who performed an employer-arranged medical examination, he provided no objective analysis as to why Dr. Tesar's opinion was incorrect. (Ex. 41).

Lastly, the resolution of the causation issue in this case requires expert analysis rather than expert observation. *Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979). In this case, Dr. Grossman's opinion is based on claimant's subjective recitation of his prior medical history and his complaints of continuing pain and symptoms. (Ex. 42A-18 to 21, 42A-32 & 33, 42A-46).[1]

In contrast, Dr. Tesar, who performed an employer-arranged medical examination, reviewed claimant's prior medical records as well as obtaining a verbal history from claimant. (Ex. 37-2 & 3). Dr. Tesar specifically addressed the concerns regarding symptom magnification of claimant's prior physicians, Dr. Geiger, Dr. Yarusso, and Dr. Quarum. (Ex. 37-6). Dr. Tesar's opinion was well-reasoned and based on an accurate and complete history. Further, Dr. Tesar's opinion is consistent with the opinions of Dr. Geiger and Dr. Yarusso.

Accordingly, we do not find Dr. Grossman's opinion to be persuasive. Thus, we conclude that claimant failed to establish that his work activities were a material contributing cause of his need for treatment or disability for his low back condition. Accordingly, the employer's denial is reinstated and upheld.[2]

ORDER

The ALJ's order dated September 30, 1999 is reversed. The employer's denial is reinstated and upheld. The ALJ's assessed penalty and the employer-paid attorney fee award are also reversed.

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[1] We acknowledge the ALJ's credibility determination concerning claimant's testimony. We generally defer to such findings. *Erck v. Brown Oldsmobile*, 311 Or 519 (1991). However, where the critical issue is dependent on the persuasive weight to be accorded to the medical opinions addressing claimant's low back condition and its relationship to claimant's work activities, as well as the accuracy and completeness of the histories provided by those medical experts, we do not consider the ALJ's credibility finding to be determinative. Instead, we base our decision on the expert medical opinions.

[2] In light of our conclusion upholding employer's denial of claimant's injury claim for his low back condition, there are no amounts then due on which to assess a penalty. *See* ORS 656.262(11). Furthermore, no attorney fee under ORS 656.386(1) is warranted. Consequently, those portions of the ALJ's order that awarded penalties and attorney fees are likewise reversed.

In the Matter of the Compensation of
JOHN H. SLAUGHTER, Claimant
WCB Case No. 99-01260
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
John E. Snarskis, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of claimant's occupational disease claim for a right shoulder condition. On review, the issue is compensability.

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

We agree with the ALJ that the medical opinions supporting the claim initially relied on an incorrect history that claimant usually worked with his right shoulder elevated at or near a 90 degree angle. But claimant did not work like that. And the doctors ultimately opined that claimant's right shoulder condition would *not* be work-related under those circumstances. (*See* Exs. 8, 14-2, 14-7-8, 15-2). Consequently, we agree with the ALJ that the claim must fail for lack of supporting medical evidence.

ORDER

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

Board Member Phillips Polich specially concurring.

I agree that the medical evidence compels this result and I am constrained by the experts on the medical question. However, I write separately to express concern that the medical evidence essentially ignores most of claimant's work history. Claimant worked at this mill for 37 years. He *did* perform numerous activities over the years that probably contributed to his right shoulder condition.[1] Claimant "pulled belt" (pulled plywood off a 5 foot moving belt); he "blocked cars" (using a wedge and 20 pound sledge to spread loads); and he swung himself into the forklift cab with his right arm elevated about every two minutes when he operated that machine. (*See* Tr. 16-18, 40).

Nonetheless, the experts agree that claimant's condition is only work-related if his right shoulder is elevated to 90 degrees, not just outstretched, when operating the forklift. But claimant only *operated* the forklift with his arm outstretched at about 45 degrees. And there is no medical evidence relying on the work that *did* involve his right shoulder.[2] Therefore, I reluctantly agree that claimant has not carried his burden of proof in this case.

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[1] This conclusion is based on Dr. Farris' description of activities that "could" have contributed. (*See* Ex. 14-6).

[2] *Compare Lawrence Luttrell*, 51 Van Natta 2030, 2032 (1999) (Board Member Phillips Polich, specially concurring) (citing *John J. Rice*, on remand, 46 Van Natta 2528, 2529 (1994) (claim compensable where preexisting degenerative disease worsened by years of traumatic work exposure, an accepted low back strain, and multiple additional work injuries).

In the Matter of the Compensation of
ROBERT C. WHITTON, Claimant
WCB Case No. 99-01464
ORDER ON REVIEW
Martin Alvey, Claimant Attorney
John Snarskis, Defense Attorney

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

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

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2): After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimants attorneys Respondent's brief and his statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's October 26, 1999 order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer.

Board Member Haynes dissenting.

I disagree with the majority that claimant proved compensability. Because the majority adopts and affirms the ALJ's order, I first provide a summary of the facts.

Claimant has a compensable claim for a 1978 low back injury. He underwent surgery in 1980, 1984, 1994, and 1995.

In September 1998, while working at home, claimant stepped off a ladder and fell on his buttocks. Claimant experienced significant low back pain, which was primarily left-sided.

In December 1998, claimant saw his treating surgeon, Dr. Schmidt. An MRI showed a large disc protrusion at L3-4, which Dr. Schmidt considered to be a new lesion.

The ALJ found that the medical evidence and claimant's testimony showed that he had right leg and right ankle foot weakness due to the multiple low back surgeries. Based on claimant's testimony, the ALJ further found that claimant fell in September 1998 because his right ankle gave way as a result of the right ankle weakness. Finally, the ALJ concluded that claimant carried his burden of proving under ORS 656.005(7)(a)(A) that the L3-4 disc protrusion was a consequential condition of the compensable 1978 injury.

I disagree that the persuasive medical opinion supports the ALJ's reasoning and conclusion. The ALJ relied on Dr. Schmidt's opinion. Dr. Schmidt did not concur with the panels report. (Ex. 25). According to Dr. Schmidt, claimant fell in September 1998 because his right ankle gave out; Dr. Schmidt found that his examination showed some residual L5 weakness in the extensors of the toes on the right and it is probable that subtle weakness in the extensors of the foot and toes resulted in this fall and his other falls. (Ex. 26). Thus, Dr. Schmidt concluded that claimant's present injury is directly related to his previous back problems. (*Id.*)

Dr. Schmidt subsequently noted that, although findings of weakness in the toes and foot were mild, experience has taught us on repetitive testing can become progressively more weak, particularly at the end of the day. (Ex. 29-1).

Dr. Schmidt's opinion was rebutted by examining physicians Dr. Dupuis, orthopedic surgeon, and Dr. Radecki, physiatrist. This panel thought that the major contributing cause of claimant's L3-4 disc herniation was degenerative in nature. (Ex. 23-7). Based on the September 1998 mechanism of injury, the panel found it unlikely that that single event would have resulted in a significant disc herniation in an otherwise normal disc. (*Id.*) Thus, although finding some contribution from the September 1998 fall, the physicians found that the major contibution was the natural history of degenerative disc degeneration. (*Id.*)

After reviewing Dr. Schmidt's report, Dr. Dupuis found no documented history of right ankle give way. (Ex. 28-1). Dr. Dupuis also reported that his examination showed only minimal motor deficit in the right big toe and that it was not medically probable that this very subtle weakness would cause ankle give way[.] (*Id.* at 1-2).

Absent persuasive reasons to the contrary, we generally defer to the treating physicians opinion. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Moreover, 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 v. Ramuda*, 130 Or App 387, 401 (1994).

Here, I find Dr. Schmidt's opinion insufficient to show that the incident was the major contributing cause of the L3-4 disc herniation. First, the evidence concerning right ankle weakness is, at best, in equipoise. As noted by Dr. Dupuis, there is no documented history of the right ankle giving way. Dr. Schmidt could rely only on findings of subtle weakness in the toes and then engage in speculation by noting that such weakness can worsen. Furthermore, as noted by the insurer, claimant's own testimony shows that it was just as likely that he stumbled because he misstepped rather than from ankle give-way. (Tr. 11).

Additionally, Dr. Dupuis and Radecki explained why degeneration was the major contributing cause, in part relying on the 1998 MRI. Dr. Schmidt, however, at no point responds to this opinion and explains why the September 1998 incident is the only factor in causing the disc herniation. In other words, although Dr. Schmidt apparently did not consider claimant's condition to have combined with a degenerative condition, he does not evaluate any contribution from degeneration and explain his rejection of this condition as a factor in causing the disc herniation.

Thus, I agree with the insurer that Dr. Schmidt's opinion is not sufficiently persuasive to carry claimant's burden of proof. I would conclude that claimant did not prove compensability of his L3-4 disc herniation.

In the Matter of the Compensation of
CHARLOTTE A. BRUFFET, Claimant
WCB Case No. 99-02306
ORDER ON REVIEW
Floyd H. Shebley, 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) Podnar's order that: (1) set aside its denial of claimant's occupational disease claim for right carpal tunnel syndrome; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ set aside the employer's denial of claimant's right carpal tunnel syndrome condition based on the uncontradicted opinions of claimant's treating physicians Drs. Rose and Weeks. The employer contends that claimant failed to meet her burden of proof with these medical opinions. We disagree.

This is an occupational disease claim. Therefore, claimant must prove that her work activities are the major contributing cause of her right carpal tunnel syndrome condition. ORS 656.802(2)(a). The only medical opinions on causation come from Dr. Rose and Dr. Weeks. In concluding that claimant's

work activities as a billing clerk were the major contributing cause of the development of her condition, Dr. Weeks relied on a correct history of claimant's working five hours per day on data entry and "10-key" tasks, primarily with her right hand. (Ex. 8-45; Tr. 7).

The employer contends that claimant did not prove that she did anything more than "use" her hands at work, as opposed to "flexion, extension, pinching or gripping," or the like, and that she has therefore not met her burden of proving the existence of potentially causative employment activities. We disagree.

During his deposition, the parties presented Dr. Weeks with a detailed description of claimant's work activities, including the monthly billing procedures, which involved tearing over 500 bills into different parts, mostly with her right hand. (Ex. 8, pp. 10-13). We are therefore satisfied that Dr. Weeks determined that claimant's work activities were sufficiently vigorous to cause her carpal tunnel condition. Accordingly, we affirm the portion of the ALJ's order that set aside the employer's denial of claimant's right carpal tunnel syndrome condition.

Penalties

The employer contends that, because medical evidence in existence at the time of its denial did not meet the standard for compensability of claimant's right carpal tunnel syndrome, a penalty for an unreasonable denial is not appropriate. We agree.

In *Joseph H. Retlinger*, 51 Van Natta 87, 88 (1999), we declined to assess penalties for an allegedly unreasonable denial, noting that the insurer had in its possession a medical report which was "ambiguous" on causation. 51 Van Natta at 88. Similarly, here, claimant's form 827 (first medical report) was dated February 2, 1999 but referenced a "date of injury" of October 1, 1998, more than four months earlier. (Ex. 1A). Moreover, neither the form 827 nor the 801 form attributed claimant's condition specifically to her work activity.

Under such circumstances, we find that the employer had a legitimate doubt as to the compensability of claimant's right carpal tunnel syndrome when it issued its denial. A penalty was therefore inappropriate. ORS 656.262(11)(a); *Brown v. Argonaut Insurance Co.*, 93 Or App 588, 591 (1988). Accordingly, we reverse the portion of the ALJ's order that assessed a penalty for an unreasonable denial.

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

ORDER

The ALJ's September 22, 1999 order is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty under ORS 656.262(11)(a) for an unreasonable denial is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the employer.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with the majority and with the ALJ that claimant's right carpal tunnel syndrome is compensable. However, I write separately to dissent from the majority's holding that the employer should not be penalized for an unreasonable denial.

The employer issued a denial on February 10, 1999, just 14 days after claimant filed her 801 form. (Exs. 1, 2). From the carrier's date stamps, we can determine that it performed little or no investigation of claimant's claim. The carrier evidently had only the 801 and 827 forms in its possession at the time of the denial. (Exs. 1, 1A). The employer did not bother to gather existing medical records from claimant's treating physicians, arrange a medical examination for claimant, or to commission a records review by a doctor of its choice.

It is the employer's responsibility to properly process claims for compensation. ORS 656.262(1). At minimum, I believe that it was incumbent on the employer to obtain claimant's existing medical records before issuing its denial. By the time of the employer's denial, February 10, 1999, claimant had seen Drs. Rose and Weeks for treatment regarding her carpal tunnel syndrome. These reports implicated claimant's work activities as causative of claimant's symptoms at least by history. (Exs. A, B). However, the employer did not even have the benefit of reviewing these reports before issuing its denial. That fact is what distinguishes this case from *Retlinger*, cited by the majority.

For these reasons, I respectfully dissent from the majority's failure to assess a penalty for an unreasonable denial. I would have affirmed the ALJ's order in this regard.

March 23, 2000 Cite as 52 Van Natta 467 (2000)

In the Matter of the Compensation of
MARY C. HAMMOND, Claimant
WCB Case No. 98-09732
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its *de facto* denial of claimant's injury claim for a low back condition; (2) assessed a 25 percent penalty for the employer's late denial; and (3) awarded claimant an attorney fee under ORS 656.382(1) for a discovery violation. In her respondent's brief, claimant moves to dismiss the employer's request for review regarding the compensability issue as moot. On review, the issues are dismissal (or alternatively, compensability), penalties, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the addition of the following facts:

On November 1, 1999 (after the ALJ's order), the employer issued a Notice of Acceptance of claimant's claim for "disabling disc herniation at L4-5 and L5-S1." On November 5, 1999, the employer requested review of the ALJ's October 6, 1999 Order on Reconsideration, which had adopted and republished an August 11, 1999 Opinion and Order. On November 23, 1999, the employer issued a denial purportedly rescinding the November 1, 1999 Notice of Acceptance.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant contends that the employer's unqualified acceptance of her claim renders the employer's request for review of the ALJ's order on the issue of compensability moot. We agree. *SAIF v. Mize*, 129 Or App 636 (1994); *Albert D. Avery*, 51 Van Natta 814 (1999).

In *SAIF v. Mize, supra*, the carrier accepted the claimant's claim by clear and unqualified notice of acceptance before it petitioned for review of a Board order that had set aside the carrier's claim denial. The court held that the carrier's acceptance rendered moot any controversy over the compensability of the claimant's claim, and dismissed the carrier's petition for judicial review. 129 Or App at 640.

The employer contends that its November 23, 1999 denial and rescission of its November 1, 1999 Notice of Acceptance clarifies or reestablishes its right to appeal the ALJ's order. We disagree. In *Timothy L. Williams*, 46 Van Natta 2274 (1994), we held that, if a carrier issues a "clear and unqualified" acceptance after an order setting aside a denial, and the acceptance is not made contingent on its right to appeal the order, it cannot subsequently deny compensability without complying with ORS 656.262(6). 46 Van Natta at 2275.[1] *See also Gerald J. Dahl*, 47 Van Natta 1055 (1995).

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[1] If the employer had simultaneously qualified its acceptance on its right to appeal the ALJ's order, it could have preserved the viability of its request for review on the compensability issue. *See Valerie Barbeau*, 49 Van Natta 189 (1997); *Donna J. Calhoun*, 47 Van Natta 454 (1995).

Here, the employer issued an unqualified Notice of Acceptance of claimant's claim on November 1, 1999, after the ALJ's October 6, 1999 Order on Reconsideration (adopting and republishing the August 11, 1999 order that set aside the employer's denial), and before its November 5, 1999 request for Board review.

Accordingly, we find that the employer's request for review insofar as it pertains to the compensability issue is moot.[2] We therefore affirm the ALJ's order on that issue.[3]

Penalties and Attorney Fees

We adopt and affirm the ALJ's order in regard to the issues of penalties and attorney fees.

Finally, we note that claimant is not entitled to an attorney fee under ORS 656.382(2) for services on review regarding the "moot" compensability issue, or the penalty and attorney fee issues. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986); *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Agripac v. Kitchel*, 73 Or App 132 (1985).

In *Timothy L. Williams*, we reasoned that dismissing the carrier's request for review based on our finding that the claimant's request for review was "moot" does not equate to a "finding on the merits" under ORS 656.382(2). 46 Van Natta at 2276. The same rationale applies here. Although technically we have not "dismissed" the employer's request for review because of the existence of the penalty and attorney fee issues, as a result of our decision that the compensability issue is moot we nevertheless have not made a finding "on the merits" that claimant's compensation should not be "disallowed or reduced." ORS 656.382(2).

ORDER

The ALJ's order dated August 11, 1999, as reconsidered October 6, 1999, is affirmed.

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[2] We note that the validity of the employer's November 23, 1999 denial, if timely appealed, is an issue for another proceeding. We decide here only that the employer's unqualified November 1, 1999 Notice of Acceptance has rendered moot its request for review of the ALJ's order on the compensability issue. In other words, the employer's actions subsequent to the acceptance have no effect on the question of whether the employer's appeal, insofar as it concerns the compensability issue, has become moot.

[3] We decline to dismiss the employer's request for review because there are two additional issues raised by the employer's request for review of the ALJ's order which are not dependent on the viability of the compensability issue.

In the Matter of the Compensation of
EDWARD A. McGARITY, Claimant
WCB Case Nos. 99-07429 & 98-07652
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that found that the SAIF Corporation is entitled to offset temporary disability compensation previously paid for the period from September 12, 1997 through March 22, 1998. On review, the issue is temporary disability.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich specially concurring.

I agree with the ALJ and the majority that SAIF must be allowed to offset previously paid temporary disability compensation for the period in question. However, I write separately to stress that this is an unfair and harsh result.

SAIF does not contend that claimant was working or that he was off work for reasons other than his compensable injury for the period from September 12, 1997 through March 22, 1998. And SAIF does not contend that claimant was medically stationary during that time. In fact, SAIF *paid* the benefits in question.

The only reason for allowing SAIF to recoup those payments is that Dr. Lin did not and could not retrospectively authorize time loss beyond 14 days, under *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999). Since *Bundy*, temporary disability is simply not due under any claim (open or closed) unless the worker's attending physician authorizes time loss within 14 days of the loss claimed. *See Douglas R. Hart*, 51 Van Natta 1856 (1999). Because there is no contemporaneous time loss authorization by claimant's attending physician in this case, I am constrained to conclude that SAIF may offset temporary disability that it paid (for the period from September 12, 1997 through March 22, 1998) against claimant's permanent disability award.

March 23, 2000 Cite as 52 Van Natta 469 (2000)

In the Matter of the Compensation of
ROBERT W. MATTSON, Claimant
WCB Case No. 99-06271
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the self-insured employer's partial denial of claimant's bilateral shoulder injury claim. Submitting a copy of an October 25, 1999 report from Dr. Hardiman, a consulting orthopedic surgeon (who already has reports in the record), claimant requests remand for admission of this report into the record. On review, the issues are remand and compensability.

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

Dr. Hardiman's report, which was written prior to the November 9, 1999 hearing, responds to a report of an insurer-arranged examination performed by Dr. Strum and Dr. Farris.[1] According to claimant, the Hardiman report should be admitted into the record because it was not obtainable with due diligence prior to the hearing and would likely affect the outcome of the case since it explains Dr. Hardiman's medical opinion regarding the cause of claimant's bilateral shoulder condition.

The employer objects to claimant's request for remand, arguing that claimant did not exercise due diligence because he could have obtained a similar response from Dr. Hardiman prior to the hearing. The employer also contends that Dr. Hardiman's report is cumulative and does not contain any new medical information regarding the cause of claimant's bilateral shoulder condition. Therefore, the employer asserts claimant has failed to show that the report would likely affect the outcome of this case.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or

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[1] The Hardiman report was addressed to the employer's claims examiner, but was not provided to either the employer's or claimant's counsel before the hearing.

App 416 (1986). A compelling reason for remand exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, the employer did not provide claimant's counsel or its own counsel a copy of the October 25, 1999 before the November 9, 1999 hearing. The employer acknowledges that the letter was untimely discovered, even though it alleges that there was no intent on its part to conceal the letter. Under these circumstances, we conclude that Dr. Hardiman's October 25, 1999 report itself was not obtainable with the exercise of due diligence at the time of the November 9, 1999 hearing.

If we further assume that the substance of Dr. Hardiman's latest report was also not obtainable with due diligence prior to the hearing, we would, nevertheless, decline claimant's remand request. Dr. Hardiman, in his October 25, 1999 report, generally agreed with the Strum/Farris report, which opined that the compensable April 27, 1999 injury, accepted for a left wrist injury, was the major contributing cause of claimant's bilateral shoulder condition. In this respect, the latest Hardiman report adds nothing to his prior opinion (rejected by the ALJ as unpersuasive) that reached a conclusion similar to that of the Strum/Farris panel. (Ex. 15). Dr. Hardiman also cautioned, however, in the October 1999 report that the lack of documentation of shoulder pain in an April 27, 1999 emergency room report makes little difference because emergency room reports are often incomplete in that they focus on only those injuries that require the most urgent care, in this case claimant's left hand and wrist.

The ALJ, however, specifically addressed claimant's explanation for the lack of references to shoulder complaints in the emergency room report. Claimant had testified that the absence of references to shoulder complaints was due to his left wrist being more painful than his shoulders. The ALJ rejected that explanation because the emergency room physician had written that there were no other complaints besides the left wrist symptoms, thus indicating that claimant was specifically asked about complaints other than in the left wrist. Given that the ALJ had addressed the concern that Dr. Hardiman's latest report raises (and found that it did not adequately explain inconsistencies in the record), we conclude that admission of the October 1999 report would likely not affect the outcome of the case.

Thus, we find no compelling reason to remand to the ALJ for additional proceedings. Accordingly, claimant's motion is denied.

Turning to the merits of the compensability issue, claimant asserts that Dr. Hardiman, Dr. Strum and Dr. Ferris provided the most well-reasoned and complete opinions as to the cause of his bilateral shoulder condition. Claimant further asserts that, because the exact mechanism of his injury is not important, any inconsistencies in the history provided to physicians should not affect the persuasiveness of their opinions.

We disagree. Because we concur with the ALJ's assessment of claimant's reliability as a witness (*i.e.*, that he was not reliable), we find that the above medical evidence that necessarily relies on the accuracy of claimant's history for its persuasiveness does not satisfy claimant's burden to prove the compensability of his bilateral shoulder condition.[2] *See Miller v. Granite Construction Co.*, 28 Or App 473 (1977). Accordingly, we affirm the ALJ's order that upheld the employer's partial denial.

ORDER

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

[2] Considering the unreliability of claimant's version of the events and of his history of complaints, it is unnecessary to resolve the issue of whether the appropriate level of proof is material or major cause. In other words, under either level the claim fails.

In the Matter of the Compensation of
TIMOTHY J. STACKHOUSE, Claimant
WCB Case No. 99-03807
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of claimant's left knee injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich dissenting.

The majority finds that claimant did not injure his left knee at work on January 11, 1999, because he initially reported that the injury happened the day before while fishing off work. But claimant explained that he said the injury occurred off work only because the employer, his sister, asked him to say that. And claimant complied with his sister's request because she promised to pay his injury-related lost wages. Claimant's sister denied any such promise.

The majority mistakenly focuses on the parties' conflicting stories and their assumed motivations. In so doing, the majority summarily dismisses the only concrete uncontradicted evidence in this record: The testimony of Daren Johnson, a co-worker who witnessed the circumstances and immediate aftermath of the work injury.

Claimant and Johnson logged together on the Monday morning in question. At about 11 a.m., claimant was trying to hurry down a steep incline dragging choker chains. He stepped on chunk of rotten log, it gave way, he slipped, and his left knee twisted and folded.

Johnson was above claimant on the hill when the injury occurred. He heard claimant exclaim and saw him holding his knee. From where he was, it appeared to Johnson that claimant had stepped in a "hole or something -- might've hyperextended -- made [his knee] go backwards, not the way it's supposed to go." (Tr. 43).

This is essentially a simple injury case: Claimant was working with an uninjured left knee until he twisted it. Then he was suddenly and visibly injured. Witness Johnson's unbiased[1] testimony is materially consistent with claimant's account of his work injury.

The parties' various motivations are merely tangential. And the parties' disagreements about promises and expectations need not be resolved to decide this case, because the only important question is whether claimant's injury happened at work. Accordingly, based on witness Johnson's credible uncontradicted testimony supporting the claim, I would conclude that claimant has carried his burden.

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[1] As the ALJ noted, there is no reason to suspect witness Johnson's motivation or his testimony, because he supported the claim before he was fired.

In the Matter of the Compensation of
DIANE K. COTTER, Claimant
Own Motion No. 99-0209M
OWN MOTION ORDER OF DISMISSAL
Kryger, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted a request for temporary disability compensation for claimant's compensable right carpal tunnel syndrome (CTS) claim. SAIF opposed authorization of temporary disability compensation, contending that claimant had withdrawn from the work force. Claimant responded that she timely perfected an aggravation claim and, therefore, her claim was not within the Board's Own Motion jurisdiction. In addition, claimant requested that we "remand" the matter to the Hearings Division for determination. SAIF disputed claimant's contention and contended that she failed to timely perfect an aggravation claim.

On October 21, 1999, we issued an order that referred the aggravation matter to the Hearings Division and postponed the own motion matter. WCB Case No. 99-07400. We requested that the assigned Administrative Law Judge (ALJ) make findings of fact and conclusions of law and opinion on the issue of whether claimant's aggravation rights had expired on her claim so as to bring that claim within our Own Motion jurisdiction. If, at hearing, jurisdiction was found to be under our Own Motion authority, we requested that the assigned ALJ make findings of fact and conclusions of law and issue a separate, unappealable Own Motion Recommendation with respect to whether claimant was in the work force at the time her condition worsened.

By Opinion and Order dated January 31, 2000, ALJ Nichols determined that the compensable right CTS condition at issue remained in open status pursuant to a prior ALJ's 1998 order that ordered SAIF to accept and process the claim. Relying on *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579 (1999), *John R. Graham*, 51 Van Natta 1740 (1999), and *Craig J. Prince*, 52 Van Natta 108 (2000), ALJ Nichols found that a compensable new condition claim is subject to the processing requirements of ORS 656.262 and 656.268. Thus, ALJ Nichols held that a carrier must issue a Notice of Closure for a compensable new condition claim, and there was no evidence that SAIF had closed the right CTS claim that it had previously been ordered to accept and process. Accordingly, ALJ Nichols found that the right CTS claim remained in open status. ALJ Nichols' order was not appealed and has become final by operation of law.

On February 2, 2000, ALJ Nichols issued an Own Motion Recommendation. Based on the reasoning in her January 31, 2000 order, ALJ Nichols recommended that the matter is not within our Own Motion jurisdiction under ORS 656.278.

The Board's own motion jurisdiction extends only to claims for which the claimant's aggravation rights have expired. ORS 656.278(1)(a); *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Here, the aggravation rights expired on claimant's initial claim on November 4, 1998. In addition, a new medical condition claim is not entitled to separate 5-year aggravation rights period; instead, the 5-year aggravation rights period is determined by the initial injury claim. *Susan K. Clift*, 51 Van Natta 646 (1999). Nevertheless, a new condition claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the initial claim is in our Own Motion jurisdiction. *Graham*, 51 Van Natta at 1745. On the other hand, the Board in its Own Motion capacity under ORS 656.278 does not have authority to direct a carrier to process a claim under ORS 656.262(7)(c). *Prince*, 52 Van Natta at 110.

Here, as a result of ALJ Nichols' unappealed order, it has been finally determined that claimant's right CTS condition, the condition for which SAIF submitted a request Own Motion relief, remains in open status pursuant to a 1998 ALJ's order that found the condition compensable. Applying the above statements of law to these facts, as ALJ Nichols has finally determined, the right CTS condition claim is to be processed to closure pursuant to ORS 656.268. Under such circumstances, we dismiss the request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT E. KILLION, Claimant
WCB Case No. 99-02409
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our January 25, 2000 Order on Review that affirmed the order of the Administrative Law Judge (ALJ) that upheld the SAIF Corporation's "de facto" partial denial of claimant's right shoulder adhesive capsulitis and impingement syndrome.

On February 23, 2000, we abated our order to further consider claimant's motion for reconsideration. Having received SAIF's response to claimant's motion, we proceed with our reconsideration.

In his motion, claimant argues that ORS 656.262(7)(a)[1] requires that future medical providers must be reasonably apprised of the nature of the compensable condition. In addition, claimant asserts that SAIF has the burden to prove that the acceptance notice reasonably apprises future medical providers of the nature of the compensable condition.

We previously addressed a similar issue in *Michal A. Fleming*, 52 Van Natta 383 (2000). In *Fleming*, we held that ORS 656.262(7)(a) sets forth an objective standard that does not require that, in every case, the claimant or medical providers subjectively understand what conditions are compensable.

Here, the ALJ relied on medical evidence that establishes that the accepted right shoulder strain and right rotator cuff tear reasonably apprised claimant and medical providers of the nature of his compensable conditions, including adhesive capsulitis and impingement syndrome. This is the kind of evidence that we have looked to in previous cases to determine whether an acceptance reasonably apprises a claimant and medical providers of the nature of the compensable conditions. *Id; see also Cynthia J. Thiesfeld*, 51 Van Natta 984 (1999).

Claimant next argues that the insurer has the burden of proof to show that future medical providers are reasonably apprised of the nature of the compensable condition.

On this record, regardless of which party has the burden of proof, the only evidence is that medical providers are reasonably apprised of the nature of claimant's compensable condition. In this regard, claimant's treating physician, Dr. Lundsgaard, has indicated that, from a medical standpoint, the acceptance of right shoulder adhesive capsulitis and right shoulder impingement would not add anything to claimant's claim. There is no contrary evidence. Thus, based on the weight of the evidence in this record, we continue to find that the acceptance of right shoulder strain and right rotator cuff tear reasonably apprises claimant and medical providers of the nature of the compensable condition.[2]

As supplemented herein, we republish our January 25, 2000 order in its entirety.[3] 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 statute provides, in relevant part: "The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions."

[2] Even assuming that the insurer has the burden of proof, that burden has been met because the only evidence in the record establishes that medical providers are reasonably apprised of the nature of the compensable claim.

[3] Member Biehl refers the parties to his special concurrence in *Fleming*.

In the Matter of the Compensation of
CLINTON L. McCORD, Claimant
Own Motion No. 97-0060M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's October 8, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from October 20, 1997 through August 31, 1999. The insurer declared claimant medically stationary as of August 31, 1999. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

FINDINGS OF FACT

On April 29, 1998, we issued our Own Motion Order authorizing reopening of claimant's 1990 injury claim for the payment of temporary disability compensation, commencing the date claimant was hospitalized for the proposed surgery. Our order informed the insurer that, when claimant was medically stationary, it should close the claim pursuant to OAR 438-012-0055.

In an August 31, 1999 Pain Center Discharge Report, Dr. Murphy, to whom claimant had been referred to for pain control treatment, assessed that claimant was able to return to full-time work on a sedentary basis. He further opined that claimant was medically stationary as of August 31, 1999.

On September 7, 1999, Dr. Belza, claimant's treating physician, recommended that claimant undergo some diagnostic studies in the form of a CT scan. Dr. Belza felt that if the scan did not reveal any problems with his fusion, then he would have to "re-look" at L2-3. He also opined that claimant was unable to work "at this time."

On referral from Dr. Belza, claimant was examined by Dr. Andrews on September 16, 1999. Dr. Andrews noted that the L5-S1 bone grafts continued to appear fragmented and prescribed physical therapy. He scheduled claimant for a follow-up visit in one month's time. At the next appointment, he would determine the possibility of further surgery or activity restriction.

Claimant returned to Dr. Belza on September 27, 1999. At that time, Dr. Belza noted that claimant was exhibiting some pain behavior although ongoing symptoms appeared significant. He recommended that claimant undergo further diagnostic studies and return for a follow-up and further evaluation. Dr. Belza again opined that claimant "remains disabled and is unable to work."

On October 8, 1999, Dr. Belza examined claimant on a follow-up visit and reviewed the diagnostic studies. He opined that the SPECT scan was consistent with facet joint arthropathy which could be a significant pain generator. Dr. Belza recommended facet blocks to alleviate claimant's persistent low back pain and scheduled him back in two weeks for a follow-up examination.

The insurer issued its Notice of Closure on October 8, 1999, declaring claimant medically stationary as of August 31, 1999.

In October 1999, claimant was examined by Dr. Porzelius, a pain psychologist. Dr. Porzelius recommended that claimant undergo a combination of physical therapy and pain management, including relaxation and coping skills training.

Dr. Andrews again saw claimant on October 13, 1999. He noted that claimant was seeing a pain psychologist to work on pain reduction techniques. He also questioned whether Dr. Belza was attempting to "try and justify reopening based on the changes seen in CT and bone scans." Dr. Andrews assessment of claimant's condition was chronic back pain with degenerative changes in lumbar spine associated with the previous surgery. He opined claimant's functional level and symptoms were unchanged since his last visit. He also noted that Dr. Belza's work-up and treatment were ongoing.

On another referral from Dr. Belza, on November 23, 1999, claimant was examined by Dr. Yundt. Dr. Yundt noted that claimant could not work due to subjective pain. He opined that claimant would not benefit from further surgery and referred him back to Dr. Belza.

On November 24, 1999, claimant returned to Dr. Belza. Dr. Belza opined that there was not surgical intervention that would help claimant with his symptoms short of a morphine pump and that would not be to his advantage. He noted that "I discussed the issues with [claimant] and believe he understands that he will have to be considered medically stationary at this point." Dr. Belza scheduled claimant to return on an as-need-basis.

In a December 22, 1999 chart note, Dr. Andrews noted that both Dr. Belza and Dr. Yundt agreed that claimant was not a surgical candidate. He noted that claimant continued to have significant pain and prescribed a different mood elevator (from Prozac to Effexor). He scheduled to see claimant in four weeks for a follow-up.

Claimant returned to Dr. Andrews in January 2000. At that time, Dr. Andrews noted that claimant continued to have chronic low back pain "due to failed fusion and instability." He prescribed anti-inflammatories and encouraged claimant to continue treating with Dr. Porzelius for pain management. He scheduled claimant for a six week follow-up.

CONCLUSIONS OF LAW AND OPINION

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 8, 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).

Various medical opinions were submitted in this matter. Claimant relies on the opinions of Drs. Belza and Andrews. In September and October 1999, Dr. Andrews, working in conjunction with Dr. Belza, recommended that claimant undergo pain management therapy in attempts to alleviate his chronic pain complaints. He scheduled various follow-up appointments to carefully monitor claimant's progress. On October 13, 1999, Dr. Andrews opined that claimant's functional levels and symptoms remained unchanged since his last visit on September 16, 1999. Dr. Andrews' October 13, 1999 report was based on a medical examination conducted on that date, just a few days after the insurer closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between the October 8, 1999 claim closure and Dr. Andrews' October 13, 1999 examination (*i.e.* claimant's condition remained unchanged from his prior examination), we conclude that Dr. Andrews' October 13, 1999 opinion addresses claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622, 625 (1987). (Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure).

In chart notes dated September 7 and October 8, 1999, prior to claim closure, Dr. Belza opined that claimant was unable to work. In addition, during this period, he recommended diagnostic testing to determine what was the status of claimant's current condition and determine if there was some treatment that may materially improve his chronic condition. However, despite various treatment modalities, claimant's condition failed to improve. Consequently, on November 24, 1999, Dr. Belza opined that claimant was medically stationary as of that date. As noted above, because of Drs. Belza's and Andrews' concurrent treatment of claimant during the period prior to and shortly after his claim was closed, we conclude that Dr. Belza's November 24, 1999 opinion regarding claimant's medically stationary status at that time also addresses claimant's condition at closure.

The insurer relies on the opinion of Dr. Murphy, who expressed the opinion that at the time claimant left the recommended pain center treatment against doctor's orders, he was capable to return to full-time work on a sedentary basis. He also opined that as of the date claimant left the program (*i.e.* August 31, 1999) he was medically stationary.

When there is a dispute between medical opinions, we rely on those opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). After our review of all opinions, we find that of Drs. Belza and Andrews most persuasive. Dr. Belza performed the October 1997 surgery and continued to treat claimant through his recovery. He has treated claimant off-

and-on since 1992 and is well acquainted with claimant's low back condition. His opinions regarding claimant's medically stationary status and his attempts to improve claimant's condition are based on objective findings as seen in the diagnostic studies (CT and bone scans demonstrated a failed fusion). Dr. Andrews, on referral from Dr. Belza, concurred that claimant required further treatment and worked with Dr. Belza in attempts to improve claimant's chronic condition. He has seen claimant since his initial visit in August 1999, every four to six weeks and continues to treat him.

We give less weight to the opinion of Dr. Murphy because he only treated claimant for brief period of time and due to claimant's untimely departure from the pain center treatment, Dr. Murphy was unable to completely assess claimant's current condition. Although he opined that claimant was medically stationary when he left the pain center program on August 31, 1999, that opinion was based on a brief initial evaluation and observations by pain center staff members during claimant's short stay. Because of claimant's departure from the pain center program, Dr. Murphy was unable to complete a formal discharge and thus, was unable to objectively assess claimant's current condition. Accordingly, we find the opinions of Drs. Belza and Andrews more persuasive.

Based on the opinions of Drs. Belza and Andrews, we conclude that claimant was not medically stationary on October 8, 1999, when the insurer closed his claim.

Accordingly, we set aside the Notice of Closure as premature. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JON E. BALL, Claimant
WCB Case No. 98-06366
SECOND ORDER ON RECONSIDERATION
Heiling & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our March 14, 2000 Order on Reconsideration, which republished our February 28, 2000 Order on Review that upheld the self-insured employer's denial of claimant's injury claim for a thoracic strain condition.

Claimant contends that, in upholding the employer's denial of claimant's claim for a thoracic strain condition, we failed to consider that Dr. Schrunk diagnosed a "trapezius strain" on April 14, 1998. (Ex. 49). Claimant cites to this exhibit suggesting we find that the diagnoses "trapezius strain" and "thoracic strain" are synonymous. However, there is no medical opinion, from Dr. Schrunk or elsewhere in the record, that supports a conclusion that these two terms are, in fact, synonymous.

Moreover, in our February 28, 2000 order, we noted that Dr. Schrunk had diagnosed a trapezius strain, yet we distinguished between that diagnosis and that of a thoracic strain, diagnosed by Dr. Rose three days later. (Ex. 56). We are unwilling to infer that these two diagnoses are identical absent medical opinion to that effect.

Accordingly, we withdraw our prior orders. On reconsideration, after reconsidering the record in light of claimant's second motion, we continue to adhere to the conclusions reached in our prior decisions.

Consequently, on reconsideration, as supplemented, we republish our February 28, 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
ANGLEE MINOR, Claimant
WCB Case No. 99-02403
ORDER ON RECONSIDERATION
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

On March 8, 2000, we abated our February 7, 2000 order that upheld the insurer's denial of claimant's left groin injury claim. We took this action to consider claimant's motion for reconsideration. Having received the insurer's response, we proceed with our reconsideration.

We begin by briefly recounting the background of the case. The Administrative Law Judge (ALJ) set aside the insurer's denial of claimant's left groin condition to the extent that it denied diagnostic medical services for claimant's alleged lifting injury. Reasoning that claimant experienced symptoms of acute pain upon heavy lifting, for which Drs. Harper and Standage provided medical services, the ALJ concluded that the lifting was directly causative of claimant seeking medical services. Thus, the ALJ concluded that claimant had proved that he sustained a compensable injury.

We reversed, relying on *Daniel L. Hakes*, 45 Van Natta 2351 (1993). We reasoned that there was no medical evidence, to a degree of medical probability, that the symptoms claimant experienced after heavy lifting were related to the heavy lifting. Although claimant suffered an acute onset of pain upon heavy lifting, we further found that there was no evidence that claimant was injured as a result of the lifting. The only condition Dr. Standage diagnosed, a left hydrocele,[1] was not related to the lifting, according to both Dr. Standage and another physician, Dr. Braun.

Therefore, because claimant had not established that he was injured or sustained physical damage as a result of the lifting, we did not find that he sustained a compensable injury. Thus, we reversed the ALJ's order and reinstated the insurer's denial in its entirety.

Claimant contends that our decision was not supported by the record. In support of this contention, claimant makes several arguments. Claimant asserts that he had objective findings of a groin pull that was reduced by ice applied in the emergency room. The medical evidence, however, does not support claimant's contention.

No diagnosis of a groin pull was ever made, not in the emergency room or thereafter. The only condition that was treated with ice was the large mass or bulge in the left lower abdominal quadrant/scrotum that was erroneously diagnosed initially as an incarcerated inguinal hernia. (Ex. 1-2). Several attempts were made to reduce the mass, but these efforts were unsuccessful and, thus, surgery was eventually performed. At surgery, the correct diagnosis of a left hydrocele was made. The medical evidence establishes that this condition was not work related. Dr. Standage, the operating surgeon, was specifically asked whether claimant sustained a groin stain or pull. Dr. Standage was unable to confirm this. (Ex. 7-11). The most he could state is that there was a "possibility." *Id.* However, it is well-settled that expressions of medical possibility are insufficient to establish medical causation. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions expressed in terms of medical possibility rather than medical probability are not persuasive).

Claimant, nevertheless, insists that the emergency room report establishes that claimant suffered a groin pull. (Ex. 1). He asserts that our original order "ignored" this evidence. Claimant is incorrect. Dr. Harper, the emergency room physician, only diagnosed an incarcerated left inguinal hernia. (Ex. 1-2). The only objective findings concerned a bulge in the left lower quadrant consistent with an inguinal hernia and a massively enlarged left scrotum determined by Dr. Harper to be consistent with an incarcerated hernia. No diagnosis of a groin strain or pull was made in that or subsequent reports.[2]

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[1] A "hydrocele" is a fluid filled sac surrounding the testis. (Ex. 4-1).

[2] Claimant notes Dr. Harper's finding of a bulge in the left lower quadrant. Claimant asserts that this is not in the area of the hydrocele and establishes that claimant sustained an injury separate from the hydrocele condition. Dr. Standage, however, testified that it is difficult to differentiate between the lower quadrant pain and the hydrocele. (Ex. 7-13). Moreover, Dr. Standage explained that the pain in the left lower quadrant was referred from the large mass in the left scrotum (that was later confirmed to be a hydrocele). (Ex. 7-12). Based on this evidence, we do not find that claimant suffered a separate work-related injury in the left lower quadrant.

Claimant also contends that *Alan L. Hussey*, 47 Van Natta 1302, *on recon* 47 Van Natta 1460 (1995), is controlling and that, therefore, his claim is compensable. We disagree. In *Hussey*, the material (if not the sole) cause of the claimant's need for medical treatment was his exposure to blood in conjunction with a cut suffered while performing his work activities. 47 Van Natta at 1303. In contrast to that case, where the claimant sustained a work-related injury (a cut), there is no evidence here that claimant experienced a work-related injury or condition. The only confirmed condition, a left hydrocele, was not related by any physician to claimant's lifting incident. As previously noted, the medical evidence does not to a degree of medical probability establish that claimant sustained a groin strain or pull or, for that matter, any other work related condition or injury.[3]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 7, 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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[3] Claimant asserts that his credible testimony alone established a compensable injury, citing *Uris v. Compensation Department*, 247 Or 420 (1967). We disagree. Because of the multiple possible causes of claimant's need for treatment (the lifting incident or the preexisting left hydrocele condition), the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Barnett v. SAIF*, 122 Or App 281 (1993).

In the Matter of the Compensation of
PATRICK BUCHANAN, Claimant
Own Motion No. 98-0517M
OWN MOTION ORDER OF DISMISSAL
Ransom & Gilbertson, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Claimant requested that the Board "take jurisdiction over SAIF Corporation's request to reconsider [his] permanent and total award (PTD)," and issue an Own Motion Order addressing that issue. SAIF responded that jurisdiction over claimant's PTD award rested with the Director at the Department of Consumer and Business Services (DCBS) and that claimant's request be denied.

On February 17, 1999, DCBS issued a Determination Order which found that claimant's entitlement to PTD benefits should continue. It also noted that the parties had one year from the date of the order to contest its findings.

On February 29, 2000, after the one-year appeal period had expired, the Board inquired as to whether the February 17, 1999 Determination Order had been appealed and if so, what effect, if any it had on claimant's initial request. In response, claimant contends that since DCBS did not issue an order adverse to claimant's position, there is not "any issue for the Board to decide."

In light of such circumstances, the basis for claimant's request for Board review (*i.e.* reconsideration by the Board of his PTD award) has been rendered moot by the February 17, 1999 Determination Order affirming his PTD status. Accordingly, the request for relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL L. ROBBINS, Claimant
WCB Case No. 99-01544
ORDER ON REVIEW
Mark W. Potter, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's left ankle prosthetic stay peg condition. On review, the issues are claim preclusion and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claim Preclusion

The insurer contends that claimant's claim is barred based on principles of claim preclusion, because an earlier request for hearing allegedly regarding the same condition was dismissed. We disagree.

Claim preclusion bars litigation of a claim based on the same factual transaction that was or could have been litigated in a prior proceeding that has reached a final determination. *Messmer v. Deluxe Cabinet Works*, 130 Or App 254, 257 (1994), *rev den* 320 Or 507 (1995).

In *James E. Templeton*, 51 Van Natta 975 (1999), the claimant filed a request for hearing on the issue of a *de facto* denial of additional cervical conditions. The claimant then withdrew that request for hearing and a dismissal order issued. 51 Van Natta at 975. Later, the claimant wrote to the insurer to request formal written acceptance of cervical and thoracic strain conditions. We held that the thoracic claim was not precluded.[1] We reasoned that the claimant had not filed a "new medical condition" claim for the thoracic strain condition before the dismissal order issued. Therefore, we determined that the earlier request for hearing insofar as it related to a thoracic strain condition was premature and void. 51 Van Natta at 976.

The same reasoning applies here. On January 15, 1999, claimant withdrew a request for hearing (the subject of which is not a matter of record) and simultaneously requested that the insurer accept a "disruption of the prosthetic stay peg" condition. (Ex. 43). On January 25, 1999, the insurer denied that condition. (Ex. 44). On January 28, 1999, a dismissal order issued regarding claimant's earlier request for hearing. Claimant then requested a hearing from the January 25, 1999 denial, which is the subject of this proceeding.

Because it was not preceded by a "new medical condition" claim, claimant's earlier request for hearing, insofar as it may have pertained to a "new medical condition" claim, was premature and void. *James E. Templeton*, 51 Van Natta at 976. Therefore, because claimant could not have litigated the stay peg condition claim when the prior hearing was dismissed, the current claim is not precluded.

The insurer next contends that claimant's request for hearing should be dismissed because he has requested reopening of an earlier (1993) Washington claim, and that request has not been finally denied. (Ex. 39A).[2] We disagree.

Miville v. SAIF, 76 Or App 603 (1985), involved the interplay of an Oregon injury and a subsequent out-of-state injury. The court held that the claimant could pursue the Oregon claim only if he had sought and been finally denied benefits from the subsequent out-of-state employer. 76 Or App at 607.

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[1] We held that the cervical condition claim was precluded. 51 Van Natta at 975.

[2] Washington's Department of Labor and Industries has denied claimant's request, but the parties stipulated that claimant's appeal of that denial is not final. (*O&O* at 1).

We do not believe the same rationale applies to an *earlier* non-final out-of-state claim. In *Silveira v. Larch Enterprises*, 133 Or App 297 (1995), the claimant experienced low back pain in 1988, while working in California. He never filed a claim in California. 133 Or App at 297, 298. In 1991, while working for the same employer in Oregon, the claimant again experienced back pain and filed an Oregon workers' compensation claim. *Id.* at 298.

The court held that, with regard to the earlier California injury, the claimant was not required to file a claim with other potentially responsible out-of-state employers to receive compensation in Oregon. 133 Or App at 303. *See also The New Portland Meadows v. Dieringer*, 153 Or App 383, *on recon* 157 Or App 619 (1998)(Initial responsibility cannot be assigned to a previous out-of-state employer under the Last Injurious Exposure Rule). 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" emphasized by the insurer. 133 Or App at 297 n3.

Here, claimant suffered an injury to his left ankle in May 24, 1993 which was accepted and processed under Washington's Department of Labor and Industries. (Ex. C). The claim was reopened and closed several times. (Exs. 1C, 1E, 2B, 3A, 5B). On June 22, 1998, claimant again injured his left ankle, giving rise to this initial Oregon claim. In addition, claimant requested reopening of his earlier Washington claim. That request was denied on October 29, 1998. (Ex. 36A). Claimant appealed that denial on November 18, 1998. (Ex. 39A).

The insurer contends that the fact that claimant's appeal of his Washington claim is not final precludes his ability to pursue this claim. Claimant has not asked that the Oregon claim be held in abeyance pending resolution of the Washington claim.[3] Accordingly, the insurer argues that this claim should be dismissed. However, as in *Silveira*, we are not convinced that claimant is required to file a claim for earlier out-of-state injuries in order to preserve the viability of his current Oregon claim. Accordingly, the fact that claimant's appeal of the denial of his request to reopen the 1993 Washington claim is not final does not preclude this claim.

Compensability

On the merits, the ALJ decided that claimant had met his burden of proving that his June 22, 1998 injury was the major contributing cause of his disability and need for treatment for his disruption of stay peg condition. ORS 656.005(7)(a)(B). The ALJ relied on the opinion of claimant's treating podiatrist Dr. Felts.

The insurer contends that Dr. Felts, DPM, should not be accorded deference as claimant's "attending physician," because she does not qualify as such under ORS 656.005(12)(b)(A). Dr. Felts has been claimant's treating physician and surgeon since September 1, 1995. (Ex. 2). She performed two surgeries on claimant's left ankle, including the removal of the stay peg on November 5, 1998. (Exs. 8, 37). Accordingly, even assuming that Dr. Felts would not qualify as an "attending physician" for claim processing issues, for purposes of determining causation, we give great weight to Dr. Felts' opinion because of her unique position as treating surgeon. *Argonaut Insurance v. Mageske*, 93 Or App 698 (1998).

The insurer next contends that Dr. Felts relied on an inaccurate history in rendering her opinion on causation. Specifically, the insurer argues that Dr. Felts mistakenly believed that claimant's ankle was relatively "problem free" prior to his June 22, 1998 Oregon injury, contrary to claimant's testimony that he had pain at a constant level of four on a scale of ten. (Tr. 11-12). However, at hearing, claimant testified merely that his symptoms improved after his November 5, 1998 surgery to replace his stay peg prosthesis. (Tr. 12). Moreover, the record is devoid of any medical reports indicating that claimant sought treatment from February 5, 1998, the date of Dr. Felts' closing examination, through June 24, 1998, the date he returned to see Dr. Felts, two days after his new injury. (Exs. 16, 18). In light of such circumstances, we disagree with the insurer's contention that Dr. Felts' opinion was premised on an inaccurate history.

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[3] We emphasize that our decision should not be interpreted as a pronouncement that parties are prohibited from choosing to seek the deferral of hearings involving claims such as this.

Finally, the insurer contends that Dr. Felts' opinion that claimant's June 22, 1998 injury made his subtalar bone "cystic" is speculative and unexplained. Even assuming that the insurer is correct, that particular point is peripheral to Dr. Felts' ultimate opinion on causation. (*See* Ex. 51)[4].

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 25, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the insurer.

[4] In her March 26, 1999 concurrence opinion, Dr. Felts reasoned that claimant's June 22, 1998 incident was a "new and distinct injury" to his left ankle. (Ex. 51). She based this opinion primarily on claimant's relatively healthy condition (claimant was "not perfect, but OK") from February 1998 through June 1998. (*Id.*)

March 24, 2000 Cite as 52 Van Natta 481 (2000)

In the Matter of the Compensation of
ROBERT L. PRICE, Claimant
WCB Case No. C000343
ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Glen J. Lasken, Claimant Attorney
Randy Rice, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On February 18, 2000, the Board approved 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.

On March 15, 2000, we received the parties addendum to the CDA. We treat the addendum as a motion for reconsideration of the approved CDA. In order to be considered, a motion for reconsideration of the CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Here, the CDA was approved and mailed on February 18, 2000. We received the addendum to the CDA on March 15, 2000, 26 days after the CDA was approved. Inasmuch as the motion for reconsideration was untimely, we cannot consider it. OAR 438-009-0035(1),(2); *Edward C. Steele*, 48 Van Natta 2292 (1996); *Paul J. LaFrance*, 48 Van Natta 306 (1996).[1]

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

IT IS SO ORDERED.

[1] The addendum seeks to correct the CDAs summary page; specifically, the claim number recited on the CDA, as well as the date of injury (February 23, 1998, rather than May 14, 1999). As previously noted, we are without authority to reconsider our approval order. Nonetheless, if the claim number and injury date set forth in the parties' CDA are inaccurate (which they apparently are because the claim number and injury date coincide with a claim that has been denied and resolved by a Disputed Claim Settlement), the addendum apparently confirms that the parties are aware of these clerical errors.

In the Matter of the Compensation of
LEROY W. STEECE, Claimant
WCB Case No. 99-06217
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of his current cervical condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's contention that SAIF's denial was a procedurally invalid "preclosure" denial under *Croman Corp. v. Serrano*, 163 Or App 136 (1999).[1]

As noted by the ALJ (Opinion and Order p. 4 n. 2), claimant did not challenge the procedural validity of SAIF's denial at hearing. Moreover, claimant did not raise the *Serrano* holding as applicable to SAIF's denial. Characterizing its procedural challenge to the validity of SAIF's denial as a "new legal theory," as opposed to a new issue, claimant argues that SAIF's preclosure denial is impermissible because the claim was never accepted as a "combined" condition. SAIF responds that claimant is prevented from raising this issue on review because it was not raised below. We agree with SAIF.

Generally, we do not consider issues that are not raised at hearing. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing). Moreover, we have previously declined to consider a challenge to the procedural validity of a preclosure denial raised for the first time on review. *See Trever McFadden*, 48 Van Natta 1804 (1996). We also decline to do so here. *See also Patricia L. Serpa*, 47 Van Natta 747, 748 (1995) (where the claimant could have raised "pre-closure" partial denial issue at hearing, ALJ should not have addressed the issue on his own initiative); *Cf. Zinaida I. Martushev*, 46 Van Natta 1601, *on recon* 46 Van Natta 2410, 2411 (1994) (the claimant's contention that the employer's "pre-closure" denial was invalid addressed on reconsideration in light of relevant court decisions that had issued after the parties' written arguments had been filed with the Board).

ORDER

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

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[1] In *Serrano*, sometime after the claim acceptance, the employer concluded that the claimant's need for ongoing medical treatment was not related to the accepted injury and issued a preclosure denial under 656.262(7)(b). After the denial, the claim was closed. On review, we held that ORS 656.262(7)(b) did not apply because the employer had not accepted a "combined condition" under ORS 656.005(7)(a)(B). We further concluded that the claimant's current conditions were not clearly separate or severable from the accepted conditions. On this basis, we held that the denial was an invalid preclosure denial. The court affirmed our order holding that, in order for ORS 656.262(7)(b) to apply, the carrier must have accepted a "combined condition." 163 Or App at 140-41.

In the Matter of the Compensation of
JAMES R. ANSON, Claimant
WCB Case No. 99-04319
ORDER ON REVIEW
Daniel J. DeNorch, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that denied his request for enforcement of an ORS 656.268(4)(g) penalty. On review, the issue is penalties.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich dissenting.

The majority adopts and affirms the ALJ's order that denied his request for enforcement of an ORS 656.268(4)(g)[1] penalty. Because I believe the previous ALJ's order must be enforced as written, I respectfully dissent.

It is first necessary to briefly recount the factual and procedural background of the claim. Claimant has an accepted claim with the insurer for an April 29, 1996 right shoulder injury. (Exs. 1, 2). A March 26, 1997 Notice of Closure awarded 18 percent unscheduled permanent disability for claimant's right shoulder condition. (Ex. 2). An August 14, 1997 Order on Reconsideration increased the unscheduled permanent disability award to 27 percent. (Ex. 4). Claimant requested a hearing.

On February 2, 1998, a previous ALJ affirmed the Order on Reconsideration award. (Ex. 5). The ALJ further concluded that claimant was entitled to a 25 percent penalty under ORS 656.268(4)(g) and OAR 436-030-0175(2). (Ex. 5-7). The "order" portion of the ALJ's order included this language:

> "IT IS FURTHER ORDERED claimant is entitled to a penalty pursuant to ORS 656.268(4)(g). Said penalty shall be based on 25 percent of the 27 percent unscheduled permanent disability awarded by the Order on Reconsideration." (Ex. 5-8).

The self-insured employer requested review of the February 2, 1998 order and the Board adopted and affirmed that order. (Ex. 6). The Board's order was not appealed and became final as a matter of law.

On June 20, 1998, the insurer issued a $1,496 check to claimant. (Ex. 7). That amount represents 25 percent of the $5,984 difference between the 18 percent unscheduled permanent disability award at closure and the 27 percent unscheduled permanent disability award on reconsideration.

Claimant requested a hearing, asserting that the employer had failed to correctly pay a penalty pursuant to ORS 656.268(4)(g).[2]

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[1] The 1999 legislature has amended ORS 656.268, but the revisions that went into effect on October 23, 1999 were not made retroactive and are therefore not applicable to this case. SB 220, 70th Leg., Reg. Sess., Sec. 1 (October 23, 1999). *See Robert E. Kelly*, 52 Van Natta 25, 26 (2000).

[2] *Former* ORS 656.268(4)(g) provides, in part:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

The ALJ determined that the employer had paid the penalty assessment in full. The ALJ reasoned that the discussion portion of the February 2, 1998 order clearly stated that the previous ALJ was assessing a penalty pursuant to ORS 656.268(4)(g) and OAR 436-030-0175(2). Relying on *Frederick W. Van Horn, Jr.*, 48 Van Natta 956 (1996), the ALJ in this case reasoned that the cited statute and rule provided for a penalty based only on the increased compensation awarded on reconsideration. The ALJ concluded that the "order" language in the February 2, 1998 order was a scrivener's error and the previous ALJ had effectively assessed a penalty only against the 9 percent increase in unscheduled permanent disability awarded on reconsideration.

After reviewing the record, I agree with claimant that the critical fact here is that the employer did not appeal the Board's order that affirmed the February 2, 1998 order. If the employer had disagreed with the previous ALJ's order, which said claimant was entitled to a penalty "based on 25 percent of the 27 percent unscheduled permanent disability awarded by the Order on Reconsideration" (Ex. 5-8), the employer had a duty to raise that issue on review. Instead, the Board's order indicated that the employer had requested review of that portion of the February 2, 1998 order that affirmed the 27 percent unscheduled permanent disability award, but did not raise the penalty issue. (Ex. 6). Claimant correctly asserts that the failure of the employer to raise the issue at the time it appealed the February 2, 1998 order is a complete and total bar to raising the issue at this time.

The majority's decision in this case is inconsistent with the recent case of *Gary S. Fox*, 52 Van Natta 425 (2000). In that case, the majority held that a carrier was not obligated to pay an unappealed "pre-Authorized Training Program (ATP)" permanent disability (PPD) award granted by a previous ALJ's order because following the claimant's completion of the ATP, his claim was re-closed and his award was reduced. Relying on *SAIF v. Coburn*, 159 Or App 413 (1999), the majority reasoned that the "pre-ATP" PPD award never became due because the award did not become final until the claimant had entered the ATP (which permitted the carrier to suspend payment of the award) and, following the ATP, the PPD award was redetermined, reduced, and timely paid. Citing *SAIF v. Sweeney*, 115 Or App 506, 511, *on recon* 121 Or App 142 (1993), the majority determined that the carrier's timely payment of the "post-ATP" award effectively excused it from paying the original award.

Here, in contrast, the penalty under ORS 656.268(4)(g) became due after the employer requested review of the ALJ's February 2, 1998 order and the Board's order became final. The Board adopted and affirmed the February 2, 1998 order, and because the Board's order was not appealed, it became final as a matter of law. Thus, unlike *Fox*, the penalty became due when the Board order became final. The majority's result in this case is contrary to the well-established principle that a final order *is* enforceable.

Finally, I disagree with the ALJ's conclusion that this is a scrivener's error. Even if the February 2, 1998 order allowing the penalty on the entire 27 percent unscheduled permanent disability award is erroneous in light of the *Van Horn* case, it is the "law of the case" and must be enforced. As the court explained in *SAIF v. Roles*, 111 Or App 597, *rev den* 314 Or 391 (1992), a final ALJ's order is enforceable (as long as the ALJ had subject matter jurisdiction), even if it is wrong. The majority errs by allowing the employer to collaterally attack a final order.

In the Matter of the Compensation of
FRANK M. DIONNE, Claimant
WCB Case No. 99-03057
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) found he was not permanently and totally disabled; and (2) increased his unscheduled permanent disability award from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 33 percent (105.6 degrees). On review, the issues are permanent total disability and, alternatively, extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the first paragraph of the findings of fact on page 1, we change the date in the fourth sentence to "September 1996."

We write only to address claimant's argument that he is entitled to a 43 percent unscheduled permanent disability award, rather than the 33 percent awarded by the ALJ.[1] For the following reasons, we affirm the ALJ's unscheduled permanent disability award.

A November 20, 1998 Determination Order awarded 49 percent (156.8 degrees) unscheduled permanent disability for claimant's low back condition. (Ex. 26). Claimant requested reconsideration. (Ex. 28). Dr. Tobin performed a medical arbiter examination on March 19, 1999. (Ex. 34). An April 13, 1999 Order on Reconsideration, as corrected on April 20, 1999, reduced the unscheduled permanent disability award to 24 percent (76.8 degrees). (Exs. 36, 37).

The ALJ concluded that claimant was entitled to 9 percent impairment for the 1996 surgery and 4.4 percent impairment for reduced range of motion, for a total of 13 percent impairment. The ALJ found that claimant's base functional capacity (BFC) was "medium" and his residual functional capacity (RFC) was "light/sedentary." The ALJ concluded that claimant's adaptability factor was "4" and awarded 33 percent unscheduled permanent disability.

On review, claimant argues that he is entitled to an award of 43 percent unscheduled permanent disability. He contends that his RFC is "restricted sedentary," which produces an adaptability factor of 6.

"Residual functional capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the compensable condition. OAR 436-035-0310(3)(b). Under OAR 436-035-0310(5), the RFC is the greatest capacity evidenced by the attending physician's release, or a preponderance of the evidence that includes but is not limited to a second-level PCE or WCE or any other medical evaluation that 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.

Claimant relies on a March 10, 1998 Physical Work Performance Evaluation Summary to establish his RFC. (Ex. 8). Dr. Hill, claimant's attending physician, concurred with that report. (Exs. 9, 32). The evaluator found that claimant was capable of performing work at the sedentary level. (Ex. 8-1). However, claimant was incapable of sustaining the sedentary level of work for an 8-hour day. (*Id.*) The evaluator noted that claimant had significant physical limitations due to nerve irritation that might require future surgical intervention. (Ex. 8-3).

The insurer argues that the March 10, 1998 evaluation is not an accurate reflection of claimant's RFC because the evaluator did not recognize that the need for surgery was due to the 1987 claim, rather than the 1996 claim. We agree with the insurer that, although Dr. Hill agreed with the March 10, 1998 evaluation, there is no indication as to which findings were related only to the 1996 injury. Under these circumstances, we do not rely on the March 10, 1998 evaluation in determining claimant's RFC.

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[1] The parties did not contest claimant's award of scheduled permanent disability pursuant to the Order on Reconsideration.

At claim closure, Dr. Hill chose not to do the closing evaluation and claimant was evaluated instead by Dr. Rosenbaum in September 1998. (Exs. 18, 20). Dr. Rosenbaum found that claimant's residual physical capacity was in the sedentary to light category with a maximum lifting on a repetitive basis of 25 pounds, based primarily on the September 1996 injury. (Ex. 20-5, -6). Dr. Hill concurred with Dr. Rosenbaum's report. (Ex. 22). Dr. Rosenbaum provided an addendum report on October 22, 1998, indicating that repetitive lifting was not recommended and a 25 pound lifting limit was appropriate. (Ex. 24).

Dr. Tobin performed a medical arbiter examination on March 19, 1999, basing his findings on claimant's September 1996 injury. (Ex. 34-6). He found that claimant could constantly lift or carry weights up to 20 pounds, frequently carry weights up to 30 pounds and occasionally carry weights up to 40 pounds. (*Id.*) He felt that, with appropriate breaks, claimant was unlimited in his ability to sit, stand or walk. (*Id.*) Because of the foot drop that resulted from claimant's 1996 surgery, Dr. Tobin found that claimant should be precluded from frequently climbing, balancing or twisting. (*Id.*)

After reviewing the record, we agree with the ALJ that Dr. Rosenbaum's report is more thorough and better-reasoned than Dr. Tobin's report. Because Dr. Rosenbaum has seen claimant on two occasions, we agree that he has a better perspective from which to assess the question of claimant's residual functional capacity. Based on Dr. Rosenbaum's report (AS CONCURRED IN BY dR. hILL), we find that claimant's RFC is "sedentary/light." A comparison of claimant's base functional capacity (medium) to his RFC of sedentary/light provides a value of "4" for adaptability. *See* OAR 436-035-0310(6).

Claimant was over 40 at claim closure and did not have a high school education equivalent, which entitles him to a value of "2." OAR 436-035-0290(2); 436-035-0300(2)(b). In addition, claimant has an SVP of "3" based on the job providing the highest SVP number during the 5 years prior to the time of determination (Concrete-Mixing-Truck Driver, DOT 900.683-010). OAR 436-035-0300(3). Multiplying the age/education value (5) times the adaptability factor (4), the product is 20. When added to the impairment value of 13, the sum is 33. Thus, we agree with the ALJ claimant's is entitled to an award of 33 percent unscheduled permanent disability.

ORDER

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

March 27, 2000 Cite as 52 Van Natta 486 (2000)

In the Matter of the Compensation of
ROBERT J. RHOTEN, Claimant
WCB Case No. 99-05094
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the SAIF Corporation's denial of his claim for a low back injury. In his reply brief, claimant moves to strike SAIF's respondent's brief. On review, the issues are compensability and motion to strike.

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

Claimant moves to strike SAIF's respondent's brief as untimely because it was due on January 17, 2000, but was not filed until January 18, 2000. Pursuant to OAR 438-011-0020(2), a party's appellant brief must be filed within 21 days after the date of mailing of the transcript to the parties. The respondent is required to file its brief within 21 days after the date of mailing of the appellant's brief. For purposes of appellate briefs, "filing" is defined as "the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing." OAR 438-005-0046(1)(c). An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. *Id.*

Here, claimant's appellant's brief was filed on December 27, 1999. SAIF's respondent's brief was therefore due on January 17, 2000. That day was Martin Luther King, Jr. Day, a federal and state holiday. Because the state's offices were closed on January 17, 2000 and because there was no U.S. mail on the holiday at issue, we deny the motion to strike. *See Harley J. Gordineer*, 50 Van Natta 1615 (1998) (brief that was due on federal and state holiday and was filed the day after the holiday was not stricken as untimely).

ORDER

The ALJ's order dated October 20, 1999 is affirmed.

March 27, 2000 Cite as 52 Van Natta 487 (2000)

In the Matter of the Compensation of
AMADOR R. GALLARDO, Claimant
WCB Case No. 99-02506
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) dismissed his request for hearing because he failed to perfect an aggravation claim; and (2) directed claimant's counsel to pay $500 to the insurer for reasonable expenses incurred by reason of a frivolous request for hearing. In its brief, the insurer requests additional sanctions concerning claimant's request for review. In his reply brief, claimant argues that the insurer's request for sanctions on review is itself frivolous and he seeks sanctions against the insurer. On review, the issues are aggravation and sanctions. We modify in part and reverse in part.

FINDINGS OF FACT

Claimant, a laborer, was compensably injured on July 22, 1996 when a truss fell on his neck and back. (Ex. 1, 3). The insurer accepted a disabling acute low back and thoracic contusion. (Ex. 13). The acceptance was later amended to include a cervical/low back strain. (Ex. 33). A December 8, 1997 Notice of Closure did not award permanent disability. (Ex. 42). Claimant requested reconsideration. (Ex. 43). A June 5, 1998 Order on Reconsideration affirmed the Notice of Closure. (Ex. 52).

On December 15, 1998, claimant's attorney sent a letter to the insurer's attorney, giving notice of a claim for aggravation. (Ex. 55). Claimant's attorney indicated that a June 9, 1998 medical report from Dr. Thomas documented diminished range of motion and increased symptoms that "establish a worsening of the accepted cervical and lumbar strain[.]" (Ex. 55-2). Claimant's attorney said that the report was already in the insurer's possession. (*Id.*) There is no evidence that any reports were included with the December 15, 1998 letter.

Dr. Thomas wrote to the insurer on January 29, 1999, stating that on June 9, 1998, claimant had a "waxing and waning of his pre-existing condition and he did not have an aggravation." (Ex. 56). Dr. Thomas noted that claimant was working full-time in construction. (*Id.*)

On April 8, 1999, the insurer objected to the validity of claimant's claim form because it did not comply with the form and format prescribed by the Director. (Ex. 57). The insurer noted that the "claim" was not accompanied by claimant's attending physician's report establishing written medical evidence supported by objective findings that claimant suffered a worsened condition attributable to the compensable injury. (*Id.*) The insurer also said that the medical evidence indicated claimant's condition was a "waxing and waning," rather than an aggravation. (*Id.*) The insurer denied claimant's aggravation claim. (*Id.*) Claimant requested a hearing concerning the insurer's *de facto* denial of his aggravation claim, as well as the April 8, 1999 denial.

The insurer filed a motion to dismiss claimant's request for hearing on the basis that there was no valid aggravation claim and, therefore, its denial was a nullity.[1] An ALJ issued an interim order on August 30, 1999 denying the insurer's motion to dismiss. The ALJ reasoned that, in the absence of an express stipulation as to the relevant facts, it was inappropriate to decide the merits of the parties' dispute and dismiss claimant's request for hearing without conducting a hearing and taking any evidence.

CONCLUSIONS OF LAW AND OPINION

Aggravation Claim

Relying on *David L. Dylan*, 50 Van Natta 276, *on recon* 50 Van Natta 852 (1998), the ALJ found that claimant failed to perfect a valid claim for aggravation. The ALJ concluded that the Hearings Division lacked jurisdiction to address the merits of claimant's claim and he dismissed claimant's request for hearing.

Claimant raises several arguments on review. Claimant argues that the Director has never prescribed a valid form or format for the filing of an aggravation claim when the claim is filed by the worker's representative. He asserts that the statutory language requires that the form and format prescribed by the Director must provide for filing by the worker's attorney. Claimant argues that the Director's "form and format" is invalid because it is inconsistent with the statute and establishes barriers to the filing of an aggravation claim. According to claimant, the aggravation claim filed in this case by claimant's attorney substantially complies with the form and format prescribed by the Director. Claimant also contends that the attending physician's report need not be physically attached to the aggravation claim form.

We first address claimant's argument that the attending physician's report need not be physically attached to the aggravation claim form. In the December 15, 1998 letter, claimant's attorney identified Dr. Thomas as claimant's attending physician and explained:

> "A medical report from the attending physician documenting diminished range of motion and increased symptoms establish a worsening of the accepted cervical and lumbar strain as of June 9, 1998. The report is already in your possession." (Ex. 55-2).

Claimant relies on *Shawn M. Drew*, 50 Van Natta 925 (1998), to argue that a medical report need not be physically attached to the aggravation claim to be considered as "accompanying" the report. According to claimant, because the June 9, 1998 chart note was already in the possession of the insurer and was clearly identified by the claim, the report "accompanied" the claim.

The insurer argues that there was no medical report accompanying claimant's attorney's claim for aggravation and, in any event, the June 9, 1998 chart note does not indicate there was a worsening of a compensable condition.

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."

Even if we assume, without deciding, that Dr. Thomas' June 9, 1998 report "accompanied" claimant's claim for aggravation, we find that report is not sufficient to perfect his aggravation claim. The June 9, 1998 chart note from Dr. Thomas stated:

> "He returns. He doesn't want to take medicines, doesn't feel P.T. helps so I had him increase lifting and he has had increased symptoms. His pain is at the base of the neck and low back. ROM forward flexion, 40 [degrees], lateral bending to the left and right, 10 [degrees], extension is 10 [degrees]. We had a discussion and he is going to continue doing his exercises. He basically wanted a slip for light duty only so I wrote him a slip for no lifting over 10 pounds and he'll call me in a couple of weeks." (Ex. 1-5, -6).

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[1] The insurer also asserted that claimant had not appealed the April 8, 1999 denial, but it later withdrew that argument.

We find that Dr. Thomas' June 9, 1998 chart note is not sufficient to establish that claimant had suffered a worsened condition "attributable to the compensable injury." *See Susan R. Foster*, 49 Van Natta 2026 (1997) (physician's chart notes did not establish that the claimant's symptoms were due to her prior compensable injury). Dr. Thomas' statement that claimant had "increase[d] lifting" and had increased symptoms could indicate his symptoms were due to a cause other than the compensable injury. Thus, even if we assume, without deciding, that Dr. Thomas' June 9, 1998 chart note "accompanied" claimant's claim for aggravation, we find that chart note is insufficient to establish "by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury." *See* ORS 656.273(3). Therefore, we agree with the ALJ that claimant has failed to perfect a valid claim for aggravation. Although the ALJ dismissed the request for hearing, the parties agree that the appropriate disposition is to set aside the insurer's denial as a nullity. In light of our conclusion that claimant's aggravation claim was procedurally defective, the insurer's aggravation denial is a nullity and without legal effect. *See Charles L. Chittim, Jr.*, 51 Van Natta 764 (1999). Consequently, we reinstate claimant's hearing request and set aside the insurer's denial as a nullity.

Sanctions at Hearing

At hearing, the insurer requested $500 in sanctions for reasonable expenses incurred by reason of claimant's request for hearing. The ALJ reasoned that, had claimant's attorney reviewed *David L. Dylan*, 50 Van Natta at 276, it would have been clear that his appeal was initiated without a reasonable prospect of prevailing. The ALJ concluded that the appeal was frivolous and directed claimant's counsel to pay the insurer $500 for reasonable expenses.

Claimant first argues that the transcript reveals that the insurer never raised the issue of sanctions "on the record." The insurer responds that the issue of sanctions was addressed in a pre-hearing conference. We are not persuaded by claimant's assertion in light of the fact that the ALJ specifically referred to the issue of sanctions as one of the issues to be decided.

Claimant contends that the insurer is not entitled to sanctions because he presented arguments that were well-founded in the language of the statute and were sufficiently developed to present a reasonable prospect of prevailing.

ORS 656.390(1) provides that if a party requests a hearing before the Hearings Division and the ALJ finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the ALJ may impose an appropriate sanction upon the attorney who filed the request for hearing. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see Bi-Mart Corp. v. Allen*, 164 Or App 288 (1999).

After reviewing the record, we find that claimant has presented a colorable argument at hearing that was sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Although the argument at hearing did not ultimately prevail, we do not find it to be "frivolous." Moreover, we find no evidence that the request for hearing was filed in bad faith or for the purpose of harassment. Consequently, we reverse that portion of the ALJ's order that imposed sanctions against claimant's attorney.

Sanctions on Review

On review, the insurer requests additional sanctions against claimant's attorney. The insurer asserts that claimant's attorney is causing the insurer to spend substantial time and resources responding to frivolous issues.

ORS 656.390(1) provides that if a party requests review before the Board 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. Here, we are persuaded by claimant's argument that the ALJ improperly dismissed his request for hearing. Instead, we found that claimant's hearing request should be reinstated and the insurer's denial should be set aside as a nullity. Under these circumstances, we deny the insurer's request for sanctions on review.

In his reply brief, claimant contends that the insurer's request for sanctions on review, in light of its concession that the ALJ should have set aside denial as a nullity, rather than dismissing the request for hearing, is itself frivolous. Claimant also argues that the "defamatory nature" of the insurer's argument demonstrates an intent to harass.

After reviewing the record, we are not persuaded that the insurer's request for sanctions on review was made in bad faith or for the purpose of harassment. Claimant correctly asserts that the insurer agreed in its brief on review that the ALJ should have set aside the denial as a nullity, rather than dismissing claimant's hearing request. Despite that concession, we are not persuaded that the insurer's request for sanctions on review was "frivolous." *See Bi-Mart Corp. v. Allen*, 164 Or App at 288 (Board's refusal to award sanctions is within its discretion).

ORDER

The ALJ's order dated November 5, 1999 is reversed in part and modified in part. That portion of the ALJ's order that directed claimant's counsel to pay the insurer $500 for reasonable expenses incurred by reason of a frivolous appeal is reversed. Claimant's request for hearing is reinstated and the insurer's aggravation denial is set aside as a nullity.

March 27, 2000 Cite as 52 Van Natta 490 (2000)

In the Matter of the Compensation of
STEVE H. SALAZAR, Claimant
Own Motion No. 99-0268M
OWN MOTION ORDER OF DISMISSAL
John C. Correll, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

On March 1, 2000, claimant submitted a letter to the Board which noted that he had filed a hearing request objecting to the processing of his claim as an Own Motion claim. Claimant's aggravation rights expired on May 14, 1995. With his request, claimant submitted copies of a May 22, 1996 Opinion and Order issued by Administrative Law Judge (ALJ) Baker and a November 29, 1996 Order on Review reviewing ALJ Baker's order. Claimant requested that the claim be referred to the Board for "proper dispensation."

Inasmuch as it was unclear from the record as to what claims processing had occurred since the insurer was finally found responsible for claimant's *right* knee condition pursuant to the November 29, 1996 Order on Review, the Board requested the parties' position regarding whether: (1) claimant's claim was reopened within his aggravation rights period; (2) it was closed; (3) claimant was objecting to the Board's July 19, 1999 Own Motion Order which reopened his claim for the provision of temporary disability compensation; (4) claimant was seeking review of the insurer's February 2000 closure; and (5) the claim was within the Board's own motion jurisdiction pursuant to ORS 656.278.

In response, the insurer explained that the 1996 orders issued by ALJ Baker and the Board, on review, pertained to that portion of claimant's claim involving his *right* knee. The more recent request for reopening was based on a worsening of that portion of claimant's claim involving his *left* knee. Claimant's *left* knee condition was as accepted as a torn medial meniscus and processed under the original injury. Claimant underwent surgery for a *left* torn medial meniscus in November 1999. Inasmuch as the recent worsening involved the same condition on the *left* knee, the insurer contends that the claim was processed "accordingly and properly as an Own Motion claim." Responding to the insurer's contentions, claimant agrees with the insurer's position and "withdraws his request for Own Motion relief."

In light of such circumstances, we find that claimant has withdrawn his request for own motion relief. Accordingly, the request for relief is hereby dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARSHALL H. NORWALK, Claimant
WCB Case No. 99-05632
CORRECTED ORDER ON REVIEW
Craine & Love, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

It has come to our attention that our March 27, 2000 Order on Review contained a clerical error. Specifically, the order included two pages numbered "Page 2," the second of which was a "draft" version of the eventual final version. To correct this oversight, we withdraw our March 27, 2000 order and replace it with the following order. The parties' rights of appeal shall begin to run from the date of this order.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's L2-5 stenosis condition; and (2) awarded an attorney fee of $4,000. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address SAIF's argument that the $4,000 attorney fee is excessive. On review, SAIF asserts that a $2,500 fee would be more appropriate.

At hearing, claimant's attorney submitted a statement of services requesting an attorney fee of $5,000. Claimant's attorney had devoted approximately 25 hours to the case. SAIF objected to the fee, noting that claimant's benefits were limited due to a prior Claims Disposition Agreement. At that time, SAIF indicated that a fee in the range of $3,500 to $4,000 would be appropriate.

The ALJ considered the factors in OAR 438-015-0010(4) and found that a reasonable fee was $4,000. The ALJ particularly considered the time devoted to the case, as reflected by the record and claimant's attorney's statement of services, as well as the complexity of the issues, the value of the interest involved and the risk claimant's counsel may go uncompensated.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4) and the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's L2-5 stenosis condition. The record includes 48 exhibits, 11 of which were generated or submitted by claimant's attorney. There were no depositions. The hearing lasted over one hour with a transcript of 25 pages. Claimant testified on his own behalf. As previously noted, claimant's counsel submitted a statement of services at hearing, indicating she had devoted 25 hours to the case.

The compensability issue primarily involved an evaluation of medical evidence and was of a complexity level that is normally faced by the Board and its Hearings Division. Because claimant's L2-5 stenosis condition has been found compensable, claimant is entitled to further workers' compensation benefits. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical evidence, there was a risk that claimant's counsel's efforts might go uncompensated.

Considering all these factors, we agree with the ALJ that $4,000 is a reasonable fee for claimant's counsel's services at the hearing level. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and claimant's counsel's statement of services), the medical and factual complexity of the issue, the value of the interest involved, the nature of the proceeding, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is

$1,200, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review related to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated November 4, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the SAIF Corporation.

March 29, 2000 Cite as 52 Van Natta 492 (2000)

In the Matter of the Compensation of
STEVEN L. RHINEHART, Claimant
WCB Case No. 99-05257
ORDER ON REVIEW
Larry D. Anderson, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) affirmed an Order on Reconsideration that awarded no permanent disability; and (2) declined to award additional temporary disability benefits from October 13, 1998 to February 1, 1999. On review, the issues are extent of unscheduled permanent disability and temporary disability.

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

ORS 656.262(4)(f) provides that temporary disability is not due and payable pursuant to ORS 656.268 "after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician." 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." 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. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999).

Here, temporary disability was authorized on February 16, 1998 through April 7, 1998. Claimant was not seen by an attending physician between April 7, 1998 and September 24, 1998. Claimant's attending physician did not authorize further temporary disability compensation, and claimant did not return to his physician after that date. Therefore, whether claimant's medically stationary date is October 13, 1998 or February 1, 1999, claimant is not entitled to temporary disability compensation after April 7, 1998.

ORDER

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

In the Matter of the Compensation of
MICHAEL T. BERGMANN, Claimant
Own Motion No. 99-0177M
SECOND OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Mitchell & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

On May 4, 1999, the SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable left knee condition. Claimant's aggravation rights expired on March 19, 1997. SAIF initially opposed reopening on the following grounds: (1) claimant's current left knee condition was not causally related to the compensable condition, and SAIF was not responsible for that condition; and (2) claimant was not in the work force at the time of disability. Also on May 4, 1999, SAIF issued a denial of a 50 percent tear of the left knee ACL. Claimant filed a request for hearing with the Hearings Division, contesting SAIF's denial. WCB Case No. 99-04680. On June 23, 1999, we issued an order consolidating the own motion matter with the pending hearing.

On November 17, 1999, the parties entered into a Stipulation and Order in which SAIF agreed to accept the "50% tear of the left knee ACL in addition to the previously accepted left knee horizontal tear of posterior horn & mid-sector of medial meniscus." The parties disagreed, however, as to whether this acceptance required a reopening of the claim, with claimant contending that it was an acceptance of a new condition requiring reopening under ORS 656.262(7)(c) and SAIF contending that the claim remained in Own Motion status. The parties explicitly preserved that issue. Finally, claimant's request for hearing in WCB Case No. 99-04680 was dismissed with prejudice. The Stipulation did not address the work force issue.

In response to an inquiry from the Board, the parties submitted their written positions regarding claimant's request for Own Motion relief. In short, the parties continued to maintain their positions as preserved in the Stipulation, with claimant contending that the accepted new condition entitled him to have his claim reopened pursuant to ORS 656.262(7)(c), and SAIF contending that the claim remained in Own Motion status pursuant to ORS 656.278. In addition, claimant requested that we "direct SAIF to close the new medical condition claim in accordance with ORS 656.262(7)(c)." Neither party addressed the work force issue.

Finally, on February 8, 2000, claimant requested a hearing with the Hearings Division, raising the issue of "failure to close [his] claim" regarding the October 17, 1991 injury. WCB Case No. 00-01126. That hearing is scheduled for May 8, 2000.

In *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), we held that a "new medical condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the original claim is in the Board's Own Motion jurisdiction. 51 Van Natta at 1745. Furthermore, in *Craig J. Prince*, 52 Van Natta 108 (2000), we determined that the Board, in its "Own Motion" capacity under ORS 656.278, does not have the authority to direct a carrier to process a claim under ORS 656.262(7)(c). In *Prince*, we explained that the issue of whether the claim should be processed under ORS 656.262(7)(c) is a "matter concerning a claim" and, under ORS 656.283, any party "may at any time request a hearing on any matter concerning a claim." 52 Van Natta at 111. Therefore, 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. *Id.*

Here, claimant has done just that by requesting a hearing with the Hearings Division and raising the issue of "failure to close [his] claim." WCB Case No. 00-01126. As litigation is pending regarding the processing of claimant's claim, we conclude that it would be in the best interest of the parties to consolidate this own motion matter with the pending litigation.

At the hearing, the Administrative Law Judge (ALJ) assigned to conduct the hearing shall resolve the claim processing issue raised by claimant (as well as any other issues properly raised by the parties). In addition, the assigned ALJ shall make findings of fact and conclusions of law and opinion regarding the effect of his or her decision on this claim processing matter on claimant's Own Motion claim. Finally, if it is determined that claims processing should proceed under ORS 656.278, the ALJ shall also make findings of fact and conclusions of law on the issue of whether claimant was in the work force at the time claimant's condition worsened. *See Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *SAIF v. Blakely*, 160 Or App 242 (1999).

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to the own motion matter(s) and a copy of the appealable order issued in WCB Case No. 00-01126. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
VICKI L. HAVLIK, Claimant
WCB Case No. 98-00608
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys

This matter is before the Board on remand from the Court of Appeals. *Havlik v. Multnomah County*, 164 Or App 522 (1999). The court has reversed our prior order, *Vicki L. Havlik*, 51 Van Natta 98 (1999), that upheld the self-insured employer's denial of claimant's occupational disease claim for a mental disorder. The court concluded that we failed to evaluate whether the working conditions that were directly responsible for claimant's mental disorder were conditions generally inherent in every working situation, as explained in *Whitlock v. Klamath County School Dist.*, 158 Or App 464 (1999). Finding that we failed to undertake that inquiry because we viewed claimant's reaction to her working conditions too generally, the court has instructed us to reconsider our decision in light of *Whitlock*.

FINDINGS OF FACT

Claimant began working for the employer as an animal control officer in 1994. In 1997, claimant's working conditions changed. The employer's animal shelter became seriously overcrowded and the animals had inadequate care.[1] They were kept without food and water too long and they slept in their own excrement or in their food and water dishes. The shelter was understaffed and employees were subject to unexpected schedule changes.[2] Claimant objected to the animals' lack of adequate care and to management's decision to hold animals rather than euthanize them.

In April 1997, a dog bit claimant while she was working in the field. About a month later, she participated in a work-related television interview that went badly. In August 1997, two pitbulls attacked claimant and one bit her. Police officers came to her aid and shot one of the dogs.

After the second bite, claimant was on light duty in dispatch at the shelter. During this time, she witnessed serious overcrowding and inadequate care of shelter animals. On two occasions, claimant became upset when managers referred to workers in disparaging terms.

Claimant became more distressed and fearful of going to work. In October 1997, claimant sought treatment for anxiety and depression. She was diagnosed with major depression and filed a claim, which the employer denied.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial, finding that claimant failed to prove that cognizable stressors were the major contributing cause of her depression. The ALJ identified claimant's stressors to include fear of being laid off due to "down sizing"[3] and reactions to management "policy changes"

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[1] The overcrowding occurred pursuant to new rules affecting euthanasia.

[2] Some of these working conditions were due to budgetary constraints.

[3] We do not find that claimant feared being laid off due to "down-sizing," because claimant did not report that fear. (*See* Ex. 12-6).

which caused the distressing overcrowding of animals at the shelter. The ALJ declined to consider these contributing causes, characterizing the former as a "budget restraint/normal business cycle" and the latter as typical or "normal." Reasoning that these contributing causes were noncompensable because they are conditions generally inherent in every working situation, and no expert evidence factored them out of the causation equation, the ALJ concluded that the claim failed under ORS 656.802.[4]

We affirmed the ALJ's decision on Board review. *Vicki L. Havlik*, 51 Van Natta 98 (1999). We adopted the portions of the ALJ's order that excluded management's disparaging remarks and claimant's fear of being attacked by dogs at work from among conditions "generally inherent in every working situation." *See* ORS 656.802(3)(b). However, we found that claimant's problems with management prioritizing (that resulted in scheduling and staffing changes and contributed to shelter overcrowding) were "generally inherent" because they were policy changes. Because the medical evidence supporting the claim did not factor out these "generally inherent" contributors, we agreed with the ALJ that claimant failed to establish that cognizable stressors were the major cause of her mental conditions.

Claimant sought judicial review. She argued that she was not stressed by policy changes, but rather from the overcrowded condition in which the animals were kept as a result of the policy changes.

The court reversed our order, reasoning that we failed to evaluate whether the working conditions that were directly responsible for claimant's mental disorder were conditions generally inherent in every working situation. *Havlik v. Multnomah County*, 164 Or App at 528. Concluding that we failed to undertake that inquiry because we viewed claimant's reaction to her working conditions too generally, the court has instructed us to reconsider our decision in light of *Whitlock v. Klamath County School Dist.*, 158 Or App 464 (1999).

The *Havlik* court stated that "[w]hether a stress-producing condition is common to the full range of employment depends, in large part, on how that stress-producer is defined." *Havlik*, 164 Or App at 527. Finding that we "viewed claimant's reaction to her working conditions as simply a reaction to 'policy changes,'" the court concluded that, in taking that view, we "pitched [our] analysis at too high a level of generality and thus failed to undertake the inquiry that *Whitlock* requires." *Id.* at 527-28.

The *Havlik* court concluded:

> "As we recognized in our first opinion in *Whitlock*, the relevant question is whether the working conditions that are *directly* responsible for a claimant's mental disorder are generally inherent in every working situation." 164 Or App at 528 (citing *Whitlock v. Klamath County School District*, 142 Or App 137, 142 (1996) (emphasis added).

Accordingly, on reconsideration, we first identify claimant's stress-producing conditions. Then we evaluate whether the claim is compensable under ORS 656.802, without relying on those stress-producers that are excluded from among compensable causes under ORS 656.802(3).[5]

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[4] The statute provides that the worker must prove that employment conditions were the major contributing cause of the claimed disease. ORS 656.802(2)(a). In addition, subsection (3) addresses mental disorders and provides in pertinent part:

> "(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes []:
>
> "* * * *
>
> "(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles."

[5] *See McGarrah v. SAIF*, 296 Or 145, 166 (1983) (the worker must prove that employment conditions, when compared to nonemployment conditions, were the major contributing cause of the mental disorder); *Patrick W. Real*, 49 Van Natta 2107, 2108 (1997), *aff'd mem* 157 Or App 723 (1998) ("To prevail, claimant must prove [] that employment conditions not otherwise statutorily excluded, were the major contributing cause of his disease."

To identify claimant's stress-producing conditions, we examine claimant's complaints and the medical experts' reports.[6]

Claimant reported gradually increasing stress due to work incidents and circumstances from spring to fall in 1997, primarily her two dog bites, inadequate staffing, the interview incident and distress at witnessing animals suffering when the shelter was severely overcrowded and the animals were neglected. (Exs. 1-1, 2-2, 2A, 3, 4, 5, 6, 7, 8, 9, 9A, 12,13 Tr. 25, 39-41, 44-45, 91, 94, 2Tr. 59-61; *see* Tr. 84-86, 104, 106, 111, 2Tr. 38, 90-92, 100-101). Based on claimant's contemporaneous conduct at work, her reporting to doctors, and the doctors' opinions (especially with regard to the dog bites and claimant's distress due to the overcrowded animals' suffering), we find that these stressors together were the major contributing cause of claimant's depression. (*See id.*).

This is not a case with conflicting medical opinions. The medical experts agree that the stressors claimant reported caused her condition. And the experts agree that claimant's condition is work related.[7] Therefore, the claim is compensable so long as the major portion of stress-producers are not excluded from among compensable causes under ORS 656.802(3).

The only statutory exclusion at issue in this case is ORS 656.802(3)(b), which provides that "[t]he employment conditions producing the mental disorder [must be] other than conditions generally inherent in every working situation[.]" As the *Whitlock* court explained,

> "a work-related mental disorder is not compensable if the stress-producing condition is common to the general range of employments, even if that condition is not necessarily inherent in every job." 154 Or App at 471.

We find that the following stressors are *not* "generally inherent" conditions: dog bites, safety concerns, the distressing television interview, lack of management support, disparagement and/or name-calling by managers, and witnessing animals suffering. We reach this conclusion because these conditions are "not common to the full range of working situations" and most jobs do not involve any of these conditions. *See id.* at 475. Having determined that the aforementioned stressors together were the major contributing cause of claimant's major depression, we conclude that the claim is compensable.[8]

Accordingly, on reconsideration, the ALJ's order dated June 3, 1998 is reversed. The 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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[6] We find no reason to disbelieve or discount claimant's reporting because it is consistent with and supported by the remainder of the record.

[7] The persuasive medical evidence rules out off work causes. (Exs. 2-1, 12-15; *see also* Ex. 1-2).

[8] Claimant also experienced stress because of her disagreement with management decision-making regarding scheduling, employee support, and the moratorium on quick euthanasia. (*See* Ex. 1-1, 6, 8-1, 12; *c.f.* Tr. 80-81). We need not determine whether such disagreement with management policy and prioritizing is a "condition generally in all working situations" because major causation is established without considering these contributors.

In the Matter of the Compensation of
REBECCA BENZEL, Claimant
WCB Case No. 99-05040
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's bilateral hand and arm condition. On review, the issue is the scope of the employer's acceptance. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following correction.

The last sentence is corrected to refer to the acceptance dated January 4, 1999.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's current bilateral hand and arm condition, finding that the denied condition was the same as the condition the employer had previously accepted. We affirm.

The pivotal question is whether the employer's acceptance of claimant's "nondisabling temporary aggravation of a pre-existing bilateral wrist condition" was an acceptance of symptoms of the preexisting condition or an acceptance of a separate condition. *See Granner v. Fairview Center*, 147 Or App 406, 411 (1997).

The parties agree that claimant had a preexisting wrist condition. The employer argues that its acceptance was limited to a *temporary* exacerbation of the preexisting condition (by its terms), so it did not accept the preexisting condition.

We find that the scope of the acceptance included claimant's Carpal Tunnel Syndrome (CTS) and the employer's later denial of claimant's CTS is precluded, for the following reasons.

At the time of the acceptance, claimant had classic CTS *symptoms*, but she did not have significant neuropathic injury. (Exs. 7, 8). Thus, the medical evidence suggested that the employer's acceptance of a "temporary exacerbation" was an acceptance of symptoms.[1] In addition, the medical evidence did not relate claimant's symptoms or her condition to specific exposure or activities and no physician predicted that her condition would resolve.[2] (*See* Exs. 2A, 6). Moreover, no medical evidence distinguished claimant's condition at the time of the claim and its acceptance from her underlying condition. Under these circumstances, we cannot say that the employer accepted a condition medically separable from her underlying condition. *See Boise Cascade Corp. v Katzenbach*, 104 Or App 732, 735 (1990), *rev den* 311 Or 261 (1991).[3]

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[1] *Compare Phillip L. Shores*, 49 Van Natta 341, 342 (1997) (where no evidence indicated that the claimant's right shoulder tendinitis was a symptom of his degeneration or disc herniation, a carrier's denial of the spinal conditions was not precluded by its acceptance of the tendinitis).

[2] *Compare Nordstrom, Inc. v. Windom-Hall*, 144 Or App 96, 99 (1996) (where the acceptance was limited to symptoms caused by certain exposure, conditions not caused by that exposure not encompassed by the acceptance); *Joan D. Anderson*, 50 Van Natta 1817 (1998) (where the medical evidence indicated that the aggravation of preexisting conditions was likely to be temporary, the employer's acceptance of a "temporary exacerbation" of those conditions was not an acceptance of the preexisting condition); *Nancie A. Stimler*, 47 Van Natta 1114 (1995) (where acceptance of a "temporary" condition was based on the medical treatment evidence, it was not a denial of future benefits for the accepted condition).

[3] *Compare Granner*, 147 Or App at 410 (acceptance of a *particular* condition does not necessarily include the cause of that condition); *Gerry L. Schreiner*, 51 Van Natta 1998 (1999) ("if the carrier's acceptance is for a separate condition, the rule of *Piwowar* does not apply) (citing *Boise Cascade Corp. v. Katzenbach*, 104 Or App 732, 735 (1990), *rev den* 311 Or 261 (1991)).

Consequently, based on the medical evidence, we conclude that the employer accepted symptoms of claimant's underlying condition. Therefore, it is precluded from denying the underlying condition.[4] *See Georgia-Pacific v. Piwowar*, 305 Or 494 (1988) (acceptance of symptoms of an underlying condition is an acceptance of the disease causing the symptoms).[5]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, 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 October 28, 1999 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

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[4] The employer also argues that it accepted a combined condition involving claimant's preexisting carpal tunnel syndrome (CTS) and her recent work exposure. Therefore, it contends that it was entitled to deny the preexisting condition when the work exposure ceased to be the major contributing cause of the current condition. *See* ORS 656.262(6)(c). But we have found that the employer accepted claimant's underlying condition. Under these circumstances, there is no preexisting condition within the meaning of ORS 656.262 and the statute does not apply. *See Janet R. Christensen*, 50 Van Natta 396, 400 (1998), *aff'd Freightliner v. Christensen*, 163 Or App 191 (1999) (Where the preexisting conditions were included in the acceptance, there was no combined condition, and ORS 656.005(7)(a)(B), 656.262(6)(c), and 656.262(7)(b) did not apply).

[5] *See Jerry L. Bliss, on recon*, 49 Van Natta 1471(1997) (acceptance of "dermatitis" symptoms included underlying condition).

March 31, 2000 Cite as 52 Van Natta 498 (2000)

In the Matter of the Compensation of
JUDY BIXEL, Claimant
Own Motion No. 99-0427M
OWN MOTION ORDER ON RECONSIDERATION
Employers Ins. of Wausau, Insurance Carrier

Claimant requests reconsideration of our February 29, 2000 Own Motion Order in which we declined to reopen her 1983 claim for the payment of temporary disability compensation because she failed to establish she was in the work force at the time of her current disability. With her request for reconsideration, claimant submitted additional information regarding the work force issue. On reconsideration, we withdraw our prior order and issue the following order in place of our prior 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.*

Claimant underwent a lumbar laminectomy and diskectomy at L3-4 on October 30, 1999. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

On reconsideration, claimant submitted a statement wherein she asserts that for the last three years, she has done "lite [sic] upholstery work" from her home. She submitted copies of invoices dated from June 5, 1999 through February 14, 2000. With particularity, claimant submitted invoices dated October 4 and October 14, 1999 which demonstrates that she worked just prior to her October 30, 1999 surgery. Additionally, claimant submitted a page from the telephone yellow pages which demonstrates that she advertised her services as an upholsterer. She also submitted a copy of a paid telephone bill which evinces that she maintained a business line.

Here, claimant has established that she performed work for remuneration in October 1999. Therefore, we find that claimant was performing work at the time of disability.[1] Because claimant has established that she worked, albeit sporadically, she is entitled to temporary disability compensation to replace any lost wages, beginning the date of surgery. *See Robert D. Hyatt*, 48 Van Natta 2202 (1996) (claimant was entitled to temporary partial disability when, although retired, claimant established he continued to work part-time).

The insurer asserts that claimant has been receiving social security disability benefits "for some time." Additionally, it contends that although claimant has been working at home "on an occasional basis in self employed capacity at upholstery repair, she has not been employed on a steady and permanent basis at this or any other employment for some time," and thus, is not entitled to temporary disability compensation. Although claimant may receive social security benefits, 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] Here, we do not find the receipt of social security benefits determinative, because claimant has established that she was working at the time of disability, and, thus entitled to temporary disability compensation. *See Robert D. Hyatt*, 48 Van Natta at 2203.

On this record, we conclude that claimant has established that she was working until the time of her surgery in October 1999.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning October 30, 1999, the date she was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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 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); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was in the work force is the time prior to her October 30, 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); *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 she 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 claimant to seek work), *see Dawkins v. Pacific Motor Trucking*, 308 Or App at 255; 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).

In the Matter of the Compensation of
JOHN R. FRAZIER, Claimant
WCB Case No. 98-03515
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that (1) upheld the self-insured employer's denial of claimant's left shoulder condition; and (2) upheld the employer's denial of claimant's aggravation claim. On review, the issues are compensability and aggravation.

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

Claimant argues that the ALJ erred by finding that the evidence did not establish that his current condition was tendinitis. In addition, claimant argues that a videotape viewed by the doctors inaccurately depicted claimant's job.

Even if claimant's current condition is tendinitis, and even if the videotape viewed by the three physicians who addressed the cause of claimant's condition is inaccurate, the fact remains that the medical evidence is insufficient to establish compensability of the current condition. In this regard, all of the physicians expressed doubts about the work-relatedness of the tendinitis condition given that claimant's symptoms continued even after he ceased the work-activities that incited the left shoulder problems. None of these physicians was able to render an opinion that the current condition was compensably related to the work activities. There is no persuasive medical evidence establishing compensability of claimant's current left shoulder condition. Accordingly, we affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich dissenting.

I disagree with, and respectfully dissent from, the majority's opinion for the reasons which follow. I begin with a brief summary of the relevant facts.

Claimant began working for the employer in about November 1995 as a round table off bearer/grader. Claimant filed a July 22, 1996 claim for a left shoulder condition. The claim was acceptd as a nondisabling left shoulder strain. Claimant was terminated on January 23, 1997.

In about July 1997, claimant returned to work for the employer. He developed the sudden onset of left shoulder pain in about mid August 1997 while pulling chain. He sought medical treatment and was released to modified work. Claimant's symptoms initially improved while he was on modified work. The left shoulder pain recurred in late 1997 and improved while he was off work due to a broken hand in January 1998. Claimant again had recurrent left shoulder pain after returning to modified work in February 1998. Claimant was terminated on March 25, 1998 and has not returned to work. The employer denied compensability of claimant's current condition on April 14, 1998 and claimant requested a hearing.

Claimant argued at hearing that a video viewed by the doctors did not accurately depict his job duties. The ALJ agreed that the video was inaccurate, but nevertheless found that claimant had not established compensability of the current condition. The ALJ, however, still found that claimant failed to establish compensability because the physicians expressed doubts about the work-relatedness of the tendinitis condition given that claimant's symptoms continued even after he ceased the work-activities that incited the left shoulder problems. I find that the record does not support a conclusion that claimant continued to have significant symptoms after ceasing work. Moreover, I conclude that the medical record is sufficient to establish compensability.

The majority adopts the ALJ's order including that portion that finds that claimant sometimes stacked veneer at and above his shoulder height and that the video viewed by the doctors does not accurately depict this. I agree with the ALJ and the majority that the video does not accurately portray claimant's work activities.

Claimant asserts that the issue is whether there is a material relationship between his current condition and his accepted claim. Claimant further argues that the evidence does not support either a consequential or combined condition claim analysis.

I agree, based on the transcript, that the issue litigated by the parties was whether or not claimant's current left shoulder condition is compensably related to the accepted 1996 left shoulder injury claim. (Tr. 4). In addition, whether or not the major contributing cause standard of ORS 656.005(7)(a)(A) or (B) applies, I find that claimant has established compensability.

Three physicians address compensability. Dr. Matteri adhered to his opinion that claimant's current symptoms are the result of repetitive overuse in a position that is not mechanically advantageous. (Exs. 25-2; 40-12). Dr. Phillips, claimant's treating physician, essentially deferred to Dr. Thompson's expertise regarding the cause of claimant's left shoulder condition. (Ex. 39, pages 25-26). Dr. Thompson, when asked to assume that claimant's employment required him to work at a faster pace than depicted on the videotape and to pull veneer onto carts stacked at or above shoulder level, agreed that work was probably the major contributing cause of claimant's left shoulder tendinitis. (Ex. 28).

Dr. Thompson expressed concern about the fact that claimant was still having symptoms on May 4, 1998, approximately five weeks after leaving work, described by Dr. Phillips as "fairly significant." Nevertheless, Dr. Phillips' May 4, 1998 chart note also indicates that claimant's left shoulder "has perhaps improved a little bit." (Ex. 35). The ALJ and the majority rely heavily on Dr. Phillips' statement in his May 4, 1998 chart note that claimant's shoulder continues to bother him "fairly significantly." When the rest of the record is considered, however, I do not believe that this isolated statement persuasively establishes that claimant was continuing to have significant problems with his shoulder in May 1998.

In this regard, the chart note itself suggests that claimant's condition may have improved somewhat after cessation of work. As claimant points out in his brief, the only objective findings noted on May 4, 1998 were "a little bit or tenderness to palpation," "a little bit of crepitus," "a little bit of clicking," and a statement that claimant's range of motion was not too bad. Thus, I am not persuaded that the isolated statement that claimant was having "significant problems" should be accorded much weight given the context of this statement.

Accordingly, I would rely on Dr. Thompson's persuasive opinion rendered prior to viewing the inaccurate videotape and prior to being sidetracked by the isolated and unsupported statement in Dr. Phillips' May 4, 1998 chart note, and find that claimant has established compensability of his current left shoulder condition.

In the Matter of the Compensation of
RABIA S. NASERY, Claimant
WCB Case No. 99-05507
ORDER ON REVIEW
James W. Moller, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the self-insured employer's denial of her injury claim for a torn medial meniscus of the left knee; and (2) declined to assess penalties for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

On page 2, we replace the first two paragraphs with the following four paragraphs:

> On March 21, 1997, claimant was walking across the employer's parking lot at the end of her shift when she slipped on a plastic bag and fell on both knees. (Tr. 18, Ex. 21). On March 24, 1997, she sought treatment from Dr. Rabie. (Ex. 16). He reported that claimant had bilateral knee contusions and had contused her right knee more than her left, but he noted that her left knee had a history of degenerative joint disease. (*Id.*) Dr. Rabie explained that claimant's left knee had moderate swelling, "which appears to be chronic since it is an indurated type of swelling without any evidence of acute effusion." (*Id.*) A McMurray's test was negative on the left. (*Id.*) He diagnosed a right knee contusion and a "left knee contusion with preexisting degenerative joint disease." (*Id.*)

Claimant was examined on March 31, 1997 by Dr. Breen. (Ex. 18). At that time, claimant was complaining of right tibia anterior pain. (*Id.*)

Claimant returned to Dr. Rabie on April 7, 1997, complaining of severe discomfort. (Ex. 22). Dr. Rabie reported that claimant had a slight limping gait and was protecting the right side more than the left. (*Id.*) He believed claimant's injury had reactivated her degenerative joint disease and he requested a bone scan. (*Id.*) An April 14, 1997 bone scan showed degenerative joint disease in both knees, left worse than right. (Ex. 23).

On April 21, 1997, claimant told Dr. Rabie she was making steady improvement and wanted to start her regular duties. (Ex. 24). He diagnosed "resolving" bilateral knee contusions, and preexisting bilateral degenerative joint disease of the knees. (*Id.*) On May 13, 1997, Dr. Rabie reported that claimant was "still having moderate discomfort from time to time but is tolerating it and is attending work on a regular basis." (Ex. 25). He concluded that claimant's trauma had subsided and she had ongoing degenerative problems in her knees. (*Id.*) Dr. Rabie concluded that claimant was medically stationary. (*Id.*)

In the third full paragraph on page 4 of the ALJ's order, we delete the second sentence.

We supplement the ALJ's order as follows.

Compensability

Claimant argues that the preexisting degenerative condition in her left knee did not combine with the March 1997 injury to cause the meniscal tear and, therefore, the standard of proof is material contributing cause. However, we need not decide whether the appropriate legal standard is material or major contributing cause because we conclude that claimant has failed to sustain her burden of proof under either standard.

There are two opinions on causation of claimant's torn medial meniscus. In December 1998, Dr. Adams said it was difficult to determine the cause of claimant's meniscal tear because there was a

significant amount of time between the initial injury and her surgery. (Ex. 47D-2). He explained that claimant had some osteoarthritis of the knee that could cause some degenerative changes and a meniscal tear. (*Id.*) He also said there was a possibility that the initial fall could have caused the tear. (*Id.*) We agree with the ALJ that Dr. Adams' conclusory comments on "possibility" are not persuasive. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

Claimant relies on the opinion of Dr. Gritzka to establish compensability of her medial meniscus tear. Dr. Gritzka examined claimant on two occasions. He first examined her on October 15, 1997 for a medical arbiter examination. (Ex. 36). At that time, he reported that claimant's right heel and right knee were "significantly painful" and she also had pain in her left knee. (Ex. 36-3). Claimant walked with a right antalgic limp. (*Id.*) He reported that claimant had "no capsular instability nor any medial or lateral collateral ligamentous instability in either knee." (Ex. 36-4). The anterior and posterior drawer signs were negative in both knees, as were the Lachman's test and the pivot shift, flexion and rotation drawer tests. (*Id.*) The McMurray's test was negative on the left. (*Id.*) Dr. Gritzka concluded that claimant had "moderate" degenerative joint disease in each knee with no associated weakness and no chronic effusion in either knee. (Ex. 36-5).

Dr. Gritzka also examined claimant on April 8, 1999. (Ex. 48). Although he had reported in October 1997 that claimant had "moderate" degenerative joint disease in each knee, in April 1999 he said claimant's bilateral degenerative arthritis was "mild." (Ex. 48-12). According to Dr. Gritzka, claimant's clinical symptoms after March 21, 1997 correlated with a left medial meniscus tear. (*Id.*) He explained that claimant developed pain in her left knee and "[s]he had locking in the left knee which was relieved by surgery." (*Id.*) He noted that claimant could not lie on her side with her knees together because it caused pain on the medial aspect of the left knee, which he said was a typical finding for a person with a medial meniscus tear. (*Id.*)

Dr. Gritzka reviewed claimant's left knee MRI scan and said it showed interstitial degeneration, except for the posterior horn of the meniscus. (*Id.*) He explained that degenerative meniscal tears are typically longitudinal and often interstitial, whereas traumatic tears are vertical or have a "parrot-beak" configuration. (*Id.*) Dr. Gritzka reviewed Dr. Khan's surgical report and reasoned that the positive results of claimant's surgery indicated that her symptoms were coming from a tear of the medial meniscus and were not due to the degenerative changes in her knee. (*Id.*)

Dr. Gritzka said that claimant had degenerative arthritis in her left knee, but it was "low grade, mild, and minimally symptomatic." (Ex. 48-13). He said claimant had some "interstitial" change in her medial meniscus before the March 21, 1997 injury, but her symptoms after that date were consistent with a traumatic tear of the meniscus and not a degenerative tear of the posterior horn. (*Id.*) Dr. Gritzka concluded that claimant's work injury was the major contributing cause of the need for treatment of her meniscal tear. (*Id.*)

Although Dr. Gritzka examined claimant on two occasions, he was not a treating physician and his opinion is not entitled to any deference on that basis. In evaluating medical evidence, we rely on opinions that are well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986). For the following reasons, we do not find Dr. Gritzka's opinion persuasive.

We are not persuaded that Dr. Gritzka had an accurate history of claimant's left knee symptoms after the March 1997 injury. According to Dr. Gritzka, claimant's clinical symptoms after March 21, 1997 correlated with a left medial meniscus tear. (Ex. 48-12). He explained that claimant had developed pain in her left knee and "[s]he had locking in the left knee which was relieved by surgery." (*Id.*) Dr. Gritzka's understanding of claimant's symptoms, however, is inconsistent with his own previous October 1997 report, which did not refer to problems with locking of the left knee. Rather, Dr. Gritzka reported in October 1997 that claimant had "no capsular instability nor any medial or lateral collateral ligamentous instability in either knee." (Ex. 36-4). The anterior and posterior drawer signs were negative in both knees, as were the Lachman's test and the pivot shift, flexion and rotation drawer tests. (*Id.*) The McMurray's test was negative on the left. (*Id.*) We find that Dr. Gritzka's October 1997 report is inconsistent with his April 1999 conclusions about claimant's symptoms after the March 1997 injury.

Furthermore, the medical record does not support Dr. Gritzka's comment that claimant had experienced "locking" in her left knee since the March 1997 injury. Dr. Rabie examined claimant on several occasions after the March 21, 1997 injury and he did not refer to any findings of "locking" of the left knee, nor did he indicate that claimant might have a torn left medial meniscus. (Exs. 16, 22, 24, 25). Rather, he said claimant had bilateral knee contusions and preexisting bilateral degenerative joint disease of the knees. (Exs. 16, 22, 24). By May 13, 1997, Dr. Rabie reported that claimant was attending work on a regular basis and he concluded that she was medically stationary. (Ex. 25). Similarly, when claimant was examined by Dr. Smith on May 21, 1997, he reported that claimant had "been experiencing no true locking of the knees[.]" (Ex. 26-3). He diagnosed knee contusions with aggravation of preexisting bilateral degenerative joint disease and he also believed that claimant was medically stationary. (Ex. 26-6, -8).

In sum, we conclude that Dr. Gritzka did not have an accurate understanding of claimant's symptoms after the March 1997 injury. Because his opinion is based on an inaccurate history, it is entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

In addition, although Dr. Gritzka reported in October 1997 that claimant had "moderate" degenerative joint disease in each knee (Ex. 36-5), he said that her degenerative arthritis in her left knee in April 1999 was "low grade, mild, and minimally symptomatic." (Ex. 48-13). Dr. Gritzka did not explain how claimant's degenerative condition apparently decreased over a two-year period or why he changed his opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

Moreover, Dr. Gritzka's April 1999 opinion that claimant's left knee degenerative arthritis was "low grade" and "mild" is inconsistent with Dr. Khan's surgical report. In his October 6, 1998 surgical report, Dr. Khan diagnosed "[d]egenerative arthritis, left knee, with a torn medial meniscus." (Ex. 47A). He reported that the findings were basically that of degenerative arthritis involving most severely on the medial side and less so on the lateral compartment and some degree in the patellofemoral joint. (*Id.*) Thus, Dr. Khan's report indicated that claimant's degenerative arthritis was severe on the medial side. Similarly, Dr. Smith reported that claimant's bone scan showed rather extensive degenerative changes in both knees. (Ex. 26-7). Also, Dr. Gritzka's opinion that claimant had "mild" degenerative arthritis is inconsistent with the August 15, 1998 MRI that showed "[t]ricompartmental osteoarthritic changes most severely involving the medial joint compartment." (Ex. 46). We are not persuaded by Dr. Gritzka's April 1999 opinion that claimant's degenerative condition in her left knee was "low grade, mild, and minimally symptomatic."

We conclude that Dr. Griztka's opinion is not sufficient to establish compensability of claimant's torn medial meniscus, under either a material or major contributing cause standard. There are no other medical reports on causation to sustain claimant's burden of proving compensability. Therefore, we agree with the ALJ that claimant has not sustained her burden of proving compensability.

Penalties

Claimant contends that she is entitled to a penalty for the employer's unreasonable denial of her claim. 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 November 12, 1999 is affirmed.

In the Matter of the Compensation of
CARLOS TRUJEQUE, Claimant
WCB Case No. 99-05933
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's denial of his injury claim for an L5-S1 disc herniation. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Biehl dissenting.

The majority affirms without opinion the ALJ's decision to uphold the SAIF's Corporation's denial of claimant's disc herniation at L5-S1. In so doing, it adopts the ALJ's finding that claimant had a preexisting degenerative condition at L5-S1 that combined with his compensable low back strain. It further adopts the ALJ's conclusion that the compensable injury is not the major contributing cause of claimant's need for treatment for the L5-S1 condition.

In contrast to the majority, I would find, based on the opinion of the attending physician and surgeon, Dr. Berselli, that claimant does not have a preexisting condition at L5-S1 and thus does not have a "combined condition" requiring application of the major contributing cause standard of ORS 656.005(7)(a)(B). Because that statute does not apply, the appropriate burden of proof is material contributing cause. *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992); *Ronnie C. Fair*, 51 Van Natta 1860 (1999). Dr. Berselli's opinion easily satisfies that legal standard and, thus, I would find that claimant satisfied his burden of proof.

As can be seen from the preceding discussion, the crucial issue in this case is whether claimant has a preexisting condition. The majority adopts the ALJ's finding that claimant, in fact, has a preexisting condition at L5-S1. However, Dr. Berselli, who performed surgery at L5-S1 specifically stated that there was no preexisting degenerative disc disease. (Ex. 40). As case law shows, the attending surgeon is in the best position to know whether or not claimant has a preexisting degenerative condition at L5-S1. *See Argonaut Insurance v. Mageske*, 93 Or App 689, 702 (1988) (treating surgeon's opinion found persuasive where he was able to observe the claimant's shoulder during surgery and indicated that there was no evidence that the claimant's condition was due to congenital defect); *William F. Wegesend, III*, 50 Van Natta 1612, 1613 (1998).

Granted, a radiologist commented that claimant had moderate degeneration at L5-S1 and Dr. Berselli also removed degenerative disc material at surgery. While this evidence implies that claimant had preexisting degenerative disc disease at L5-S1, neither the radiologist nor Dr. Berselli specifically stated this. In fact, as previously noted, Dr. Berselli specifically stated to the contrary. Therefore, the ALJ (and the majority by adopting the ALJ's order) make an inference from the record that lacks persuasive support in the record.

The ALJ relied on the opinion of an examining physician, Dr. Fuller, who opined that claimant has preexisting degenerative disc disease at L5-S1. However, I do not find his opinion more persuasive than Dr. Berselli's, given that the latter doctor actually observed the condition at L5-S1 during surgery. Thus, I cannot agree with the ALJ's reliance on Dr. Fuller's opinion.

For the above reasons, I would reverse the ALJ's order. Because the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
ENEDINA WEATHERS, Claimant
WCB Case Nos. 99-02287 & 98-09589
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside the SAIF Corporation's responsibility denial (on behalf of Oregon Parkway Inn) of claimant's low back condition and; (2) upheld EBI's denial (on behalf of Assisted Living Concepts) of claimant's "new injury" claim for the same condition. In her appellant's brief, claimant requests an "extraordinary fee" for her attorney's services on review regarding the responsibility issue. On review, the issues are responsibility and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the ALJ's Ultimate Finding of Fact No. 5.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Claimant suffered an injury to her low back in 1989 while working for SAIF's insured. SAIF accepted a "low back strain L5-S1." (Ex. 6). That claim was closed by a Notice of Closure dated June 24, 1992 that awarded claimant 27 percent unscheduled permanent disability for her low back. (Ex. 63). An October 30, 1992 Order on Reconsideration increased that award to 34 percent. (Ex. 65).

Claimant began working for EBI's insured on August 3, 1998. (Ex. 79). On August 6, 1998, claimant sustained another on-the-job injury to her low back. (Exs. 79, 80). Claimant's condition was diagnosed as L4-5 radiculopathy on the right, secondary to neural element compromise at L4-5. (Ex. 86-3). Claimant filed claims with both insurers. SAIF denied responsibility only for claimant's condition. (Ex. 109). EBI denied both compensability and responsibility. (Ex. 98).[1]

This is a successive injury case where the issue is responsibility for claimant's current low back condition, *i.e.* a L5-S1 degenerative disc condition. The ALJ assigned responsibility to SAIF, reasoning that claimant's August 6, 1998 injury with EBI's insured did not "actually contribute to a worsened condition." (*O&O* at 8).

However, in a case of successive injuries where neither carrier has accepted a new, but compensable condition, ORS 656.308(1) does not apply. *Albert H. Olson*, 51 Van Natta 685 (1999). Instead, the last injurious exposure rule applies to assign responsibility to the last carrier that contributed to claimant's condition. *See Bracke v. Baza'r*, 293 Or 239, 245 (1982); *Brian A. Bergrud*, 50 Van Natta 1662, 1663 (1998).[2]

Here, claimant's treating physician and surgeon Dr. Freeman concluded that, although her earlier (1989) injury and surgery likely caused degenerative disc disease and scarring at L4-5, the trauma from claimant's August 6, 1998 injury with EBI's insured created a vascular complex at the L4-5 disc space which represented "at least 90 percent of her present deficit and pain." (Exs. 95, 111-36). We give deference to the opinion of Dr. Freeman, given his unique position as claimant's treating surgeon. *Argonaut Insurance v. Mageske*, 92 Or App 698 (1998).

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[1] On review, EBI does not contest the ALJ's determination that the claim is compensable.

[2] Claimant urges us to apply the "*Kearns* presumption" to find EBI responsible for her claim. The *Kearns* presumption is a rebuttable presumption that the last carrier with an *accepted* claim remains responsible for subsequent conditions involving the same body part. *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984). However, the *Kearns* presumption does not apply when only one accepted claim is involved. *Brian A. Bergrud*, 50 Van Natta 1662, 1663 (1998); *Lynette D. Barnes*, 44 Van Natta 993 (1992).

Drs. Gardner and Donahoo, who performed a medical examination on behalf of EBI, concluded that claimant's August, 1998 injury combined with her preexisting condition at L4-5 to cause her disability and need for treatment. (Ex. 97). Drs. Gardner and Donahoo, therefore, support a conclusion that the 1998 injury independently *contributed* to claimant's current L5 radiculopathy problem. (Ex. 97-8). This is so even though these physicians ultimately concluded that claimant's condition reflected a "natural progression" of her preexisting degenerative disc disease. (Ex. 97-8).

The other medical opinions in this case, from neurosurgeon Dr. Williams and radiologist Dr. Garnock, are to the effect that the 1998 injury did not cause any "acute changes" to claimant's L4-5 disc condition. (Exs. 105A, 110). These opinions are not sufficiently persuasive to overcome the deference we accord to Dr. Freeman. In this regard, we note that Drs. Williams and Garnock performed records reviews only; they never examined claimant. Moreover, Dr. Freeman persuasively rebutted Dr. Williams' report commenting on his January 25, 1999 operative report in several particulars. (Ex. 107).

The opinion of Dr. Freeman, as well as that of Drs. Gardner and Donahoo, establishes that claimant's 1998 injury with EBI's insured contributed to claimant's low back condition. In light of such evidence, responsibility is assigned to the later insurer. *Brian A. Bergrud*, 50 Van Natta at 1663. Therefore, EBI, the most recent carrier, is responsible for claimant's low back condition. The ALJ's order on the issue of responsibility is reversed.

Attorney Fees

Claimant asserts that she is entitled to an attorney fee greater than $1,000 for her attorney's efforts in setting aside EBI's responsibility denial, due to the "extraordinary circumstances" represented by the time devoted to her request for review to the Board. ORS 656.308(2)(d). At hearing, the parties submitted a total of 111 exhibits to the ALJ, none of which were submitted by claimant. The transcript of the hearing numbers 27 pages. On review, claimant submitted a 14-page appellant's brief and one-page reply brief.

We decline to award claimant a fee greater than $1,000. We acknowledge that claimant has successfully argued for overturning EBI's responsibility denial. However, we consider the medical, legal and factual issues presented in this case to be of a complexity level comparable to responsibility cases generally litigated before this forum. Consequently, we are not persuaded that this case presents "extraordinary circumstances."[3] *See Daniel S. Kaleta*, 51 Van Natta 309, 311 (1999)(Absent extraordinary circumstances, the claimant is limited by ORS 656.308(2)(d) to a cumulative attorney fee of $1,000 for all levels of review for services attributable to finally prevailing over a responsibility denial); *Brett S. Huston*, 51 Van Natta 1790 (1999)(No extraordinary circumstances found where 142 exhibits were submitted at hearing, including a 40-page deposition, and claimant's attorney submitted an extensive appellate brief on Board review).

ORDER

The ALJ's order dated October 1, 1999 is reversed in part and affirmed in part. That portion that set aside SAIF's responsibility denial and upheld EBI's denial insofar as it denied responsibility is reversed. EBI's denial of responsibility is set aside and the claim is remanded to EBI for processing. SAIF's responsibility denial is reinstated and upheld. In lieu of the ALJ's award of a $1,000 attorney fee under ORS 656.308(2)(d) on the responsibility issue payable by SAIF, claimant's attorney is awarded a $1,000 attorney fee, payable by EBI. The remainder of the ALJ's order is affirmed.

[3] Claimant does not contest the ALJ's $3,000 attorney fee awarded for services at the hearing level in regard to EBI's compensability denial.

In the Matter of the Compensation of
ROBERT WILLIS, Claimant
WCB Case No. C000679
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Member Meyers and Phillips Polich.

On March 22, 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 "summary page" of the agreement provides that claimant shall receive $500, with claimant's attorney receiving $1,500. Contrary to the above mentioned distribution, page 3, number 14 of the agreement recites that claimant's attorney will receive an attorney fee in the amount of $500.

After reviewing the summary page and the body of the document, we conclude that the attorney fee and the amount payable to claimant have been inadvertently transposed.[1] Thus, we find that the parties' intent is for the disposition proceeds to be distributed as follows:

$ 500	Total Due Attorney
$1,500	Total Due Claimant

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $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.

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[1] We note that a $500 attorney fee is consistent with OAR 438-015-0052(1).

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

Cite as 330 Or App 102 (2000) March 16, 2000

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Roland A. Walker, Claimant.

SAIF CORPORATION, Insurer, and GOLD CREEK CENTER, INC., Employer,
Respondents on Review,
v.
ROLAND A. WALKER, Petitioner on Review.
(WCB 93-07081; CA A89100; SC S44116)

On review from the Court of Appeals.*

Argued and submitted January 7, 1998.

Robert Wollheim, of Welch, Bruun, Green & Wollheim, Portland, argued the cause for petitioner on review. With him on the petition and brief on the merits was W. Todd Westmoreland, Tillamook.

David L. Runner, SAIF Corporation, Salem, argued the cause and filed the brief on the merits for respondents on review. On the response to the petition for review was Julene M. Quinn, SAIF Corporation, Salem.

James L. Edmunson and G. Duff Bloom, of Cole, Cary & Wing, P.C., Eugene, filed a brief on behalf of amici curiae Oregon Trial Lawyers Association and Oregon Workers' Compensation Attorneys.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, and Durham, Justices.**

CARSON, C.J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

*Judicial review from the Workers' Compensation Board. 145 Or App 294, 930 P2d 230 (1996).

**Fadeley, J., retired January 31, 1998, and did not participate in the consideration or decision of this case; Graber, J., resigned March 31, 1998, and did not participate in this decision; Kulongoski, Leeson, and Riggs, JJ., did not participate in the consideration or decision of this case.

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330 Or 105> In this workers' compensation case, we must interpret the wording of ORS 656.273(1) (1995),[1] which sets out the requirements for establishing a worsened condition for the purpose of filing an aggravation claim. The Court of Appeals concluded that, under that statute, a worker must prove a "pathological" worsening of the underlying condition itself, rather than only a worsening of symptoms. *SAIF v. Walker*, 145 Or App 294, 305, 930 P2d 230 (1996). For the reasons that follow, we conclude that ORS 656.273(1) (1995) requires proof of a worsened condition; proof of a worsening of symptoms arising from the underlying condition, by itself, is insufficient. We also conclude, however, that evidence of a symptomatic worsening may support a physician's conclusion that the underlying compensable condition itself has worsened. We affirm the decision of the Court of Appeals and remand the case to the Workers' Compensation Board (the Board) for further proceedings.

The relevant facts, taken from the Court of Appeals' opinion and the record, are as follows. Claimant, a timber faller, injured his lower back and left leg on the job in 1991. Claimant was diagnosed by Dr. Buza, his treating physician, as having an "L5-S1 herniated disc." Claimant filed a claim for compensation. His injury was deemed compensable, and SAIF Corporation (SAIF), his employer's insurer, paid the claim.

In May 1992, Buza declared claimant medically stationary and released him to regular work, beginning in June 1992, without restriction. At that time, claimant's work required heavy lifting of up to 100 pounds. 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 awarded claimant 12 percent permanent partial disability (PPD) and closed the claim.

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[1] ORS 656.273(1) (1995) is set out in the text below. The current version of ORS 656.273(1) is the same as the 1995 version. For the sake of clarity, because we also refer to earlier versions of the statute in this opinion, we denote the 1995 version by year throughout.

330 Or 106> Claimant requested reconsideration of the closure. In February 1993, he was examined by a medical arbiter, Dr. Burr. Burr concluded that claimant had a chronic and permanent medical condition arising from his accepted injury, and that he was capable of "medium work occasionally, light to medium work constantly, without repeated crouching, or bending." Based upon that report, SAIF increased claimant's PPD award to 16 percent.

Also in February 1993, claimant experienced increased pain while working and returned to Buza for treatment. At Buza's suggestion, claimant underwent an MRI scan, which revealed evidence of scar tissue but no residual or recurrent disc herniation. Buza referred claimant to a rehabilitation center to evaluate his physical capabilities. That evaluation concluded that claimant had "residual physical capacities in the light-medium work range, lifting and carrying 35 pounds occasionally with increased symptoms."

In May 1993, Burr re-examined claimant 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, Buza concurred with Burr's diagnosis.

Claimant filed an aggravation claim under ORS 656.273 (1993). SAIF denied the claim in April 1993, concluding that claimant's underlying condition had not worsened since his earlier award. Claimant requested a hearing, which was held in March 1994. The administrative law judge (ALJ)[2] noted that, to prevail on his aggravation claim under ORS 656.273(1) (1993), "claimant must show that increased symptoms *or* worsening of the underlying condition resulted in diminished earning capacity." (Emphasis added.) The ALJ concluded that, because the evidence demonstrated that claimant's increased symptoms reflected more than a mere waxing and waning of the symptoms anticipated at the time of the PPD award, claimant had proved his aggravation claim. On June 1, 1995, the Board affirmed the ALJ's order.

330 Or 107> Meanwhile, the 1995 Legislature enacted extensive amendments to the Workers' Compensation Law, including an amendment to ORS 656.273(1) that became effective on June 7, 1995. Or Laws 1995, ch 332, sections 31, 69. That amendment applied retroactively to claimant's case. Or Laws 1995, ch 332, section 66. On June 29, 1995, SAIF petitioned for judicial review of the Board's order, arguing that claimant had not proved his aggravation claim under the 1995 version of ORS 656.273(1).

A majority of the Court of Appeals concluded that, under ORS 656.273(1) (1995):

> "[T]here [must] be direct medical evidence that a condition has worsened. It is no longer permissible for the Board to infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim. Here, both the hearings officer and the Board considered the claim under the old standard. The Board specifically held that an actual worsening of the condition may be proven by a symptomatic worsening, and it based its conclusion that claimant had proven an aggravation claim on evidence of claimant's increased symptoms. We hold that proof of a pathological worsening is required. * * *"

Walker, 145 Or App at 305. Accordingly, the Court of Appeals reversed the Board's order and remanded the case to the Board for reconsideration. *Id.* Two judges dissented, asserting that an aggravation claim may be proved by evidence of increased symptoms "greater than those that were contemplated in the prior award." *Id.* at 310 (Armstrong, J., dissenting). We allowed claimant's petition for review.

At the time when claimant filed his aggravation claim, ORS 656.273(1) (1993) provided, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. *A worsened condition resulting from the original injury is established by medical evidence* supported by objective findings. * * *"

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[2] Before 1995, ALJs were known as referees. *See* Or Laws 1995, ch 332 (changing "referee" to "administrative law judge" throughout the Workers' Compensation Law). We refer to the referee in this case as an ALJ throughout this opinion.

330 Or 108> (Emphasis added.) The 1995 Legislature amended that statute by deleting the words "including medical services" and by adding the wording set out below in boldface type:

> "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. * * *"

Or Laws 1995, ch 332, section 31 (boldface type in original; deleted text omitted; emphasis added). As noted, the amended wording applies retroactively to claimant's claim.

SAIF contends that, to prove "an actual worsening of the compensable condition" under the amended version of ORS 656.273(1), an injured worker must prove a worsening of the underlying condition itself, rather than a worsening of the symptoms arising from that condition. Claimant, on the other hand, contends that a worker may present evidence of either an actual worsening of the compensable condition itself, which the Court of Appeals characterized as a "pathological worsening," *or* of a "symptomatic worsening" -- a worsening of the symptoms arising from the compensable condition -- that is greater than the symptomatic worsening anticipated at the time of the original award.

As explained more fully below, two questions are before us, both of which present issues of statutory construction. First, we must determine whether ORS 656.273(1) (1995) requires proof of a worsening of the underlying condition itself, or whether proof of a certain degree of symptomatic worsening would satisfy that statute. Second, and in a related vein, we must determine the role -- if any -- that worsened symptoms play in the course of proving an aggravation claim.

Our task in resolving those issues is to determine the legislature's intent when it amended ORS 656.273(1) in 1995. In doing so, we follow the template set out in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). We first examine the text and context of the statute. *Id.* at 610-11. Context includes other related statutes <330 Or 108/109> and earlier versions of the statute at issue. *Id.* at 611; *Owens v. Maass*, 323 Or 430, 435, 918 P2d 808 (1996). At our first level of analysis, we also consider case law interpreting the statute at issue and related statutes, including earlier versions of those statutes. *State v. Toevs*, 327 Or 525, 532, 964 P2d 1007 (1998); *Owens*, 323 Or at 435. If the legislature's intent is clear from an examination of text and context, then our inquiry is at an end. *PGE*, 317 Or at 611.

We begin by examining the wording of the phrase added to ORS 656.273(1) in 1995 -- "actual worsening of the compensable condition." Although not defined specifically in the Workers' Compensation Law, the term "compensable condition," as used in ORS 656.273(1) (1995), refers to the medical condition for which a worker already has been compensated. *See Stepp v. SAIF*, 304 Or 375, 380, 745 P2d 1207 (1987) (defining the phrase "worsened condition[] resulting from the original injury" in an earlier version of ORS 656.273(1) as "the condition resulting from the original injury that gave rise to the initial award or arrangement of compensation"). As used in the Workers' Compensation Law, the term "condition" is not the same as the symptoms that relate to the underlying condition. *See, e.g.*, ORS 656.214(7) (noting a distinction between a "condition" and its "symptoms").

Under the structure of the phrase at issue, the term "compensable condition" modifies the term "actual worsening," that is, what must "actual[ly] worsen" is the "compensable condition." As to the "actual worsening" requirement, the dictionary definition for the word "actual" provides, in part:

> "**2 a** : existing in act <our - intentions> : EXISTENT -- contrasted with *potential* and *possible* **b** : existing in fact or reality : really acted or acting or carried out -- contrasted with *ideal* and *hypothetical* <in life> <the - conditions>: distinguished from *apparent* and *nominal* <the - cost of goods> **3** : not spurious : REAL, GENUINE <an - blizzard> <- falsehood> <hard-pressed but not in - poverty> * * * **syn** see REAL"

Webster's Third New Int'l Dictionary, 22 (unabridged ed 1993) (emphasis and boldface type in original). Applying that <330 Or 109/110> meaning to ORS 656.273(1) (1995), an "actual worsening of the compensable condition" is one in which the underlying condition in fact has worsened, as opposed to one in which the underlying condition has not worsened.

The foregoing textual analysis of ORS 656.273(1) (1995) demonstrates 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. That answers the first question before us here, that is, whether a worker can satisfy the requirements of ORS 656.273(1) (1995) by presenting evidence of worsened symptoms alone. The answer is "no."

In SAIF's view, that conclusion ends the matter, because -- again, in SAIF's view -- that reading of the statute precludes a worker from proving an aggravation claim by presenting evidence only that his or her symptoms have worsened, leaving it to a factfinder to infer whether that symptomatic worsening demonstrates the existence of a worsened condition. We do not agree with SAIF that this case is resolved by that latter proposition. Rather, the question for us that remains unanswered -- and it is the crux of the second issue before us -- is, given our reading of the "actual worsening" requirement of ORS 656.273(1) (1995), when or how, if ever, does proof of a symptomatic worsening come into play when a worker seeks an aggravation award? Stated differently, this case requires that we determine 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. The statutory text of ORS 656.273(1) (1995) is not helpful in that regard. We turn to the statutory context, as well as the applicable case law, to address that question.

The original version of ORS 656.273(1), enacted in 1973, provided:

> "After the last award or arrangement of compensation, an injured work[er] is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

330 Or 111> Or Laws 1973, ch 620, section 5.[3] In the years that followed the enactment of that statute, this court issued a series of decisions that laid the foundation for the "symptomatic worsening" question before us now. The first decision was *Smith v. SAIF*, 302 Or 396, 401, 730 P2d 30 (1986), in which this court held that, under the extant version of ORS 656.273(1), increased symptoms were not compensable "unless the worker suffers pain or additional disability that results in loss of the worker's ability to work and the worker thereby suffers a loss of earning capacity." The court did not hold specifically that the statute required that the underlying condition itself actually have worsened; rather, the court focused upon a change in the condition that made the worker "more disabled," that is, "less able to work." *Id.* at 399 (internal quotation marks omitted).

Next, in *Gwynn v. SAIF*, 304 Or 345, 352, 745 P2d 775 (1987), this court explained:

> "Compensation is not payable under the Workers' Compensation Law for symptoms alone, but to the extent that symptoms, such as pain, dizziness, nervousness, etc., cause loss of function of the body or its parts and, in the case of unscheduled disability, resulting loss of earning capacity, the disabling effects of the symptoms are to be considered in fixing awards for disability. * * * The mere 'waxing' of a physical condition or of a symptom, whether or not anticipated, will not amount to a worsening sufficient to satisfy the requisites for a claim under ORS 656.273. But what if the waxing results in a greater disability?
>
> "If waxing continues to the point where the worker is incapacitated from regularly performing work at a gainful and suitable occupation, * * * [i]t is logically inescapable that this is a worsening. * * *
>
> "If waxing continues to the point where the worker's condition falls short of total disability, * * * but becomes medically stationary at an extent greater than previously awarded, this too must be a worsening, for the worker's loss of capacity to earn has been increased."

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[3] ORS 656.273(1) replaced an earlier statute, ORS 656.271, that governed aggravation claims. *See* Or Laws 1973, ch 620, section 4 (repealing ORS 656.271).

330 Or 112> (Citations omitted.) Again, the court focused upon the worker's ability to work, rather than upon a medical assessment of changes in the underlying condition. Finally, in *Perry v. SAIF*, 307 Or 654, 657, 772 P2d 418 (1989), the court clarified that the central inquiry in determining the existence of a worsened condition under the extant version of ORS 656.273(1) was "whether the symptoms such as pain have caused loss of function of the body and resulted in loss of earning capacity."

Taken together, *Smith*, *Gwynn*, and *Perry* stood for the proposition that, under an earlier version of ORS 656.273(1), evidence of worsened symptoms alone could prove an aggravation claim if the worsened symptoms resulted in a loss of bodily function such that the worker was less able to work and, consequently, suffered a loss of earning capacity. Additionally, in *Gwynn*, the court clarified that evidence of a "*mere* waxing of a physical condition *or* of a symptom, whether or not anticipated," could *not* prove an aggravation claim. 304 Or at 352 (internal quotation marks omitted; emphasis added).

In light of those three cases, the Board began analyzing aggravation claims under ORS 656.273(1) by determining, as relevant here: (1) whether a worker had suffered a worsened condition, in the form either of a worsening of the underlying condition itself or of an exacerbation of symptoms; (2) whether that worsening or symptomatic exacerbation had resulted in diminished earning capacity; (3) whether an earlier award of compensation had anticipated future exacerbation of the condition or of its symptoms, accompanied by diminished earning capacity; and (4) whether the worker's actual diminished earning capacity had exceeded that anticipated by the earlier arrangement or award of compensation. *See, e.g., Edward D. Lucas*, 41 Van Natta 2272, 2274-75 (1989), *rev'd on other grounds by Lucas v. Clark*, 106 Or App 687, 809 P2d 712 (1991) (setting out analysis). In its opinion in *Lucas*, the Court of Appeals emphasized that, under *Gwynn*, "[i]f the last award or arrangement of compensation included consideration of anticipated future exacerbations of the condition or symptoms, the [worker] must prove that the worsening has been greater than was anticipated." *Lucas*, 106 Or App at 690. Thus was born a test of **<330 Or 112/113>** sorts requiring an inquiry into whether a worsening of the condition *or* of its symptoms was within the range "anticipated" by an earlier award.

In 1990, the legislature enacted a series of amendments to the Workers' Compensation Law, including an amendment adding the requirement to ORS 656.273(1) that a "worsened condition" be "established by medical evidence supported by objective findings." Or Laws 1990, ch 2, section 18. Additionally, the 1990 Legislature enacted ORS 656.273(8), which has remained unchanged since its enactment and provides:

> "If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the *worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award.*"

(Emphasis added.) Thus, ORS 656.273(8) requires a worker with permanent disability -- such as claimant -- who seeks an aggravation award to establish that the "worsening" at issue is more than "waxing and waning of symptoms of the condition" that were "contemplated" by the earlier permanent disability award. The word "waxing," in this context, means an increase in symptoms. *See Webster's Third New Int'l Dictionary* at 2587 (defining the verb "wax", in part, as "to increase in * * * intensity * * *: * * * to grow in volume or duration"). Applying that meaning, ORS 656.273(8) speaks to an increase in symptoms beyond what was "contemplated" at the time of the original award. That reading is consistent with the body of law that grew out of *Smith*, *Gwynn*, and *Perry*, requiring a worker to prove either a worsening of the condition *or* of the symptoms arising out of the condition that exceeded the range anticipated by an earlier award or arrangement of compensation. It also is logical to conclude that, in light of that body of law -- which allowed a worker to claim aggravation for worsened symptoms alone (resulting in the loss of earning capacity) -- the legislature intended ORS 656.273(8) to clarify that a worker could not prove an aggravation claim under ORS 656.273(1) merely by presenting evidence of a symptomatic worsening that fell *within* the range anticipated by an earlier permanent disability award, but **<330 Or 113/114>** could do so by presenting evidence of a symptomatic worsening that exceeded that amount.

After the enactment of ORS 656.273(8) in 1990, the Court of Appeals and the Board repeatedly held that a worker with permanent disability seeking an aggravation award must establish that his or her symptoms had worsened to a degree greater than that anticipated by the earlier award. *See, e.g., Nethercott v. SAIF*, 126 Or App 210, 213, 867 P2d 566 (1994) (ORS 656.273(8) requires proof that increased

symptoms are more than waxing of symptoms contemplated by earlier permanent disability award); *Leroy Frank*, 43 Van Natta 1950, 1951 (1991) (ORS 656.273(8) codified requirement that symptomatic worsening be more than waxing of symptoms contemplated by earlier award). The Board, however, continued its practice of allowing a worker to establish a worsened condition by presenting either evidence of a worsening of the underlying condition itself or evidence of a worsening of symptoms, leaving it to a factfinder in the latter case to infer from such evidence that a worsened condition existed. *See, e.g., Lloyd G. Currie*, 45 Van Natta 492, 494 (1993) (so requiring, in addition to requiring proof of symptomatic worsening greater than anticipated by earlier award under ORS 656.273(8)); *Frank*, 43 Van Natta at 1950-51 (same). Additionally, the Board imposed the requirement set out in ORS 656.273(8) only in cases in which a worker sought to establish a worsened condition under ORS 656.273(1) by presenting medical evidence of a *symptomatic* worsening. In the Board's view, if a worker presented evidence that the underlying condition, not merely its symptoms, had worsened, then subsection (8) of ORS 656.273 did not apply. *See, e.g., Richard C. Wendler*, 47 Van Natta 87, 87 (1995) (so explaining).

In 1995, as already discussed to some extent, the legislature again enacted a series of amendments to the Workers' Compensation Law, including adding the "actual worsening of the compensable condition" wording to ORS 656.273(1). Or Laws 1995, ch 332, section 31. The 1995 Legislature also enacted ORS 656.214(7), which provides:

> "All permanent disability contemplates future waxing and waning of symptoms of the condition. The results of **<330 Or 114/115>** waxing and waning of symptoms may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization."

Under ORS 656.214(7), an original award of permanent disability, like claimant's, assumes that a worker's symptoms related to the compensable condition might wax or wane. That statute therefore complements ORS 656.273(8), because, together, they clarify that a worker with a prior permanent disability award who experiences only a "waxing" of symptoms associated with the underlying condition -- that is, increased symptoms contemplated by the earlier award -- will not qualify for an aggravation award.

Finally, two additional statutes also relate to our inquiry into the "symptomatic worsening" question. The first is ORS 656.273(3), which provides:

> "A claim for aggravation must be in writing in a form and format prescribed by the [D]irector [of the Department of Consumer and Business Services] 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.*"

(Emphasis added.) Thus, to prove an aggravation claim under subsection (1) of ORS 656.273 (1995), subsection (3) requires submission of a written physician's report containing the same information required by subsection (1), that is, "medical evidence supported by objective findings" that the worker has suffered a worsened condition.

The other contextually relevant statute is ORS 656.005(19), which sets out the definition of the term "objective findings" for purposes of the Workers' Compensation Law. That statute provides:

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to **<330 Or 115/116>** physical examinations that are not reproducible, measurable or observable."

Applying that definition to ORS 656.273(1) (1995), as well as to ORS 656.273(3), a worker must prove an "actual worsening of the compensable condition" by presenting "verifiable indications of injury" that may include a worsening of symptoms, such as decreased range of motion, decreased muscle strength, or atrophy. Stated differently, ORS 656.005(19) demonstrates that, in the context of proving an aggravation claim under ORS 656.273(1) (1995), a worker's medical evidence may be supported by

objective findings that demonstrate that his or her symptoms have worsened. The question, however, is how evidence of a symptomatic worsening *alone* comes into play when ORS 656.273(1) (1995) requires a worker to establish the existence of a worsened *condition*.[4]

To summarize the relevant statutes, the legislature amended ORS 656.273(1) in 1995 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. As its text clearly demonstrates, the 1995 version of ORS 656.273(1) requires something different: Proof, based upon medical evidence supported by objective findings, of a worsening of the underlying condition itself, not merely of its symptoms. Under ORS **<330 Or 116/117>** 656.005(19), however, such "objective findings" may *include* evidence of worsened symptoms. Additionally, ORS 656.273(8), which has remained unchanged since its enactment in 1990, continues to require -- as did the case law that preceded it -- 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.

In view of the statutory chronology set out above, it appears that ORS 656.273(8) represented the legislature's first attempt to prevent aggravation awards based solely upon evidence of worsened symptoms -- specifically, a symptomatic worsening *within* the range contemplated by an earlier award of permanent disability. As discussed, before 1995, the Court of Appeals and the Board construed that statute together with ORS 656.273(1) to allow a worker to prove an aggravation claim by presenting evidence of a symptomatic worsening that *exceeded* the range contemplated by an earlier award. The 1995 Legislature then went a step further, by amending ORS 656.273(1) to require that a "worsened condition" be established by medical evidence of an actual worsening of the underlying condition itself, rather than evidence of *any* degree of symptomatic worsening alone.

In amending ORS 656.273(1) in 1995, the legislature neither repealed nor amended ORS 656.273(8). That suggests that those two statutes continue to serve different functions. Our examination of the text and context of those statutes confirms that conclusion. ORS 656.273(8) provides that the worker's proof must consist of something more than a waxing of symptoms of the 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).

The standards established in ORS 656.273(1) (1995) and (8) do not limit the admissibility or relevance of competent evidence of worsened symptoms or their disabling **<330 Or 117/118>** effects. As noted above, ORS 656.005(19) anticipates that that kind of evidence may support the "objective findings" and "medical evidence" that ORS 656.273(1) (1995) requires. Thus, the legislature's amendment to ORS 656.273(1) in 1995 does not affect this court's conclusion in *Gwynn*, 304 Or at 352, that the effects of worsened symptoms upon bodily function and earning capacity "are to be considered" in claims under ORS 656.273(1) (1995).[5]

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[4] Both parties also point to ORS 656.225, which pertains to the compensability of certain preexisting conditions, as contextual support for their respective readings of ORS 656.273(1) (1995). That statute provides, in part:

> "In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:
>
> "(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a *pathological worsening of the preexisting condition*.
>
> "(2) In occupational disease or injury claims involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of an *actual worsening of the preexisting condition and not just of its symptoms*."

(Emphasis added.) We have considered the parties' arguments concerning ORS 656.225, but conclude that that statute is not helpful in determining the issue before us.

[5] However, as explained above, ORS 656.214(7) now clarifies that an initial award of permanent disability contemplates that the effects of a waxing of symptoms may include periods of temporary total or temporary partial disability, or loss of earning capacity.

What the 1995 amendment to ORS 656.273(1) introduced was the requirement that a worker prove, through medical evidence supported by objective findings, that the compensable condition itself actually has worsened. In that context, evidence of worsened symptoms, while relevant, is not sufficient by itself to meet the proof standard created by ORS 656.273(1) (1995). However, because evidence of worsened symptoms is relevant to the question whether the compensable condition actually has worsened, and might in some cases be the best evidence regarding that fact, 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 (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.

In sum, when considered together, the text, context, and applicable case law surrounding the 1995 amendment to ORS 656.273(1) clarify the legislature's intended meaning of that statute, as well as the interplay between that statute and ORS 656.273(8). We hold 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, **<330 Or 118/119>** a physician concludes, based upon objective findings (which may incorporate the particular symptoms), that the underlying condition itself has worsened. Stated differently, in the circumstances just described, the statutory requirement set out in ORS 656.273(8) can operate together with ORS 656.273(3) and ORS 656.005(19) as a means of establishing a worsened condition under ORS 656.273(1) (1995). However, 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, as noted, the ALJ required claimant to prove *either* that increased symptoms *or* a worsened condition had resulted in diminished earning capacity. The ALJ then reviewed the evidence of claimant's worsened symptoms and inferred from that evidence alone that claimant's underlying condition had worsened. By affirming the ALJ's application of that legal standard, the Board erred. Accordingly, we reverse the Board's order and remand the case to the Board for further proceedings. On remand, the Board must apply the legal standard set out above to determine whether claimant has established a worsened condition under ORS 656.273(1) (1995). *See Gwynn*, 304 Or at 349 (court's function in workers' compensation cases is not to determine facts, but to clarify legal premises upon which factual determinations must be made).[6]

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

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[6] In addition to the question whether claimant sufficiently established the existence of a worsened condition, our review of the record discloses 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. On remand, the Board must weigh the facts pertaining to all the elements of an aggravation claim under ORS 656.273(1) (1995) -- including causation -- to determine whether claimant qualifies for an aggravation award.

Cite as 164 Or App 320 (1999) December 15, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Melissa R. Schuler, Claimant.

MELISSA R. SCHULER, Petitioner,
v.
BEAVERTON SCHOOL DISTRICT NO. 48J, Respondent.
(WCB No. 97-01397; CA A101276)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 30, 1998.
Charles Robinowitz argued the cause and filed the brief for petitioner.
David L. Johnstone argued the cause for respondent. With him on the brief was VavRosky, MacColl, Olson, Busch & Pfeifer, P. C.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Warden, Senior Judge.
DEITS, C. J.
Affirmed.
Warden, S. J., dissenting.

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164 Or App 322> Claimant seeks review of a decision by the Workers' Compensation Board that upheld employer's denial of her claim. The Board determined that claimant did not prove that her work injury was the major contributing cause of the need for treatment of her combined condition. We affirm.

We take the following undisputed facts from the record. Claimant is a substitute instructional aide employed by the Beaverton School District. In February 1995, she injured her back and neck in a noncompensable motor vehicle accident. At that time, x-rays revealed degenerative disc disease at C6-7. On June 8, 1995, claimant was injured when she slipped and fell at work. She sought treatment with Dr. Soot in August 1995. At that time, an MRI revealed a disc protrusion at C6-7. In November 1995, employer accepted the claim for low back, cervical, groin and right-wrist strains.

In March 1996, employer issued a partial denial of claimant's degenerative disc disease at C6-7. Claimant did not appeal this denial and her claim was closed in April 1996. She was awarded temporary partial disability but no permanent partial disability. In June 1996, claimant again sought treatment with Soot because of increased difficulty with pain in her neck and left shoulder and arm. At that time, claimant told Soot that she had not engaged in any unusual activity nor were these symptoms precipitated by any injury. In July 1996, claimant reported to Soot that she had felt a pop in her neck while putting in eye drops and that she was pain free for several days afterward. However, later, after moving bark dust, she again experienced significant pain.

While at work on September 26, 1996, claimant physically restrained a student who was misbehaving. She experienced neck and shoulder pain at home that evening. On September 30, claimant again saw Soot. She reported that her left shoulder and arm had become progressively worse since the week before. Soot noted that this worsening occurred after some activity at work, but that "there was no really acute increase following any one particular episode. The pains now have been very difficult to cope with." Soot referred claimant to a neurosurgeon, Dr. Waller, whom **<164 Or App 322/323>** claimant saw on October 1. An MRI, conducted on that day, revealed degenerative disc changes at C6-7 with progression of left-sided disc protrusion/herniation with compromise of the left foramen and possible slight displacement of the left side of the spinal cord. Waller diagnosed persistent C7 radiculopathy with increased symptoms due to left C6-7 disc herniation. He performed left cervical C6-7 diskectomy and foraminotomy surgery on October 3. The surgery was successful, and claimant was released to return to work on October 25, 1996.

On November 8, 1996, claimant filed an 801 form, claiming benefits for her alleged September 26 injury. Employer denied the claim on the basis that claimant's work was not the major cause of the worsening of her preexisting degenerative disc disease and herniation at C6-7.

Claimant sought review of the employer's denial. After a hearing the ALJ set aside employer's denial holding that, although the preexisting condition was the major portion of the condition being treated, the work injury was the immediate cause of the need for treatment and, therefore, the treatment was compensable. The Board reversed the ALJ, noting that the case relied on by the ALJ, *SAIF v. Nehl*, 148 Or App 101, 939 P2d 96, *modified on recons* 149 Or App 309, 942 P2d 859 (1997), *rev den* 326 Or 389 (1998), had since been modified by this court to clarify that, under ORS 656.005(7)(a)(B), a claimant must establish that the work injury was not only the precipitating cause but the major contributing cause of the claimant's disability or need for treatment. The Board explained, relying on *Dietz v. Ramuda*, 130 Or App 397, 401, 882 P2d 618 (1994), *rev dismissed* 321 Or 416 (1995), that the determination of a major contributing cause includes evaluating the relative contributions of different causes of the claimant's need for treatment of the combined condition and then deciding which is the primary cause.

Claimant seeks review of the Board's decision upholding employer's denial. She makes two assignments of error. She agrees that the Board articulated the correct legal standard; namely, that claimant must establish the major contributing cause of the need for treatment of the combined **<164 Or App 323/324>** condition. She contends, however, that it is apparent from the Board's discussion of the issue and from its reliance on Dietz that the Board actually applied the incorrect legal standard for determining the compensability of the disability. She asserts that, by relying on *Dietz*, the Board evaluated the major cause of claimant's *combined condition* rather than the major cause of claimant's *need for treatment* of the combined condition.

The major cause of the combined condition is discussed in the Board's order. As noted above, however, the Board does ultimately determine the major contributing cause of the need for treatment for claimant's combined condition. The Board's reliance on *Dietz* is not inconsistent with that conclusion. The Board relied on *Dietz* for the proposition that the determination of the major contributing cause requires evaluation of the relative contribution of different causes, both work-related and preexisting. That is equally true whether what is being evaluated is the major contributing cause of the need for treatment of the combined condition or the compensability of the combined condition itself. *Nehl*, 149 Or App at 312. *See Worldmark The Club v. Travis*, 161 Or App 644, 649, 984 P2d 898 (1999). We conclude that the Board applied the correct legal standard.

Claimant's second assignment of error is that there is not substantial evidence in the record to support the Board's finding that Waller, claimant's treating neurosurgeon, failed to weigh the relative contribution of claimant's preexisting conditions against her work injury to determine the major contributing cause of claimant's need for treatment of the combined condition. The Board explained its conclusion:

> "After reviewing the medical evidence, we are not persuaded that claimant has established that the work injury was the major contributing cause of the disability or need for treatment of the combined condition. In this regard, although Dr. Waller believed that the injury provoked symptoms and precipitated the need for claimant's surgery, we are not persuaded that Dr. Waller weighed the contribution from the work injury against the contribution from the preexisting disc herniation to determine which was the major contributing cause of claimant's need for treatment **<164 Or App 324/325>** of the combined condition. *See Dietz v. Ramuda*, 130 Or App [at] 401-402. Under such circumstances, we find that claimant has not established compensability of the combined condition."

Substantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990); ORS 183.482(8)(c). This court must evaluate the substantiality of supporting evidence by considering all of the evidence in the record. *Younger v. City of Portland*, 305 Or 346, 356, 752 P2d 262 (1988). Viewing the record as a whole, the question presented here is whether the Board's finding, that Waller did not weigh the relative contributions of claimant's preexisting condition and her work injury to the need for treatment, is supported by substantial evidence. That finding is critical, of course, because it led to the Board's conclusion that claimant did not prove that her work injury was the major contributing cause of her need for treatment of the combined condition.

At the outset, we would note that, because the question of what is the major contributing cause of claimant's need for treatment involves a complex medical opinion, the Board must rely on expert medical evidence in making that determination. *Uris v. Compensation Department*, 247 Or 420, 424-26, 427 P2d 753, 430 P2d 861 (1967). The Board cannot supply its own diagnosis. *SAIF v. Strubel*, 161 Or App 516, 521, 984 P2d 903 (1999).

Here, there was evidence from three doctors. The testimony of Soot, and Dr. Zivin, a neurologist, who reviewed claimant's medical records but did not examine her, was inconclusive with respect to the question of what was the major contributing cause of claimant's need for treatment. Soot, who, as noted above, had previously treated claimant and referred her to Waller, stated that the disc protrusion could have worsened over time, or it could have been caused by claimant's work activities. He said that he could not determine the major contributing cause of the worsening. Zivin suggested that claimant's disc condition preexisted her work **<164 Or App 325/326>** exposure and could have occurred in the absence of employment exposure. He did not offer an opinion on the major contributing cause of her need for treatment.

The only medical evidence that directly addressed the question of what was the major contributing cause of claimant's need for treatment of her combined condition was Waller's statements. In a letter dated November 14, 1996, from claimant's counsel, Waller was asked:

> "I have a few basic questions regarding Ms. Schuler's condition. First, do you feel that her trying to control the unruly student several days before her appointment with you was the major cause of her need for the surgery which you performed on October 3, 1996?
>
> "If you do not feel it was the major cause of her need for surgery, do you feel that the fall which she had in the school cafeteria in June of 1995 was the major cause of her need for surgery, or do you feel that her need for surgery was the underlying pre-existing condition?"

In response to that inquiry, in a letter dated November 26, 1996, Waller stated:

> "Thank you for your letter of November 14, 1996 regarding Melissa Schuler. I have reviewed the history that she provided to me. As you recall, she has had more than one episode of neck symptomatology. Based on my review of the records however, it would appear that she did have symptoms of a pre-existing condition, when she developed symptoms of neck and left arm [pain] after a vacation in Arizona. An MRI scan on August 1, 1995, identified a disk herniation or osteophyte or combination of the two on the left at C6-7. She improved and surgery was not being considered.
>
> "The event that led to the need for surgery was the control of an unruly student when she developed a profound exacerbation of left-sided neck and shoulder pain that became incapacitating. This prompted a new MRI scan. It was difficult for me to tell if there was actually any anatomical worsening between the two studies, but her symptoms certainly did.
>
> "Therefore, I would state that she had a pre-existing condition that was producing fairly minimal symptomatology, certainly not to the point that surgery was being considered, until the event with the unruly student. Therefore, **<164 Or App 326/327>** I believe that event should be considered the major contributing cause to the need for surgery."

Waller's deposition also was part of the record of this proceeding. In that deposition, Waller testified that it was claimant's work injury that *precipitated* the need for treatment.

> "[Counsel for Claimant] As I understand your letter to me of -- I think it was November 26th of 1996, it's Exhibit 41 in this record, do you believe that the -- is it your opinion that the event that she had was the major contributing cause of her need for surgery based on a medically probable standard?
>
> "[Waller] I'll answer that by saying I don't -- I don't want to take anything out of context. In the same letter I commented that I couldn't tell if there was any anatomical worsening between the new and the old MR[I] scans, but it was the precipitation of symptoms provoked by the control of an unruly student that prompted the need for surgery."

As discussed above, based on the evidence before it, the Board concluded that Waller's testimony only supported the finding that claimant's work injury *precipitated* the need for surgery and that he did not weigh the contribution of claimant's preexisting condition against her work injury in determining the need for treatment. Based on that finding, the Board concluded that claimant failed to prove that the work injury was the major contributing cause of the need for treatment of her combined condition.

After reviewing all of the evidence in the record, we conclude that the Board's finding is supported by substantial evidence. Waller's statements, when considered in context, certainly could support a finding that claimant's work injury was the major contributing cause of her need for treatment. *See Worldmark The Club*, 161 Or App at 650; *SAIF v. Strubel*, 161 Or App at 521-22. If the decision were ours to make in the first instance, we might well read the evidence as the dissent has. As we have discussed, however, our review is quite limited. The issue that we are reviewing is whether the finding that the Board *did make* is supported by substantial evidence. We cannot say that, in view of all the evidence, a reasonable person could not find that Waller did **<164 Or App 327/328>** not weigh the relative contributions of claimant's preexisting condition and the work injury to determine her need for treatment. Waller did state that claimant's work injury was the major contributing cause of the need for treatment. However, his supporting analysis focused on increased symptoms and identifying the precipitating cause of the need for treatment. He did not directly discuss the contributions of the preexisting condition versus the work injury to the need for treatment. *See Robinson v. SAIF*, 147 Or App 157, 935 P2d 454 (1997). In view of this deficiency and the other medical evidence in the record, we conclude that the Board's order is supported by substantial evidence and that the Board did not err in upholding employer's denial of the claim.

Affirmed.

WARDEN, S. J., dissenting.

Because the majority errs in concluding "that the Board's order is supported by substantial evidence," I dissent.

ORS 656.005(7)(a)(B) provides:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the *major contributing cause of the need for treatment* of the combined condition." (Emphasis added.)

The only issue presented is whether the injury claimant sustained in the course of her duties as a teacher on September 26, 1996, while restraining an out-of-control student was the major contributing cause of her need for treatment. The only material medical evidence on this issue, as the majority concedes, is that of Dr. Waller, who stated in his report of November 26, 1996:

> "The event that led to the need for surgery was the control of a unruly student when she [claimant] developed a profound exacerbation of the left-sided neck and shoulder pain that became incapacitating. This prompted a new MRI scan. It was difficult for me to tell if there was actually any **<164 Or App 328/329>** anatomical worsening between the two studies, but her symptoms certainly did.
>
> "Therefore, I would state that she had a pre-existing condition that was producing fairly minimal symptomatology, certainly not to the point that surgery was being considered, until the event with the unruly student. Therefore I believe that event should be considered the major contributing cause to the need for surgery."

In his deposition, Waller testified:

> "* * * I couldn't tell if there was any anatomical worsening between the new and the old MR[I] scans, but it was the precipitation of symptoms provoked by the control of an unruly student that prompted the need for surgery."

As the majority points out:

> "[T]he question of what is the major contributing cause of claimant's need for treatment involves a complex medical opinion, the Board must rely on expert medical evidence in making that determination." 164 Or App at 325.

Then, the majority joins with the Board in disregarding the only real evidence on that question. In its last sentence, the majority refers to "other medical evidence in the record," without telling us what that evidence is; the majority has already told us that the only other medical evidence, that of Dr. Soot and Dr. Zivin, is of no help.

The majority cites both *SAIF v. Strubel*, 161 Or App 516, 984 P2d 903 (1999), and *Worldmark The Club v. Travis*, 161 Or App 644, 984 P2d 898 (1999), apparently without reading those decisions closely. In both, there was other medical evidence bearing on the issue of the claimants' need for treatment, and in both this court concluded that the Board could find that the injuries were the major contributing cause of the claimant's disabilities or the need for treatment. Here, there is no contrary evidence, but the majority would affirm the Board's conclusion that claimant has not "established that the work injury was the major contributing cause of the disability or need for treatment * * *." Waller's letter and deposition testimony cannot be read to support anything but the contrary conclusion. His is the only competent material **<164 Or App 329/330>** medical evidence on the issue, and it is contrary to the Board's conclusion that this majority affirms.

The majority, agreeing with the Board on what both see as critical, states that Waller "did not directly discuss the contribution of the preexisting condition versus the work injury to the need for treatment."

Waller had a complete and accurate history of claimant's neck problems. He clearly was aware of claimant's preexisting condition when he concluded that the injury was the major contributing cause of the need for treatment. His awareness of that condition came both from the November 14 letter from counsel, and from the information provided for his deposition. As discussed in the majority opinion and quoted above, Waller was specifically asked in the letter from counsel if the major cause of the need for surgery was the work injury or the preexisting condition. He answered that the event with the unruly student "should be considered the major contributing cause to the need for surgery."

The Board's conclusion that Waller failed to weigh the relative contributions of the different causes was not supported by substantial evidence. Accordingly, the Board erred in holding that claimant's work injury was not the major contributing cause of her need for treatment.

For all of the above reasons, I respectfully dissent.

Cite as 164 Or App 522 (1999) December 22, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Vicki I. Havlik.

VICKI I. HAVLIK, Petitioner,
v.
MULTNOMAH COUNTY, Respondent.
(98-00608; CA A105086)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 1, 1999.
R. Adian Martin argued the cause and filed the brief for petitioner.
Jenny Morf argued the cause for respondent. On the brief were Jacqueline A. Weber and Thomas Sponsler.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded.
Edmonds, P.J., dissenting.

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164 Or App 524> Claimant petitions for review of an order of the Workers' Compensation Board denying her stress claim. The Board concluded that claimant failed to establish that cognizable stressors were the major cause of her depression because her depression was caused, in part, by conditions "generally inherent in every working situation." ORS 656.802(3)(b). We reverse and remand.

Claimant began working as an animal control officer at Multnomah County's Animal Control Center in 1994. On October 16, 1997, she received a mental health evaluation and was diagnosed with major depression. The day after the mental health evaluation, she filed a workers' compensation claim for stress. Claimant identified several events, and management's response to those events, as the cause of her condition. Those events include two incidents where claimant was bitten by dogs, a television interview that went badly, and several incidents where management used disparaging language to refer to the persons who worked with the animals in the shelter. Claimant also asserts that she experienced stress due to the overcrowded and substandard conditions in which the animals at the shelter were kept.

Employer denied claimant's stress claim, and the administrative law judge (ALJ) affirmed employer's denial. The ALJ reasoned that because the stress caused by the dog bites, the television interview,[1] and the disparaging language were not generally inherent in every working situation, those work conditions could be considered in determining the major cause of claimant's depression. However, the ALJ concluded that the stress caused by the overcrowded and substandard conditions in which the animals in the shelter were kept was caused by a policy change and that policy changes are generally inherent in every working situation. Because that source of claimant's stress could not be considered in determining the cause of her depression, the ALJ found that **<164 Or App 524/525>** claimant had not met her burden of proving that her work was the major contributing cause of her condition as required by ORS 656.802(2)(a).[2]

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[1] The ALJ stated that he would not "give any 'value' to the level of stress stemming from whatever discipline claimant thought she was going to receive as a result of her performance during the television interview." However, the ALJ stated the stress from participating in the interview is a "bona fide stressor."

[2] ORS 656.802(2)(a) provides that "[t]he worker must prove that employment conditions were the major contributing cause of the disease." The ALJ reasoned that, when a physician has said that several combined causes constitute a major cause of the mental condition, the doctor's conclusion of major cause becomes invalid if any one of those causes is eliminated, unless the doctor has quantified the specific proportion of causation that resulted from the eliminated factor as compared to the causation attributable to the remaining causes. In this case, claimant's doctor did not quantify the specific proportion of causation attributable to each of the factors claimant claims combined to cause her mental condition. Instead, the doctor's assessment stated only that all of the work factors combined constituted the major contributing cause of the stress.

The Workers' Compensation Board affirmed. It reasoned:

> "Claimant also contends that the ALJ erred in characterizing some of claimant's stressors as excluded from among compensable stressors because they were 'conditions other than conditions generally inherent in every working situation.' *See* ORS 656.802(3)(b). In addition, claimant argues that she was not stressed by the employer's recent policy changes, only by the *effects* of those changes. We disagree with both arguments.
>
> "Claimant reported stress in part due to 'continuing problems dealing with management.' She believed that the employer's new management decisionmakers knew nothing about animal control. Claimant specifically disagreed with new management policies that put an end to quick euthanasia and caused the shelter to be overcrowded. In claimant's view, management's mistaken prioritizing caused numerous stressors, including unexpected schedule changes, understaffing, and inadequate care for overcrowded shelter animals.
>
> "But there is uncontradicted evidence that management's scheduling and staffing changes were direct responses to budgetary constraints and the overcrowded conditions resulted largely from reliance on legal advice (regarding the proper holding time for feral cats). These stressors are not compensable because they are conditions 'generally inherent in every working situation.' *See* ORS 656.802(3)(b). *See Patrick W. Real*, 49 Van Natta 2107 **<164 Or App 525/526>** (1997), *aff'd mem* 157 Or App 723[, 972 P2d 1231] (1998) (Employer's new management methods are conditions generally inherent in all working situations); *Gary W. Helzer*, 47 Van Natta 143, 144 (1995) (New management and administrative procedures are generally inherent in every working situation); *Karen M. Colerick*, 46 Van Natta 930 (1995) (Changes in procedures and altered job descriptions are conditions generally encountered in all working situations)." (Footnote and citations to record omitted.)

The Board accordingly concluded that claimant had failed to establish "that cognizable stressors were the major cause of her mental condition."

On appeal, claimant argues that the Board erred in stating that she was stressed by policy changes and also in finding that policy changes that resulted in overcrowded conditions for animals at the shelter were generally inherent in every working situation.[3] Claimant argues that she was not stressed by policy changes but rather from the overcrowded conditions in which the animals were kept as a result of the policy changes. Claimant reasons that "[t]he shelter was not meeting the requirements of the ordinances she was charged with enforcing. Because animals sleeping in excrement and being without food and water flows from a policy, it does not follow that such egregious wrongs are generally inherent in every working situation." Employer responds that changes in policy to comply with the law are conditions common to all occupations, even if the results of those changes are disruptive and disturbing.

ORS 656.802(3)(b) provides that a mental disorder is not a compensable condition unless "[t]he employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation * * *." We review the Board's determination that policy **<164 Or App 526/527>** changes that resulted in overcrowded conditions for animals at the shelter were generally inherent in every working situation "to determine whether it 'appears to be within the legislative policy that inheres in the statutory term.'" *Whitlock v. Klamath Cty. School District*, 158 Or App 464, 474, 974 P2d 705, *rev den* 329 Or 61 (1999) (quoting *Fuls v. SAIF*, 321 Or 151, 162, 894 P2d 1163 (1995)). In *Fuls*, the court reviewed the legislative history of the statute and concluded that the legislative policy that inheres in the statutory term is to "curtail compensable claims for mental disorders based on on-the-job stressors." 321 Or at 161. However, the policy is intended only to curtail such claims "if, or to the extent that, the stress-producing condition was common to the full range of employment." *Whitlock*, 158 Or App at 475.

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[3] Claimant also raises a second assignment of error arguing that the Board erred in concluding that her claim must fail because the medical evidence did not exclude noncognizable stressors. Claimant argues that because employer did not raise medical causation in its denial or at the hearing before the close of the record, employer effectively waived that issue. Because we reverse and remand based on claimant's first assignment of error, we do not reach her second assignment of error.

Whether a stress-producing condition is common to the full range of employment depends, in large part, on how that stress-producer is defined. As a general rule, "because no two cases are identical, the operative 'condition' cannot be defined solely and specifically by reference to the claimant's particular circumstances." *Whitlock*, 158 Or App at 473. As *Whitlock* also explained, however, "if categories are drawn sufficiently broadly, virtually any stress-inducing employment condition could be characterized as a sub-species of a much broader condition common to all employments. Such an approach would not merely 'curtail,' but would preclude, compensability." *Id.* at 474.

The Board issued its order in this case before we issued our decision in *Whitlock*. The Board did not have the benefit of *Whitlock's* reasoning and did, we believe, precisely what *Whitlock* cautioned against. The Board viewed claimant's reaction to her working conditions as simply a reaction to "policy changes." Virtually all working conditions, however, can be traced back to a policy change. If the category is drawn that broadly, it would effectively preclude compensability even though the conditions that are directly responsible for the worker's stress are not generally inherent in every working situation. There was evidence in the record, which the Board appeared to accept, that the inadequate and perhaps unlawful conditions in which the animals were being kept was one cause of plaintiff's stress. In viewing that cause as a policy change, the Board pitched its analysis at too high **<164 Or App 527/528>** a level of generality and thus failed to undertake the inquiry that *Whitlock* requires.

As we recognized in our first opinion in *Whitlock*, the relevant question is whether the working conditions that are directly responsible for a claimant's mental disorder are generally inherent in every working situation. *See Whitlock v. Klamath County School District*, 142 Or App 137, 142, 920 P2d 175 (1996) (quoting employer's concession with approval). Our later decision in *Whitlock*, of course, also teaches that the stress-producing condition cannot be described so narrowly that every stress-producing condition becomes compensable. *See* 158 Or App at 473. The task of identifying the conditions that are directly responsible for the worker's stress is not always an easy one, but the legislature has entrusted that task in the first instance to the Board. *See* ORS 183.482(7). We accordingly reverse the Board's order and remand for reconsideration in light of our recent decision in *Whitlock*.

Reversed and remanded.

EDMONDS, P. J., dissenting.

In this workers' compensation case involving ORS 656.802(3)(b) and a worker at the Multnomah County Animal Control Center, the majority holds that "[t]he Board did not have the benefit of [our reasoning in *Whitlock v. Klamath Cty. School District*, 158 Or App 464, 974 P2d 705, *rev den* 329 Or 61 (1999),] and did, we believe, precisely what *Whitlock* cautioned against." 164 Or App at 527. Because I believe the Board's ruling is consistent with *Whitlock* and the Supreme Court's holding in *Fuls v. SAIF*, 321 Or 151, 894 P2d 1163 (1995), on which *Whitlock* is based, I dissent.

ORS 656.802(3)(b) provides that a mental disorder is not compensable under ORS Chapter 656 unless the worker establishes that:

> "[t]he employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the **<164 Or App 528/529>** employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles."

In ruling on claimant's claim, the Board said,

> "Claimant also contends that the [administrative law judge] erred in characterizing some of claimant's stressors as excluded from among compensable stressors because they were 'conditions other than conditions generally inherent in every working situation.' *See* ORS 656.802(3)(b). In addition, claimant argues that she was not stressed by the employer's recent policy changes, only by the *effects* of those changes. We disagree with both arguments.
>
> "Claimant reported stress in part due to 'continuing problems dealing with management.' She believed that the employer's new management decisionmakers knew nothing about animal control. Claimant specifically disagreed with new management

> policies that put an end to quick euthanasia and caused the shelter to be overcrowded. In claimant's view, management's mistaken prioritizing caused numerous stressors, including unexpected schedule changes, understaffing, and inadequate care for overcrowded shelter animals.
>
> "But there is uncontradicted evidence that management's scheduling and staffing changes were direct responses to budgetary constraints and the overcrowded conditions resulted largely from reliance on legal advice (regarding the proper holding time for feral cats). These stressors are not compensable because they are conditions 'generally inherent in every working situation.' *See* ORS 656.802(3)(b)." (Footnote omitted; citations omitted.)

In *Fuls*, the claimant suffered from a conversion disorder that resulted from a customer, with whom the claimant was acquainted, walking up behind the claimant and greeting him with a "bear hug." After interpreting the intent of the legislature in promulgating ORS 656.802(3)(b), the court held that the disorder was not compensable because greetings as human interactions are conditions inherent in every working situation. In arriving at its decision in this case, the Board expressly acknowledged *Fuls*.

In *Whitlock*, the claimant was an elementary school music teacher who was reassigned to a secondary school **<164 Or App 529/530>** social studies teaching position after the employer school district eliminated his position because of budget constraints. He felt overwhelmed by his new duties. The claimant worked 12 to 14 hours each day, including four to six hours each night preparing for the next day's classes. As a consequence, he was diagnosed with "'a single episode of nonpsychotic major depression due to stress at work.'" *Whitlock*, 158 Or App at 467. We remanded for consideration of whether the off-duty preparation time was the major contributing cause of the claimant's mental disorder, after ruling that the Board erred in determining that preparation time is a condition "generally inherent in every working situation." We noted that, "because no two cases are identical, the operative 'condition' cannot be defined solely and specifically by reference to a claimant's particular circumstances" and that "the statutory inquiry focuses not on the work conditions of teachers, or even professionals, generally, but on the complete range of employments." *Id.* at 473.

According to the majority, the Board, without the benefit of *Whitlock*, attributed claimant's stress in this case as a reaction to "policy changes." The majority reasons that the Board erred because compensability based on policies would be precluded in every case, inasmuch as virtually all working conditions can be traced back to a work-related policy.[1] I understand the Board's decision differently. The first and second paragraphs of the Board's opinion quoted above refer to "policy changes" in the context of claimant's argument. The second paragraph concludes with a description of stressors identified by claimant that resulted from the policy changes. Specifically, the stressors included "unexpected schedule changes, understaffing, and inadequate care for overcrowded shelter animals." The third paragraph reflects the Board's reasoning about how the stressors asserted by claimant engage with the language of ORS 656.802(3)(b). In **<164 Or App 530/531>** other words, the Board made the same kind of factual inquiry in this case that the Supreme Court made in *Fuls* and we made in *Whitlock*.

Nothing in *Whitlock* provides a revelation about the meaning of the statute. We simply relied on the Supreme Court's interpretation in *Fuls*. Nothing we said in *Whitlock* is determinative of the outcome of this case because each case must be evaluated on its own facts. Moreover, claimant's particular work circumstances, *i.e.*, working at an animal shelter, do not define the inquiry. Rather, the proper inquiry is whether the legislature would have contemplated that the particular stressors relied on by claimant are conditions that are generally inherent in the complete range of employments. Scheduling and staff changes and the adequacy of the employer's physical facility to handle the workload are the kinds of conditions that are generally inherent in the complete range of employments. It is evident that the Board asked the correct question and arrived at the correct answer. Consequently, there is no reason for remand, and I would affirm.

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[1] ORS 656.802(3)(b) focuses on "employment conditions" that produce mental disorders. It excludes from compensable mental disorders those disorders that are produced by conditions that have as their source "employment decisions attendant upon ordinary business or financial cycles." In light of the language of the statute, it is not peculiar that the Board would point out in its recitation of claimant's argument that the source of the conditions at issue were budgetary constraints and legal advice, sources that are attendant to the ordinary conduct of business and financial cycles.

Cite as 164 Or App 628 (1999) December 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daral T. Morrow, Claimant.

BARRETT BUSINESS SERVICES, Petitioner,
v.
DARAL T. MORROW, Respondent.
(WCB 96-06161, 95-08182; CA A100632)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 22, 1998.
Scott H. Terrall argued the cause for petitioner. On the brief were Travis L. Terrall and Terrall & Associates.
Michael Strooband argued the cause for respondent. With him on the brief was Bischoff, Strooband & Ousey, P.C.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

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164 Or App 630> Petitioner Barrett Business Services (Barrett) seeks review of a unanimous en banc order and an order on reconsideration of the Workers' Compensation Board that set aside a denial of claimant's current condition and awarded claimant permanent partial disability. We review for substantial evidence and errors of law, ORS 183.482(8) and ORS 656.298(7), and affirm.

In 1991, claimant injured his low back while working for an employer who was insured by SAIF. SAIF accepted a lumbosacral strain and the claim was closed in 1992 with an award of permanent partial disability. In June 1994, while working for Barrett, claimant sustained another low back injury, which was also diagnosed as lumbosacral strain. Both SAIF and Barrett denied compensability and responsibility for claimant's low back condition. Applying ORS 656.308(1), the administrative law judge (ALJ) and the Board held that the June 1994 injury was the major contributing cause of claimant's current disability and need for treatment. Thus, claimant sustained a new injury and Barrett was held responsible. We affirmed. *Barrett Business Services v. Morrow*, 142 Or App 311, 920 P2d 181 (1996).

Barrett issued a notice of closure, which did not award claimant any permanent disability. However, a reconsideration order awarded claimant three percent unscheduled permanent disability. Barrett requested a hearing seeking the elimination of any permanent disability.

Meanwhile, in May 1995, Dr. Geist examined claimant at the request of Barrett. ORS 656.325(1)(a). Geist concluded that claimant's symptoms were a recurrence of the 1991 SAIF injury and that the 1994 injury was not the major contributing cause of claimant's current need for treatment. Based on Geist's report, in July 1995 Barrett issued a denial, stating that the 1994 injury was not the major contributing cause of claimant's current disability or need for treatment. The denial stated that there was "no medical information to substantiate that the [June 1994 injury was] the major contributing cause of [claimant's] current low back condition." Rather, Barrett again suggested that the 1991 SAIF injury **<164 Or App 630/631>** remained the cause of claimant's current low back condition. The ALJ, relying on Geist's report, agreed with Barrett. The ALJ also eliminated claimant's award of permanent disability. The Board reversed the ALJ's order and reinstated the award of three percent unscheduled permanent partial disability.

On review, Barrett raises several arguments. It asserts that the Board erred in treating its July 1995 denial as denying only responsibility for claimant's current low back condition, contending that it also denied the compensability of that same condition. Barrett also argues that ORS 656.262(6)(c) and ORS 656.262(7)(b) authorize its July 1995 denial and challenges the Board's holding that ORS 656.308(1) prohibits Barrett from issuing its July 1995 denial because responsibility for claimant's 1991 strain has shifted to Barrett. Finally, Barrett argues that claimant is not entitled to any permanent disability.

ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving

> the same condition. *If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer.* The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section." (Emphasis added.)

At the outset, we note that in *Multifoods Specialty Dist. v. McAtee*, 164 Or App 654, ___ P2d ___ (1999), we held that, for the purpose of ORS 656.308(1), a new compensable injury "involves the same condition" when the new compensable injury encompasses, or has as part of itself, the prior compensable injury. In that circumstance, responsibility for the claimant's prior compensable injury shifts to the subsequent employer, and "all further compensable medical services and disability involving the same condition [as the prior injury] shall be processed as a new injury claim by the **<164 Or App 631/632>** subsequent employer." We understand that statutory language to mean that all further medical treatment and disability compensably related to the prior compensable injury become the responsibility of the subsequent employer and are to be processed as a part of the new injury claim.

With that understanding in mind, we note that in this case it is undisputed that claimant's circumstances fall within ORS 656.308(1) and that the second lumbar strain involves the same condition as the earlier lumbar strain. There is an unchallenged finding that claimant's new compensable strain is the same condition previously accepted by SAIF. Accordingly, we do not address whether claimant's new compensable injury involves the same condition as the earlier accepted claim.[1] Pursuant to ORS 656.308(1), responsibility for claimant's preexisting strain shifted to Barrett. The remaining question is whether Barrett could nonetheless issue its July 1995 denial pursuant to ORS 656.262(6)(c) and ORS 656.262(7)(b).[2] In construing those statutes, we apply the familiar methodology described in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). We first examine the text of the statutes, because the words of the statute are the best evidence of the legislature's intent. *Id.* at 610. Also at the first level of analysis we consider rules of statutory construction that bear directly on how to read the statutes. For example, we are neither to insert words into a statute that have been omitted nor are we to omit words from a statute that have been inserted. ORS 174.010. Finally, at **<614 Or App 632/633>** the first level of analysis we consider the context of the statutory provisions at issue that include other provisions of the same or related statutes. *Id.* at 611.

ORS 656.262(6)(c) relates to the processing of a claim for a combined condition. It provides that a self-insured employer or insurer's acceptance of a *combined* condition under ORS 656.005(7) shall not preclude it from later denying the compensability of the combined condition if the compensable injury ceases to be the major contributing cause of the combined condition. ORS 656.262(7)(b) provides that once a claim has been accepted, the self-insured employer or insurer must issue a written denial when the accepted injury is no longer the major contributing cause of the combined condition before claim closure.

We considered the operation of those statutes in *SAIF v. Belden*, 155 Or App 568, 964 P2d 300 (1998). The precise issue there was whether ORS 656.262(6)(c) and (7)(b) applied retroactively. *Id.* at 571. In deciding the question, we considered why those statutes were enacted in 1995. Before 1995, "once an insurer had accepted a combined condition [under the terms of ORS 656.005(7)(a)(B)] it could not avoid paying for compensation for that condition, even if it were no longer compensable." *Id.* at 573. ORS 656.262(6)(c) gave the self-insured employer or insurer the opportunity to "accept a combined condition pursuant to ORS 656.005(7)(a)(B) without being concerned that it will be obliged to continue to pay

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[1] We do not understand how a 1991 strain and a 1994 strain are the same condition.

[2] ORS 656.262(6)(c) provides:

> "An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

ORS 656.262(7)(b) provides:

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

compensation for that condition if it stops being compensable." *Id.* at 574. ORS 656.262(7)(b) gave the self-insured employer or insurer a procedure to follow in order to take advantage of the ability to deny a combined condition if it ceased to be the major contributing cause of the worker's need for treatment or disability. We concluded that "an insurer may now deny an accepted [combined] condition when it is no longer compensable. However, to be effective under ORS 656.262(7)(b), the denial must be issued to the claimant, in writing, before claim closure." *Id.* at 575.

Thus, ORS 656.262(6)(c) and (7)(b) provide a procedural "way out" for the employer who has accepted a *combined* condition under ORS 656.005(7)(a)(B) when the "otherwise compensable" injury is no longer the major contributing **<164 Or App 633/634>** cause of the combined condition. The Board concluded that, despite the existence of ORS 656.262(6)(c) and (7)(b), Barrett could not deny claimant's current condition before claim closure, because Barrett had accepted a "new compensable injury" under ORS 656.308(1) and, under the terms of the second sentence of that statute, it is now fully responsible for claimant's preexisting compensable condition and all of its treatment. The Board further supported its conclusion by reasoning that ORS 656.262(6)(c) and (7)(b) do not explicitly provide that they apply when the preexisting injury is compensable and the claimant experiences a "new compensable injury" under ORS 656.308(1).

Contrary to that second portion of the Board's reasoning, we conclude that the texts of ORS 656.262(6)(c) and (7)(b) do not exclude from their scope combined conditions involving preexisting compensable conditions. They speak about combined conditions generally and without limitation. On their face, they apply to all accepted claims for combined conditions. We will not read language into the statutes that the legislature has not included. ORS 174.010; *SAIF v. Drews*, 318 Or 1, 6, 860 P2d 254 (1993).

Nonetheless, we conclude that the Board reached the correct result, based on the language of ORS 656.308(1) and the Supreme Court's opinion in *Drews*. In *Drews*, the court said:

> "If the preexisting condition was compensable, then the provisions of ORS 656.308(1) apply to determine whether responsibility shifts to the subsequent employer. If the accidental injury described in ORS 656.005(7)(a) was found not to be the 'major contributing cause' under subparagraph (B), then the first sentence of ORS 656.308(1) applies, because the claimant has not sustained a 'new compensable injury involving the same condition' and, thus, the first employer remains responsible. *If the accidental injury described in paragraph (a) of ORS 656.005(7) was found to be 'the major contributing cause' under subparagraph (B), then the second sentence of ORS 656.308(1) applies, because a new compensable injury has occurred, and responsibility shifts to the subsequent employer.*" *Id.* at 9 (emphasis added).

164 Or App 635> As we said in *Multifoods*, the second sentence of ORS 656.308(1) referred to by the court in *Drews* compels the conclusion that when, as here, ORS 656.308(1) is applicable and responsibility for a preexisting compensable condition shifts to the subsequent employer, the subsequent employer becomes responsible "for any future compensable medical treatment or disability" of the preexisting condition. Contrary to employer's argument, it may not later deny responsibility for treatment or disability related to the preexisting condition on the ground that the new compensable injury is no longer the major contributing cause. Because claimant has experienced a new compensable injury involving the same condition as the previous compensable injury, responsibility for the entire preexisting condition, its medical treatment and disability, has shifted forward and it may not shift back. Responsibility remains with the subsequent employer unless and until the claimant experiences another new compensable injury involving the same condition at a subsequent employment, in which case responsibility would once again shift forward.[3] There is no room in the statutory language for employer's theory that responsibility may shift back to the original employer if the new compensable injury is no longer the major contributing cause of the disability and need for treatment. Once there has been a new compensable injury, responsibility shifts from the previous employer.

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[3] We make no suggestion concerning the implication of a subsequent off-the-job injury.

Barrett takes the position that ORS 656.308(1) assigns to it responsibility only for "compensable" medical treatment and disability, and that such benefits are not "compensable" unless the new compensable injury is their major contributing cause. Accordingly, it contends, it may deny those benefits when the new compensable injury is no longer their major contributing cause. We reject that reading of the statute. The second sentence of the statute plainly assigns to the subsequent employer responsibility for any future compensable medical treatment and disability *relating to the original, compensable injury*. The compensability of that treatment and disability is not contingent on the second injury remaining as their major contributing cause.

164 Or App 636> We recognize that our interpretation of ORS 656.308(1) is potentially at odds with our conclusion that ORS 656.262(6)(c) and (7)(b) apply to combined conditions involving preexisting compensable conditions. The potential conflict is narrow, however. ORS 656.308 applies only when the original compensable injury and the second injury involve the same condition. ORS 656.262(6)(c) and (7)(b) apply to all combined conditions. If, as employer suggests, it can now deny future treatment and disability related to the preexisting compensable injury, that would substantially undermine ORS 656.308. Our interpretation best preserves the integrity of each statute.

The Board correctly held that Barrett is precluded from denying treatment for claimant's current condition. Furthermore, we conclude that the Board's award of permanent disability is supported by substantial evidence.

Affirmed.

Cite as 164 Or App 637 (1999) December 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Daniel I. VanWechel, Claimant.

FLEETWOOD HOMES OF OREGON, Petitioner,
v.
DANIEL I. VANWECHEL, Respondent.
(WCB 97-06406; CA A102189)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 9, 1999.
Richard D. Barber argued the cause for petitioner. With him on the brief was Sheridan and Bronstein.
R. Adian Martin argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

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164 Or App 637> Employer seeks review of a Workers' Compensation Board order requiring a claim to be reopened following acceptance of additional medical conditions. ORS 656.262(7)(c). We review the order for errors of law, ORS 183.482(8), and affirm.

The relevant facts are undisputed. In January 1993, claimant injured his right knee while working for employer. In early March, claimant underwent knee surgery which revealed no meniscus tear as had been diagnosed but, instead, revealed injuries to the anterior cruciate ligament (ACL) and medial femoral condyle, which were repaired. After the surgery was performed, employer accepted a "right knee meniscus tear" claim. The claim was closed in February 1994 by a determination order with an award of partial permanent disability (PPD) for a right knee meniscus tear. An order on reconsideration affirmed the determination order.

After claim closure, claimant requested that employer accept additional conditions. Employer amended its claim acceptance to include two new conditions--the right knee ACL tear and fragmentation of the medial femoral condyle. Claimant then requested a hearing alleging a *de facto* denial of the ACL and medial femoral condyle conditions. An administrative law judge (ALJ) awarded claimant attorney fees for getting the new conditions accepted.

Next, claimant wrote to Department of Consumer and Business Services (DCBS) requesting that the claim be reopened for processing. DCBS denied the request, stating that the new conditions had been addressed at the time of closure. Claimant then requested a hearing for failure to process the newly accepted conditions. An ALJ held that employer did not have a duty to process the new conditions. The Board reversed, concluding that the new conditions must be "processed" but that reopening the claim might or might not be necessary. Employer then informed claimant that it was processing the new conditions, but that the processing did not require reopening the claim. Again, claimant requested a hearing.

164 Or App 640> Between the issuance of the Board's order to process the new conditions and employer's subsequent letter to claimant confirming processing but declining to reopen the claim, the legislature amended ORS 656.262(7) to include paragraph (c). ORS 656.262(7)(c) provides, in part:

> "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."

This amendment applies retroactively to include "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 * * *." Or Laws 1997, ch 605, section 2. The effective date of the act was the date of its passage--July 25, 1997. *Id.* at section 4.

In December 1997, an ALJ concluded that employer was required to reopen the claim to process the post-closure accepted conditions because ORS 656.262(7)(c) requires claim reopening without regard to prior rating or impairment. The Board affirmed the ALJ, finding no ambiguity in the text of ORS 656.262(7)(c) when applied to the facts of this case. Using a plain language reading of the statute, the Board explained that once the statutory prerequisite of accepting a new condition after claim closure is met, an insurer or self-insured employer has an absolute duty, under ORS 656.262(7)(c), to reopen the claim for processing with respect to the new condition.

On appeal, employer raises two assignments of error. The first is that the Board erred when it required employer to reopen the claim to process conditions already processed. The second is that the Board erred in interpreting ORS 656.262(7)(c) when it failed to find the statute's terms to be ambiguous or that a direct reading of the statute would lead to an unreasonable or absurd result. Claimant responds that the Board correctly interpreted the unambiguous language of ORS 656.262(7)(c) to require reopening and processing of new conditions accepted after claim closure.

164 Or App 641> In interpreting the statute, we apply the methodology set forth in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). The first level of analysis is to examine the text and context of the statute. *Id.* at 610. Words of common usage should be given their "plain, natural and ordinary meaning." *Id.* at 611. We are permitted neither to insert what the legislature omitted nor to omit what the legislature inserted. ORS 174.010. Only if the meaning of the statute is ambiguous from the text and context are we to look to legislative history and, if necessary, to maxims of statutory construction. *Id.* at 611-12.

The plain language of ORS 656.262(7)(c) is clear. Insurers and self-insured employers are required to state which conditions are compensable at the time a claim is closed. Here, employer described the condition accepted and rated for compensation at closure as the "right knee meniscus tear." ORS 656.262(7)(c) further states that once a claim is closed, if a new condition is accepted, the insurer or self-insured employer must reopen the claim to process the newly accepted condition. Here, when employer accepted the ACL and medial femoral condyle conditions after claim closure, employer was required to reopen the claim and process those conditions. The text of the statute is unambiguous and employer concedes as much.

The context of a statute includes other provisions of the same statute and other related statutes. *Id.* at 611. The other provisions of ORS 656.262 address processing of claims, payment of compensation by employers, reporting, acceptance and denial of claims, penalties for unreasonable payment delays, and worker-attorney cooperation in claim investigations. Nothing in those provisions creates ambiguity in the language of paragraph (7)(c). Likewise, nothing in the related statutes leads to a conclusion that the words contained in ORS 656.262(7)(c) are susceptible to more than one reasonable construction. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 669, 866 P2d 514 (1994). Because the meaning of ORS 656.262(7)(c) is unambiguous after an examination of the text and context of the statute, our statutory analysis ends here. *See Northwest Reforestation Contractors v. Summit Forests, Inc.*, 143 Or App 138, 144, 922 P2d 1240 (1996).

164 Or App 642> Employer posits, as "context," two hypothetical situations that employer claims, produce impossible, unreasonable, and absurd results warranting an investigation into the legislative history of ORS 656.262(7)(c). We disagree. Employer's hypotheticals do not constitute context. Instead, they raise the issue of the appropriate application of the absurd results principle within the statutory analysis framework of PGE.

We recently examined the role of the absurd results principle in statutory construction in *Young v. State of Oregon*, 161 Or App 32, 37-40, 983 P2d 1044, *rev den* 329 Or 447 (1999). *Young* concluded that we do not apply the absurd results principle to determine legislative intent when there is no ambiguity in the text and context of the statute. *Id.* at 39-40. The absurd results principle is applicable only at the third level of the PGE analysis--as a general maxim of statutory construction--when the language of a

statute remains ambiguous after an examination of its text, context, and legislative history. *Jahnke v. US West Communications*, 161 Or App 44, 47-48, 983 P2d 1053 (1999). Where the legislature's intent is known before reaching the third level of the PGE analysis, it is inappropriate to apply the absurd results principle. *State v. Vasquez-Rubio*, 323 Or 275, 283, 917 P2d 494 (1996). Quite simply, we cannot subvert the plain meaning of a statute to avoid a supposedly absurd result. *Safeco Ins. Co. v. Laskey*, 162 Or App 1, 9, 985 P2d 878 (1999). Even if the conflicts that employer hypothesizes actually arise, PGE recognizes that the legislature's power "includes the authority to write a seemingly absurd law, so long as the intent to do that is stated clearly." *Young*, 161 Or App at 38. For these reasons we do not consider employer's absurd results arguments.

Because the text and context of ORS 656.262(7)(c) are unambiguous, we conclude that the Board correctly interpreted that statute to require employer to reopen the claim for processing the newly accepted conditions.

Affirmed.

Cite as 164 Or App 643 (1999) December 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Scott Alltucker, Claimant.

SCOTT ALLTUCKER, Petitioner,
v.
CITY OF SALEM, Respondent.
(97-03007; CA A101436)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 1, 1998.
Ralph E. Wiser, III, argued the cause for petitioner. With him on the brief was Bennett, Hartman, Reynolds & Wiser.
Chess Trethewy argued the cause for respondent. On the brief were Joseph D. Robertson and Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.
Before Landau, Presiding Judge, Deits, Chief Judge,* and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

* Deits, C. J., *vice* Rossman, S. J.

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164 Or App 645> Claimant seeks review of a Workers' Compensation Board order upholding the City of Salem's (city) denial of his claim. We review for errors of law, ORS 656.298(7) and ORS 183.482(8), and affirm.

Claimant is a firefighter and paramedic for the city. His monthly schedule consists of alternating shifts as either a paramedic or a firefighter. He can be assigned to any of the city's stations. The city issues a monthly report that shows the shift schedules for the month. In addition, the city issues a daily report based on last minute changes. For this reason, employees are expected to call in each morning to verify where to report for work.

Before his March 26, 1996, shift, claimant did not call in to check for schedule changes. Claimant reported to work at his scheduled station, Station 2. When claimant arrived at work, he discovered that his schedule had changed and that he was required to report for work at Station 5. Claimant left Station 2 and rode his bicycle to Station 5. Claimant injured his left forearm while riding to Station 5 when his bike trailer, carrying his work clothes, became caught in a railroad track and claimant was thrown over the handle bars of his bicycle.

The city denied the claim, contending that claimant was not injured in the course and scope of his employment. Claimant requested a hearing, and the administrative law judge (ALJ) set aside the denial. On appeal, the Board reinstated the city's denial, relying on the "going and coming rule." The going and coming rule provides that an injury sustained while a worker is going to or coming from work is not considered to have occurred in the course of employment and, therefore, is not compensable. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526, 919 P2d 465 (1996).

ORS 656.005(7)(a) defines a compensable injury as one "arising out of and in the course of employment." In *Rogers v. SAIF*, 289 Or 633, 643, 616 P2d 485 (1980), the Supreme Court held that "in the course of" and "arising out of" employment are two prongs of a single unitary work-connection test. The court noted that the ultimate inquiry **<164 Or App 645/646>** remained: "[I]s the relationship between the injury and the employment sufficient that the injury should be compensable?" *Id.* at 642. It is well established that the "in the course of" prong concerns the time, place, and circumstances of the injury. Likewise, it is also well established that the "arising out of" prong requires a causal connection between the injury and the worker's employment. *Krushwitz*, 323 Or at 525-26; *Illiaifar v. SAIF*, 160 Or App 116, 120, 981 P2d 353 (1999).

In *Krushwitz*, the Supreme Court described the going and coming rule as providing that "injuries sustained while an employee is traveling to or from work do not occur in the course of employment and, consequently, are not compensable." *Id.* at 526. The reason for the rule is that the employer exercises no control over the worker and the worker is rendering no services for the employer. *Krushwitz* was an action for wrongful death where the decedent died in an automobile accident while driving home from work. The defendant argued that the exclusive remedy provision of the Workers' Compensation Law, ORS 656.018, barred the wrongful death action because the injury was compensable. The defendant argued that the "special errand" exception to the going and coming rule applied. The special errand exception to the going and coming rule applies when a worker sustains an off-premises injury while performing a special task or mission for the employer. *Id.* at 527. In order for that exception to apply, either the worker must be acting in furtherance of the employer's business or the employer must have had the right to control the worker's travel in some respect. *Id.* at 528. The Supreme Court noted that it traditionally takes a narrow approach in applying an exception to the going and coming rule and concluded that the special errand exception did not apply. Because the accident was not compensable, the exclusive remedy provision did not bar the wrongful death action. *Id.* at 529, 533.

Claimant relies on *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 943 P2d 197 (1997), to support his argument that his injury was "in the course of" his employment. There the claimant was injured after her shift ended while going to her car, which was parked in employer's parking lot. The Supreme Court held:

> **164 Or App 647>** "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." *Id.* at 598.

Claimant argues that, because firefighters travel from one station to another, "[t]raveling across town is simply part and parcel of the duties of a fire fighter." Further, claimant argues that the fact that he was not paid at the time of his injury is not relevant, because in *Hayes*, the Supreme Court held that certain purely personal activities still occur in the course of employment.

We agree with the Board that claimant's injury did not occur "in the course of" his employment. The going and coming rule applies. Claimant has not established any exception to the going and coming rule. While it is true that traveling across Salem is part of claimant's work as a firefighter, the injury did not occur while claimant was acting as a firefighter. The fact that claimant was traveling from one station to another is not relevant under the circumstances of this case. If claimant had called in, in accordance with the city's policy, to determine where he was scheduled to work the morning of the injury, he would have discovered that he was scheduled to work at Station 5, not Station 2. If claimant's injury had occurred while he was traveling on his bicycle from home to Station 5, that injury would not be compensable due to the going and coming rule. We see no reason why the result should be different because claimant failed to call in that morning and first reported to Station 2.

Nonetheless, claimant argues that his injury should be compensable because it arose out of his employment. For an injury to arise out of claimant's employment, he must establish a causal connection between the injury and his work. *Krushwitz*, 323 Or at 525-26. Basically, claimant argues that, because traveling across the city is part of claimant's job, any injury incurred while traveling arises out of his employment as a firefighter. That argument might have **<164 Or App 647/648>** some merit if the injury occurred while claimant was traveling in the course of his employment as a firefighter. We reject, without further discussion, claimant's argument that an injury while traveling to work is compensable merely because claimant was required to travel as part of his employment.

Affirmed.

Cite as 164 Or App 649 (1999) December 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth L. Green, Claimant.

JAMES RIVER CORPORATION, aka Fort James Corporation, Petitioner,
v.
KENNETH L. GREEN, Respondent.
(WCB 97-02171; CA A101134)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 10, 1998.
Jerald P. Keene argued the cause and filed the brief for petitioner.
Robert Pardington argued the cause for respondent. With him on the brief was Pozzi, Wilson Atchison LLP.
Before Landau, Presiding Judge, and Linder and Wollheim, Judges.
WOLLHEIM, J.
Reversed and remanded.

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164 Or App 651> Self-insured employer James River Corporation (James River) seeks review of an order of the Workers' Compensation Board declining to apportion responsibility between James River and claimant's former employer, Crown Zellerbach, and assigning responsibility for claimant's entire hearing loss to James River. Because we agree with James River that the Board erred, we reverse its order and remand for reconsideration.

The facts are undisputed. Claimant has worked as a millwright at the same mill for approximately 27 years, where he has been exposed to high levels of noise. Until 1976, the mill was owned by Crown Zellerbach and insured by SAIF. In 1976, James River acquired the mill. Within 180 days preceding the change in ownership, claimant had an audiogram that measured his hearing loss at 22.25 percent in each ear. He did not file a claim at that time. In 1995, claimant had his hearing tested again and, after taking into account the effects of age, claimant's rateable hearing loss was determined to be 27.5 percent in the right ear and 18.75 percent in the left ear.

It is not disputed that claimant's hearing loss in excess of age-related hearing loss is related to his employment of the last 27 years and that the major contributing cause of claimant's hearing loss was his employment with Crown Zellerbach. Claimant filed claims with both James River and Crown Zellerbach. Pursuant to an ORS 656.307 order, James River was held responsible. Later James River issued a notice of closure awarding claimant disability for his hearing loss as measured in 1995, less the loss attributable to claimant's work for Crown Zellerbach before 1976.

Claimant challenged James River's notice of closure, and the Board ultimately determined that James River should pay claimant disability for his entire rateable hearing loss. James River asserts that the Board erred and that, pursuant to OAR 436-035-0250, responsibility for claimant's hearing loss must be apportioned between James River and Crown Zellerbach. We agree.

164 Or App 652> The parties agree that OAR 436-035-0250 applies. It provides, in part:

> "Compensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure, if adequately documented by a baseline audiogram obtained within 180 days of assignment to a high noise environment."

In affirming the order of the administrative law judge (ALJ) that assigned responsibility for claimant's total hearing loss to James River, the Board did not discuss the administrative rule but instead reasoned that James River had succeeded to Crown Zellerbach's interests. It further reasoned that, although the medical evidence showed that the major contributing cause of claimant's hearing loss was his work for Crown Zellerbach, James River, by seeking an order under ORS 656.307 to determine responsibility between it and Crown Zellerbach, had implicitly acknowledged its responsibility under the last injurious exposure rule.

We agree with James River that the record does not support the Board's conclusion that James River assumed Crown Zellerbach's obligations to injured workers. The Board's further reason gives no support to its decision to assign full responsibility to James River; if anything, it supports apportionment pursuant to the administrative rule.

We also agree with James River that our case law, specifically *Nomeland v. City of Portland*, 106 Or App 77, 806 P2d 175 (1991), and *Papen v. Willamina Lumber Co.*, 123 Or App 249, 859 P2d 1166 (1993), generally supports the concept of apportionment of responsibility between employers in hearing loss cases. We recognize, as claimant asserts, that both of those cases can be read to suggest that when the entire hearing loss is employment related, the last injurious exposure rule might be applicable to assign responsibility for the entire hearing loss to the most recent employer, although the loss occurred through successive employments. *Id.* at 253; *Nomeland*, 106 Or App at 81. That discussion is dictum, however, and it is followed in *Nomeland* by the dispositive language providing that, "when injuries are so distinct that it is possible to segregate them in terms of causation, responsibility for the injuries can and will be apportioned between or **<164 Or App 652/653>** among the employers." *Id.* at 81 (citing *Cascade Corporation v. Rose*, 92 Or App 663, 759 P2d 1127 (1988)).

That analysis is particularly apt in the context of a claim for hearing loss when, as here, the loss attributable to successive employments can be determined by audiograms. It is undisputed that claimant's 1976 audiogram establishes the hearing loss that is attributable to his employment with Crown Zellerbach and that the 1995 audiogram establishes the hearing loss attributable to claimant's employment with James River. In that circumstance, OAR 436-035-0250 achieves apportionment in a manner consistent with our cases, as well as the requirement of ORS 656.214(2) that a worker receive benefits for permanent partial disability "due to" the industrial injury. Claimant did not challenge the rule in this proceeding. We therefore reverse and remand the Board's order for reconsideration and apportionment of responsibility pursuant to OAR 436-035-0250.

Reversed and remanded.

Cite as 164 Or App 654 (1999) December 29, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David E. McAtee, Claimant.

MULTIFOODS SPECIALTY DISTRIBUTION, Petitioner,

v.

DAVID E. MCATEE, Respondent.

(97-01943; CA A101980)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 14, 1999.
Jerald P. Keene argued the cause and filed the brief for petitioner.
Donald M. Hooton argued the cause and filed the brief for respondent.
Before Linder, Presiding Judge, and Deits, Chief Judge, and Brewer, Judge.
BREWER, J.
Reversed.

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164 Or App 656> Employer seeks review of a Workers' Compensation Board order overturning its denial of claimant's combined condition. We review for substantial evidence and errors of law, ORS 656.298(7), ORS 183.482(7), (8), and reverse.

In 1981, claimant suffered a compensable low-back injury while working for Papa John's Sandwich Co. Wausau Insurance Co. accepted the claim, and claimant underwent a lumbar laminectomy and discectomy at L5-S1. The post-operative diagnosis was a right side herniated disc at that location. The claim was closed in 1982 with a determination order that awarded claimant 20 percent unscheduled disability and 5 percent right leg disability. The claim was re-opened in 1983. The physicians who treated claimant at that time diagnosed a worsening of claimant's low-back condition with symptoms on both sides of the back, including recurrent disc herniation at L5-S1 and degenerative disc disease. In August 1983, Wausau accepted the reopened claim as an aggravation, and claimant had a second surgery at L4-5 and L5-S1, including a lumbar laminectomy, two-level bilateral discectomy, and fusion of the iliac bone. The claim was closed again with claimant receiving a further award of permanent partial disability arising from the second surgery.

Claimant began working for Multifoods Specialty Distribution (employer) thereafter. He experienced no significant recurring low-back problems until November 1996, when he slipped at work and suffered an acute low-back strain. X-rays taken at the time disclosed severe post-operative and degenerative changes at L4-5 and L5-S1 and mild to moderate degenerative changes at other lumbar levels. Claimant's physician concluded that the November 1996 strain combined with claimant's preexisting low-back condition and required treatment.

On January 30, 1997, employer accepted the 1996 injury as "acute lumbar strain (combined condition)." On January 31, employer issued a denial pursuant to ORS 656.262(7)(b) stating "[c]urrent medical evidence indicates your pre-existing condition is now the major contributing cause for medical treatment." Employer closed the claim with **<164 Or App 656/657>** an award of benefits through January 31, 1997. Claimant requested a hearing, and an administrative law judge (ALJ) upheld the denial. Claimant then appealed to the Board. The Board reversed the ALJ on the ground that, although the new injury was no longer the major contributing cause of the need for treatment, employer remained responsible for the preexisting component of claimant's combined condition, because responsibility for the preexisting condition had shifted to employer under ORS 656.308(1). This petition for review followed.

We begin our analysis by examining the statutes that interact in the resolution of this case.

ORS 656.005(7)(a)(B) provides:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

It is undisputed that claimant's November 6, 1996, strain was a compensable injury and that it combined with his preexisting compensable degenerative back condition to require treatment. It is also undisputed that, until January 30, 1997, the November 1996 injury was the major contributing cause of the combined condition and the need for treatment.

In the Board's view, because claimant's preexisting low-back condition was compensable, this case is controlled by ORS 656.308(1), which provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition *unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer.* **<164 Or App 657/658>** The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section." (Emphasis added.)

The Board found that, although claimant's new compensable injury is a strain rather than a degenerative back condition, claimant's accepted combined condition "involves the same degenerative changes and related surgeries that were part of the accepted claim with Wausau." It concluded, therefore, that responsibility for claimant's preexisting condition shifted in its entirety to employer under ORS 656.308(1). The Board further reasoned that, because of the shift in responsibility under ORS 656.308(1), the claim was not subject to the provisions for preclosure denial found in ORS 656.262(6)(c) and ORS 656.262(7)(b).[1] It determined that those provisions apply only in the context of combined condition claims involving preexisting *noncompensable* conditions.

We first consider the text of ORS 656.308. The first sentence provides that when a worker sustains a compensable injury, the responsible employer shall remain responsible "for future compensable" medical services and disability unless that worker sustains a "new compensable injury" involving the "same condition." The second sentence provides that "[i]f a new compensable injury" occurs, then "all further compensable" medical services and disability for that same condition, i.e., the preexisting compensable injury, shall be the responsibility of the subsequent employer and shall be processed by that subsequent employer as a new injury claim. The second sentence necessarily implies that if it is **<164 Or App 658/659>** determined that a "new compensable injury" involving the same condition occurred, then the former employer is relieved of responsibility for the same condition, because the latter employer is now responsible for that condition. The third and final sentence of ORS 656.308(1) provides that the standard for determining whether the worker sustains a new compensable injury shall be the standard for determining the compensability of a "combined condition" in ORS 656.005(7).

In *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993), the Supreme Court considered the potential interplay of ORS 656.005(7)(a)(B) and ORS 656.308(1) and determined that the standard set out in ORS 656.005(7)(a)(B) for determining the compensability of combined conditions is applicable for the purpose of determining whether a worker has sustained a "new compensable injury" so as to shift responsibility to the subsequent employer. Implicit in the court's reasoning is its assumption that ORS 656.308(1) encompasses "combined condition[s]," as the term is discussed in ORS 656.007(a)(B).

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[1] 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."

ORS 656.262(7)(b) provides:

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

The court said:

> "'Compensable injury' [as used in ORS 656.308(1)] encompasses an application of the criteria found in ORS 656.005(7)(a), including the limitations found in subparagraphs (A) and (B) of that statute, in making an initial determination of compensability. If the accidental injury described in paragraph (a) *combines* with a preexisting condition, a determination is made under subparagraph (B) whether the accidental injury described in paragraph (a) is 'the major contributing cause of the disability or need for treatment.' *That determination is made under subparagraph (B) whether or not the preexisting condition was compensable.*" *Id.* at 8-9 (emphasis added).

In *Drews*, the court also said:

> "If the preexisting condition was compensable, then the provisions of ORS 656.308(1) apply to determine whether responsibility shifts to the subsequent employer. If the accidental injury described in ORS 656.005(7)(a) was found not to be 'the major contributing cause' under subparagraph (B), then the first sentence of ORS 656.308(1) applies, because the claimant has not sustained a 'new compensable injury involving the same condition' and, thus, the first employer remains responsible. *If the accidental injury* **<164 Or App 659/660>** *described in paragraph (a) of ORS 656.005(7) was found to be 'the major contributing cause' under subparagraph (B), then the second sentence of ORS 656.308(1) applies, because a new compensable injury has occurred, and responsibility shifts to the subsequent employer.*" *Id.* at 9 (emphasis added).

The court's language must not be read to sidestep the express limitation of ORS 656.308(1) that the new compensable injury "involv[e] the same condition" as the earlier compensable injury. *Drews* indeed involved an original compensable condition that was the same condition as the later injury. In the context of its facts, the court's precise holding in *Drews* is that, if a worker experiences a new compensable injury *involving the same condition as the original compensable injury*, the provisions of ORS 656.308(1) and the major contributing cause standard of ORS 656.005(7)(a)(B) are applicable for the purpose of determining whether responsibility for the earlier injury shifts to the subsequent employer. The court reached no conclusion with respect to the circumstance now before us, when the new compensable injury is not the same condition as the original compensable injury.

The Board in this case extended the application of ORS 656.308(1) a step further than *Drews* and implicitly reasoned that, when a new compensable injury combines with an original compensable injury, it necessarily involves that same condition, as required by ORS 656.308(1). We reject that analysis and agree with employer that this claim for a strain does not involve the same condition previously accepted and that ORS 656.308(1) is therefore inapplicable.

In several of our cases, we have read the words of ORS 656.308(1) to require a shift of responsibility only when the claimant's new compensable injury is for or includes the same condition previously accepted. In *Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 182, 914 P2d 708 (1996), we said that "under ORS 656.308(1), responsibility for claimant's 1993 treatment is assigned to the insurer with the most recent accepted claim involving *that same condition.*" (Emphasis added.)

In *SAIF v. Yokum*, 132 Or App 18, 23, 887 P2d 380 (1994), we said "for [ORS 656.308(1)] to be triggered, there **<164 Or App 660/661>** must be an accepted claim *for the condition.*" (Emphasis added.)

In *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371-72, 848 P2d 116 (1993), we said:

> "We conclude that, when benefits are sought for 'further compensable medical services and disability subsequent to a new injury,' ORS 656.308 is applicable if it is determined that the 'further' disability or treatment for which benefits are sought is compensable, *i.e.*, that it is materially related to a compensable injury, and that *it involves a condition that has previously been processed as a part of a compensable claim. Responsibility is then assigned to the employer or insurer with the most recent accepted claim for that condition.*" (Emphasis added.)

On remand from our decision in *Sanford*, the Board also concluded that a new injury "involve[s]" the same condition so as to give rise to a shift of responsibility under ORS 656.308(1) only when the new injury for which compensation is sought is the same condition previously processed as a part of a compensable claim. *Archiel F. Sanford*, 49 Van Natta 122, 123 (1997); *see also Fred L. Dobbs*, 50 Van Natta 2293, 2296-97 (1998).

We note, particularly, that for ORS 656.308(1) to apply, it is the *new injury*, not the *claim*, that must involve the same condition. A combined condition may be a part of the claim, but it is not the new injury. A new injury leading to a combined condition certainly could, but need not, involve the same condition previously accepted. Each case is dependent on its facts. Here, claimant's earlier accepted claims were for a herniated disc and degenerative changes. Claimant's new compensable injury is a lumbar strain. Thus, claimant's new injury does not involve the same conditions earlier accepted. Furthermore, employer's acceptance of a strain that combined with a previously accepted condition was not an outright acceptance of the earlier condition itself. The Board has so held in at least two cases. *See Mitchell D. Joy*, 50 Van Natta 824, 825 (1998); *Karen S. Carman*, 49 Van Natta 637 (1997); *compare Freightliner v. Christensen*, 163 Or App 191, 986 P2d 1263 (1999) ("Where employer accepted low back 'pain,' it accepted all the conditions that the medical **<164 Or App 661/662>** evidence shows underlie the low back pain, including claimant's preexisting degenerative back conditions.") Rather, it is the "combined condition" that is accepted, and only to the extent that the work injury was the major contributing cause of disability or the need for treatment of the combined condition. *SAIF v. Nehl*, 149 Or App 309, 315, 942 P2d 859 (1997), *rev den* 326 Or 389 (1998).

Claimant asserts that the term "involves" lends itself to a broader meaning than the one we now give it and that the word "involves" necessarily encompasses "combines." We disagree. The very fact that the legislature chose different words is a strong indication that it intended different meanings. The legislature has not chosen, however, to define either term. The pertinent dictionary definition of "involve" is "to have within or as part of itself: contain, include." *Webster's Third New Int'l Dictionary*, 1191 (unabridged ed 1993). Thus, a new injury involves the same condition as the earlier accepted injury when it has the earlier compensable injury within or as part of itself. The term "combine" has a broader common meaning. It 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." *Id.* at 452. 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.

Ordinarily, the question whether a new injury involves the same condition would be a question of fact. *See* **<164 Or App 662/663>** *Sanford*, 140 Or App at 182; *Smurfit Newsprint*, 118 Or App at 372. Here, however, we can conclude as a matter of law that, although claimant's lumbar strain *combined* with the earlier accepted degenerative condition, it is not one involving the previously accepted degenerative condition, because there is no evidence that the strain has the previously accepted condition within or as a part of itself. Accordingly, we conclude that claimant's new injury does not involve the same condition previously subject to an accepted claim. For that reason, we hold that ORS 656.308(1) is inapplicable and that responsibility for claimant's previously accepted degenerative condition remains with Wausau. The Board therefore erred in concluding that responsibility for claimant's previously accepted degenerative low-back condition shifted to employer.

Because of our disposition, we need not determine whether, if ORS 656.308(1) had been applicable, the provisions of ORS 656.262(6)(c) and (7)(b) would be applicable. On that point, see our discussion in *Barrett Business Services v. Morrow*, 164 Or App 628, ___ P2d ___ (1999).

Reversed.

Cite as 164 Or App 733 (2000) January 5, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael W. Vestal, Claimant.

MICHAEL W. VESTAL, Petitioner,
v.
BARRETT BUSINESS SERVICES, Respondent..
(96-11164; CA A100974)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 20, 1998.
Robert Sola argued the cause for petitioner. On the brief was Richard Dobbins.
Scott Terrall argued the cause for respondent. With him on the brief were Travis L. Terrall and Scott H. Terrall & Associates.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
ARMSTRONG, J.
Affirmed.

*Kistler, J., *vice* Warren, P.J., retired.

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164 Or App 735> Claimant seeks review of a final order in which the Workers' Compensation Board held that respondent Barrett Business Services was not his employer at the time of his injury. The Board rejected claimant's contention that he was an employee of Wayne Allen and Allen Family Construction, which had an agreement with Barrett by which Allen's workers became employees of Barrett, which then leased the workers to Allen.[1] The Board held that another person, Chad Jackson, was Allen's employer for the job on which claimant worked and that Allen hired and supervised claimant on Jackson's behalf, not his own. We affirm.

We state the facts as the Board found them; claimant does not challenge those findings. On October 5, 1996, claimant went to a street corner in Portland seeking work to fill a few days when his regular employer would have nothing available. Allen pulled up at the corner in a truck that had a sign that said "Allen Family Construction" and that offered roofing services. He shouted "work" in Spanish; claimant and several other workers got into the truck. Allen took the workers to an apartment complex in Beaverton where he put them to work removing rotten siding. Claimant used tools that Allen provided. Jackson had a contract that included replacing the siding on the complex and had engaged Allen to assist, because Allen had siding experience, which Jackson did not.[2] Allen Family Construction, however, was a roofing, not siding, business. Allen originally did the work by himself, but Jackson thought that it was going too slowly. Allen therefore hired additional workers, including claimant, because he thought that that was what Jackson wanted. He had done that once before October 5, and Jackson had given him money to pay the workers' wages.

Claimant saw Jackson at the work site but did not know who he was. Other workers talked with Jackson, who **<164 Or App 735/736>** supervised their work on a different part of the building, away from the area where claimant worked. Allen supervised claimant's work. Several hours after beginning work, claimant fell off a ladder and fractured his ankle.[3] Allen, Allen's wife, and Jackson took claimant

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[1] Allen was the owner and sole proprietor of Allen Family Construction. Barrett was responsible for workers' compensation coverage for the employees whom Allen hired under the agreement. We will hereafter refer to Allen or Allen Family Construction, rather than Barrett, as claimant's putative employer.

[2] At the end of the job, Jackson paid Allen by a check for $1,800 without deducting taxes or other amounts from the check.

[3] Although claimant did not know so at the time, the ladder belonged to Jackson.

to a hospital emergency room, with Jackson driving his vehicle. While claimant was in the hospital, Allen brought $40 that Jackson had given him and placed it in claimant's pants. Some time during that period he also told claimant that Jackson was his employer. The day that claimant had surgery on his ankle, Allen visited him and asked him not to file a workers' compensation claim but instead to use the Oregon Health Plan. The day that claimant left the hospital, Allen brought him food from a church food bank, had claimant's prescriptions filled, and indicated that he would help with rent and utilities.

From these facts the Board concluded that Allen was Jackson's employee and that Allen had hired claimant on Jackson's behalf, not his own. In doing so, it emphasized its findings that Jackson had a contract with the building owner to replace the siding, that Allen's normal business was roofing, and that Jackson hired Allen to work outside of the normal work of his business because of Allen's experience with siding. The Board recognized that Allen's actions after the accident suggested that he felt exposed to a workers' compensation claim, but it concluded that those actions were not sufficient to show that Allen was the employer.

On review, claimant argues that Allen was his employer as a matter of law, because Allen had and had exercised the right to control claimant's work. ORS 656.005(3); *see Trabosh v. Washington County*, 140 Or App 159, 915 P2d 1011 (1996). As we pointed out in *Trabosh*, when the facts are undisputed, whether a person is an employee or an independent contractor is a matter of law for the court. 140 Or App at 163. Here, if Allen was an independent contractor, claimant was his employee; if Allen was Jackson's employee, claimant was also.[4] In this case, determining many of **<164 Or App 736/737>** the essential facts requires drawing inferences from the limited information available. Although claimant does not assert that there is insufficient evidence to support the Board's findings of fact and the inferences that it drew, his argument essentially asks us to draw different conclusions and inferences.[5] Claimant focuses on evidence that shows that Allen actually hired him and directed his work. As Barrett points out, however, those actions are consistent with the Board's conclusion that Allen acted as Jackson's supervisory employee rather than on his own account. Determining the weight to give to other factors, such as Allen giving claimant $40 after his injury, apparently for his wages, or Jackson's failure to withhold taxes from the check that he gave Allen, is the Board's responsibility, not that of a reviewing court. The evidence supports the Board's conclusions, and the Board adequately explained how it reached them. We therefore affirm its order.

Affirmed.

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[4] The Board implicitly rejected claimant's argument that he was a joint employee of Allen and Jackson when it found that Allen was Jackson's employee.

[5] Claimant also asserts on review that Allen was an independent contractor as a matter of law under ORS 656.027(7)(b), because he was registered with the Construction Contractor's Board and claimant was engaged in work within the scope of that registration. Claimant did not make that argument, or any argument tangentially related to it, to the Board, and we therefore do not consider it. Claimant also did not argue, at the Board or on review, that Allen was a party to the employment contract because he was an agent for an undisclosed principal. *See Salem Tent & Awning v. Schmidt*, 79 Or App 475, 478-79, 719 Or 899, *rev den* 302 Or 326 (1986).

Cite as 165 Or App 279 (2000) January 26, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DOUGLAS GERARD BROWN and BETTINA MARIE BROWN, Appellants,
v.
COLLEEN ELAINE PETTINARI, LARRY D. SMITH, Defendants,
and WESTSPAN HAULING, INC., a Washington corporation, Respondent.
(96-CV-0099-ST; CA A100218)

Appeal from Circuit Court, Deschutes County.
Stephen N. Tiktin, Judge.
Argued and submitted March 5, 1999.
Gregory P. Lynch argued the cause for appellants. With him on the briefs were Stanley D. Austin and Hurley, Lynch & Re, P.C.
James G. Breathouwer argued the cause for respondent. With him on the brief were Ridgway K. Foley, Jr., Breathouwer & Gilman and Greene & Markley, P.C.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded as to plaintiffs' first claim for relief; otherwise affirmed.

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165 Or App 281> The trial court ruled, on summary judgment, that defendant Westspan Hauling, Inc., was neither vicariously liable for defendant Colleen Pettinari's negligence nor independently negligent for hiring or failing to train her. The court accordingly entered judgment in Westspan's favor. We affirm in part, reverse in part, and remand.

Because this case arises on Westspan's motion for summary judgment, we state the facts in the light most favorable to plaintiffs. *See Jones v. General Motors Corp.*, 325 Or 404, 420, 939 P2d 608 (1997). Westspan is in the business of transporting mobile homes, typically for manufacturers and dealers. It arranges for truck tractors, commonly known as toters, to pick up and deliver completed mobile homes. Depending on the size of the load, the toter may be accompanied by a pilot car, which usually bears a sign stating "oversize load." *See* OAR 734-075-0035(2)(a).

Westspan owns two toters and employs drivers for them. Westspan also leases toters from "owner operators," who agree to provide the labor necessary to transport the mobile homes for Westspan. On July 10, 1995, Westspan entered into a vehicle operation contract with defendant Larry Smith.[1] Pursuant to Interstate Commerce Commission (ICC) regulations in force at the time, the contract provided that Westspan leased the toter from Smith. *See former* 49 CFR section 1057.11 (1994).[2] The contract also provided, pursuant to those regulations, that "[d]uring the term of this contract, [Westspan] shall have exclusive possession, control and use of the vehicl[e] leased hereunder * * *." *See* n 2 above. As part of the contract, Smith agreed to provide qualified labor to transport the mobile homes. The contract thus contemplated **<165 Or App 281/282>** that, when requested by Westspan, Smith would provide qualified drivers for both the toter and, when necessary, arrange for a pilot car and driver.[3] The contract provided that "[s]uch driving personnel must be qualified and authorized by [Westspan]." For its part, Westspan agreed to pay Smith $1.45 per loaded mile for his labor and for the use of his toter. In addition, Westspan reimbursed Smith for the cost of any pilot vehicle required by state law.

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[1] The contract was for one month but was automatically renewed unless either Westspan or Smith gave 10-days advance notice.

[2] The regulations stated that an "authorized carrier may perform authorized transportation in equipment it does not own only under the following conditions[.]" *Former* 49 CFR section 1057.11. The regulations then set out a series of conditions, one of which is that the carrier enter into an equipment lease that provides "that the authorized carrier lessee shall have exclusive possession, control, and use of the equipment for the duration of the lease." *Former* 49 CFR section 1057.12(c)(1). Westspan entered into the contract before the ICC was abolished in 1996. *See* Pub L 104-88, section 101, 109 Stat 803 (1995).

[3] Under the contract, Smith was responsible for paying any person he hired to drive either the toter or the pilot cars and also for withholding and reporting income taxes, social security taxes, and the like.

The contract recites that Smith is an independent contractor, and Smith's affidavit states that "[o]nce the mobile home has been delivered, Westspan has no right to control when, where, how or if I transport my equipment from the delivery site."[4] Smith's affidavit also states that, if a pilot car is required, the pilot driver's compensation for the trip terminates when the mobile home is delivered. His affidavit states that once the mobile home is delivered, "I retain no control, nor right to control, when, where, how or if the pilot driver conducts himself or herself following delivery."

On December 26, 1995, Westspan dispatched Smith to transport a mobile home from a factory in Bend, Oregon, to a storage yard in Biggs, Oregon. Smith in turn hired Pettinari to drive a pilot vehicle to accompany him. Although Pettinari's affidavit states that she was, at that time, the "sole owner of an independent contracting pilot car service known as 'Colleen's Pilot Service,'" plaintiffs introduced evidence that Smith made the down payment on Pettinari's car and paid for the insurance on it, that he taught her to drive, that she got her drivers' license in June 1995, that she began working as a pilot car driver in August 1995, and that she had not worked as a pilot car driver for anyone other than Smith. Plaintiffs also introduced evidence that Pettinari had not registered an assumed business name with the state, that she did not "open up any kind of business record" for her business, and that she did not advertise her business in any **<165 Or App 282/283>** manner. Finally, Pettinari explained that when Westspan paid Smith for a delivery, Smith would transfer "my whole paycheck or part of my paycheck" to a personal account that she and Smith held jointly.

The trip to Biggs occurred without incident. On the trip back to Bend, Pettinari drove her car into the oncoming lane, hit plaintiffs' car, and injured plaintiffs. Plaintiffs sued Pettinari, Smith, and Westspan. They settled their claims against Pettinari and Smith, and only two claims for relief against Westspan remain.[5] Plaintiffs' first claim for relief against Westspan alleges that Pettinari drove negligently and that Westspan is vicariously liable for her negligence. Their second claim for relief alleges that Westspan negligently hired and trained Pettinari to be a pilot car driver and that Westspan's own negligence contributed substantially to plaintiffs' injuries.[6] Westspan moved for summary judgment on both claims. The trial court granted its motion, and plaintiffs appeal from the resulting judgment.

On plaintiffs' first claim for relief, Westspan does not dispute, at least on summary judgment, that Pettinari was driving negligently when she hit plaintiffs' car. Rather, it advances two separate but related reasons why it is not vicariously liable for Pettinari's negligence. Westspan argues initially that both Smith and Pettinari were independent contractors, not its employees. Plaintiffs counter that the evidence shows that Smith was Westspan's employee and that Pettinari was Smith's employee, making Pettinari Westspan's employee.[7] Westspan argues alternatively that **<165 Or App 283/284>** even if Pettinari were its employee, it had no right to control her once the mobile home was delivered in Biggs. Rather, it contends that Pettinari was free at that point either to serve as a pilot car driver for some other toter or to go wherever she chose. It follows, Westspan reasons, that Pettinari's job was over and that the coming and going rule applies to her trip home. Plaintiffs respond that the evidence would permit the jury to find that Smith and Pettinari were on a special errand for Westspan, which would make Westspan vicariously liable for Pettinari's negligence on the trip back to Bend.

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[4] Westspan's affidavit similarly states: "Once a delivery is made, Westspan exercises no control over the owner-operator's time or activities unless and until the next job is assigned and accepted by him."

[5] Smith and Pettinari settled with plaintiffs, and plaintiffs executed covenants not to sue. Based on plaintiffs' stipulations, the trial court entered judgments of dismissal as to Smith and Pettinari.

[6] Plaintiffs' second claim for relief is not based on vicarious liability. Rather, it is based on the proposition that Westspan's own negligence in hiring and failing to train Pettinari contributed substantially to plaintiffs' injuries and that Westspan is liable for that reason alone, without regard to whether Pettinari was within the scope of her employment on the return trip to Bend.

[7] Plaintiffs phrase the question as whether Smith was Westspan's agent and Pettinari was Smith's agent, making Pettinari Westspan's subagent. Although employees are agents, not all agents are employees. *See Restatement (Second) of Agency* section 2 comments a & b (1958). Some agents may be independent contractors. *Id.* We accordingly use the term employee, which appears to be the concept on which plaintiffs' argument is based.

The first issue is whether either Smith or Pettinari was an independent contractor. If either was, then Westspan may not be held vicariously liable for Pettinari's negligence. The evidence on Smith's status is mixed. The contract between Smith and Westspan recites that Smith was an independent contractor and not an employee. Moreover, Westspan hired Smith to perform a task, Smith provided his own equipment, which he leased to Westspan, and provided the labor to perform the task. Those facts suggest that Smith was an independent contractor, although none establishes his status dispositively. *See Jenkins v. AAA Heating*, 245 Or 382, 385, 421 P2d 971 (1966).

The contract, however, also gave Westspan "exclusive possession, control and use of the vehicle(s) and equipment leased hereunder." Plaintiffs reason that Westspan's right to control the vehicle implies a right to control Smith's performance under the contract. *See Little Donkey Enterprises, Inc. v. SAIF*, 107 Or App 400, 402-03, 812 P2d 25 (1991), *mod in part*, 121 Or App 643, 856 P2d 323 (1993). We recognize that the language on which plaintiffs rely was included pursuant to an ICC regulation and that the ICC has explained that that language was not intended to create an employee-employer relationship. *See Little Donkey Enterprises, Inc. v. SAIF*, 121 Or App 643, 646, 856 P2d 323 (1993) (explaining the ICC's position).[8] It may be that the contract **<165 Or App 284/285>** language, viewed in light of the ICC's explanation, did not in fact give Westspan the right to control how Smith did his job. But we cannot say, as a matter of law, that the contract does not mean what it appears to say. Rather, the ICC's explanation of its intent creates an ambiguity both as to the meaning of that provision and the nature of Smith's relationship with Westspan, which a fact finder must resolve. *See Little Donkey Enterprises, Inc.*, 121 Or App at 646 (remanding for agency to reconsider its finding that the owner-operator was the motor carrier's employee in light of the ICC's explanation).[9]

Two other related facts, viewed together, support the inference that Smith was Westspan's employee. Plaintiffs alleged that Smith was Westspan's employee, and Westspan's affidavits do not completely negate that allegation. Rather, Westspan's affidavits are qualified. They say that Westspan had no right to control Smith *after* he delivered the mobile home, implying that it had a right to control him until the delivery was made. The second fact bears on Westspan's right to control Smith after the delivery was made. The contract requires Smith to "devote [his toter] to the exclusive service of the Lessee for its transportation of commodities." If Westspan had the exclusive right to use Smith's toter, a fact finder could reasonably infer that it also had the right to control when and how he brought the toter back to Bend. Otherwise, the toter would not be available for Westspan's next job. Contrary to Westspan's arguments, the evidence permits a reasonable inference that Westspan had the right to control Smith on both the trip to Biggs and the return trip to Bend.

165 Or App 286> The same conclusion holds true for Pettinari, although the evidence differs. Pettinari's affidavit states that she owned "an independent contracting pilot service." A fact finder could reasonably find, however, that there was a sufficient right of control to make her Smith's employee. As noted above, Smith paid for part of Pettinari's car; he taught her to drive in March 1995; she began her pilot car business in August 1995; and she drove a pilot car only for Smith. Beyond that, all indicia of an independent business were lacking. She had not registered an assumed business name, she did not keep business records, and she did not advertise. Finally, when asked how Smith compensated her, she

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[8] In 1992, the ICC added a new subsection to 49 CFR section 1057.12(c). That subsection provides:

> "Nothing in the provisions required by paragraph (c)(1) of this section [requiring that equipment leases give the lessee 'exclusive possession, control, and use' of the leased vehicle] is intended to affect whether the lessor or driver provided by the lessor is an independent contractor or an employee of the authorized carrier lessee. An independent contractor relationship may exist when a carrier lessee complies with 49 USC 11107 and attendant administrative requirements."

Former 49 CFR section 1057.12(c)(4) (1994).

[9] The question whether Smith's and Westspan's contract made Smith an employee or an independent contractor is a question of state law. In the absence of some indication that the ICC intended to preempt state law, and the terms of the regulation do not reveal any, then what the ICC intended at most bears on the interpretation of the language the parties included in their contract. To take an obvious example, if the ICC had required that the contract include a provision stating that Westspan had the right to control Smith's performance of his job, the ICC's statement that the provision was not intended to create an employee-employer relationship could not negate the legal effect that state law would otherwise give those words.

referred to his giving her a "paycheck" periodically, a reference that implies an ongoing employment relationship. We also note that the Oregon regulations state that pilot vehicles "are considered to be under the direct control and supervision of the oversize vehicle operator." OAR 734-075-0035(10). In short, a fact finder reasonably could conclude from this evidence that Pettinari was Smith's full-time employee and thus Westspan's employee to the same extent that Smith was.[10]

Even if Smith and Pettinari were Westspan's employees, the remaining question is whether they were in the course of their work when they returned to Bend. On that point, Westspan does not appear to argue that Pettinari was hired for this job only and that her employment terminated when the mobile home was delivered to Biggs. Rather, Westspan presumably recognizes that, given the evidence of an ongoing business relationship between Smith and Pettinari, a fact finder could reasonably infer that Smith hired her to work full time as his pilot car driver. Westspan's argument turns instead on the proposition that because it had no right to control Smith and Pettinari once they delivered the mobile **<165 Or App 286/287>** home to Biggs, the going and coming rule applies: Their work was done and, in its view, they were headed home as any employee would be at the end of the day. *See Heide/Parker v. T.C.I. Incorporated*, 264 Or 535, 539, 506 P2d 486 (1973). Plaintiffs counter that because the evidence permitted a juror reasonably to find that Pettinari and Smith were still subject to Westspan's control on the return trip, the special errand rule applies. *See Wilson v. Steel Tank & Pipe Co.*, 152 Or 386, 395-402, 52 P2d 1120 (1936).

The court explained in *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 528, 919 P2d 465 (1996), that "[i]n view of this court's decision in Heide/Parker, it is clear that Oregon's special errand exception applies only when either the employee was acting in furtherance of the employer's business at the time of the injury or the employer had the right to control the employee's travel in some respect." 323 Or at 528 (emphasis in original).[11] On this point, Westspan introduced evidence that it had no right to control either Smith or Pettinari once the mobile home was delivered. Plaintiffs, however, introduced evidence that would reasonably permit a contrary inference. As noted above, the contract between Smith and Westspan gave Westspan the exclusive right to use Smith's toter for the duration of the contract and to call upon him during that time to deliver mobile homes. A fact finder could reasonably draw three inferences from that fact, and the other facts discussed above.

First, a fact finder could infer that Westspan had the right to control when and how Smith returned the toter. Westspan's exclusive right to use the toter for the period of the contract implies a right to direct Smith when to return it to Bend so that it would be available for Westspan's next delivery. Second, a fact finder could reasonably infer that returning the toter to Bend benefitted Westspan. If the toter were not returned, it would not be available for the next delivery that Westspan required. Finally, because a fact finder could find that Smith employed Pettinari full time to **<165 Or App 287/288>** be his pilot car driver, it could infer that Westspan's right to control Smith included a right to control Pettinari and that her availability as a pilot car driver was as great a benefit to Westspan as Smith's and the toter's availability. On this evidence, a fact finder reasonably could infer that both of the conditions for establishing the special errand exception were present. A fact finder, of course, could draw the contrary inference, but Westspan was not entitled to summary judgment on plaintiffs' first claim for relief.[12]

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[10] Although plaintiffs describe Pettinari as Westspan's subagent or subservant, Mechem reasons that it is better to view a person such as Pettinari as Westspan's employee. Floyd R. Mechem, *Outlines of the Law of Agency* section 445 (1952). He explains:

> "A more realistic and fundamental answer [to the question of subagency] would be to say that the helper, though hired and paid by the operator, is simply the company's servant. *** It would be absurd to say that the company may control the driving of Jones, the operator, but not that of Smith, hired by Jones to drive the truck." *Id.*

[11] Earlier cases had suggested that both requirements had to be met, *see, e.g., Gossett v. Simonson*, 243 Or 16, 26, 411 P2d 227 (1966), but *Krushwitz* appears to say that either is sufficient. We need not resolve that question because we find that both requirements are met here.

[12] Westspan also argues that summary judgment was appropriate because the covenants not to sue Smith and Pettinari exonerated Westspan. *See* n 5 above. A release of one party operates as a release of other parties in an action only if the parties intend it to have that effect. *Stanfield v. Laccoarce*, 284 Or 651, 661-62, 588 P2d 1271 (1978). The covenants not to sue Smith and Pettinari each expressly provide that it is the intention of the parties to reserve any and all rights against any other party arising out of the accident Those covenants did not exonerate Westspan.

Plaintiffs also assign error to the trial court's ruling granting summary judgment on their second claim for relief. They allege that Westspan was negligent in hiring Pettinari to drive a pilot car and in training her how to perform that job and that the facts are disputed on that point. The question whether defendant was negligent in hiring and failing to train Pettinari to operate a pilot car is relevant only if Pettinari was acting as a pilot car driver at the time of the accident. Once Pettinari and Smith delivered the mobile home in Biggs, Pettinari was no longer serving as a pilot car driver on the return trip to Bend. She was merely driving her own car. There is no evidence that Pettinari was neither qualified nor trained to do that. Even if Westspan were negligent in hiring Pettinari to drive a pilot car or in failing to train her how to do so, there is no causal connection between that negligence and the accident that caused plaintiffs' injuries.

Reversed and remanded as to plaintiffs' first claim for relief; otherwise affirmed.

Cite as 165 Or App 517 (2000) February 23, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Laura R. Franke, Claimant.
LAURA R. FRANKE, Petitioner,
v.
LAMB-WESTON, INC., Respondent.
(96-04464; CA A102043)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 12, 1998.
R. Adian Martin argued the cause and filed the brief for petitioner.
Steven T. Maher argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
EDMONDS, P. J.
Reversed and remanded for reconsideration.
Armstrong, J., concurring.

* Kistler, J., *vice* Warren, P. J., retired.

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165 Or App 519> Claimant seeks review of an order of the Workers' Compensation Board (Board) that held that claimant had not carried her burden of proving that her current condition is work related. We review for errors of law and for substantial evidence and reverse. ORS 183.482(8).

After an appeal by claimant from the administrative law judge (ALJ)'s order that upheld employer's denial, the Board adopted and affirmed the ALJ's order. The ALJ found that on May 25, 1995, claimant was injured at work when she experienced neck and shoulder pain as a result of turning over boxes of product. She was treated by various doctors in early June 1995, and Dr. Oltman became her attending physician on June 13. He concluded that claimant had suffered a soft tissue injury with possible nerve irritation, and he prescribed treatment consisting primarily of physical therapy. He released claimant to go back to light work as of July 2, 1995, and employer accepted claimant's claim as a cervical strain condition.

Claimant was still experiencing symptoms in September 1995, and Oltman referred her to a neurosurgeon. As a result of his examination and a MRI, the neurosurgeon suggested treatment by a pain clinic. Claimant declined, requesting instead, a second opinion. Thereafter, she was seen by Dr. Keenen, who concluded that claimant had a cervical strain without evidence of disc herniation. He recommended physical therapy and claimant was taken off work.

In November 1995, claimant was evaluated by a panel of examiners. Dr. Laycoe and Dr. Watson indicated that they believed that claimant was suffering from chronic neck pain because of the over-use of her neck. They found no evidence of cellular or intervertebral disk problems. They did note that "functional overlay" was present. Dr. Davies, a psychologist, opined that "secondary gain" factors were present.

Claimant returned to work in January 1996. She underwent a second medical examination in April 1996 with Drs. Wilson and Klecan. The ALJ found,

> **165 Or App 520>** "* * * Dr. Wilson speculated claimant could have had an overuse syndrome without objective findings. In his opinion claimant was medically stationary with no further treatment needed and no impairment. The major cause of claimant's condition, he added, was non-organic findings as opposed to the May 25, 1995 injury. Psychiatrist, Dr. Klecan, found no mental disorder or personality disorder present. Like Dr. Davies, he believed secondary gain factors were operating. Although, agreeing some somatization[1] was present, Dr. Oltman otherwise declined to concur with the IME opinions.

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1 "Somatization" is defined as "the production of physiological disfunction often resulting in irreversible structural changes by the exaggeration and persistence of an emotional state." *Webster's Third New Int'l Dictionary*, 2171 (unabridged ed 1993).

"On April 30, 1996, as amended on May 2, 1996, the employer issued a current condition denial on the basis the major cause of the present condition was no longer the May 25, 1995 injury."

On May 8, 1996, claimant returned to Keenen, who recommended anesthetic and steroid injections in claimant's cervical area. Subsequently, Dr. Slack administered several injections to claimant's spine. Thereafter, claimant rated her pain level as zero on a scale from 1 to 10 in response to Slack's inquiry after receiving the injections. Before the hearing with the ALJ occurred, Oltman was deposed. Based on Slack's report regarding the effect of the injections, he opined that claimant's current condition was a physical result of her work injury.

In the part of her opinion labeled "CONCLUSIONS OF LAW AND OPINION," the ALJ explained her reasoning in arriving at the conclusion that claimant had not carried her burden of persuasion and why she rejected Oltman's opinion.

"On April 4, 1996, Drs. Wilson and Klecan examined claimant. In their respective reports, they concluded claimant's present condition was subjective only, *i.e.*, not an illness, injury or condition in the usual sense. Dr. Klecan explained nonanatomical and noninjury factors were now operating as the major cause. Prior to closure, and relying on the April 4, 1996 report, the employer issued a current **<165 Or App 520/521>** condition denial on the basis the accepted May 25, 1995 injury was no longer the major contributing cause of claimant's chronic condition. ORS 656.262(7)(b).

"The evidence establishes claimant sustained a cervical injury on May 25, 1995. Despite extensive medical attention the injury developed into a chronic condition. Improvement has proven to be elusive. Thorough diagnostic testing has not revealed a physical basis for claimant's continuing symptoms.

"Moreover, the medical issue has been compounded by the presence of psychological factors. Although not diagnosing a psychiatric illness or disorder, Dr. Klecan has described the noninjury factors as twofold: (1) a personal style of anxious, somatic over focus, and (2) external rewards coming in response to her anxious somatic over focus. Dr. Wilson described claimant as being very over focused on her somatic complaints. Dr. Keenen's reports also suggest he does not disagree that a psychosomatic element is present. Even claimant's attending physician, Dr. Oltman, has acknowledged the presence of some somatization. The evidence further supports the finding psychological factors combined with the May 25, 1995 injury to produce a combined condition.

"In this regard, ORS 656.005(7)(a)(B) provides that if a otherwise compensable injury combines at any time with a preexisting disease or condition to cause or prolong disability or the 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. Under the statute, the quantitative contribution of each cause must be weighed to establish the primary cause of claimant's need for treatment. *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997).

"The preponderance of the evidence establishes claimant's current cervical condition is not supported by objective findings of a physical injury. This is the assessment of the doctors who have examined claimant. Even assuming, the presence of residuals from the May 25, 1995 injury, the evidence is not convincing the injury remains the major contributing cause of claimant chronic cervical condition. **<165 Or App 521/522>** Rather, the evidence points to psychological factors in explaining claimant's current condition.

"In contrast, it was the opinion of Dr. Oltman [that] claimant's continuing symptoms were due to a physical as opposed to psychological condition based on the fact claimant showed improv[ment] after being injected by Dr. Slack in late May 1996. *In his deposition Dr. Oltman stated that if claimant had declared 100 percent improvement within a few minutes of being injected, he would have suspected more of a psychological component. As it was, she had a history of delay with substantial improvement noted 10 days post injection* leading Dr. Oltman to think inflammation was present in the area injected. Thus, he was more convinced of a physically based condition.

> "*Review of Dr. Slack's report, however, does not correspond to a delayed response. He records that claimant reported immediate improvement.* While at his office, using a pain scale of 1 to 10, she gave a pain level of 0. In other words, shortly after the injections claimant was reporting she was pain free. This history casts doubt on the medical history relied on by Dr. Oltman in forming his opinion. As a consequence, his opinion is weakened.
>
> "Accordingly, for the above reasons, I find the weight of evidence does not establish the May 25, 1995 injury was the major contributing cause of her disability and need for treatment of the combined condition. * * *" (Exhibit references omitted; emphasis added.)

On review, claimant makes two assignments of errors. The first assignment says, "The Board erred * * * in not addressing the procedural validity of [the] denial." Claimant argues that because she has made no claim for the compensability of a psychological condition or for a combined condition, the Board was without "jurisdiction" to uphold employer's denial. Employer responds,

> "Here, the Board had jurisdictional authority precisely because the matter at issue involved a worker's right to receive compensation. Claimant's sole purpose for requesting a hearing on May 8, 1996 was to gain compensation for the current cervical condition, which was denied by the employer. At the hearing level, claimant framed the issue as 'whether or not the denial should be set aside--benefits according to law.' Claimant's opening argument clearly **<165 Or App 522/523>** states that 'the medical bills need to be paid and she needs her time loss and her expenses for seeing her doctors down in Portland.' Without claimant's attempts to gain compensation for a condition that she claims is work related, there would not have been a matter concerning a claim, and neither the Hearings Division nor the Board would have had jurisdiction. However, because claimant's case involves her right to receive compensation for an injury that she claims is work related, both the Hearings Division and the Board have jurisdiction pursuant to ORS 656.726(2) and 656.704(3)." (Internal references omitted.)
>
> ORS 656.704(3) provides:
>
> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning *a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue.* However, such matters do not include any disputes arising under ORS 656.245, 656.248, 656.260, 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340, except as those provisions may otherwise provide." (Emphasis added.)

As employer points out, claimant's position before the hearings division and the Board triggered the provisions of ORS 656.704(3) because her requests constituted a "claim." Accordingly, the Board has jurisdiction over this matter.

In her second assignment of error, claimant contends: "Substantial evidence does not support the decision of the ALJ[.]" We examine the record as a whole to determine whether or not there is substantial evidence to support the ALJ's findings in this case and whether her conclusion is based on substantial reason. ORS 183.482(8)(c).[2] The ALJ discounted Oltman's opinion because Oltman interpreted Slack's report to say that claimant reported delayed relief from the injections. Instead, the ALJ understood Slack's **<165 Or App 523/524>** report as saying that claimant had immediate relief from pain after the injections, a response that would be more consistent with a psychological reaction to the injections. According to claimant, the Board's opinion is not supported by substantial evidence because "the ALJ misstated critical medical evidence."

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[2] The statute provides, in part:

"Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

In his report, Slack recounted that he gave claimant injections, and immediately after the procedure, the claimant evaluated her pain as "zero." The injections apparently included a local anesthetic and a steroid that was intended to have a long term anti-inflammatory effect. He also gave claimant a prescription for pain control. Slack then included in the last page of his report claimant's evaluation of her condition after treatment. In that evaluation, claimant stated that on the evening of the treatment, her neck symptoms were worse than before or were the same as before. Thereafter, she experienced gradual improvement over a ten-day period and subsequently, she reported substantial improvement in all areas. Thus, the last portion of 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.

In reviewing the Board's order for substantial evidence, it is not our role to determine which understanding of Slack's report is correct or what role it plays in the overall evaluation of the weight of the evidence. However, in *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990), the court explained: "If a finding is reasonable in light of counterveiling as well as supporting evidence, the finding is supported by substantial evidence." In that case, the structure of the ALJ's opinion is curious. She reaches her conclusion about the weight of the evidence and whether the evidence is persuasive regarding the issue of the cause of claimant's complaints apparently before she considers Oltman's report. Also, we cannot discern from her opinion whether her discounting of Oltman's opinion was the result of weighing all of the evidence and whether she considered, in rejecting his opinion, Oltman's reliance on claimant's report to Slack about her condition after the local anesthetic wore **<165 Or App 524/525>** off. Regardless, it was incumbent on the Board to weigh all of the evidence before it reached its conclusion. If, in fact, the ALJ's opinion on which the Board relied failed to consider the report by claimant of her gradual improvement over a ten-day period after the injections were administered, that omission was error under *Garcia*. Accordingly, remand is required for the Board to consider claimant's claim in light of the entire medical record including the medical reports that pre-date Slack's treatment.[3]

Reversed and remanded for reconsideration.

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[3] Contrary to the concurrence's assertion, it is for the Board on remand to assess the relative weight of the various medical opinions in the record.

ARMSTRONG, J., concurring.

I agree with the majority that the Board's treatment of Dr. Slack's report and Dr. Oltman's testimony concerning the cause of claimant's current condition requires reversal and remand to the Board. I write to emphasize that, in my opinion, the Board could not possibly find, on this record, that claimant's current condition is primarily psychological in nature rather than a physical result of her compensable injury.

Although there is evidence in the record that suggests that the cause of claimant's current condition was primarily psychological, all of that evidence precedes Slack's treatment and thus does not take the results of the treatment into account. Those opinions were based on the best information available at the time, but they are now outdated. When one reads Slack's report of his treatment in conjunction with Oltman's explanation of it, the only possible conclusion is that, contrary to those earlier opinions, claimant's current condition is primarily physical in nature and is the result of her compensable injury. The record does not currently contain any substantial evidence to support any different result. Because the heart of the Board's error was its failure to understand what Slack's report contained and what Oltman explained in his testimony, I will discuss those things in some detail.

165 Or App 526> An essential part of the foundation for the Board's decision was its conclusion that the positive results of the steroid injections that Slack administered were best explained by psychological rather than physical factors. Neither Slack nor any other expert who was aware of Slack's report gave an opinion that directly supported that conclusion. Oltman was the only physician who knew of Slack's report when he gave his opinion, and his opinion supported the compensability of claimant's current condition. Rather, the Board misunderstood Slack's report in a way that led it to discount Oltman's opinion and to fall back on the opinions that other physicians had given before claimant saw Slack.

The Board correctly noted that Slack's report showed that claimant experienced immediate relief from the injections; however, it incorrectly assumed that the report also showed that the relief was permanent. Oltman, on the other hand, correctly understood, from Slack's report and from claimant's direct statements to him, that claimant's permanent improvement had been gradual, not immediate. He testified that improvement to a physical problem would have occurred over a period of time, while immediate improvement would suggest a psychological cause. Because the Board failed to understand Slack's report, it saw Oltman's testimony as inconsistent with the result of Slack's treatment. As a result of that perceived inconsistency, the Board discounted Oltman's opinion of the cause of claimant's current condition. However, the only possible reading of Slack's report as a whole is that claimant's permanent improvement was gradual, which is consistent with Oltman's opinion and deprives the previous contrary opinions of any substantial evidentiary value.

Slack's report contains four pages. The first three pages are his summary of claimant's condition and his description of the procedures that he employed. He noted that before the procedure claimant rated her pain at three on a scale of one to ten, stating that it was lower than usual because she had not worked for the previous week. He then described the procedures, which involved first anesthetizing the skin in claimant's neck and then inserting needles in four different positions. Slack injected a combination of Celestone Soluspan and Marcaine through three of the needles; in the **<165 Or App 526/527>** fourth he injected only Marcaine to anesthetize several nerve branches. Immediately after the procedures, claimant reported her pain as zero on a scale of one to ten.

The fourth page of Slack's report, which the Board appears to have ignored, was claimant's report of her condition in the ten days following the treatment. She reported that on the evening of the day of treatment her neck pain was worse and her arm and shoulder pain were the same as before the treatment. Three days later her neck pain continued to be worse, but she had some improvement in her arm and shoulder pain. Seven days after treatment she had some improvement in the neck and substantial improvement in the arm and shoulder. Finally, ten days after treatment she had substantial improvement in all areas.

In his deposition, Oltman discussed his understanding of the nature of Slack's treatment:

> "He used Marcaine, which is a local anesthetic, you know, for trying to make sure he found the spot that was definitely causing pain. And then he injected a steroid into that area. So, I mean, the celestone band, the soluspan that he mentions on the second page is the steroid that he gave.
>
> "And the lidocaine and Marcaine - he used both kinds - is more like a local anesthetic like, of course, the dentist gives you before surgery. And that, of course, is a brief one, a short-acting sort of thing, just to try to find the area that is bothering them.
>
> "And the celestone is the cortisone type of medication that lasts for several - you know, probably several weeks or more and is the one that, you know, no doubt actually did the good that she needed."

Oltman emphasized that the steroid was the drug that actually treated the cause of claimant's problems by attacking the inflamation in her neck. Although he recognized that there might be a psychological component to claimant's condition, he believed, based in large part on her reaction to Slack's treatment, that it played a minor role.

Oltman explained his reasons for rejecting a psychological explanation in his answers to questions from Lamb-Weston's attorney about the nature of claimant's response to **<165 Or App 527/528>** the treatment. He first noted that, based on her statements to him, claimant eventually had a substantial improvement from the injection. The first few days after treatment she felt flu-like and not really well, but by the fifth day she was feeling substantially improved. For a period she felt almost as though she did not have a problem, but then some mild aches and stiffness returned. Despite that problem, she thought that she could put in a full day's work if she were able to take a break. Oltman continued:

> "So that kind of a response when a person is unable to do much work at all, and then they come back and say, 'Hey, you know, I think if I have a little break, I feel I'm enough better that I probably can put in a full eight-hour day,' that's not a typical response you would get from somebody who is trying to get out of work or trying to make a case of something that's not really there.
>
> "And the way that she responded to the injection also seems to be like I've already described; a typical, normal response to the beneficial effect of medicine rather than a psychiatric response.
>
> "Q. What is a typical response from a psychiatric level of something like this?
>
> "A. I think most people, if they've decided that's all the gain they are going to get from a particular thing, and they're looking for some cure, and then they get an injection, they would probably notice a fairly immediate benefit, long lasting, and without any waxing and waning of symptoms, and so forth and so on. I think it would be an all-or-nothing phenomenon."

The Board rejected Oltman's opinion and concluded that claimant's condition was based on psychological factors, primarily because Oltman based his opinion on his understanding that claimant's condition had improved over a period of time rather than immediately after the treatment. The Board stated that

> "[r]eview of Dr. Slack's report, however, does not correspond to a delayed response. He records that claimant reported immediate improvement. While at his office, using a pain scale of 1 to 10, she gave a pain level of 0. * * * In other words, shortly after the injections claimant was reporting she was pain free. This history casts doubt on the **<165 Or App 528/529>** medical history relied on by Dr. Oltman in forming his opinion. As a consequence, his opinion is weakened."

I agree with claimant that the only reasonable way to read her statement that her pain was zero on a scale of one to ten after the treatment is that it referred to the immediate reduction in her pain that was a result of the local anesthetics that Slack administered, not to the long-term results of the steroid treatment. In reviewing the Board's order for substantial evidence, we must examine the order in the light of the record as a whole, which means that we must consider the evidence that detracts from the Board's conclusion as well as the evidence that supports it. *See* ORS 183.482(8)(c). "If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence." *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990). Here, substantial evidence does not support the Board's finding that claimant experienced an immediate and permanent improvement in her condition as a result of Slack's treatment, rather than the gradual improvement that Oltman described. The only conclusion that the record does support is that Slack's injections were effective because they treated the physical cause of claimant's current condition.

Although Slack stated that, immediately after the procedure, claimant rated her pain as zero, he also gave her a prescription for post-block pain control, which might suggest that he did not expect her immediate improvement to last. More significantly, claimant's own evaluation of her condition after the treatment, which, as I noted, is part of Slack's report, shows that on the evening after the treatment her symptoms were as bad as or worse than they had been before. She thereafter experienced gradual improvement until ten days later, when she reported substantial improvement in all areas. Slack's report as a whole, thus, is consistent only with claimant's description of her symptoms to Oltman and is inconsistent with the Board's finding.

It is impossible both to treat claimant's evaluation of her progress as genuine and to read Slack's report in the way that the Board read it. If claimant had experienced immediate and total relief from the treatment, and if, as the Board **<165 Or App 529/530>** necessarily found, that immediate and total relief had been permanent, she would not have had the slow steady progress that she chronicled in the evaluation. Unless the Board allows new evidence on remand that significantly alters the picture that the current record provides, the only reasonable conclusion that the Board can reach is that claimant's current condition is a direct physical result of her injury and, therefore, is compensable.

Cite as 165 Or App 596 (2000) February 23, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DON McPHAIL, Appellant,
v.
MILWAUKIE LUMBER CO., an Oregon corporation; STEVE MORSE and PATRICK FITZGERALD, Respondents.
(9606-04339; CA A98729)

Appeal from Circuit Court, Multnomah County.
Robert D. Newell, Judge pro tempore.
Argued and submitted November 30, 1998.
Charles J. Merten argued the cause and filed the briefs for appellant.
James Westwood argued the cause for respondents. With him on the brief were Thomas C. Sand, Sharon L. Toncray and Miller, Nash, Wiener, Hager & Carlsen.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
ARMSTRONG, J.
Reversed and remanded as to Milwaukie Lumber Co. on first, third, fourth and fifth claims; otherwise affirmed.

*Kistler, J. *vice* Warren, P.J., retired.

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165 Or App 598> Plaintiff appeals from a summary judgment that dismissed all of his claims against Milwaukie Lumber Co., his former employer, Steve Morse, the primary owner of Milwaukie Lumber, and Patrick Fitzgerald, a Milwaukie Lumber sales manager. All of the claims arise from Milwaukie Lumber's termination of plaintiff's employment. We reverse as to Milwaukie Lumber on all but two of the claims and affirm as to the individual defendants.[1]

Plaintiff began working for Milwaukie Lumber in 1992 after Morse and Fitzgerald recruited him from Parr Lumber, where he had worked for a number of years. While working at Parr, plaintiff was covered by a union contract that protected him from termination without just cause, and he had sufficient seniority that it was highly unlikely that he would lose his job as the result of a layoff. As part of the inducement for plaintiff to move to Milwaukie Lumber, Morse promised that he would have a job until his retirement, which at the time was approximately 17 years away. There was no discussion of termination for cause, but plaintiff does not assert that he was protected from termination for actual misconduct.

In 1994, Milwaukie Lumber produced its first employee handbook. Among other things, the handbook stated that employment at the company was at will. The handbook also provided that an employee would be suspended for a week without pay if the employee received three written notices of an unsatisfactory event or situation during any calendar year. Plaintiff signed a receipt for his copy of the handbook in which he stated, in part, "I understand that my employment with Milwaukie Lumber Co. will continue at the will of the Company and myself and may be terminated at any time for any reason, by any party." He did not receive a pay increase or other obvious consideration in return for **<165 Or App 598/599>** signing that statement. Morse was unable to identify anything else that plaintiff received in exchange for his signature.

In late 1994, Fitzgerald became increasingly volatile and demanding, placing great stress on plaintiff, who had to work closely with him. That stress affected plaintiff's relationships with other sales staff, which in turn increased the stress on plaintiff. Morse failed to deal effectively with Fitzgerald's actions because of the large amount of business that Fitzgerald produced. At the same time, plaintiff

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[1] Plaintiff's claims against the individual defendants are based on aider and abettor liability and general agency principles. He recognizes that *Schram v. Albertson's* 146 Or App 415, 934 P2d 483 (1997), *rev dismissed* 328 Or 366, 328 Or 419 (1999), is against his position but asks that we overrule that case. We decline to do so and therefore affirm the judgment as to those defendants.

began suffering severe gastric and intestinal problems, for which he first sought treatment in January 1995. His physicians found the problems difficult to diagnose but concluded that their cause was the stress that plaintiff was suffering at work. He went to the emergency room on one occasion because of the problems and missed work several times for the same reason.

Several events in June 1995 preceded plaintiff's termination on June 27. The role, if any, that each event played in the termination is disputed. On June 9, one of plaintiff's female coworkers was the subject of a crude sexual remark from another employee; the remark seriously upset her. She reported it to Morse on the same day; Morse checked with her several times later that day to see how she was feeling. He left for vacation the next day. When plaintiff heard about the remark, he told the employee that she might have a good sexual harassment and retaliation claim if she lost her job over her complaints. On June 11, plaintiff told Fitzgerald that the affected employee could sue over the incident. On June 13, the employee and her husband met with Fitzgerald, Michael Crosgrove, the operations manager and plaintiff's direct supervisor, and Tracy Thor, Fitzgerald's assistant; the employee and her husband insisted that the offending employee be fired. Instead, the employee received a week's suspension pending Morse's return. The possibility of a lawsuit scared Fitzgerald; Thor, with Fitzgerald's and Crosgrove's assistance, began keeping a log of plaintiff's activities to discuss with Morse when he returned.

On June 12, plaintiff's stomach problems became acute, forcing him to go home early. The next day, June 13, Fitzgerald berated plaintiff for doing so and threatened him **<165 Or App 599/600>** with firing if he again left without getting in touch with Fitzgerald. That afternoon plaintiff had to leave early again. On June 15, plaintiff's physician scheduled him for a colonoscopy on June 21 and told him not to return to work until after that procedure; he gave plaintiff a written excuse from work, as a result of which Milwaukie Lumber gave plaintiff the time off. During the period between receiving the excuse from work and the colonoscopy, plaintiff went to Reno, Nevada, for a couple days to gamble. Sometime during this period, plaintiff also made statements that suggested that he either had or could get a job offer from another company.

After the colonoscopy, plaintiff's physician told him to rest and not to return to work until Monday, June 26. Milwaukie Lumber later told him not to return until June 27. On June 26, when Morse returned from vacation, Thor, using the log that she had kept of plaintiff's activities, described the events that had taken place after June 11. When plaintiff showed up for work on June 27, Morse fired him, allegedly because plaintiff was disloyal in seeking work elsewhere and because he had taken a pleasure trip to Reno when he was on sick leave.

We first consider plaintiff's claims arising from his employment contract with Milwaukie Lumber. In the fifth claim, which he asserts solely against Milwaukie Lumber, plaintiff alleges that, when he came from Parr to Milwaukie Lumber, he was promised employment until age 65 and that Milwaukie Lumber breached that agreement by firing him at age 51. The record on summary judgment, read most favorably to plaintiff, supports the allegations of his complaint. Milwaukie Lumber argues, however, that the employee handbook provides for employment at will and that plaintiff recognized that fact in the acknowledgment that he signed when he received his copy. Plaintiff responds, in part, that there was no consideration for any modification of the original employment contract. We agree with plaintiff.

A modification of an existing contract requires additional consideration in order for the modification to be binding. *Jole v. Bredbenner*, 95 Or App 193, 196, 768 P2d 433 (1989). Consideration is "the accrual to one party of some **<165 Or App 600/601>** right, interest, profit or benefit or some forbearance, detriment, loss or responsibility given, suffered, or undertaken by the other." *Shelley v. Portland Tug & Barge Co.*, 158 Or 377, 387, 76 P2d 477 (1938). Under that definition, "benefit" means that the promisor has, in return for the promise, acquired a legal right to which the promisor would not otherwise be entitled; "detriment" means that the promisee has forborne some legal right that the promisee would otherwise have been entitled to exercise. *Id.* at 388.

When plaintiff received the employee handbook, he had been working under the original oral contract for well over a year. Taking the evidence in his favor, he was entitled to continue working under that contract until he retired. Morse could not identify any specific benefit or improvement in plaintiff's employment status that occurred when plaintiff received the handbook. The only

consideration for the alleged modification that Milwaukie Lumber attempts to identify in its brief is that "[w]ithout remonstrance or complaint, Plaintiff continued to work at Milwaukie Lumber, and to reap the benefits of an efficient, streamlined work environment that maximized sales and profits and supported his paycheck[.]"

Milwaukie Lumber's description of the alleged consideration shows that what it describes is not consideration. If plaintiff "continued" to work and to reap the described benefits, he did not gain anything new. Because he had a right to employment until retiring, his continuing to work could not constitute consideration for any change in the term of his employment. Even assuming that the employee handbook somehow improved the work environment from what it had previously been, something that Milwaukie Lumber does not attempt to prove, and even accepting the questionable proposition that an improved work environment can be consideration in this context, there is nothing in the handbook that gives plaintiff any legally enforceable right to that improved environment. Indeed, the whole tone of the handbook is that it does *not* create *any* enforceable rights. Milwaukie Lumber's argument is one that any employer could make any time it reorganized its operations; one purpose for a reorganization is, presumably, to improve the business' profits. Whether or not employees ultimately benefit from such changes, they are not the sort of benefit that will support a **<165 Or App 601/602>** modification of an individual employee's contract. The trial court erred in granting summary judgment to Milwaukie Lumber on the fifth claim.

In his sixth claim, which he asserts in the alternative to the fifth claim, plaintiff argues that he was entitled to the benefit of the provision in the employee handbook that an employee will receive a written notification of any unsatisfactory situation and will receive one week's suspension if there are three notifications within any calendar year. However, that provision does not limit the other portions of the handbook that make it clear that Milwaukie Lumber retains the authority to terminate an employee without cause. Milwaukie Lumber did not, by describing a situation in which it would suspend an employee, detract from its ability to suspend or terminate an employee in other circumstances. The trial court correctly granted summary judgment on the sixth claim. We turn to the claims based on alleged torts and statutory violations.

In his first claim, plaintiff asserts that Milwaukie Lumber violated ORS 659.410(1) when it discharged him. That statute provides in part that it is an unlawful employment practice for an employer to discriminate against a worker "because the worker has applied for benefits or invoked or utilized the procedures provided for in" the Workers' Compensation Law (the Law). The record on summary judgment, including the unchallenged portions of plaintiff's complaint,[2] show that plaintiff notified Milwaukie Lumber in April 1995 that he was having stress at work and that his physician had told him that the stress was the cause of his stomach problems. In June, when he went home early because of those problems, his manager cursed him and threatened his job. Milwaukie Lumber knew that plaintiff was scheduled for tests on June 21 concerning those problems and that his physician had told him not to return to work until June 26. Morse, the majority owner and manager, was upset about paying workers' compensation benefits and **<165 Or App 602/603>** premiums. When plaintiff had previously twisted his knee or ankle, Morse and Crosgrove had told him not to file a claim but to go to a specific physician, whom Milwaukie Lumber paid directly. From these facts, plaintiff argues that a jury could find that preventing a potentially draining workers' compensation claim was a substantial factor in the decision to discharge plaintiff.

Milwaukie Lumber's first response is that plaintiff would be unable to persuade a reasonable jury that his trip to Reno and announcement that he would get another job were only pretexts for his termination. That argument appears to be based in part on the federal burden-shifting approach to civil rights law, in which the plaintiff must show that the defendant's explanation for the challenged action was only a pretext. Oregon has rejected that approach. *See Callan v. Confed. of Oreg. Sch. Adm.*, 79 Or App 73, 75-78, 717 P2d 1252 (1986). It is sufficient in Oregon for the plaintiff to show that the unlawful motive was a substantial and impermissible factor in the discharge decision. *See Winnett v. City of Portland*, 118 Or App 437, 442-43, 847 P2d 902 (1993). In addition, Milwaukie Lumber appears to be asking us to evaluate how strong plaintiff's case would appear to a jury, something that we cannot do if

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[2] For the purposes of a motion for summary judgment, we treat allegations in the pleadings of the nonmoving party that are not challenged by the evidence in the summary judgment record as true. *See Cottle v. Hayes*, 128 Or App 185, 188-89, 875 P2d 493 (1994).

there is any evidence in the record that would support a verdict in plaintiff's favor. Or Const, Art VII (amended), section 3; *see Brown v. J.C. Penney Co.*, 297 Or 695, 705, 688 P2d 811 (1984); *Wooton v. Viking Distributing Co., Inc.*, 136 Or App 56, 62, 899 P2d 1219 (1995), *rev den* 322 Or 613 (1996).[3]

Milwaukie Lumber's primary argument is that plaintiff did not take any actions that might have brought him within the protections of ORS 659.410(1). It points out that the statute protects a worker only if the worker "has applied for benefits" or "invoked or utilized the procedures" of the Law. Because plaintiff never filed a written claim or **<165 Or App 603/604>** otherwise expressly sought workers' compensation benefits, Milwaukie Lumber argues, he does not have a statutory claim. It says that his statements relaying his physician's conclusion that job stress was responsible for his stomach problems were too vague to lead to an actionable claim. Finally, Milwaukie Lumber asserts that the workers' compensation statutes involving accident claims show that a claim must be in writing in order to be a claim; because plaintiff had not filed a written claim, it argues, he did not invoke the provisions of the Law.

Milwaukie Lumber relies on ORS 656.265(1) and (2), which require an injured worker or a dependent of the worker to give written notice of an accident resulting in injury or death to the employer not later than 90 days after the accident. Failure to give the notice bars a claim unless the notice is given within one year after the accident and the employer knew of the injury or death or the worker died within 180 days of the accident. As plaintiff points out, any workers' compensation claim was probably an occupational disease rather than accident claim. The requirements for occupational disease statutes are similar to those for injury claims. Under ORS 656.807(1), an occupational disease claim is void unless it is filed with the insurer or self-insured employer within a year from certain dates.

The underlying problem with Milwaukie Lumber's argument is that the statutes that it cites do not describe what constitutes a claim but, instead, describe what is necessary to perfect an existing claim. ORS 656.005(6) defines a workers' compensation claim as "a written request for compensation from a subject worker or someone on the worker's behalf, *or any compensable injury of which a subject employer has notice or knowledge.*" (Emphasis added.) Thus, if Milwaukie Lumber knew that plaintiff had an occupational disease, that knowledge constituted a claim, even if plaintiff had not given the written notice that was required to perfect it. The effect of ORS 656.265 is to make an accident claim void in the absence of the written notice within the times that the statute describes. ORS 656.807 has a similar effect for an occupational disease claim. Neither statute limits the statutory definition of a claim. By verbally notifying Milwaukie **<165 Or App 604/605>** Lumber of his stomach condition and of its possible relationship to the stress that he experienced at work, plaintiff gave it knowledge of an existing claim. When Milwaukie Lumber terminated his employment, the time for filing the written notice had not yet elapsed, and the claim remained viable.

The Bureau of Labor and Industries, which is charged with enforcing ORS 659.410, has adopted a rule that defines "invoke" under the statute as including "a worker's reporting of an on-the-job injury or a perception by the employer that the worker has been injured on the job or will report an injury." OAR 839-006-0105(2). Although the Bureau's rules do not determine the meaning of the statute, they are entitled to substantial deference because of the Bureau's expertise and the role that the legislature has given it with regard to these statutes. *See Knapp v. City of North Bend*, 304 Or 34, 40-42, 741 P2d 505 (1987). We have, in fact, at times accepted the Bureau's interpretations of these laws. *See, e.g., Lane County v. State of Oregon*, 104 Or App 372, 376-77, 801 P2d 870 (1990), *rev den* 759 P2d 1116 (1991). In this case, the Bureau's rule is consistent with the Law's definition of "claim" and with the policy of the statute to prohibit discrimination based on using the workers' compensation system. We think that it correctly states the meaning of "invoke" in ORS 659.410. *Cf. Parker v. Fred Meyer, Inc.*, 152 Or App 652, 654-56, 954 P2d 1272, *rev den* 327 Or 123 (1998) (upholding claim under ORS 659.410(1) when worker did not file a claim until after the allegedly discriminatory action). As a result, we hold that, based on the evidence on summary judgment, a jury could conclude that plaintiff had invoked the procedures provided in the Law. There are, thus, triable issues of fact on plaintiff's first claim; the trial court erred in granting summary judgment in favor of Milwaukie Lumber on it.

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[3] Milwaukie Lumber argues that it could not have avoided liability under the workers' compensation system for plaintiff's job stress if he had a valid claim. It appears to suggest that that fact somehow means that it cannot be liable under ORS 659.410(1). The point of the statute, however, is to protect a worker's right to pursue a claim without fear of employer retaliation for doing so. That the claim is valid does not mean that an employer can not illegally discriminate against the worker for having asserted it.

In the alternative to his first claim, plaintiff alleges in his second claim that Milwaukie Lumber fired him because he "had or would invoke or utilize" the procedures of the Law and that that action violates the public policy underlying ORS chapter 656 and ORS 659.410(1). He recognizes that ORS 659.410(1) provides his exclusive remedy if that statute is applicable. *Farrimond v. Louisiana-Pacific Corp.*, <165 Or App 605/606> 103 Or App 563, 798 P2d 697 (1990). Under the statute as the Bureau construed it in OAR 839-006-0105(2), a construction that we have adopted, terminating plaintiff because of a concern that he would invoke or use the procedures of the Law is a violation of ORS 659.410(1). That statute, therefore, applies to all of the facts that plaintiff pled in his second claim for relief. As a result, it provides his exclusive remedy; there is nothing left for a common-law wrongful discharge claim. For that reason, we affirm the dismissal of plaintiff's second claim.

In his third claim, plaintiff alleges that he was discharged for opposing the sexual harassment of a fellow employee. He appears to bring this claim both as a statutory claim under ORS 659.030(1)(f) and as a common-law wrongful discharge claim under the principles established in *Holien v. Sears, Roebuck & Co.*, 298 Or 76, 689 P2d 1292 (1984). Milwaukie Lumber's primary response is that there was no actionable sexual harassment for plaintiff to oppose. It points out that the employee who made the offensive remark was not a managerial employee and argues that the company acted immediately to deal with the situation that the remark created, to the ultimate satisfaction of the offended employee. That argument incorrectly shifts the focus from the reason for Milwaukie Lumber's termination of plaintiff's employment to the merits of a claim that the female employee might bring against Milwaukie Lumber.

The statute prohibits discrimination against an employee who has opposed practices that the statute forbids, who has filed a complaint, testified, or assisted in any administrative proceeding to enforce those statutory rights, or who has attempted to do so. ORS 659.030(1)(f). Sexual harassment constitutes prohibited discrimination on the basis of sex if the harassment creates a work environment that is intimidating or hostile or offensive. OAR 839-007-0550; *see Fred Meyer, Inc. v. BOLI*, 152 Or App 302, 307, 954 P2d 804 (1998). The statutory protections for filing a complaint, testifying, or assisting in an administrative proceeding, of course, do not require that the complaint be valid; the legislature considered it important to protect those who do those things whether or not the claim was ultimately successful. *See, e.g.*, <165 Or App 606/607> *Lewis and Clark College v. Bureau of Labor*, 43 Or App 245, 602 P2d 1161 (1979), *rev den* 288 Or 667 (1980).

The foundation of Milwaukie Lumber's argument is that the legislature somehow decided to treat a person who simply opposed unlawful discrimination differently from a person who participated in processing a complaint of unlawful discrimination. It is not entirely clear why the legislature would make that distinction, and the words of the statute do not require it.[4] However, we do not need to decide the issue, because Milwaukie Lumber did not make that argument at the trial court. Plaintiff, thus, did not have an opportunity to present evidence relevant to the argument, and we will not consider it on appeal. *See Zerba v. Ideal Mutual Ins. Co.*, 96 Or App 607, 611-12, 773 P2d 1333 (1989).

At the trial court Milwaukie Lumber argued that the employee reported the incident and was pleased with Milwaukie Lumber's response. Because the employee was not subject to any retaliation, Milwaukie Lumber argued,

> "it strains credulity for [plaintiff] to assert that the basis for his discharge was the comment he made about an incident that Milwaukie Lumber had addressed and resolved to [the employee's] satisfaction, particularly when she was the one to report the incident."

The argument, thus, was that Milwaukie Lumber's failure to discriminate against the affected employee meant that it had also not discriminated against plaintiff. That argument does not suggest that there was in fact no sexual harassment--which is Milwaukie Lumber's argument on appeal--only that the harassment was satisfactorily resolved. Milwaukie Lumber's argument at the trial court was one that would be appropriate for a jury but that was not appropriate for a court on summary judgment. The court's role on summary judgment is not to decide whether its credulity has been strained <165 Or App 607/608> but to determine whether there is a genuine issue of material fact.

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[4] A person may well have "opposed any practices forbidden by this section [and other statutes]" whether or not those practices actually occurred, by opposing the threatened or perceived actions. *Cf. McQuary v. Bel Air Convalescent Home, Inc.*, 69 Or App 107, 684 P2d 21, *rev den* 298 Or 37 (1984) (it is sufficient for wrongful discharge claim that the plaintiff believed in good faith that patient abuse occurred; she did not have to prove that the actions in fact constituted patient abuse).

Finally, in his fourth claim plaintiff alleges that Milwaukie Lumber discriminated against him on the ground of disability in violation of ORS 659.425(1) by failing to make a reasonable accommodation of his physical disability--the gastric problems that resulted from his work-related stress. Milwaukie Lumber's only argument on this claim is that it had no duty to accommodate plaintiff by giving him time to take a pleasure trip to Reno. Again, that is an argument that is more appropriate for a jury than for a court on summary judgment. According to plaintiff's evidence, his physician told him not to return to work before his colonoscopy, which was scheduled for, and occurred on, June 21. Based on the physician's statement, Milwaukie Lumber allowed plaintiff to take the intervening time as sick leave. That action could be seen as a reasonable accommodation to his disability, while subsequently penalizing him for the way in which he used that necessary time off could be seen as an *ex post facto* failure to accommodate. Milwaukie Lumber was not entitled to summary judgment on this claim.

Reversed and remanded as to Milwaukie Lumber Co. on first, third, fourth, and fifth claims; otherwise affirmed.

Cite as 165 Or App 634 (2000) March 1, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Earnest E. Lasley, Claimant.
EARNEST E. LASLEY, Petitioner,
v.
SAIF CORPORATION and ONTARIO RENDERING, Respondents.
(WCB No. 94-03312; CA A95509)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 27, 1998.
David W. Hittle argued the cause for petitioner. On the brief were Robert Wollheim and Welch, Bruun, Green & Wollheim, and Douglas J. Rock and Coughlin, Leuenberger & Moon.
David L. Runner argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Deits, Chief Judge, and Armstrong, Judge.
EDMONDS, P. J.
Affirmed.
Deits, C. J., dissenting.

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165 Or App 636> Claimant seeks review of a 1996 Workers' Compensation Board order that held that claimant was not permitted to present additional evidence at the hearing and that he was not permanently and totally disabled. Claimant argues that he was denied due process of law under the Fourteenth Amendment. We affirm.

Claimant originally injured his lower back in 1979. A claim for the injury was accepted and first closed in 1980 with no award of permanent disability. Claimant requested a hearing and was awarded 15 percent unscheduled permanent partial disability (PPD) in 1982. His claim was reopened in 1984 and remained open for the next several years. The claim was then closed again in January 1992. Claimant's award of unscheduled PPD was increased to 51 percent, and he was also granted an award of 36 percent scheduled PPD for his left leg.

In the meantime, claimant had been evaluated for vocational assistance in 1989. As a result, he was assigned to an authorized training program. In June 1989, claimant's vocational assistance program was terminated because he failed to cooperate in the development of a return-to-work plan. Claimant challenged the termination of his eligibility, but ultimately it was upheld. *See Lasley v. Ontario Rendering*, 114 Or App 543, 836 P2d 184 (1992).

In March 1992, claimant requested reconsideration of the January 1992 determination order. He raised issues of premature closure and the extent of his permanent disability to the Department of Consumer & Business Services (the Department). The Department sent the parties a notice that informed them that they could present any additional information on reconsideration. In April 1992, the Department issued an order on reconsideration that set aside the January 1992 determination order as premature. Employer requested a hearing and sought to have the January 1992 determination order reinstated. Also, claimant requested a hearing on the issue of the extent of his disability. At the hearing, the issues were limited by the administrative law judge (ALJ) to **<165 Or App 636/637>** the closure issue raised by employer. The April 1992 reconsideration order was vacated by the ALJ's order in March 1993. On appeal, the Board affirmed the ALJ's decision, and that decision was not appealed further.

After the January 1992 determination order was set aside by the Department, but before the ALJ ruled, the Department issued another determination order in February 1993. Claimant requested reconsideration of that order, but before the reconsideration process was completed, the hearings division reinstated the January 1992 determination order. Left unresolved was the extent of the disability. The Department then issued an order on reconsideration in April 1993 in which it declined to complete the reconsideration of the February 1993 determination order. Neither party requested a hearing on that order, and it became final by operation of law.

In March 1994, claimant filed a new request for hearing on the extent of disability and sought permanent total disability. That request for hearing led to the proceeding at issue here. The hearing on claimant's request began in August 1995. By that time, ORS 656.283(7) had been amended by Oregon Laws 1995, chapter 332, section 34. That amendment made evidence regarding the extent of disability

inadmissible at hearing unless the evidence had been submitted on reconsideration. Aware of the impediment to admitting additional evidence as the result of the retroactive effect of the amendment, the ALJ proceeded with the hearing, limiting the record to that presented to the Department on reconsideration. Claimant objected, arguing that he had been deprived of due process because of the amendment. In response, the ALJ permitted the parties to introduce additional documents and testimony as offers of proof but limited the offers of proof to the direct examination of witnesses. Included in the offer of proof by employer was the testimony of SAIF's vocational expert, Stipe. Ultimately, the ALJ concluded that he had jurisdiction to review the January 1992 and February 1993 determination orders. In his decision on the merits, he modified the determination order and denied claimant's request for permanent total disability (PTD).

165 Or App 638> Claimant appealed to the Board, and it adopted the ALJ's order with supplementation. The Board ruled that it was unnecessary to address claimant's constitutional argument concerning the retroactive application of ORS 656.283(7) because, after having considered the excluded evidence, it found that the evidence in the offers of proof would not have changed its conclusion about the claim for PTD. Specifically the Board said:

> "Claimant relies on the opinion of Dr. Carroll, his current family physician, who stated in February 1995 that claimant will never be able to perform employment due to his physical pain and related depression. Dr. Dahlin subsequently concurred with Dr. Carroll's assessment. In addition, claimant relies on his own testimony and the testimonies of his wife and vocational expert, Mr. Hughes, who opined that claimant is unable to engage in gainful employment due to his physical limitations and psychological difficulties. Mr. Hughes also opined that claimant was employable in 1993.
>
> "Notwithstanding the medical opinions declaring claimant unemployable in 1995 (and in 1993), we find that claimant was not medically incapacitated from obtaining and performing work in 1989 and 1991. We base our finding on the contemporaneous opinions of Dr. Dahlin, who reported that claimant was capable of light to sedentary employment in 1989 and capable of sedentary employment in 1991. Yet, claimant did not cooperate with the development of a return-to-work plan in 1989, resulting in termination of vocational assistance and potential retraining, and there is no evidence that he has made any further efforts to obtain employment.
>
> "For these reasons, even if we considered the evidence excluded by the ALJ, we would still find that claimant has not carried his burden of proving that he is willing to seek employment and that he has made reasonable efforts to obtain employment. Accordingly, we agree with the ALJ that claimant is not entitled to permanent total disability benefits." (Exhibit references omitted.)

On review to this court, claimant reiterates his due process argument. In *Koskela v. Willamette Industries, Inc.*, 159 Or App 229, 978 P2d 1018, *rev allowed* 329 Or 318 (1999), **<165 Or App 638/639>** we held that the claimant's due process rights were not violated by the application of ORS 656.283(7), which, as amended by Oregon Laws 1995, chapter 332, section 34, makes evidence regarding the extent of disability inadmissible in the hearing process if it "was not submitted at the reconsideration required by ORS 656.268[.]" The constitutional challenge in *Koskela* was a facial attack, and we expressly left open the question whether the retroactive effect of the 1995 amendment could result in a deprivation of due process where the claimant's opportunity to present evidence in the reconsideration process had passed but the hearing process was not complete at the time that the amended statute took effect. *See Koskela*, 159 Or App at 241 n 7. This case presents that question.

Whether a statute denies due process as applied depends on the particular circumstances of each case. *Mathews v. Eldridge*, 424 US 319, 96 S Ct 893, 47 L Ed 2d 18 (1976). Claimant argues that he was denied due process because he was not given the opportunity to cross-examine SAIF's vocational expert. The ALJ told the parties that the offer of proof "will be for the purpose of allowing each party to put on the best of its evidence" without being subject to cross-examination. He explained, "I'm only required to have each of you provide me with a statement of what your witnesses would say. But I am willing to let your witnesses have their say." Counsel for SAIF responded to the ALJ, "[t]he only witness I have is a vocational expert." Thereafter, claimant's counsel moved to prevent SAIF from making any offer of proof because "they're not taking the position that any additional evidence should come in." The ALJ responded that either party could put on an unrestricted offer of proof that would not be subject to cross-examination.

Claimant then called himself, his wife, and his expert witness, Hughes, as his witnesses in his offer of proof and rested. He offered no testimony from SAIF's expert, Stipe, although the ALJ's ruling would have permitted him to call Stipe as his own witness. SAIF then offered a videotape of claimant, a photograph of claimant's residence and the testimony of Stipe. Also, both parties offered written exhibits as part of the offers of proof. The issue then is whether, under these circumstances, claimant has been denied due process **<165 Or App 639/640>** in presenting his claim for permanent total disability by the retroactive effect of ORS 656.283(7) in light of the fact that the Board considered the evidence in the offers of proof.

ORS 656.206(3) provides:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

Under the statute, claimant must prove that, "but for the compensable injury, [he] (1) is or would be willing to seek gainful employment and (2) has or would have made reasonable efforts to obtain such employment" unless seeking such work would have been futile. *SAIF v. Stephens*, 308 Or 41, 48, 774 P2d 1103 (1989).

The record on reconsideration and claimant's testimony in his offer of proof are uncontroverted that he has not made any effort to work from 1985 to 1995.

"Q[:] When is the last time you worked?

"[Claimant:] '85.

"* * * * *

"Q[:] How come haven't you worked since 1985?

"[Claimant:] I was never released from the doctors. And after my surgery, instead of being better, I got worse.

"Q[:] Have you wanted to return back to work?"

"[Claimant:] Yes, I have.

"Q[:] Why haven't you even though you wanted to?

"[Claimant:] On account of, I'm unable to.

"Q[:] How come you are unable to return back to work?

"[Claimant:] Just deterioration and confusion."

Before the Board, claimant relied on the opinion of Dr. Carroll who stated in February 1995 that claimant would never be able to perform gainful employment due to his physical pain and related depression. Dr. Dahlin concurred with Dr. Carroll's assessment in a letter dated March 1994, which was considered by the Board as part of claimant's offer of **<165 Or App 640/641>** proof. The Board was not persuaded by that evidence. It expressly based its ruling on Dr. Dahlin's opinions in 1989 and 1991 that claimant was able to work at that time in addition to the fact that he had not cooperated with vocational assistance efforts in 1989. That evidence was not part of the offer of proof and had been part of the record on reconsideration. Because of that evidence, the Board concluded that claimant had not carried his burden of proving under *Stephens* that he was willing to seek and had made reasonable efforts to obtain employment when it would not have been futile.[1]

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[1] Claimant does not argue that the Board could not rely on his physical status and conduct between 1989 and 1991, when it concluded that he did not meet his burden under ORS 656.206(3).

Neither SAIF's expert nor claimant's expert testified about claimant's physical ability to perform work in 1989 and 1991. All of their testimony focused on job availability in 1995 in light of claimant's condition and the degree of his impairment at that time. Claimant's inability to cross-examine Stipe could not have changed the record that during part of the time in question claimant had been able to work but had not made an effort to seek work and had, in fact, been terminated from a vocational assistance program. As to claimant's offer of proof, there is nothing in the record to suggest that claimant was prevented from calling Dr. Dahlin to recant his opinion about claimant's physical status in 1989-91. Moreover, claimant himself had the opportunity to address that issue and did in fact testify that he had been unable to work since 1985. Under the circumstances, there is no due process violation that could have played any role in the Board's decision regarding claimant's failure of proof.[2]

Affirmed.

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[2] The dissent says that, although the majority opinion accurately identifies the question of whether the procedures in this case satisfied due process, it "never answers that question." 165 Or App at 642. It also says that the procedures "effectively prevented claimant from presenting any evidence of the kind in question at any stage of the process," *id.*, that the majority opinion stands for the proposition "that federal constitutional error is presumptively harmless" and that "due process was unnecessary." *Id.* at 644. As should be evident from this opinion, none of those assertions is an accurate characterization of the holding of the opinion. The opinion stands for the simple proposition that, on these facts, the cross-examination of SAIF's expert could have made no difference in the outcome before the Board.

165 Or App 642> DEITS, C. J., dissenting.

The majority correctly states:

> "In *Koskela v. Willamette Industries, Inc.*, 159 Or App 229, 978 P2d 1018, *rev allowed* 329 Or 318 (1999), we held that the claimant's due process rights were not violated by the application of ORS 656.283(7), which, as amended by Oregon Laws 1995, chapter 332, section 34, makes evidence regarding the extent of disability inadmissible in the hearing process if it 'was not submitted at the reconsideration required by ORS 656.268[.]' The constitutional challenge in *Koskela* was a facial attack, and we expressly left open the question whether the retroactive effect of the 1995 amendment could result in a deprivation of due process where the claimant's opportunity to present evidence in the reconsideration process had passed but the hearing process was not complete at the time that the amended statute took effect. *See Koskela*, 159 Or App at 241 n 7. This case presents that question." 165 Or App at 638-639.

However, notwithstanding its accurate identification of the question in the case, the majority never answers that question. I will therefore begin by doing so.

The most fundamental requirement of due process is that the procedures that are afforded to affected persons be sufficient "to insure that they are given a meaningful opportunity to present their case." *Mathews v. Eldridge*, 424 US 319, 349, 96 S Ct 893, 47 L Ed 2d 18 (1976). The procedures here did not suffice because, as applied, they effectively prevented claimant from presenting evidence of the kind in question at any stage of the process. Claimant was under no compulsion to produce the evidence at the time that the reconsideration procedures were conducted. However, by the time of the hearing, he had no opportunity to present evidence that had not been adduced at the reconsideration stage.

SAIF and employer contend that claimant *could* have presented much, if not all, of the evidence in question in the reconsideration process and that the fact that he was not *required* to do so at the relevant time in order to preserve his ability to rely on the evidence in the hearing process should **<165 Or App 642/643>** not assist him now. According to SAIF and employer, claimant "simply failed to use [the] opportunity" that was available for the presentation of evidence on reconsideration, and "due process does not guarantee 'two bites of the apple.'" However, SAIF's and employer's metaphor is inapt. The better analogy for this situation is one in which a customer chooses one apple over another at a fruit stand and, after paying for it with his last dime, is informed by the storekeeper that he is not allowed to eat it without first having eaten the other apple.

It is difficult to imagine a more effective way of defeating the right to a fair hearing than by imposing new preservation requirements for what may be presented at the hearing after it is too late to satisfy them. That is precisely what the retroactive application of the amendment to ORS 656.283(7) does under the facts here. Consequently, I agree with claimant that his right to due process of law was violated.

SAIF and employer further argue, however, that any violation of claimant's due process rights in connection with the exclusion of the evidence that he offered at the hearing was harmless, because the ALJ took offers of proof of the excluded evidence, and the Board made an "alternative" finding that, "even if we considered the evidence excluded by the ALJ, we would still find that claimant has not carried his burden of proving that he is willing to seek employment and that he has made reasonable efforts to obtain employment." Although the majority does not explicitly say so, the apparent basis for its holding is its agreement with that harmless error argument or some variation of it.

Seemingly, the harmless error argument is close to self-refuting because, as claimant points out, he was given no opportunity at the hearing to cross-examine the witnesses whose testimony his opponent offered in the offer of proof itself, let alone to cure any antecedent defects in his ability to confront the proponents of adverse evidence. Nevertheless, the majority postulates that, notwithstanding his exclusion of evidence pursuant to the amended ORS 656.283(7), the ALJ allowed the parties to "put on the best of [their] evidence" in the guise of the offers of proof. The majority then **<165 Or App 643/644>** engages in an elaborate analysis of the evidence that was before the Board, via the offers of proof or otherwise, as well as the unpursued opportunities that the offers of proof ostensibly gave claimant to present other items of evidence. Based upon its assessment of the evidence that was--or was not--advanced in the offers of proof or on reconsideration, and its assessment of the Board's response to the evidence that was before it, the majority concludes that any limitation on claimant's ability to produce or to refute evidence "could [not] have played any role in the Board's decision regarding claimant's failure of proof." 165 Or App at 641.[1]

Although some of the particulars in the majority's reasoning are elusive, its ultimate point is clear: The majority concludes that any denial of claimant's constitutional right to present his case could not have affected the result, either because he would not have presented any different evidence or cross-examination than he did even if he had been given a fair opportunity, or because the Board would have made the same decision no matter what evidence was presented to it.

In my view, the majority's reasoning stands the issue on its head. The fact that claimant was able to present only the evidence that he did through the inadequate procedures that were afforded him is not a basis for assuming that he could not have made a different or better showing if different procedures had been provided. Rather, it is a basis for assuming that the inadequate procedures interfered with claimant's ability to present his case. Because I do not share the majority's view that federal constitutional error is presumptively harmless, I do not agree with the majority that due process was unnecessary in this case and, therefore, I respectfully dissent.

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[1] I accept, for purposes of this occasion only, the correctness of the majority's unusual understanding that an offer of proof *can* serve to cure the erroneous exclusion of evidence, as distinct from performing its normal function of preserving the error for appellate review.

Cite as 166 Or App 73 (2000) March 8, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Melvin C. Woda, Claimant.
WEYERHAEUSER COMPANY, Petitioner,
v.
MELVIN C. WODA, Respondent.
(96-11475; CA A101658)

Judicial review from Workers' Compensation Board.
Argued and submitted December 28, 1998.
John M. Pitcher argued the cause and filed the brief for petitioner.
Christopher D. Moore argued the cause for respondent. With him on the brief was Malagon, Moore & Jensen.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
LANDAU, P. J.
Affirmed.
Deits, C. J., dissenting.

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166 Or App 75> At issue in this case is whether claimant's respiratory condition--a sudden allergic reaction to wood dust at work--must be analyzed as a claim for an occupational disease or as an occupational injury. Different burdens of proof pertain to occupational diseases and occupational injuries, so the distinction is significant. The Workers' Compensation Board (Board) concluded that the condition was properly analyzed as an occupational injury, because it consisted of an event that occurred suddenly in reaction to exposure to the dust. Employer seeks review of the Board's decision, arguing that, under the applicable statutes, claims arising out of exposure to dust are to be treated as occupational diseases, whether sudden in onset or not. We conclude that the Board was correct and affirm.

The relevant facts are not in dispute. Claimant began working for employer as a kiln operator in February 1996. He had worked in the same position for other employers for the previous 30 years. He suffered from long-standing seasonal allergies, with symptoms of sneezing, nasal congestion, itching of the eyes, and occasional breathing difficulties when exposed to grass. In September 1996, claimant was transferred from his position as a kiln operator to a position in a sawmill. The sawmill work exposed claimant to a significant quantity of wood dust. Immediately after starting work at the sawmill, claimant developed shortness of breath, coughing, and wheezing. The symptoms resolved within two to three hours of leaving the mill. During the first three days of work at the mill, the pattern was the same. Claimant's first weekend off, the symptoms completely disappeared, but when he returned to work the following Monday, he immediately experienced worsened shortness of breath, which prompted him to seek emergency hospital care.

Claimant was diagnosed with "acute bronchospasm," "allergic rhinitis," and allergic asthma. Claimant filed a claim based on the allergic reaction to the wood dust at the sawmill. Employer denied the claim. At the hearing on the claim, employer argued that the claim must be analyzed as an occupational disease claim based on the worsening of a preexisting disease or condition, under ORS 656.802(2)(b), **<166 Or App 75/76>** which requires that claimant establish that his work activity was the major contributing cause of the combined condition and the pathological worsening of the disease. Claimant argued that the claim must be analyzed as one for an occupational injury under ORS 656.005(7)(a)(B), which requires only that he establish that his work activity was the major contributing cause of his disability or need for treatment of the combined condition. The administrative law judge agreed with claimant and further concluded that claimant satisfied his burden under ORS 656.005(7)(a)(B).

Employer appealed to the Board, and a divided Board affirmed. The majority concluded that, in accordance with a long line of appellate court decisions, the difference between an occupational disease and an occupational injury turns on the extent to which the symptoms of a condition are gradual in onset and not attributable to a specific activity or event. In this case, the Board held, the evidence shows that claimant's condition was an immediate reaction to exposure to wood dust at the sawmill and was not gradual in onset. The Board concluded that the claim had been analyzed properly as one for an occupational injury. Two Board members dissented, arguing that ORS 656.802(1)(a) expressly defines "occupational disease" to include any disease caused by contact with dust.

On review, employer takes up the banner of the dissenting Board members. It argues that the Board's decision is directly contrary to the "plain meaning" of the definition of occupational disease in ORS 656.802(1)(a), which, it contends, shows that the legislature intended that all claims resulting from toxic exposures be treated as "diseases or infection." Claimant argues that the Board was correct and that employer's argument neglects to address the fact that the reference in ORS 656.802(1)(a) to diseases caused by exposure to dust necessarily incorporates the definition of "disease" that has been used by the courts consistently for many years and never altered by the legislature, namely, that a disease is a condition the symptoms of which develop over a period of time and are not sudden in onset.

We acknowledge at the outset that the issue is a difficult one and that we are benefitted by the careful consideration that all members of the Board and the parties have <166 Or App 76/77> devoted to it. Having said that, we conclude that the Board majority and claimant have the better of the argument.

Our analysis begins with the text of the relevant statute in its context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). That analysis includes consideration of the Supreme Court's prior construction of the statute, which, the court instructs us, becomes part of the statute itself. *Stephens v. Bohlman*, 314 Or 344, 350 n 6, 838 P2d 600 (1992). It also includes consideration of prior versions of the statute. *Krieger v. Just*, 319 Or 328, 336, 876 P2d 754 (1994).

What is now ORS 656.802(1) dates back to 1959, when an occupational disease was defined as

> "[a]ny disease or infection which arises out of and in the scope of employment, and to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

ORS 656.802(1) (1959). That version of the statute did not define the term "disease," much less identify the distinction between a "disease" and an "injury" as those terms are used in the workers' compensation statutes. We first addressed that question in *O'Neal v. Sisters of Providence*, 22 Or App 9, 537 P2d 580 (1975). In that case, we adopted the distinction articulated in Professor Larson's treatise on workers' compensation law:

> "'What set[s] occupational diseases apart from accidental injuries [is] both the fact that they can[not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] gradual rather than sudden in onset.'"

Id. at 16 (quoting 1B Larson's, *Workmen's Compensation Law* section 41.31 (1973)).

In *James v. SAIF*, 290 Or 343, 614 P2d 565 (1981), the Supreme Court first addressed the question. After describing our holding in *O'Neal*--specifically our reliance on the gradual versus sudden onset distinction derived from the Larson treatise--the court declared that we were correct. *Id.* As we have noted, we must treat that construction of ORS <166 Or App 77/78> 656.802(1) as having become part of the statute. *Stephens*, 314 Or at 350 n 6.

In 1987, the legislature amended ORS 656.802, in effect, to create three categories of occupational diseases:

> "(1) As used in this chapter, 'occupational disease' means:
>
> "(a) Any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death.
>
> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.
>
> "(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

ORS 656.802(1) (1987). The statute still contained no definition of the term "disease." And nothing in the language of the amended statute or its legislative history suggests that the legislature intended to alter the judicially created definition adopted in *O'Neal* and *James*. *See Goodyear Tire & Rubber Co. v. Tualatin Tire & Auto*, 322 Or 406, 416, 908 P2d 300 (1995) (examining legislative history of related statutes as part of statutory context).

In 1990, the legislature again amended ORS 656.802(1). This time, the legislature enacted a general definition of the term "occupational disease," followed by the three categories that originated with the 1987 amendments:

> "(1) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:
>
> **166 Or App 79>** "(a) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.
>
> "(b) Any mental disorder which requires medical services or results in physical or mental disability or death.
>
> "(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death."

ORS 656.802(1) (1991). Once again, however, the legislature did not define the term "disease." And, once again, nothing in the language of the amended statute or its enactment history suggests that the legislature intended to abandon the definition of the term adopted in *O'Neal* and *James*. To the contrary, the Supreme Court held that the definition of the term--more precisely, the distinction between a disease and an injury based on the suddenness of symptom onset--survived the enactment of the 1987 and 1990 amendments.

In *Mathel v. Josephine County*, 319 Or 235, 875 P2d 455 (1994), the court addressed the question whether the claimant's stress-induced heart attack must be analyzed as an occupational disease or an occupational injury. The court began by noting that the legislature did not define either the term "injury" or the term "disease." The court referred to ordinary dictionary definitions of the terms that describe an injury as a discrete event and a disease as an ongoing condition or state of the body or mind. *Id.* at 240 (citing *Webster's Third New Int'l Dictionary*, 648, 1164 (unabridged ed 1993)). The court then remarked that those definitions suggest that a heart attack is an injury, because it is a discrete event, rather than an ongoing condition.

The court then turned to its decision in *James*:

> "That conclusion [that a heart attack is an injury] is consistent with this court's decision in *James v. SAIF*, 290 Or 343, 614 P2d 565 (1981). In that case, this court considered the difference between 'injury' and 'disease' under the Workers' Compensation Law and adopted the following distinction:
>
> "'"What set[s] occupational diseases apart from accidental injuries [is] * * * the fact that they [are] gradual **<166 Or App 79/80>** rather than sudden in onset. * * *"' *Id.* at 348 (quoting 1B Larson's Workmen's Compensation Law section 41.31 as cited in *O'Neal v. Sisters of Providence*, 22 Or App 9, 537 P2d 580 (1975))."

Mathel, 319 Or at 240; *see also Fuls v. SAIF*, 321 Or 151, 894 P2d 1163 (1995) ("[T]his court's cases have drawn a distinction between occupational diseases and occupational injuries along the lines that occupational diseases are gradual rather than sudden in onset.").

In 1995, the legislature again amended ORS 656.802(1) so that it now reads:

> "(1)(a) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

> "(A) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.
>
> "(B) Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death.
>
> "(C) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death.
>
> "(b) As used in this chapter, 'mental disorder' includes any physical disorder caused or worsened by mental stress."

The principal changes were to add the clause "whether sudden or gradual in onset," to subsection (1)(a)(B) and to specify what is included in the term "mental disorder."

As was true of all previous amendments to the statute, the 1995 amendments do not define the term "disease." And, as was true of all previous amendments, there is nothing in the text or the history of the 1995 enactment that suggests that the legislature intended to abandon the now familiar distinction between a disease and an injury. If anything, **<166 Or App 80/81>** the amendments suggest the opposite. By adding the clause "whether sudden or gradual in onset" to subsection (1)(a)(B), the legislature expressly invoked the judicially created distinction adopted in *O'Neal* and reaffirmed in *James*, *Mathel*, and *Fuls*. The legislature expressly excepted mental disorders from the general rule that a disease within the meaning of the occupational disease statute refers to conditions the symptoms of which are gradual in onset.

In the light of the foregoing history, several things seem clear. First, the legislature never has defined the term "disease" as the term is used in ORS 656.802(1). Second, in the absence of a legislative definition, the courts have created one and have used it consistently for 25 years. That judicially created definition was adopted by the Supreme Court, and, according to Supreme Court doctrine, it became part of the statute subject to change by legislative amendment only. Third, since the adoption of that definition by the Supreme Court, the legislature has not defined the term differently and has not enacted language that is inconsistent with the judicially created definition. Instead, the subsequent amendments suggest implicit legislative adoption of the judicially created definition. In short, all the relevant interpretive considerations lead us to conclude that the Board was correct in holding that to determine whether a given condition is a disease or an injury requires examination of whether the symptoms of the condition were sudden or gradual in onset.

Employer's and the dissenting Board members' arguments to the contrary cannot be squared with the language of the statute and the manner in which it has been interpreted by the courts. Their principal contention is that ORS 656.802(1)(a)(A) requires this case to be analyzed as an occupational disease, because it commands that "[a]ny disease or infection caused by * * * inhalation of or contact with dust" is an occupational disease. Thus, they argue, any disease caused by inhalation of dust applies, whether sudden or gradual in onset. The argument, however, neglects to consider that the word "any" still modifies the term "disease," which has been construed to mean only conditions the symptoms of which are gradual in onset.

166 Or App 82> For similar reasons, employer's and the dissenting Board members' other arguments are unavailing. They argue, for example, that the reasoning of the Supreme Court in its *Fuls* decision suggests that "[a]ny disease" means any disease however sudden its onset. In *Fuls*, the court addressed whether the claimant's mental disorder must be analyzed as an occupational disease or an occupational injury when it was precipitated suddenly by a single work-related incident. 321 Or at 158. The court held that, although it had adopted a distinction between a disease and an injury on the basis of the suddenness of onset, because the legislature provided in ORS 656.802(1)(b) (1990) that "[a]ny mental disorder" be regarded as an occupational disease, the usual distinction between disease and injury was rendered irrelevant. *Id.* Employer and the dissenting Board members argue that, for the same reason, the statutory reference to "[a]ny disease" caused by inhalation to dust must also be construed to apply without reference to suddenness of onset.

The argument, however, ignores the fact that the reference to "[a]ny disease" in ORS 656.802(1)(a)(A) retains the use of the term "disease," which is a term that has acquired a specific definition that cannot simply be ignored. The term "mental disorder" has not acquired the same definitional patina. Thus, the court's reasoning in *Fuls* is inapplicable.

Chief Judge Deits adopts the reasoning of employer and the dissenting Board members, but she offers additional arguments, which we also find unpersuasive. The linchpin of her dissent is her assertion that we conflate the terms "disease" and "occupational disease." According to Judge Deits, the existing case law defines only the term "occupational disease," and that term has since been superseded by the more recent amendments to the statute. Therefore, she concludes, the prior case law does not constrain the proper interpretation of the statute. *See* 166 Or App at 85. With respect, Chief Judge Deits simply is incorrect.

The prior case law construed the term "disease" as it is used in the term "occupational disease." *Mathel* makes that point clear in concluding that the dictionary definition of the **<166 Or App 82/83>** term "disease" is consistent with what the court had said earlier in James, in which "this court considered the difference between 'injury' and 'disease' under the Workers' Compensation Law." *Mathel*, 319 Or at 240. Thus, we have conflated nothing, but rather have adhered to the definitional distinctions that are clearly described in the relevant cases.

In a similar vein, Chief Judge Deits complains that we have ignored the definition of "disease" adopted by the Supreme Court in *Mathel*. 166 Or App at 85-86. To the contrary, we have cited and applied Mathel, which held that the dictionary definition of the term "disease" that it described was entirely consistent with the definition that it had applied in *James*. *Mathel*, 319 Or at 240. Indeed, if the definition of "disease" adopted by the court in *Mathel* did not change the law--as the court itself took pains to emphasize--we are hard pressed to understand how the decision somehow frees us from the constraints of prior definitions of occupational "disease," as Chief Judge Deits suggests.

We conclude that the Board did not err in holding that claimant's condition must be analyzed as an occupational injury under ORS 656.802(1)(a)(A).

Affirmed.

DEITS, C. J., dissenting.

As the majority acknowledges, this case presents a close question of law. In my view, however, after considering the text and context of the pertinent statute, the Board's dissenting opinion has the better argument.

The question here is whether the compensability of claimant's condition should be assessed as an injury, under ORS 656.005(7)(a)(B), or as an occupational disease under ORS 656.802(2)(b). As the majority points out, that makes a significant difference here because, if the compensability of the claim is assessed as an injury, claimant must prove that his work activity was a material contributing cause of his disability or need for treatment of the combined condition. On the other hand, if the claim is assessed as an occupational disease, claimant faces the more difficult burden of proving that his work activity was the major **<166 Or App 83/84>** contributing cause of the combined condition and the pathological worsening of the disease.

The statutory language that we must interpret, ORS 656.802(1), provides:

> "(1)(a) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:
>
> "(A) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.
>
> "(B) Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death.
>
> "(C) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death.
>
> "(b) As used in this chapter, 'mental disorder' includes any physical disorder caused or worsened by mental stress."

The majority concludes that, although the term "disease" is not defined in ORS chapter 656, well accepted definitions of the terms "occupational injury" and "occupational disease" have developed in our

case law. Under those definitions, the decision whether a condition is a disease or an injury depends on whether the symptoms of the condition are gradual or sudden in onset. The majority holds that, in order to come within the terms of ORS 656.802(1)(a)(A), a condition must satisfy the definition of occupational disease found in the case law. In other words, in order to be considered an occupational disease under ORS 656.802(1)(a)(A), the symptoms of the condition must have been gradual in onset. Here, of course, the symptoms were sudden in onset and, consequently, under the majority's view, the claim must be assessed as an occupational injury under ORS 656.005(7)(a)(B).

166 Or App 85> The majority's holding is a plausible reading of the statutory language. However, in my opinion, the text and context of the statute support a different understanding of what is included as an occupational disease under this subsection of the statute. First, looking at the text of the statute, an occupational disease is defined by the *entire* subsection. That includes both the general definition set out in subsection (1)(a) as well as the three specific categories included in subsections (A) through (C) of subsection (1)(a). One of those categories is, of course, the one at issue here, which specifically includes as an occupational disease:

> "(A) Any *disease* or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances."

ORS 656.802(1)(a)(A) (emphasis added).

The majority's interpretation of the term "disease," as used in subsection (1)(a)(A), gives it the same meaning as the term "occupational disease" as generally used in our case law. The majority is essentially defining the term "occupational disease," as used in subsection (1)(a), by using the term "occupational disease." It seems unlikely that that is what the legislature intended. Further, under the majority's interpretation of "disease," as used in ORS 656.802(1)(a)(A), the remaining language of the subsection becomes completely unnecessary because a condition that is gradual in onset and caused by dust, fumes, vapors, gases, radiation, or other substances, is already covered by the general definition of an occupational disease. Presumably, by adding the language listing specific categories of conditions to be included in the general definition of occupational diseases, the legislature meant to add conditions that may not otherwise come within the general definition of "occupational disease" as found in ORS 656.802(1)(a).

The majority appears to believe that it has no other choice but to use the definition of occupational disease found in our case law. However, in addition to the fact that, as discussed above, the legislature included language adding specific categories to the definition. Thus, the majority's definition of "disease" is not the only definition of "disease" available. As the dissenting opinion of the Board points out, **<166 Or App 85/86>** in the Supreme Court's decision in *Mathel v. Josephine County*, 319 Or 235, 875 P2d 455 (1994), in discussing whether the condition there was a "disease" or an "injury," the court used the definition of disease found in *Webster's Third New Int'l Dictionary* (unabridged ed 1993), which defines a disease as:

> "any impairment of the normal state of the living animal or plant body or any of its components that interrupts or modifies the performance of the vital functions, being a response to environmental factors (as malnutrition, industrial hazards, or climate) * * *." *Id.* at 648.

As the Supreme Court did in *Mathel*, it is reasonable here to interpret the term disease as used in ORS 656.802(1)(a)(A) in this general sense. That understanding of the term is completely consistent with the text and context of the statute. In adding subsections (A) to (C) to ORS 656.802(1)(a), it is apparent that the legislature intended to require that the categorization of certain types of conditions as occupational diseases or occupational injuries be determined differently from the traditional analysis, which focuses on whether the onset of the injury is gradual or sudden. The language of subsection (A) clearly indicates that, with respect to conditions caused by the ingestion, absorption, contact with or inhalation of specified substances, the legislature intended the focus to be on the *cause* of the condition.

In *Mathel*, the Supreme Court recognized exactly that. It stated that there are some conditions for which the categorization of the condition as a disease or an injury does depend on the cause of the condition, citing ORS 656.802(1)(a)(A). The court stated:

> "Under the Workers' Compensation Law as a whole--that is, with respect to both 'injury' claims and 'occupational disease' claims--workers make claims for accidental injuries or occupational diseases, not for the causes of those accidental injuries or occupational diseases. *See* ORS 656.005(7)(a) (providing in part that a 'compensable injury' is an accidental injury meeting certain criteria); ORS 656.802 (providing **<166 Or App 86/87>** in part that an 'occupational disease' is a disease or infection meeting certain criteria). *Some provisions of the Workers' Compensation Law expressly describe certain causes, which are differentiated from the concepts of 'compensable injury' and 'occupational disease.' See* ORS 656.005(7)(b) ('compensable injury' does not include injuries caused by various activities such as consumption of alcoholic beverages); ORS 656.802(1)(a) (*'occupational disease' includes diseases or infections caused by ingestion, absorption or inhalation of, or contact with, various substances*)." *Id.* at 242 (emphasis added).

My interpretation of ORS 656.802(1)(a)(A) is also supported by the fact that the Supreme Court reached a similar conclusion with respect to subsection (B) of ORS 656.802(1)(a). In *Fuls v. SAIF*, 321 Or 151, 894 P2d 1163 (1995), the claimant was seeking compensation for a mental disorder that he alleged was caused by a distinct work incident. The claimant attempted to rely on the general case law distinction between occupational injuries and diseases in arguing that his condition should be analyzed as an injury. The court rejected that argument, concluding that the definition of an occupational disease in ORS 656.802(1)(a)(B) included any mental disorder without regard to the suddenness of the condition's onset:

> "Claimant argues that, despite the language of ORS 656.802, a 'sudden onset injury in the form of a mental disorder' should not be analyzed under ORS 656.802 but, rather, should be treated as an 'injury,' as defined in ORS 656.005(7). It is true that this court's cases have drawn a distinction between occupational diseases and occupational injuries along the lines that occupational diseases are gradual rather than sudden in onset. *See, e.g., James v. SAIF*, 290 Or 343, 624 P2d 565 (1981) (so indicating); *see also Mathel*, 319 Or at 240-42, (citing *James*, noting that heart attack was sudden onset condition, and rejecting argument that it was an occupational disease). However, ORS 656.802(1)(b) specifically includes '[a]ny mental disorder' within the definition of 'occupational disease,' without regard to the suddenness of its onset." *Fuls*, 321 Or at 158.

The majority acknowledges the holding in *Fuls*, but concludes that subsection (A) is different from subsection (B), because subsection (A) refers to "any disease" while subsection (B) does not. As discussed above, the majority reasons that, by using the term disease in subsection (A), the legislature intended that we must use the accepted case law definition of disease. However, for the reasons discussed above, we are not compelled to use that definition in interpreting subsection (B). The court's reasoning in *Fuls*, that the specific categories of conditions included in subsections (A) through (C) of ORS 656.802(1)(a) are *part of* the definition of an occupational disease under that statute, is directly applicable here. Under ORS 656.802(1)(a)(A), conditions caused by the ingestion, inhalation, absorption or contact with certain substances are occupational diseases regardless of the suddenness of the onset of the condition.

The final point that the majority relies on to support its conclusion is the fact that, in 1995, the legislature added the language "whether sudden or gradual in onset" to subsection (B). The majority reasons that, because similar language was not added to subsection (A), that subsection may not be read to include conditions with symptoms that are sudden in onset. However, as the Board's dissenting opinion notes, the addition of this language was essentially meaningless because the court, in *Fuls*, had already concluded before the language was added that the subsection included conditions where the onset was sudden.

I would hold that ORS 656.802(1)(a)(A) applies to any claim for a condition caused by the ingestion, absorption, inhalation or contact with dust, fumes, vapors, gases, radiation or other substances, regardless of the onset of the condition. Consequently, in my view, the claim here must be analyzed as an occupational disease. Because claimant here did not establish a compensable occupational disease, I would reverse the Board and uphold the employer's denial. For all of the above reasons, I respectfully dissent.

Cite as 166 Or App 145 (2000) March 8, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

THOMAS WILLIAMS, Respondent,
v.
AMERICAN STATES INSURANCE COMPANY, Appellant.
(9712-10069; CA A102719

Appeal from Circuit Court, Multnomah County.
Kristena A. LaMar, Judge.
On respondent's Petition for Reconsideration filed October 12, 1999. Former opinion filed September 29, 1999.
Steven A. Kahn for the petition.
Brian J. Scott, *contra.*
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Petition for reconsideration allowed; opinion adhered to.

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166 Or App 147> Plaintiff has petitioned for reconsideration of our previous decision, in which we held that the trial court should have deducted $8,600, the full amount of his workers' compensation settlement, from the $14,375 arbitration award on his claim under the uninsured motorist coverage of defendant's policy. We accordingly reversed the trial court's judgment and remanded for entry of an amended judgment. *Williams v. American States Ins. Co.*, 163 Or App 179, 986 P2d 1260 (1999). We allow the petition but adhere to our decision for the reasons set forth below.

The primary issue litigated both at trial and on appeal was whether, under ORS 742.504(7)(c)(B) or the terms of defendant's insurance policy, the workers' compensation settlement should be deducted from the limits of the uninsured motorist policy or from an arbitrators' award that was less than the policy limits. We held that the proper deduction was from the arbitrators' award. In a footnote, we observed that plaintiff had raised an issue on appeal that he had not raised to the trial court--that the settlement may have included compensation for some elements of loss that were different from those that the award covered.[1] Because defendant's policy prohibits double recoveries only for the same element of loss, the result, if plaintiff were correct, would be to limit the deduction under the policy. In rejecting plaintiff's argument, we explained:

> "Even though plaintiff won below, there is no basis for saying that the arbitrators' award does not compensate him for the same damages that the workers' compensation settlement did. In these circumstances, we cannot say that the **<166 Or App 147/148>** trial court was right (or at least partially right) for the wrong reason."

163 Or App at 183 n 4.

Plaintiff raises two separate but related arguments in his petition for reconsideration. He argues initially that he in fact raised this issue below, but he bases his argument on letters that are not part of the record. Plaintiff's initial argument is misplaced for two reasons. First, not only are the letters not part of the record, but they do not present the issue that he raises in his petition for reconsideration.

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[1] The argument plaintiff advanced in his brief on that point is limited to the following passage:

> "Plaintiff relinquished his statutory entitlement to medical care and treatment benefits for the rest of his life for any condition caused by the collision. He relinquished his statutory entitlement to total and partial disability payments, to vocational rehabilitation benefits, to an award of permanent partial disability and to any other benefits to which he was entitled under the worker[s'] compensation statutes."

Although plaintiff speculated about what the settlement might have included, he advanced no reason in his brief why the losses covered by the settlement differed from those covered by the arbitrators' award.

Second, plaintiff's argument on reconsideration misses the mark. The problem with plaintiff's previous argument was not so much that he raised it for the first time on appeal; he won below and thus may be entitled to raise new reasons on appeal in support of the trial court's ruling. *See State v. Maddox*, 165 Or App 573, ___ P2d ___ (2000); *State v. Ysasaga*, 146 Or App 74, 78, 932 P2d 1182 (1997).[2] Rather, the problem with plaintiff's argument was that he advanced no basis in his brief, and we were aware of none, for saying that the arbitrators' award and the workers' compensation settlement did not constitute duplicate payments for the same elements of loss within the meaning of the policy.

The second argument that plaintiff raises in his petition for reconsideration is closer to the mark. He explains, for the first time in his petition for reconsideration, why, in his view, the record shows that at least some of the losses included in the workers' compensation settlement do not duplicate the losses included in the arbitrators' award. Defendant takes a different position. Regardless of whether plaintiff or defendant has the better of the argument at this point, we conclude that plaintiff's contentions come too late. *See Kinross Copper Corp. v. State of Oregon*, 163 Or App 357, 360, 988 P2d 400 (1999). As we explained in *Kinross*, "[i]f a **<166 Or App 148/149>** contention was not raised in the brief, * * * it is not appropriate to assert it on reconsideration." *Id.* The contentions that plaintiff has raised in his petition for reconsideration go far beyond anything that he raised in his brief.

Another consideration supports our conclusion. Although we may affirm the trial court's ruling on a ground that was not raised below, "'[w]e may not do so if the parties were not allowed to develop the factual record at trial to address the issue raised for the first time on appeal.'" *Maddox*, 165 Or App at 576 (quoting *Ysasaga*, 146 Or App at 78) (emphasis omitted). In this case, the record is partially developed. However, because plaintiff did not raise the contentions below that he now pursues in his petition for reconsideration, defendant did not have an opportunity to develop a complete record on this issue. Even if we attempted to reach the issue and could resolve pieces of it, we have no basis for knowing what the case would look like if defendant had been put on notice of the contentions that plaintiff has raised for the first time on reconsideration. In these circumstances, we adhere to our opinion.

Petition for reconsideration allowed; opinion adhered to.

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[2] We explained in *Maddox*:

> "'We generally may affirm a ruling of the trial court on grounds different from those on which it relied, provided that there is evidence in the record to support the alternate ground. We may not do so if the parties were not allowed to develop the factual record at trial to address the issue raised for the first time on appeal.'"

165 Or App at 576 (quoting *Ysasaga*, 146 Or App at 78) (emphasis omitted).

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