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

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

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In the Matter of the Compensation of
ROBERT A. RODGERS, Claimant
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ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) found claimant entitled to interim compensation; and (2) assessed a penalty for an allegedly unreasonable failure to pay interim compensation. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We first note claimant's request for oral argument. Granting such a request is solely within the Boards discretion. OAR 438-011-0015(2). 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 deny the request for oral argument. *See Glen D. Roles*, 45 Van Natta 282, 283 n. 2 (1993).

Entitlement to Temporary Disability

Claimant has an accepted claim for a "herniated disc L4-5." (Ex. 3-1). Claimant underwent surgery for the condition. On September 2, 1994, a Notice of Closure issued awarding temporary and permanent disability.

In August 1999, claimant again sought treatment for low back pain. On November 16, 1999, claimant's treating orthopedic surgeon, Dr. Lewis, released claimant from work. (Ex. 10).

In December, claimant's attorney provided a written request to SAIF to process "a new medical condition," including recurrent disc herniation at L4-5, severe post-traumatic disc degeneration and nerve root pain. (Ex. 12b). SAIF did not respond to the new medical condition request but submitted a recommendation to reopen the claim under the Board's Own Motion jurisdiction.

On January 17, 2000, claimant's attorney submitted a new medical condition claim to SAIF for a "consequential soft tissue stenosis condition." (Ex. 19). By the date of hearing, SAIF had not responded to the claim.

Relying on *John B. Graham*, 51 Van Natta 1740 (1999), the ALJ found that, although claimant's aggravation rights had expired, claimant was entitled to interim compensation pending acceptance or denial of the new medical condition claim. On review, SAIF challenges this conclusion. SAIF first asserts that the claimant did not perfect a new medical condition claim because: (1) the recurrent disc herniation condition is only a worsening of the accepted condition; (2) the severe post-traumatic disc degeneration condition is encompassed by the previous acceptance; (3) nerve root pain is only a description of symptoms and not an actual condition; and (4) the consequential soft tissue stenosis condition preexisted the initial claim and so is not new.

Under ORS 656.262(7)(a), a new medical condition: (1) arises after acceptance of an initial claim; (2) is related to an initial claim; and (3) involves a condition other than the condition initially accepted. *Johansen v. SAIF*, 158 Or App 672, 680 (1999). Specifically, in *Johansen*, the court found that the carriers acceptance of a herniated disc following its acceptance of an acute low back strain obligated it to provide benefits under ORS 656.262(4)(a) rather than 656.273 because the herniated disc condition constituted a new medical condition rather than a worsening of the accepted condition.

Here, based on the medical evidence in this particular record, we agree with claimant that the recurrent herniated disc condition qualifies as a "new medical condition." Dr. Lewis explained that this condition was to some extent "a separate condition from his L4-5 disc herniation of 1993, and in some respect it is related." (Ex. 14). Dr. Lewis also stated that, following the 1993 surgery, claimant had a staph infection and this "left a significant postoperative degeneration of the area" and "set up the current conditions which allowed for the disk to herniate on a recurrent basis." (Ex. 16). Based on this evidence in this particular record, we find that the recurrent disc herniation condition arose after the initial acceptance, and is related to the initial claim but is different from the condition accepted.

Thus, because we conclude that the recurrent disc herniation condition qualifies as a "new medical condition" claim, we need not address whether the remaining conditions also come under ORS 656.262(7)(a). We turn to whether claimant is entitled to interim compensation.

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). Such entitlement includes new medical condition claims. *Labor Ready, Inc. v. Mann*, 158 Or App 666, 669 (1999). 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).

SAIF argues that, even if claimant perfected a new medical condition claim, he is not entitled to interim compensation because his aggravation rights have run. SAIF contends that *John R. Graham* does not require the result reached by the ALJ because the Board in that case decided that the claim had to be reopened and did not address the specific issue of interim compensation.

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.

Based on statutory interpretation, 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 held 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, whether or not aggravation rights had expired on the original claim. 51 Van Natta at 1745.

We see no reason why this new medical condition claim should be treated differently than the one in *Graham*. That is, we find no reason why the fact that the claim in *Graham* was accepted and the Board ordered it reopened under ORS 656.262 means that this new medical condition claim, which has not yet been accepted or denied, means that it also does not come under ORS 656.262. Benefits provided under ORS 656.262 include temporary disability and interim compensation. *See* ORS 656.262(4)(a). As explained above, the court has held that a new medical condition is entitled to interim compensation. Consequently, the new medical condition claim here must be processed under ORS 656.262, entitling claimant to interim compensation.[1]

Thus, for the reasons discussed in *Graham*, we conclude that, as a new medical condition claim, claimant is entitled to interim compensation even though his aggravation rights have expired. As claimant concedes, because the treating physician did not authorize time loss until November 16, 1999, interim compensation begins on that date. *See Fred Meyer v. Bundy*, 159 Or App 44 (1999).[2]

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[1] We find no merit to SAIF's argument that, because claimant would not be substantively entitled to interim compensation for his aggravation claim, he is not entitled to such benefits for a new medical condition. Because the new medical condition claim is processed under ORS 656.262 rather than 656.273, whether or not aggravation rights have expired, we do not look to any substantive entitlement under the aggravation claim in deciding this issue.

[2] Claimant also argues that the holding in *Bundy* will be reversed in *Menashe Corp. v. Crawford*, 164 Or App 174 (1999), and is preserving this issue in order to be able to argue that time loss is due as of September 3, 1999.

Penalties and Attorney Fees

The ALJ assessed a penalty after deciding that *Graham* was "on all fours" and SAIF's disagreement with its holding did not rise to the level of legitimate doubt. SAIF also contests this conclusion.

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.

Here, although we have found that *Graham* applies to this case, SAIF correctly asserts that we had not addressed the specific issue of entitlement to interim compensation in new medical condition claims preceded by an original claim with expired aggravation rights. In the absence of such authority, we find that SAIF had a legitimate doubt as to its legal liability for interim compensation. *See, e.g., Richard R. Elizondo*, 47 Van Natta 377 (1997). Thus, we do not assess a penalty.

Finally, claimant requests an attorney fee of $3,000 for services on review. SAIF opposes the request, asserting that it is not reasonable under the factors set forth in OAR 438-015-0010(4). SAIF contends that a fee of $1,000 to $1,200 is more reasonable.

We agree with SAIF. In particular, although the legal issues were complex, the value of the interest was minimal because the case involved only interim compensation. Although providing skillful argument, claimant's respondents brief was of average length and a small portion addressed the penalty issue, for which claimant does not receive an attorney fee. Based on these factors, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by SAIF.

ORDER

The ALJ's January 27, 2000 order is affirmed in part and reversed in part. That portion assessing a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the SAIF Corporation.

July 7, 2000 Cite as 52 Van Natta 1245 (2000)

In the Matter of the Compensation of
CARTER G. HART, Claimant
WCB Case No. 97-07993
ORDER OF DISMISSAL
Ransom & Gilbertson, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Claimant requested Board review of Administrative Law Judge (ALJ) Lipton's April 17, 2000 order that upheld the SAIF Corporation's denial of his occupational disease claim for a mental disorder. Claimant's attorney has advised us that claimant has died while this case was pending Board review. Counsel is further unaware of any beneficiaries statutorily authorized under ORS 656.218 and ORS 656.204 to pursue a claim based on the decedent's occupational disease claim.

Based on these unrebutted representations, we conclude that there are no statutory beneficiaries authorized to further pursue the deceased worker's claim. Accordingly, the request for Board review is dismissed. *SAIF v. Balcom*, 162 Or App 325 (1999); *Timothy D. Stone*, 50 Van Natta 2421 (1998).

IT IS SO ORDERED.

In the Matter of the Compensation of
QUINA F. TUCKER, Claimant
WCB Case No. 99-08144
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of her medical services claim for a cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable cervical and dorsal injury on August 25, 1992, while washing windows as a housekeeper. Dr. Skotte, an osteopath, diagnosed cervical/dorsal myospasm. (Ex. 6). SAIF accepted the claim as a "nondisabling" cervical and thoracic "strain." (Ex. 13).

Claimant, on occasion, was also treated by another osteopath, Dr. Eschelbach, who practiced in the same clinic as Dr. Skotte. Dr. Eschelbach had x-rays taken in March 1993, when claimant reported a recurrence of numbness and tingling in the left hand. (Ex. 15). Dr. Eschelbach interpreted the film as showing cervical spondylolisthesis. An MRI was taken and revealed small posterior disc protrusions at C4-5 and C5-6 and minimal bulging at C6-7. The radiologist, Dr. Jett, indicated there was no apparent cord impingement, compression or displacement and no stenosis. (Ex. 16).

Dr. Newby, a neurosurgeon, evaluated claimant's cervical condition in April 1993 and concluded that the plain films of claimant's cervical spine were "unremarkable," with minimal degenerative changes. (Ex. 17-2). According to Dr. Newby, the MRI showed only slight bulging of the cervical discs at the 4-5, 5-6 and 6-7 levels. Dr. Newby diagnosed a chronic cervical strain. (Ex. 18).

The claim was eventually reclassified to "disabling" in September 1993. (Ex. 24). Claimant, in the meantime, received treatment from a physical medicine and rehabilitation specialist, Dr. Stewart, and Dr. Belza, a neurosurgeon, for ongoing chronic neck pain. A repeat MRI scan of the cervical spine was performed in April 1994 and was interpreted as "normal," except for a small paramedian extrusion at C4-5. (Ex. 39). Because of claimant's persistent neck pain and reports of numbness in the upper extremities, another cervical MRI was taken in January 1995. (Ex. 53). The radiologist, Dr. Drutman, reported that there was no significant change from the April 1994 MRI scan.

On February 13, 1995, the claim was closed by Notice of Closure that awarded 11 percent unscheduled permanent disability. (Ex. 55). Claimant requested reconsideration that resulted in a medical arbiter's examination by Dr. Marble. (Ex. 58). Although he had no x-rays available for review, Dr. Marble interpreted the MRI reports as describing changes consistent with early degenerative disc disease at C4-5, C5-6, and C6-7. (Ex. 58-5). On August 25, 1995, an Order on Reconsideration reduced claimant's permanent disability award to zero. (Ex. 59-2).

In December 1995, the Board approved a Claim Disposition Agreement (CDA), in which claimant released her rights to compensation for "all past, present, and future conditions, except compensable medical services," for a specific sum of money. (Ex. 60).

Thereafter, there are no records of medical treatment present in the record until January 1999, when claimant sought treatment for neck pain. Dr. Eschelbach assumed care of claimant, reporting on January 26, 1999 that he had been "retaking care" of claimant since September 1998. Dr. Eschelbach diagnosed an acute flare of cervicodorsal myospasm. (Ex. 64).

In the ensuing months, claimant also reported left shoulder pain, for which Dr. Eschelbach referred claimant to Dr. Belza. In May 1999, Dr. Belza reported a history that claimant had neck pain and arm symptoms that had not changed over time, but that, in July 1998, claimant had fallen to the ground and scraped her nose. Dr. Belza wrote that this had aggravated symptoms in the second and third fingers of the hands. (Ex. 72). Diagnosing left shoulder pain, Dr. Belza recommended another MRI scan of the cervical spine to determine whether claimant had aggravated her cervical condition. That MRI revealed small protrusions at C4-5 and C5-6. (Ex. 74).

In June 1999, Dr. Eschelbach requested approval of palliative care. (Ex. 79).

Dr. Belza opined on June 21, 1999 that claimant's neck symptoms and cervical radiculopathy had been aggravated by the July 1998 fall. According to Dr. Belza, the left shoulder symptoms were a "new" condition. (Ex. 80).

In July 1999, SAIF disapproved the palliative care request. (Ex. 83). Claimant then returned to Dr. Skotte's care in September 1999. (Ex. 94). In October 1999, claimant requested a modified Notice of Acceptance to include a C4-5 disc protrusion, ulnar nerve pain, left shoulder pain, cervical dorsal myospasm, and cervical strain.

After an examining physician, Dr. Rich (who, along with Dr. Marble, had examined claimant on behalf of SAIF in November 1999) opined that claimant's ongoing symptoms were due to degenerative disc disease, SAIF issued a denial on December 22, 1999 of the conditions asserted to be compensable. SAIF alleged that the August 1992 injury was not the major contributing cause of the disputed conditions or of the need for treatment for these conditions. (Ex. 106). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The parties framed the issue at hearing as concerning the causal relationship between medical services for claimant's cervical dorsal myospasm and C4-5 disc herniation and her original compensable injury in August 1992.[1] The ALJ upheld SAIF's denial of medical services, finding that claimant had failed to establish that her 1992 neck injury remained the major contributing cause of the need for treatment of her cervical conditions. In so doing, the ALJ evaluated the opinions of claimant's attending physicians, Drs. Skotte and Eschelbach, who opined that claimant's current need for treatment was due to the original compensable injury, and determined that they were unpersuasive.

On review, relying on the medical opinions of Drs. Skotte and Eschelbach, claimant contends that a preponderance of the evidence establishes that her current cervical condition is compensably related to the original injury in 1992. For the following reasons, we agree with claimant's contention and conclude that claimant's current medical treatment is compensable.

In determining whether claimant's current medical treatment was compensable, the ALJ applied ORS 656.005(7)(a)(B).[2] The initial issue is whether the ALJ correctly applied the major contributing cause standard of that statute. In order for ORS 656.005(7)(a)(B) to apply, the compensable 1992 injury must have "combined" with a preexisting condition to cause or prolong disability or a need for treatment. Therefore, at a minimum, the statute requires the presence of a "preexisting condition" and a combination of that condition with the compensable injury.

The primary evidence concerning the etiology of claimants alleged degenerative condition came from Dr. Marble and Dr. Rich. In their initial report, Drs. Rich and Marble stated that all of claimant's MRI scans showed "early degeneration" at C4-5, C5-6 and C6-7. (Ex. 104-5). In a separate report, Dr. Rich later attributed claimant's cervical complaints to multi-level degenerative disease. (Ex. 105-2).

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[1] As previously noted, the parties entered into a CDA in 1995 by which claimant released her rights to all workers compensation benefits, with the exception of compensable medical services, for "all past, present, and future conditions." (1996). However, pursuant to the express terms of ORS 656.236(1) and OAR 438-009-0001(1), a CDA can have no effect on a claimant's right to future medical benefits for any condition compensably related to the accepted claim. *See Lynn Amstutz*, 50 Van Natta 1436 (1998).

[2] That statute 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."

The Rich/Marble panel, however, specifically stated that claimant's imaging studies were "not" available for review. (Ex. 104-5). Therefore, the panel's attribution of claimant's cervical condition to degenerative disease was based on an interpretation of written reports describing the findings of various MRI scans conducted throughout the course of the claim. However, the Rich/Marble panel does not explain how the reports of the various studies establish "early degeneration" of various levels of the cervical spine. Indeed, as noted by claimant, most of the reports of the multiple imaging studies show minimal, if any, degenerative disease. (Exs. 16, 17-2, 39, 53, 74).

In any event, even assuming that claimant, in fact, has significant degenerative disease in the cervical spine, the record does not establish that it preexisted the compensable 1992 injury. The Rich/Marble panel never confirmed that it did. (Exs. 104, 105, 109). Moreover, even assuming the alleged degenerative condition preexisted the 1992 injury, no physician confirmed that it "combined" with the compensable injury to cause disability or a need for treatment.

Considering the state of the medical evidence, we disagree with the ALJ's application of ORS 656.005(7)(a)(B). Because that statute does not apply, we apply a material contributing cause standard in determining whether treatment for claimant's cervical condition is compensably related to the 1992 injury. *See Albany General Hospital v. Gasperino*, 113 Or App 411 (1992); *Antonio E. Sanchez*, 50 Van Natta 967, 968 (1998); *Ronald L. Ledbetter*, 47 Van Natta 1461 (1995) (major contributing cause standard of ORS 656.005(7)(a)(B) applies only if there is evidence that a compensable injury combined with a preexisting condition).

Because of the multiple potential causes of claimant's need for treatment and the apparent gap in medical 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 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 do not find persuasive reasons not to give greater weight to the opinions of Dr. Skotte and Dr. Eschelbach, who have both treated claimant.

Dr. Skotte agreed with the contents of a concurrence letter from claimant's attorney that confirmed that claimant had treated with his office beginning in September 1992 for her upper back and neck injury. Dr. Skotte also confirmed that the diagnosis in September 1992 was cervical dorsal myospasm and that that diagnosis was still applicable. Dr. Skotte further agreed that claimant had treated periodically from September 1992 to the present and that claimant's current neck and upper back condition and need for treatment were still due to the August 1992 injury. (Ex. 107-1).

This conclusion was based on the similarity of claimant's diagnosis, complaints and findings over time, the lack of intervening injuries or incidents of a "significant" nature,[3] Dr. Skotte's assessment that claimant was a straightforward historian, and the MRI scans over the years that have shown mild protrusions at C4-5 and C5-6. (Ex. 107-2). According to Dr. Skotte, the disc protrusions "may be" responsible for claimant's ongoing symptoms and it was "possible" that the 1992 injury left scarring of the cervical/dorsal muscle tissue. Dr. Skotte confirmed, however, that, whatever the underlying cause, claimant's need for treatment was due to the original 1992 injury based on the "continuation of consistent symptoms and physical findings." *Id.*

The ALJ discounted Dr. Skotte's opinion because of the expressions of medical possibility in his concurrence letter and because the gap in medical records between the 1995 CDA and the resumption of treatment in 1999 cast doubt on the alleged continuation of consistent symptoms. We disagree with the ALJ's criticisms of Dr. Skotte's report.

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[3] We acknowledge Dr. Belza's statement that a July 1998 fall aggravated claimant's cervical symptoms. (Ex. 80). However, the record does not contain any further input from Dr. Belza apart from his brief comments in the above chart note. In addition, no other physician has attributed any significance to the July 1998 event. Under these circumstances, we do not consider the July 1998 incident to have been a "significant" intervening injury.

Although Dr. Skotte used the words "may be" and "possible," he also listed several other reasons for his conclusion that claimant's current treatment was related to the original injury, such as the consistent diagnosis, complaints and physical findings, the lack of significant intervening injuries, lack of secondary gain, and continuation of consistent symptoms and physical findings. Given these other reasons for Dr. Skotte's opinion, we do not find that the isolated references to medical possibility render Dr. Skotte's overall opinion tentative or unpersuasive.

Nor do we find the gap in medical records constitutes a break in consistent medical treatment. Claimant credibly testified that she sought treatment on a fairly regular basis between 1995 and 1999. (Tr. 15). Claimant further testified that her private insurance companies paid her medical bills during this interim period. (Tr. 14). In light of this unrebutted testimony, and Dr. Skotte's report that claimant had sought treatment periodically between 1992 and the present, we conclude that Dr. Skotte's opinion was based on an accurate history. Moreover, because it is well reasoned and based on accurate and complete information, we further find Dr. Skotte's opinion persuasive.

Dr. Skotte's opinion is supported by Dr. Eschelbach, who not only concurred with Dr. Skotte's opinion, but also concluded that the 1992 injury was the major contributing cause of the need for treatment for claimant's cervical and upper back condition. (Ex. 108). We find it significant that both Dr. Skotte and Dr. Eschelbach have the advantage of having treated claimant contemporaneously with the 1992 injury and also in connection with the current round of treatment in 1999. *See Kienow's Food Stores v. Lyster*, 79 Or App 416, 421 (1986).

The opposing medical evidence is provided by Drs. Rich and Marble. However, their initial report was contradictory in that, at one point, they attributed claimant's cervical symptoms to the compensable injury and, at another, to the alleged degenerative condition. (Ex. 104-7, 10). Although Dr. Rich subsequently clarified his opinion (Ex. 105, 109), we do not find his attribution of claimant's condition to degenerative disease more persuasive than the evidence from Drs. Skotte and Eschelbach, given that Dr. Rich did not review the actual imaging studies taken during the course of claimant's treatment. (Ex. 104-5). Moreover, Dr. Rich's opinion does not consider claimant's credible, unrebutted history that she periodically sought medical treatment from 1992 to the present, including the period from 1995 to 1999.

Accordingly, we find that a preponderance of the medical evidence proves that claimant's current medical treatment is materially related to the compensable 1992 injury.[4] Therefore, we conclude that this treatment is compensable. Thus, we reverse the ALJ's decision upholding SAIF's 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 regarding the compensability issue 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 March 13, 2000 is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,500, to be paid by SAIF.

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[4] Even if we applied the major contributing cause standard of ORS 656.005(7)(a)(b), we would still conclude that the opinions of Drs. Skotte and Eschelbach prove the compensability of claimant's current medical treatment.

In the Matter of the Compensation of
GEORGE M. BROWN, Claimant
WCB Case No. 99-04980
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's right ankle injury claim. Specifically, SAIF contends that the language in the "Order" portion of the ALJ's order is overbroad and should be corrected. In his brief, claimant moves for dismissal of SAIF's request for review and seeks imposition of sanctions under ORS 656.390 for an allegedly "frivolous" request for review. On review, the issues are whether the ALJ's order should be modified, motion to dismiss, and sanctions. We deny claimant's motion to dismiss[1] and request for sanctions and modify the ALJ's order.

FINDINGS OF FACT

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

On February 4, 1999, claimant filed a claim for a right ankle injury that allegedly occurred on January 13, 1999. SAIF denied the claim on June 7, 1999, providing the following rationale:

> "You [claimant] filed a claim for an injury to your right ankle which occurred on or about January 13, 1999, while you were employed at ***. We are unable to accept your claim for the following reasons:
>
> "You have preexisting medical conditions diagnosed as probable right ankle fracture with distal tibiofibular syndesmosis injury and advanced degenerative changes secondary to tibiotalar mismatch in the ankle mortise. *Your work injury combined with the preexisting condition(s), but your work injury is not the major cause of the combined condition.*" (Ex. 11) (emphasis added).

Claimant requested a hearing, at which time he requested that the denial be set aside and that penalties and fees be assessed. (Tr. 1).

CONCLUSIONS OF LAW AND OPINION

The ALJ first determined that an incident of injury occurred on January 13, 1999 as alleged by claimant. The ALJ then wrote:

> "The next issue is whether the fall resulted in a condition requiring medical services or disability. Claimant saw a doctor for the right ankle two weeks before the accident. X-rays showed preexisting severe arthritic changes in the ankle with moderate subtalar arthritic changes. Dr. Beaman's surgery included right ankle arthrodesis and debridement, right subtalar joint for right ankle and subtalar athrosis. Dr. Beaman concluded the January 13, 1999 injury made the preexisting condition symptomatic, but the preexisting condition was the major cause of the need for treatment or disability. This condition is not compensable." ORS 656.005(7)(a)(B).

Although finding the "combined condition" not compensable (which was the basis for SAIF's denial), the ALJ proceeded to address claimants contention that his injury caused a right peroneal tendon tear. In so doing, the ALJ rejected SAIF's contention that the compensability of this condition should not be decided because the condition was not diagnosed until after its denial and it was never asked to accept the condition. The ALJ determined that "tendon tear" was properly considered in the case because the entire claim had been denied and, thus, any evidence that established an injury on January 13, 1999 that required medical services or disability may be considered.

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[1] We agree with SAIF that there is no basis for dismissing its request for review. Thus, we deny claimant's motion to dismiss.

The ALJ then determined that claimant had proved by a preponderance of the evidence that he suffered a right peroneal tendon tear at work on January 13, 1999. Thus, the ALJ determined that the condition was compensable. In the Order portion of his Opinion and Order, the ALJ wrote:

> "SAIF Corporation's June 7, 1999 denial is set aside and the claim is remanded to the SAIF Corporation for acceptance of a right ankle peroneal tendon tear."

On review, SAIF notes the portion of the ALJ's order that upheld its denial of the "combined condition," but also observes that the order portion of the ALJ's order set aside its denial and remanded the claim for acceptance of a right ankle peroneal tendon tear. SAIF asserts that the order portion of the ALJ's order is "overbroad" and contradictory in that it set aside the denial even though the ALJ determined that the "combined condition" was not compensable. SAIF, therefore, requests that we correct the alleged contradiction in the ALJ's order.

We agree with the SAIF that the "Order" portion of the ALJ's order requires modification. Although the order remands for acceptance of the right ankle peroneal tendon tear (the only condition determined to be compensable), it also sets aside SAIF's denial without apparent limitation. This is inconsistent with other portions of the order because the "combined condition" aspect of the denial was upheld in the body of the ALJ's order. Therefore, we find that the "Order" portion of the ALJ's order should be modified to reflect that SAIF's denial is set aside to the extent that it denied a right peroneal tendon tear and that this portion of the claim should he remanded to SAIF for acceptance. The denial, however, should be upheld to the extent that it denied a "combined condition."[2]

ORDER

The ALJ's order dated March 16, 2000, for which reconsideration was denied on April 3, 2000, is modified in part and affirmed in part. The "ORDER" portion of the ALJ's order is modified to read: "SAIF's June 7, 1999 denial is set aside to the extent that it denied a right peroneal tendon tear and the claim is remanded to SAIF Corporation for acceptance and processing in accordance with law. The denial is upheld to the extent that it denied claimant's combined condition." The remainder of the ALJ's order is affirmed.

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[2] In light of our determination that the ALJ's order should be modified, it follows that SAIF's request for review was not "frivolous". Accordingly, we deny claimant's request for sanctions under ORS 656.390.

In the Matter of the Compensation of
PAUL D. HAMILTON, Claimant
WCB Case No. 99-05803
SECOND ORDER DENYING RECONSIDERATION
Jon C. Correll, Claimant Attorney
Reinisch, et al, Defense Attorneys

On June 26, 2000, we denied claimant's request for reconsideration of our May 16, 2000 Order on Review that had affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of his injury claim for a neck condition. In reaching our conclusion, we reasoned that, although claimant's request was mailed to the Board on June 15, 2000 (within 30 days of our May 16, 2000 order), we did not receive the request until June 16, 2000, which was the day after our authority to further consider our decision had expired. Relying on the "mail box rule," claimant asserts that, because his request was postmarked on June 15, 2000, his request "is lawful and within limits of the 30 day period."

As acknowledged in our previous order, claimant *mailed* his initial request for reconsideration to the Board on June 15, 2000 (within 30 days of our May 16, 2000 order). However, as explained in our prior decision, the mere act of mailing a request for reconsideration of a Board order does not suspend

the running of the 30-day statutory appeal period.[1] Instead, that 30-day appeal period continues to run unless another Board order issues within that appeal period that either withdraws, "stays," reconsiders, or otherwise modifies the initial Board order.

Here, as we previously explained in our June 26, 2000 order, claimant's request was not brought to our attention until after the 30-day statutory appeal period had expired. Thus, by that time, our authority to further consider our May 16, 2000 order had ended.

Accordingly, as supplemented herein, we adhere to our June 26, 2000 order that denied claimant's motion for reconsideration.[2]

IT IS SO ORDERED.

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[1] The "Notice of Appeal" paragraph on Page 4 of our May 16, 2000 order stated that a dissatisfied party could mail (by registered or certified mail) a petition for judicial review with the State Court Administrator. Claimant's June 15, 2000 request was mailed within that 30-day period. Nevertheless, because claimant addressed his request to the Board and entitled that request as "Claimant's Brief," we interpret his initial submission as a request for reconsideration of our May 16, 2000 order, rather than a petition to the Court of Appeals for judicial review of our order.

[2] As we observed in our June 26, 2000 order, had we retained authority to reconsider our May 16, 2000 decision, we would continue to adhere to our prior conclusion that the persuasive medical evidence does not support a determination that claimant's neck condition is compensable.

In the Matter of the Compensation of
STELLA T. YBARRA, Claimant
WCB Case No. 99-07856
ORDER OF DISMISSAL
Reinisch, et al, Defense Attorneys

Claimant, *pro se*, has requested Board review of Administrative Law Judge Crummé's May 16, 2000 order.[1] Contending that claimant neglected to provide notice of her appeal to all parties to the proceeding within 30 days of the ALJ's order, the insurer 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 May 16, 2000, the ALJ issued an Opinion and Order that: (1) upheld the insurer's denial of a right rotator cuff tear; and (2) set aside the insurer's denial of a cervical-thoracic strain. Copies of that order were mailed to claimant, claimant's then-attorney, the employer, the insurer 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 June 15, 2000, the Board received claimant's letter by certified mail requesting Board review of the ALJ's May 16, 2000 order. Claimant's request, which was enclosed in an envelope postmarked June 13, 2000, did not indicate that copies had been provided to the other parties to the proceeding.

On June 16, 2000, the Board mailed its computer-generated letter to all parties acknowledging its receipt of a request for Board review.

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[1] The order was initially issued on May 13, 2000, but was withdrawn and reissued as corrected on May 16, 2000.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *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*, 63 Or App at 853.

Here, the 30th day after the ALJ's May 16, 2000 order was June 15, 2000. Inasmuch as claimant's request for review was mailed by certified mail to the Board on June 13, 2000, within 30 days of the ALJ's May 16, 2000 order, 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 insurer's counsel's submission, the insurer's first notice apparently occurred when it received a copy of the Board's June 16, 2000 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 May 16, 2000 order.[2] 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).

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.

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[2] In the event that claimant can establish that she provided notice of her request for Board review to the other parties to the proceeding within 30 days after the ALJ's May 16, 2000 order, she 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 her submission as soon as possible.

In the Matter of the Compensation of
LARA COYLE, Claimant
WCB Case No. 99-02706
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's current right knee condition. Claimant cross-requests review of that portion of the ALJ's order that awarded a $2,500 attorney fee; claimant seeks an attorney fee award of $3,500. On review, the issues are the propriety of the denial, compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant compensably injured her right knee on May 31, 1998. On July 7, 1998, the insurer accepted a disabling right medial meniscus tear. During surgery on the knee, Dr. Kaesche found no tear of the medial meniscus. He changed his diagnosis from a tear to arthritis and strain of the right knee. Dr. Hardiman examined claimant's right knee on September 22, 1998 and believed claimant's right knee problems were related to chondromalacia. Dr. Hardiman performed an arthroscopic evaluation and debridement of the right knee on October 30, 1998.

Claimant was examined, on behalf of the insurer, by Drs. Tesar and Brooks on March 4, 1999. On March 29, 1999, the insurer corrected its July 7, 1998 acceptance, indicating that it was accepting a contusion of the right knee. (Ex. 27). On the same date, the insurer issued a denial of claimant's current right knee condition, stating that the current need for treatment of the right knee was due to preexisting early degenerative arthritis of the right knee. The denial stated that medical information indicated that claimant had recovered completely from the effects of the accepted right knee contusion. (Ex. 28). An April 28, 1999 Notice of Closure closed the claim. (Ex. 30A).

Dr. Thomas performed a review of claimant's medical records and issued a report on June 24, 1999.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the insurer issued an invalid preclosure denial of the claim. The ALJ also addressed the merits, however, and found that claimant's compensable injury remained the major contributing cause of her current right knee condition.

On Board review, the insurer argues that its denial was not an invalid preclosure denial and specifically argues that, at the time the denial was issued, the medical evidence supported a conclusion that the chondromalacia condition was separate or severable from the accepted contusion. The insurer also contends that the claim is not compensable on the merits.[1]

Generally, preclosure denials are disfavored but, if they pertain to a condition separate or severable from the accepted condition, they are procedurally valid. *See Corinne L. Birrer*, 51 Van Natta 163 *on recon* 51 Van Natta 467 (1999); *Zora A. Ransom*, 46 Van Natta 1287 (1994) (preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition).[2]

Here, the ALJ found that the evidence did not establish that the current condition was unrelated to the accepted contusion. Drs. Tesar and Brooks opined that claimant's preexisting condition combined

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[1] The insurer also argues on page 3 of its appellant's brief that no claim was ever made for chondromalacia. Because this issue was not raised before the ALJ, we are not inclined to address it. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991). In any case, the insurer issued a denial of the current right knee condition and then litigated compensability of that condition at the hearing without objection. Under such circumstances, we find that the insurer has waived any potential procedural challenge to claimant's request for hearing. *Thomas v. SAIF*, 64 Or App 193 (1983); *Ezra J. Tolman*, 52 Van Natta 310 (2000).

[2] Because the accepted condition was not a "combined" condition, ORS 656.262(7)(b) does not permit a preclosure denial. *Croman Corp. v. Serrano*, 163 Or App 136 (1999).

with her injury to prolong her condition and need for treatment. They believed that 12 weeks after the May 31, 1998 injury, claimant's symptoms from the compensable contusion would have resolved and that the major contributing cause of her current condition and need for treatment was her preexisting early arthritis. (Ex. 26-8). Dr. Kaesche, claimant's attending physician immediately after the May 1998 compensable injury, concurred with Drs. Tesar and Brooks. (Ex. 31-2).

Dr. Thomas, an orthopedic surgeon, performed a review of claimant's medical records on behalf of the insurer. Dr. Thomas opined that the preexisting condition was the major contributing cause of claimant's present need for treatment. (Ex. 33-4).

Dr. Hardiman, claimant's current attending physician, opined that claimant's compensable injury was greater than 51 percent responsible for her current condition. (Exs. 30; 32; 35-17). Dr. Hardiman first saw claimant on September 22, 1998. At his deposition, Dr. Hardiman agreed that the basis for his opinion was that claimant did not have symptoms before the injury, but did have symptoms following the injury. (Ex. 35-14).

After reviewing the medical evidence, we are not persuaded by the opinion of Dr. Hardiman. Dr. Hardiman did not examine claimant until September 22, 1998, three and a half months after the May 31, 1998 injury. In addition, based on his deposition testimony, Dr. Hardiman based his opinion regarding causation of the current condition in large part upon the temporal relationship between the injury and the symptoms. Such an opinion is unpersuasive. *See Allie v. SAIF*, 79 Or App 284, 288 (1986) (causation cannot be inferred from temporal relationship alone). The remaining medical evidence in the record does not support compensability.

Based on the persuasive medical evidence in this record, we conclude that a preponderance of the evidence (from Drs. Tesar, Brooks, Kaesche and Thomas) supports a conclusion that claimant's current right knee condition is separable from and unrelated to the accepted right knee condition. In addition, based on the same evidence, we conclude that claimant's right knee condition is not compensable. Accordingly, we find that the insurer's denial of claimant's current right knee condition is not invalid and should be upheld.[3]

ORDER

The ALJ's order dated December 9, 1999 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[3] Because we have found that the medical evidence in existence both before and after the denial issued supports our conclusion that the denial is valid, we need not address the insurer's argument that only medical evidence in existence at the time the preclosure denial issued can be considered to determine the validity of the denial.

In the Matter of the Compensation of
ROBERT J. VEGA, Claimant
WCB Case Nos. 99-00670 & 99-00079
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Claimant has requested reconsideration of our May 11, 2000 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld AIG's denial of his aggravation claim for his current right upper extremity conditions; and (2) upheld Liberty Northwest Insurance Corporation's denial of his occupational disease claim for the same conditions. On reconsideration, claimant contended that we did not "address the substantive merits of the evidence." Consequently, we withdrew our May 11, 2000 order and allowed the carriers an opportunity to respond. Having received the carriers' responses, we proceed with our reconsideration.

On reconsideration, we disagree with claimant's argument that we did not address the merits of this case. In our order, we first "adopted and affirmed" the order of the ALJ. By doing that, we have

set forth the facts and conclusions relied on in this case. *See Jorge Pedraza*, 49 Van Natta 1019 (1997); *George v. Richard's Food Center*, 90 Or App 639 (1998) (An order on review need not set forth its own findings of fact and conclusions if it affirms or adopts an administrative law judge's order that is itself sufficient for substantial evidence review). Accordingly, because we have previously considered claimant's arguments prior to adopting the order of the ALJ, and because claimant raises no new arguments on reconsideration, we adhere to our prior order.

Therefore, as supplemented 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.

July 11, 2000 Cite as 52 Van Natta 1256 (2000)

In the Matter of the Compensation of
KENNETH G. CULP, Claimant
Own Motion No. 66-0066M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On June 27, 2000, the SAIF Corporation submitted claimant's request for medical benefits relating to his November 28, 1951 spinal cord injury. SAIF recommends reopening of this claim under our Own Motion authority for the provision of home site modifications. In addition, SAIF recommends that the claim remain open until medical services are no longer required.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

In order to establish compensability of 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). Where reasonable and necessary, remodeling services to accommodate a claimant's disabilities are compensable medical services. *SAIF v. Glubrecht*, 156 Or App 339, 349-50 (1998) (holding that text and context of ORS 656.245(1)(b) revealed legislature's intent to compensate, as "prosthetic appliances, braces and supports," a quadriplegic claimant for expenses of remodeling a house to accommodate a wheelchair and other quadriplegia-related devices); *see also Stoddard v. Credit Thrift Corporation*, 103 Or App 283 (1990) (holding that the fact that the claimant who was rendered a quadriplegic as result of work-related injury would require assistance of care givers after his house was remodeled to make it more accessible did not make remodeling costs noncompensable).

Here, claimant's compensable injury resulted in partial paralysis of the lower extremities. Additionally, he developed osteomyelitis which required a below-the-knee amputation of his right leg. These injuries eventually resulted in a permanent total disability award. The modifications to claimant's home are required to assist with his everyday living and care. Considering such circumstances, we find that the requested medical services are reasonable and necessary and causally related to the compensable injury. Accordingly, claimant's claim is reopened to provide the above medical services. *See* OAR 438-012-0037.

This order shall supplement our June 26, 1992 and May 28, 1998 orders that previously reopened claimant's 1951 claim for the payment of medications, office visits, tests, medical supplies, prescriptions, prosthetic supplies, and medical treatment for claimant's right olecranon bursitis. Claimant's claim shall remain reopened to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD C. JOHNSON, Claimant
WCB Case No. 98-08935
ORDER ON REVIEW
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant, *pro se*, requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) upheld the self-insured employer's denial of his cervical disc syndrome and C6-7 disc herniation conditions as part of his May 1998 accepted cervical injury claim; and (2) found that claimant was not entitled to interim compensation benefits from February 22, 1999 through May 10, 1999. With his brief, claimant submitted copies of a medical record, a letter from the employer to claimant, and a "post-ALJ's order" letter from a physician. 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 interim compensation.

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 and that his treating physician took him off work on February 4, 1999 for surgery. 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 document dated January 7, 1999 scheduling claimant's neck surgery for February 4, 1999. The second document is a letter dated April 10, 2000 from Dr. Bert to "To Whom it May Concern" stating that claimant was off work due to his surgery on February 4, 1999 for his disc surgery. The third submission is a letter dated January 7, 1999 from the employer to claimant placing him on light duty for three months and requiring a job change as of April 7, 1999.

We are not convinced that these submissions were not obtainable with due diligence at the time of hearing, which was continued to allow the parties to submit additional evidence regarding the interim compensation issue until January 26, 2000. In other words, the record does not provide a persuasive reason why claimant could not have obtained these documents or a similar letter from Dr. Bert before the hearing and submitted the documents at that time.

In addition, even if we were to consider these documents, they would not change the result. Records of claimant's surgery were already admitted into the record. The fact that Dr. Bert had placed claimant on light duty on December 7, 1998, prior to the February 4, 1999 surgery, was already admitted into the record. (Ex. 20a-2). Finally, even if we were to consider Dr. Bert's April 10, 2000 letter indicating that claimant was off work on February 4, 1999 as an authorization of time loss, such a retroactive authorization would be ineffective.[1]

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[1] 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.*" (Emphasis supplied).

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 February 14, 2000 is affirmed.

In the Matter of the Compensation of
MIKEL T. HOLBROOK, Claimant
WCB Case No. 99-03861
ORDER ON RECONSIDERATION
John M. Pitcher, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Claimant requested reconsideration of our May 16, 2000 Order on Review that affirmed an Administrative Law Judge's (ALJ) order that upheld the self-insured employer's denial of his occupational disease claim for binaural hearing loss. To further consider claimant's motion, we abated this matter and allowed the self-insured employer an opportunity to respond. Having received the employer's response, we proceed with our reconsideration.

Claimant asserts that the "Allocation of Causes Method" used by Dr. Hodgson contains mathematical errors and therefore should not be relied upon. Instead, claimant contends that we should rely on the opinions of Dr. Doyle and Dr. Boyd. Assuming, without deciding, that claimant is correct, we continue to conclude that claimant has not carried his burden of proof.

Like the ALJ, we find the opinion of Dr. Doyle to be conclusory and not well-explained. Moreover, while Dr. Doyle opined that claimant's work exposure since 1974 were the major cause of the hearing loss condition, Dr. Doyle does not address the relevant inquiry[1], *i.e.*, was the work exposure since 1992 the major contributing cause of claimant's hearing loss condition. (Exs. 17, 19). Finally, in addition to the reasoning provided by the ALJ, Dr. Boyd's opinion suffers from a similar defect. (Exs. 16, 19A). Because neither Dr. Doyle's nor Dr. Boyd's opinion are sufficient to carry claimant's burden of proof, we continue to agree with the ALJ that the self-insured employer's denial should be upheld.

Accordingly, as supplemented herein, we adhere to and republish our May 16, 2000 Order on Review. The parties' rights of appeal shall begin running from the date of this order.

IT IS SO ORDERED.

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[1] *See SAIF v. Cessnun*, 161 Or App 367 (1999).

In the Matter of the Compensation of
MARJORIE F. KELLY, Claimant
WCB Case No. 99-04489
ORDER ON REVIEW
Walsh & Associates, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that dismissed her request for hearing regarding an alleged *de facto* denial of her cervical brachial syndrome, cervical sprain/strain and thoracic sprain/strain. In her brief, claimant argues that the ALJ failed to address compensability of those conditions. On review, the issue is propriety of the dismissal and, potentially, compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] In the first paragraph of the findings of fact, we change the date in the second sentence to "February 3, 1998." In the third full paragraph on page 2, we replace the seventh and eighth sentences with the following:

> "Dr. Olson's chart note also indicated claimant had seen Dr. Thorsett, who felt that she had cervical degenerative joint disease and osteophyte formation that was causing her pain. (Ex. 37). Dr. Olson reported that claimant's cervical and thoracic spine were not tender and she had no muscle spasm. (*Id.*)"

In the last paragraph beginning on page 2, we change the third sentence to read: "On June 1, 1998, Dr. Whitmire reported that claimant presented without antalgia, her gait was normal and her thoracic range of motion was normal. (Ex. 35A-10)."

On page 3, we replace the first full paragraph with the following:

> "On October 8, 1998, the insurer issued an updated notice of acceptance at closure that referred to the accepted conditions as: medial collateral ligament strain, partial thickness medial meniscal tear and medial compartment synovitis. (Ex. 38A)."

In the first paragraph on page 4, we change the first date in the second sentence to "February 3, 1998." We delete footnote 3 on page 4.

The ALJ found that claimant's request for acceptance of additional conditions involved conditions that were not "in being" at the time of the insurer's February 27, 1998 acceptance. The ALJ found there was no hint of an upper back or neck problem before April 30, 1998 and, therefore, claimant's request to accept a cervical brachial syndrome, cervical sprain/strain, and thoracic sprain/strain was a request to accept a new medical condition pursuant to ORS 656.262(7)(a). Because claimant's request for hearing was filed before 90 days had elapsed, the ALJ concluded that the request for hearing was premature and a nullity.[2] *See James E. Templeton*, 51 Van Natta 975 (1999). The ALJ dismissed claimant's request for hearing.

On review, claimant does not address the propriety of the ALJ's dismissal of her request for hearing. Rather, she contends that the ALJ failed to address the issue of compensability. On *de novo* review, we agree with the ALJ's conclusion that claimant's request for hearing was premature and a nullity. At hearing, claimant's attorney chose not to amend the request for hearing or to request a continuance. (Tr. 3-4). Under these circumstances, because the only issue before the Board is the propriety of the ALJ's dismissal order, we do not address the merits of compensability.

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[1] We modify the ALJ's order to note that Exhibits 26A and 38B were also admitted in evidence.

[2] Claimant's attorney's March 26, 1999 letter requesting that the insurer accept additional conditions specifically referred to the insurer's February 27, 1998 acceptance, not the October 8, 1998 updated notice of acceptance at closure. *Compare Kimberly R. Rice*, 52 Van Natta 138 (2000) (because the claimant's condition was in existence before the updated notice of acceptance at closure and the claimant's attorney objected to the updated notice of acceptance, ORS 656.262(6)(d) applied).

ORDER

The ALJ's order dated February 11, 2000 is affirmed.

In the Matter of the Compensation of
DIXIE J. HENDERSON, Claimant
WCB Case No. C001143
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Heiling & Associates, Claimant Attorneys
Thomas A. Sieg (Saif), Defense Attorney

Reviewed by Board Member Haynes and Phillips Polich.

On May 10, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in exchange for the SAIF Corporation's "waiver" of $2,500 of its statutory share of any third party settlement, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

In the CDA, the parties acknowledged that SAIF had filed a valid third party lien in the amount of $14,045.59 that would be recoverable from the third party settlement. In addition to reciting SAIF's "waiver" of $2,500 of its statutory share of any third party settlement, the proposed CDA also stated that this would convert to a $5,525 "value" to claimant before SAIF would have any entitlement to part of the settlement between claimant and the third party.

On May 19, 2000, we wrote the parties seeking clarification of how the "value" of $5,525 was determined. Moreover, we noted that the Board generally disapproves of CDAs in which the consideration consists of a carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment and/or the amount of the carrier's lien. *See Kenneth Hoag*, 43 Van Natta 991 (1991). In light of such circumstances, we requested additional information to assist us in ascertaining the "value" of any consideration flowing to claimant from the third party settlement and the carrier's waiver of its lien.

Noting that the proposed agreement did state the amount of the third party lien, but did not provide the amount of the third party settlement or whether the third party case had been settled, we also requested confirmation of the settlement and the settlement amount. Finally, we requested that, in the event that no settlement of the third party case had occurred, the parties address the effect of *Michael Salber*, 48 Van Natta 757 (1996).

On June 26, 2000, we received the parties' response to our letter. The parties averred that the "value" of the CDA should be $5,625, not $5,525 as stated in the proposed agreement. In addition, the parties provided a calculation that assumed a gross settlement of $5,625, of which one-third would be allocated to claimant's attorney ($1,875), leaving a balance of $3,750. Of that remaining balance, one-third would be allocated to claimant ($1,250), leaving SAIF's lien share of $2,500 that it was willing to waive as consideration for the proposed CDA.

The parties reported that, on April 14, 2000, claimant had made a settlement demand of $5,500 in the third party claim and that the third party had offered $2,000. The parties observed that, if the case settled for either of those amounts or somewhere in between, SAIF would receive nothing from the settlement because its statutory share would not exceed the $2,500 it had already waived as consideration for the CDA. Finally, the parties related that SAIF had agreed that it would not oppose or object to any settlement of the third party claim.

Having reviewed the parties' response to our request for more information, both the amount of SAIF's statutory lien and the amount it is willing to "waive" as consideration are apparent. Nevertheless, it is also clear that the parties have not reached a settlement of the third party claim, even though offers have been exchanged and SAIF has relinquished its right to object to any settlement between claimant and the third party.

Under these circumstances, we are persuaded that, although the exact amount of the third party settlement is unknown, the amount of the carrier's otherwise recoverable lien and the amount of its "waiver" are known. In other words, based on the proposed offer and counter-offer concerning the third-party settlement, we find SAIF is statutorily entitled to receive a portion of the settlement proceeds, but, in return for claimant's release of his "non-medical service" benefits, has waived its right of recovery for the first $2,500. Consequently, we find that the "value" of the consideration flowing to claimant under the CDA (i.e., the waiver of SAIF's statutory right to receive reimbursement of its claim costs up to the first $2,500 to which it would otherwise be entitled) is sufficiently ascertainable to gain Board approval.[1] *See Anthony G. Allen*, 49 Van Natta 460 (1997).

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.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we distinguish *Michael Salber*. In that case, we disapproved a proposed CDA when we were unable to determine the value of any consideration the claimant would receive because the CDA neither provided the amount of the lien being waived nor the amount of the third party settlement. We pointed out in *Salber* that, although it was conceivable that we may not need to know all of the provisions in the "confidential" settlement, it was imperative for us to be provided with information regarding the amount of the settlement and the dimensions of the insurer's "waived" third party lien. 48 Van Natta at 757. In contrast to *Salber*, in this case, we are persuaded that the parties have provided sufficient information regarding the dimensions of the "waived" third party lien (the carrier's recoverable lien from, at a minimum, a $2,000 settlement), although the exact amount of the third party settlement is obviously not yet known.

In the Matter of the Compensation of
CATHLEEN A. BRADFORD, Claimant
Own Motion No. 99-0421M
OWN MOTION ORDER

The self-insured employer submitted claimant's request for temporary disability compensation for her 1988 bilateral knee claim. Claimant's aggravation rights on that claim expired on August 22, 1996. The employer denied the compensability of claimant's current left knee condition on which claimant requested a hearing. (WCB Case No. 99-09301). The Board postponed action on the own motion matter pending resolution of that litigation. In addition, the employer recommended against reopening on the grounds that: (1) the employer was not responsible for claimant's current condition; and (2) surgery or hospitalization was not reasonable and necessary for the compensable injury.

By Opinion and Order dated June 12, 2000, Administrative Law Judge (ALJ) Howell set aside the employer's November 12, 1999 denial and found that the employer remained responsible for claimant's left knee condition. That order was not appealed, and has become final by operation of law.

However, in his June 12, 2000 order, ALJ Howell noted that the employer and claimant entered into a Claim Disposition Agreement (CDA), which fully released claimant's rights to all "non-medical service" workers' compensation benefits including: own motion reopening pursuant to ORS 656.278, temporary disability benefits, permanent disability benefits, vocational rehabilitation, aggravation rights pursuant to ORS 656.273, and survivor's benefits. The Board approved the CDA on June 1, 1993.

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

In light of the fact that claimant has fully relinquished her rights to reopening her Own Motion claim for temporary disability compensation as a result of the June 1, 1993 CDA, she is no longer entitled to any temporary disability compensation related to her January 22, 1988 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 own motion relief is denied.

IT IS SO ORDERED.

July 12, 2000 Cite as 52 Van Natta 1262 (2000)

In the Matter of the Compensation of
RONALD S. MILLER, Claimant
WCB Case No. 96-03652
ORDER ON REMAND
Cole, Cary, et al, Claimant Attorneys
Paul Louis Roess, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *International Paper Company v. Miller*, 151 Or App 131 (1997). The court has reversed our order that adopted and affirmed an Administrative Law Judge's (ALJ's) order setting aside the self-insured employer's denial of claimant's aggravation claim for a low back condition. Relying on its decision in *SAIF v. Walker*, 145 Or App 294 (1996), the court concluded that we erroneously assumed that proof of a symptomatic worsening was sufficient to establish an "actual worsening" of the compensable condition under ORS 656.273(1). Consequently, the court has remanded for reconsideration and application of the appropriate legal standard. In accordance with the court's directive, we now proceed with our reconsideration.

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

Claimant, a log-truck driver, sustained a compensable low back injury on November 20, 1991, accepted as a low back strain with left leg numbness. The claim was eventually closed on March 24, 1993, with an award of 20 percent unscheduled permanent disability and 7 percent scheduled permanent disability for the left leg.

In November 1994, the employer accepted an aggravation claim after claimant experienced an exacerbation of symptoms due to vibration while driving over rough roads. As part of claimant's treatment, a neurosurgeon, Dr. Burchiel, implanted a spinal cord stimulator for pain relief. Dr. Burchiel later declared claimant's condition medically stationary and the claim was closed on November 10, 1995 by Notice of Closure increasing claimant's total award of unscheduled permanent disability to 23 percent.

Claimant did not work between November 1995 and March 6, 1996. However, when claimant did return to work, he experienced another flare-up of low back pain, as well as bilateral leg pain. On March 7, 1996, claimant sought treatment from Dr. Schlessinger, who filed an aggravation claim on claimant's behalf that was denied on the ground that claimant's compensable condition had not worsened. Claimant requested a hearing.

The ALJ set aside the employer's aggravation denial, finding that claimant had sustained a worsening of his compensable low back condition that exceeded the waxing and waning of symptoms contemplated by his last permanent disability award and that had rendered him less able to work. The employer requested Board review, which resulted in our Order on Review of December 13, 1996 that adopted and affirmed the ALJ's order. The employer requested judicial review of our order.

The Court of Appeals reversed. In so doing, the court agreed with the employer that we had erroneously assumed that proof of an symptomatic worsening, as opposed to a pathological worsening, of claimant's condition was sufficient to establish an "actual worsening" of the compensable condition under ORS 656.273(1). Citing its decision in *Walker*, the court remanded for reconsideration in light of the legal standard set forth in that case. We now proceed with our analysis.

At the outset, we note that the Supreme Court has issued its opinion in *Walker*. *SAIF v. Walker*, 330 Or 102 (2000). After analyzing the text of ORS 656.273(1), the Court determined that, to prove an aggravation claim, a worker must present evidence of a worsening of the compensable condition itself, not merely a worsening of the symptoms related to the underlying condition. Consequently, the Court concluded that a worker cannot satisfy the requirements of ORS 656.273(1) (which requires "an actual worsening of the compensable condition") by presenting evidence of worsened symptoms alone. *SAIF v. Walker*, 330 Or at 110.

The Court next addressed the question of whether and to what degree a factfinder may consider evidence of worsened symptoms when determining whether a worker has presented medical evidence of an actual worsening of the compensable condition. Because the statutory text of ORS 656.273(1) (1995) was not helpful, the Court turned to the statutory context, as well as the applicable case law. *Id.*

In summarizing the relevant statutes, the Court observed that the 1995 legislature amended ORS 656.273(1) after years of case law had held that a worker could establish a "worsened condition" by presenting evidence of a worsening of the underlying condition itself or of its symptoms -- in the latter case, with a factfinder inferring the existence of a worsened condition from evidence of a symptomatic worsening. The Court further noted that the 1995 version of ORS 656.273(1) required something different: Proof, based upon medical evidence supported by objective findings, of a worsening of the underlying condition itself, not merely of its symptoms. Nonetheless, based on ORS 656.005(19), the Court reasoned that "objective findings" may include evidence of worsened symptoms. Finally, under ORS 656.273(8) (which had remained unchanged since its 1990 enactment), the Court commented that the statute -- as did the case law that preceded it -- continues to require that a worker with permanent disability establish that the "worsening" at issue is more than a waxing of symptoms associated with the underlying condition, that is, an increase in symptoms that exceeds the degree anticipated by the earlier award.

When considered together, the Supreme Court determined that the text, context, and applicable case law surrounding the 1995 amendment to ORS 656.273(1) clarified the legislature's intended meaning of that statute, as well as the interplay between that statute and ORS 656.273(8). Accordingly, the Court held that evidence of a symptomatic worsening that exceeds the amount of waxing anticipated by an original permanent disability award -- that is, the degree of worsening addressed in ORS 656.273(8) -- may prove an aggravation claim under ORS 656.273(1) (1995) if, but only if, a physician concludes, based on objective findings (which may incorporate the particular symptoms), that the underlying condition itself has worsened. Stated differently, the Court reasoned that, if, in a physician's medical opinion, a symptomatic worsening that exceeds the degree anticipated does not demonstrate the existence of an actual worsening of the underlying condition, then the worker does not qualify for an aggravation award. *Id.* at 119.

In accordance with the *Miller* court's instructions and mindful of the *Walker* Court's holding, we examine this record to determine if medical evidence--*i.e.*, a physician's expert opinion--establishes that claimant's symptomatic worsening represents an "actual worsening" of the underlying condition. In other words, if a medical expert's opinion that an increase of symptoms signifies an actual worsening of a particular compensable condition, then the actual worsening standard of ORS 656.273 is satisfied. *SAIF v. January*, 166 Or App 620, 624 (2000). *See Lepage v. Rogue Valley Medical Center*, 166 Or App 627, 631 (2000); *Roland Walker*, 52 Van Natta 1018 (2000) (on remand).

There are two physicians (Dr. Burchiel and Dr. Schlessinger) who expressed opinions on whether claimant's compensable low back condition had worsened since the claim closure in November 1995. Dr. Burchiel treated claimant both before and after the alleged aggravation and, thus, was in an advantageous position to determine whether claimant's compensable condition had worsened. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 421 (1986). Dr. Burchiel opined that, while he could not say that claimant's symptoms did not increase, there were no objective changes or worsening since the claim was closed. (Exs. 33, 35). Because he did not indicate that claimant's increased symptoms represented an "actual worsening" of the underlying low back and left leg condition, Dr. Burchiel's opinion does not establish an "actual worsening" of the compensable condition within the meaning of ORS 656.273(1).

With respect to Dr. Schlessinger, he agreed that claimant had suffered a worsening of his condition since the November 1995 claim closure. (Ex. 34). Dr. Schlessinger, however, did not indicate that the underlying low back condition had worsened.[1]

Accordingly, we conclude that claimant has failed to prove an "actual worsening" of the compensable low back condition since the claim closure in November 1995. Therefore, we find that claimant has failed to prove a compensable aggravation claim under ORS 656.273(1).

Thus, on reconsideration, and in lieu of our prior order, we reverse the ALJ's August 14, 1996 order and reinstate and uphold SAIF's denial of claimant's aggravation claim. The ALJ's attorney fee award is also reversed.

IT IS SO ORDERED.

[1] Dr. Schlessinger agreed that development of scar tissue constitutes objective medical evidence of a worsening. (Ex. 34-2). However, Dr. Schlessinger relied on a history provided to him by claimant's attorney's paralegal that Dr. Burchiel had performed surgery on June 14, 1996 to remove significant scar tissue. Dr. Burchiel stated that the surgery was not to remove scar tissue but rather to remove an electrode and place a dual electrode system. (Ex. 35). In light of Dr. Burchiel's statement regarding the purpose of the June 14, 1996 surgery, we are not persuaded that Dr. Schlessinger's opinion proves an "actual worsening" of the compensable condition.

In the Matter of the Compensation of
JOHN A. WILLIAMS, Claimant
WCB Case No. 99-08657
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's injury claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a truck driver, sought treatment for pain in his right buttock once prior to beginning work for the employer, in April 1999, after lifting furniture at home. (Ex. 1). Claimant's symptoms resolved before he began work for the employer on June 7, 1999. (Ex. 9-2). Claimant's work requires him to couple and uncouple trailers, adjust weights, and load and unload the trailers. He is required to lift up to 80 pounds. (Tr. 11, 12).

Claimant suffered an injury to his low back on July 20, 1999, when he fell backwards after pulling forcibly on a "slide release." (Tr. 13, 14). Claimant experienced immediate low back symptoms, but continued working until August 17, 1999, when he sought treatment with Dr. Miller. (Tr. 15). On August 20, 1999, an MRI demonstrated the presence of an L4-5 disc herniation and small disc protrusion at L5-S1. (Ex. 5). On September 24, 1999, SAIF denied claimant's claim for a low back condition. (Ex. 11).

The ALJ set aside SAIF's denial based on the opinion of claimant's treating physician, Dr. Hellner. Dr. Hellner concluded that claimant's work activities were the major contributing cause of claimant's disc herniation at L4-5. (Ex. 14). In contrast, Drs. Strum and Brooks, who performed an examination at the request of SAIF, stated that claimant's condition was attributable primarily to preexisting degenerative disc disease. (Exs. 9, 12). Dr. White, who performed a file review at the request of SAIF, reached a similar conclusion. (Ex. 13).

Initially, SAIF contends that the ALJ erred in finding that claimant does not have a preexisting low back condition. We disagree with SAIF's arguments and agree with the ALJ that the more persuasive evidence proves that claimant did not have a "preexisting condition" in his low back that combined with the effects of either the July 20, 1999 work injury or claimant's work activities.

A "preexisting condition" is an "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); *Clara S. Vinson*, 52 Van Natta 200 n1 (2000).

We agree with the ALJ that claimant does not have a preexisting low back condition that combined with his on-the-job injury or work activities to cause disability and need for treatment. We rely on the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to rely on Dr. Hellner as claimant's treating physician. Dr. Hellner concluded that claimant did not have a "preexisting condition" that combined with his work activities to cause claimant's disability and need for treatment for his low back condition. (Ex. 14-2).

The imaging studies of claimant's low back are supportive of Dr. Hellner's opinion. An x-ray taken on April 20, 1999 revealed "mild posterior disc space narrowing at L5-S1." (Ex. 2). The radiologist, Dr. Wagner, also observed that "[t]he intervertebral disc spaces, vertebral body heights, facets, pedicles and posterior elements are otherwise intact and unremarkable." (*Id.*) SAIF argues that this x-ray is "silent" as to the L4-5 disc space and therefore not persuasive evidence of a lack of a preexisting condition. However, the x-ray is not entirely silent in regard to the L4-5 disc space. In fact, by implication, the x-ray findings suggest that the L4-5 disc space was "intact and unremarkable." (Ex. 2).

SAIF next contends that Drs. Strum and Brooks concluded that the August 20, 1999 MRI revealed preexisting degenerative disc disease. (Ex. 9-6). However, these examiners did not have the MRI available for direct review, and instead relied on the MRI report. (Ex. 9-6). The examiners also failed to comment on the April 20, 1999 x-ray. Drs. Strum and Brooks do not offer an adequate explanation for concluding that claimant has degenerative disc disease in his low back, in the absence of any mention of disc disease in either the x-ray or the MRI report. (*See* Exs. 2, 5). In light of such circumstances, we consider their opinion unpersuasive, particularly in contrast to Dr. Hellner's persuasive opinion.

We also agree with the ALJ that claimant has met his burden of proving that his July 20, 1999 work injury and work activity are the major contributing cause of his disability and need for treatment for his low back condition. ORS 656.005(7)(a); ORS 656.802(2)(a). Initially, we note that claimant may prove that his work injury and work activities, separately or in combination, were the major contributing cause of his low back condition. *See Kepford v. Weyerhaeuser*, 73 Or App 363, 366, 367, *rev den* 300 Or 722 (1986). Therefore, we need not resolve whether claimant's work exposure is properly characterized as an "injury" or "occupational disease." *Ronald L. Merwin*, 51 Van Natta 1678 n2 (1999).

We defer to Dr. Hellner as claimant's treating physician on the issue of causation as we deferred to Dr. Hellner's conclusions on the issue of whether claimant has a "preexisting condition." Dr. Hellner concluded that claimant's work activity was the major contributing cause of his disability and need for treatment for his low back condition. (Ex. 14).

We also rely on medical opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). We find that Dr. Hellner's opinion is better-reasoned than that of either Drs. Strum and Brooks or Dr. White, and therefore persuasive. In this regard, we note that Dr. White's report is inconsistent with that of Drs. Strum and Brooks. Although Dr. White purportedly concurs with Drs. Strum and Brooks, he doubts that there was a "combining" between claimant's injury and his preexisting degenerative disc disease. (Ex. 13-2, -3). However, Drs. Strum and Brooks' opinion is that claimant's degenerative disc disease combined "by definition" with his work activities. (Ex. 9-6). This internal inconsistency is unexplained and undermines the forcefulness of Dr. White's opinion.

Finally, we find that Dr. Hellner did not engage in an impermissible "precipitating cause" analysis, but rather, relied on his examinations of claimant, the history of claimant's injury and work activity and the above-referenced imaging studies to reach his opinion. (Ex. 14). In reaching his conclusions, Dr. Hellner relied in part on the onset of claimant's radicular symptoms with his work activity. (Ex. 14-1). However, this reasoning is not necessarily a "precipitating cause" analysis when read in context with his chart notes and ultimate conclusion. Specifically, we note that Dr. Hellner considered whether or not claimant had a preexisting low back condition, but concluded that he did not. (Ex. 14). As stated above, this conclusion is consistent with both the April 20, 1999 x-ray and August 20, 1999 MRI scan. (Exs. 2, 5). Therefore, we are satisfied that Dr. Hellner considered the relative contribution of any preexisting condition. *Dietz v. Ramuda*, 130 Or App 297 (1994), *rev dismissed* 320 Or 416 (1995).

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

ORDER

The ALJ's order dated February 25, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by SAIF.

In the Matter of the Compensation of
JANICE K. BOCK, Claimant
Own Motion No. 00-0021M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's April 6, 2000 Notice of Closure that closed her claim with an award of temporary disability compensation from December 6, 1999 through March 30, 2000. SAIF declared claimant medically stationary as of March 30, 2000.

In her request for review, claimant requests that her claim "not be closed at this time. I do not feel I received adequate treatment from Dr. Lovejoy." Claimant also seeks entitlement to temporary disability compensation beginning July 26, 1999, when she asserts she left work due to increased pain due to her compensable condition. We interpret such statements as a contention that claimant was not medically stationary at claim closure and that she is entitled to additional temporary disability compensation.

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

The propriety of the closure turns on whether claimant was medically stationary at the time of the April 6, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

Claimant contends that she requires additional medical care because Dr. Lovejoy, her current attending physician, has not paid attention to her when she has tried to tell him about her continued pain. Because of her problems with Dr. Lovejoy, claimant has requested that she be referred to a different physician for a second opinion. She indicates that her request is still pending. Additionally, she contends that she was told in 1990 that down the road she would be a candidate for a total knee

replacement. She raised this issue with Dr. Lovejoy but he informed her that: (1) she was too young; (2) there was nothing in her knee to attach it to; and (3) he would go no further. Claimant submits a copy of an article regarding total knee replacements in support of her contention that she requires said operation because of her constant pain. Claimant relies on these contentions to support her current request for relief.

Even if we were to consider claimant's assertion that she may require further treatment if seen by a different physician, this does not establish that her condition was not medically stationary when her 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 that further or ongoing medical treatment would "materially improve" claimant's compensable condition at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996). Additionally, other than a generic article regarding total knee replacements, claimant offers no medical documentation to support her contention that she requires further surgery.

Finally, and most importantly, in a March 30, 2000 response letter to an inquiry from SAIF, Dr. Lovejoy, claimant's attending physician, concluded that claimant has reach a point that her condition is stationary and is not going to improve. His opinion is unrebutted.

Based on this uncontroverted medical evidence, we find that claimant was medically stationary on the date her claim was closed.[1] Therefore, we conclude that SAIF's closure was proper.[2]

Accordingly, we affirm SAIF's April 6, 2000 Notice of Closure in its entirety.[3]

IT IS SO ORDERED.

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[1] In reaching this conclusion, we again emphasize that the need for continuing medical treatment to address fluctuating symptoms does not establish that claimant's condition is not medically stationary. *Maarefi*, 69 Or App at 531.

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

[3] The Board is authorized to award temporary disability compensation to claimants whose compensable conditions have worsened requiring surgery or inpatient hospitalization. ORS 656.278(1)(a). This temporary disability compensation begins as of the date of actual surgery or hospitalization, which in this case is December 6, 1999. *Id.* Inasmuch as we are not authorized to award temporary disability compensation prior to the date of surgery, we find that claimant is not entitled to additional temporary disability compensation.

In the Matter of the Compensation of
STEPHEN T. CLARK, Claimant
WCB Case Nos. 99-03809, 98-04830, 98-07763 & 98-06829
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the SAIF Corporation's responsibility denial, on behalf of Northwest Printed Circuits (NWPC), of claimant's L4 on L5 spondylolisthesis condition;[1] and (2) upheld SAIF's responsibility denial, on behalf of Rogue Valley Masonry (RVM), for the same condition. On review, the issues are compensability and responsibility, and (possibly) penalties and attorney fees.

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[1] This claim is in own motion status. NWPC opposes reopening of the claim on the ground that claimant's current condition is not causally related to its accepted condition.

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

The ALJ concluded that claimant had not established the independent compensability of his spondylolisthesis L4 on L5. On review, claimant first contends that his spondylolisthesis was sustained as a direct result of his work injury on May 2, 1985, when a box fan fell on his back. Claimant further contends that, because responsibility for his low back condition shifted to NWPC, his spondylolisthesis is compensable as part of an accepted claim.

Compensability of claimant's spondylolisthesis condition must be proven as a threshold matter before proceeding to a determination of responsibility. *E.g., James M. Hedinger*, 49 Van Natta 1797 (1997). After *de novo* review of the record, we agree with the ALJ that claimant has failed to sustain his burden of proof.

Because of the passage of time and the number of possible causes of claimant's spondylolisthesis, compensability involves a complex medical question, Therefore, we must rely on expert medical opinion to establish causation. *Barnett v. SAIF*, 122 Or App 279 (1993); *Uris v. Compensation Department*, 247 Or 420 (1967). 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 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).

Following the May 1985 accident, Dr. Peterson diagnosed a contusion dorsolumbar back. In October 1985, Northbrook Indemnity Company (now St. Paul Fire and Marine Company), closed the claim with no award of permanent disability. In October 1985, claimant sustained a new low back injury at NWPC when he jumped off a Hyster. NWPC accepted a low back injury and herniated disc. (Exs. 20, 22).

As discussed by the ALJ, there was no medical evidence of claimant's spondylolisthesis until after his 1997 injury at RVM. (Exs. 58; 63-16, -18; 65-28, -29). Prior to that time, in addition to the 1985 compensable injuries, claimant suffered a low back injury in 1984 and was treated for low back symptoms in 1988 and 1990.

Opinions regarding the cause of claimant's spondylolisthesis were provided by Dr. James, orthopedic surgeon, Dr. Maurer, physician, and Dr. Henderson, orthopedist. Dr. James opined that, in view of the clear x-ray taken at the time of the May 1985 injury, claimant's spondylolisthesis probably was not caused by that injury. (Ex. 58). Dr. James also stated that a traumatic spondylolisthesis can be the result of non-symptom producing events. (Ex. 63). Dr. Maurer opined that it was impossible to determine the cause of claimant's spondylolisthesis condition. (Ex. 60).

Dr. Henderson initially stated that the spondylolisthesis was of traumatic origin and was "related to" a fan falling on him in May 1985. (Exs. 40, 54, 65-27). Although Dr. Henderson acknowledged that the May 1985 x-rays did not show spondylolisthesis (Ex. 65-7), and he agreed that trying to figure out exactly when the spondylolisthesis happened would be difficult to prove (Ex. 65-8), he did not explain why he thought that the May 1985 injury caused the condition.

In light of the other experts' opinions that spondylolisthesis can be the result of non-symptom producing events, the lack of x-ray evidence in 1985 and claimant's history of repeated low back incidents, we conclude that Dr. Henderson's unexplained opinion is not persuasive. Accordingly, we conclude that claimant has not established that the May 1985 injury was a material cause of his spondylolisthesis condition. Consequently, because claimant has not established the threshold issue of compensability, we do not address the second part of claimant's argument regarding whether responsibility for claimant's spondylolisthesis shifted to NWPC.

Claimant also raises a challenge to the procedural propriety of RVM's denial. Specifically, claimant argues that RVM's denial is improper either as an impermissible denial of the independent compensability of a preexisting condition that was part of an accepted "combined" condition, or an impermissible pre-closure denial because RVM did not accept a "combined" condition.

Claimant identified the issues at hearing as compensability and responsibility for claimant's current low back condition.[2] (Tr. 7). Because claimant did not raise a procedural challenge to the propriety of RVM's denial at hearing, we decline to address that issue on review. *Fister v. Smith Hills Health Care*, 149 Or App 214, 942 P2d 833 (1997); *Janice A. Talevich*, 48 Van Natta 2318, 2319 (1996) (declining to consider "back-up" denial issue raised for first time on review).

ORDER

The ALJ's order dated December 6, 1999, as amended December 7, 1999, is affirmed.

[2] Moreover, the record does not show that the procedural issue was raised in claimant's specification of issues.

In the Matter of the Compensation of
MICHAEL A. McGARVEY, Claimant
WCB Case No. 98-07764
ORDER ON RECONSIDERATION
Mitchell & Associates, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Claimant requests reconsideration of our June 15, 2000 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's right knee injury claim. In our order, we reinstated and upheld the employer's denial, concluding that claimant had failed to meet his burden of proof. Specifically, after examining in detail the medical evidence regarding causation that was provided by four orthopedists, we determined that it was, at best, in equipoise. In addition, claimant provided inconsistent histories regarding the alleged work incident. These inconsistencies included, but were not limited to, a report of "no clear injury" when claimant initially sought medical treatment from Dr. Seier, M.D., three days after the alleged work incident.

On reconsideration, claimant does not address the medical evidence except to repeat his contention that he told Dr. Seier that he tripped on a curb at work and she neglected to accurately record his statement. Thus, claimant argues, we should disregard Dr. Seier's report, rely on the May 8, 1998 801 form (which indicates that the employer first knew of the claim on March 18, 1998), and find his injury claim compensable.

As noted above, there were several bases for our decision, which were thoroughly explained in our prior order. Consequently, we find that claimant's argument was adequately addressed in our initial Order on Review and have nothing further to add.

Accordingly, we withdraw our June 15, 2000 order. On reconsideration, as supplemented herein, we republish our June 15, 2000 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Biehl dissenting.

For the reasons explained in my dissent to the majority's initial order, I would adopt and affirm the ALJ's Opinion and Order that found claimant's right knee injury claim compensable. Therefore, I continue to respectfully dissent from the majority's decision to the contrary.

In the Matter of the Compensation of
ANGEL J. RODRIGUEZ, Claimant
Own Motion No. 00-0175M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his 1977 left knee claim. Claimant's aggravation rights expired on April 28, 1992. SAIF opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery and/or hospitalization; (2) the current condition is not causally related to the accepted condition; (3) SAIF is not responsible for claimant's current condition; (4) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (5) claimant was not in the work force at the time of the current disability.

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

Claimant's 1977 claim was first closed on April 28, 1987, and his aggravation rights expired on April 28, 1992. ORS 656.273(4)(a). Thus, when claimant's condition worsened in March 2000, claimant's claim was under our own motion jurisdiction. Inasmuch as we have exclusive own motion jurisdiction over the claimant's 1977 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.

Here, the record does not establish that claimant requires surgery or hospitalization. As a result, we are not authorized to grant claimant's request to reopen the claim.[1]

Accordingly, we deny the request for own motion relief. *Id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

IT IS SO ORDERED.

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[1] The issue of whether claimants current condition is part of his accepted 1977 claim is not determinative because, as noted above, the record does not establish that claimants current condition requires surgery and/or hospitalization. Thus, claimant is not entitled to temporary disability compensation at this time.

In the Matter of the Compensation of
LAURA R. FRANKE, Claimant
WCB Case No. 96-04464
SECOND ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Steven T. Maher, Defense Attorney

Claimant has requested reconsideration of our May 19, 2000 Order on Remand. Specifically, claimant contends that, in addition to the $3,675 attorney fee awarded by the Court of Appeals, her counsel is entitled to $13,600 for services at hearing and on Board review. On June 8, 2000, we withdrew our order to consider claimant's request. Having considered that request, claimant's counsel's statement of services and the employer's counsel's response,[1] we proceed with our reconsideration.

Where, such as here, a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); *Deana F. Marshall*, 51 Van Natta 415, 416 (1999). Although statutory authority to award an attorney fee for services rendered at the hearings, Board, and court levels rests with this forum (because claimant did not finally prevail until the issuance of our Order on Remand), the court already granted claimant a $3,675 fee.

Neither party challenges the statutory basis for the court's attorney fee award for services on judicial appeal. In any event, after considering the factors set forth in OAR 438-015-0010(4), we would find that the court's $3,675 award represents a reasonable fee for claimant's counsel's services performed before that forum.

We next turn to the determination of a reasonable fee for claimant's counsel's services at hearing and on Board review for finally prevailing over the employer's denial of claimant's current cervical condition. As previously noted, claimant requests $13,600 for an attorney fee. This is based on 34 hours of attorney time "to date." The employer responds that time devoted to services at the court (for which a fee has already been awarded) and time devoted to pending litigation pertaining to an aggravation claim have not been excluded.

Claimant's counsel's statement of services does not expressly state whether time allocated to court services has been separated from those devoted to litigation before the Hearings Division and the Board. Nevertheless, we find that it has been in light of claimant's specific request for a fee based on services at hearing and on review. Moreover, the statement of services indicates that all hours pertain to the instant case. Thus, we do not find that clamant has included time devoted to separate litigation concerning an aggravation claim. With these considerations in mind, we now turn to our analysis of the various factors involved in determining a reasonable fee for counsel's services before the Hearings Division and the Board.

The hearing lasted an hour (15 page transcript) and claimant was the only witness who testified. The record contains 99 exhibits, including one deposition and one medical report obtained by claimant's counsel that, while helpful in deciding the case, was not determinative. The issue was medical causation: Whether claimant's cervical condition (as of the employer's April 30, 1996 "current condition" denial) remained related to her May 22, 1995 work injury. This issue was of average complexity, as compared to those normally presented to this forum for resolution. The ALJ upheld the employer's denial and claimant requested Board review. Claimant's counsel submitted about 10 pages of briefing in her Appellant's and Reply briefs on Board review. We note, however, that claimant's reply brief was entirely devoted to a challenge to the procedural validity of the employer's denial, an argument that we refused to consider because it was untimely raised.

The case did involve travel to Hermiston for a deposition and travel to Pendleton for the hearing. This travel time is appropriately considered in determining a reasonable attorney fee. *See Marilyn E. Keener*, 49 Van Natta 110, 113 (1997). Claimant will likely receive compensation for medical services for her compensable condition, demonstrating a value of the interest involved that is generally

[1] The self-insured employer has objected to claimant's fee request, arguing that it is excessive.

comparable to other compensability disputes litigated before this forum. As demonstrated by the extent of litigation, there was a significant risk that claimant's counsel's efforts would go uncompensated.[2] Finally, we note that the attorneys advocated their respective cases in a professional manner.

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on Board review is $6,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's appellate arguments to the Board, claimant's counsel's statement of services and the employer's response), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated.[3] This award is in addition to the $3,675 awarded for services performed before the court, resulting in a total award for services rendered before all prior forums of $9,675, to be paid by the employer.

Accordingly as supplemented and modified herein, we adhere to and republish our May 19, 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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[2] We do not, however, take administrative notice of the Department's denial statistics that claimant has submitted on reconsideration. *See Marc Grossetete*, 50 Van Natta 2235 n. 2 (1998).

[3] We do not apply a contingency factor or "multiplier" in a strict mathematical sense. *See June E. Bronson*, 51 Van Natta 928, 931 n. 5 (1999).

In the Matter of the Compensation of
ARTHUR WACHTRUP, Claimant
Own Motion No. 00-0217M
OWN MOTION ORDER
Travelers Casualty & Surety Co., Insurance Carrier

The insurer submitted claimant's request for temporary disability compensation for his 1991 low back claim. Claimant's aggravation rights on that claim expired on July 30, 1996.

In its June 28, 2000 recommendation, the insurer conceded that claimant's current condition is compensable and that it is responsible for his current condition. Additionally, the insurer acknowledged that claimant's current condition requires surgery. However, the insurer recommended denying reopening because claimant was not in the work force at the time of his current disability.

However, on September 29, 1992, the Board approved the parties' Claim Disposition Agreement (CDA) wherein claimant released all his rights to "non-medical service" benefits including temporary disability benefits, permanent disability benefits, vocational rehabilitation, own motion benefits under ORS 656.278, burial benefits, aggravation rights per ORS 656.273, death benefits, survivor's benefits, and all other workers' compensation benefits except compensable medical services under ORS 656.245.

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

In light of the fact that claimant has permanently relinquished his rights to all past, present and future temporary disability compensation, the work force issue is moot. In other words, as a result of the September 29, 1992 CDA, claimant is no longer entitled to any temporary disability compensation related to his March 18, 1991 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
RONALD V. PEARCE, Claimant
WCB Case No. 98-07657
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's aggravation claim for his current right knee condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is a 46 year-old self-employed automobile technician. In 1978, he had a surgery to remove a loose body related to an osteochondritis dessicans condition in his right knee. (Ex. 32). Claimant was relatively pain-free from 1978 until 1993, when he experienced symptoms of "clicking" on the medial side of his right knee. On June 21, 1993, claimant underwent an arthroscopic procedure by Dr. Duncan. Dr. Duncan diagnosed "traumatic degeneration of articular cartilage consistent with medial meniscal tear." (Ex. 2). Claimant then resumed his regular work with minimal right knee complaints. (Tr. 26).

On November 10, 1995, claimant compensably injured his right knee as he was pushing a portable tool box. (Ex. 3). SAIF accepted a right medial meniscus tear. (Exs. 7A, 9). On December 11, 1995, Dr. Duncan performed a second surgery, a partial medial meniscectomy. (Ex. 4). After this surgery, claimant continued to have pain and stiffness in his right knee. (Tr. 27). In February 1996, claimant returned to Dr. Duncan complaining of medial-side right knee pain, especially with activity. (Ex. 10A).

SAIF issued a Notice of Closure on May 16, 1996, awarding 10 percent scheduled permanent disability for the right knee. (Ex. 12). An Order on Reconsideration dated October 3, 1996 increased this award to 15 percent. (Ex. 16). On March 26, 1998, claimant sought treatment for his right knee with Dr. Meyers, who believed that claimant had signs and symptoms consistent with an extension of his meniscus tear. (Ex. 19-2). On March 31, 1998, claimant filed a claim for aggravation, which SAIF denied on the basis that claimant's compensable injury was not the major contributing cause of his current right knee condition. (Exs. 21, 25).

Dr. Meyers concluded that the major contributing cause of claimant's current disability and need for treatment was his compensable meniscal tear and resultant degenerative changes. (Exs. 28A, 35). In comparison, Dr. Schilperoort, who performed an examination at the request of SAIF, reasoned that claimant's current right knee condition was the result of an "idiopathic" degenerative joint disease. (Ex. 23). Dr. James, who performed a records review for SAIF, basically concurred with Dr. Schilperoort in opining that the major contributing cause of claimant's current condition was preexisting degenerative arthritis. (Ex. 31).

The ALJ set aside SAIF's denial based on the opinion of Dr. Meyers. The ALJ found Dr. Meyers' conclusions persuasive because, in contrast to Dr. Schilperoort and James, he took into account claimant's greater "symptomatic and functional" disability after his most recent injury and surgery.

ORS 656.273(1) provides:

> "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."

The statute requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening," and (2) a compensable condition. Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995).

The primary dispute in this case is whether claimant's current condition is compensably related to his injury and resultant surgery, as opposed to a preexisting or idiopathic disease process. We agree with the ALJ that Dr. Meyers' opinion that the current condition is so related is persuasive. In particular, unlike Dr. Meyers, neither Dr. Schilperoort nor Dr. James adequately explains their opinion in the context of claimant's increased symptoms and disability after the 1995 injury and surgery.

SAIF contends that the ALJ erred in dismissing the opinion of Dr. Schilperoort for the reason that he was "too enthusiastic," and because his opinion was in the minority. However, even if we were to agree with SAIF that consideration of these particular factors is inappropriate, there are other bases on which to find Dr. Schilperoort's opinion unpersuasive. Like Dr. James, Dr. Schilperoort never adequately incorporates into his opinion claimant's greater symptoms and disability since 1995. In fact, Dr. Schilperoort stated at deposition that he could not explain why claimant sought treatment for increased right knee pain in 1998, "absent the '95 episode." (Ex. 30-44).

SAIF argues that the ALJ failed to accord Dr. James deference as a "nationally-recognized" expert on knee problems. Dr. James submitted a curriculum vitae that establishes him as a prominent orthopedic surgeon with particular expertise in the treatment of knee conditions. (*See* Ex. 31-5). Although there is no evidence in the record of similar qualifications from Dr. Meyers, he, like Dr. James, is an orthopedic surgeon. (Ex. 19). The ALJ recognized, therefore, that Dr. Meyers' qualifications were "comparable" to those of Dr. James, not necessarily equivalent. (*O&O* at 6).

Moreover, a physician's qualifications are but one factor that the Board uses to determine the persuasiveness of an opinion. In addition to the source of the opinion (to which the particular qualifications of a doctor are relevant), we also look to the factual basis and logical force of the opinion. *See generally Earl M. Brown*, 41 Van Natta 287, 291 (1989). As we explained above, we agree with the ALJ that the logical force of Dr. James' opinion is outweighed by that of Dr. Meyers because of Dr. James' failure to explain claimant's increased symptoms and disability due to the combined condition in reference to the compensable injury.

Next, SAIF contends that the ALJ "glossed over" several defects in Dr. Meyers' opinion to find it persuasive. We disagree. In particular, we find that Dr. Meyers considered the effect of claimant's prior surgeries and degenerative joint disease in arriving at his opinion. (Exs. 28A, 35). As SAIF acknowledges, Dr. Meyers ultimately was aware of and considered claimant's 1993 surgery. (Ex. 28A). We are therefore satisfied that Dr. Meyers relied on a complete and accurate history. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Moreover, we find that Dr. Meyers did not engage in merely a "temporal analysis" in reaching his opinion. Instead, Dr. Meyers considered and separated claimant's degenerative condition related to his 1978 osteochondral surgery from the compensable meniscal tear and the more specifically-located degenerative condition caused by the tear and resultant 1993 surgery. (Ex. 35).[1] We agree with the ALJ that Dr. Meyers' opinion considers the effect of any preexisting conditions given the context in which it has been rendered. *Worldmark The Club v. Travis*, 161 Or App 644 (1999). We do not find *Travis* distinguishable from this case, as SAIF urges. Here, Dr. Meyers concurred with two letters prepared by counsel for claimant, both of which considered the impact of claimant's degenerative changes in his right knee. (Exs. 28A, 35). In rejecting SAIF's contention regarding Dr. Meyers' opinion, we further note that medical opinions are to be evaluated based on their completeness, thoroughness and logical force, not on the format in which they are delivered. *Roseburg Forest Products v. Glenn*, 155 Or App 318, 320 (1998).

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[1] Just as we declined to find Dr. Schilperoort's opinion unpersuasive because it is in the minority, we similarly decline SAIF's invitation to find Dr. Meyers' analysis unpersuasive merely because it does not coincide with that of Drs. Schilperoort and James on this issue.

SAIF also contends that Dr. Meyers' final opinion is inconsistent with his prior reports and the operative reports from Dr. Duncan, and is therefore unpersuasive. However, in Dr. Meyers' initial opinion, he stated that the chondromalacia noted by Dr. Duncan was related to "the injury causing the initial tear of the posterior horn of the right medial meniscus." (Ex. 28A-2). As claimant argues, this opinion, if anything, is consistent with Dr. Duncan's statement that the chondromalacia was "as a result of injury." (Ex. 15). However, Dr. Duncan's statement is ambiguous as to which "injury" he is referring to (*i.e.* the 1978 or 1993 injury), and we cannot determine on this record whether Dr. Meyers' opinion is in fact inconsistent with Dr. Duncan's report. We therefore disagree with SAIF's argument.

Dr. Meyers' later opinion letter states that claimant's chondromalacia and meniscal tear (with resultant degenerative change) conditions are separate conditions, based on new information regarding claimant's 1978 surgery. (Ex. 35). SAIF contends that this conclusion "does not comport with the record," citing to Dr. Duncan's reports. However, in the absence of a medical opinion criticizing this analysis, we are unable to determine that Dr. Meyers' opinion is "incorrect," as SAIF urges.

Having established a compensable condition, under ORS 656.273(1), claimant must then prove an "actual worsening." *Gloria T. Olson, supra,* 47 Van Natta 2348. SAIF contends that the ALJ erroneously failed to rely on the opinions of Drs. Schilperoort and James, who were the only physicians to offer conclusions on this issue based on "objective findings." We disagree.

Dr. Meyers concluded that claimant's increased symptoms are consistent with a worsening or extension of claimant's degenerative condition, which were caused in major part by his November, 1995 compensable meniscal tear injury and subsequent surgery. (Exs. 19-2, 28A). This analysis squares with the requirements for establishing a compensable aggravation, pursuant to the Supreme Court's framework in *SAIF v. Walker,* 330 Or 102 (2000); *Roland A. Walker, on remand,* 52 Van Natta 1018 (2000). In other words, evidence of a symptomatic worsening may prove an aggravation claim if, but only if, a physician concludes, based on objective findings (which may incorporate claimant's symptoms) that the underlying condition has worsened. *SAIF v. Walker,* 330 Or at 118-119. We are satisfied that Dr. Meyers' opinion meets claimant's burden of proving an actual worsening pursuant to the *Walker* rationale.

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 $2,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 3, 1999 is affirmed. For services on review, claimant's attorney is awarded $2,500, payable by SAIF.

In the Matter of the Compensation of
BARBARA J. WARREN, Claimant
WCB Case No. 99-06401
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

Claimant requests reconsideration of our June 21, 2000 Order on Review that: (1) reversed an Administrative Law Judge's (ALJ's) order that affirmed the Order on Reconsideration's award of 8 percent (10.8) degrees scheduled permanent disability benefits for loss of use or function of the right foot; and (2) reinstated a Notice of Closure's award of no permanent disability. In our order, we explained why we found the opinion of Dr. Beaman, M.D., claimant's attending physician, more persuasive than that of Dr. Hanley, M.D., the medical arbiter. On reconsideration, claimant repeats her contention that Dr. Hanley's opinion is more persuasive.

After further consideration of claimant's contention, we continue to reject it for the reasons explained in our prior order. As we found in our prior order, because the self-insured employer objected to the Order on Reconsideration and sought reduction of the award, it has the burden to show that the standards were incorrectly applied in the reconsideration proceeding. We continue to find that the employer met its burden of proof under the facts of this case.

On reconsideration, claimant reasserts her contention that the employer failed to meet its burden of proof, contending that Dr. Beaman's opinion does "not establish that claimant's supposed preexisting condition is *the major* contributing cause of the existing impairment." (Motion for Reconsideration, page 1 [emphasis in original]). Therefore, claimant contends, at best, the evidence is in equipoise, which results in the employer failing to meet its burden of proof.

Claimant cites no authority for her statement of law regarding the major contributing cause standard of proof. However, OAR 436-035-0007 (WCD Admin. Order 98-055) provides the general principles for rating disability and provides, in relevant part:

> "(1) Except for sections (4) and (5) of this rule, a worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted compensable condition, an accepted consequential condition and direct medical sequelae. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules. Permanent total disability shall be determined pursuant to OAR 436-030-0055.
>
> "* * * * *
>
> "(4) Where a worker has a preexisting condition, the following applies:
>
> "(a) For purposes of these rules only, a prior Oregon workers' compensation claim is not considered a preexisting condition.
>
> "(b) In accordance with 1995 Or. Laws Chapter 332, section 3, disability caused solely by a worker's preexisting condition shall be rated completely if work conditions or events were the major contributing cause of a pathological worsening of the preexisting physical condition or an actual worsening of the preexisting mental disorder. Apportionment of disability is not appropriate.
>
> "(c) Where a worker's compensable condition combines with a preexisting condition, pursuant to ORS 656.005(7), the current disability resulting from the total accepted combined condition shall be rated in accordance with these rules as long as the compensable condition remains the major contributing cause of the accepted combined condition, i.e., a major contributing cause denial has not been issued pursuant to ORS 656.262(7)(b). Apportionment of disability is not appropriate. * * *.
>
> (5) If the compensable condition is no longer the major contributing cause of the combined or superimposed condition, and a major contributing cause denial has been issued, the following applies:

"* * * * *"

As we found in our prior order, Dr. Beaman explicitly found that claimant's noncompensable preexisting arthrosis was the source of her impairment. (Ex. 47). We also found Dr. Beaman's opinion persuasive because he treated claimant over time and displayed a better knowledge of the medical record. In addition, given the fact that Dr. Hanley did not address claimant's preexisting arthrosis condition, we did not find his opinion persuasive. On the other hand, there is no medical evidence that claimant's preexisting arthrosis condition "combined" with the work injury. Although Dr. Beaman related claimant's mild impairment to her preexisting arthrosis, he did not discuss whether the work injury "combined" or was superimposed on the arthrosis condition.

Based on Dr. Beaman's opinion, we find that claimant's right foot impairment is solely caused by her preexisting arthrosis. As a result, claimant is not entitled to an impairment rating under the standards. ORS 656.225; OAR 436-035-0007(1); *Bonnie L. Bursell*, 50 Van Natta 2323 (1998); *William H. Pauley*, 49 Van Natta 1605 (1997).

Claimant argues that a finding of no impairment contradicts the employer's acceptance of a disabling right medial sesamoid fracture and the symptomatology listed in Dr. Hanley's report. However, claimant was awarded *temporary* disability for various periods of time in 1998 and 1999. (Exs. 49-1, 53-2). Nevertheless, the record does not establish entitlement to *permanent* disability.

Claimant also argues that Dr. Beaman's opinion is inaccurate that her medial sesamoid injury "resolved with treatment," and the "symptoms completely resolved." (Ex. 4-1, -2). Instead, claimant relies on Dr. Hanley's report, which lists a history of claimant having "persistent pain in the right foot" since the April 1998 injury. (Ex. 52-1). Based on the following reasoning, we find Dr. Beaman's opinion persuasive.

Dr. Beaman's chart notes and reports indicate that claimant's symptoms significantly diminished as she approached medically stationary status. On December 4, 1998, Dr. Beaman examined claimant and noted that she had improved significantly in the past six weeks, having regained good motion and diminished pain. (Ex. 35). On January 8, 1999, Dr. Beaman examined claimant and reported that she was doing well, with most of her pain diminished, although she was wearing clogs because she was unable to wear regular shoes yet. (Ex. 38). At that time, claimant reported that she thought she had improved 75 percent since her initial visit. (*Id.*). Claimant continued with physical therapy and, by February 23, 1999, she was wearing closed shoes. (Ex. 42). On March 18, 1999, Dr. Beaman examined claimant and found her medically stationary without permanent impairment. (Ex. 45). He reported that she was doing well and could return to her regular work duties full time. Finally, in his April 7, 1999 report, Dr. Beaman opined that: (1) claimant had recovered well; (2) the medial sesamoid injury had resolved with treatment; and (3) the mild degree of permanent impairment was related to the preexisting arthrosis. (Ex. 47).

Dr. Hanley does not address Dr. Beaman's reports of claimant's improvement over time or his conclusion that the sesamoid injury and resulting symptoms completely resolved. Instead, without explanation or any reference to the medical record, Dr. Hanley took a history of persistent pain in the right foot since the date of injury. (Ex. 52-1). Furthermore, as discussed in our prior order, Dr. Hanley also did not address claimant's preexisting arthrosis, which Dr. Beaman opined resulted in her current mild impairment. Given Dr. Beaman's treatment history, we find his opinion regarding claimant's compensable condition more persuasive.

Accordingly, we withdraw our June 21, 2000 order. On reconsideration, as supplemented herein, we republish our June 21, 2000 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN R. DAVIS, Claimant
WCB Case No. 99-07458
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Meyers, Bock, and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that increased claimant's unscheduled permanent disability for a left shoulder condition from 10 percent (32 degrees), as awarded by an Order on Reconsideration, to 34 percent (108.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for left shoulder rotator cuff tear and left supraspinatus tendon tear. Following the acceptance, claimant's surgeon performed an "acromioplasty, excision of the coracoacromial ligament, debridement and repair of the biceps tendon and repair of the rotator cuff."

A Notice of Closure awarded 19 percent unscheduled permanent disability. The Order on Reconsideration reduced the award to 10 percent unscheduled permanent disability.

The ALJ first agreed with claimant that he was entitled to an additional 5 percent award under OAR 436-035-0330(13) because his surgery had included a "partial resection of the clavicle." The ALJ further found that, when claimant was declared medically stationary, he had not been released to regular work. Thus, the ALJ applied age, education and adaptability factors, resulting in an increase in the award.

On review, the insurer continues to assert that claimant's award should be based only on impairment because, first, he was released to regular work and, second, claimant returned to regular work.

Impairment is the only value considered in evaluating permanent disability if: (1) the worker returns to regular work at the job held at the time of injury, (2) the attending physician releases the worker to regular work and the job is available but the worker fails or refuses to return to that job, and (3) the attending physician releases the worker to regular work but the worker's employment is terminated for causes unrelated to the injury. ORS 656.726(3)(f)(D).

The insurer argues that claimant's attending physician, Dr. Hoda, released claimant to regular work. A March 23, 1999 chartnote from Dr. Hoda stated that light work was not available for claimant "so he would like to return to regular work." (Ex. 22). The chartnote further indicated that claimant "is allowed to return to work on a trial basis." (*Id.*) A Form 828 showed that claimant was released to regular work on March 29, 1999. (Ex. 23).

On May 3, 1999, Dr. Hoda noted that claimant "was laid off and is not doing anything now." (Ex. 24). After the Notice of Closure issued, Dr. Hoda reported that claimant "was allowed to return to modified work requiring no overhead lifting with his left arm and general lifting to be limited to 50 pounds with the left arm on a permanent basis." (Ex. 27). The medical arbiter panel also found that claimant could "lift/carry 50 pounds maximum with the left arm on a frequent basis" and that he was permanently restricted from working the same number of hours as before the injury. (Ex. 28-4).

We disagree with the insurer that claimant was released to regular work. Although the "Form 828" indicates such, the accompanying chartnote shows that the release was on a "trial basis" and Dr. Hoda subsequently clarified that claimant could return to modified work. Thus, we find that the preponderance of evidence shows that claimant was not released to regular work.

The insurer also argues that claimant returned to regular work. The record contains almost nothing concerning this issue. As noted above, on May 3, 1999, claimant told Dr. Hoda that he had been "laid off." The medical arbiters reported that, since the surgery, claimant had been "unable to return to his regular work[.]" (Ex. 28-2).

Although the record shows that claimant probably returned to work, we find insufficient evidence that he returned to regular work. Claimant's report to the medical arbiters that he was unable to return to regular work is consistent with evidence from Dr. Hoda and the medical arbiters that claimant is permanently restricted to modified work. Consequently, based on this record, we conclude that claimant did not return to regular work.

Thus, we further conclude that claimant's permanent disability should not be based only on impairment. Because the parties do not object to the values of the factors applied by the ALJ, we adopt this portion of the ALJ's order.

Finally, the insurer challenges the ALJ's finding that claimant was entitled to additional impairment under OAR 436-035-0330(13) because his surgery included a "partial resection of the clavicle." Although claimant's surgeon did not specifically refer to such a procedure, the ALJ decided that the rule allowed for such an award because the surgeon excised a small protruding portion of the clavicle; relying on medical dictionaries, the ALJ found that such a procedure qualified as a "resection."

In *SAIF v. Calder*, 157 Or App 224 (1998), the court explained that we may resort to medical dictionaries to define medical terms. The court further stated, however, that the Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge and our findings must be based on medical evidence in the record.

Here, by deciding that excision of a portion of the clavicle constituted a "resection," we find that the ALJ went beyond using the medical dictionaries to define medical terms.[1] When looking only at the medical evidence in this case, we find no proof that claimant underwent a "partial resection of the clavicle." *Jan M. Hulke*, 50 Van Natta 1393 (1998) (Board rejected the claimant's argument that, based on medical dictionaries, her surgery included arthroplasty and, in absence of medical evidence of such a procedure, found no entitlement to that impairment value). Thus, we conclude that claimant is not entitled to a value under OAR 436-035-0330(13).

Assembling the factors, claimant has an impairment value of 10 percent (5 percent for loss of range of motion combined with 5 percent for acromioplasty surgery). Claimant's value for age (1) and the value for education (4) results in a factor of 5. The adaptability factor (5) results in a value of 20. Adding the value of 10 percent for impairment, claimant's unscheduled permanent disability award is 30 percent.

Finally, because our order resulted in a decrease of compensation, claimant's attorney is not entitled to an assessed fee for services on review. ORS 656.382(2).

ORDER

The ALJ's February 15, 2000 order, as corrected February 16, 2000, is modified. In lieu of the award of 34 percent (108.8 degrees) unscheduled permanent disability, claimant is awarded 30 percent (96 degrees) unscheduled permanent disability. The ALJ's attorney fee award is modified accordingly.

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[1] In fact, when discussing the issue, the ALJ himself stated that "the specific question is a very technical one and well beyond the expertise of any person who is not a trained physician, yet in this particular case we see three legally trained persons (including the ALJ) trying to 'play doctor.'"

Board Member Biehl dissenting in part.

I disagree with the portion of the majoritys order finding that claimant is not entitled to impairment for surgery under OAR 436-035-0330(13). The majority found that the ALJ "went beyond using the medical dictionaries to define medical terms." I find no error in the ALJ's analysis.

First, at hearing, the parties specifically argued to the ALJ application of the rule, citing to medical dictionaries in support of each of their positions. The employer in particular argued that there was no "resection" as that term is defined by a medical dictionary.

Consistent with *SAIF v. Calder*, 157 Or App 224 (1998), the ALJ resorted to medical dictionaries in deciding whether the administrative rule applied to claimant's surgery. Under *Calder*, the court stated that the Board may rely on dictionary definitions and "reasonable inferences" from the medical evidence in making impairment findings. 157 Or App at 228.

Here, the ALJ, as the parties requested, did just that. In particular, the ALJ compared definitions of words in the administrative rule to the surgery report, reasonably inferred from that medical evidence, and decided that the surgery qualified as a "resection."

In short, the ALJ was not "playing doctor," but he was appropriately analyzing the medical evidence and deciding that a medical procedure qualified as a "resection" under the rule, entitling claimant to that impairment. Because the majority decides to the contrary, I dissent.

In the Matter of the Compensation of
AUDREY J. BIGELOW, Claimant
Own Motion No. 99-0391M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's 1976 cervical claim. Claimant's aggravation rights expired on April 13, 1982. SAIF opposed reopening the claim on the grounds that: (1) no surgery or hospitalization had been requested; (2) surgery or hospitalization was not reasonable and necessary; and (3) claimant was not in the work force at the time of her current disability. Furthermore, claimant had appealed a Managed Care Organizations (MCO's) disapproval of claimant's surgery request as medically unnecessary to the Director of the Medical Review Unit (MRU) of the Workers' Compensation Division. (MRU File No. 12997).

On November 10, 1999, we postponed action on this Own Motion matter pending outcome of that litigation. On May 1, 2000, the MRU issued an Administrative Order (MTX 00-064) which found that the proposed anterior C6-7 discectomy and fusion with graft was inappropriate medical treatment for claimant's compensable injury. That order has not been appealed.

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

Here, the dispute regarding the reasonableness and necessity of claimant's proposed surgery has been resolved. ORS 656.327. In light of the MRU's order, we are unable to find that claimant is entitled to temporary disability compensation for an unauthorized and noncompensable surgery. *See Dorothy Vanderzanden*, 48 Van Natta 1573 (1996). Furthermore, based on MRU's decision, claimant, through her counsel, acknowledges that she is not currently entitled to have her claim reopened under the Boards Own Motion authority.

Under these circumstances, we are unable to grant claimant's request for temporary disability. Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JIMMY G. DEMING, Claimant
WCB Case Nos. 99-07707, 99-07651, 99-04232 & 99-06812
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
James Booth (Saif), Defense Attorney
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Meyers, Bock, and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that upheld Liberty Northwest Insurance Corporation's (Liberty's) compensability and responsibility denial, on behalf of Crown Pacific, Ltd., of cervical "bulging discs and spondylosis other than at the C5-6 level[.]" The SAIF Corporation, on behalf of Mountain High Timber Company, cross-requests review of that portion of the ALJ's order that indicated SAIF's denial of an occupational disease claim was "withdrawn." On review, the issues are compensability and responsibility. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We delete footnote 1. In the third paragraph on page 2, we change the first sentence to read: "On April 4, 1997, Liberty denied the claim concerning the February 1997 injury." In the fourth full paragraph on page 3, we replace the last sentence with the following:

> "On May 7, 1999, Dr. Newby said that claimant's 1997 injury and C5-6 disc herniation remained stable and had not been worsened by the September 1998 injury. (Ex. 41). He believed that claimant's current need for treatment was related to the September 1998 injury. (*Id.*)"

On page 4, we delete the third paragraph. We do not adopt the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

We recap the procedural posture of this case. As a result of 1997 litigation regarding its "combined condition" denial, Liberty has accepted a C5-6 disc herniation related to claimant's February 1997 injury. (Ex. 18). A February 5, 1998 Determination Order awarded claimant 14 percent unscheduled permanent disability for his cervical condition. (Ex. 20).

On September 18, 1998, claimant was injured while working for SAIF's insured. (Ex. 21). SAIF accepted a "contusion right occipital and contusion right posterior neck muscles." (Ex. 27).

A cervical MRI on November 13, 1998 showed that claimant had fusion at C5-6 without residual disc herniation, disc protrusions at C3-4, C4-5 and C6-7, moderate spinal canal stenosis at C3-4, neuroforaminal stenoses, most pronounced at C4-5, and cervical spondylosis. (Ex. 29).

On December 7, 1998, claimant wrote to SAIF regarding the bulging discs shown on the November 13, 1998 MRI. (Ex. 33). Claimant requested that SAIF include those as part of his accepted condition. (*Id.*) On April 2, 1999, SAIF issued a partial denial of claimant's disc bulges at C3-4, C5-6 and C6-7, on the basis that the September 18, 1998 injury was not the major or material cause of those conditions. (Ex. 37). An April 6, 1999 Notice of Closure awarded claimant temporary disability benefits related to the September 18, 1998 injury. (Ex. 40).

On July 21, 1999, Liberty responded to claimant regarding two requests. (Ex. 42). Claimant had requested that Liberty accept disk bulges at C3-4, C4-5 and C6-7, as well as a right trapezius/cervical strain combined with preexisting degenerative cervical spine disease at C3-4 through C6-7. (*Id.*) Liberty said it would seek clarification of whether those conditions were causally related to the February 1997 injury. (*Id.*)

On September 14, 1999, Liberty issued a partial denial of claimant's "disk bulges at C3-4, C4-5 and C6-7 and right trapezius/cervical strain combined with pre-existing degenerative cervical spine disease at C3-4 through C6-7 and responsibility of the conditions and current medical treatment." (Ex. 44-2).

On December 2, 1999, SAIF wrote to the ALJ and indicated that, among other things, claimant was withdrawing his request that SAIF accept additional conditions of bulging discs at C3-4, C4-5 and C6-7. SAIF agreed to withdraw its April 2, 1999 denial and claimant's request for hearing was to be dismissed without prejudice. In addition, SAIF said that claimant was withdrawing his request for hearing regarding SAIF's September 22, 1999 denial of an occupational disease claim of the cervical spine at C3-4, C4-5 and C6-7. The parties agreed that claimant's September 24, 1999 request for hearing was withdrawn and the case was to be dismissed without prejudice.

The ALJ found that the holding in *King v. Building Supply Discount*, 133 Or App 179 (1995) did not apply to this case. The ALJ also found that responsibility for claimant's C5-6 disc herniation did not shift from Liberty to SAIF. The ALJ upheld Liberty's September 14, 1999 denial of compensability and responsibility for "bulging discs and spondylosis other than at the C5-6 level[.]"

On review, claimant relies on *King* to argue that claim preclusion applies as a result of prior litigation and, therefore, Liberty is responsible for his degenerative cervical disease at C3-4 through C6-7. In contrast, Liberty relies on ORS 656.005(7)(a)(B) and ORS 656.262(6)(c) and contends that *King* does not apply here because the statutory frame work has changed.

The doctrine of claim preclusion applies in workers' compensation cases when there is an opportunity to litigate an issue before a final determination and the party against whom the doctrine could be applied fails to litigate the issue. *Drews v. EBI Companies*, 310 Or 134, 140, 142 (1990). "Where there is an opportunity to litigate the question along the road to the final determination of the action or proceeding, neither party may later litigate the subject or question." *Id.* at 140.

In *King v. Building Supply Discount*, the claimant filed a claim for a heart attack. The carrier issued a written denial that denied not only the heart attack claim, but also the claimant's preexisting coronary artery disease (CAD). At hearing, the ALJ found that the heart attack was compensable and the denial was set aside "in its entirety" and remanded to the carrier for processing. The ALJ's order was not appealed. Later, the carrier issued a denial of the CAD. The court held that the carrier was precluded by the prior ALJ's order from contesting the compensability of the CAD. The court found that although no specific claim had been previously made for the CAD, the condition arguably could have been encompassed within the original claim. Moreover, the carrier's denial specifically included that condition. The court reasoned that if the claimant had later sought compensation for the CAD, a denial of that claim would have been upheld on the ground that the denial had become final. Thus, the claimant's opportunity to seek compensation for the CAD would have been lost with his failure to appeal the denial. The court concluded: "[A]lthough no specific claim had been made by claimant for the [CAD], employer's denial specifically including that condition framed the issues that were subject to litigation." *Id.* at 182. The court held that the referee's order setting aside the denial, even if wrong, had the effect of ordering the acceptance of the CAD. Therefore, further litigation of the claimant's CAD condition was barred by claim preclusion. *Id.* at 182-83.

We examine the facts in this case to determine whether the holding in *King* applies here. Claimant was injured on February 7, 1997 while working for Liberty's insured and he filed a claim referring to a right neck injury. (Ex. 1). A March 19, 1997 MRI showed a right-sided disc protrusion at C5-6 with neuroforaminal stenosis and underlying changes of chronic cervical spondylosis involving C3-4 through C5-6 with neuroforaminal compromise at those levels. (Ex. 6). On April 22, 1997, Dr. Newby performed an anterior cervical discectomy at C5-6. (Ex. 10). His postoperative diagnosis was a C5-6 cervical disc herniation. (*Id.*)

On April 4, 1997, Liberty issued a denial, which said, in part:

> "We have received your claim for a right trapezius/cervical strain sustained on February 7, 1997 while employed by [the employer]. Medical information obtained during our investigation of your claim establishes that your right trapezius/cervical strain combined with pre-existing degenerative cervical spine disease at C3-4 through C6-7. The record also shows that the major contributing cause of that combined condition was the pre-existing degenerative cervical spine disease. Furthermore, the record fails to establish that your work exposure with [the employer] was the major contributing cause of any worsening of your pre-existing degenerative cervical spine disease at C3-4 through C6-7.

> "Therefore, without waiving further questions of compensability, we submit this denial of your claim for the combined condition resulting from your right trapezius/cervical strain and your pre-existing degenerative cervical spine disease at C3-4 through C6-7, as your employment with [the employer] did not constitute the major contributing cause of this combined condition." (Ex. 9a).

Claimant requested a hearing, which was held on July 2, 1997. The previous ALJ framed the issue as "[w]hether claimant sustained a compensable C5-6 disc herniation." (Ex. 17-1; footnote omitted). The ALJ found that claimant's preexisting degenerative disc disease combined with the February 7, 1997 injury to produce a "combined condition (*i.e.*, the disc herniation)." (Ex. 17-2). The ALJ concluded that the work injury was the major contributing cause of claimant's disability and need for treatment of the combined condition. The ALJ set aside Liberty's April 4, 1997 denial and ordered the insurer to "accept claimant's claim and process it according to law." (Ex. 17-3). Liberty then accepted a "C5-6 disc herniation." (Ex. 18).

To support his claim preclusion argument, claimant relies on the following portion of Liberty's April 4, 1997 denial:

> "Medical information obtained during our investigation of your claim establishes that your right trapezius/cervical strain *combined with pre-existing degenerative cervical spine disease at C3-4 through C6-7.* The record also shows that the major contributing cause of that *combined condition was the pre-existing degenerative cervical spine disease.* Furthermore, the record fails to establish that your work exposure with [the employer] was the major contributing cause of any worsening of your *pre-existing degenerative cervical spine disease at C3-4 through C6-7.*" (Ex. 9A; emphasis supplied).

We acknowledge that Liberty's denial said that the record failed to establish that claimant's work exposure with the employer was the major contributing cause of any worsening of his preexisting degenerative cervical spine disease at C3-4 through C6-7. (Ex. 9a). Nevertheless, the actual denial language in Liberty's letter referred only to the "combined condition." The letter stated: "Therefore, without waiving further questions of compensability, we submit this *denial of your claim for the combined condition* resulting from your right trapezius/cervical strain and your pre-existing degenerative cervical spine disease at C3-4 through C6-7, as your employment with [the employer] did not constitute the major contributing cause of this combined condition." (*Id.*; emphasis supplied). Thus, although Liberty issued a denial of a "combined condition" that included preexisting degenerative cervical spine disease at C3-4 through C6-7, Liberty did *not* issue a denial of the preexisting cervical degenerative disease itself.

In the *King* case, the carrier's denial said, in part: "Therefore, without waiving further questions of compensability we must issue this partial denial for your recent condition and need for medical treatment, as well as your pre-existing coronary artery disease." Based on that language, the court concluded that the carrier's denial specifically included the coronary artery disease condition. Here, unlike *King*, Liberty's denial did *not* specifically include a denial of claimant's cervical degenerative disease at C3-4 through C6-7. Rather, Liberty denied a "combined condition" that it was subsequently ordered to accept pursuant to the prior ALJ's order. Thus, we conclude that the holding in *King* does not apply to this case. Consequently, we affirm the ALJ's order.[1]

SAIF's Cross-Request for Review

SAIF, on behalf of Mountain High Timber Company, cross-requests review of that portion of the ALJ's order that indicated its denial of an occupational disease claim was "withdrawn." SAIF asserts that the parties agreed that WCB No. 99-07651 could be dismissed without prejudice. SAIF states that the ALJ's order should have said that claimant's request for hearing was withdrawn, not that SAIF's denial was withdrawn. Claimant does not dispute SAIF's cross-request for review. We modify the portion of the ALJ's order regarding WCB No. 99-07651 accordingly.

ORDER

The ALJ's order dated January 10, 2000 is affirmed in part and modified in part. We modify the portion of the ALJ's order concerning WCB No. 99-07651 to read: "Claimant's September 22, 1999 request for hearing (WCB No. 99-07651) is withdrawn and the case is dismissed without prejudice." The remainder of the ALJ's order is affirmed.

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[1] We note that claimant's arguments at hearing and on review were limited to claim preclusion.

Board Member Biehl concurring in part and dissenting in part.

I agree with the majority's decision regarding SAIF's cross-request for review. I disagree, however, with the majority's conclusion that the holding in *King v. Building Supply Discount*, 133 Or App 179 (1995), does not apply to this case.

The majority errs in its interpretation of Liberty's April 4, 1997 denial, which provided, in part:

> "We have received your claim for a right trapezius/cervical strain sustained on February 7, 1997 while employed by [the employer]. Medical information obtained during our investigation of your claim establishes that your right trapezius/cervical strain combined with pre-existing degenerative cervical spine disease at C3-4 through C6-7. The record also shows that the major contributing cause of that combined condition was the pre-existing degenerative cervical spine disease. *Furthermore, the record fails to establish that your work exposure with [the employer] was the major contributing cause of any worsening of your pre-existing degenerative cervical spine disease at C3-4 through C6-7.*
>
> "Therefore, without waiving further questions of compensability, we submit this denial of your claim for the combined condition resulting from your right trapezius/cervical strain and your pre-existing degenerative cervical spine disease at C3-4 through C6-7, as your employment with [the employer] did not constitute the major contributing cause of this combined condition." (Ex. 9a; emphasis supplied).

In its April 4, 1997 letter, Liberty said that the "record fails to establish that your work exposure with [the employer] was the major contributing cause of any worsening of your pre-existing degenerative cervical spine disease at C3-4 through C6-7." (Ex. 9a). Based on that language, I would find that Liberty denied compensability of claimant's degenerative cervical disease at C3-4 through C6-7. Although the previous ALJ focused on compensability of claimant's C5-6 disc herniation during the 1997 litigation, Liberty's denial also specifically included a denial of claimant's cervical degenerative disease at C3-4 through C6-7. As in the *King* case, although no specific claim had been made for that condition, it arguably could have been encompassed within the original claim. The medical evidence discussed a possible occupational disease claim for cervical degenerative disease. On May 27, 1997, Dr. Newby, claimant's treating surgeon, said that claimant's "degenerative changes are probably due to an occupational accumulative injury as relates to his work rather than a normal degenerative condition of wear and tear." (Ex. 13-2). Liberty responded by obtaining a June 13, 1997 report from Dr. Farris, who did not believe claimant's degenerative changes were related to his work activities. (Ex. 14-3).

The majority has interpreted Liberty's April 4, 1997 denial in a hypertechnical manner to conclude that the denial portion of the letter only referred to a combined condition. (Ex. 9a). I do not believe that is a reasonable interpretation, in light of Liberty's express statement that "the record fails to establish that your work exposure with [the employer] was the major contributing cause of any worsening of your pre-existing degenerative cervical spine disease at C3-4 through C6-7." (Ex. 9a). That statement is a denial of claimant's degenerative cervical condition and, therefore, the parties had an opportunity to litigate that condition in 1997.

As in the *King* case, if Liberty's April 4, 1997 denial had been upheld and claimant later sought to establish compensability of his cervical degenerative disease at C3-4 through C6-7, a denial of that claim would likely have been upheld on the ground that Liberty's denial had become final. Although no specific claim had been made by claimant for the cervical degenerative disease, Liberty's denial specifically including that condition framed the issues that were subject to litigation. I agree with claimant that the ALJ's order setting aside Liberty's denial, even if wrong, had the effect of ordering the acceptance of cervical degenerative disease at C3-4 through C6-7. Litigation of that condition is barred by claim preclusion.

I do not agree with Liberty's argument that, pursuant to ORS 656.005(7)(a)(B) and ORS 656.262(6)(c), it is allowed to issue a denial when the compensable injury is no longer the major contributing cause of a combined condition. Claimant correctly responds that Liberty's reliance on those statutes is misplaced because it has accepted the degenerative condition itself as a result of claim preclusion.

I believe that the previous ALJ's order that set aside Liberty's April 4, 1997 denial had the effect of ordering the acceptance of claimant's cervical degenerative disease at C3-4 through C6-7. Thus, the cervical degenerative disease was accepted as a compensable condition in and of itself. The statutes that Liberty cites in support of its position are dependant on the existence of a combined condition in the legal sense. A combined condition in the legal sense is a compensable injury that combines with a preexisting condition or conditions. ORS 656.005(7)(a)(B); *see Freightliner Corp. v. Christensen*, 163 Or App 191 (1999).[1] Here, the preexisting degenerative condition itself is deemed accepted as a matter of law, based on the doctrine of claim preclusion, and may not be denied except as a "back-up" denial pursuant to ORS 656.262(6)(a).

Based on the foregoing reasons, I respectfully dissent from the portion of the majority's opinion that affirms the ALJ's order and upholds Liberty's denial.

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[1] In *Christensen*, 163 Or App at 191, the court said that although the claimant's preexisting conditions combined to give rise to the claimant's need for treatment, they were compensable in their own right as a matter of law under *Georgia-Pacific v. Piwowar*, 305 Or 494 (1988). The court rejected the carrier's argument that ORS 656.005(7)(a)(B), ORS 656.262(6)(c) and ORS 656.262(7)(b) allowed it to deny the degenerative conditions when the injury was no longer the major contributing cause of the combined condition, because the preexisting degenerative conditions were compensable as a matter of law and could not be denied. I would reach a similar conclusion in this case.

In the Matter of the Compensation of
CHRISTOPHER K. HARDING, Claimant
WCB Case No. 99-07198
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that denied his request to change the date of aggravation rights of a new medical condition. On review, the issue is the proper date for claimant's aggravation rights.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 10, 2000 is affirmed.

Board Member Phillips Polich dissenting.

The issue in this case is whether a claimant with a "new medical condition" claim under ORS 656.262(7)(a), which was closed under ORS 656.262(7)(c), is entitled to a new five-year period of aggravation rights. By adopting and affirming the ALJ's order, the majority agrees with the ALJ's conclusion that *John R. Graham*, 51 Van Natta 1740 (1999), did not implicitly overrule *Susan K. Clift*, 51 Van Natta 646 (1999). I respectfully dissent.

I agree with claimant that the *Clift* case should be disavowed. As I stated in *Graham* (Board Members Phillips Polich and Biehl, specially concurring), I would disavow *Clift* based on the reasoning in Member Biehl's dissent in that case. I agree with claimant that he is entitled to new aggravation rights dating from the first closure of the new condition claim.

In the Matter of the Compensation of
JAMES C. HUBBARD, Claimant
WCB Case No. 99-02437
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

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

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

The insurer contends that claimant failed to prove that he sustained a compensable injury. In particular, the insurer argues that: (1) claimant's testimony is not sufficient, considering the inconsistencies of that testimony, to carry claimant's burden of proof that a compensable event occurred; and (2) Dr. Frank's opinion, upon which the ALJ relied, is insufficient to establish the work injury as the major contributing cause of claimant's combined condition. We disagree with each of the insurer's contentions.

We generally defer to an ALJ's demeanor-based credibility findings, and we do so here. *See Bush v. SAIF*, 68 Or App 230, 233 (1984). The ALJ observed claimant closely and carefully during the hearing. (O&O p. 3). Based upon claimant's attitude, appearance, demeanor and responsiveness, the ALJ concluded he was a truthful witness and a reliable historian in all material respects. (O&O p. 3). Because the ALJ had the opportunity to observe the claimant's testimony, she is in a much better position to assess his credibility; her determination is entitled to considerable weight. *See Sherri L. Williams*, 51 Van Natta 75, 77 (1999).

Turning to the substance of claimant's testimony, we note that claimants statement regarding incidents of tripping and stumbling and stepping through pallets as being a common work place occurrence is supported by the testimony of co-worker, Mark Havig.[1] (Tr. 39-40). We also note that claimant's testimony that he had pain after the work incident and had not had that type of pain prior to the incident is supported by the testimony of his wife. (Tr. 31).

We do not dismiss the insurer's credibility argument lightly. We acknowledge that claimant did not report his back pain to the employer until 10 days after the incident. We also recognize that claimant failed to be completely thorough in reporting histories to inquiring doctors.

Nevertheless, considering all the evidence, the substance of claimant's testimony as supported by the testimony of his wife and co-worker, Mark Havig, and the ALJ's credibility finding based upon claimant's demeanor, we conclude that claimant is credible regarding the incident at work whereby he stepped through a pallet and stumbled backward. In other words, we are persuaded that such an event occurred and that claimant experienced low back pain following that event.

The parties do not contest the ALJ's conclusion that the compensability of claimant's low back strain injury is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that his low back condition is compensable, claimant must show that his work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 149 Or App 309, 315 (1997) *rev den* 326 Or 389 (1998).

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of claimant's preexisting condition and

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[1] Havig has no specific memory of the event in question. (Tr. 37). However, Havig did testify that worker's tripping and stumbling was commonplace. (Tr. 39). He further testified that workers have "pallets break on them" three to four times a night. (Tr. 39-40).

the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986).

The ALJ determined that Dr. Frank's opinion, as the treating surgeon, was sufficient to establish medical causation of a combined low back condition. The insurer argues that Dr. Frank's opinion is insufficient to establish medical causation because: (1) is it based upon an incorrect history; and (2) it is unexplained. The insurer suggests that Dr. Fuller's opinion is better reasoned, and based upon more complete information. Therefore, the insurer concludes that Dr. Fuller's opinion more persuasive. We disagree with the insurer's contention that Dr. Fullers opinion is more persuasive.

Dr. Fuller originally saw claimant in April 1999 at the request of the insurer. At the time he took the following description of the injurious event:

> "On 02/05/99, he was a member of a crew which was unloading a semi. His job was to put product for the hardware department onto a pallet. He was carrying a box weighing up to 30 pounds, stepping on the slat of a pallet when the board broke and he went down several inches. He staggered and was grabbed by another worker and thus he didnt hit the ground. He reports that he felt an immediate twinge of pain in his low back, which he figured was a pulled muscle and which he therefore ignored."[2] (Ex. 11-2).

As a result of that description, Dr. Fuller opined: "The mechanism of injury alleged to have occurred on 02/05/99 is also reasonable to cause a disc herniation." (Ex. 11-5).

In July 1999, the insurer's counsel had a telephone conference with Dr. Fuller. During that conference, the insurer's counsel asked Dr. Fuller to assume that the mechanism of injury was "far less spectacular" than what had been reported to him in April 1999. (Ex. 22-1). Following the telephone conference, Dr. Fuller opined: "the specific incident described on 02/05/99 is not medically probable to have a caused the disc herniation at L4-5." (Ex. 22-2). Based upon a proposed set of facts from the insurer's counsel, Dr. Fuller changed his opinion regarding the work incidents ability to cause a herniated disc.[3]

We note that in rendering his July 1999 opinion, Dr. Fuller did not review Dr. Frank's operative report. Moreover, having previously concluded that the work incident as described by claimant most likely occurred, to the extent that Dr. Fuller's opinion rests on some other event, his opinion is based upon incomplete information. Accordingly, it is not persuasive and we do not rely on it. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

In July 1999, Dr. Frank first concluded that claimant's work injury was the major contributing cause of claimant's disability and need for treatment of claimant's combined low back condition. (Ex. 18-2). Dr. Frank explained that during surgery he found a distinct disc fragment on the right side that had herniated upwards. (Ex. 23-3). Based on that surgical finding, and on a complete copy of the medical records, the various imaging studies, and claimant's description of the work event, Dr. Frank opined that the work injury resulted in further herniation of disc material, causing the fragment found during surgery. (Ex. 23-3). He further opined: (1) that it was the disc fragment that caused the need for claimant's surgery; and (2) that claimant's preexisting degeneration (aging) of the spine did not play a significant role in either the work injury or the subsequent need for surgery. (Ex. 23-2, 3).

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[2] At hearing, claimant's description of the event is essentially the same as that reported to Dr. Fuller except that at hearing the height of the pallet was reported as 4 inches instead of "several inches." (Tr. 6-7). In addition, it was reported at hearing that claimant did not actually know if a co-worker caught him. Apparently as he stumbled backward, he made physical contact with a co-worker; the physical contact kept him from falling. (Tr. 6, 19-20).

[3] Because the description of the work incident as related by the insurer's counsel to Dr. Fuller is not contained in this record, we consider Dr. Fuller's change of opinion to be unexplained. An unexplained change of opinion renders a physician's opinion unpersuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

The insurer argues that Dr. Frank's demur to a direct inquiry about the work injury having sufficient force to cause a disc herniation, undercuts his opinion that the work injury was major contributing cause of claimant's disability and need for treatment of the combined low back condition. (Ex. 22A-2, 23-3). We disagree. We conclude, based upon the wording of the inquiry, that Dr. Frank interpreted the question as whether the work injury was of sufficient force to cause an initial disc herniation, as opposed to the additional herniated material that made up the disc fragment he found during surgery.

As the treating surgeon, Dr. Frank had the opportunity to view claimant's disc fragment first hand.[4] Accordingly, his opinion based upon his actual surgical observations is entitled to great weight. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988). Dr. Frank's opinion is also supported by the opinion of Dr. George, who reviewed the records at the request of claimant's counsel, and the concurrence of Dr. Gallagher, the original treating physician. (Ex. 20, 20A).

In conclusion, based upon the extent of Dr. Frank's explanation, including his opinion that claimant's preexisting degenerative problems had little significance in claimant's need for surgery, we conclude that Dr. Frank's well reasoned opinion, as supported by Drs. George and Gallagher, persuasively establishes that the major contributing cause of claimant's disability or need for treatment of his combined low back condition was the work injury of February 1999. Consequently, we affirm the ALJ's order that set aside the insurer's denial of that claim.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,462.50, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsels uncontested request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 12, 2000 is affirmed. For services on review, claimant is awarded a $1,462.50 attorney fee, payable by the insurer.

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[4] The insurer argues, that because Dr. Frank did not provide a detailed description of the disc fragment, that his opinion must not be based upon his surgical observations. We disagree. Considering the extent to which Dr. Frank analyzed the preexisting degeneration and disc bulge, as well as the additional herniated material that resulted the disc fragment found during surgery, we conclude that his opinion is necessarily based upon his surgical observations. Accordingly, we give it great weight.

In the Matter of the Compensation of
VERNA J. JOHNSON, Claimant
WCB Case No. 99-08233
ORDER ON REVIEW
Raymond Bradley, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Nichol's order that: (1) upheld the SAIF Corporation's denial of claimant's injury claim for a left knee condition; and (2) declined to asses a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm the order of the ALJ with the following supplementation. Claimant contends the history of the injury contained in the medical records together with the physician's statements that the history is consistent with the mechanism of injury is sufficient establish the compensability of her left knee condition. We disagree.

Even if we assume that claimant's history of injury is consistent, the medical record does not relate the cause of claimant's meniscal tear to the injury she described at work. Moreover, the record lacks a medical opinion indicating that the described injury is consistent with a mechanism that can cause a torn meniscus. In other words, the record is completely devoid of any medical opinion concerning the cause of claimant's torn meniscus.

On this record, claimant has failed establish the compensability of her left knee condition. ORS 656.266; ORS 656.005(7)(a).

ORDER

The ALJ's order dated February 7, 2000 is affirmed.

In the Matter of the Compensation of
CINDY MAY-ARTHUR, Claimant
WCB Case No. 99-09069
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Bock, Haynes, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that awarded 1 percent (3.2 degrees) unscheduled permanent disability for claimant's post traumatic stress disorder. Claimant cross-requests review, arguing that her unscheduled permanent disability award should be increased to 6 percent. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's order findings of fact with the following changes. In the third sentence of the first paragraph on page 2, we delete the date. At the end of the first paragraph on page 2, we add the following sentence: "On October 26, 1998, the employer accepted a disabling post traumatic stress disorder. (Ex. 17)." In the first paragraph on page 3, we change the first sentence to read: "On June 18, 1999, the employer issued a Notice of Closure that did not award any permanent disability. (Ex. 74)."

CONCLUSIONS OF LAW AND OPINION

We briefly recap the procedural posture of this claim. In August 1989, claimant began working for the employer as an assistant branch manager. In August 1998, a claim was filed for claimant's work-related stress related to a robbery and a subsequent trial of the alleged robber. (Ex. 4). On October 26, 1998, the employer accepted a disabling post traumatic stress disorder. (Ex. 17).

On June 18, 1999, the employer issued a Notice of Closure that did not award any permanent disability. (Ex. 74). Dr. Klein, psychiatrist, performed a medical arbiter examination on September 28, 1999. (Ex. 90). A November 10, 1999 Order on Reconsideration awarded only temporary disability benefits. (Ex. 92). Claimant requested a hearing.

At hearing, claimant argued that her post traumatic stress disorder resulted in a Class 1 permanent psychological impairment and she is entitled to a 5 percent impairment value, based on a sliding scale of zero to 5 percent. The employer argued that claimant was not entitled to an award of unscheduled permanent disability.

The ALJ relied on the opinions of Drs. Klein and Klecan and found that claimant qualified for a Class 1 permanent impairment for an anxiety disorder, pursuant to OAR 436-035-0400(5)(a). The ALJ rejected claimant's argument that the administrative rule provided for a sliding scale of zero to 5 percent. The ALJ reasoned that Class I impairment only provided for a zero percent impairment value

and, therefore, her post traumatic stress disorder was ratable, but ratable at a value of zero. The ALJ concluded that claimants Class 1 anxiety disorder was "measurable" and found that claimant was entitled to a social/vocational factor of "1" under OAR 436-035-0300, which gave her an unscheduled permanent disability award of 1 percent.

On review, the employer argues that even if claimant qualifies for Class 1 mental disorder impairment, that value is zero and, therefore, there is no measurable impairment. *See* OAR 436-035-0270(2) (if there is no measurable impairment under these rules, no award of unscheduled permanent partial disability shall be allowed). The employer contends that if there is no measurable impairment, there can be no consideration of the non-impairment factors.

Claimant cross-requests review, arguing that her unscheduled permanent disability award should be increased to 6 percent. She contends that Class 1 impairment under OAR 436-035-0400(5) provides a range of zero to 5 percent impairment. Claimant relies in part on the fact that Class 2 impairment ranges from 6 to 35 percent.

OAR 436-035-0400(5) (WCD Admin. Order No. 98-055) provides, in part:

> "Loss of function attributable to permanent symptoms of affective disorders, anxiety disorders, somatoform disorders, and chronic adjustment disorders shall be rated according to the following classes, with gradations within each class based on the severity of the symptoms/loss of function:
>
> "(a) Class 1: (0%) A worker belongs in Class 1 when one or more of the following residual symptoms are noted:
>
> "(A) Anxiety symptoms: Require little or no treatment, are in response to a particular stress situation, produce unpleasant tension while the stress lasts, and might limit some activities."

For the purpose of rating permanent disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter's findings, if any, may be considered. *See* ORS 656.245(2)(b)(B), ORS 656.268(7); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). Under OAR 436-035-0007(14), 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."

Claimant's attending physician at the time of claim closure was Dr. O'Hearn. Her treating psychologist was Dr. Wicher. Drs. O'Hearn and Wicher concurred with Dr. Klecan's April 22, 1999 report. (Exs. 56, 67, 91).

Dr. Klecan found that claimant's post-traumatic stress disorder had resolved and she had no current psychological problems, except for some relatively minor residual and occasional lapses in concentration or attention. (Ex. 56-12). He noted that it still disturbed claimant to recall the events of the last year and "probably always will to some extent." (*Id.*) Dr. Klecan concluded that claimant no longer suffered from a mental or emotional disorder and she had "only occasional and mild residual subjective symptoms[,]" which he felt were more or less permanent. (Ex. 56-13). Objectively, claimant's mental state was normal. (*Id.*) In response to a question of whether claimant was capable of working at her regular employment, Dr. Klecan said:

> "Yes. [Claimant] is capable of working at her regular employment now. She has no impediments to doing so. Her reported occasional lapse in attentiveness was not observed by us today, although we do not doubt that she may sometimes experience this. Even if present, such a complaint is not a significant limitation." (Ex. 56-14).

Dr. Klecan concluded that claimant's permanent impairment was "very mild, limited to subjective reports of occasional lapses in attentiveness in conversation." (*Id.*)

Dr. Klein performed a medical arbiter examination on September 28, 1999. (Ex. 90). She reported that claimant's post traumatic stress disorder had resolved and was no longer an issue. (Ex. 90-5). She noted, however, that claimant had a significant problem with resentful feelings about the employer because she felt they had not supported her. (*Id.*) Nevertheless, Dr. Klein said that claimant was functioning well and had good relationships at work. (*Id.*) Claimant reported to Dr. Klein that she was not increasing her hours "because she just doesn't feel motivated at this time." (*Id.*) Claimant also reported that, despite having occasional lapses of concentration and attention, she was functioning well at her job and was exceeding expectations. (Ex. 90-6). Dr. Klein explained:

> "In short, this is an individual who still ruminates a bit about her problems, has some mild attention and concentration problems at times and at times feels like isolating herself a bit but otherwise is doing well. These complaints are remnant of what happened with the robbery and then what happened with her relationship with [the employer], but these do not constitute a psychiatric disorder.
>
> "I do not feel that the patient has any disability of a psychiatric nature with the single exception that she reports having some discomfort in going back to working with cash out front where she might be robbed. I think this is a frequent residual from this type of occurrence, i.e., a traumatic situation. Some people never do get back to the 'scene of the crime,' and I think it probably makes sense to allow this nice lady to make a decision whether to handle cash or not. She herself thought that maybe some time in the future she could. * * * This is really a matter of common sense whether or not she should handle cash rather than a psychiatric question." (*Id.*)

Both Dr. Klecan and Dr. Klein concluded that claimant's post traumatic stress disorder had resolved. They both indicated that claimant had occasional mild concentration or attention problems. Dr. Klein relied on claimant's report that she had occasional lapses of concentration and attention. (Ex. 90-6). Dr. Klecan noted that claimant's occasional and mild residual symptoms were "subjective" and objectively, her mental state was normal. (Ex. 56-13). Dr. Klecan reported that claimant's current level of functioning both on and off the job was normal. (Ex. 56-13). Similarly, Dr. Klein said that claimant was functioning well at her job and was exceeding expectations. (Ex. 90-6).

Despite the fact that Dr. Klein reported that claimant had some "discomfort" about going back to working with cash in a branch, Dr. Klein said that claimant herself thought she might be able to do so at some time in the future. (Ex. 90-6). Dr. Klecan concluded that claimant was capable of working at her regular employment and had no impediments to doing so. (Ex. 56-14). Drs. O'Hearn and Wicher concurred with Dr. Klecan's report. (Exs. 67, 91). Dr. Klein explained that claimant was not increasing her hours at work because "she just doesn't feel motivated at this time." (Ex. 90-5).

Based on the medical reports, we are not persuaded that claimant had a "[l]oss of function attributable to permanent symptoms" of an anxiety disorder, as required by OAR 436-035-0400(5). Under OAR 436-035-0007(1), a worker is entitled to a value only for those findings of impairment that are *permanent*. The medical evidence does not support the conclusion that claimant's subjective symptoms of anxiety are permanent. Moreover, Dr. Klein said that whether or not claimant should handle cash at work was not a psychiatric question, but was a matter of common sense. (Ex. 90-6). Under these circumstances, we conclude that claimant is not entitled to an award of unscheduled permanent disability.[1]

ORDER

The ALJ's order dated March 28, 2000 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

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[1] In light of our conclusion, we need not address claimant's argument that her unscheduled permanent disability award should be increased from 1 percent to 6 percent.

Board Member Biehl concurring in part and dissenting in part.

The majority concludes that claimant is not entitled to an unscheduled permanent disability award for her post traumatic stress disorder. Although I do not agree with claimant that her unscheduled permanent disability award should be increased to 6 percent, I would affirm the ALJ's order that awarded 1 percent unscheduled permanent disability. For the following reasons, I respectfully dissent.

The majority errs by finding that claimant is not entitled to Class 1 impairment under OAR 436-035-0400(5)(a). The medical evidence in this case clearly satisfies the requirements of that administrative rule. OAR 436-035-0400(5)(a) provides that a worker belongs in Class 1 when one or more of these residual symptoms are noted:

> "(A) Anxiety symptoms: Require little or no treatment, are in response to a particular stress situation, produce unpleasant tension while the stress lasts, and might limit some activities."

I agree with the ALJ's analysis of the medical evidence. The ALJ relied on the opinion of the medical arbiter, Dr. Klein, who concluded that claimant had some permanent disability in the form of "some discomfort in going back to working with cash out front where she might be robbed." (Ex. 90-6). In addition, Dr. Klecan, who examined claimant on behalf of the employer, agreed that claimant had permanent impairment in the form of very mild, limited occasional lapses in attentiveness in conversation and disturbing emotions with recollection of the robbery. (Ex. 56-12 to 56-14). Dr. O'Hearn, claimant's attending physician, and Dr. Wicher, claimant's psychologist, concurredwith Dr. Klecan's report. (Exs. 67, 91). Based on those reports, I agree with the ALJ that claimant's discomfort in working with cash where she might be robbed qualifies as anxiety symptoms in response to a particular stress situation, which produce unpleasant tension while the stress lasts and might limit some of her activities. Based on OAR 436-035-0400(5)(a), claimant qualifies for Class 1 permanent impairment for an anxiety disorder.

Furthermore, I agree with the ALJ that claimant is entitled to a 1 percent unscheduled permanent disability award. The ALJ reasoned that the fact that claimant's post traumatic stress disorder qualifies as a Class 1 anxiety disorder for purposes of rating permanent disability means that claimant's impairment under these rules is measurable. Although that measure is zero, the Class 1 impairment criteria were created to allow for the measurement of mental impairment less than Class 2. The ALJ correctly determined that claimant's residual anxiety symptoms prevent her from returning to her position at injury, which involved dealing with cash, thereby resulting in diminished earning capacity. Claimant is entitled to an unscheduled permanent disability award if the social and vocational factors provide for such an award.

OAR 436-035-0280 explains how the factors are assembled that relate to unscheduled permanent disability. The first step is to determine the basic value that represents impairment. OAR 436-035-0280(1). OAR 436-035-0400(5)(a) provides for an impairment value of zero. The appropriate value for the age factor is then determined. OAR 436-035-0280(2). Claimants uncontested brief indicates that she was 34 years old and, therefore, a value of zero is given. OAR 436-035-0290(2).

Next, the appropriate value for the education factor is determined. OAR 436-035-0280(3). Claimants unrebutted brief indicates she has a high school education. Under OAR 436-035-0300(2)(a), a value of zero is allowed. Under OAR 436-035-0300(3), a value for a worker's "Specific Vocational Preparation" (SVP) time is allowed based on the job(s) the worker has performed during the five (5) years preceding the date of issuance. The ALJ correctly found that claimant's position as an assistant branch manager of a financial institution is described in DOT 187.167-070, which has an SVP of 7. Under OAR 436-035-0300(4), claimant is entitled to a value of 1. Thus, claimants final education factor is valued at 1. The age and education values are added, for a total of 1. OAR 436-035-0280(4).

The appropriate value of the adapability factor is then determined.[1] OAR 436-035-0280(5); OAR 436-035-0310. Claimant's adaptability is measured by comparing her Base Functional Capacity (BFC) to her maximum Residual Functional Capacity (RFC). OAR 436-035-0310(2). The evidence indicates that claimant's BFC was "light." There is no evidence to indicate that claimant's RFC has changed. Comparing claimant's BFC of "light" with her RFC of "light" results in an adaptability factor of 1. OAR 436-035-0310(6).

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[1] Although claimant's brief indicates she is entitled to an adaptability factor of "zero," OAR 436-035-0310(1) provides that the range of impact for the adaptability factor is from "1 to +7."

OAR 436-035-0280(6) provides that the age and education total (1) is multiplied by the adaptability factor (1), which equals 1. Under OAR 436-035-0280(7), that result (1) is added to the impairment value (0), which equals the percentage of permanent unscheduled disability to be awarded. Thus, by applying the factors of age, education and adaptability pursuant to OAR 436-035-0280, I agree with the ALJ that claimant is entitled to an award of 1 percent unscheduled permanent disability. The majority errs by reaching a contrary result.

In the Matter of the Compensation of
LESLIE MOON, Claimant
Own Motion No. 00-0228M
OWN MOTION ORDER DENYING CONSENT TO DESIGNATION
OF PAYING AGENT (ORS 656.307)
Christopher A. Slater, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

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 Libety NW Insurance Corp. expired March 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 contains no request for surgery for claimant's compensable condition. Thus, the record fails to establish that there has been a worsening of the compensable injury which requires inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, based on this record, the Board may not authorize the payment of temporary disability compensation on its own motion.

Accordingly, the Board is without authority to consent to an order designating a paying agent for the purposes of temporary disability compensation. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. *See* OAR 436-060-0180(13).

IT IS SO ORDERED.

In the Matter of the Compensation of
BYRON PHILLIPS, Claimant
WCB Case No. 99-07172
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that awarded claimant 5 percent (16 degrees) scheduled permanent disability for loss of use or function of his left foot (ankle), whereas an Order on Reconsideration awarded no scheduled permanent disability. With his respondent's brief, claimant, *pro se*, has submitted documents pertaining to medical services. The documents were not previously admitted at hearing. We treat such submissions as a motion for remand. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand, medical services, and extent of scheduled permanent disability. We vacate in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the second paragraph on page 3 of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Remand/Medical Services

Claimant has submitted documents not admitted at hearing. Generally, we would treat such submissions as a request for remand. *See, e.g., Judy A. Britton*, 37 Van Natta 1262. However, in this case, we need not determine whether remand is appropriate as we conclude that neither we nor the ALJ had jurisdiction over the matter raised by claimant.

Specifically, in correspondence to the ALJ, the parties indicated that an issue existed regarding the payment of medical bills.[1] Claimant argued that a medical bill for a bone scan had not been completely paid by the insurer. The insurer contended, however, that it had paid approximately one-third of the bill and because the bill exceeded the fee schedule or customary allowance, the provider was not allowed to bill claimant for the remainder. In her Opinion and Order, the ALJ listed the insurer's failure to pay the medical bills as an issue to be decided. The ALJ also found that the insurer was responsible for the bills and the Order portion of the Opinion and Order provided that, "With respect to medical services claimant received in April, 1999, namely exrays [sic] and a bone or CT scan, they are compensable and the responsibility of [the insurer]." Opinion and Order, pg. 5.

We conclude that the Board and its Hearings Division do not have jurisdiction over the issue of the medical services dispute in this case. We recently held that whether medical treatment qualified as compensable medical services under ORS 656.245, or whether a carrier was required to pay for requested medical services, was a matter that was subject to the Director's jurisdiction. *Vicki L. Mangum*, 52 Van Natta 1006 (2000).

In *Mangum*, we noted that, in 1999, the legislature amended ORS 656.704(3)(b), which addresses jurisdiction regarding medical service disputes. Consistent with the statute, the Board and Director have adopted rules providing that questions of causation are determined by the Board and its Hearings Division, whereas, once causation is resolved, the Director proceeds with review of any remaining medical service dispute. *See* OAR 436-009-0008(2)(b), (d); 436-010-0008(4), (6). In other words, the Board has jurisdiction to resolve disputes over the compensability of medical conditions and over whether medical treatment is causally related to the compensable injury. *Id.*

Here, however, there is no dispute that the bills are related to claimant's compensable injury and are the responsibility of the insurer under the Director's rules regarding the payment of medical

[1] The case was decided on the written record, in lieu of convening a hearing.

bills.[2] Moreover, ORS 656.248(12) provides that, when a dispute exists between an injured worker, insurer or self-insured employer and a medical service provider regarding either the amount of the fee or nonpayment of bills for compensable medical services, the injured worker, insurer, self-insured employer or medical service provider shall request administrative review by the director. Consequently, we find that jurisdiction over this matter lies with the Director, rather than the Board or Hearings Division.

Accordingly, to the extent that the ALJ's order purported to address the medical services dispute existing in this case between claimant, the insurer and the medical services provider, that portion of the order is vacated.

Extent of scheduled permanent disability

The ALJ found that the opinion of Dr. Buuck, claimant's treating doctor, was sufficient to establish that claimant had a chronic condition limiting repetitive use of his ankle. We disagree.

The applicable rule provides, in pertinent part, that a worker is entitled to a 5 percent scheduled chronic condition impairment value when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of a body part. OAR 436-035-0010(5).

Here, the medical arbiter, Dr. Madhani, found that claimant was "currently working full time as an electrician but avoids climbing ladders." However, Dr. Madhani did not find that claimant had a chronic condition with regard to his left ankle. (Ex. 18).

On February 16, 1999, Dr. Buuck reported that claimant had been previously cleared for all activities and, with the exception of some slight aching in his ankle, seemed to be "getting along fine." Dr. Buuck found that claimant was medically stationary and was cleared for all activities. (Ex. 11). On April 30, 1999, Dr. Buuck reported that claimant seemed to do fine if kept at level ground and was not working at heights or up on platforms. Dr. Buuck reported that he had agreed to change claimant's work restrictions "temporarily, for the next three months, to just working on level ground and not at heights." (Ex. 17).

After reviewing Dr. Buuck's opinion, we are unable to find that claimant has established an entitlement to a chronic condition award. Dr. Buuck has indicated that claimant's restrictions were only temporary, which is not sufficient to establish an award of permanent disability. *See Sandra A. Burns*, 48 Van Natta 2481 (1996) (doctor's statements that restrictions were going to be in place until a subsequent evaluation did not establish that it was medically probable that the claimant required permanent restrictions). Moreover, 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., Gorden L. Atkins*, 52 Van Natta 284 (2000); *Rena L. Rose*, 49 Van Natta 2007 (1997).

Accordingly, we conclude that the record does not support an award of scheduled permanent disability for a chronic condition involving claimant's left ankle. That portion of the ALJ's order is therefore reversed.

ORDER

The ALJ's order dated April 3, 2000 is vacated in part and reversed in part. To the extent that the ALJ's order purports to address an issue involving disputed medical services, it is vacated. The ALJ's award of 5 percent scheduled permanent disability is reversed. The Order on Reconsideration is affirmed in its entirety.

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[2] Claimant is this case contests his responsibility for "two thirds of the bill." That reference may suggest that the medical service provider is billing claimant for the remainder of a bill. If that is accurate, claimant may wish to seek Director review under ORS 656.248(12). Because claimant is not represented, 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
MARILYN J. WATKINS, Claimant
WCB Case Nos. 99-08963 & 99-06210
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
VavRosky, et al, Defense Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

EBI Insurance Company requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its responsibility denial of claimant's "new injury" claim for a low back condition; and (2) upheld SIMS, Inc.'s denial of claimant's aggravation claim for the same condition. On review, the issues are responsibility and aggravation. 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 Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is a 46 year-old registered nurse who began working for the employer in 1989. She suffered an on-the-job injury to her low back in 1982. This injury resolved quickly without permanent impairment. On October 10, 1995, claimant re-injured her back attempting to catch a 200-pound patient. (Ex. 11). She was diagnosed with a low back strain. Her claim was accepted by the employer's processing agent, SIMS. (Ex. 16).

Claimant suffered a similar injury catching a patient on March 12, 1997. She again had the onset of low back pain and a diagnosis was made of sacroiliac strain. (Ex. 27). SIMS accepted claimant's claim for "sacroiliac strain." (Ex. 41). She missed more than two months from work as a result of this injury, but returned to her regular duties and was awarded no permanent disability. (Ex. 43).

On January 21, 1999, claimant again experienced increased low back symptoms after moving furniture at work. She had the immediate onset of low back pain which worsened the next morning. (Tr. 25). Claimant filed a claim for this injury, which was denied by the employer's insurer, EBI. Claimant also filed a claim for aggravation with SIMS, alleging that her 1995 and 1997 injuries had compensably worsened. In response, SIMS issued a responsibility and aggravation denial.

The ALJ set aside EBI's responsibility denial, relying on the opinion of claimant's treating physician, Dr. Stewart. On review, EBI challenges the ALJ's interpretation of the medical evidence, (particularly that from Dr. Stewart) in assigning it responsibility for claimant's low back condition. We disagree with the ALJ's analysis and reverse the responsibility decision.

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. * * * 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."

ORS 656.308(1) operates together with ORS 656.005(7) to assign responsibility when a compensable preexisting condition resulting from a prior injury combines with a subsequent accidental injury.[1] *SAIF v. Drews*, 318 Or 1, 18-19 (1993), *Darold E. Perry*, 50 Van Natta 788, 789 (1998). If the

[1] There is no dispute here that claimant's new injury is for the same condition as her prior compensable condition.

subsequent accidental injury is found to be the major contributing cause of the ensuing disability or need for treatment, then the claimant is considered to have sustained a "new compensable injury," and responsibility shifts to the subsequent carrier. If, however, the preexisting compensable condition is the major contributing cause of the "combined condition," then the first sentence of the statute applies and responsibility remains with the original carrier. *Darold E. Perry*, 50 Van Natta at 789.

In evaluating conflicting medical opinions, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). Moreover, generally, we rely on the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Stewart.

Dr. Stewart initially concurred (for the most part) with the opinion of examining physicians Drs. McKillop and Dietrich, who concluded that claimant's January 21, 1999 injury was not a "new injury" but instead an "exacerbation or recurrence of her original injury in 1995." (Exs. 60-6, 63).

However, Dr. Stewart then concurred with the opinion of Drs. Fuller and Snodgrass, who performed an examination of claimant at the request of SIMS. Drs. Fuller and Snodgrass believed that claimant's January 1999 injury was a new injury, and not a worsening of her prior back condition. (Ex. 73A-9). Dr. Stewart then wrote a letter to claimant's counsel, in which he stated that the 1999 injury was not a new injury, but "more of a waxing and waning of her symptoms." (Ex. 83-3).

Inconsistent medical opinions are entitled to little, if any, weight. *Constance D. Wilbourn*, 51 Van Natta 1541 (1999). Dr. Stewart's opinions, summarized above, have been inconsistent. Moreover, Dr. Stewart's final opinion attributes responsibility to the earlier (1995 and 1997) injuries, not to the 1999 injury. (Ex. 83-3). Therefore, even if we were to rely on Dr. Stewart as claimant's treating physician, his final opinion supports a finding of responsibility against SIMS, not EBI.

We find that the opinion of Drs. McKillop and Dietrich is the most well-reasoned and therefore persuasive. In particular, Drs. McKillop and Dietrich relied on an accurate history of no specific injury in 1999. Claimant consistently stated that she was moving chairs at work on January 21, 1999, but never identified a specific injury associated with that activity. (*See* Tr. 24, Ex. 56). In contrast, Drs. Fuller and Snodgrass failed to distinguish between claimant's earlier, distinct injuries in 1995 and 1997, and her reoccurrence of back pain with activity in 1999. (Ex. 73A; Tr. 18, 21, 25).

Moreover, Dr. Detweiler, claimant's former treating physician, concurred with Drs. McKillop and Dietrich. (Ex. 62). As EBI correctly notes, Dr. Detweiler is the only physician to have treated claimant both before and after her January 1999 work incident. (Exs. 20A, 21, 24A, 45A). *Kienow's Food Stores v. Lyster*, 79 Or App 416, 421 (1986)(Opinion by physician who examined the claimant before and after an injury is persuasive). As such, we also find Dr. Detweiler's concurrence persuasive and corroborative of the opinion of Drs. McKillop and Dietrich.

In conclusion, based on our *de novo* review, the more persuasive medical opinion from Drs. McKillop and Dietrich indicates that claimant's 1999 injury was merely a waxing and waning of symptoms related in major part to her 1995 and 1997 injuries. Therefore, we are not persuaded that claimant sustained a new compensable injury. As such, responsibility for claimant's low back condition remains with SIMS. Accordingly, we reverse that portion of the ALJ's order that assigned responsibility to EBI.

Because we have determined that SIMS is the responsible carrier, we must then analyze whether claimant has proved a compensable aggravation of her 1997 injury.[2] ORS 656.273(1). Because the ALJ found EBI responsible for claimant's claim, this issue has not been addressed. In accordance with *SAIF v. Walker*, 330 Or 102 (2000), we examine this record to determine if medical evidence establishes that claimant's symptomatic worsening represents an "actual worsening" of the underlying condition. *Norma L. Lamerson*, 52 Van Natta 1086 (2000).

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[2] The parties stipulated that claimant's 1995 and 1997 injuries can be treated as one injury (the 1997 date of injury) for purposes of this litigation. (Ex. 78A).

Claimant has not advanced any argument that she has proved a compensable aggravation. Moreover, our review of the record does not review persuasive evidence to support an "actual worsening" of claimant's compensable condition, Specifically, Dr. Fuller and Dr. Stewart stated that claimant's 1999 injury represented a "waxing and waning" of symptoms related to her earlier low back injuries. (Ex. 82-1, 83-3). Such evidence does not satisfy claimant's burden of proving a compensable aggravation. *SAIF v. Walker*, 330 Or at 119. Because there is no medical evidence that claimant's low back condition has actually worsened since the May 30, 1997 Notice of Closure, we affirm that portion of the ALJ's order that upheld SIMS' aggravation denial.

ORDER

The ALJ's order dated February 24, 2000 is reversed in part and affirmed in part. SIMS' denial of responsibility is set aside, and the claim is remanded to SIMS for processing according to law. EBI's denial is reinstated and upheld. As the responsible carrier, SIMS is now responsible for payment of the ALJ's attorney fee award. The ALJ's order is otherwise affirmed.

In the Matter of the Compensation of
HENRY M. PARNELL, Claimant
WCB Case Nos. 99-06167 & 99-06166
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our June 28, 2000 order that affirmed the classification of claimant's right elbow injury as disabling. Specifically, the insurer contends that our order failed to properly weigh Dr. Lundquist's record entries indicating he expected claimant's right elbow condition to improve over time. After considering the employer's arguments, we continue to adhere to our prior order with the following supplementation.

We acknowledge that Dr. Lundquist's records from December 29, 1998, through April 14, 1999, indicate improvement in claimant's right elbow condition. (Ex. 72, 74, 75). We also note that on May 14, 1999, Dr. Lundquist records a set back in claimant's condition. (Ex. 78). We further note that Dr. Lundquist was not asked to comment and consequently did not comment on whether there was a reasonable likelihood that permanent disability would result from claimant's right elbow condition. Under these circumstance, contrary to the urging of the employer, we will not infer that Dr. Lundquist's observations of improvement in claimant's condition from December 29, 1998, to April 14, 1999, is equivalent to an opinion that there exists no reasonable likelihood of permanent disability from the right elbow condition.[1]

On reconsideration, as supplemented herein, we republish our June 28, 2000 order in its entirety. The parties rights of appeal shall begin to run from the date of this order.

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[1] In contrast, the sole purpose of Dr. Williams's medical arbiter examination was to determine the existence of the likelihood for permanent impairment from the right elbow condition. (Ex. 85-2). We note that on December 14, 1998, Dr. Watson, who saw claimant at the employer's request, indicated that claimant's right elbow condition was resolving, with residua. (Ex. 70-5). We conclude from those remarks that Dr. Watson was of the opinion that a reasonable likelihood of permanent disability existed as a result of claimant's accepted right elbow conditon.

In the Matter of the Compensation of
JOSEPH R. ZWINGRAF, Claimant
WCB Case No. 99-04299
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Reinisch, 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: (1) found its denial of claimant's current condition encompassed a right medial meniscus tear; (2) denied its motion to continue the hearing before proceeding on the medial meniscus compensability issue; and (3) set aside its denial. On review, the issues are the ALJ's procedural rulings and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW

Procedural Motions

Claimant injured his right knee on February 2, 1998. On April 13, 1998, the insurer accepted the injury as a disabling "right knee strain." (Ex. 16). The claim subsequently closed on July 21, 1998. (Ex. 25). The insurer's updated notice of acceptance at closure listed the accepted condition as "right knee strain." (Ex. 24).

Claimant continued to have knee problems after claim closure. On January 13, 1999, Dr. Booker, the then treating physician, noted recurrent right knee swelling and opined claimant had a likely meniscal injury. (Ex. 26).

On May 13, 1999, Dr. Fuller examined claimant at the insurers request. Dr. Fuller diagnosed: (1) bilateral chondromalacia patella, worse on the right; and (2) degenerative changes posterior horn right medial meniscus. (Ex. 28-3). Additionally, Dr. Fuller opined that claimant needed right knee arthroscopy, but that the arthroscopy was not attributed to the January 1998 strain incident. (Ex. 28-5).

On May 24, 1999, the insured issued its current condition denial, which stated in pertinent part:

> "We have received information that you are seeking additional benefits in connection with your accepted claim of 1/29/98. In reviewing this matter [the insurer] concludes that your current condition and need for treatment are not compensably related to your accepted claim.
>
> "Accordingly, your current condition and need for treatment are hereby denied." (Ex. 29-1).

At hearing, the insurer argued that because claimant had not formally requested acceptance of his right medial meniscus condition, either through ORS 656.262(6)(d), which governs conditions incorrectly omitted from a Notice of Acceptance, or through ORS 656.262(7)(a), which governs new medical conditions discovered after claim acceptance, the May 1999 denial did not include a denial of claimant's right medial meniscus condition. The insurer contended that because its denial did not encompass the right medial meniscus condition, claimant's request for hearing contesting that denial did not vest jurisdiction of that condition with the Hearings Division. Accordingly, the insurer requested that the ALJ not proceed to the merits of that condition. In the alternative, the insurer argued that if was surprised by the meniscus condition and asked for a postponement to better develop the medical record.[1]

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[1] Both parties and the ALJ refer to the insurer's motion as a "motion to postpone." However, because it occurred after the hearing had commenced, and was in response to what the insurer claimed was an issue "raised for the first time at hearing," the motion is actually a "motion for continuance" under the terms of OAR 438-006-0091(3). *See David E. Collins*, 49 Van Natta 561 (1997).

The ALJ, citing *Tattoo v. Barrett Business Services*, 118 Or App 348 (1993), reasoned that the insurer was bound by the express language of it denial, and concluded that the words "current condition" included claimant's right medial meniscus condition. The ALJ also concluded that because the insurer had received the records from claimant's treating surgeon, Dr. Thomas, including the video tape of the surgery itself, and had all those records reviewed by Dr. Fuller, an insurer-arranged examiner, the insurer was not surprised by the medical meniscus condition and that the medical record was fully developed. We affirm the ALJ's procedural ruling.

The ALJ may continue a hearing for further proceedings for any party to respond to an issue raised for the first time at hearing. OAR 438-006-0091(c). Because the language of the continuance rule is permissive (*i. e.*, "may") and delegates to the ALJ a range of discretion in granting a continuance, we review an ALJ's ruling (on a continuance motion) for abuse of discretion. *See Georgia-Pacific Corp. v. Kight*, 126 Or App 244, 246 (1994); *David E. Collins*, 49 Van Natta 561, 562 (1997).

The insurer issued its denial eleven days after it received Dr. Fuller's report, suggesting that claimant had degenerative changes of the posterior horn of his right medial meniscus and that claimant was in need of arthroscopy. While not denying a specific condition, the insurer unambiguously denied the condition for which claimant needed arthroscopy. The record establishes that the condition in question was a right medial meniscus. Under these circumstances, we conclude that claimant's request for hearing on the May 24, 1999 denial vested jurisdiction of his right medial meniscus condition with the Hearings Division.

The insurer argues that it did not understand that claimant's right medial meniscus condition was at issue. Consequently, the insurer claims it was "surprised" by this issue at hearing, and not adequately prepared to litigate the compensability of that medical condition.

Having already concluded that claimant's right medial meniscus condition was in question at the time the insurer issued its current condition denial, we conclude that issue was raised at the time of the initial request for hearing, and not raised, as suggested by the insurer, for the first time at hearing.[2] Accordingly the ALJ did not abuse his discretion in denying the insurer's motion for continuance.

Compensability

We adopt and affirm the remainder of the ALJ's order with the following supplement to address the insurer's contention that the ALJ incorrectly relied upon the opinion of Dr. Thomas, the treating surgeon, rather than the opinion of Dr. Fuller, an insurer-arranged medical examiner.

The ALJ analyzed the medical causation issue using the "major contributing cause" standard.[3] Neither party argues that the ALJ erred in using the major contributing cause standard. Consequently, we use the "major contributing cause standard" on review.

Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

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[2] Even if we assume that the compensability of the medial meniscus condition was raised for the first time at hearing, we conclude that because the insurer had received all the records of Dr. Thomas, including the video tape of the surgery, and had those records reviewed by Dr. Fuller, and subsequently submitted Dr. Fullers report as a hearings exhibit, three days before the hearing commenced, that the insurer was adequately prepared to litigate the compensability of the disputed condition.

[3] We note that though Drs. Thomas and Fuller disagree regarding the relative contribution that degenerative changes play in claimant's right knee condition, they both agree that degenerative changes are present. Accordingly, we conclude that claimant's right medial meniscus condition, is a "combined condition" under the terms of ORS 656.005(7)(a)(B). We further note that neither party argues otherwise.

Drs. Thomas and Fuller are the only doctors in the record to address the medical causation issue. Dr. Thomas opined that the meniscal tear was traumatically induced by claimants ladder climbing in January 1998. (Ex. 38-3; 40-3) Dr. Fuller opined that the meniscal tear was "100%" caused by claimant's age. (Ex. 39-3). Upon performing surgery, Dr. Thomas noted the degenerative changes in claimants knee as "minimal." (Ex. 38-3). Dr. Fuller, upon viewing the videotape of the surgery, characterized the degenerative changes in claimant's knee as "typical for a 52 year old knee." (Ex. 39-2).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986).

In concluding that claimant's meniscal tear was "100% caused by claimant's age," Dr. Fuller reasoned, in part, that following the work injury, claimant "never complained of posteromedial or joint line pain in his initial presentation to either Dr. Vigeland, myself, or to Dr. Thomas." (Ex. 39-2). We note this is not consistent with Dr. Fuller's earlier report in which he stated: "He does have some minimal posteromedial joint line discomfort in this area, coinciding with the MRI findings."[4] (Ex. 21-6). Consequently, we conclude that Dr. Fuller's subsequent opinion regarding the cause of claimant's meniscus tear is based upon incomplete information. Because his opinion is based upon incomplete information, the opinion is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998). Accordingly, we do not rely upon it.[5]

We acknowledge the insurer's argument that Dr. Fuller had the opportunity to examine claimant before and after his current claim for medical services for his meniscus condition. As a general rule, such an opportunity can place a physician in an advantageous position to offer an opinion. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). Nevertheless, as previously noted, there are other reasons to bring Dr. Fuller's opinion into question. In light of these deficiencies, we do not consider Dr. Fuller's observations to be persuasive.

In contrast to the opinion of Dr. Fuller is the opinion of Dr. Thomas. As the treating surgeon, Dr. Thomas had the opportunity to view the interior of claimant's knee first hand.[6] Accordingly, his opinion, based upon his actual surgical observations, is entitled to great weight. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988). In addition, Dr. Thomas considered the stresses and forces on claimant's knee during ladder climbing in relation to the meniscal tear that was surgically repaired.[7] (Ex. 38-2).

In conclusion, we find Dr. Thomas' opinion to be the better reasoned. We conclude that his opinion takes into account: (1) claimant's history; (2) all of claimant's initial knee complaints; (3) the MRI findings; (4) the clinical findings; and (5) Dr. Thomas' own observations of the knee during surgery. Consequently, we find that claimant's work injury was the major contributing cause of his disability and his need for treatment for his right medial meniscus condition. Accordingly, we affirm the ALJ's order that set aside the insurer's denial of that claim.

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[4] The MRI findings are contained in this record as Exhibit 19. The MRI as interpreted by Dr. Bocchi, shows an "oblique nondisplaced tear involving the posterior third of the medial meniscus." (Ex. 19).

[5] In light of Dr. Fuller's finding that the degeneration in claimant's right knee was "typical for a 52 year old knee," we are troubled by his broad assertion that claimant's meniscal tear was "100% caused by claimant's age." (Ex. 39-2, 3). We note that Dr. Thomas takes exception to Dr. Fuller's statement, indicating there is no basis for believing that the meniscal tear is 100 percent related to claimant's age. (Ex. 40-2). Without further explanation, Dr. Fuller's statement is conclusory and unsupported. Accordingly, we do not find his analysis well reasoned.

[6] We note that Dr. Fuller viewed the videotape of claimant's surgery. Without additional expert evidence, we cannot conclude that he was able to observe everything in claimant's knee in the same manner and to the same degree as Dr. Thomas.

[7] Dr. Fuller considered the forces and stresses of claimant's ladder climbing in relation to the claimant's knee synovitis. (Ex. 21-5). However, he does not appear to have considered those same forces and stresses in relation to the meniscal tear. (Ex 39).

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

ORDER

The ALJ's order dated February 18, 2000 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by the self insured employer.

In the Matter of the Compensation of
LINDA RATLIFF, Claimant
Own Motion No. 00-0209M
OWN MOTION ORDER
Welch, Bruun & Green, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's right knee condition. Claimant's aggravation rights expired on June 25, 1997. 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. Claimant has not responded to insurer's contention. Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JANIS L. EAMES, Claimant
WCB Case No. 98-09045
ORDER ON REVIEW (REMANDING)
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) denied claimant's request for postponement of the scheduled hearing; (2) found that claimant's failure to appear at a scheduled hearing was unjustified; and (3) dismissed claimant's request for hearing. With her request for review, claimant submitted documents that were not admitted at hearing. We treat this submission as a request for remand. On review, the issues are remand, postponement and dismissal. We remand.

FINDINGS OF FACT

We base the following findings of fact on the hearing file and the parties' briefs on review.

Claimant filed a claim for workers' compensation benefits for a mental disorder she attributed to her work at the employer. The insurer issued a "noncooperation" denial. *See* ORS 656.262(15). On November 16, 1998, claimant filed a request for hearing. The matter was set in the normal course for February 12, 1999. At the request of Mr. Pister, claimant's therapist, the hearing was postponed because of claimant's psychological condition. The matter was rescheduled for hearing on May 12, 1999, but was again postponed for the same reason and because claimant needed time to find an attorney. The hearing was rescheduled for 9:00 a.m. on September 29, 1999.

On September 28, 1999, claimant again requested postponement of the hearing because of her mental state. The ALJ's secretary left a message for claimant that no postponement had been granted and that claimant needed to be at the hearing when her request for postponement would be addressed. The hearing convened at 9:00 a.m. on September 29, 1999. Claimant did not appear.

On the insurer's motion, the ALJ issued an order on October 7, 1999, denying claimant's request for postponement and dismissing claimant's hearing request. On November 8, 1999, the Board received a letter requesting review of the dismissal order. With this letter, claimant provided a letter from Mr. Pister in which he stated that claimant's emotional stress "has deteriorated to a situation of major depression, resulting in virtual inability to address the worksite situation and the ensuing legal proceedings."

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 find that claimant's letter to the Board following the Order of Dismissal constitutes an additional motion for postponement (separate from the "pre-hearing" postponement motion denied in the ALJ's dismissal order). In the letter, claimant attempts to explain her failure to appear and provides medical documentation explaining her failure to appear.

Consequently, we conclude that, because the ALJ did not have the opportunity to rule on the "post-dismissal order" 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 7, 1999 order is vacated. This matter is remanded to ALJ Tenenbaum 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.[2]

We also note that, subsequent to the ALJ's order, the court issued *SAIF v. DuBose*, 166 Or App 642 (2000), which addresses the jurisdictional effect of a claimant's failure to request an "expedited hearing" on a claim denied for worker noncooperation. The parties and the ALJ may wish to consider the effect of the *DuBose* holding in this case on remand.

IT IS SO ORDERED.

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[1] We note that the ALJ stated in her order that the appeal rights include a provision by which claimant may request that the ALJ reconsider the decision. The appeal rights did not include such a provision. Moreover, the ALJ did not issue a "combined order" (*i.e.*, an order giving claimant a period of time (such as 15 days) to show "good cause" for her 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, 300 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 warranted.

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

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

In the Matter of the Compensation of
DAVID F. ETCHER, Claimant
WCB Case No. 99-08021
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that awarded claimant temporary partial disability benefits August 12, 1999 to December 8, 1999. Specifically, SAIF contends that the ALJ should have found that the rate of temporary partial disability benefits for that period was zero. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to award temporary disability benefits after December 15, 1999; and (2) declined to assess a penalty for an allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are temporary partial disability benefits and penalties. We modify.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's "Conclusions and Opinion," with the following supplementation and modification.

On review, SAIF does not contest the ALJ's finding that claimant is entitled to temporary partial disability benefits from August 12, 1999 to December 8, 1999. Rather, SAIF argues that, pursuant to the Board's decision in *Alejandra R. Trevino*, 50 Van Natta 2302 (1998), the temporary partial disability award should be found to be calculated at the rate of zero.

In *Trevino*, we held that, because the claimant's disability was partial, the claimant was entitled, at least theoretically, to temporary partial disability benefits (TPD) during the period in question. *Trevino, supra*; ORS 656.212. In *Trevino*, the claimant's wages at modified employment were the same as her at-injury wages. Consequently, we held that a calculation of the claimant's TPD equaled zero.

Here, claimant's treating doctor released him to modified work which would have been available to claimant had he not been terminated from work due to reasons unrelated to the compensable injury. (Ex. 23). The modified job offer provided that claimant would have been paid at his regular rate. (Ex. 24). We agree with the ALJ that claimant is entitled to temporary partial disability benefits for the period in question because claimant was disabled due to the injury. Nevertheless, because claimant was offered a modified job which would have been available to him if he had not been terminated, and the job offer was made at claimant's regular wage rate, we agree with SAIF that claimant's TPD rate should be calculated at a rate of zero.

Claimant has cross-requested review of that portion of the ALJ's order that declined to award temporary disability benefits after December 8, 1999. However, claimant's treating doctor again approved modified work for claimant following the December 8, 1999 surgery. Consequently, for the reasons expressed above, we conclude that any temporary disability benefits to which claimant was entitled would be calculated at the rate of zero.

In light of our conclusion that claimant's temporary partial disability benefits are payable at a rate of zero, there are no "amounts then due" upon which to base a penalty. Therefore, we do not address claimant's arguments regarding entitlement to a penalty.

ORDER

The ALJ's order dated March 7, 2000 is modified. Claimant's temporary partial disability benefits for the period of September 9, 1999 to December 8, 1999 are calculated at a rate of zero. The ALJ's out-of-compensation attorney fee award is modified accordingly.

July 19, 2000 Cite as 52 Van Natta 1305 (2000)

In the Matter of the Compensation of
JOHN W. HYATT, Claimant
WCB Case Nos. 99-01329 & 98-04242
ORDER OF ABATEMENT
Bruce D. Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our June 23, 2000 Order on Review that reversed in part, affirmed in part and modified in part the Administrative Law Judge's (ALJ's) order setting aside the insurer's denials of claimant's occupational disease and aggravation claims for a left shoulder condition. In his motion, claimant asserts that our order should be revised to reflect either that the portion of the insurer's April 30, 1998 denial that denied claimant's need for surgery is set aside, or that claimant's rights to medical services associated with her occupational disease claim are not affected by the April 30, 1998 denial.

In order to consider this matter, we withdraw our June 23, 2000 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH C. MOLZ, Claimant
WCB Case Nos. 99-08189, 99-07954, 99-08188 & 99-05875
ORDER ON REVIEW
Kasubhai & Sanchez, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denials of claimant's left knee medial meniscus tear; (2) set aside its denial of claimant's current low back condition; and (3) affirmed an Order on Reconsideration that awarded 8 percent (25.6 degrees) unscheduled permanent disability for claimant's low back condition. On review, the issues are compensability and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the third paragraph on page 3, we change the second sentence to read: "An April 27, 1995 MRI showed a tear of the posterior horn of the medial meniscus and findings consistent with a partial tear of the anterior cruciate ligament. (Ex. 16; 99-058075 & 99-08188)." In the last paragraph on page 4, we change the third sentence to read: "Dr. Smith concluded that claimant's flare-up of back pain on March 31, 1999 was an aggravation of a preexisting low back condition, which had its onset on December 2, 1994. (Ex. 18; 99-08189)." In the last paragraph beginning on page 6 and continuing on page 7, we change the citation after the last sentence to "(Ex. 18; 99-07954)."

CONCLUSIONS OF LAW AND OPINION

Left Knee Medial Meniscus Tear

The ALJ relied on Dr. Casey's opinion to find that claimant's torn medial meniscus was compensable either as an injury or an occupational disease.

The employer argues that claimant has failed to satisfy his burden of proof under either theory. The employer contends that claimant had a preexisting knee condition that combined with the December 2, 1994 incident, and, therefore, ORS 656.005(7)(a)(B) applies to this case. The employer contends that Dr. Casey's opinion is not sufficient to establish that the December 1994 work incident was the major contributing cause of his claimant's medial meniscus tear. The employer also argues that claimant failed to prove that his medial meniscus tear was compensable as an occupational disease.

We begin by recapping claimant's left knee symptoms and medical treatment. Claimant began working for the employer in 1982 and has performed several jobs. From April 1991 to May 1995, claimant worked as a gluing utility person, which involved cleaning the glue spreader machines. (Ex. 0-5 to 0-7; 99-05875 & 99-08188).[1] Claimant's job duties included bending, kneeling and crouching.

In December 1994, claimant filed an "801" form for a left knee injury showing a date of injury as December 2, 1994. (Ex. 7). Claimant sought medical treatment from Dr. Fowler on December 12, 1994. Dr. Fowler reported the following history:

> "[Claimant] is a 43-year-old gentleman who had a one-year history of popping in the left knee. This is not particularly painful for him, but he does note a chronic aching in that knee. The popping was quite irritating about two weeks ago, but has settled down significant [sic] since then. He denies any real locking sensation in the knee. He does remember striking his kneecap about a year ago, but he denies other significant injury." (Ex. 2).

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[1] The remaining citations in this section of the order concerning claimant's claim for a medial meniscus tear are from the exhibit file for WCB Nos. 99-05875 and 99-08188, unless otherwise stated.

Knee x-rays on December 12, 1994 showed mild osteoarthritis primarily involving the medial joint compartments of each knee, as well as minimal degenerative change of the left patella. (Ex. 3). Dr. Fowler believed that claimant had some patellofemoral syndrome that was probably related to his kneecap contusion one year ago. (Ex. 2). He suspected an old partial anterior cruciate ligament tear or a meniscus tear and he recommended physical therapy. (*Id.*) Claimant was released to regular work on January 8, 1995. (Ex. 8).

On February 6, 1995, the employer accepted a nondisabling left knee strain. (Ex. 9).

On April 11, 1995, claimant was examined by Dr. Casey, who reported that claimant had experienced left knee pain for about a year. (Ex. 13-1). Dr. Casey explained: "[Claimant] states he has had some injuries at work -- mainly twisting injuries -- that have bothered his knee over the years, and that he now has medial and anterior knee pain that causes popping and discomfort and the feeling of instability at times." (*Id.*) Dr. Casey noted that claimant "has had no single injury that caused significant swelling of his knee." (*Id.*) He diagnosed a probable meniscal tear with mild early degenerative arthritis. (*Id.*) Dr. Casey became claimant's attending physician. (Ex. 15).

An MRI on April 27, 1995 showed a tear of the posterior horn of the medial meniscus and findings consistent with a partial tear of the anterior cruciate ligament. (Ex. 16). Dr. Casey recommended surgery. (Ex. 17). Claimant testified that he cancelled the left knee surgery because he was offered a new job that did not involve as much strain to his knee. (Tr. 35-36; Ex. 19). On January 8, 1996, claimant returned to Dr. Casey because he continued to have intermittent pain in his left knee. (Ex. 22-1).

The employer reclassified the left knee strain as disabling on May 1, 1996. (Ex. 23). A May 2, 1996 Notice of Closure awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left knee. (Ex. 26).

On December 16, 1998, claimant sought treatment for left knee pain from Dr. Hanesworth. (Ex. 28). Dr. Hanesworth reported that claimant "apparently banged his knee back in December of 1994." (Ex. 28-1). He recommended left knee arthroscopy. (Ex. 28-2). Dr. Hanesworth signed a "Notice of Claim for Aggravation of Occupational Injury or Disease" on December 18, 1998, but he did not authorize any time loss. (Ex. 29).

On July 23, 1999, claimant's attorney filed an occupational disease claim for the left knee condition. (Ex. 37).

The employer issued a partial denial on July 26, 1999, stating that claimant's work was not the major contributing cause of the ACL or meniscus conditions. (Ex. 38). The denial also stated that the December 18, 1998 aggravation form did not meet the requirements for an aggravation claim.[2] (*Id.*)

On August 30, 1999, claimant signed an "801" form related to an August 24, 1999 left knee injury. (Ex. 39). He indicated he had crouched down to look for a felt pen and when he stood up, his left knee buckled and his knee hit the ground. (Exs. 39, 41). On August 31, 1999, claimant sought treatment from Dr. Bidleman, who diagnosed a probable worsening meniscus tear. (Exs. 40, 41). The employer denied claimant's August 24, 1999 claim on September 30, 1999. (Ex. 49).

Dr. Casey examined claimant on September 13, 1999 and reported that he had fallen at work and reinjured his left knee. (Ex. 45). He diagnosed "[m]edial meniscus tear; possible anterior cruciate tear, probably old." (*Id.*) Dr. Casey performed a partial medial meniscectomy of claimant's left knee on September 28, 1999. (Ex. 48).

To summarize, claimant has filed a claim for a December 2, 1994 left knee injury, an August 24, 1999 left knee injury, and an occupational disease claim for a left knee condition. (Exs. 7, 37, 39). Because of the number of possible causes of claimant's left knee medial meniscal tear, this case presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

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[2] The ALJ found that compensability of claimant's torn medial meniscus of the left knee was based on a theory of a primary or secondary consequence of injuries on December 2, 1994 and August 24, 1999, or as an occupational disease. We find no evidence that claimant disputed the portion of the employer's denial that stated that the December 18, 1998 aggravation form did not meet the requirements for an aggravation claim.

Claimant relies on the opinion of Dr. Casey to establish compensability of his medial meniscus tear. Dr. Casey did not believe claimant's August 24, 1999 incident was the primary cause of his need for treatment. Claimant indicated that on August 24, 1999, he had crouched down to look for a felt pen and when he stood up, his left knee buckled and hit the ground. (Exs. 39, 41). Dr. Casey reported that claimant had "reinjured" his left knee, but he noted that claimant had not had a "normal" knee since the previous injury. (Ex. 45). In a later report, Dr. Casey concluded that claimant's "recent injury," *i.e.*, the August 1999 incident, was not the primary reason for his need for surgery, although it made him more symptomatic. (Ex. 50). Instead, Dr. Casey's reports attribute causation of the left medial meniscus tear to the December 1994 injury and to his work activities generally.

Therefore, 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)). An occupational disease stems from conditions that develop gradually over time. ORS 656.802; *Mathel v. Josephine County*, 319 Or 235, 240 (1994). By contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Id.*; *Valtinson v. SAIF*, 56 Or App 184, 188 (1982).

Claimant's "801" form, signed on December 27, 1994, referred to a "date of injury" as December 2, 1994. (Ex. 7). The "801" form indicated that the accident had occurred while claimant was sliding press boards into place and twisted his knee. (*Id.*) At hearing, claimant was asked about his first knee injury. (Tr. 32). He explained that he had been going to the company nurse every two to three months for approximately one year because he had popping and clicking in his knee. (*Id.*) Claimant said that his knee pain kept getting worse and he had difficulty squatting on the rollers to clean the machines. (*Id.*) He said "it was an ongoing thing." (*Id.*)

Claimant's testimony of a gradual onset of left knee symptoms is consistent with Dr. Fowler's December 12, 1994 report. Dr. Fowler said that claimant had a one-year history of "popping" in the left knee. (Ex. 2). He indicated the "popping" was quite irritating about two weeks ago, but had settled down. (*Id.*) Dr. Fowler said that claimant remembered striking his kneecap about a year ago, but he denied other significant injury. (*Id.*)

Similarly, when claimant sought treatment from Dr. Casey in April 1995, he reported that claimant had experienced left knee pain for about a year. (Ex. 13-1). Dr. Casey explained: "[Claimant] states he has had some injuries at work -- mainly twisting injuries -- that have bothered his knee over the years, and that he now has medial and anterior knee pain that causes popping and discomfort and the feeling of instability at times." (*Id.*) Dr. Casey said that claimant "has had no single injury that caused significant swelling of his knee." (*Id.*)

Based on claimant's testimony and the medical reports from Drs. Fowler and Casey, we find that the onset of claimant's symptoms in this case did not correspond to a specific "event." Rather, claimant's symptoms related to an ongoing condition with a gradual onset. Therefore, we conclude that claimant's left knee claim is most appropriately analyzed as an occupational disease.

Under ORS 656.802(2)(a), claimant must establish that his employment conditions were the major contributing cause of his medial meniscus tear. 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). In this case, we need not decide whether ORS 656.802(2)(a) or ORS 656.802(2)(b) applies to claimant's medial meniscus tear, however, because that condition is not compensable under either standard.

Claimant relies on the opinion of Dr. Casey to establish compensability of the medial meniscus tear. 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. Casey.

We briefly summarize Dr. Casey's treatment of claimant's left knee and his reports on causation. He first examined claimant on April 11, 1995. At that time, he indicated that claimant had experienced left knee pain for about a year and had sustained some twisting injuries at work. (Ex. 13-1). He

specifically noted, however, that claimant had not experienced a single injury that caused significant swelling of his knee. (*Id.*) Dr. Casey diagnosed a probable meniscal tear with early degenerative arthritis and recommended surgery. (Exs. 12, 13, 15, 18). On May 2, 1995, Dr. Casey explained that claimant's work involved frequent squatting, which he felt was consistent with a medial meniscus tear. (Ex. 17). Claimant chose not to have surgery at that time because he changed jobs.

Claimant returned to Dr. Casey in January 1996 because he continued to have intermittent left knee pain. (Ex. 22). At that time, Dr. Casey noted that claimant had changed jobs and did not have to squat as much. (*Id.*) Dr. Casey said: "I do think he has a medial meniscus tear, and I do think it was related to his work activities as previously described[.]" (*Id.*)

Claimant returned to Dr. Casey in September 13, 1999. (Ex. 45). He reported that claimant had fallen at work a week and a half ago and reinjured his left knee. (Ex. 45). He diagnosed "[m]edial meniscus tear; possible anterior cruciate tear, probably old." (*Id.*) Dr. Casey performed a partial medial meniscectomy of claimant's left knee on September 28, 1999. (Ex. 48). He reported that claimant had a complex ragged tear of the posterior medial meniscus, but the anterior cruciate was normal. (*Id.*)

On September 27, 1999, Dr. Casey wrote to claimant's attorney regarding causation of claimant's current left knee condition. He explained that claimant's recent twisting injury, *i.e.*, the August 24, 1999 incident, was an "aggravation of his underlying problem, which is his old work injury, and not related to any other problems of which I am aware." (Ex. 46). He concluded that "this is an exacerbation of his previous work injury that in the past he has chosen not to have treated surgically[.]" (*Id.*)

On September 28, 1999, Dr. Casey's chart note said that claimant had originally injured his knee "back around 1995 while working." (Ex. 47). He said that claimant's knee had bothered him ever since with occasional pain and popping. (*Id.*)

On September 30, 1999, Dr. Casey wrote to the employer's attorney, summarizing his opinion of claimant's left knee problems. He explained:

> "It is my opinion that his need for surgery was caused by his 1994 industrial injury while being employed at [the employer], and that his recent injury, although making him more symptomatic, was not the primary reason for his need for surgery, having had a previous injury with a documented medial meniscus tear. I understand that he had some arthritic change in his x-ray prior to his 1994 injury, and we discussed that that probably means he had a small cartilage tear even before that injury, but it is my opinion that unless there is evidence that he sought persistent medical advice because of his knee problems before his 1994 injury, that there is no reason to think that his condition was such that it required significant medical treatment until his industrial accident in 1994." (Ex. 50).

Thus, Dr. Casey's September 30, 1999 report indicated that claimant had sustained a "1994 industrial injury" that caused a medial meniscus tear. Nevertheless, Dr. Casey said that claimant had some arthritic change and a small cartilage tear before the 1994 injury. Dr. Casey did not indicate what had caused the small cartilage tear before the 1994 injury.

On November 24, 1999, Dr. Casey wrote to claimant's attorney regarding claimant's left knee symptoms. He explained:

> "As you have correctly stated, I first saw [claimant] on April 11, 1995, when he was referred here by his family physician, Dr. Steven Bidleman, for problems with his left knee. At that time, he stated that his knee had been bothering him for about a year and it was mainly related to what he felt were twisting injuries at work. He had originally seen Dr. Brad Fowler for this problem and described, at that time, a repetitive twisting activity that he felt led to his knee injury. An MRI was performed shortly thereafter that was interpreted by the radiologist as a torn posterior horn of the medial meniscus with some thinning of the anterior cruciate. As you also know, I have seen [claimant] steadily over the years for this and other problems, and I do believe he has had persistent knee problems but simply chose not to have it treated surgically because he could continue to work full time and only recently decided that it bothered him enough to do so. At the time of his knee arthroscopy, he did indeed have some significant medial compartment arthritis that is more likely the result of his cartilage tear rather

> than the cause of his problems themselves. His anterior cruciate appeared to be normal. I am not aware of any non work activities that have led to [claimant's] problems and he has not had arthritis in general. I do not believe he has a significant anterior cruciate ligament injury and feel his main pathology was his medial meniscus tear and resultant arthritic change in his knee, most likely from wear due to the cartilage tear. It is my feeling that since this began after repetitive work activities that he report [sic], there is no reason to think any other activity led to this. It is certainly consistent with his history, and I do have personal rememberance of [claimant] continuing to complain about this problem to some extent over the entire period of time." (Ex. 51).

Although Dr. Casey's September 30 report indicated that claimant's medial meniscus tear was caused by a 1994 industrial injury (Ex. 50), his November 24, 1999 report indicated that the medial meniscus tear was caused by repetitive work activities. (Ex. 51). Dr. Casey did not provide an explanation for his apparent change of opinion. Furthermore, although Dr. Casey's September 30, 1999 report said that claimant had some arthritic changes in his knee before the 1994 injury, including a preexisting small cartilage tear (Ex. 50), his November 24, 1999 report said that claimant had "some significant medial compartment arthritis that is more likely the result of his cartilage tear rather than the cause of his problems themselves." (Ex. 51). In other words, although Dr. Casey's September 30, 1999 report said that claimant had arthritic changes in his knee and a small cartilage tear before the 1994 injury, his November 24, 1999 report said that claimant's arthritis was caused by the cartilage tear.

Because Dr. Casey provided no explanation for his apparent change of opinion regarding causation of claimant's medial meniscus tear, his opinion is entitled to little weight. *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). Moreover, we find that Dr. Casey's reports on causation are inconsistent and lack adequate explanation. We conclude that Dr. Casey's opinion on causation is, at best, ambiguous and is not sufficient to establish compensability of claimant's medial meniscus tear.

The remaining medical opinions are not sufficient to establish a compensable occupational disease claim for claimant's left medial meniscus tear. In a concurrence letter from the employer's attorney, Dr. Hanesworth agreed that he could not state whether claimant's work activities over time, as opposed to a single injury, were the major contributing cause of his medial meniscus tear and need for treatment. (Ex. 35-3).

In his April 30, 1999 report, Dr. Smith said that the changes in claimant's medial meniscus were "probably associated with the type of squatting and twisting work he did for a number of years while working in the mill." (Ex. 32-6). In a later concurrence letter from the employer's attorney, however, Dr. Smith agreed that in his previous report, he meant only that claimant's work activities of squatting and twisting probably brought on the changes to the medial meniscus, but he did not mean to state that claimant's work activities were the major contributing factor, when compare to all causative factors. (Ex. 34-5). Dr. Smith agreed that he could not state that claimant's work activities were the major contributing cause of the medial meniscus tear. (Ex. 34-6). In light of Dr. Smith's later opinion explaining his change of opinion, we attribute little weight to his April 30, 1999 report.

In sum, we conclude that the medical evidence is not sufficient to establish that claimant's employment conditions were the major contributing cause of his medial meniscus tear, *see* ORS 656.802(2)(a), nor is it sufficient to establish compensability under ORS 656.802(2)(b).

Current Low Back Condition

We begin by recapping claimant's low back symptoms and medical treatment. Claimant testified that he first injured his back in 1995, when he was pushing veneer on crates and he had problems with the wheels on the carts. (Tr. 36). Claimant said his right foot slipped as he pushed hard on the cart and he had immediate pain on the right side of his low back. (Tr. 37). Claimant signed an "801" form on December 18, 1995, indicating that he was injured on that day. (Ex. 2; 99-08189).[3] He did not seek

[3] The remaining citations in this section of the order concerning claimant's low back claim are from the exhibit file for WCB No. 99-08189, unless otherwise stated.

medical treatment, however, because he thought it would improve in a short time. (Tr. 38). Claimant testified that since the original injury, he would "reaggravate" his low back every three or four months while having difficulties pushing a cart at work. (*Id.*) His back condition kept getting worse. (*Id.*)

In February 1999, claimant signed an "801" form for an injury on January 25, 1999. (Ex. 3). Claimant indicated he strained his back while pushing carts that would not roll properly and his back was made worse by picking up dunnage boards. (Ex. 3, Tr. 38-39).

On February 17, 1999, claimant sought treatment from Dr. Hanesworth, who reported the following history:

> "He also reports that if [sic] he has problems with back pain over the last number of years. He said he had an injury where he pushed a very large pile of wood in 1995 and felt something kind of pop and give in his back. Since that time, he has probably had five or six episodes where his back seems to kind of go out, causing a lot of pain. Most all of the pain seems to be in the lower right side of the back and radiating somewhat into the right buttock and posterior thigh." (Ex. 6-1).

Dr. Hanesworth diagnosed "[i]sthmic spondylolisthesis at L5/S1 with acute back pain." (*Id.*) He said that claimant's back problem was "just an acute flare-up, and he already tells me he feels about 95% better." (*Id.*) Dr. Hanesworth did not anticipate further treatment and he released claimant to full duty. (Ex. 6-1, -2).

On March 8, 1999, the employer accepted a nondisabling low back muscle strain related to the January 25, 1999 incident. (Ex. 7).

On April 2, 1999, claimant sought treatment from Dr. Wallace, D.C. (Ex. 9). He reported that claimant's right-sided low back pain had begun two days before, when he was pushing a cart at work. (*Id.*) He noted that claimant had a similar episode three years ago. (*Id.*) Dr. Wallace diagnosed an "acute traumatic S/S[,]" L-spine somatic dysfunction and mild spasm. (*Id.*) Dr. Wallace's "827" form, signed on April 3, 1999, showed a date of injury as March 31, 1999. (Ex. 10).

On April 5, 1999, Dr. Hanesworth examined claimant and explained: "[Claimant] reports last week, he just woke up and got out of the bed and had severe pain in his low back." (Ex. 11). He diagnosed an acute low back strain with L5-S1 spondylolisthesis. (*Id.*)

Claimant sought treatment from Dr. Wallace on the same day and continued to have chiropractic treatments. (Exs. 12, 15, 17). Dr. McKellar examined claimant on May 11, 1999. (Ex. 20). He diagnosed a chronic recurrent sacral iliac strain and authorized further treatments with Dr. Wallace. (Exs. 19, 20, 21).

On April 30, 1999, Dr. Smith examined claimant on behalf of the employer. (Ex. 18). He reported that February 1999 films of claimant's lumbosacral spine showed a grade I spondylolisthesis with a pars defect and degenerative changes at T12-L1, narrowing at L3-4 and mild narrowing at L4-5. (Ex. 18-5). Dr. Smith diagnosed "bilateral spondylolysis with grade I spondylolisthesis, L5-S1, with recurrent mechanical low back pain brought on by his work[,]" and longstanding degenerative changes in the lumbosacral spine. (*Id.*) He felt that claimant's low back condition was medically stationary. (Ex. 18-6).

On May 19, 1999, the employer reclassified the low back muscle strain as a disabling injury. (Ex. 23). The employer determined that claimant was medically stationary on May 17, 1999 and it issued a Notice of Closure on June 7, 1999, awarding only temporary disability. (Ex. 29). A September 9, 1999 Order on Reconsideration awarded 8 percent unscheduled permanent disability for claimant's low back condition. (Ex. 18; 99-07954).

Claimant continued to treat with Dr. Wallace in May and June 1999. (Exs. 22, 25, 27, 30). On June 18, 1999, claimant sought treatment from Dr. McKellar and requested authorization for further chiropractic care. (Ex. 32). Dr. McKellar reported that claimant felt his problem had started in 1995, but he could not remember the approximate date. (Ex. 32-1). Claimant referred to pushing a 4000 pound cart when his right foot slipped and he twisted his back. (*Id.*) Claimant had pain in his right back and right lower leg, although he did not seek medical treatment at that time. (*Id.*) He told Dr. McKellar he felt better three weeks later, but was having low back discomfort three months later. (*Id.*) Dr. McKellar reported that claimant had been having back pain off and on since the injury in 1995. (*Id.*)

Regarding the recent back injury, Dr. McKellar noted that claimant initially told him the injury was in February 1999, but later indicated it might have been in January. (*Id.*) He said that claimant was pushing another heavy cart when he sustained pain in his lower back. (*Id.*) Dr. McKellar noted that claimant had been treating with Dr. Wallace, but continued to have persistent right-sided pain with radiation into his right buttock and down his right leg. (Ex. 32-1, -2). Dr. McKellar concluded that claimant had "sustained an injury to his SI joint, probably in 1995 and certainly most recently." (Ex. 32-2). He felt that claimant was "medically stable with chronic strain to the right SI joint" that required intermittent chiropractic treatment. (*Id.*)

Claimant continued to treat with Dr. Wallace from June through October 1999. (Exs. 33, 35, 38, 40, 42, 46, 48).

On September 1, 1999, Dr. Wallace reported that claimant had initially presented with a lumbar spine sprain with significant antalgia and radiculalgia. (Ex. 43). He explained that the preponderance of symptoms was in the right sacroiliac region and right lumbar spine and claimant experienced "global lumbar spine, lumbosacral dysfunction" and "episodic midline lumbar spine pain and pervasive sacroiliac dysfunction." (*Id.*) On September 7, 1999, claimant wrote to the employer, requesting that it accept the diagnosis in Dr. Wallace's September 1, 1999 letter. (Ex. 44).

On October 8, 1999, the employer issued a partial denial of claimant's low back condition, stating that he had recovered from the January 25, 1999 injury and that injury was not the major contributing cause of Dr. Wallace's diagnosis and treatment. (Ex. 47). Claimant requested a hearing.

Relying on *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992), the ALJ found that claimant had to establish that the accepted low back injury was at least a material contributing cause of his current low back condition. Based on the opinions of Drs. Hanesworth, Wallace, McKellar and Smith, the ALJ found that claimant's current low back condition was the same condition accepted by the employer as a low back strain. The ALJ concluded that the January 1999 injury continued to be a material contributing cause, if not the major contributing cause, of claimant's low back condition. On review, claimant relies on the ALJ's analysis to establish compensability of his current low back condition.

The employer argues that the ALJ erred in applying a material contributing cause standard. The employer asserts that claimant has a preexisting low back condition that combined with the January 25, 1999 injury to cause a need for treatment and disability and, therefore, ORS 656.005(7)(a)(B) applies. The employer contends that the medical evidence does not establish that claimant's January 25, 1999 injury is the major contributing cause of his current low back condition.

Because of the number of possible causes of claimant's current low back condition, this causation issue presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or at 420; *Barnett v. SAIF*, 122 Or App at 279. For the following reasons, we need not address the employer's argument that ORS 656.005(7)(a)(B) applies to claimant's current low back condition because we find that the medical evidence is not sufficient to establish that claimant's current low back condition is related, even in material part, to the accepted January 25, 1999 injury. Claimant relies on the ALJ's analysis to establish compensability of his current low back condition. The ALJ relied on the opinions of Drs. Wallace, Hanesworth, McKellar and Smith. We review each medical opinion in turn.

Dr. Wallace's diagnosis of claimant's current condition is not entirely clear. On April 2, 1999, Dr. Wallace initially diagnosed an "acute traumatic S/S[,]" L-spine somatic dysfunction and mild spasm. (Ex. 9). His "827" form referred to a diagnosis of "acute lumbar sprain/strain with resultant L/S BML ( ) attended by lumbalgia ( ) myospasm ( ) complicated by lumbar disc degenerative and kyphosis." (Ex. 10). The "827" form showed a date of injury as March 31, 1999. (Ex. 10).

On April 26, 1999, Dr. Wallace diagnosed "SI dysfunction w/L-spine dysfunction." (Ex. 15). On April 30, 1999, he reported that claimant continued to experience "SI dysfunction, L-spine dysfunction w/mild myofascial component." (Ex. 17). In his September 1, 1999 report, Dr. Wallace explained that claimant was experiencing "global lumbar spine, lumbosacral dysfunction" and "episodic midline lumbar spine pain and pervasive sacroiliac dysfunction." (Ex. 43).

Based on this record, we are unable to determine whether Dr. Wallace's diagnoses of claimant's current low back condition, which include sacroiliac and lumbosacral dysfunction, are the same as the accepted low back muscle strain. In other words, we find no medical evidence to indicate that claimant's accepted low back muscle strain is the same as Dr. Wallace's diagnoses of his current low back condition. *See SAIF v. Calder*, 157 Or App 224, 227 (1998) (Board's findings must be based on the medical evidence in the record).

In any event, even if we assume that Dr. Wallace's current diagnosis is a low back muscle strain, his medical reports attribute that condition to an injury on March 31, 1999, not January 25, 1999. Dr. Wallace initially examined claimant on April 2, 1999 and he reported the following history:

> "Presents as a new pt w/chief complaint of LBP, Rt sided radiation into his gluteale that began *two days ago* when he was pushing a cart at work. He sts he was bending over picking up boards which is what he does on a daily basis. He sts that he does this repetitive [sic] throughout the day and was pushing a large cart which seems to tighten him up as the day progresses and by morning he couldn't get up or move. Has a similar episode about three years ago that was very self limiting for him. He has not experienced pain to the extent that he is currently experiencing." (Ex. 9; emphasis supplied).

The "827" form signed by Dr. Wallace showed a date of injury as March 31, 1999. (Ex. 10). Although claimant wrote to the employer and indicated that his treatment from Dr. Wallace was related to the January 25, 1999 injury (Exs. 24, 26), we find no evidence that Dr. Wallace was subsequently informed of the correct date of injury. His September 1, 1999 report said only that "the local injury to the lumbar spine was paramount on initial presentation." (Ex. 43). Thus, even if we assume that Dr. Wallace believed claimant's current low back condition is a low back muscle strain, we find no evidence that he attributed that condition to the January 25, 1999 work incident. Dr. Wallace's opinion is not sufficient to establish compensability of claimant's current low back condition.

We turn to Dr. Hanesworth's medical reports. Dr. Hanesworth treated claimant for low back pain on February 17, 1999 and he diagnosed "[i]sthmic spondylolisthesis at L5/S1 with acute back pain." (Ex. 6). He said that claimant's back problem was "just an acute flare-up, and he already tells me he feels about 95% better." (Ex. 6-1). Thus, the February 17, 1999 chart note indicates that claimant's low back injury had almost resolved by that time. In fact, Dr. Hanesworth did not anticipate any further treatment and he released claimant to full duty. (Ex. 6-1, -2). The "827" form signed by Dr. Hanesworth showed a date of injury as January 25, 1999. (Ex. 5).

In contrast, Dr. Hanesworth examined claimant for an acute onset of low back pain on April 5, 1999 and explained: "[Claimant] reports last week, he just woke up and got out of bed and had severe pain in his low back." (Ex. 11). He diagnosed an acute low back strain with L5-S1 spondylolisthesis. (*Id.*) Thus, Dr. Hanesworth's reports indicate that claimant had experienced a new onset of low back pain in early April 1999 that was not related to work activity. There is nothing in Dr. Hanesworth's reports to indicate that claimant's April 5, 1999 back pain was a continuation of the back symptoms from January 25, 1999.

In a later concurrence letter from the employer's attorney, Dr. Hanesworth agreed that claimant's back pain was not the result of a symptomatic spondylolisthesis. (Ex. 39-2). Rather, he agreed that it was more likely that claimant "has suffered a series of independent low back strains resulting from his activity of pushing a cart." (*Id.*) Dr. Hanesworth did not explain his April 5, 1999 report that said claimant had woken up with back pain. In any event, his reference to a series of independent low back strains is not sufficient to establish that claimant's current low back condition is related to his January 25, 1999 injury.

Claimant also sought treatment from Dr. McKellar. In May 1999, he diagnosed a chronic recurrent sacral iliac strain. (Ex. 19). The "827" form signed by Dr. McKellar referred to the date of injury as January 25, 1999. (*Id.*) Dr. McKellar's initial chart notes did not provide much information about the history of claimant's low back symptoms. (Ex. 20). On June 18, 1999, however, Dr. McKellar reported the following history:

> "[Claimant] feels that his problem started in 1995 but he cannot remember the approximate date. States that he was working at [the employer] pushing a 4000 pound cart when his right foot slipped and his [sic] twisted his back. He sustained pain in his right back and right lower leg. He stated that he experienced a dull aching discomfort in his right back radiating into his right leg. He did not seek medication [sic] attention or report the incident at that time. He filled out an incident report and filed it in his locker. Three weeks later, he was feeling better. Three months later, he was having low back discomfort and he turned the report in. Approximately two years ago he was evaluated by Dr. Casey. [Claimant] states that no examination was performed and no specific recommendations were made other than stretching exercises. Dr. Casey indicated that he thought it was a muscle strain. In the chart notes that I have from Dr. Wallace, Chiropractor, he states that the patient sustained a similar injury three years ago that was very 'self-limiting.' [Claimant] states that he has been having back pain off and on since the injury in 1995. However, he has not filed any incident reports nor did he seek any medical attention other than from Dr. Casey two years ago. This last injury is equally poorly documented. He initially told me that the injury was in February 1999 and then later on he indicated that it might have been January. Dr. Wallace did not see [claimant] until 4/2/99 and he does not indicate when the original injury occurred. At any rate, [claimant] was pushing another heavy cart when he sustained pain in his lower back. States that he could not walk for three days. He presented himself to Dr. Hanesworth who is an orthopedist." (Ex. 32-1).

Dr. McKellar continued his report by noting that claimant had been treating with Dr. Wallace, but continued to have persistent right-sided pain with radiation into his right buttock and down his right leg. (Ex. 32-1, -2). Dr. McKellar concluded that claimant had "sustained an injury to his SI joint, probably in 1995 and certainly most recently." (Ex. 32-2). He felt that claimant was "medically stable with chronic strain to the right SI joint" that required intermittent chiropractic treatment. (*Id.*)

Although Dr. McKellar indicated that claimant had sustained an "injury" to his SI joint "certainly most recently[,]" it is not entirely clear what injury he means. His comments that claimant had been having back pain on and off since the 1995 injury further confuse the matter. Even if we assume that Dr. McKellar is referring to the January 25, 1999 work injury, we find no evidence that he was aware of Dr. Hanesworth's chart note reporting that claimant's back symptoms were "95% better" by February 17, 1999, and that he did not need further treatment. Moreover, the accepted claim was a low back muscle strain. Dr. McKellar has diagnosed a chronic recurrent sacral iliac strain and an SI joint injury. (Exs. 19, 32). We find no medical evidence to indicate that claimant's accepted low back muscle strain is the same as Dr. McKellar's diagnosis of an SI joint injury. *See SAIF v. Calder*, 157 Or App at 227 (Board's findings must be based on the medical evidence in the record). Based on this record, we find that Dr. McKellar's opinion is not sufficient to establish that claimant's January 25, 1999 injury is related to his current low back condition.

Claimant also relies on the opinion of Dr. Smith to establish compensability of his current low back condition. On April 30, 1999, Dr. Smith examined claimant on behalf of the employer and reported the following history of his low back pain:

> "On about December 2, 1994, [claimant] was working in the mill pushing with all his strength on a cart. As he did so, his right foot slipped and he had immediate, severe right low back pain. He was able to continue working. The pain lasted for a couple of weeks and then subsided. He had no medical care at that time. He recalls having a list which disappeared. Since then, he has had a recurrence of right low back pain every four to six months, generally brought on by heavy pushing. During the last year and a half he has had some constant aching in the low back in addition to these episodes of more acute pain." (Ex. 18-2).

Although Dr. Smith referred to claimant's February 17, 1999 examination by Dr. Hanesworth, his April 30, 1999 report made no reference to claimant's injury at work on January 25, 1999. Rather, Dr. Smith said that on about March 31, 1999, claimant had a "flare-up of severe low back pain without known reason." (Ex. 18-3).

In his April 30, 1999 report, Dr. Smith diagnosed "[b]ilateral spondylolysis with grade I spondylolisthesis, L5-S1, with recurrent mechanical low back pain brought on by his work[,]" as well as longstanding mild, progressive, degenerative changes in the lumbosacral spine. (Ex. 18-5). Dr. Smith explained that claimant's back pain started with the episode of heavy pushing in "1994" and he had experienced episodes of recurrent back pain since that time. (*Id.*) He said that claimant's degenerative changes in his back preexisted any injuries and combined with the injuries. (Ex. 18-6, -7). He said it was "possible" that the spondylolysis occurred during the heavy pushing in December 1994. (Ex. 18-6). Dr. Smith concluded that claimant's flare-up of back pain on March 31, 1999 was an "aggravation of a pre-existing condition in his low back, which had its onset on December 2, 1994." (Ex. 18-8).

We find no evidence in the record that claimant sustained a low back injury in December 1994. Moreover, Dr. Smith made no reference to claimant's accepted January 25, 1999 injury claim. Because Dr. Smith apparently had an inaccurate history of claimant's low back symptoms, his report is entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive). Dr. Smith's report of a "flare-up" on March 31, 1999, however, is consistent with Dr. Hanesworth's April 5, 1999 chart note that said claimant had woken up the prior week with severe low back pain. (Ex. 11).

In any event, Dr. Smith changed his opinion on causation in a later concurrence letter from the employer's attorney. Dr. Smith agreed that in his April 30, 1999 report, he had not performed a "true weighing test" where he had considered all the relative contributing factors. (Ex. 34-5). Dr. Smith agreed that claimant's spondylolysis was a defect in the pars intraarticularis, which occurs by age ten and had nothing to do with claimant's work. (Ex. 34-3). He agreed that claimant's spondylolysis was a "preexisting causative component of the spondylolysthesis." (*Id.*) Dr. Smith agreed that he could not state that claimant's work was the major contributing cause of claimant's symptomatic spondylolisthesis condition or his spondylosis. (Ex. 34-3, -4). He also agreed that when he weighed all the relative contributions of claimant's recurrent low back pain, he could not state that work activities were the major contributing cause of his condition and need for treatment. (Ex. 34-4).

After reviewing Dr. Smith's reports, even if we rely only on his April 30, 1999 report, we find that it is not sufficient to establish that claimant's current low back condition is related, even in material part, to the January 25, 1999 injury. First, as noted above, Dr. Smith's April 30, 1999 report did not even refer to a January 25, 1999 injury. Second, he did not diagnose a low back muscle strain. Rather, he diagnosed "bilateral spondylolysis with grade I spondylolisthesis, L5-S1, with recurrent mechanical low back pain brought on by his work[,]" as well as longstanding mild degenerative changes in the lumbosacral spine. (Ex. 18-5). We find no medical evidence to establish that Dr. Smith's diagnosis is the same as a low back muscle strain.

After reviewing the record, we find that the preponderance of the medical evidence indicates that claimant's accepted January 25, 1999 low back muscle strain has resolved. The medical record does not support the conclusion that claimant's current low back condition is the same as the accepted low back muscle strain, nor does the record support the conclusion that his current low back condition is related to the January 25, 1999 injury. Claimant has failed to sustain his burden of proving compensability of his current low back condition.

Extent of Unscheduled Permanent Disability

Claimant injured his back at work on January 25, 1999. (Ex. 1; 99-07954).[4] The employer accepted a nondisabling low back muscle strain on March 8, 1999. (Ex. 7; 99-08189). On May 19, 1999, the employer modified its acceptance to accept a disabling low back muscle strain. (Ex. 11). The employer determined that claimant was medically stationary on May 17, 1999 and issued a Notice of Closure on June 7, 1999, which awarded only temporary disability. (Ex. 13).

Claimant requested reconsideration. (Ex. 14). On August 17, 1999, a medical arbiter examination was performed by Drs. Schilperoort, Williams and Couregan. (Ex. 17). A September 9, 1999 Order on Reconsideration awarded 8 percent (25.6 degrees) unscheduled permanent disability for claimant's low back condition. (Ex. 18). The employer requested a hearing. The ALJ relied on the medical arbiter panel examination and affirmed the Order on Reconsideration.

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[4] The remaining citations in this section of the order concerning extent of permanent disability are from the exhibit file for WCB No. 99-07954, unless otherwise stated.

On review, the employer contends that the ALJ erred by finding that the employer had the burden of proof because it had requested the hearing seeking reduction of the permanent disability award. We need not address the employer's argument regarding burden of proof because we would reach the same conclusion no matter which party has the burden of proof.

On the merits, the employer relies on the medical arbiter panel report and contends that claimant has no impairment due to the accepted condition. Claimant also relies on the medical arbiter evaluation, but argues that he is entitled to an 8 percent unscheduled permanent disability award.

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).

Claimant's attending physician at the time of claim closure was Dr. McKellar. (Ex. 18). On May 17, 1999, Dr. McKellar reported that claimant had full range of motion in the "LS" spine. (Ex. 9). He noted tenderness in the right "SI" joint and diagnosed a chronic SI joint strain. (*Id.*) Dr. McKellar released claimant for regular work on May 17, 1999. (Ex. 10).

Dr. McKellar provided a summary of findings without any explanation and he did not provide a formal closing examination. We find that the medical arbiter panel evaluation is a more complete and well-reasoned evaluation of claimant's injury-related impairment.

Drs. Schilperoort, Williams and Couregan reported that the accepted condition was a low back muscle strain. (Ex. 17). They said that claimant continued to have low back pain and had problems picking up boards and handling the crates. (Ex. 17-1). They reported that claimant's lumbar flexion was 38 degrees, lumbar extension was 20 degrees, right lateral flexion was 8 degrees and left lateral flexion was 10 degrees. (Ex. 17-2). The panel said that claimant passed reproducibility validity criteria, but he failed the mid-sacral motion test. (Ex.17-2). They explained that claimant's lumbar flexion test was not valid. (Ex. 17-4).

Claimant's motor strength testing was normal. (Ex.17-2). Regarding sensory loss, the panel explained:

> "It is felt the sensory loss is due to unrelated conditions, namely, the grade I spondylolisthesis at L5-S1 with pars defect, degenerative changes at T12-L1, L3-4 and L4-5 and that no impairment is present based on the accepted condition. Therefore, 100% is based on pre-existing condition and 0% based on accepted condition." (*Id.*)

The employer argues that the medical arbiter panel said there was no impairment based on the accepted condition and, therefore, 100 percent of claimant's impairment was based on preexisting conditions.

Entitlement to permanent disability requires a claimant to establish the impairment by a preponderance of medical evidence based upon objective findings. ORS 656.726(4)(f)(B). Claimant also must establish that the impairment is due to a compensable injury. ORS 656.214(5). In *SAIF v. Danboise*, 147 Or App 550, 553, *rev den* 325 Or 438 (1997), the Court of Appeals held that

> "when the record discloses no other possible source of impairment, medical evidence that rates the impairment and describes it as 'consistent with' the compensable injury supports a finding that the impairment is due to the compensable injury."

The issue in *Danboise* was whether the claimant had established that his neck impairment was due to the compensable injury. Although the medical evidence described the claimant's impairment as "consistent with" the compensable injury rather than "due to" that injury, the court affirmed the Board's award of unscheduled PPD.

In *Danboise*, the court relied on the fact that the record identified no noncompensable factors that may have contributed to the claimant's impairment. *Id.* at 533. Here, unlike *Danboise*, the medical arbiter panel report referred to another source of claimant's low back impairment, *i.e.*, the panel reported that 100 percent of claimant's sensory loss was due to grade I spondylolisthesis at L5-S1 with

pars defect and degenerative changes at T12-L1, L3-4 and L4-5. (Ex. 17-2). In contrast to the *Danboise* case, we find no medical evidence that rated claimant's impairment and described it as "consistent with" the compensable injury. The medical arbiter panel did not explain that claimant's reduced range of motion findings were consistent with, or due to, the compensable injury. Moreover, claimant's attending physician at claim closure had reported full range of motion in the "LS" spine and had released claimant for regular work on May 17, 1999. (Exs. 9, 10).

Because the medical evidence discloses other possible sources of claimant's low back impairment and there is no medical evidence that rates claimant's range of motion impairment and describes it as "consistent with" or "due to" the compensable injury, we conclude that the holding in *Danboise* does not apply. *See SAIF Corp. v. Gaffke*, 152 Or App 367 (1998) (because there was no evidence of impairment or a causal link to the claimant's compensable injury, the claimant was not entitled to a permanent disability award); *Kenneth W. Emerson*, 51 Van Natta 655 (1999) (where no medical evidence established that the claimant's impairment was consistent with the accepted injuries, *Danboise* was inapplicable). We conclude that claimant is not entitled to an award of unscheduled permanent disability for his reduced lumbar range of motion. We therefore reverse the Order on Reconsideration award of 8 percent unscheduled permanent disabilty.

ORDER

The ALJ's order dated March 1, 2000 is reversed. The self-insured employer's denials of claimant's left knee medial meniscus tear are reinstated and upheld. The employer's denial of claimant's current low back condition is reinstated and upheld. The September 9, 1999 Order on Reconsideration that awarded 8 percent (25.6 degrees) unscheduled permanent disability for claimant's low back condition is modified to award zero. The ALJ's attorney fee awards are also reversed.

Board Member Phillips Polich concurring in part and dissenting in part.

Although I agree with the majority that claimant's current low back condition is not compensable, I disagree with the remainder of its opinion. Because I would find that claimant's left knee medial meniscus tear is compensable and I would affirm the 8 percent unscheduled permanent disability award, I respectfully dissent.

I agree with the ALJ that Dr. Casey's opinion establishes compensability of claimant's left knee medial meniscus tear under either an injury or occupational disease theory. We generally give deference to the opinion of a treating physician who has had the opportunity to evaluate a claimant over time. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). In this case, we should defer to Dr. Casey's opinion because he treated claimant's left knee condition in 1995 and in 1999. Moreover, as claimant's treating surgeon, the opinion of Dr. Casey 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 he had treated the claimant for a substantial time and was able to observe the shoulder during surgery).

After considering the record as a whole, including the other medical opinions, I find no persuasive evidence that claimant's left knee condition is anything other than work-related. The preponderance of the medical evidence establishes that claimant's left knee medial meniscus tear was caused, in major part, by his work activities. I would affirm the ALJ's decision finding claimant's left knee condition compensable. The majority's decision to the contrary is a matter of legal semantics, *not* medical evidence.

Furthermore, I disagree with the majority's conclusion that claimant is not entitled to an award of unscheduled permanent disability for his reduced lumbar range of motion. The ALJ correctly determined that claimant is entitled to an 8 percent unscheduled permanent disability award, based on the medical arbiter panel's findings.

The medical arbiter panel reported that claimant continued to have low back pain and had problems picking up boards and handling crates. (Ex. 17-1). He had a constant ache while walking and picking up items weighing more than 40 pounds. (*Id.*) The panel said that claimant's lumbar flexion was 38 degrees, lumbar extension was 20 degrees, right lateral flexion was 8 degrees and left lateral flexion was 10 degrees. (Ex. 17-2). Claimant passed reproducibility validity criteria, except for the mid-

sacral motion test. (Ex.17-2). Although the panel said that claimant's sensory loss was due to unaccepted conditions (Ex. 17-2), they made no such comments with regard to claimant's range of motion findings. Under these circumstances, it is not reasonable to infer that the panel's comment concerning sensory loss also pertains to range of motion findings. *See Jerrin L. Hickman*, 52 Van Natta 869 (2000) (medical arbiters' finding that lumbar flexion was invalid did not pertain to the validity of lumbar extension measurements). I agree with the ALJ that claimant is entitled to an 8 percent unscheduled permanent disability award for his low back condition.

In the Matter of the Compensation of
JOHN L. MONTGOMERY, Claimant
WCB Case No. 99-03372
ORDER ON REVIEW
Walsh & Associates, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of claimant's claim for medical services for a right knee meniscal tear on the basis that the claim was barred by a prior Claim Disposition Agreement (CDA). On review, the issues are claim preclusion and compensability. We affirm.

FINDINGS OF FACT

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

Claimant, a 75-year-old former truck driver, compensably injured his low back on August 16, 1994, when he was thrown from a pallet jack. SAIF accepted the claim as a lumbar strain/sprain.

Claimant was initially treated by Dr. Glasser, chiropractor, and Dr. Drips, his family physician. In January 1995, claimant's low back and ongoing right leg symptoms were evaluated by Dr. Collada, neurosurgeon. After steroid injections at L4-5 and L5-S1, claimant continued to see Dr. Drips and Dr. Collada for ongoing right leg pain. In July 1995, claimant was examined by Drs. Fuller and Snodgrass. In September 1995, claimant continued to complain of right leg pain; later that month, Dr. Collada operated on claimant's low back.

In February 1996, claimant complained of right hip pain aggravated by weight bearing. Dr. Drips diagnosed osteoarthritis.

An April 9, 1996 Notice of Closure awarded 41 percent unscheduled permanent disability, which was reduced to 34 percent by an August 30, 1996 Order on Reconsideration.

In June and July 1996, claimant was examined for ongoing back and right leg pain by Dr. Wayson, neurosurgeon, Dr. Olson, neurosurgeon, and Dr. Gerry, a physician. Claimant was also evaluated at the Oregon Spine Center.

In August 1996, SAIF denied the compensability of claimant's current low back and right hip condition and need for treatment. On January 13, 1997, the parties entered into a Disputed Claim Settlement concerning the August 1996 denial. On the same date, the parties entered into a CDA concerning claimant's August 16, 1994 claim.

On March 10, 1998, claimant was examined by Dr. Becker, orthopedic surgeon. An MRI revealed a torn medical meniscus in claimant's right knee; Dr. Becker requested authorization for arthroscopic surgery.

In a December 17, 1998 letter, claimant's attorney requested that SAIF amend its November 4, 1994 acceptance to include the torn right medial meniscus. SAIF denied the claim on May 26, 1999.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his claim for medical services under ORS 656.245 for his torn right medial meniscus is compensably related to the accepted August 1994 injury. Citing *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996), for the proposition that claimant fully released all of his rights concerning his August 1994 claim, except medical services, the ALJ concluded that the issue was compensability and not medical services. Accordingly, the ALJ upheld SAIF's denial of claimant's torn right medial meniscus, on the basis that claimant was barred from arguing that that condition is compensably related to the accepted injury. We disagree.

We agree that a CDA that settles "all issues raised or raisable" can extinguish all rights to further non-medical benefits for accepted conditions enumerated in the CDA, as well as other conditions that have been diagnosed, treated and related to the accepted injury prior to the execution of the CDA. *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996).[1] However, pursuant to the express terms of ORS 656.236(1) and OAR 438-009-0001(1), a CDA can have no effect on a claimant's right to future medical benefits for any condition compensably related to the accepted claim.

ORS 656.236(1)(a) permits parties, by agreement, to make such disposition of "any or all matters regarding a claim, *except for medical services*, as the parties consider reasonable, subject to such terms and conditions as the Workers' Compensation Board may prescribe." (Emphasis added.) The statute also expressly provides that, unless otherwise specified, a CDA resolves all matters and all rights to compensation potentially arising out of claims, *except medical services, regardless of the conditions stated in the agreement.*

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[1] In *Trevitts*, medical benefits were not at issue. *Trevitts* addressed whether the claimant was entitled to *non-medical* benefits for a condition not expressly specified in a CDA. Applying standard rules of contract construction, the court concluded that the parties intended a full release of all benefits, *except medical services*, related to the compensable injury. *Trevitts* was limited to the scope of the parties' contract in relation to non-medical benefits and does not support a conclusion that claimant was barred from attempting to establish the compensability of his knee condition in relation to the previously accepted claim. The case establishes only that claimant's eventual rights to compensation are limited to medical services.

SAIF also cited *D & D Company v. Kaufman*, 139 Or App 459 (1996), and *Cindy K. Christian*, 50 Van Natta 1729 (1998), as support for its contention that a CDA bars claims for new conditions resulting directly or indirectly from the original injury claim. We find both these cases inapposite.

As in *Trevitts*, medical benefits were not at issue in either of these cases. In *Kaufman*, the claimant compensably injured his middle and low back in April 1992. The claim was closed. In August 1992, the claimant reinjured his middle and low back. Before the CDA was approved by the Board, the carrier formally accepted the August 1992 claim as an aggravation. When the Board approved the CDA, the carrier discontinued time loss payments. The claimant continued to receive medical treatment for his back. In September 1993, claimant requested that his claim be reopened or that the August 1992 injury be processed as a new injury claim.

The issue before the court in *Kaufman* was whether a CDA that mentioned only one accident released the employer from liability for a subsequent new injury claim where the condition was in existence at the time of the CDA. Because the new injury was not mentioned in the CDA, the claimant argued that the CDA did not bar litigation and that the claimant was entitled to a hearing on the *de facto* denial of the new injury claim. The court, after analyzing the contractual intent of the parties, concluded that the CDA incorporated and released the claimant's rights regarding the second incident.

Kaufman supports the conclusion that claimant may be precluded from bringing a new *initial* claim for his knee condition, assuming that the condition was in existence at the time of the CDA. However, *Kaufman* does not support a conclusion that claimant is precluded from attempting to establish the compensability of his knee condition under the previously accepted claim. The case merely establishes that claimant's eventual rights to compensation are limited to medical services, should claimant prove that the condition is compensable.

Christian is a Board case with facts similar to those in *Kaufman*. In *Christian*, the medical record established that the claimant's 1998 CTS and ulnar nerve entrapment conditions, for which she made a new occupational disease claim, were part of her claim for "neck and arm" pain arising out of her work activity in 1996. The Board, citing *Kaufman*, concluded that these conditions were the same conditions encompassed by the CDA and, therefore, the claimant's subsequent occupational disease claim was barred pursuant to ORS 656.236(1)(a).

OAR 438-009-0001(1) defines a "claim disposition agreement" as "a written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 *except for medical services,* in an accepted claim." (Emphasis supplied).

Therefore, claimant is entitled to establish the compensability of a denied condition on which his medical services claim is based. *See, e.g., Lynn E. Amstutz,* 50 Van Natta 1434 (1996) (claimant not barred from asserting an impingement syndrome is compensably related to the accepted injury in medical services claim); *John L. Partible,* 48 Van Natta 434 (1996) (notwithstanding CDA limiting accepted condition to a cervical strain and disc, claimant may seek medical benefits for thoracic strain under prior accepted claim).

Claimant can establish compensability of his medical services claim by proving that the August 1994 injury directly and materially contributed to the right knee meniscal tear. *Albany General Hospital v. Gasperino,* 113 Or App 411 (1992).[2]

Claimant relies on the opinion of Dr. Becker to establish compensability. Because the first diagnosis of a meniscal tear in claimant's right knee did not occur until March 1998, more than three and a half years after the injury, we conclude that the causation issue in this case is a complex medical question. Therefore, claimant must present persuasive, supporting medical opinion to carry his burden of proof in this matter. *Uris. v. Compensation Department,* 247 Or 420 (1967); *Barnett v. SAIF,* 122 Or App 279, 283 (1993).

On March 10, 1998, claimant sought treatment for right knee swelling and pain at the medial joint line of his right knee. Dr. Becker initially diagnosed claimant's right knee condition as osteoarthritis, primarily medial compartment changes, which, based on claimant's history, dated from a 1994 sprain. (Ex. 57). An MRI revealed an extensive tear of the medial meniscus with severe loss of articular cartilage in the medial tibiofemoral compartment and a small area of bone bruise or edema in the anterior aspect of the medial tibial plateau. (Ex. 58). Dr. Becker requested approval for arthroscopic surgery. (Ex. 59).

After reviewing copies of the medical records of physicians who treated claimant from 1994 to 1997, Dr. Becker replied to questions from the claims adjuster. Dr. Becker agreed that, based on those medical records, there was neither a subjective nor objective examination with either complaints or findings of a knee injury, right or left, as a result of the 1994 injury. Dr. Becker stated that evidence of a preexisting condition was found during the 1998 surgery that revealed extensive tearing of the medial meniscus with secondary chondromalacial changes and that those changes occurred over an indeterminable period of time that was in excess of six to twelve months. Dr. Becker was unable to ascertain the age or cause of the tears. Dr. Becker also noted that claimant had not reported a new injury or incident [after 1994] that would account for his current right knee condition. Finally, Dr. Becker stated that the major contributing cause of claimant's need for treatment was the torn medial meniscus and the resulting articular damage. *Id.*

Subsequently, after being provided by claimant's attorney with a detailed hypothetical based on claimant's history, Dr. Becker opined that the major contributing cause of claimant's torn medial meniscus and articular damage was his 1994 injury. (Ex. 67). Dr. Becker's opinion was based on the following assumptions: (1) claimant had not experienced any preexisting problems with his right knee; (2) the right knee had swollen up horribly and turned black and blue the day after the occupational injury; (3) claimant had complained to his treating doctors that the knee hurt but his medical care givers had been too worried about the back injury to pursue treatment for the knee; and (4) claimant had turned, twisted and borne weight on the knee at the time of the injury, not just hit it against the side of the semi. (Ex. 67). There is no contrary medical opinion.

The ALJ made no credibility finding. 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).

[2] As noted by the ALJ, claimant does not contend that the right knee condition was an indirect consequence of the injury under ORS 656.005(7)(a)(A).

Here, the contemporaneous medical records do not contain any mention of an injury to the right knee, bruising of the right knee, or swelling of the right knee. (Exs. 1, 2, 4, 6, 7). Claimant's right leg complaints to treating doctors Gasser, Drips, Collada, and Hiebert involved radiation in the posterior and lateral aspect of his right leg. The doctors concluded that this radiating pain was from the low back and sciatic area. (Exs. 6 through 9, 11 through 13, 15, 16, 18, 20, 22 through 26). Subsequent to low back surgery, Dr. Collada and claimant reported that claimant's right leg symptoms were improved. (Exs. 29, 31).

The first mention of right knee involvement was on January 14, 1995, when claimant reported to Dr. Collada that he had noticed intense aching around the right knee. (Ex. 8). In July 1995, Drs. Fuller and Snodgrass noted right knee arthritis during an examination. (Ex. 23-5). On July 9, 1996, Dr. Olson noted prepatellar right knee swelling. (Ex. 40). But it was not until March 10, 1998, when claimant first sought treatment for his knee, that claimant attributed his right knee complaints to the August 1994 injury.

On this record, we find the history contained in the contemporaneous medical reports more persuasive than claimant's belated report of a severe right knee injury in August 1994, particularly in light of earlier assessments that the 1994 injury was minor, claimant's earlier report that he was "lucky not to break his left leg" and claimant's demonstrated memory problems. (Exs. 23, 69, and transcript generally). Based on those contemporaneous medical reports, we find insufficient evidence to establish that a severe injury to claimant's right knee did in fact occur on August 16, 1994. Accordingly, we are not persuaded by Dr. Becker's opinion that relied on that history. Therefore, we find that claimant failed to sustain his burden of proving that a compensable right knee injury occurred on August 16, 1994.

ORDER

The ALJ's order dated January 31, 2000, as corrected February 9, 2000, is affirmed.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with that portion of the majority opinion concerning the scope of the CDA. For the following reasons, however, I disagree with the majority's conclusion that claimant failed to prove compensability of his right knee injury.

Claimant relied on the opinion of Dr. Becker to establish compensability. Dr. Becker opined that the major contributing cause of claimant's torn medial meniscus and articular damage was his 1994 injury, based on claimant's history. There is no contrary medical opinion regarding causation. Accordingly, I would find that Dr. Becker's unrebutted medical opinion that the major contributing cause of claimant's torn right medical meniscus and articular damage was the 1994 injury persuasively establishes compensability.

In the Matter of the Compensation of
MICHAEL D. LITTLEFIELD, Claimant
Own Motion No. 99-0428M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Furniss, Shearer & Leineweber, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights expired on April 12, 1999. SAIF recommends against reopening on the grounds that surgery or hospitalization is not appropriate for the compensable injury. Pursuant to ORS 656.327, SAIF has requested Director's review of the requested medical treatment. (Medical Review Case No. 14352).

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 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
LADAWNA L. POST-BOOZE, Claimant
WCB Case Nos. 99-03864 & 99-01343
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys
Lundeen, 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: (1) set aside its compensability and responsibility denials of claimant's occupational disease claim for a right shoulder condition and; (2) upheld Liberty Northwest Insurance Company's compensability and responsibility denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility.

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

The ALJ set aside the self-insured employer's denial based on the opinion of claimant's treating physician and surgeon Dr. Mandiberg. Dr. Mandiberg concluded that claimant's work activities on the Hawthorne Bridge welding project for the most recent employer were the major contributing cause of her disability and need for treatment for her right shoulder bursitis/tendonitis condition. (Ex. 62). Dr. Mandiberg acknowledged that claimant has "a significant preexisting problem that was aggravated by the Hawthorne Bridge activity." (Ex. 39). Dr. Mandiberg reasoned that, although claimant's preexisting Type III acromion "plays a part," in causing claimant's right shoulder condition, it did not play a "dominant part." (Ex. 50).

On review, the employer contends that claimant has not met her burden of proving a compensable right shoulder condition through Dr. Mandiberg's opinion, because he did not properly consider claimant's Type III acromion condition. We disagree.

Where the medical opinion is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). We give deference to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Special deference is generally owed to the opinion of a treating surgeon, because of that physician's unique ability to observe the condition at surgery. *Argonaut Insurance v. Mageske*, 93 Or App 698 (1988).

Here, we find no persuasive reasons not to defer to Dr. Mandiberg, who performed surgery on claimant's right shoulder in June of 1999. (Ex. 57A). Although Dr. Mandiberg disputed the notion that claimant's Type III acromion was a "preexisting condition," because 40 percent of the population has this condition, he nevertheless considered the effect of the Type III acromion in reaching his final opinion on causation. (Ex. 39, 50). We are therefore satisfied that Dr. Mandiberg's opinion considered all potential causes of claimant's right shoulder condition. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev. dismissed*, 321 Or 416 (1995).

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

ORDER

The ALJ's order dated February 2, 2000 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the self-insured employer.

July 19, 2000 Cite as 52 Van Natta 1323 (2000)

In the Matter of the Compensation of
DAVID A. ROBBINS, Claimant
WCB Case No. 99-06641
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Hitt, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of his claim for his current groin condition. On review, the issue is compensability.

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

On review, claimant argues that the ALJ should have applied *Georgia Pacific v. Piwowar*, 305 Or 494 (1988) to the facts of this case. Specifically, claimant contends that, by accepting a "groin strain," the insurer also accepted claimant's current groin condition. Claimant further contends that this case is similar to our decision in *Frank M. Dionne*, 50 Van Natta 2290 (1998). In *Dionne*, the claimant submitted a claim for a "hurt back." The carrier accepted the claim, but did not identify the condition it was accepting. The claimant subsequently sustained new low back injuries in separate work incidents, for which he submitted new claims for a back strain and pulled muscles. The carrier then accepted the claims as part of the initial claim, rather than processing them as new injuries. Accordingly, in *Dionne*, we concluded that the carrier's acceptance must be construed as constituting an acceptance of the claim as filed. Therefore, we held that, by adding new injury claims to an earlier accepted injury claim, the carrier accepted whatever condition was causing claimant's "hurt back."

We find the *Dionne* case to be distinguishable. First, as noted in that case, we must determine whether the carrier accepted a claim for *symptoms*. If we find that an acceptance does not identify a specific condition, we will generally look to the contemporaneous medical records to determine what condition was accepted. *Id.* Here, however, we agree with the ALJ that the insurer did accept a specific condition (groin strain), rather than symptoms. Consequently, we conclude that it is not necessary to resort to the medical records to determine what was accepted. Therefore, the analysis set forth in *Georgia Pacific v. Piwowar*, 305 Or 494 (1988) and *Dionne*, does not apply.

ORDER

The ALJ's order dated February 25, 2000 is affirmed.

In the Matter of the Compensation of
EUGENE J. SENGER, Claimant
WCB Case No. 99-09137
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of his occupational disease claim for depression. On review, the issues are compensability and claim preclusion.

We adopt and affirm the ALJ's order based on the following reasoning.

Claimant has an accepted low back claim with SAIF with a date of injury of December 14, 1992. On May 19, 1998, claimant requested that SAIF accept his depression condition under the accepted December 14, 1992 low back injury claim. SAIF denied the claim and the denial was upheld in a March 17, 1999 Opinion and Order. The ALJ's March 17, 1999 order in that case has become final by operation of law.

In this claim, claimant is seeking compensation for his depression condition under an occupational disease theory. SAIF argued at hearing that the occupational disease claim was barred by *res judicata*. The ALJ found that the issue of whether claimant's depression was related to his work exposure had never been claimed or litigated. On this basis, the ALJ concluded that claimant's current occupational disease claim for depression was not barred by claim preclusion. The ALJ upheld the denial based on the merits.

Claimant contends on review that his work activities are the major contributing cause of his depression condition. Citing *Olive Bonham*, 51 Van Natta 1710 (1999), and ORS 656.262(7)(a), claimant argues that his occupational disease claim for depression is a "new medical condition" claim and that there is an exception to the doctrine of claim preclusion for "new medical condition" claims. On this basis, claimant asserts that the occupational disease claim is not barred by claim preclusion and that his claim is compensable on the merits. SAIF responds that the claim is barred by claim preclusion.

Based on the following reasoning, we conclude that ORS 656.262(7)(a) and *Bonham* do not apply to this occupational disease claim and we further conclude that the present claim is barred by claim preclusion.

In *Johansen v. SAIF*, 158 Or App 672 (1999), the court stated that a "new medical condition" under ORS 656.262(7)(a): (1) arises after acceptance of an initial claim; (2) is related to an initial claim; and (3) involves a condition other than the condition initially accepted.

Here, claimant's claim is for an occupational disease. In other words, claimant is contending that his depression condition was caused by all of his work activities during his employment with SAIF's insured, as opposed to his 1992 accepted low back injury as he had previously claimed. The occupational disease claim is not related to or based on an initial injury claim. It exists and is brought independently of the 1992 accepted injury claim. Because this claim does not involve a "new medical condition," ORS 656.262(7)(a) and the *Bonham* holding are not applicable.[1]

Res judicata, or "preclusion by former adjudication," precludes relitigation of claims and issues that were previously adjudicated. *Drews v. EBI Companies*, 310 Or 134, 139 (1990); *North Clackamas School Dist. v. White*, 305 Or 48, *mod* 305 Or 468 (1988). The term comprises two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation of a subject issue only if that issue was actually litigated and determined in a setting where the determination of that issue was essential to the final decision reached. *White*, 305 Or at 53. Issue preclusion can apply to issues of either fact or law. *Drews*, 310 Or at 140. Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate

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[1] *Bonham* held that ORS 656.262(7)(a) created an exception to claim preclusion for "new medical condition" claims because the statute states that a new medical condition claim may be initiated "at any time."

of operative facts. *Million v. SAIF*, 45 Or App 1097, *rev den* 289 Or 337 (1980). Claim preclusion does not require actual litigation, but it does require the opportunity to litigate, whether or not used. *Drews*, 310 Or at 140.

Here, claimant could have raised the occupational disease theory at the time of the February 17, 1999 hearing regarding compensability of the depression condition as a consequence of the December 14, 1992 injury. The present claim is for the same condition. There is no allegation from claimant that the depression condition is different or has changed from his condition at the time of the earlier final adjudication. Moreover, at that time, claimant's physician implicated claimant's work activities as a cause of the depression. Thus, the occupational disease claim could have been alleged under the same aggregate of operative facts. The ALJ's order in the previous adjudication is final by operation of law. Under such circumstances, claimant's occupational disease claim is barred by claim preclusion.

ORDER

The ALJ's order dated February 7, 2000 is affirmed.

Board Member Phillips Polich specially concurring.

I disagree with the majority's opinion to the extent that I believe that claimant is not precluded by claim preclusion from arguing that his work activities after the 1992 injury caused his condition. However, for the reasons set forth in the ALJ's order I agree that the claim is not compensable and would adopt and affirm the order.

In the Matter of the Compensation of
THOMAS D. CAWARD, Claimant
Own Motion No. 99-0454M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our April 20, 2000 Own Motion Order Reviewing Carrier Closure, that affirmed the SAIF Corporation's February 4, 2000 Notice of Closure. In his request, claimant contends that he was not medically stationary at the time of closure because he needed further treatment and physical therapy to improve his condition. Claimant submitted a May 1, 2000 medical report from Dr. Bowman, his attending physician, in support of his contention.

In response to claimant's motion, SAIF advises that it has received additional medical information from Dr. Bowman and requests that we set aside its February 4, 2000 Notice of Closure and reinstate "time loss benefits from December 30, 2000 [sic] to current." Based on SAIF's response, we do not find that claimant's compensable right knee condition was medically stationary on February 4, 2000, the date of claim closure.[1]

Accordingly, we set aside SAIF's February 4, 2000 Notice of Closure and direct it to resume payment of temporary disability compensation commencing on December 30, 1999. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] Although SAIF does not provide copies of the "new information" it received from Dr. Bowman, the record does contain claimant's submission of a May 1, 2000 medical report from Dr. Bowman wherein he states that "[claimant] was in appropriately [sic] declared medically stationary in December. He continues to have some difficulty with ambulation, and as I understand the workers' compensation rules, he is not medically stationary."

In the Matter of the Compensation of
STEVEN P. STEWART, Claimant
WCB Case Nos. 98-06193 & 98-03468
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Barrett Business Services, Inc. (Barrett) requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its responsibility denials of claimant's scapholunate dissociation, including a "back-up" denial of responsibility; (2) upheld Freightliner Corporation's (Freightliner's) responsibility denial of the same condition; and (3) assessed a penalty against Barrett for its allegedly unreasonable compensability denial. In his brief, claimant argues that: (1) he is entitled to an increased attorney fee related to Barrett's compensability denial; (2) he is entitled to an increased attorney fee related to Freightliner's compensability denial; (3) he is entitled to a penalty for Freightliner's allegedly unreasonable compensability denial; and (4) he is entitled to an increased attorney fee for services related to the responsibility issue. In Freightliner's brief, it contends that claimant's attorney fee award concerning its compensability denial should be reduced. On review, the issues are responsibility, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the fourth paragraph of the findings of fact on page 2, we change the first sentence to read: "Freightliner initially accepted right wrist tenosynovitis as a nondisabling injury, but later changed it to disabling. (Exs. 11, 12)."

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt and affirm the ALJ's order regarding Barrett's "back-up" denial and the issue of responsibility with the following supplementation. We write only to address Barrett's argument regarding claimant's alleged misrepresentation.

Barrett contends that claimant provided conflicting and misleading histories to the physicians that contributed to the confusion regarding causation and contributed to its acceptance of the claim.

Freightliner argues that Barrett is precluded from asserting misrepresentation as grounds for its "back-up" denial because it raised this issue for the first time during closing argument. Claimant asserts that, although his history may not have been entirely accurate, there is no evidence of fraud or misrepresentation.

Barrett issued a denial on September 16, 1998, rescinding its acceptance of claimant's scapholunate dissociation because new information indicated his condition on March 25, 1997 was due to his prior injury with Freightliner. (Ex. 80-3). The record indicates that Barrett raised the issue concerning claimant's alleged misrepresentation for the first time in written closing arguments. In its closing argument, Freightliner said that Barrett was precluded from raising this defense because it had not raised that issue during opening statement. The ALJ did not address the issue of misrepresentation.

We will not consider an issue raised for the first time during closing argument. *E.g., Patricia M. McKinzey*, 51 Van Natta 1933 (1999); *see also Clive G. Osbourne*, 47 Van Natta 2291 (1995) (Board declined to address carrier's argument on review that "back-up" denial was based on "later obtained evidence," when the carrier argued at hearing that the denial was based on misrepresentations). Consequently, we do not address Barrett's argument concerning misrepresentation.

Penalty and Penalty-Related Attorney Fee - Barrett

The ALJ found that Barrett's compensability denial was unreasonable. The ALJ assessed a penalty under ORS 656.262(11) of "all benefits that were owed to claimant for the period March 16, 1998 to September 11, 1998 and were not timely paid during that period as a result of the denial." (Opinion and Order at 8).

Barrett contends that there are no amounts due upon which to base a penalty and, therefore, a penalty is not justified. Barrett argues that claimant worked from March 16, 1998 to September 11, 1998 and was not entitled to any temporary disability benefits.

Claimant responds that time loss was not paid from the date of the denial to the date the "307" order issued, so a penalty could be calculated by Barrett. He asserts that a paying agent was not designated early in this case, in part, because of Barrett's compensability denial.

If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. ORS 656.262(11)(a). If 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, a claimant is not entitled to penalties or related attorney fees. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991).

Here, the record does not establish that there are amounts due upon which to base a penalty against Barrett. On review, Barrett contends there are no amounts due. In particular, Barrett asserts that claimant worked from March 16, 1998 to September 11, 1998 and was not entitled to any temporary disability benefits. Claimant does not dispute Barrett's argument.

At hearing, claimant testified that, after the March 1997 injury at Barrett, he performed light duty with the same wages and hours. (Tr. 43). On March 16, 1998, Barrett denied that the March 1997 injury was the major contributing cause of claimant's current condition. (Ex. 68). Until July 1998, claimant continued to work at Re Use It through Barrett. (Tr. 48). On July 8, 1998, Barrett wrote to claimant and advised that his modified light duty job assignment was ending because the claim had been closed by Notice of Closure. (Ex. 75A, Tr. 48). Barrett said that claimant's assignment through Barrett with Re Use It was terminated. (Ex. 75A). Claimant testified that he then began working directly for Re Use It in the same manner he had been paid at Barrett. (Tr. 44). He continued working directly for Re Use It for about three months. (Tr. 45, 49, 50). Claimant testified that he did not believe he had any lost wages up through September 1998. (Tr. 50). On September 16, 1998, Barrett issued a denial of responsibility only. (Ex. 81B).

We agree with Barrett that there is no evidence of "amounts due" from March 16, 1998 to September 11, 1998 upon which to base a penalty or a penalty-related attorney fee. Claimant argues, however, that, even if no compensation was due from Barrett, a penalty and related attorney fee may be based on amounts due from the responsible carrier. Here, however, Barrett *is* the responsible carrier. *Compare SAIF v. Whitney*, 130 Or App 429 (1994) (penalty payable by "nonresponsible" carrier based on amounts due from responsible carrier). Consequently, there are no "amounts then due," on which to base a penalty and there has been no unreasonable resistance to the payment of compensation that would support a penalty or penalty-related attorney fee from Barrett. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App at 292.

Penalty and Penalty-Related Attorney Fee - Freightliner

At hearing, claimant sought a penalty or penalty-based attorney fee for Freightliner's allegedly unreasonable compensability denial. The ALJ found that issue was moot because there was no sum upon which to base a penalty under ORS 656.262(11) and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee.

On review, claimant argues that he is entitled to a penalty or penalty-based fee for Freightliner's allegedly unreasonable compensability denial. However, he does not dispute the ALJ's conclusion that there were no "amounts then due" upon which to base a penalty.

If Freightliner's compensability denial is deemed to be unreasonable, even though there is no compensation "then due" from Freightliner, a penalty and related attorney fee under ORS 656.262(11) may be based on the "amounts then due" from Barrett, the responsible carrier. *See SAIF v. Whitney*, 130 Or App at 429. Nevertheless, as discussed earlier, we find no evidence of "amounts then due" from Barrett. Under these circumstances, we agree with the ALJ that claimant is not entitled to a penalty or penalty-related attorney fee concerning Freightliner's compensability denial. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App at 292.

Attorney Fees - Freightliner

The ALJ awarded a $3,000 attorney fee to claimant's attorney for services rendered in obtaining the rescission of Freightliner's compensability denial before the hearing.

On review, claimant requests an assessed fee against Freightliner of "$4,500 on the issue of compensability pursuant to ORS 656.386(1)[,] penalties to claimant for the unreasonable denial, or an additional penalty based fee pursuant to ORS 656.382(1)." (Claimant's br. at 7). Claimant asserts that this case required three significant physician depositions, motion hearings by telephone, written argument and other work before the hearing, including client meetings and phone conferences. Claimant's counsel asserts that he spent over 35 hours on this case "before the close of the record at hearing" and issuance of the ALJ's order. (Claimant's br. at 8).

In contrast, Freightliner contends that claimant's attorney fee regarding rescission of its compensability denial should be reduced to $1,800.

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

In determining the amount of an attorney fee for services regarding a rescinded denial, we review claimant's counsel's services *before* the rescission. *E.g., Kimberly R. Rice*, 52 Van Natta 138 (2000). Claimant's counsel did not submit a statement of services or an affidavit describing counsel's time expenditures. Although claimant's brief indicates that his attorney spent over 35 hours on this case before the close of the record at hearing, he did not provide information as to the time devoted to the case prior to Freightliner's rescission of its compensability denial.

Our review of the record reveals the following information. Freightliner withdrew its compensability denial on March 25, 1999, a month before the April 30, 1999 hearing. (Ex. 92). Approximately 117 exhibits were received into evidence, at least 13 of which were submitted by claimant's attorney. Prior to the hearing, claimant's attorney participated in depositions of Dr. Van Allen (34 pages), Dr. Vessely (42 pages), and Dr. Gambee (62 pages). The compensability issue involved questions of medical and legal complexity comparable to disputes generally presented to this forum. We agree with the ALJ that the claim's value and the benefits secured are significant, because substantial medical services, including surgery, are involved. No frivolous issues or defenses were presented and the parties' positions were advocated in a professional manner.

Based upon the application of the previously enumerated factors, and considering the parties' arguments, we agree with the ALJ that a reasonable fee for claimant's attorney's "pre-hearing" services in rescinding Freightliner's compensability denial is $3,000, payable by Freightliner. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), the complexity of the issue, the nature of the proceeding (*i.e.*, a "pre-hearing" rescission of a compensability denial), and the value of the interest involved.

Attorney Fees - Barrett

The ALJ awarded a $1,000 attorney fee to claimant's attorney for services rendered in obtaining the rescission of Barrett's compensability denial before the hearing. On review, claimant contends he is entitled to an attorney fee of $2,500 under ORS 656.386(1) for services involved with the rescission of Barrett's compensability denial.

We determine the amount of claimant's counsel's attorney fee for services regarding Barrett's compensability denial by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. The ALJ found that, for a period of six months, Barrett maintained a compensability denial. On September 16, 1998, Barrett issued a denial of responsibility only. (Ex. 81B). Barrett withdrew its compensability denial before the three physicians were deposed. Claimant's counsel did not submit a statement of services or an affidavit describing his time expenditures concerning Barrett's compensability denial.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we agree with the ALJ that a reasonable fee for claimant's attorney's "pre-hearing" services in obtaining the rescission of Barrett's compensability denial is $1,000, payable by Barrett. We note that claimant is not entitled to an attorney fee for his counsel's "post-rescission" services concerning the attorney fee award. *See Amador Mendez*, 44 Van Natta 736 (1992).

Attorney Fees - Responsibility

The ALJ awarded a $1,000 attorney fee under ORS 656.307(5), payable by Barrett, for claimant's counsel's appearance and active and meaningful participation in the responsibility proceeding.

On review, claimant also requests an additional attorney fee under ORS 656.307(5) in the amount of $1,000. Freightliner argues that claimant is not entitled to an extraordinary attorney fee because he did not raise that issue at hearing.

This case arises under ORS 656.307, and the attorney fee for services at hearing is authorized under ORS 656.307(5).[1] Under that provision, claimant is entitled to a reasonable fee for his counsel's appearance and active and meaningful participation at the hearing.

We agree with the ALJ that claimant's counsel "actively and meaningfully" participated at the responsibility hearing. The ALJ noted that claimant had endorsed Freightliner's analysis of responsibility and that position has prevailed. We proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee regarding the responsibility issue.

Our review of the record reveals the following. At hearing, the issue in dispute was assignment of responsibility. As the ALJ noted, claimant's counsel successfully argued that Barrett should be found responsible. Approximately 117 exhibits were received into evidence, including three physician depositions. The hearing lasted approximately two hours, resulting in a 68-page transcript. Claimant's written closing argument was nine pages.

The responsibility issue in this case was of average complexity and involved two carriers. The claim's value and the benefits secured are significant, because substantial medical services, including surgery, are involved. No frivolous issues or defenses were presented and the parties' positions were advocated in a professional manner.

After considering the above factors, in particular the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved, we agree with the ALJ that a reasonable attorney fee for claimant's counsel's services at the "307" proceeding regarding responsibility is $1,000, to be paid by Barrett.

Claimant is not entitled to an attorney fee award under ORS 656.307 for his counsel's services on review. *See* ORS 656.307(5); *Lynda C. Prociw*, 46 Van Natta 1875 (1994). Moreover, claimant's right to compensation was not at risk of disallowance, because a "307 order" issued prior to hearing. Nor was claimant's right to compensation at risk of reduction. The ALJ assigned responsibility to Barrett and it had the lowest rate of compensation. (*See* Ex. 91). Consequently, under these circumstances, claimant is not entitled to an assessed attorney fee under ORS 656.382(2) for services on review. *See Richard Flores*, 51 Van Natta 411 (1999). Finally, claimant's attorney is not entitled to a fee for services related to securing the attorney fee award. *See id.*

ORDER

The ALJ's order dated January 19, 2000 is reversed in part and affirmed in part. The portion of the ALJ's order that assessed a penalty against Barrett for its allegedly unreasonable compensability denial is reversed. The remainder of the ALJ's order is affirmed.

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

In the Matter of the Compensation of
JOHN H. ZIMMERMAN, Claimant
WCB Case No. 99-01164
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Reinisch, et al, Defense Attorneys
Nicholas M. Sencer, Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's claim for his L3-4 disc herniation and spinal canal stenosis at L3-4. On review, the issue is compensability.

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

On review, the insurer argues that the ALJ should not have accepted the opinion of Dr. Woodward. Specifically, the insurer contends that Dr. Woodward's opinion is not persuasive because Dr. Woodward included the 1979 surgery as part of the major contributing cause of the L3-4 disc herniation. The insurer also argues that Dr. Woodward believed that the spinal stenosis condition was caused by degenerative changes. Accordingly, the insurer contends that Dr. Woodward's opinion cannot meet claimant's burden of proof. We disagree.

Dr. Woodward was specifically asked by claimant's counsel whether the major cause of claimant's need for surgery and treatment of the condition in 1998 was the compensable injury and the surgeries in 1979 and 1981. (Ex. 118-15). Dr. Woodward agreed with that statement and also explained that claimant did not have a significant stress on the L3-4 level until his fusion following the compensable injury. (Ex. 118-15). Dr. Woodward also testified that studies supported a finding that age-related degenerative changes would be only a minor contributing factor, whereas 25 percent of individuals who had fusion surgeries had symptomatic degeneration of the adjacent disc.[1] (Ex. 118-26).

After considering Dr. Woodward's opinion in its entirety, we agree with the ALJ that the opinion is persuasive and that it meets claimant's burden of proof. We therefore affirm the ALJ on the issue of compensability.

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). On review, claimant has requested an assessed attorney fee of $2, 275. The insurer, argues, however, that a more appropriate fee in this case is $1,500.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). Those factors are: (1) the time devoted to the case; (2) the complexity of the issue involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issue on review in this case was the compensability of claimant's consequential condition claim for his L3-4 disc herniation and spinal canal stenosis at L3-4. Claimant's attorney submitted a 16 page brief. With his brief, claimant submitted a request for a fee of $2,275, based on 13 hours of time devoted to the brief. The record contains 126 exhibits, including three depositions. The case involved a compensability issue of above-average complexity. The value of the claim and benefits secured are significant in that we have affirmed the ALJ's determination that claimant's L3-4 disc herniation and spinal canal stenosis at L3-4 are compensable. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the insurer's vigorous defense of the claim and the conflicting medical evidence, there was a risk on Board review that claimant's counsel's efforts might have gone uncompensated.

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[1] In this regard, we find that Dr. Woodward's opinion is consistent with a prior opinion provided by Dr. McKillop. Dr. McKillop performed claimant's 1979 fusion and the 1981 repair surgery. In February 1984, Dr. McKillop reported that "virtually all of [claimant's impairment] is due to the injury occurring in 1978." (Ex. 47-3).

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $2,275 is a reasonable fee for services regarding the compensability issue at the Board level. We have reached this conclusion particularly because of the time devoted to the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated February 23, 2000, as amended February 29, 2000, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $2,275, to be paid by the insurer.

In the Matter of the Compensation of
JANICE K. CONNELL, Claimant
Own Motion No. 98-0271M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Hollander & Lebenbaum, Claimant Attorneys

Claimant requests review of the SAIF Corporation's April 17, 2000 Notice of Closure which closed her claim with an award of temporary disability compensation from June 1, 1998 through April 14, 2000. SAIF declared claimant medically stationary as of April 14, 2000. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

In an May 22, 2000 letter, 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. Having received the parties submissions and respective positions, we proceed with our review.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 17, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

In support of its closure, SAIF relies on a April 14, 2000 response from Dr. Grewe, claimant's attending physician, who had last examined claimant on January 27, 2000. Dr. Grewe opined that claimant was not a surgical candidate at that time and therefore, I would say she is currently medically stationary with risk for needing treatment in the future due to worsened pathology due to accepted work condition.

On April 21, 2000, Dr. Grewe sent an e-mail message to SAIF wherein he expands on his April 14, 2000 response. Dr. Grewe explained that although claimant was not a good surgical candidate at that time, she did have extensive pathology including flat back changes, progressive spondylosis and multiple levels of spondylolisthesis, as revealed in an April 3, 2000 CT scan and myelogram. He further acknowledged that any of these pathologies could become at least a radiographic reason to consider a surgical intervention. Dr. Grewe concluded that because claimant's conditions are often gradually progressive and may result in surgery, the question of whether claimant is medically stationary could not be answered with a simple yes or no.

Following the April 17, 2000 closure, Dr. Grewe examined claimant on May 2, 2000. Reporting that claimant had significant new complaints as well as taking into consideration the diagnostic April 2000 CT scan and myelogram which demonstrated that claimant had surgical pathology, Dr. Grewe recommended: (1) that claimant undergo further diagnostics in the form of x-rays; (2) that claimant be

referred to a spine specialist for a second opinion; and (3) consideration of a possible extension wedge osteotomy surgery. In that same chart note, Dr. Grewe opined that he was not comfortable in closing her claim.

Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Here, Dr. Grewe retracted his earlier opinion that claimant was medically stationary in April 2000 (which was rendered without an examination since January 2000) and recommended that claimant undergo further diagnostic testing and a second opinion with a spine specialist. Specifically, based on the CT scan and myelogram findings as well as a number of additional complaints (significantly claimant's inability to dorsiflex her right foot and toes), Dr. Grewe concluded that claimant condition was not stable and required additional treatment.

Dr. Grewe's May 2000 chart note is sufficiently explained to overcome his initial April 2000 opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physicians opinion found unpersuasive). Dr. Grewe's subsequent opinion was based on a medical examination conducted only 2 weeks after SAIF closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between April 17, 2000 claim closure and Dr. Grewe's May 2, 2000 examination, we conclude that Dr. Grewe's subsequent opinion addresses claimant's condition at claim closure. *See Scheuning v. J. R. Simplot & Co.*, 84 Or App at 622.

Based on Dr. Grewe's unrebutted opinion, we conclude that claimant was not medically stationary on April 17, 2000 when SAIF closed her claim.

Accordingly, we set aside the Notice of Closure as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $750, 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
BILL OWENS, Claimant
Own Motion No. 00-0222M
OWN MOTION ORDER
Daniel Spencer, Claimant Attorney

The insurer has submitted a request for temporary disability compensation for claimant's left groin condition. Claimant's aggravation rights expired on August 12, 1999. The insurer recommends that we authorize the payment of temporary disability compensation.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning 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, in its recommendation form, the insurer indicates that claimant is represented. Based on such a reference, claimant's attorney may be entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, on this record, we cannot approve such a fee because: (1) no current retainer agreement has been filed with the Board (*see* OAR 438-015-0010(1)); and (2) no evidence demonstrates that claimants attorney was instrumental in obtaining increased temporary disability compensation OAR 438-015-0080.

In conclusion, because no retainer agreement has been received to date and the record does not establish that claimants attorney was instrumental in obtaining increased temporary disability compensation, the prerequisite for an award of an out-of-compensation attorney fee have not been met at this time. Consequently, no out-of-compensation attorney fee award has been granted. In the event that a party disagrees with this decision, that party may request reconsideration and submit information that is currently lacking from this record. Because our authority to further consider this matter expires within 30 days of this order, any such reconsideration request must be promptly submitted.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAUNENE R. KAEO, Claimant
WCB Case Nos. 99-04103 & 99-02254
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Bostwick, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Cigna Insurance Company (Cigna) requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its responsibility denial of claimant's aggravation claim for a current low back condition; and (2) upheld Kemper Insurance Company's (Kemper's) responsibility denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. 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 number 17 on page 3. We supplement and briefly summarize the facts as follows.

On November 24, 1992, claimant compensably injured her low back in a motor vehicle accident that took place when she was working for Cigna's insured. Cigna accepted a disabling "lumbar strain." (Ex. 31). The claim was closed on July 9, 1993, with no award of permanent disability for the low back. (Exs. 23, 38).

Claimant sought further treatment for increased low back pain in September 1993. Dr. Cox diagnosed a flare-up of chronic low back pain and treated with physical therapy. By March 1994, her low back pain was under good control. (Exs. 24, 39).

Claimant next sought treatment for low back pain in December 1994. She was diagnosed with chronic low back strain and began treating with Dr. Strutin. Dr. Strutin attributed claimant's chronic low back pain to the 1992 injury and treated with physical therapy. Her condition stabilized on March 29, 1995. (Exs. 45 through 52).

In December 1996, claimant treated for her low back after she slipped on stairs at home. Dr. Strutin diagnosed back pain aggravated by a recent strain and a cough. (Ex. 60).

Claimant's back pain recurred in March 1997; Dr. Strutin diagnosed recurrent back strain and spasm.

In September 1997, claimant again sought treatment. Dr. Strutin treated her back strain with anti-inflammatories, heat and ice. (Ex. 60).

Claimant did not seek treatment for her low back until November 1998, when she complained of abdominal pain. Dr. Strutin found tenderness in the low back in addition to pelvic pain. He diagnosed pelvic pain and low back pain of questionable relationship. (Ex. 65). Claimant returned complaining of low back pain in December 1998 after carrying many 20-pound buckets. She was again treated with anti-inflammatories, heat and ice. (Ex. 67).

On January 22, 1999, claimant experienced low back pain when she slipped on snow while she was inspecting a company vehicle that had skidded into a ditch. Claimant continued to work until February 18, 1999, but her low back pain increased and she experienced radiation down both legs. A comparison with 1994 x-rays revealed narrowing of the posterior disk space. Dr. Strutin referred her for neurosurgical evaluation.

On March 12, 1999, Dr. Van Pett, neurosurgeon, examined claimant on referral from Dr. Strutin.

On May 18, 1999, Drs. Williams and Woodward examined claimant for Kemper. (Ex. 81).

On August 10, 1999, claimant was examined by Dr. Karasek, neurosurgeon, on referral from Dr. Strutin. (Ex. 87).

CONCLUSIONS OF LAW AND OPINION

The parties do not dispute the ALJ's conclusion that claimant's "current" low back condition is compensable. Applying ORS 656.308(1), the ALJ found that claimant did not sustain a "new injury" under Kemper's coverage and that responsibility remained with Cigna. On review, Cigna contends that claimant's current condition is not the same condition it accepted in 1992, and therefore, ORS 656.308(1) does not apply in this case. We agree.

Here, Cigna specifically accepted claimant's 1992 disabling lumbosacral strain. Based on the specific acceptance and absent evidence that Cigna accepted any condition other than claimant's 1992 lumbosacral strain (by providing notice of responsibility and obligation to provide benefits), we conclude that Cigna's acceptance is limited to the 1992 lumbosacral strain. *See Eleanor I. Crockett*, 51 Van Natta 950 (1999).

Having determined the accepted condition resulting from the 1992 claim, we now determine the nature of claimant's current low back condition and whether it is the same as the prior accepted condition. In doing so, we agree with the ALJ that there is conflicting expert medical opinion regarding the nature and cause of claimant's current condition.

When claimant first sought treatment on February 18, 1999, Dr. Strutin found lumbar tenderness. Straight leg raises elicited pain in the low back. Dr. Strutin compared current x-rays to those of 1994. The current x-rays differed in showing a significantly narrowed posterior disc space. Dr. Strutin diagnosed claimant's condition as "chronic low back pain" and referred claimant to Dr. Van Pett, neurosurgeon, for further evaluation. (Ex. 70).

A March 10, 1999 MRI revealed desiccation of the L4-5 and L5-S1 discs with foraminal narrowing on the left, as well as annular fissures at both levels. (Ex. 74). On March 12, 1999, Dr. Van Pett examined claimant and treated with epidural steroid injections (ESIs) into the L4 interspace. Dr. Van Pett also requested discography and axial tomography based on diagnoses of "sciatica" and "disc degeneration." (Ex. 77).

On April 24, 1999, after noting claimant's improvement after the injections, Dr. Strutin diagnosed claimant's condition as low back pain with presumed L5-S1 disc syndrome as the cause. (Ex. 80A).

On May 18, 1999, Drs. Williams and Woodward examined claimant for Kemper. After reviewing claimant's medical records, they opined that claimant's 1992 strain had resolved. They also opined that, because claimant had been able to work at her regular job for four weeks after the January 22, 1999 injury, that injury was not the cause of her current condition. They attributed claimant's low back symptoms to idiopathic causes.

After a discogram was performed on May 21, 1999, Dr. Van Pett reassessed claimant's condition. Dr. Van Pett reported that claimant had good relief of her pain after the injections and total pain resolution after the discogram. Dr. Van Pett also reported that the discogram showed significant degeneration at L5-S1, but no concordance with the pain. Dr. Van Pett was not sure whether the lack of concordance was because all the pain resolved with the injection or because claimant's pain originated from a different source than the disc. (Ex. 84).

In discussing the case with Cigna's attorney subsequent to Dr. Van Pett's report, Dr. Strutin attributed claimant's 1999 increase in pain to a musculoligamentous strain accompanied by inflammation and muscle spasm. Dr. Strutin stated that the major contributing cause of claimant's condition was the

1992 injury and that the 1999 injury pathologically worsened the 1992 condition. (Ex. 85). Dr. Strutin did not mention the disc condition and provided no reasoning for his current diagnosis.

In July 1999, claimant's low back symptoms significantly worsened after she carried a heavy ladder at Kemper's injured. She reported numbness and tingling through both of her legs to her toes and difficulty with walking. (Tr. 15). In August 1999, Dr. Karasek evaluated the source of claimant's ongoing pain, which was diffuse at L4-5 and L5-S1 radiating out into the sacroiliac joints and the thighs. (Ex. 87). After he eliminated the facet and sacroiliac joints as the source of claimant's pain, Dr. Karasek opined that the cause was discogenic.

After reviewing the record and his clinical notes, he opined that claimant had a pathological worsening of one of her lumbar discs with a tear in the annulus or that she tore paraspinous ligaments as a result of the 1999 incident. (Exs. 87, 89, 90, 92, 94). Dr. Karasek repeated an ESI at L5-S1; he then opined that claimant may have torn a disc.

Dr. Karasek informed Cigna's attorney that claimant's current low back condition was most consistent with a new injury, noting that claimant had sustained the old injury in 1992, treated off and on for many years, but had not sought medical care for her low back for the two years prior to her 1999 injury. Dr. Karasek thought it probable that claimant increased her discal tear or tore paraspinous ligaments at the time of her 1999 fall. (Ex. 93).

We interpret Dr. Karasek's opinion as supporting the absence of causal connection between the 1992 injury and the current condition and conclude that his opinion is more persuasive than those of Dr. Strutin or Drs. Woodward and Williams or Dr. Van Pett. *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).

Dr. Strutin initially deferred to Dr. Van Pett's diagnosis of a disc syndrome as the cause of claimant's symptoms. But he subsequently changed his opinion to conclude that claimant's condition was a musculoligamentous strain accompanied by inflammation and muscle spasm. However, neither his nor Dr. Van Pett's examinations documented muscle spasm, and Dr. Strutin did not explain his change of opinion. Moreover, Dr. Strutin offered his opinion before claimant underwent the tests and ESI ordered by Dr. Karasek and did not take into consideration Dr. Karasek's opinion that it was medically probable that claimant had suffered a torn annulus as a result of the January 1999 industrial injury.

Because Dr. Strutin's opinion is conclusory, without explanation, and is not based on a complete medical record, we are not persuaded that claimant sustained a new compensable injury involving the same lumbar strain condition. Similarly, because Dr. Van Pett changed her opinion regarding causation without explanation, *compare* Exs. 75 and 88, we do not find it persuasive.

Finally, at the time of their report, Drs. Woodward and Williams did not have the benefit of the subsequent tests and treatment results for the disc condition diagnosed by Dr. Van Pett or Dr. Karasek.

Because claimant's current low back condition (torn annulus) is an unaccepted condition, ORS 656.308(1) does not apply in deciding responsibility. Moreover, as discussed above, there is no persuasive evidence that claimant's 1992 accepted injury is the major contributing cause of her current low back condition. *See* ORS 656.005(7)(a)(A). Finally, there is no evidence of a combined condition. *See* ORS 656.005(7)(a)(B). Therefore, because the preponderance of the evidence establishes that Cigna's accepted 1992 injury is not a contributing factor to claimant's current low back condition, we conclude that Kemper is responsible.[1]

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[1] Citing *SAIF v. Britton*, 145 Or App 288, 292 (1996) and *Walter H. Magby*, 51 Van Natta 436,438 (1999), Kemper argues that the medical record must establish that the 1999 injury constituted the major contributing cause of claimant's current condition or need for treatment. These cases are inapposite.

In *Britton* and *Magby*, unlike in this case, ORS 656.308(1) was applied to shift responsibility. ORS 656.308(1) applies only when two compensable injuries involve the same condition. As discussed above, the 1999 condition is not the same condition as was accepted in 1992. Therefore, ORS 656.308(1) is inapplicable here. Moreover, there is no medical evidence that the 1999 injury combined with the 1992 low back strain. Without medical evidence of a combining of conditions, ORS 656.005(7)(a)(B) does not apply.

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 Cigna. Inasmuch as Kemper'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 $1,000, payable by Kemper. 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. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252-53 (1992), *mod* 119 Or App 447 (1993).

ORDER

The ALJ's order dated March 6, 2000 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside Cigna Insurance Company's (Cigna's) responsibility denial is reversed. Cigna's responsibility denial is reinstated and upheld. That portion of the order that upheld Kemper Insurance Co.'s (Kemper's) denial is reversed. Kemper's 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 Cigna is modified. That fee is payable by Kemper, rather than Cigna. For services on review, claimant is awarded a $1,000 attorney fee, to be paid by Kemper. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
RICHARD R. MERRIMAN, Claimant
WCB Case No. 99-03859 & 99-01950
ORDER OF REVIEW
David L. Bussman, Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's denial of claimant's current low back condition including claimant's T8-9 and T9-10 disc conditions. With his appellate brief, claimant also submitted a motion to remand for the taking of additional evidence. The self-insured employer objects to the motion. On review, the issues are remand and compensability.

We adopt and affirm the order of the ALJ with the following supplementation to address claimant's motion to remand.

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

Claimant contends the record has been improperly, incompletely, or otherwise insufficiently developed. Specifically, he wishes to obtain additional deposition testimony from Drs. King and Puziss, both of whom have treated claimant.[1] If remand is granted, claimant seeks to question the doctors

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[1] Claimant alleges the depositions, which were taken by his former counsel, were taken without claimants knowledge, thereby violating his right to attend the deposition. Claimant further alleges that had he been present at the depositions, information critical to the medical cause of his current low back condition would not have been left out of the record.

about an MRI scan from March 1985 allegedly showing no degenerative changes in claimant's thoracic spine.[2]

The employer objects to the motion to remand arguing primarily that the information claimant seeks could have been obtained at the time of the hearing and that the information claimant seeks is not likely to affect the outcome of the case. We agree.

Even if we assume that the additional evidence claimant seeks concerns his disability and was not obtainable at the time of hearing, we are unable to conclude that it is likely to affect the outcome of the case.[3]

One problem with claimant's position is that the record does not reflect that the MRI scan, to which he refers, exists. The record contains an x-ray report of March 6, 1985, but does not mention an MRI scan in that time period. (Ex. 14). Nor has claimant yet submitted such an MRI scan or a report referencing such an MRI scan.

Other problems with claimant's position are: (1) Dr. King's opinion that claimant's work injury was a simple strain; and (2) Dr. Puziss' opinion that the T8-9 and T9-10 disc herniations do not explain claimant's current pain complaints. (Ex. 132-14; & 133-13). Consequently, even if we assume that the MRI scan claimant refers to exists, and if we further assume it establishes what claimant alleges, we still cannot conclude that Drs. King and Puziss would likely change their opinions regarding the nature and cause of claimant's current condition. Accordingly, we do not find a compelling reason to remand.[4] *Compton v. Weyerhaeuser Co.*, 301 Or at 646.

ORDER

The ALJ's order dated February 7, 2000 is affirmed.

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[2] Claimant argues that if his doctors are made aware of that MRI scan, their opinions regarding the role, if any, degenerative changes play in his current low back condition would change.

[3] The depositions of Drs. King and Puziss, Exhibits 132 and 133 respectively, were taken in early June 1999. On or about August 5, 1999, claimant became aware of the depositions, began representing himself, and requested a postponement of a hearing that was then scheduled for August 12, 1999. (Tr. 2; WCB file). The record does not establish, what actions, if any, claimant took between August 5, 1999, and January 19, 2000, to obtain the additional deposition testimony of Drs. King and Puziss.

[4] It appears that claimant is not clear as to his rights under the accepted portion of his claim. The Workers' Compensation Board is an adjudicative body within an agency of the State of Oregon. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial party and cannot give legal advice. Because 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, at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT. OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE, ROOM 160
SALEM OR 97301-3878

In the Matter of the Compensation OF
ROLAND A. WALKER, Claimant
WCB Case No. 93-07081
ORDER DENYING RECONSIDERATION
Charles R. Mundorff, Claimant Attorney
David L. Runner (Saif), Defense Attorney

Claimant requests reconsideration of our June 15, 2000 Order on Remand that, on reconsideration of our June 1, 1995 order, reversed the ALJ's December 1, 1994 order and reinstated and upheld the SAIF Corporation's denial of claimant's aggravation claim. Because we find that our prior order has become final, we lack authority to reconsider the Order on Remand.

A Board order is final unless, within 30 days after the date of mailing copies of the order, one of the parties files a petition for judicial review with the Court of Appeals. ORS 656.295(8). The time within which to appeal an order continues to run unless the order had been "stayed," withdrawn or modified. *International Paper Co. v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656, 659 (1986).

The 30th day following our June 15, 2000 Order on Review was July 15, 2000. Although claimant mailed a request for reconsideration by certified mail to the Board on July 14, 2000, the Board did not receive claimant's motion until July 18, 2000. Thus, before we could respond to claimant's motion, the 30-day period of ORS 656.295(8) had expired. Because our June 15, 2000 order has not been stayed, withdrawn, modified or appealed within 30 days of its mailing to the parties, we are without authority to alter our prior decision. *See* ORS 656.295(8); *International Paper Co. v. Wright*, 80 Or App at 447; *Fischer v. SAIF*, 76 Or App at 659; *Paul D. Hamilton*, 52 Van Natta 1063, 52 Van Natta 1251 (2000) (Second Order Denying Reconsideration); *Darlene E. Parks*, 48 Van Natta 190 (1996); *see also Barbara J. Cuniff*, 48 Van Natta 1032 (1996) day, the statutory period had expired by the time the motion was brought to the Board's attention). Consequently, claimant's motion for reconsideration is denied.

As we have noted on prior occasions, the Board attempts to respond to motions for reconsideration as expeditiously as possible. *See Connie A. Martin*, 42 Van Natta 495, *recon den* 42 Van Natta 853 (1990). Notwithstanding these stated intentions, the ultimate responsibility for preserving a party's right of appeal must rest with the party. *Id.*

Here, as noted above, the statutory 30-day period had already expired by the time claimant's reconsideration motion was received by the Board. Consequently, even with our stated intention to expeditiously respond to such motions, our authority to conduct reconsideration of our decision had expired prior to our receipt of the motion.

Accordingly, claimant's motion for reconsideration is denied.[1]

IT IS SO ORDERED.

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[1] Had we retained our authority to reconsider our decision, we would continue to adhere to our prior conclusion that the record does not establish an "actual worsening" of the compensable condition within the meaning of ORS 656.273(1). In addition, we would decline claimant's request for remand because we find that the record was sufficiently developed for review. *See* ORS 656.295.

In the Matter of the Compensation of
JULIETA M. MULLEN, Claimant
WCB Case Nos. 99-09226 & 98-02071
ORDER ON REVIEW
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of claimant's "new injury," aggravation, and occupational disease claims for her upper back condition. With her appellate briefs, claimant submitted additional evidence, some of which is not in the record. We treat this submission as motion to remand for the taking of additional evidence. On review, the issues are remand and compensability.

We adopt and affirm the order of the ALJ with the following supplementation to address claimant's motion to remand.

The proffered evidence, not already in the record, consists of: (1) a September 13, 1995, physical therapy record; (2) a representation letter dated June 2, 1998, from claimant's former counsel to the insurer; (3) a completed, but unsworn interrogatory of May 24, 2000, from claimant's co-worker; (4) various work schedules from the employer; (5) claimant's performance review for the period of March 18, 1993 to March 18, 1994; (6) claimant's dental assistant licensing information; (7) a telephone log note from claimant's doctor dated July 31, 1997.

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

Even if we assume that the proffered evidence concerns claimant's disability and was not obtainable at the time of hearing, we conclude that it is not likely to affect the outcome of the case.[1]

Because of claimant's preexisting condition and the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). None of the proffered evidence consists of the type of expert medical opinion that is necessary to help resolve the complex medical questions presented in this case. Accordingly, we do not find a compelling reason to remand. *Compton v. Weyerhaeuser Co.*, 301 Or at 646.

ORDER

The ALJ's order dated February 28, 2000 is affirmed.

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[1] We note that, except for the co-worker's interrogatory, all the proffered evidence could have been presented at hearing.

We also note that claimant is presently unrepresented and that some of her concerns do not fall under Oregons Workers' Compensation law, but involve other legal issues. The Workers' Compensation Board is an agency of the State of Oregon that adjudicates only issues that fall within Oregons Workers' Compensation law. Because claimant's lunch break concerns and her dental assistant licensing concerns are not part of the Workers' Compensation law and because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman, at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT. OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE, ROOM 160
SALEM OR 97301-3878

In the Matter of the Compensation of
SHARON M. BATTIN, Claimant
WCB Case No. 99-02619
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a right carpal tunnel syndrome condition. Claimant also challenges the ALJ's ruling that declined to admit proposed Exhibit 15. On review, the issues are remand and compensability.

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

On review, claimant contends that the ALJ erred in not admitting proposed Exhibit 15, a medical report to which claimant's treating surgeon, Dr. Hubbard responded. Claimant submitted the report just before the hearing convened. The employer objected to its admission; the ALJ sustained the objection on the basis that claimant did not act with due diligence in generating the report. Claimant contends that the ALJ "erred as a matter of law" and moves to remand the case for admission of the document.

Specifically, claimant seeks to admit the report as evidence that she satisfied the "rule of proof" of the last injurious exposure rule. We need not decide this issue because, whether or not we consider proposed Exhibit 15, we conclude that claimant did not prove compensability.

Whether or not claimant invokes the last injurious exposure rule, she must show that employment conditions were the major contributing cause of right carpal tunnel syndrome condition. *See* ORS 656.802(2). The last injurious exposure rule of proof allows a claimant to prove the compensability of an occupational disease without having to prove the degree, if any, exposure to disease-causing conditions at a particular employment actually caused the claimant's condition. *Roseburg Forest Products v. Long*, 325 Or 305, 309 (1997). In other words, whether we consider only claimant's employment with this employer (Wal-Mart), or her entire employment history, she must establish that work activity was the major contributing cause of her condition.

Here, claimant began working for Wal-Mart in approximately 1994. For three years prior to that employment, claimant was retired and cared for her two young grandchildren. (Tr. 17). From approximately 1988-94, claimant worked for a company cleaning apartments. (*Id.* at 19). For eighteen months before that employment, claimant worked for K-Mart as a cashier. (*Id.*) For six months before that job, claimant made Mexican-style food for a restaurant. (*Id.* at 20).

As explained by the ALJ, Dr. Hubbard found that claimant's age and idiopathic factors were of equal weight as her work with Wal-Mart in causing the carpal tunnel syndrome condition. (Ex. 13-30). In providing this opinion, however, Dr. Hubbard did not consider claimant's previous work before 1994. In proposed Exhibit 15, Dr. Hubbard gives a "best guess" as to the contribution of these prior employments. Specifically, Dr. Hubbard indicates that the restaurant work contributed 5 percent, the apartment cleaning work contributed 4 percent,[1] and the work at K-Mart contributed 5 percent.

Claimant argues that, because Dr. Hubbard previously found contribution from Wal-Mart was fifty percent, this evidence shows that Dr. Hubbard considers claimant's total employment conditions as outweighing that period when she stayed home taking care of her grandchildren. We understand claimant as contending that we should add the work contribution from previous employments to the fifty percent exposure from Wal-Mart.

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[1] This figure is not clear and could also be 1 percent. In any case, our conclusion would be the same whether 4 or 1 percent.

We disagree with claimant's interpretation of this evidence. Because Dr. Hubbard does provide an opinion in the report whether the entire work history constitutes the major contributing cause of the right carpal tunnel syndrome, he could also have considered the Wal-Mart contribution as diminished by the prior employment and continued to think that claimant's period at home was of equal weight. In other words, because Dr. Hubbard does not clarify his opinion in light of contribution from previous jobs, it would be speculative for us to determine that his opinion carries claimant's burden of proof under the last injurious exposure rule.

Therefore, we conclude that, because the outcome would not be affected by admission of the additional report, remand is not warranted. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

ORDER

The ALJ's order dated January 26, 2000 is affirmed.

July 21, 2000 Cite as 52 Van Natta 1341 (2000)

In the Matter of the Compensation of
ELLIS L. SEIFERT, Claimant
WCB Case No. 98-09066
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our June 26, 2000 Order on Review that awarded an assessed fee of $1,000 for claimant's counsel's services on review. Noting that a statement of services was filed on June 13, 2000, requesting an assessed fee of $2,000, and that the employer did not object to the statement of services, claimant requests that we award the above fee.

After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorneys services on review is $2,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondents brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our June 26, 2000 order. On reconsideration, as modified herein, we adhere to and republish our June 26, 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
PATRICK C. McGEEHAN, Claimant
WCB Case No. 99-09543
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the SAIF Corporation's *de facto* denial of claimant's omitted medical condition claim for left shoulder, neck, and upper back conditions. On review, the issue is scope of acceptance.

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

Claimant suffered a compensable injury on December 26, 1998 when he lifted a heavy trash can. (Ex. 1). SAIF accepted claimant's claim for disabling cervical strain/sprain. (Exs. 5, 22). On August 23, 1999, SAIF issued a Notice of Closure awarding no permanent disability for claimant's accepted condition. (Ex. 23). That Notice of Closure was affirmed by a December 21, 1999 Order on Reconsideration. (Ex. 27).

On October 19, 1999, claimant requested SAIF to accept the additional conditions of "left periscapular strain; thoracic strain; left trapezius strain; and left rhomboid strain." (Ex. 28). SAIF never responded to the claim. Claimant therefore requested a hearing challenging SAIF's *de facto* denial of these conditions. *See* ORS 656.386(1)(b)(B) and (C).

The ALJ upheld SAIF's denial, reasoning that the medical evidence indicated that SAIF's acceptance "reasonably apprised" claimant and medical providers of the nature of the compensable conditions. ORS 656.262(7)(a).

On review, claimant contends that ORS 656.262(6)(d) applies to his "omitted medical condition claim," as opposed to ORS 656.262(7)(a). ORS 656.262(6)(d) does not contain the "reasonably apprises" language of ORS 656.262(7)(a). Even assuming that ORS 656.262(6)(d) applies here, we find that claimant has not met his burden of proving through expert medical evidence that the notice of acceptance should be amended.

As the ALJ correctly stated, whether the requested conditions should be accepted as part of claimant's compensable claim constitutes a scope of acceptance issue that must be resolved based on expert medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967); *Lorinda L. Zabuska*, 52 Van Natta 191 (2000). Here, there is no medical evidence supportive of claimant's position that the additional claimed conditions are separate diagnoses from that of "cervical strain/sprain" already accepted by SAIF. On the contrary, the only medical evidence (from Drs. Wong and Fuller) establishes that claimant's additional claimed conditions are encompassed in the accepted condition of cervical strain/sprain. (Exs. 17, 30). *See Elsie M. Culp*, 47 Van Natta 760 (1995) (denial of claim for tenosynovitis condition was properly upheld because the only medical evidence indicated that the claimant's tenosynovitis condition was "a component" of her accepted carpal tunnel condition). Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated March 28, 2000 is affirmed.

In the Matter of the Compensation of
MOUREEN J. ROSERA, Claimant
WCB Case No. 99-09315
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denials of claimant's L4-5 and L5-S1 radiculopathy conditions; and (2) awarded a $6,435 assessed attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

Compensability

The insurer contends that the ALJ incorrectly relied on the medical opinions of Dr. Toffler, claimant's treating physician, and Dr. Frank, a consulting neurosurgeon, instead of the medical opinion of Dr. Morton, a medical examiner who saw claimant at the insurer's request.

Relying on claimant's testimony describing her pushing of the heavy cart and the medical opinions of Drs. Toffler and Frank, the ALJ concluded that claimant established the compensability of her L4-5 and L5-S1 radiculopathy conditions. The ALJ found the opinions of Drs. Toffler and Frank to be based upon complete information and the most persuasive in discussing all the aspects of claimant's symptoms, her early medical care for the injury, the various diagnostic tests, and the clinical findings. In contrast, the ALJ found the opinion of Dr. Morton to be inconsistent and not persuasive. We agree with the ALJ.

The parties do not contest the ALJ's conclusion that the compensability of claimant's L4-5 and L5-S1 radiculopathy conditions are subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that the L4-5 and L5-S1 radiculopathy conditions are compensable, claimant must show that her work injury was the major contributing cause of the disability or need for treatment of the combined conditions. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 279, 283 (1993). Because of claimant's preexisting conditions and the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that her compensable injury contributed more to claimant's need for medical treatment or disability for the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). After applying the aforementioned standards, we consider Dr. Frank's opinion to be the most persuasive.

When asked to explain the mechanism surrounding claimants radiculopathy conditions, Dr. Frank opined as follows:

> "As stated in my previous letter, the lateral recess stenosis and degeneration were pre-existing to the injury she had. She was asymptomatic by all the history I have.
>
> "Certainly the injury did not cause the stenosis. What I believe happened, is that when one has a pre-existing stenosis and one has an injury, one sets up inflammation in the nerve root, reproducing a radiculopathy. The injury may entail an actual physically

narrowing the neuro foramina and irritating the nerve root, due to compression of the spine or a bulging of the disc that temporarily irritates the nerve root and then may regress."[1] (Ex. 24-1).

Dr. Frank further opined that in claimant's case, a bulging disc contributed to the recess narrowing likely resulting in radiculopathy. (Ex. 24-2). We conclude from these remarks that Dr. Frank's opinion considers the relative contributions of both claimant's preexisting stenosis condition and her work injury to produce claimant's radiculopathy conditions. Moreover, we conclude that Dr. Frank also considered claimant's lack of prior radiculopathy problems, her description of the injury, her numbness corresponding to the L5 determatones, the MRI scans, as well as his physical exam of claimant on three separate occasions, to render his overall opinion that the major reason for her continued medical treatment (*i.e.*, radiculopathy conditions) was the work injury.[2] (Ex. 23-1 & 2). Accordingly, we find his opinion persuasive.

In response to Dr. Frank's opinion, Dr. Morton writes as follows:

"In regard to exhibit 24, I do not concur with Dr. Frank's opinion of Ms. Rosera's development of radicular symptoms. She has spinal stenosis, ligamentum flavum hypertrophy degenerative joint disease and degenerative disc disease, all of which are degenerative and progressive conditions that would have produced symptoms whether there had been an injury or not and certainly are not related to pushing carts at work." (Ex. 25-2).

We interpret Dr. Morton's remarks as a type of "but for" test; that "but for" claimant's preexisting conditions, the radiculopathies would not have occurred. This type of medical reasoning is not probative. Moreover because it does not weigh the contributions of claimant's work injury and the contributions of her preexisting conditions in producing the L4-5 and L5-S1 radiculopathy conditions, it is not persuasive.[3] *See Elaine Baxter*, 51 Van Natta 1898 (1999).

In conclusion, based upon Dr. Frank's well reasoned and persuasive opinion, as supported by Dr. Toffler, we find that claimant's work injury was the major contributing cause of her disability and her need for treatment for her L4-5 and L5-S1 radiculopathy conditions. Consequently, we affirm the ALJ's order that set aside the insurer's denials of those conditions.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the L4-5 and L5-S1 radiculopathy conditions is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Attorney Fees

At the hearing level, claimant's counsel submitted a statement of services seeking a $6,435 attorney fee award. The insurer did not respond to claimant counsel's statement. The ALJ, applying the factors set forth in OAR 438-015-0015, awarded the requested amount as a fee. In his evaluation, the ALJ noted that: (1) the case was very complicated in terms of the medical issues; (2) claimant's

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[1] The insurer argues that Dr. Frank's use of the word may suggests an opinion based on speculation, instead of medical probability. *Gormley v. SAIF*, 52 Or App 1055 (1981). We disagree. The second sentence of Dr. Frank's report reads: "You ask that I explain a little more in detail the *probable* mechanism injury for Maureen J. Rosera." (Ex. 24-1)(emphasis added). Accordingly, we conclude that his explanation is based upon medical probability and is not mere speculation.

[2] While not expressly discussing claimant's obesity, we conclude that Dr. Frank necessarily considered it as a part of his three physical exams of claimant.

[3] If we assume that Dr. Morton means that claimant's work injury could not have contributed in any way to the L4-5 and L5-S1 radiculopathy conditions, then we note that she offers no explanation why those conditions occurred coincident with claimant's work injury and not at some other time. To that extent, her opinion appears conclusory and unexplained, and therefore, not persuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980).

counsel generated substantial medical evidence to support the claim; (3) the potential benefit to claimant, in light of the likelihood of surgery, was substantial; and (4) there was a significant risk that claimant's counsel would go uncompensated.

The insurer contends that the ALJ's attorney fee award of $6,435 was excessive. In particular the insurer argues that the assessed fee is roughly twice the "going rate" for such cases. (Appellant's Brief, p. 6).

Claimant is entitled to a fee for services devoted to overcoming the insurer's denials of her L4-5 and L5-S1 radiculopathy conditions.[4] *See* ORS 656.386(1).

Claimant's counsel spent 19.5 hours on the case. However, time devoted to the case is but one factor we consider in determining a reasonable attorney fee. 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). 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).

When compared to compensability disputes generally presented to this forum, the value of the claim and the benefits secured, especially considering the likelihood of surgery, are above average. Although the hearing was relatively short, the medical issues presented are more complex than those generally litigated in the Hearings Division. Moreover, claimant's attorney generated substantial medical evidence in support of the claim in the face of similar medical evidence generated by the insurer to defeat the claim. 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 considerable 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 $6,435 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. Accordingly, we affirm the ALJ's attorney fee award in view of the factors in OAR 438-015-0010(4).

ORDER

The ALJ's order dated March 17, 2000 is affirmed. For services on review regarding the compensability issue, claimant is awarded an $1,500 fee, payable by the insurer.

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[4] Specifically, claimant had to litigate two denials: (1) a *de facto* denial of the L4-5 radiculopathy condition; and, (2) a formal written denial of her L5-S1 radiculopathy condition. Each denial involved separate and complex medical issues.

In the Matter of the Compensation of
SHAWN W. FLOHR, Claimant
WCB Case No. 99-03843
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

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

We adopt and affirm the ALJ's order with the following change and supplementation. In the second paragraph on page 2, we change the citation after the fourth sentence to: "(Ex. 4)."

On review, we write only to address claimant's argument that the parties did not agree to allow SAIF to expand its denial beyond the issue of "course and scope." SAIF's denial stated that claimant's back injury did not arise out of or occur within the course of his employment. (Ex. 7).

In *Mary K. Phillips*, 50 Van Natta 519 (1998), we held that a denial stating that an injury did not occur in the "course and scope" of employment included the defense of medical causation. We reasoned that the course and scope denial mimicked the language in ORS 656.005(7)(a) by stating that the claimant's condition did not arise out of or in the course and scope of employment. Because of the similarity in language, we construed the denial as asserting that the claimant did not sustain a "compensable injury" or an "occupational disease." We relied on *Tektronix, Inc. v. Nazari*, 117 Or App 409, 411 (1992), *mod* 120 Or App 590 (1993), in which the court said that the "definition of compensable injury, in particular the 'arising out of' language, encompasses the concept of medical causation[.]" *See also Arthur A. Conner*, 52 Van Natta 649 (2000); *Vernon L. Minor*, 52 Van Natta 320 (2000). We reach the same conclusion in this case.[1]

ORDER

The ALJ's order dated January 17, 2000 is affirmed.

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[1] At hearing, claimant's attorney argued that claimant injured his back at work and the water skiing incident was not a factor in his seeking medical treatment. (Tr. 2). SAIF's attorney contended there was no work incident that caused injury and when claimant sought medical treatment, it was for the water skiing incident or some subsequent incident. (Tr. 3). We find that, in any event, these statements that weighed the contribution of the work incident against the water skiing incident, were sufficient to put medical causation at issue. Parties to a workers' compensation proceeding may, by express or implicit agreement, try an issue that falls outside the express terms of a denial. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990); *Sandra M. Goodson*, 50 Van Natta 1116 (1998).

In the Matter of the Compensation of
EARL F. GOODMANSON, Claimant
WCB Case No. 99-05936
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that denied claimant's request to set aside the self-insured employer's denials on the ground that the denials are procedurally invalid. On review, the issues are jurisdiction and whether the employer's denials are procedurally valid.

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

On June 12, 1997, claimant compensably injured his left shoulder, left arm, neck and left knee while working for the employer as a building engineer. (Ex. 56). The employer's processing agent closed claimant's claim on February 19, 1998 by virtue of a Notice of Closure awarding 17 percent scheduled permanent disability. (Ex. 92).

Claimant continued to treat with Dr. Wells and Dr. Wayson for neck and arm symptoms unrelated to his compensable injury. In July 1998, the processing agent received a request for authorization for a cervical myelogram and CT scan. In May 1999, Dr. Wayson requested the processing agent to authorize a referral for a neurological evaluation to evaluate the possibility of a central nervous system degenerative disorder. Dr. Kirschner examined claimant for the employer on June 10, 1999, and concluded that none of claimant's current conditions were related to the compensable injury, but instead primarily to depression and cervical degenerative disease. (Ex. 114).

The processing agent then issued a denial on June 21, 1999 which stated that "At this time, there is insufficient medical evidence to support that your current condition and need for treatment are a result of your industrial injury of 6/12/97. Therefore, without waiving further issues of compensability or responsibility, we respectfully issue this Partial Denial of your current condition and related benefits." (Ex. 116). The processing agent then amended its denial to clarify that it continued to accept responsibility for claimant's compensable conditions. (Ex. 120).

On review, claimant first contends that the Board lacks jurisdiction in the absence of a "dispute" pursuant to ORS 656.704(3)(b)(A). Although this issue was not raised at hearing, we have continuing authority to examine our own jurisdiction. Subject matter jurisdiction cannot be waived by the parties or the Board. *Bill D. Coleman*, 48 Van Natta 2154 (1996); *Daryl R. Gabriel, II*, 48 Van Natta 137 (1996). Even if the issue were not raised by the parties, it is our duty to raise a want of jurisdiction on our own motion. *Southwest Forest Industries v. Anders*, 299 Or 205 (1985).

Here, we conclude that we have jurisdiction over this dispute. ORS 656.283(1) provides: "Subject to ORS 656.319, any party * * * may at any time request a hearing on any matter concerning a claim * * *." ORS 656.704(3)(b)(A) now provides "The respective authority of the board and the director to resolve medical services disputes, other than disputes arising under ORS 656.260, shall be determined according to the following principles: (A) Any dispute that requires a determination of the compensability of the medical condition for which medical services are proposed is a matter concerning a claim."

Here, the processing agent's denials expressly denied claimant's current condition on the basis that the compensable injury was not the major contributing cause of his disability and need for treatment for his various conditions. (Exs. 116, 120). In those circumstances, resolution of this issue requires a determination of the compensability of the medical conditions for which medical services have been sought. ORS 656.704(3)(b)(A). We therefore have jurisdiction over this dispute. *See David L. Dylan*, 50 Van Natta 852 (1998).

With regard to the merits of this case and the validity of the employer's denials, we adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated March 2, 2000 is affirmed.

In the Matter of the Compensation of
DANIEL M. CAN, Claimant
WCB Case No. 99-06890
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

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

We adopt and affirm the order of the ALJ with the following supplementation to address the insurer's arguments that the ALJ incorrectly relied on the medical opinion of Dr. Waring, the treating physician, instead of Dr. Bergquist, an insurer arranged medical examiner.

The parties do not contest the ALJ's conclusion that the compensability of claimant's low back condition is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that the low back condition is compensable, claimant must show that his work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101 (1997), *rev den* 326 Or 389 (1998). Because of claimant's preexisting condition and the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to his need for medical treatment or disability for the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician, absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to Dr. Waring's opinion.

Dr. Bergquist, a neurosurgeon on whom the insurer relies, believed that claimant's lifting activities at work on March 2, 1999, were a material cause of the L5- S1 disc herniation, but not the major contributing cause. (Ex. 26-5). His reasoning appears to rest on three particular beliefs: (1) "discs can herniate under virtually any circumstances;" (2) "trauma does not result in disk herniation;" and (3) "the etiology of disk herniation is degenerative disk disease."[1]

Without further explanation, his beliefs appear to be internally inconsistent and conclusory.[2] *Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980). Moreover, Dr. Bergquist's opinion appears to be a type of "but for" analysis; *i.e.*, "but for" degenerative disc disease, there is no disc herniation, therefore,

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[1] Dr. Camp, a consulting neurosurgeon, who saw claimant at the request of Dr. Waring, indicated that Dr. Bergquist's "pathophysiological view of disc herniation is fanciful, the conclusions reasonable." (Ex. 28).

[2] For example, Dr. Bergquist does not explain why trauma is excluded from the set of "virtually any circumstances" that can herniate disks.

regardless of the circumstances under which a disc herniates, degenerative disc disease is the major cause of the herniation. This type of analysis is not helpful in evaluating the relative contributions of the different causes of claimant's need for treatment for his combined condition and determining which is the primary cause. *See Dietz v. Ramuda*, 130 OR App 397 (1994), *rev dismissed* 320 Or 416 (1995). Accordingly, we do not find Dr. Bergquist's opinion persuasive and we do not rely upon it.

In contrast to Dr. Bergquist, Dr. Waring, who began seeing claimant on March 16, 1999, opined that claimant's lifting incident at work on March 2, 1999 was the major contributing cause of claimant's need for treatment of the L5-S1 disc herniation. (Ex. 36-3). In rendering that opinion, Dr. Waring reviewed the following: (1) records of claimant's compensable low back strain from May 1995, and compensable contusions in October 1998; (2) the history of claimant's injury of March 1999; (3) the mechanism of injury including the forces of lifting and twisting associated with moving a large conveyor weighing over 100 pounds; (4) his own report of August 1999; (5) his own clinical findings; and (6) the extent, if any, of claimant's preexisting degenerative problems.[3] (Ex 36). We note further that Dr. Waring acknowledged that back pain can be caused by degenerative disc disease, but that it can also be caused by traumatic disc injury, soft tissue injury, and mechanical back pain. Dr. Waring further observed that it would surprising for significant degenerative disc disease to be present in someone of claimant's age (27). (Ex. 36-4 & 6).

Citing *Robert L. Beatty*, 49 Van Natta 860 (1997), the insurer argues that Dr. Waring's opinion, as expressed in Exhibit 36, is not persuasive because, without explanation, he changed his opinion from that expressed in an earlier chart note. We disagree that the chart note in question reflects a change in Dr. Waring's opinion regarding the cause of claimant's L5-S1 herniated disc.

Prior to the radiology studies, Dr. Waring's working diagnosis was lumbosacral strain. (Ex. 11-2; 14-2). The MRI, as read by Dr. Abvel, showed a large disc herniation at L5/S1 as well as mild disk desiccation with minimal loss of disk space height. (Ex. 19). On April 20, 1999, in his first chart note subsequent to the x-ray and MRI studies, Dr. Waring's working diagnosis was "lumbosacral sprain with radiculopathy and evidence of disc herniation at two levels." (Ex. 20-2). On April 27, 1999, Dr. Waring described his diagnosis as "low back strain, degenerative disc disease/left L5-S1 radiculopathy." (Ex. 22). In his chart notes after April 27, 1999, Dr. Waring used the terms "discogenic disease" and "disc disease." (Ex. 27-2; 30-2; 31-2; 33-2). In none of his chart notes does Dr. Waring express an opinion as to the cause claimant's disc problem. We conclude from the chart notes that Dr. Waring used the terms "disc herniation," "degenerative disc disease," "discogenic disease," and "disc disease" interchangeably when referring to the L5-S1 disc. We note he also used the terms "sprain" and "strain" interchangeably. We do not attribute any special significance in his use of these terms to imply causation.

In conclusion, we find no persuasive reason not to defer to Dr. Waring's well reasoned and persuasive opinion.[4] Consequently we conclude that claimant's lifting injury of March 2, 1999, was the major contributing cause of his disability and his need for treatment for his L5-S1 disc 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 $1,700, 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.

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[3] Dr. Maroldo, who interpreted the lumbar spine x-ray studies, reported the presence of "a minimal degree of annular osteophyte at the lumbosacral junction." (Ex. 17). Dr. Avbel, who interpreted the MRI study, reported "left paracentral disk herniation at L3/4" (not symptomatic according to both Dr. Bergquist and Waring), and a "large left paracentral disk herniation at L5/S1." (Ex. 19-2). Dr. Avbel also reported "mild disk desiccation, with minimal loss of disk space height." (Ex. 19-1).

[4] The insurer, citing *Mike Sepull*, 42 Van Natta 470 (1990), also argues that we should not rely on Dr. Waring's opinion because Dr. Waring has crossed the line from medicine to advocacy. We disagree.

The basis for this argument is the last paragraph of Exhibit 35, in which Dr. Waring states: "If there is anything further that I can provide to help clarify my position in this regard or that would be beneficial to a favorable determination for this patient, please do not hesitate to contact me at the address or telephone number on the letterhead." (Ex. 35-2). We note that Exhibit 35 is a letter addressed to the insurer and was generated by Dr. Waring when the insurer elicited his comments regarding Dr. Bergquist's IME report. Under the circumstances, we conclude that Dr. Waring's remarks are merely an invitation to the insurer to contact Dr. Waring if the insurer wished to discuss things further.

ORDER

The ALJ's order dated February 10, 2000 is affirmed. For services on review, claimant is awarded a $1,700 attorney fee, payable by the insurer.

In the Matter of the Compensation of
ANTHONY C. BRENTON, SR., Claimant
Own Motion No. 99-0289M
OWN MOTION ORDER
Black, Chapman, et al, Claimant Attorneys

The self-insured employer submitted claimant's request for temporary disability compensation for his compensable low back condition. Claimant's aggravation rights expired on November 16, 1997.

Although agreeing that claimant's L4-5 condition is compensably related to claimant's 1992 work injury, the employer opposed reopening the claim on the grounds that: (1) claimant's request for surgery was not reasonable and necessary treatment for his compensable condition; (2) claimant's current L3-4 condition is not causally related to the accepted condition; and (3) the employer is not responsible for claimant's current L3-4 condition. The employer denied the compensability of claimant's L3-4 condition as it related to his 1992 work injury on which claimant timely requested a hearing with the Hearings Division. (WCB Case No. 99-09813). In addition, the employer requested Director's review of the requested medical treatment. (Medical Review Case No. 3974).

On November 24, 1999 and January 25, 2000, we postponed action on the own motion matter pending outcome of that litigation in both forums. On April 11, 2000, Administrative Law Judge (ALJ) Tenenbaum set aside the employer's November 8, 1999 denial. ALJ Tenenbaum found that claimant had not made a claim for a condition at L3-4 and therefore the denial was premature and a nullity. That order was not appealed and is final by operation of law.

On June 19, 2000, the MRU issued Administrative Order TX 00-342, which found that the proposed surgery, Intradiscal Electrothermal Annuloplasty (IDET), was appropriate medical treatment for claimant's L4-5 condition. The employer submitted an amended Own Motion recommendation acknowledging the Director's order and announcing that it was not appealing said order. However, it did not answer the question of whether it was or was not recommending reopening of claimant's 1992 claim. Rather, the employer stated that "[d]ue to Administrative Order TX00-342, no opinion can be made."

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

Here, the proposed surgery was found to be reasonable and necessary treatment for claimant's L4-5 condition. The employer does not dispute that claimant's L4-5 condition is a compensable component of his 1992 work injury. Inasmuch as the proposed surgery for claimant's L4-5 condition has been found to be appropriate treatment, we conclude that claimant's compensable injury has worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1992 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery at L4-5. When claimant's condition 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 $1,500, payable by the employer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
BETHANY DAVIDSON, Claimant
WCB Case No. 99-09504
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Lundeen, et al, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's injury claim for a low back condition. On review, the issue is whether claimant's injury arose out of and in the course of her employment. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We summarize the relevant facts as follows. Claimant began working for the employer, a restaurant, in January 1998. She worked part-time as a waitress, cashier and hostess. The employer had a dress code that required employees to wear black pants or khakis, a white button-down shirt, a tie and an apron.

On September 12, 1999, claimant was scheduled to begin work at 4:00 p.m. She arrived at work five minutes early and went back to the "cubby," a storage area, to leave her personal belongings. Claimant was then confronted by her manager, who informed her that she would need to change her clothes. The options presented to claimant were either to have someone bring her an appropriate set of clothes, or to return home and change. Because claimant had driven her parent's van to work, her only option was to drive back home.

Claimant drove directly home, a 30-minute trip. Claimant changed clothes and immediately set off back to work. On her way back to the restaurant, claimant was involved in a motor vehicle accident and injured her back. That injury gave rise to this claim. The insurer denied claimant's claim on the basis that her injury did not arise out of and in the course of her employment. (Ex. 17).

The ALJ set aside the insurer's denial, reasoning that the "special errand" exception to the "going and coming" rule applied. On review, the insurer contends that claimant has not established that her injury fits within the "special errand" exception to the going and coming rule. We disagree.

To be compensable, an injury must arise out of and in the course of a worker's employment. ORS 656.005(7)(a). The Supreme Court has interpreted this rule as a unitary test consisting of two prongs, the goal of which is to determine whether a claim is sufficiently work-related to merit compensability. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). Under the "arises out of" prong, the question is whether the injury is sufficiently causally related to the claimant's employment. The "in the course of" prong requires that the time, place and circumstances of the employee's injury justify connecting the injury to the employment. *Norpac Foods, Inc. v. Gilmore*, 318 Or at 366. Although neither requirement is determinative, both must be satisfied to some degree. *Id.*

The unitary test has several corollaries. Under the "going and coming" rule, injuries that occur while the worker is traveling to or from work are generally not compensable. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 527 (1996); *Cope v. West American Ins. Co.*, 309 Or 232, 237 (1990). One exception to the going and coming rule is the "special errand" exception. Under that theory, an injury that happens when a worker is performing a special task at the direction of the employer is compensable. *See Philpott v. State Ind. Acc. Comm.*, 234 Or 37, 41 (1963); *Hickey v. Union Pacific Railroad Co.*, 104 Or App 724 (1990). For the "special errand" exception to apply, either the worker must be acting in furtherance of the employer's business or the employer must have the right to control the worker at the time of the injury. *Krushwitz v. McDonald's Restaurants*, 323 Or at 528.

We agree with the ALJ that the "special errand" exception applies here to bring claimant's injury within the realm of a compensable claim. Claimant's automobile accident occurred when she was returning to work after going home to change clothes at the employer's direction. Although the employer did not have the "right to control" claimant at the time of her accident, claimant was acting in furtherance of the employer's business by returning home to change clothes. *Krushwitz*, 323 Or at 528.

At hearing, there was conflicting evidence as to whether claimant "clocked in" when she arrived at work before turning around to go back home. (Tr. 8, 16). However, we do not find that resolution of that issue is determinative. In this regard, we note the Court of Appeals decision in *Iliaifar v. SAIF*, 160 Or App 116 (1999). In *Iliaifar*, the claimant had been asked by his employer to deliver an "off-work" authorization form to the office on a day when he was off work due to a prior on-the-job injury. The claimant traveled in an employer-provided vehicle from his home in Beaverton to the employer's office in east Portland to deliver the off-work slip. On the way, he stopped downtown to do a personal banking errand at his credit union. Shortly after leaving his credit union parking lot, the claimant was injured in an auto accident. 160 Or App at 118. The court held the claimant's injury compensable as "arising out of and in the course of" his employment. 160 Or App at 123.

We find *Iliaifar* analogous to this case. In fact, here, the sequence of events argues more strongly in favor of compensability. Claimant did not detour to perform any personal errands on her way to or from home to change clothes. (Tr. 11). Even assuming claimant did not "clock in" when she reported to work shortly before 4:00 p.m., she had arrived at the employer's restaurant and was acting at the employer's direction in returning home to change her clothing. The insurer acknowledges that this extra trip back home was in furtherance of the employer's business. *See Krushwitz*, 325 Or at 528.

Contrary to the dissent's criticism, we have not disregarded the fact that claimant was not paid for her journey back home. In *Iliaifar*, it was implicit that the claimant was not paid for any part of his automobile trip to the employer's office, as the claimant embarked on the journey on a day that he was already off work due to a prior injury. Therefore, although the dissent correctly notes that we have looked to whether the claimant was paid at the time of the injury as a factor in our analysis with regard to "course and scope," cases such as *Iliaifar* demonstrate that that factor alone is not determinative.

As the ALJ correctly noted, this case is distinguishable from *Alltucker v. City of Salem*, 164 Or App 643 (1999). In *Alltucker*, the claimant, a firefighter, was injured while traveling to work after initially reporting to the incorrect job site. The court found the claim not compensable because it did not arise "in the course and scope" of the claimant's employment. 164 Or App at 647. The claimant in *Alltucker* had not yet arrived at work when he was injured. He was therefore still subject to the "going and coming" rule and the circumstances of his injury did not fit into the "special errand" exception. Here, because claimant was acting according to the employer's direction after reporting to work when she returned home to change her clothes, the "special errand" exception applies.

The insurer cites to *Darlynda J. McClain*, 48 Van Natta 542 (1996), in support of its position that the "special errand" exception does not apply here. The claimant in *McClain* was injured in an automobile accident on the way to an awards banquet. The claimant's attendance at the awards banquet was "expected, but not required." *McClain*, 48 Van Natta at 542. In contrast, here, claimant had no alternative but to return home to change clothes. Her trip home was mandatory and at the direction of the employer.

Finally, the insurer contends that claimant's extra trip home created no increased risk, beyond that to which claimant was exposed on her normal drive to work, and that therefore claimant's injury did not "arise out of" her employment. In *Hickey v. Union Pacific Railroad Co.*, 104 Or App 724 (1990), the claimant, a warehouse foreman, returned to work at 11:00 p.m. to load a truck, after completing his regular shift and attending a church meeting. At midnight, on the way home after finishing the job, the claimant was killed in a collision with a train. 104 Or App at 728. The court held the injury compensable, based on the "special errand" exception to the going and coming rule. *Id.* at 729, 730. Among other factors, the court found persuasive the fact that the accident occurred during the only hours that the train passed over the crossing where claimant's accident occurred. *Id.* at 729.

The insurer contends that *Hickey* mandates a finding of an "increased risk" associated with claimant's trip home. However, we find no such general requirement beyond the specific facts of *Hickey*. In fact, the Supreme Court has expressly rejected this "special risk" or "increased risk" analysis. *Phil A. Livesly Co. v. Russ*, 296 Or 25, 31 (1983); *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997).

In summary, although the "time, place and circumstances," of claimant's injury would seem to weigh against a finding that claimant's injury was in the "course and scope" of her employment, we believe the fact that claimant returned home at the specific request of her employer after reporting to work is strongly supportive of claimant's injury "arising out of" her employment. When the factors supporting one prong of the unitary work connection test are many, the factors supporting the other prong may be minimal. *Redman Industries v. Lang*, 326 Or 32, 35 (1997). Under the particular facts of this case, claimant's injury fits within the "special errand" exception to the going and coming rule. The overall circumstances of claimant's injury merit a finding of compensability. *Rogers v. SAIF*, 289 Or 633, 643 (1980).

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, claimant's counsel's request, and the insurer's reply), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 27, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,750, payable by the insurer.

Board Member Haynes dissenting.

Because I believe that claimant's injury did not occur in the course of her employment, I respectfully dissent. Unlike the majority and the ALJ, I do not believe that our analysis should even reach the "special errand" exception. In my view, claimant's injury occurred before she had officially started work, and is therefore not compensable.

It is well-established that an injury incurred while a claimant is going to or from work is not compensable. *See Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526 (1996); *Cope v. West American Ins. Co.*, 309 Or 232, 237 (1990). The reason for the "going and coming" rule is that "the relationship of employer and employee is ordinarily suspended from the time the employee leaves his work to go home until he resumes his work, since the employee, during the time that he is going to or coming from work, is rendering no service for the employer." *Heide/Parker v. T.C.I. Incorporated*, 264 Or 535, 540 (1973).

Here, claimant rendered no service for the employer until she arrived at work, ready to work. In other words, in my view, at the time of her injury, claimant's work shift had not yet begun. When claimant first arrived she was inappropriately attired. She was not ready for work. Although claimant testified that she "clocked in" when she first arrived at work, the employer disputed that assertion, and the uncontradicted evidence is that she was not paid for her journey back home. (Tr. 8, 16, 18). When the auto accident occurred, therefore, claimant was merely on her way to begin her shift, bringing her injury squarely within the "going and coming" rule.

Unlike the majority, I would find that this case is not distinguishable from *Alltucker v. City of Salem*, 164 Or App 643 (1999). Just as the firefighter in *Alltucker*, claimant's extra trip back home to change clothing was not reasonably incidental to her work at the employer's restaurant. While returning to the employer's restaurant, claimant obviously was not acting as a waitress, cashier or hostess, just as the claimant in *Alltucker* was not acting as a firefighter when he was injured en route to the correct fire station. *Alltucker*, 164 Or App at 647.

As I alluded to above, I also find it significant that claimant was not paid for her trip home to change clothes, a fact that the majority glosses over. (*See* Tr. 18). The Board in prior cases has looked to that factor in determining whether the claimant was acting in the course and scope of employment. *See, e.g., Jacqueline D. Bradford*, 49 Van Natta 236, 237 (1996).

By arriving to work in inappropriate clothing, claimant committed an error in judgment similar to the firefighter's mistake in arriving at the wrong fire station in *Alltucker*. 164 Or App at 647. In so construing the law, we are not attributing "fault" to the worker. We are simply recognizing that such an error delays the worker's entry into the work force on that particular day, making the worker subject to the "going and coming" rule. In my view, in light of the above factors, the majority erroneously applies the "special errand" exception to this case.

For all of the foregoing reasons, I respectfully dissent.

In the Matter of the Compensation of
JAMES G. EARNEST, Claimant
WCB Case No. 99-04497
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that: (1) found claimant entitled to interim compensation; and (2) assessed a penalty for an allegedly unreasonable failure to pay interim compensation. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Entitlement to Temporary Disability

We adopt and affirm that portion of the ALJ's order finding claimant entitled to interim compensation, based upon our decision in *Robert A. Rodgers*, 52 Van Natta 1243 (2000). (A carrier is obligated to provide interim compensation pending its acceptance or denial of a claimant's "new medical condition" claim, even though the claimant's 5-year "aggravation rights" had expired prior to the filing of his "new medical condition" claim).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding claimants entitlement to temporary disability benefits is $300, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Penalties and Attorney Fees

The ALJ assessed a penalty after deciding that *John R. Graham*, 51 Van Natta 1740 (1999) was controlling and SAIF's disagreement with its holding did not rise to the level of legitimate doubt. SAIF contests this conclusion.

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.

In *Rodgers, supra,* we found that although *Graham* applied to the facts of the case, we had not yet addressed the specific issue of entitlement to interim compensation in new medical condition claims preceded by an original claim with expired aggravation rights. Consistent with *Rodgers*, we find that SAIF had a legitimate doubt as to its legal liability for interim compensation. Therefore, a penalty is not warranted.

ORDER

The ALJ's March 31, 2000 order is affirmed in part and reversed in part. That portion assessing a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $300, to be paid by the SAIF Corporation.

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

Claimant requests review of the insurer's April 24, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from May 28, 1999 through April 4, 2000. The insurer declared claimant medically stationary as of April 4, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he/she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 24, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

On February 1, 2000, Dr. Ulloth, claimant's attending physician, examined claimant and diagnosed "a patient with a complicated course for attempted repair of umbilical hernia with mesh infection still with hernia present, though not incarcerated, finally healed over the mesh infection." She recommended that: (1) claimant stop smoking; (2) get better control of his diabetes; and (3) use an antibiotic cream on a tiny "open" area around his incision. She determined that claimant did not need to follow-up on a regular basis.

On February 17, 2000, claimant attended an insurer-arranged examination (IME) conducted by Dr. Braun. Dr. Braun opined that claimant was not medically stationary at that time because he had a subcutaneous infection. He also noted that claimant "probably will require additional surgery."

Responding to an inquiry by the insurer, Dr. Ulloth submitted an April 4, 2000 medical report which declared that claimant was medically stationary as of that date. Dr. Ulloth explained that claimant was considered medically stationary because: (1) he did not need follow-up treatment on a regular basis; and (2) he did not require special medical treatment for his hernia at that time. Dr. Ulloth disagreed with Dr. Braun regarding the presence of an infection. She also noted that she advised claimant not to seek further treatment for his hernia because he has had so many complications and further attempts at repair "may cause more harm than good." Finally, Dr. Ulloth opined that claimant's condition was stable, "but may require repair of hernia in spite of the risks."

The insurer requested that Dr. Ulloth respond to a couple of multiple choice questions regarding claimant's medically stationary status. On April 14, 2000, Dr. Ulloth reasserted that claimant was medically stationary and that he was medically stationary when she examined him on February 1, 2000.

Dr. Ulloth reexamined claimant on May 11, 2000 and did not alter her prior opinion regarding claimant's medically stationary status. She continued to assert that claimant was medically stationary. Dr. Ulloth explained that claimant had a chronic abdominal hernia that would not improve short of surgery, but that surgery was inadvisable at this time because said surgery "could make him worse." She noted that claimant's wound was the "best" she had ever seen it.

The record also contains a May 9, 2000 Urgent Medical Clinic report from Dr. Thornton. In that report there is a notation of "no work 'til seen by surgeon for work release." Claimant relies on the opinions of Drs. Braun and Thornton to support his contention that he was not medically stationary when his claim was closed. However, we do not find either of these opinions persuasive. Dr. Braun's opinion was rendered at least two months before claimant's claim was closed and does not address claimant's medically stationary status at the time of closure. Additionally, Dr. Braun was not treating claimant. Rather, he examined claimant only once when he conducted an IME on behalf of the insurer. Dr. Thornton's "notation" does not address claimants medically stationary status. It only references claimant's inability to work. The definition of medically stationary outlines the criteria by which a physician must determine a claimant's medically stationary status. *See* ORS 656.005(17). Therefore, although Dr. Thornton opined that claimant was unable to work, the pivotal question is whether his condition was 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). In this case, we find no persuasive reason not to defer to the opinion of Dr. Ulloth, claimant's treating physician. We do not find Dr. Braun's opinion persuasive in that he had only examined claimant one time and his report does not address claimant's medically stationary status at closure. On the other hand, Dr. Ulloth treated claimant following his surgery and had examined him prior to and subsequent to claim closure. Although acknowledging that claimant's condition would not improve "short of surgery," Dr. Ulloth explained that surgery was not advisable at this time because of the chronicity of claimant's hernia condition. Additionally, Dr. Ulloth noted that none of claimant's current complaints "necessarily require" surgery. Finally, Dr. Ulloth reported that claimant's chronic hernia was not incarcerated and not infected. Under such circumstances, we find Dr. Ulloth's opinion to be more persuasive.

Dr. Ulloth's reports establish that claimant was medically stationary at the time of the April 24, 2000 claim closure. Therefore, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.[1]

Accordingly, we affirm the insurer's April 24, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] Should claimant's compensable condition subsequently worsen to the extent that surgery and/or inpatient hospitalization is eventually required, 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
ROBERT A. RODGERS, Claimant
WCB Case No. 99-09641
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 5, 2000 Order on Review that affirmed that portion of the Administrative Law Judge's (ALJ's) order that found claimant entitled to interim compensation.

Specifically, in requesting reconsideration, SAIF contends that we should not have awarded interim compensation as of November 16, 1999, when the treating physician authorized time loss.

Instead, according to SAIF, time loss should begin on December 6, 1999, when it had notice of the new medical condition claim. Claimant has submitted a response and agrees with SAIF.

SAIF correctly states that interim compensation is not due until the carrier receives notice of the claim. ORS 656.262(4)(a); *Spivey v. SAIF*, 79 Or App 568, 571 (1986). Accordingly, we withdraw our July 5, 2000 order. On reconsideration, as modified herein, we adhere to and republish our July 5, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND L. HARRIS, Claimant
WCB Case No. 99-09033
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that affirmed an Order on Reconsideration finding that claimant's left knee condition was prematurely closed. The employer also moves to vacate the ALJ's order and the October 15, 1999 Order on Reconsideration as "void." On review, the issues are motion to vacate and premature closure. We deny the motion to vacate and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Vacate

The employer moves to vacate the ALJ's order and the October 15, 1999 Order on Reconsideration as "void." The employer submits a copy of its March 23, 2000 "back-up" denial of claimant's left knee claim and asserts that claimant has requested a hearing from the denial. According to the employer, there is no longer a compensable claim and, therefore, the Notice of Closure and the Order on Reconsideration are void. The employer contends that, because there is no underlying claim, the ALJ's order should be vacated.

Claimant responds that there is no authority for the employer's motion to vacate. She contends that, because she appealed the employer's "back-up" denial, the denial is not final and, until the denial is final, there is still a compensable claim.

We have no authority to consider evidence not in the record. As a general rule, however, 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 the existence of a request for hearing and docketed appeals. *E.g., Gaspar Lopez*, 48 Van Natta 1774 (1996); *Mark A. Crawford*, 46 Van Natta 725, 727, *on recon* 46 Van 873 (1994). Here, the parties agree that the employer has issued a "back-up" denial and that claimant has requested a hearing of that denial. Under these circumstances, we take administrative notice of the request for hearing concerning the employer's March 23, 2000 denial, but only for the purpose of considering the employer's motion to vacate. *See Eula M. Zarling*, 50 Van Natta 1189, 1191 (1998) (Board may take administrative notice of a subsequent litigation order involving the same claimant so long as the litigation order is not considered as evidence on any issue regarding the rating of the claimant's accepted conditions); *compare Tony D. Houck*, 51 Van Natta 1301 (1999) (Board did not consider an administrative order concerning a medical treatment dispute as evidence because it could have impacted Board's decision about premature closure).

We do not agree with the employer that, because it has issued a "back-up" denial of claimant's left knee claim, there is no longer a compensable claim. As claimant points out, the denial is not final and, if the employer does not meet its burden of proof at the hearing regarding the "back-up" denial, there is still a compensable claim.

Furthermore, we disagree with the employer's assertion that the ALJ's order is "void." A judgment is void only when the tribunal rendering it has no jurisdiction of the parties or the subject matter. *SAIF v. Reddekopp*, 137 Or App 102, 106, *rev den* 322 Or 360 (1995); *SAIF v. Roles*, 111 Or App 597, 601, *rev den* 314 Or 391 (1992). The employer makes no argument that the ALJ did not have jurisdiction of the parties or the subject matter. Moreover, we are not persuaded that the October 15, 1999 Order on Reconsideration was "void." Consequently, we deny the employer's motion to vacate the ALJ's order and the Order on Reconsideration.

Premature Closure

Claimant compensably injured his left knee on December 15, 1998. (Ex. 2). Dr. Hanley performed a diagnostic arthroscopy, joint debridement and arthroscopic drilling on March 23, 1999. (Ex. 4).

The employer accepted a left knee strain and left anterior cruciate ligament tear. (Exs. 5, 6). An August 13, 1999 Notice of Closure awarded 9 percent scheduled permanent disability for loss of use or function of claimant's left knee. (Ex. 12). An October 15, 1999 Order on Reconsideration found that the claim was prematurely closed and rescinded the Notice of Closure. (Ex. 16). The employer requested a hearing.

The ALJ found that further material improvement was reasonably expected in claimant's left knee condition at the time of closure. The ALJ relied on Dr. Hanley's opinion and concluded that claimant was not medically stationary when the claim was closed.

On review, the employer argues that the ALJ erred by finding that claim closure was premature. The employer contends that there is no evidence that claimant's accepted left knee strain or anterior cruciate ligament tear were not medically stationary or required additional treatment. The employer argues that the only condition that was not medically stationary was an unaccepted cartilage condition.

An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Whether the carrier has prematurely closed the claim depends on whether claimant was medically stationary at the time of the Notice of Closure, without consideration of subsequent changes in his condition. *See Scheuning v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987); *Alvarez v. GAB Business Services*, 72 Or App 524, 527 (1985).

In *James L. Mack*, 50 Van Natta 338 (1998), we concluded that a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure. In reaching this conclusion, we relied on ORS 656.262(7)(c), which provides that if a condition is found compensable after claim closure, the carrier shall reopen the claim for processing regarding that condition.

At the time of the August 13, 1999 Notice of Closure, the employer had accepted a left knee strain and left anterior cruciate ligament tear. (Exs. 5, 6, 12). The Notice of Closure said that claimant was medically stationary on June 30, 1999. (Ex. 12).

Claimant's attending physician was Dr. Hanley, who performed left knee surgery on March 23, 1999. (Ex. 4). Dr. Hanley's postoperative diagnosis was "[l]arge chondral defect medial femoral condyle with chronic anterior cruciate ligament tear." (Ex. 4). There are no medical records in the record discussing claimants postoperative knee condition before June 1999.

On June 30, 1999, Dr. Schilperoort examined claimant on behalf of the employer. His diagnoses included a medial femoral condyle delamination condition, "[s]tatus post old anterior cruciate ligament disruption, left knee[,]" symptomatic left medial parapatellar plica and substantial leg length discrepancy. (Ex. 7-6). Dr. Schilperoort found that the major contributing cause of claimants ongoing symptomatology was "paracondylar fracture." (Ex. 7-6). He explained that was a non-injury-based condition that involved "delamination of the superficial from the deep surfaces of the articular cartilage surfaces." (Ex. 7-6, -7). He did not believe that any of claimants conditions, including the anterior cruciate ligament disruption, were traumatically induced. (Ex. 7-7). He reviewed Dr. Hanley's surgical

report and explained that the anterior cruciate ligament disruption was old because the scarring implied substantial age. (*Id.*) He also felt that claimants congenital leg length discrepancy was contributing to his symptoms. (*Id.*) Dr. Schilperoort concluded that claimant's condition was medically stationary. (*Id.*) In early August 1999, Dr. Hanley concurred with Dr. Schilperoort's report. (Exs. 9, 10).

Although Dr. Hanley had performed claimant's left knee surgery in March 1999, his first postoperative report in the record is a July 19, 1999 chart note. At that time, he reported that claimant had "ligamentous laxity" consistent with his anterior cruciate ligament injury. (Ex. 8). He said that claimant had a chronic anterior cruciate ligament deficiency with a defect on his articular cartilage. (*Id.*) He recommended waiting a full six months to see if there was good cartilage ingrowth into the defect. (*Id.*) Dr. Hanley explained: "[i]f this does not occur, we have options of a mosaic-type plasty along with an anterior cruciate ligament reconstruction." (*Id.*)

On September 3, 1999, Dr. Hanley said that claimant continued to have left knee pain with significant weakness and he noted that claimant was not medically stationary. (Ex. 13). He commented that it was possible that claimant might be a candidate for a cartilage transplant operation, but he believed that a continued nonoperative treatment course was indicated. (*Id.*) He recommended that claimant see another physician for a second opinion. (*Id.*)

Dr. Hanley wrote to the employer on September 13, 1999, explaining:

> "With regard to [claimant], I am in general accordance with the IME report by Dr. Steve Schilperoort. I do believe that from a standpoint of [claimant's] surgery he is medically stationary.
> He does, however, continue to have significant symptoms with pain and loss of function in the involved knee. The arthroscopic examination did reveal articular cartilage changes which I believe are causing his residual symptoms.
>
> "He is certainly not back to full function and does have some residual disability. I believe that he can be considered medically stationary from the standpoint that I would not recommend any further surgery. I have asked [claimant] to see Dr. Baldwin for a second opinion." (Ex. 14).

In a later concurrence letter from claimant's attorney, Dr. Hanley agreed that claimant was not medically stationary with regard to the December 15, 1998 left knee injury. (Ex. 15).

Claimant contends that Dr. Hanley has consistently opined that he is not medically stationary with regard to his December 15, 1998 left knee injury. Claimant relies on Dr. Hanley's July 19, 1999 chart note to argue that he did not believe claimant was medically stationary at that time. According to claimant, by concurring with Dr. Schilperoort's report, Dr. Hanley agreed only that he was medically stationary from the arthroscopic procedure.

We find that Dr. Hanley's reports regarding claimant's medically stationary status have been inconsistent. In early August 1999, Dr. Hanley concurred with Dr. Schilperoort's report, which said that claimant's condition was medically stationary. (Exs. 7-7, 9, 10). Dr. Schilperoort was asked whether continued treatment was reasonable and necessary and he replied:

> "No further physical therapy is judged appropriate. The examinee is felt to have reached medically stationary status in that there is no abnormal instability, range of motion, strength or sensory aberrancy. The examinee is medically stationary from his arthroscopic procedure as regards any industrial injury incurred." (Ex. 7-7).

In response to a question whether claimants condition was medically stationary, Dr. Schilperoort answered, "[y]es, it is." (*Id.*)

We do not agree with claimant's assertion that Dr. Schilperoort commented only on whether claimant had recovered from surgery. Dr. Schilperoort stated that claimant did not need further physical therapy and he felt claimant had reached medically stationary status because there was no abnormal instability, range of motion, strength or sensory aberrancy. (Ex. 7-7).

Although Dr. Hanley concurred with Dr. Schilperoort's report in August 1999, he explained on September 3, 1999 that claimant was *not* medically stationary. (Ex. 13). On September 13, 1999, however, Dr. Hanley indicated that he was "in general accordance" with Dr. Schilperoort's report and he believed that, from a standpoint of surgery, claimant was medically stationary. (Ex. 14). Dr. Hanley explained that claimant could be "considered medically stationary from the standpoint that I would not recommend any further surgery." (*Id.*) On September 30, 1999, Dr. Hanley signed a concurrence letter from claimant's attorney, agreeing that claimant was *not* medically stationary with regard to the December 15, 1998 left knee injury. (Ex. 15).

We find that Dr. Hanley's reports are not persuasive because they are inconsistent and lack adequate explanation. Furthermore, even if we assume that Dr. Hanley was only agreeing with Dr. Schilperoort that claimant was medically stationary from the surgery, we find that, for the following reasons, Dr. Hanley's reports did not indicate that he expected further material improvement for claimant's accepted left knee strain or left anterior cruciate ligament tear.

In his July 19, 1999 chart note, Dr. Hanley said that claimant had a "chronic anterior cruciate ligament deficiency with a defect on his articular cartilage." (Ex. 8). On September 13, 1999, Dr. Hanley said that claimant's arthroscopic examination revealed "articular cartilage changes" that he believed were causing claimant's residual symptoms. (Ex. 14).

The employer did not accept "articular cartilage changes." Although the employer accepted a left anterior cruciate ligament tear, Dr. Hanley's post-operative diagnosis was [l]arge chondral defect medial femoral condyle with chronic anterior cruciate ligament tear. (Ex. 4-1). In his operative report, Dr. Hanley explained that the "medial compartment of the knee showed areas of full thickness articular cartilage loss off the medial femoral condyle with articular cartilage peeling noted." (*Id.*) Thus, Dr. Hanley's operative report indicates that claimant's articular cartilage changes were related to the "[l]arge chondral defect medial femoral condyle[.]" The employer did not accept a chondral defect of the medial femoral condyle. We note further that Dr. Hanley had concurred with Dr. Schilperoort's report that the major contributing cause of claimant's symptoms was a "paracondylar fracture," which Dr. Schilperoort explained was a *non-injury-based* condition that involved "delamination of the superficial from the deep surfaces of the articular cartilage surfaces." (Ex. 7-6, -7, 9, 10).

With respect to claimant's accepted left knee strain and left anterior cruciate ligament tear, we find no evidence in the record that any further material improvement was reasonably expected from medical treatment, or the passage of time. We conclude that Dr. Hanley's reports do not establish that claimant's continued symptoms were related to either of the accepted conditions. Rather, he explained that "articular cartilage changes" were causing claimant's residual symptoms. (Ex. 14). We find that the medically stationary status of claimant's non-accepted articular cartilage changes is irrelevant to the premature closure determination. *See Vicky L. Woodward*, 52 Van Natta 796 (2000); *Eugene I. Bisceglia*, 52 Van Natta 404 (2000).

The only other medical opinion is from Dr. Schilperoort. Claimant contends that the ALJ properly refused to rely on Dr. Schilperoort's opinion because he did not believe that claimant had sustained a work-related injury. Even if we discount Dr. Schilperoort's opinion for that reason, it does not follow that his report is entitled to no weight whatsoever. *See Kuhn v. SAIF*, 73 Or App 768 (1985) (because physician's report conflicted with the law of the case, his conclusion was discounted). Dr. Schilperoort explained that claimant did not need further physical therapy and he had reached medically stationary status in that there is no abnormal instability, range of motion, strength or sensory aberrancy. (Ex. 7-7). On this record, we find that the preponderance of the medical evidence indicates that claimant's left knee strain and left anterior cruciate ligament tear were medically stationary. Consequently, we conclude that the August 13, 1999 Notice of Closure properly closed the claim.[1]

ORDER

The ALJ's order dated December 16, 1999 is reversed. The Order on Reconsideration's rescission of the Notice of Closure is reversed. The ALJ's attorney fee award is reversed.

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[1] At hearing, the employer's attorney noted that claimant had not requested a medical arbiter examination. (Tr. 10). Under these circumstances, it is not necessary to remand this case to the ALJ for deferral pending receipt of a medical arbiter's report. *Compare Vicky L. Woodward*, 52 Van Natta at 796; *Katherine M. Tofell*, 51 Van Natta 1845 (1998).

In the Matter of the Compensation of
TONY D. HOUCK, Claimant
WCB Case No. 99-06589
ORDER ON REVIEW
G. Victor Tiscornia II, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that awarded temporary disability benefits through November 16, 1998. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact as summarized and supplemented herein.

Claimant has an accepted claim for bilateral carpal tunnel syndrome and left epicondylitis. The Medical Review Unit has determined in an order dated November 16, 1998, that bilateral carpal tunnel release surgery proposed by claimant's attending physician, Dr. Worland, is not reasonable or necessary medical treatment. The November 16, 1998 order was affirmed by a Director's Proposed and Final Order issued on March 24, 1999. (Ex. 67).

The employer closed claimant's claim by a March 12, 1998 Notice of Closure that found claimant medically stationary on January 27, 1998. The closure was ultimately set aside as premature by an Opinion and Order dated January 21, 1999. The Board affirmed the ALJ's order finding the claim prematurely closed on July 21, 1999. (Ex. 75).

The employer reclosed the claim by a March 12, 1999 Notice of Closure that again found the compensable conditions medically stationary on January 27, 1998. (Ex. 69).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the opinion of claimant's attending physician, Dr. Worland, established that claimant was not medically stationary on January 27, 1998, the medically stationary date found by the Order on Reconsideration. Relying on *Thomas Suby*, 50 Van Natta 1088 (1998), however, the ALJ found that claimant was not entitled to temporary disability benefits following the November 16, 1998 Medical Review Unit order finding that the carpal tunnel release surgery proposed by Dr. Worland was inappropriate medical treatment. Consequently, the ALJ modified the Order on Reconsideration to award temporary disability benefits until November 16, 1998, the date of the Medical Review Unit order.

The employer argues that claimant is not entitled to temporary disability benefits following January 27, 1998, because Dr. Worland based his opinion that claimant was not medically stationary at that time solely on the belief that the proposed bilateral carpal tunnel surgery would improve claimant's condition. Claimant responds by arguing that deference should be given to Dr. Worland as claimant's attending physician and also notes that our order addressing the prior closure of this claim found Dr. Worland's opinion more persuasive regarding the medically stationary issue than the opinions of Dr. Jewell, Dr. Becker or Dr. McMahon.[1]

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[1] We acknowledge the fact that we relied on Dr. Worland's opinion in our order regarding the first closure of this claim. *Tony D. Houck*, 51 Van Natta 1301 (1999). In that order, however, we declined to consider the Medical Review Unit order finding the surgery unnecessary because it was not part of the reconsideration record in that case and therefore could not be considered under ORS 656.283(7). In this proceeding regarding the later claim closure, the Medical Review Unit order is a part of the reconsideration record and the order establishes that claimant's proposed surgery (and the basis for Dr. Worland's belief that claimant was not medically stationary) was not reasonable and necessary. Under such circumstances, because the evidence in this case differs from that in our prior order and supports a different conclusion, we find that the medically stationary date found in the March 24, 1999 closure order is correct.

In *Thomas E. Suby*, 50 Van Natta 718 (1998) (Suby I), and *Thomas E. Suby*, 50 Van Natta 1088 (1998) (Suby II), we addressed the relationship between a Director's order that found a surgery not reasonable and necessary and the claimant's entitlement to temporary and permanent disability benefits related to that surgery. We found that the Director's final determination that the surgery in question was not reasonable and necessary broke the chain of causation between the accepted condition and any disability associated with that surgery. Thus, we found the claimant not entitled to any disability benefits related to the inappropriate surgery, whether those benefits were classified as procedural, substantive, temporary, or permanent.[2]

Dr. Worland did not agree that claimant was medically stationary as of January 27, 1998 based only on his belief that the surgery would improve claimant's condition. The carpal tunnel surgery proposed by Dr. Worland has been finally determined not to be reasonable or medically necessary treatment for claimant's compensable condition. Thus, pursuant to the holdings in *Suby*, the chain of causation between the accepted condition and any disability associated with the proposed surgery has been broken. Because the surgery is not appropriate, we do not find Dr. Worland's opinion regarding the medically stationary issue persuasive. There is no other medical evidence that establishes that claimant was not medically stationary on January 27, 1998. Under such circumstances, we find that claimant is not entitled to temporary disability benefits following the January 27, 1998 medically stationary date.

ORDER

The ALJ's order dated January 14, 2000 is reversed.

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[2] In similar cases where a claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if a 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). The present case differs from those cited above in that, regardless of claimant's control or lack of control over the postponement of the surgery, the surgery at issue here has been determined not to be medically necessary. Under such circumstances, we are persuaded that claimant has not established that he was not medically stationary on January 27, 1998.

In the Matter of the Compensation of
AUDREY J. BIGELOW, Claimant
Own Motion No. 99-0391M
OWN MOTION ORDER OF ABATEMENT AND POSTPONEMENT OF ACTION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our July 18, 2000 Own Motion Order, in which we found that, in light of the Medical Review Unit's (MRU) order, claimant was not entitled to temporary disability compensation for an unauthorized and noncompensable surgery. Furthermore, we found that claimant, through her counsel, acknowledged that she was not entitled to have her claim reopened under the Board's Own Motion authority. By letter dated July 24, 2000, claimant's counsel notified the Board that claimant has appealed the MRU's May 1, 2000, order *pro se.* (MRU File No. 12997).

Under such circumstances, we find it appropriate to withdraw our prior order and 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 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
EDWARD M. JANUARY, Claimant
WCB Case No. 96-08893
ORDER ON REMAND
Carney, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. January*, 166 Or App 620 (2000). The court has reversed our prior order, *Edward M. January*, 49 Van Natta 1477 (1997), that had reversed an Administrative Law Judge's (ALJ's) order that had upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition. In concluding that claimant had established a compensable aggravation claim, we found that his attending physician's opinion (that claimant's increased symptoms represented a temporary worsening of his compensable lumbar strain condition) constituted an "actual worsening" under ORS 656.273(1). Relying on *SAIF v. Walker*, 330 Or 102 (2000), the court observed that a symptomatic worsening may meet the proof standard for an actual worsening if a medical expert concludes that the "symptoms demonstrate the existence of a worsened condition" and the Board determines that the expert's opinion is persuasive. Nonetheless, noting that the attending physician had submitted two opinions (one supportive of a conclusion that claimant's condition had actually worsened and another suggesting that claimant's condition constituted a waxing and waning of symptoms), the court has determined that we must consider and decide whether the two opinions were fatally inconsistent or explain our reasons for relying on one opinion notwithstanding the other opinion. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Relying on the Court of Appeals' decision in *SAIF v. Walker*, 145 Or App 294 (1996), the ALJ found that the evidence showed only a symptomatic worsening rather than a worsening of the condition. On this basis, the ALJ concluded that claimant had failed to establish an actual worsening under ORS 656.273 and upheld SAIF's aggravation denial. Claimant sought Board review. On review, we relied on the opinion of Dr. Kelly, claimant's attending physician, to find that claimant had sustained an actual worsening. Specifically, we relied on Dr. Kelly's opinion that claimant's increased symptoms represented a temporary worsening of claimant's compensable lumbar strain condition, to conclude that claimant had sustained an actual worsening. On the basis of this reasoning, we reversed the ALJ's order and set aside SAIF's aggravation denial. SAIF requested judicial review of our order.

The Court of Appeals, relying on *SAIF v. Walker*, 330 Or 102 (2000), noted that a symptomatic worsening may meet the proof standard for an actual worsening if a medical expert concludes that the "symptoms demonstrate the existence of a worsened condition" and the Board determines that the expert's opinion is persuasive. Noting that the attending physician, Dr. Kelly, had submitted two opinions (one supportive of a conclusion that claimant's condition had actually worsened and another suggesting that claimant's condition constituted only a waxing and waning of symptoms), the court determined that we must consider and decide whether the two opinions are fatally inconsistent or explain our reasons for relying on one opinion over the other. Consequently, the court has reversed and remanded for reconsideration. We proceed with our reconsideration in light of the court's decision.

In *SAIF v. Walker*, 330 Or 102 (2000), the Supreme Court analyzed the text of ORS 656.273(1) and determined that in order to prove an aggravation claim, a worker must present evidence of a worsening of the compensable condition itself, not merely a worsening of the symptoms related to the underlying condition. Consequently, the Court concluded that a worker cannot satisfy the requirements of ORS 656.273(1) (which requires "an actual worsening of the compensable condition") by presenting evidence of worsened symptoms alone. *SAIF v. Walker*, 330 Or at 110.

After considering the text, context, and applicable case law surrounding the 1995 amendment to ORS 656.273(1), as well as the interplay between that statute and ORS 656.273(8), the Supreme Court in *Walker* concluded that if expert medical opinion establishes that a symptomatic worsening represents an actual worsening of the underlying condition, such evidence may carry the worker's burden. *See also Lepage v. Rogue Valley Medical Center*, 166 Or App 627, 631 (2000) (applying *Walker*); *Roland Walker*, 52 Van Natta 1018 (2000) (on remand).

While the Court of Appeals agreed with the Board in this case that Dr. Kelly had rendered an opinion that could satisfy the legal standard set forth in *Walker*, it noted that Dr. Kelly had given one opinion that potentially would satisfy the "actual worsening" requirement of ORS 656.273(1) and a second opinion that potentially could mean that claimant was entitled only to curative care under the "waxing and waning" provision of ORS 656.245(1)(c)(L). The court reasoned that we did not reconcile Dr. Kelly's two opinions and did not explain why we found Dr. Kelly's opinion of an "actual worsening" persuasive notwithstanding her later agreement that she was treating claimant for a "waxing and waning" of symptoms.

We now proceed with our reconsideration of the medical evidence in this case. The record contains two expert medical opinions addressing whether claimant's condition has actually worsened. Drs. Wilson and Arbeene examined claimant on behalf of SAIF. They opined that claimant had a *symptomatic* flare up of his low back pain. (Ex. 27).

Dr. Kelly, claimant's attending physician, concurred with Drs. Wilson and Arbeene. (Ex. 28). In an August 27, 1996 letter, Dr. Kelly stated that claimant experienced an acute exacerbation of his low back pain. (Ex. 38). In a December 16, 1996 check the box opinion, Dr. Kelly agreed with a statement that claimant's increased symptoms represented a temporary worsening of claimant's chronic lumbar strain. (Ex. 42-2). However in response to a December 16, 1996 query from SAIF, Dr. Kelly also agreed with a statement that claimant had experienced a temporary and acute waxing and waning of symptoms of his low back condition. (Ex. 43).

After reconsidering the medical evidence in this case, we are unable to reconcile Dr. Kelly's opinions. Dr. Kelly first apparently agreed with the examining physicians that claimant had a symptomatic flare up. Then, in a check the box format, Dr. Kelly agreed that claimant's increased symptoms represented a temporary worsening of the underlying strain condition. Finally, Dr. Kelly agreed that claimant had experienced a temporary waxing and waning of symptoms. After reconsidering this evidence, we find Dr. Kelly's opinion to be conflicting, ill-explained and confusing. In light of her conflicting opinions, we are unable to conclude, based on this record, that Dr. Kelly believed that claimant's symptomatic worsening represented an actual worsening of the underlying *condition*. Under such circumstances, we are persuaded on reconsideration that claimant has failed to establish a compensable aggravation claim under ORS 656.273(1).

Thus, on reconsideration, and in lieu of our prior order, we affirm the ALJ's order dated January 15, 1997 and reinstate and uphold SAIF's denial of claimant's aggravation claim.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD E. STIENNON, Claimant
Own Motion No. 00-0055M
OWN MOTION ORDER DENYING RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requested reconsideration of our May 25, 2000 Own Motion Order, which authorized the insurer to reopen his July 11, 1988 injury claim for the payment of temporary disability compensation beginning the date he was hospitalized for surgery. Specifically, citing *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), claimant contends that his claim is subject to the processing requirements of ORS 656.262 and 656.268 and contends that his current condition is not subjected to our jurisdiction under ORS 656.278.

In order to allow sufficient time to consider claimant's motion for reconsideration and allow the insurer an opportunity to respond, we abated our order on June 20, 2000 and established a briefing schedule.

The insurer submitted its opening brief on June 28, 2000. In response, claimant submitted a letter dated July 19, 2000, wherein he withdraws his motion for reconsideration and requests that our May 25, 2000 Own Motion Order be "reinstated as soon as possible."

Accordingly, claimant's request for reconsideration is denied. The issuance of this order neither "stays" our May 25, 2000 order nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656 (1985).

IT IS SO ORDERED.

In the Matter of the Compensation of
BRYAN E. JOHNSON, Claimant
WCB Case No. 99-07576
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, 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) Tenenbaum's order that: (1) disallowed a portion of the insurer's offset for overpaid temporary disability; and (2) awarded a $500 insurer paid attorney fee under ORS 656.382(1) for allegedly unreasonable claim processing. In his respondent's brief, claimant contests those portions of the ALJ's order that: (1) declined to remand claimant's left knee (leg) claim to the Director for the promulgation of a temporary rule; and (2) affirmed an Order on Reconsideration that awarded 16 percent (24 degrees) scheduled permanent disability for loss of use or function of the left knee (leg). On review, the issues are remand, permanent disability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Penalties/Attorney Fee

On February 19, 1999, the insurer received the treating physician's report declaring claimant medically stationary and requesting an "independent examiner" rate claimant's physical impairment. The insurer made arrangements for the requested exam through the Orthopeadic Consultants. That exam was performed by Dr. Gambee on March 22, 1999.

The insurer received Dr. Gambee's report on March 29, 1999. That same day, the insurer forwarded the report to Dr. Bald, who concurred with the report on March 31, 1999. The insurer received Dr. Bald's concurrence on April 2, 1999, then issued its Notice of Closure on April 7, 1999.

The ALJ found that the insurer took two weeks to make arrangements for the rating exam. The ALJ concluded that a two-week delay to establish the exam appointment was an unreasonable delay, which constituted unreasonable resistance to the payment of compensation. The ALJ assessed a penalty equal in amount to one week of claimants TTD (thereby disallowing a portion of the insurers claimed overpayment), and assessed an attorney fee pursuant to ORS 656.382(1).

Claimant's request for penalties appears to be based upon ORS 656.262(11)(a) and/or ORS 656.262(5)(d).[1] An unreasonable delay in timely seeking claim closure can result in the assessment of

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[1] Under ORS 656.262(11)(a), if an insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amount then due. Under ORS 656.268(5)(d), if an insurer or self-insured employer has unreasonably closed or unreasonably refused to close a claim, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount of 25 percent of all compensation determined to be due the claimant. Where a carrier delays seeking closure but continues to pay temporary disability, any unpaid temporary disability and any permanent disability awarded by a later Notice of Closure or Determination Order constitutes amounts "then due" for the assessment of a penalty. *Virgil E. Moon*, 42 Van Natta 1003 (1990); *Brenda Hinkle*, 40 Van Natta 1655, 1661 (1988).

penalties and attorney fees against the carrier. *See Georgia Pacific Corp. v. Awmiller*, 64 Or App 56 (1983). The determination of what constitutes "unreasonable delay" is done on a case by case basis and must depend on the particular fact and circumstances of each case. *Lester v. Weyerhaeuser Co.*, 70 Or App 307, 310-311 (1984); *See Barrett v. Coast Range Plywood*, 56 Or App 371 (1982). In making that determination we look to the length of the delay as well as the cause of and/or the justification for it. *Williams v. SAIF*, 31 Or App 1301, 1305 (1977).

Here, Dr. Bald's treating physician report declaring claimant stationary and requesting a closing exam to rate claimant's physical impairment was received by the insurer on February 19, 1999. (Ex. 58). Dr. Gambee's impairment rating exam was performed on March 22, 1999, 31 days later. (Ex. 61). The same day it received Dr. Gambee's report, the insurer forwarded the report to Dr. Bald for concurrence. (Ex. 63). Within 5 days of receiving Dr. Bald's concurrence, the insurer issued its Notice of Closure. (Ex. 63 & 64). Thus, 47 days elapsed between Dr. Bald's request for a "closing/rating" exam and the insurer's issuance of a Notice of Closure.

Neither the statutes, the Director's administrative rules, nor case law specify a time limit for scheduling a closing exam upon the request of the treating physician.[2] In the absence of such a requirement, we do not consider a 31 day period between the treating physicians request for a closing exam and the performance of that exam to constitute an unreasonable delay in seeking claim closure. In reaching our conclusion, we particularly note that the claim was closed within 47 days of the insurer's receipt of Dr. Bald's request for a closing exam and report and within 9 days of the insurer's receipt of the eventual closing exam report.[3]

Accordingly, we reverse the ALJ's penalty assessment. In light of this conclusion, it follows that the insurer did not unreasonably delay the payment of compensation. Consequently, we also reverse the ALJs award of an attorney fee under ORS 656.382(1).

Scheduled Permanent Partial Disability/Remand

We adopt and affirm these portions of the ALJ's order.

ORDER

The ALJ's order dated March 6, 2000 is reversed in part and affirmed in part. Those portions that assessed a penalty and awarded an attorney fee are reversed. The remainder of the order is affirmed.

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[2] OAR 436-010-0250 governs the timelines for obtaining insurer-arranged medical opinions upon notice of a treating physicians request for surgery. OAR 436-010-0250 allows an insurer 28 days to obtain the medical opinion.

[3] *Awmiller*, cited above, involved a delay of over 5 months in seeking claim closure. *Lester*, also cited above, involved a 6 month delay to furnish medical information required to allow claim closure. In light of such delays, and considering the absence of a statutory/administrative requirement for the scheduling of a closing examination, we do not consider an approximate month and one-half period between the request for a closing/rating examination and claim closure to constitute unreasonable claim processing (particularly when the claim was closed 9 days after the insurer's receipt of the closing exam report, which included obtaining the treating physician's concurrence with that report).

Member Phillips Polich specially concurring.

I agree with the conclusion that this record does not support an award of penalties for unreasonable delay in timely seeking closure of the claim. I write separately to express my concern regarding the period of time taken by an insurer to establish a rating examination after receipt of a treating physician's request for such an examination.

In the absence of a statutory or regulatory requirement setting a time limit for scheduling a closing exam upon the request of the treating physician, I would examine the record to see if the insurer used due diligence in timely seeking closure of the claim. For example, we have found that a claimant's unexplained delay of 17 days to arrange for depositions to cross examine medical experts did not constitute due diligence sufficient to warrant a hearing continuance. *Cathy A. Inman*, 47 Van Natta 1316 (1995).

Here, a period of 31 days elapsed from the date the insurer received Dr. Bald's request for a rating examination until the performance of the examination by Dr. Gambee. If review of the record had established an unexplained time delay in arranging for the rating examination, similar to the claimants unexplained delay in *Inman, supra,* then the insurer would not have used due diligence in timely seeking closure of the claim. In such circumstances, penalties would be warranted.

In the Matter of the Compensation of
ROBERT K. LARSON, Claimant
Own Motion No. 99-0397M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schneider, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of insurer's April 3, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from September 23, 1999 through March 7, 2000. The insurer declared claimant medically stationary as of March 7, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 3, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a June 5, 2000 letter, we requested that the insurer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. Having received the parties' responses, we will proceed with our review.

Claimant contends that the insurer erroneously interpreted a March 7, 2000 chart note from Dr. Wilson, claimant's attending physician, as indicating that he was medically stationary on that date. Claimant points out that there is no evidence that Dr. Wilson declared him medically stationary on that date nor did the insurer schedule a closing examination prior to closing his claim. Additionally, claimant submitted a June 12, 2000 work release form indication that claimant was released to full work on that date. We assume that claimant is contending that since he was not released to work prior to June 12, 2000, then he was not medically stationary until at least June 12, 2000.

The definition of medically stationary outlines the criteria by which a physician must determine a claimant's medically stationary status. *See* ORS 656.005(17). Therefore, although claimant asserts that he was not returned to full work until June 2000, the pivotal question is whether his condition was medically stationary. Claimants condition, in the opinion of the medical experts, must have reached a state where it will not improve with further treatment or the passage of time.

Here, although Dr. Wilson does not specifically state in his March 7, 2000 chart note that claimant was "medically stationary," the use of "magic words" or statutory language is not required. *Liberty Northwest Ins. Corp. v. Cross,* 109 Or App 109 (1991), *rev den* 312 Or 676 (1992), as cited in *U-Haul of Oregon v. Burtis*, 120 Or App 353 (1993); *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412, 417 (1986). In his March 7, 2000 chart note, Dr. Wilson indicated that on physical examination there was no evidence of effusion and claimant was able to achieve full extension. He saw no evidence to suggest asymmetric atrophy in the lower extremities. Diagnostic testing did not reveal any significant degenerative changes or chondral wear. He concluded that claimant could return to work. Although there was no indication for significant pain medicine to be utilized, Dr. Wilson did prescribe some pain

medication. He did not schedule a follow-up examination, but noted that he would see claimant back for a closing examination. Finally, in response to an inquiry from the insurer, on March 20, 2000, Dr. Wilson did concur that claimant was medically stationary as of March 7, 2000. His opinion is unrebutted.

Based on the uncontroverted medical evidence (*i.e.* the opinion of his attending physician), we find that claimant was medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's April 3, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHELE A. PERKINS, Claimant
WCB Case No. 99-09174
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral upper extremity 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 incorrectly failed to find the opinion of Dr. Ellis, the treating physician, as supported by Dr. Greenberg, a consulting physician, persuasive.

Claimant seeks to establish the compensability of a bilateral arm condition, diagnosed as either thoracic outlet syndrome or chronic regional pain syndrome, as an occupational disease. Therefore, she must prove that her work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

To satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *see Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

The record establishes that claimant has a preexisting left-sided condition. (Ex. 9-11; 54A-1; 55-2). That preexisting condition is deemed a cause in the determination of the major contributing cause of the left-sided portion of claimant's occupational disease. ORS 656.802(2)(e). The record also establishes that claimant suffered an off-the-job fall at home in August of 1998, which caused an increase in her left-sided symptoms. (Ex. 26; 27). Because of the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find persuasive reasons not to defer to Dr. Ellis' opinion.

Dr. Ellis has opined that claimant's work is the major contributing cause claimant's left-sided condition. In explaining his opinion Dr. Ellis discussed claimant's preexisting left thoracic outlet syndrome, but did not discuss the role, if any, played by claimant's fall in August 1998. (Ex. 55). We note that Dr. Ellis records reflect that "she was able to live with the symptoms until 8/98 when she fell, sustaining a concussion and further injuring the left upper extremity neuropathic disorder." (Ex. 27-1). In light of Dr. Ellis' chartnote suggesting that claimant had an off-work injury that contributed to her condition, we conclude that Dr. Ellis' opinion is not sufficient to meet claimant's burden of proof. Specifically, we find that Dr. Ellis' opinion is inadequate as it fails to evaluate the relative contribution of all the different causes of claimant's left-sided condition. Accordingly, we do not find it persuasive. *Stacy*, 131 Or App at 614 (1994).

In similar fashion Dr. Ellis has opined that the major cause of claimant's right-sided condition is her work. His opinion appears to be based upon his prior experience of treating other workers with the same medical condition, who perform the same job function as claimant, but who work for a different employer. Without an explanation comparing the work activities of those other patients to the activities performed by claimant, we find that Dr. Ellis' statement regarding claimant's right-sided condition is conclusory and unsupported.[1] Moreover, to the extent that his opinion is grounded in a statistical type analysis of other workers and not sufficiently related to claimant's individual circumstances, it is unpersuasive. *Jackie T. Ganer*, 50 Van Natta 2189, 2191 (1998); *Sueyen A. Yang*, 48 Van Natta 1626, 1628 (1996). Accordingly, we do not do not rely on his opinion.

Nor do we find that Dr. Greenberg's opinion meets claimants burden of proof. With regard to both conditions, he has offered no evaluation weighing the contributions of claimant's preexisting condition and her work activities in producing the conditions he diagnosed.[2] Accordingly, we do not find Dr. Greenberg's opinion persuasive.

On this record, we agree with the ALJ that claimant has failed to establish the compensability of her bilateral upper extremity condition.

ORDER

The ALJ's order dated March 21, 2000 is affirmed.

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[1] Dr. Ellis did not rebut the opinion of Dr. Cline, who saw claimant at SAIF's request, that the type of mechanical factors involved in causing thoracic outlet syndrome, are using the arms above the level of the shoulders or head as well as repeated powerful maneuvers that build up the muscles of the chest. (Ex. 48-10). The record does not establish that claimant performed these type of maneuvers.

[2] Without specifically diagnosing a preexisting condition on claimants right side, Dr. Greenberg stated that claimant's right-sided condition would not likely develop absent a preexisting condition or propensity. (Ex. 54A-5). We conclude from that statement that he believes claimant has a right-sided preexisting condition. Accordingly, for his opinion on causation to be persuasive, it must offer some evaluation of the relative contributions of the preexisting condition and claimant's work activities on the conditions he diagnosed. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994).

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

Claimant requested reconsideration of our April 7, 2000 Own Motion Order, which declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she was in the work force at the time of disability.

In order to allow sufficient time to consider claimant's motion for reconsideration and allow the insurer an opportunity to respond, we abated our order on May 8, 2000. Having received the parties' written positions, we will proceed with our review.

In our prior order, we found that claimant was willing to seek work based on her affidavit.[1] However, we found that claimant had failed to satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Our conclusions were based on the following reasoning. We noted that the January 2000 Own Motion recommendation included a November 4, 1999 operative report demonstrating that claimants *right* foot underwent surgery on that day. Inasmuch as that was the only medical document in the record, we concluded that the request for reopening pertained to a worsening of claimant's *right* foot. Since the relevant time period to determine whether claimant was in the work force is at the time of disability, on that record, we found that claimant's condition worsened requiring surgery on November 4, 1999 on her *right* foot, which is the date of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990).

In her affidavit, claimant admitted that she did not seek work for the period between September 9 and December 2, 1999, because *she* thought it was futile. Claimant did not offer a medical opinion that would support her "futility" contentions, nor did the record demonstrate that it would have been futile for her to work or seek work at the time of the current worsening. There was no medical evidence that demonstrated that surgery had been recommended for her *left* foot nor, more importantly, that it would have been futile for her to seek work while waiting for an "upcoming" surgery. Accordingly, claimant had not established that she was a member of the work force at the time of the current disability, which is the worsening of her *right* foot.

On reconsideration, claimant argues that surgery for her *left* foot had been recommended and that she did not seek work while waiting for the impending surgery. She submitted a December 7, 1999 chart note from Dr. Woll, her attending physician and a December 20, 1999 request for surgery authorization in support of her contention that she was in the work force at the time of her disability.

However, when SAIF submitted its January 2000 Own Motion recommendation, the November 4, 1999 operative report for surgery on claimant's *right* foot was the only medical documentation submitted. Therefore, claimant had to establish that she was in the work force at the time her condition worsened requiring surgery on her *right* foot. On reconsideration, claimant has not submitted any new documentation or supplied any new argument that would change the outcome of our decision regarding her work force status at the time of disability for her *right* foot, *i.e.* November 4, 1999.

However, claimant has submitted documentation regarding a worsening of her *left* foot condition requiring surgery as of Dr. Wolls December 7, 1999 chart note. We interpret this submission as a request for own motion benefits as the worsening relates to her *left* foot condition. Accordingly, SAIF is

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[1] In her January 2000 affidavit, claimant explained that when her claim was closed in September 1999, her doctor had indicated to her that she was going to require surgery to her *left* foot and that such surgery was eminent. Accordingly, she did not seek work from September 9 through December 2, 1999 expecting to undergo surgery "any day now." When authorization for the requested surgery on her *left* foot was not forthcoming, claimant outlined an extensive job search beginning December 9, 1999. Finally, claimant attested that she had been willing to work since her release in September 1999 and would have sought work but she "thought the treatment for [her] compensable injury (the upcoming surgery) made a job search futile."

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.[2]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our May 25, 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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[2] Concurrently with the issuance of this order, we have requested, by letter, that SAIF process claimant's request for own motion benefits in relation to her *left* foot worsening.

In the Matter of the Compensation of
SCOTT R. WROOT, Claimant
WCB Case Nos. C970428, C970427, C970426, C970425 & C970424
SECOND ORDER DENYING RECONSIDERATION
OF CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

On March 3, 1997, the Board approved the parties' claim disposition agreement (CDA) in the above captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury.

The Board is in receipt of claimant's July 10, 2000 letter requesting review of our December 17, 1999, Order Denying Reconsideration of Claim Disposition Agreement. We treat claimant's letter as another request for reconsideration. As stated in our prior order, 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). In this case, the "final" order is the March 3, 1997 order approving the CDA.

We received claimant's first letter requesting reconsideration of the March 3, 1997 order on November 9, 1999, approximately 2 1/2 years after the CDA was approved. Thus, the initial reconsideration request was denied. Claimant's appeal of the December 10, 1999 Order Denying Reconsideration of Claim Disposition Agreement was received on July 12, 2000, over 3 years after the March 1997 final order issued. Inasmuch as this motion for reconsideration is also untimely, we cannot consider it.[1] OAR 438-009-0035(1),(2); *Edward C. Steele*, 48 Van Natta 2292 (1996); *Paul J. LaFrance*, 48 Van Natta 306 (1996).

Moreover, we approved the CDA in a final order pursuant to ORS 656.236. The approved CDA is final and is not subject to review. ORS 656.236(2). Consequently, we lack either statutory or regulatory authority to alter the previously approved CDA.

IT IS SO ORDERED.

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[1] In any event, our December 10, 1999 order denied further reconsideration, and contained no appeal rights.

In the Matter of the Compensation of
RICHARD L. BENNETT, Claimant
Own Motion No. 00-0123M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The has submitted a request for temporary disability compensation for claimant's left low back condition. Claimant's aggravation rights expired on October 28, 1999. opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; and (2) surgery or hospitalization is not reasonable and necessary.

On March 31, 2000, the Managed Care Organization (MCO) disapproved lumbar discectomy surgery recommended by Dr. Brett, claimant's attending physician. Dr. Brett appealed the MCO's decision and on May 17, 2000, the Joint Medical Committee (JMC) upheld the MCO's decision. There is no indication that the JMC's decision has been appealed. As noted above, SAIF contends that the surgery is not reasonable and necessary.

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

The Director has subject matter jurisdiction regarding the reasonableness and necessity of medical services. ORS 656.245(6), 656.327 and 656.704(3); *Newell v. SAIF*, 136 Or App 280 (1995). Here, the dispute pertains to the appropriateness of the surgery recommended by Dr. Brett. Because that dispute falls under ORS 656.327(1)(a), jurisdiction over that portion of the claim rests exclusively with the Director.

In *Dustin L. Crompton*, 50 Van Natta 1206 (1998), we found that the issue of the appropriateness of the surgeries in question was essential to the issue of claimant's entitlement to having his claim reopened for own motion benefits. Citing our decisions in *Thomas E. Suby*, 50 Van Natta 718 (1998) and *Thomas E. Suby*, 50 Van Natta 1088 (1998) (the Director's final determination that the surgery in question was not reasonable and necessary broke the chain of causation between the accepted condition and any disability associated with that surgery), we reasoned that the ultimate determination by the Director regarding the appropriateness of the surgeries would have a significant impact on the question of claimant's entitlement to temporary disability under ORS 656.278(1).

Here, the JMC's decision has not been appealed to the Director. Therefore, the dispute regarding the reasonableness and necessity of claimant's proposed surgery is unresolved. Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1993 injury claim for the payment of temporary disability benefits. *See* ORS 656.278(1)(a). Should claimant's circumstances change, and the surgery subsequently be determined to be reasonable and necessary, 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
GARY L. BLACKBURN, Claimant
WCB Case No. 97-08691
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of claimant's aggravation claim for his current right knee condition. In its respondent's brief, the employer contests those portions of the ALJ's order that: (1) set aside an Order on Reconsideration because the employer had not provided the Appellate Review Unit (ARU) with all documents pertaining to claimant's right knee claim as required by OAR 436-030-0135(5)(a); (2) remanded the claim to the ARU for further reconsideration; and (3) assessed a penalty for allegedly unreasonable claim processing. The employer also seeks sanctions against claimant under ORS 656.390 for an allegedly frivolous appeal.[1] On review, the issues are aggravation, claim processing, penalties, and sanctions. We deny the motion for sanctions, affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Facts" and his "Ultimate Findings of Facts," with the exception of the second sentence.

CONCLUSIONS OF LAW AND OPINION

Aggravation/Current Condition

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

Sanctions

In arguing for reversal of the employer's September 24, 1997 aggravation denial, claimant relied on our decisions in *David E. McAtee*, 50 Van Natta 649 (1998), and *Tracey A. Blamires*, 50 Van Natta 1793 (1998), as well as on *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, *rev den* 324 Or 305 (1996). As the employer notes, before the filing of the appellants brief on February 9, 2000, the Court of Appeals had reversed our decision in *McAtee*. *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654 (1999). In addition, the court had effectively overruled *Blamires* in *Croman Corp. v. Serrano*, 163 Or App 136 (1999). Finally, legislative amendments to ORS 656.262(10) had overruled *Messmer*. The employer contends that claimant's request for review was, therefore, "frivolous" and requests an award of sanctions under ORS 656.390.

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

Claimant's arguments concerning the compensability of his current condition/aggravation claim are severely weakened in light of the legislative amendments to ORS 656.262(10) and the recent court decisions cited above. However, in addition to these procedural arguments, claimant has also advanced the substantive argument that his condition is compensable on the merits. Under such circumstances, we conclude that claimant has presented a colorable argument based on the medical evidence that his aggravation/current condition claim is compensable. Accordingly, we decline to impose sanctions.

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[1] The employer moves for consideration of a supplemental brief. In support of its motion, the employer requests the opportunity to respond to claimants reply brief and to refer the Board to a recent Board decision. *Melody R. Ward*, 52 Van Natta 241 (2000). The motion is denied. Because the employer did not file a cross-request for review (but rather chose to raise its challenge to the ALJ's order in its respondent's brief), it is not entitled to file a "cross-reply" brief. Finally, *Ward* issued 12 days before the employer filed its respondent's brief. Thus, we deny its request for the submission of supplemental authority.

Remand/Penalty

The ALJ set aside a September 25, 1997 Order on Reconsideration and remanded the claim to the ARU for further reconsideration of the extent of disability after determining that the employer's failure to submit all claims documents had caused an inaccurate calculation of scheduled permanent disability. Specifically, the ALJ found that, as a result of the employer's failure to provide claims documents pertaining to a prior industrial injury in 1994 for which another insurer was responsible, and its omission of some of the documents concerning claimant's compensable 1997 injury, the ARU had misapplied the contralateral joint rule of OAR 436-035-0007(22) and treated a preexisting right knee as a noncompensable condition. Relying on *Gallino v. Pontiac-Buick-GMC.*, 124 Or App 538 (1993), the ALJ determined that he had authority to remand to the Department for further proceedings based on a complete record. Finally, the ALJ found the employer's claim processing to have been unreasonable, thus justifying assessment of a 25 percent penalty under ORS 656.262(11)(a), based on any increase in compensation from the reconsideration order.

On review, the employer contends that the ALJ's decision to remand the claim to the ARU was in error, asserting that there is no authority for remand under these circumstances and further that its actions were not unreasonable. For the following reasons, we conclude that remand was inappropriate and that there is no basis for an assessment of penalties.

After the ALJ's order issued, we reversed an ALJ's determination that a claim should be remanded to the ARU when the carrier did not provide all claims documents to the ARU. *Donna J. Balogh*, 52 Van Natta 1057 (2000) (Member Biehl dissenting); *see also Jeffrey L. Scott*, 49 Van Natta 503 (1997). Specifically, the carrier in *Balogh* had failed to submit the claimant's statement to the ARU, even though it had previously disclosed the statement to the claimant's counsel. We acknowledged that the withheld statement could affect the result of the permanent disability issue. We reasoned, however, that remand was inappropriate (even assuming that the ALJ had authority to do so) because the claimant could have submitted the document when he requested reconsideration and also could have requested abatement of the reconsideration order after the order had issued and informed the parties that the reconsideration record contained insufficient information regarding the social/vocational factors relevant to the permanent disability issue.

In this case, it appears that claimant was unaware of what documents the employer had submitted when he requested reconsideration and thus, arguably, was justified in not submitting records concerning his prior injury or his current claim. However, the Order on Reconsideration indicated that the contralateral joint rule would not be applied in the absence of evidence of a prior injury and further indicated that the preexisting knee condition was noncompensable. As was true in *Balogh*, it was apparent after the reconsideration order had issued that additional information should be supplied to the ARU in order for permanent disability to be accurately rated. (Ex. 68). Like the claimant in *Balogh*, claimant here could have sought abatement of the reconsideration order and supplied additional information to the ARU.[2] For this reason, we conclude that remand to the ARU in this case was also inappropriate (even assuming that the ALJ had the authority to do so). Therefore, we reverse the ALJs decision to remand.

We now turn to the penalty issue. As a result of our determination that the ALJ improperly set aside the reconsideration order and remanded the claim to the ARU, we reinstate and affirm the Order on Reconsideration.[3] Inasmuch as we have affirmed the reconsideration order, there is no compensation due on which to base a penalty, even assuming that the employer's claim processing was unreasonable. *See* ORS 656.262(11). Therefore, we also reverse the ALJs penalty assessment.[4]

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[2] As we noted in *Balogh*, there is no time limitation on the Department's authority to abate and reconsider its Order on Reconsideration. *See Boydston v. Liberty Northwest Insurance Corp.*, 166 Or App 336 (2000).

[3] Claimant has not contested the Order on Reconsideration's evaluation of the permanent disability issue based on the records the ARU was provided.

[4] We note, however, that the Department has the authority to assess a civil penalty for violation of its claim processing rules. *See* ORS 656.745; OAR 436-030-0580.

ORDER

The ALJ's order dated December 1, 1999 is reversed in part and affirmed in part. Those portions of the ALJ's order that remanded the claim to the ARU and assessed a 25 percent penalty are reversed. The September 25, 1997 Order on Reconsideration is affirmed. The remainder of the ALJ's order is affirmed.

Board Member Biehl dissenting.

Just as it did in *Donna J. Balogh*, 52 Van Natta 1057 (2000), the majority reverses an ALJ's decision to remand to the Department for consideration of claims documents that the employer failed to provide during the reconsideration process. For the reasons cited in my dissent in *Balogh*, I cannot accept the majority's decision to reverse the ALJ's action and reiterate my belief that an ALJ does have the authority under *Gallino v. Pontiac-Buick-GMC*, 124 Or App 538 (1993), to remand to the Department for consideration of claims documents a carrier fails to provide. Accordingly, I respectfully dissent.

July 28, 2000 Cite as 52 Van Natta 1375 (2000)

In the Matter of the Compensation of
MYRNA GARDNER, Claimant
WCB Case Nos. 99-07634 & 99-04687
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Stoel Rives LLP, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) upheld the self-insured employer's partial denial of her left ankle pain over dorsum; and (2) reduced her scheduled permanent disability award for the loss of use or function of her left foot (ankle) from 19 percent (25.65 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issues are compensability and extent of scheduled permanent disability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 14, 2000 is affirmed.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with the majority that the employer's denial is not a back-up denial and that claimant's left ankle pain over dorsum is not compensably related to the accepted condition. However, the medical arbiter, Dr. Thomas, found that claimant had loss of range of motion of the left ankle which he attributed to the compensable sprain. Because claimant's lost range of motion is not specifically attributable to pain, I would not discount his opinion. Rather, I would rely on the medical arbiter's findings, as it is his responsibility to rate impairment due to the compensable condition. Consequently, I respectfully dissent in part.

In the Matter of the Compensation of
ROBERT J. GOOD, Claimant
WCB Case No. 99-08765
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the following supplementation. We do not adopt the ALJ's "Findings of Ultimate Fact."

Claimant, a 35-year-old warehouseman, injured his low back at work on September 8, 1999 while lifting a spool of wire. The accident was unwitnessed. However, a coworker saw claimant "wincing" shortly after the injury. Claimant then filed an "incident report" with his foreman. Claimant first sought treatment on September 14, 1999 from Dr. Yarusso. Dr. Yarusso initially diagnosed a lumbar strain, dependent on the results of an MRI scan. (Ex. 6). Dr. Yarusso felt that the major reason for claimant's seeking treatment was degenerative disc disease. (Ex. 13).

An MRI scan performed on September 17, 1999 revealed multi-level degenerative disc disease, most prominently at L4-5. (Ex. 9). Another MRI on September 24, 1999 showed a herniated disc at L3-4 with a disc fragment. (Ex. 11A). Claimant was referred to neurosurgeon Dr. Waller on October 8, 1999. Based on his examination of claimant and review of the MRI studies, Dr. Waller diagnosed preexisting lumbar degenerative disc disease and an acute lumbar disc herniation related to the September 8, 1999 injury. (Ex. 13B). Dr. Shenoy, an earlier treating physician, concurred with Dr. Waller. (Ex. 19). Because claimant's symptoms improved, Dr. Waller ultimately did not propose surgery. (Ex. 17).

On January 27, 2000, Dr. Farris performed a file review at the request of SAIF and concluded that claimant's disc herniation at L3-4 occurred spontaneously as a result of degeneration, and was merely coincident to claimant's work activities. (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial based on the opinions of Drs. Yarusso and Farris. The ALJ rejected the opinion of Dr. Waller, claimant's treating doctor, because it was based on inaccurate information and depended solely on a temporal relationship between claimant's injury and his disability and need for treatment. On review, claimant contends that we should rely on the opinion of treating physician Dr. Waller. We agree.

Initially, claimant contends that, in the absence of medical opinion that his injury combined with his preexisting degenerative disc disease, he need only prove that his work injury was a material contributing cause of his disability and need for treatment. *Beverly Enterprises v. Michl*, 150 Or App 357 (1997); *William J. Barabash*, 50 Van Natta 1561 (1998). We agree.

Although the ALJ stated that "it is concluded that, if the disc herniated in the lifting incident, the injurious exposure combined with the preexisting degenerative condition," (*O&O* at 4), there is no medical opinion in the record supportive of this statement. In fact, the medical evidence is uniform that claimant's preexisting degenerative disc disease did not combine with his September 8, 1999 work injury. (Exs. 13, 13B, 20, 21). Nevertheless, we find that, even if there has been a "combining," claimant has met his burden of proving that his work injury is the major contributing cause of his disability and need for treatment for his low back condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 149 Or App 309 (1997).

Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). In addition, we generally rely on the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find no reasons not to defer to the opinion of Dr. Waller. Initially, we note that Dr. Waller is the only neurosurgeon to have offered an opinion regarding causation. In contrast, Dr. Yarusso is an occupational medicine specialist and Dr. Farris (for whom the record does not reveal a specialty) performed only a file review at the request of SAIF.

Dr. Waller offered a well-reasoned opinion based on his examination of claimant and review of the various MRI scans. (Ex. 17). His opinion was not based on merely a "temporal analysis," but rather on his opinion that claimant's work injury was the sole cause of his herniated disc at L3-4. (Ex. 13B). Moreover, contrary to SAIF's contention, Dr. Waller's opinion did not fail to consider claimant's preexisting degenerative disc disease. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev den* 321 Or 416 (1995). Dr. Waller noted a diagnosis of "preexisting and asymptomatic" degenerative disc disease during his first examination of claimant. (Ex. 13B). Dr. Waller reasoned that the degenerative disc disease played a very minor, if any, role in causing claimant's disability and need for treatment. (Ex. 20). This conclusion was based on Dr. Waller's examination of claimant and review of the MRI scans, which in Dr. Waller's opinion, revealed a disc herniation at L3-4 coexistent with, but separate from, the multi-level degenerative disc disease. (Ex. 13B).

We rely on opinions that are based on complete and accurate information. *Miller v. Granite Construction Co.*, 28 Or App 473 (1977). The ALJ noted that Dr. Waller took a history of claimant's lifting a 45-pound spool of wire on September 8, 1999, whereas claimant testified to lifting a "35-40 pound" spool. However, we do not find this discrepancy significant enough to completely undermine Dr. Waller's opinion. Moreover, there is no medical evidence stating that this discrepancy is significant. Dr. Yarusso's opinion, in contrast, suffers from the more critical defect of not being afforded the opportunity to review the later MRI scans, which revealed the presence of the L3-4 disc herniation. (Exs. 11A, 12, 13).

Finally, as previously noted, we do not find Dr. Farris' opinion persuasive given the fact that she performed only a records review at the request of SAIF, and never examined claimant. Accordingly, based on Dr. Waller's persuasive opinion, we find that claimant has met his burden of proving that his September 8, 1999 work injury is the major contributing cause of his disability and need for treatment for his low back condition. The ALJ's order is therefore reversed.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devote to the case, (as represented by the record and claimant's appellant's brief), the complexity of the issues, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 28, 2000 is reversed. The SAIF Corporation's October 15, 1999 denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $5,000, payable by SAIF.

In the Matter of the Compensation of
BRIAN K. LUTZ, Claimant
Own Motion No. 94-0392M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our March 10, 2000 Own Motion Order Reviewing Carrier Closure, which affirmed the insurer's August 5, 1999 Notice of Closure. That closure declared claimant medically stationary as of July 21, 1999, and awarded temporary disability compensation from May 6, 1994 through July 21, 1999. On April 10, 2000, we abated our March 10, 2000 order to further consider claimant's request and provide the insurer an opportunity to respond to claimant's motion. Having received the insurer's response and claimant's reply, including his submission of additional evidence, we proceed with our reconsideration.

As we explained in our prior order, it is claimant's burden to prove that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (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). In determining whether a claim was prematurely closed, we determine whether the claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. *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). Thus, the propriety of the closure turns on whether claimant was medically stationary at the time of the August 5, 1999 Notice of Closure.

On reconsideration, claimant repeats his argument that we should rely on the opinion of his current treating physician, Dr. Phuntshog, to find that he was not medically stationary when his claim was closed. After further consideration of claimant's argument, we continue to reject it for the reasons explained in our prior order. In reaching this decision, we continue to find the opinion of Dr. Sheppard, an associate professor of surgery at OHSU and claimant's prior treating physician, more persuasive for several reasons, including the fact that he performed claimant's 1994 hernia surgeries and followed his care until March 1998,[1] a greater period of time than Dr. Phuntshog followed his care. In addition, Dr. Sheppard's opinion is supported by the opinions of Dr. Braun, examining urologist and surgeon, and Dr. Dordevich, examining rheumatologist.

With his reply brief, claimant submitted the following documents, all of which were authored by his physical therapist: (1) June 12, 1999 physical therapy notes; (2) a June 21, 1999 physical therapy follow-up treatment plan; and (3) a July 6, 1999 physical capacities evaluation. The June 21, 1999 follow-up treatment plan was presented on a form that provided spaces to respond to preprinted questions; only that form addressed claimant's medically stationary status. Specifically, in response to the question "[i]s patient medically stationary?" the physical therapist circled "no." The physical therapist also indicated that no further physical medicine was indicated, noting only that claimant's weight loss was to be monitored twice a month.

We do not find that the physical therapist's unexplained indication that claimant was not medically stationary meets claimant's burden of proof. In this regard, we find that, as medical doctors, Drs. Sheppard, Braun, and Dordevich have more expertise to determine claimant's medically status than does the physical therapist. In addition, as surgeons, Drs. Sheppard and Braun specialize in the treatment of medical conditions with surgery. Moreover, Dr. Sheppard performed claimant's 1994 hernia surgeries. For all of these reasons, we find that Drs. Sheppard, Braun, and Dordevich have specialized expertise over that of the physical therapist. Therefore, we find it appropriate to defer to Dr. Sheppard's specialized expertise, as supported by the opinions of Drs. Braun and Dordevich. *See Abbott v. SAIF*, 45 Or App 657, 661 (1980).

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[1] Claimant states that he last saw Dr. Sheppard in March 1998, which confirms our prior finding that Dr. Sheppard followed claimant's care at least until March 1998. Claimant also contends that, during the March 1998 examination, Dr. Sheppard did not weigh him and did not consider his "limitations." Under the facts of this case as enumerated in our prior order, we do not find that these contentions decrease the persuasiveness of Dr. Sheppard's opinion regarding claimant's medically stationary status.

Claimant argues that the opinions of Drs. Braun and Dordevich represent "subsequent developments" to the date of closure and, as such, do not address his condition at the time of closure, as required under ORS 656.268(1). Claimant contends that, because the insurer declared him medically stationary as of July 21, 1999 (the date Dr. Sheppard found claimant medically stationary), the August 5, 1999 examination conducted by Drs. Braun and Dordevich was a "subsequent development" and, as such, cannot be considered in determining his medically stationary status. We disagree.

Claimant appears to rely on the medically stationary date rather than the date of closure to argue that Drs. Braun's and Dordevich's August 5, 1999 medical report may not be considered. But the relevant issue is whether claimant's condition was medically stationary *at claim closure,* which occurred on August 5, 1999, the date the Notice of Closure was issued. Due to claims processing procedures, a claim might not be closed on the same date that the claimant is found medically stationary. Moreover, if the claim is closed well after the claimant is found medically stationary, his or her condition might have changed in the interim and might no longer be medically stationary at claim closure. Under such circumstances, because medically stationary status is determined at claim closure, the claim would be prematurely closed even if the claimant had been medically stationary at some point prior to closure.

That is not the case here, however, where Dr. Sheppard found claimant medically stationary as of July 21, 1999, and the claim was closed 15 days later, on August 5, 1999. There is no evidence that claimant's condition changed in the 15 day interval between July 21, 1999, and August 5, 1999.

In arguing that the medical report from Drs. Braun and Dordevich should not be considered, claimant stresses that it was authored on August 5, 1999, the same day the claim was closed and, thus, contends that it represents post-closure evidence. However, even if the claim was closed before this medical report was issued, we can consider it under the facts of this case.

Medical reports authored after closure may be considered where there has been no post-closure change in claimant's condition, the only question is whether claimant was stationary at the time of closure, and the post-closure evidence addresses claimant's condition at the time of claim closure. *Wojick v. Weyerhaeuser Co.*, 89 Or App 561 (1987); *Schuening v. J. R. Simplot*, 84 Or App 622 (1987). Here, because the medical report from Drs. Braun and Dordevich was authored the same day the claim was closed, we find that it addresses claimant's condition at the time of claim closure. Furthermore, there is no indication of any change in claimant's condition after closure, which occurred on the same day as the medical report in question.

Finally, claimant disputes our finding of fact regarding his examination at the Liechtenstein Institute, contending that surgery was postponed "in part" due to missing OHSU medical records regarding the May 13, 1994 exploratory surgery. However, evidence in the record regarding that examination consists of a notation in Drs. Braun's and Dordevich's report that "surgery was rejected due to [claimant's] obesity and asthma." (August 5, 1999 report, page 2).

Accordingly, we withdraw our March 10, 2000 order. On reconsideration, as supplemented herein, we republish our March 10, 2000 Own Motion Order Reviewing Carrier Closure. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Biehl dissenting.

For the reasons explained in my dissent to the majority's initial order, I would find that claimant's claim was prematurely closed. In addition, in his briefs on reconsideration, claimant explains that, after he last treated with Dr. Sheppard on March 6, 1995, he saw Dr. Sheppard once in March 1998. During that March 1998 examination, Dr. Sheppard did not weigh claimant or consider his limitations. Importantly, Dr. Sheppard did not examine claimant at the time he declared him medically stationary as of July 21, 1999. Instead, Dr. Sheppard rendered his opinion "per [a] phone conversation" with the claims examiner. Moreover, there is no indication that Dr. Sheppard even reviewed the medical record or was aware of claimant's recent success in losing weight in preparation for the proposed hernia surgery at the time he declared claimant medically stationary. Under these circumstances, I do not find Dr. Sheppard's opinion persuasive.

Instead, I would rely on claimant's current treating physician, Dr. Phuntshog, who has treated him since January 1998 and has first-hand knowledge of his condition *at claim closure*, which is the relevant time to determine claimant's medically stationary status. *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). I continue to find that the majority's focus on events occurring *prior to claim closure* misplaced. Thus, I continue to respectfully dissent from the majority's decision.

In the Matter of the Compensation of
MARK A. MANION, Claimant
WCB Case No. 99-07833
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of those portions Administrative Law Judge (ALJ) Livesley's order that: (1) interpreted its denial of January 4, 2000, as a current condition denial; and (2) set aside its denials of claimant's occupational disease claim for a low back condition. On review, the issues are scope of denial and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scope of Denial

On August 4, 1999, SAIF issued a denial of claimant's occupational disease claim for a low back condition, contending the claim was not supported by objective findings. (Ex. 13). On January 4, 2000, one day prior to hearing, SAIF issued a "supplemental denial" contending that claimant's work activities were not the major contributing cause of his low back condition. (Ex. 23). At hearing, claimant amended his request for hearing to include SAIF's January 4, 2000 denial.[1] (Tr. 2).

From analyzing the record, our understanding of what transpired at hearing is as follows: (1) the ALJ found objective findings to support the low back condition claim contrary to SAIF's August 4, 1999 denial; (2) as a result, the ALJ found claimant's occupational disease claim compensable and set aside the August 4, 1999 denial; and (3) having thus found claimant's low back condition compensable, the ALJ then concluded that SAIF's January 4, 2000 denial was a current condition denial.

SAIF contends that its January 4, 2000 letter was not a current condition denial, but instead merely an amendment of its previous denial. Accordingly, SAIF contends the ALJ should have considered the two letters together and not separately. We agree with SAIF.

OAR 438-006-0031 and OAR 438-006-0036 freely allow for amendments to the specification of issues and the responses thereto up to the date of hearing. If a party is surprised and prejudiced by the additional issues so raised, the ALJ may grant a continuance to allow a party to cure the surprise and prejudice. OAR 438-006-0031 and OAR 438-006-0036. Moreover, case law allows a carrier to amend its denial at hearing. *SAIF v. Ledin*, 149 Or App 94 (1997). Consequently, we conclude that SAIF's letter of January 4, 2000, was not a separately issued current condition denial, but rather an amendment to its previous letter of August 4, 1999, thereby raising an additional ground for the denial of claimant's occupational disease claim.

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[1] Neither party objects to this amendment of claimant's request for hearing.

Compensability

Claimant seeks to establish the compensability of a low back condition as an occupational disease. Therefore, he must prove that his work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

To satisfy the "major contributing cause" standard, claimant must establish that his work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The record establishes that claimant has a preexisting degenerative condition in his low back. (Ex. 19; 21-4; 22-1; 22A). That preexisting condition is deemed a cause in the determination of the major contributing cause of low back condition. ORS 656.802(2)(e). Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find persuasive reasons not to defer to Dr. Greer's opinion.

Dr. Greer, the treating physician, has opined that the major contributing cause of claimant's low back condition is claimant's prolonged work-related driving of a pick-up with a rough suspension and a poor seat. (Ex. 18-1). In arriving at his opinion, Dr. Greer relied upon the mechanism of injury, claimant's symptoms, the clinical findings, and an x-ray study showing minimal spondylosis. (Ex. 18-1 & 2). However, the record reflects that Dr. Greer has not reviewed the MRI study of December 17, 1999.[2] The record further reflects that he has not reviewed the reports of either Dr. Stewart or Dr. Fuller.[3] Because the evidence shows degenerative disc disease in claimant's low back, we conclude that he was unaware of such changes in claimant's low back. Thus his opinion is based upon incomplete information, and is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998). Accordingly, we do not rely upon it.

Both Dr. Stewart and Dr Fuller, the only other medical examiners to render opinions in this case, are essentially in agreement; the major contributing cause of claimant's low back condition is his preexisting degenerative disease.[4] (Ex. 21-7; 22A). Accordingly, we conclude that claimant has failed in his burden to prove that his work activities are the major contributing cause of his low back condition.

ORDER

The ALJ's order dated April 3, 2000 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denials of claimant's low back condition is reversed. SAIF's denials of claimant's low back condition are reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

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[2] The MRI report, as interpreted by Dr. Johnson, shows disc protrusions at L4-5 and L5-S1, and notes degenerative changes at the two lumbar interspaces. (Ex. 19).

[3] Dr. Stewart is a consulting orthopedist, who saw claimant at Dr. Greer's request. Dr. Fuller is an orthopedist, who examined claimant at SAIF's request.

[4] Claimant argues that Dr. Stewart's opinion that the work activities are the major cause of the need for treatment is sufficient to prove the compensability of his low back condition. We disagree. In an occupational disease claim, claimant must prove that his work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

In the Matter of the Compensation of
RALPH E. PRICE, Claimant
WCB Case No. 99-04230
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome (CTS). On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following supplementation to address SAIF's argument regarding claimant's attorney fee request for services on review.

Claimant's counsel submitted a statement of services requesting a fee of $2,625 for services on review. SAIF contends that claimant's counsel's fee request is excessive and that a reasonable attorney fee should not exceed $1,200. SAIF argues that the only issue was compensability, that the record was not lengthy and that claimant's counsel, who tried the case at hearing, was familiar with the record, the legal standards and SAIF's arguments. In other words, SAIF is raising a challenge to the time devoted to the case on review.

Claimant is entitled to a fee for services on review for successfully defending against SAIF's challenge to the ALJ's order finding his right CTS claim to be compensable. ORS 656.382(2). Claimant's counsel attests that he spent 15 hours on the case on review at a rate of $175 an hour. SAIF provides no evidence that claimant's counsel spent fewer hours on the case than the number to which he attests.

We consider the factors in OAR 438-015-0010(4), which includes time devoted to the case, the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the 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).

Here, the sole issue was compensability of claimant's occupational disease claim for right CTS. SAIF denied the claim on the ground that claimant's work was not the major contributing cause of the disease and that the disease did not arise out of and in the course of employment. (Ex. 8). In its brief, SAIF raised the same arguments.

As compared to typical compensability cases, the issue here was of average complexity. Because claimant's right CTS condition has been found compensable, he is entitled to workers' compensation benefits, and the interest involved and the benefit secured for claimant are valuable (*i.e.*, payment for his surgery, as well as time loss compensation). The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. Finally, considering the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses were presented at hearing.

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,625, 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 and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 22, 2000 is affirmed. For services on review, claimant's counsel is awarded a fee of $2,625, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MATTHEW J. SOOTS, Claimant
WCB Case No. 99-03153
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

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

We adopt and affirm the order of the ALJ with the following supplementation to address the employer's contention that the ALJ incorrectly relied upon the opinion of Dr. Flemming, the treating surgeon, as supported by Dr. Gritzka, rather than the opinions of Drs. Fuller and Schilperoort, employer-arranged medical examiners.

Claimant contends that his L5-S1 disc condition is compensable as either an injury or an occupational disease. The ALJ analyzed claimant's L5-S1 disc condition as an injury. The employer argues that claimant conceded his L5-S1 condition is an occupational disease and that it should be analyzed as such.[1]

When symptoms occur over a discrete, identifiable period of time, are unexpected and due to a specific activity or event, the condition is properly analyzed as an injury. On the other hand, when the symptoms are gradual in onset, not attributable to a specific activity or event, and due to an ongoing condition or state of the body, the condition is treated as an occupational disease. *See James v. SAIF*, 290 Or 343 (1981); *Valtinson v. SAIF*, 56 Or App 184 (1982); *Jeff R. Elizalde*, 50 Van Natta 2229, 2230 (1998).

Claimant is a truck driver. He contends that his L5-S1 disc condition is due to his work activities of "hostling" on October 14, 1998, not his normal truck driving work.[2] Although the record establishes that claimant had prior back pain from a preexisting and compensable L3-4 disc condition, the record also establishes that he experienced worse pain following his "hostling" shift on October 14, 1998. The medical record establishes that claimant had no symptoms specifically identified with the L5-S1 nerve root prior to October 14, 1998, and that his "hostling" work could herniate a disc. Consequently, we agree with the ALJ's conclusion to analyze the L5-S1 disc condition as an injury claim instead of an occupational disease claim.

The parties do not contest the ALJ's conclusion that the compensability of claimant's L5-S1 disc condition is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that his L5-S1 disc condition is compensable, claimant must show that his work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 149 Or App 309, 315 (1997), *rev den* 326 Or 389 (1998). Because of claimant's preexisting condition and the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

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[1] We disagree with the employer's contention that claimant conceded this claim was an occupational disease claim rather than an injury claim. Our interpretation of claimant's counsel's remarks in closing argument is that claimant's counsel thought the ALJ would find it an occupational disease claim, not that claimant agreed it was an occupational disease claim. (Closing Argument, 40). The ALJ did not set forth the reasoning for his conclusion that the L5-S1 disc condition was an injury. Accordingly, we address that issue on review.

[2] "Hostling" involves moving truck trailers around the employers yard with a motorized vehicle, and requires lifting and moving heavy axle sets by hand. (Tr. 7, 8).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find no persuasive reasons not to defer to Dr. Flemming's opinion.

Dr. Flemming has been claimant's treating physician since claimant compensably injured his back in 1996.[3] He first saw claimant following his October 14, 1998, injury on October 22, 1998.[4] (Ex. 104). He performed claimant's May 1999 back surgery, which consisted of a left L5-S1 hemilaminotomy, L5-S1 diskectomy, and L5-S1 foraminotomy. (Ex. 118-1). It is Dr. Flemming's opinion that claimant's "hostling" work activity on October 14, 1998, tore the L5-S1 annulus to the extent that disc material subsequently ruptured and eventually migrated to impinge on the nerve root, necessitating the May 1999 surgery.[5] (Ex. 120-2; 123A-1; 124; 130-9-11; 130-36). As the treating surgeon, Dr. Flemming had the opportunity to view claimants disc fragment first hand. Accordingly, his opinion based upon his actual surgical observations is entitled to great weight.[6] *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988).

The employer argues that Dr. Flemming's opinion is not based upon the correct legal standard. In particular, according to the employer, his opinion is based upon a "precipitating cause" standard and not a "major contributing cause" standard. We disagree.

Dr. Flemming was given the correct legal standard by claimant's counsel.[7] (Ex. 130-35 & 36). Additionally, Dr. Flemming demonstrated his understanding of the "major contributing cause" concept, when, in a response to an inquiry from the employer's counsel he indicated the "last straw" (precipitating cause) could potentially be the "major cause." (Ex. 130-27).

Dr. Fuller, on whom the employer relies, initially believed that claimant incurred his new L5- S1 disc herniation in the time period of October to November of 1998. (Ex. 114-8). Dr. Fuller agreed that claimant's "hostling" activities of October 14, 1998, could herniate a disc. (Ex. 127-13). He also agreed that in approximately 19 to 20 percent of the population disc material comes out slowly and does not immediately produce sciatica. (Ex. 127-8, 9). Nonetheless, he concluded that the "hostling" work was not the major contributing cause of the L5-S1 disc condition due to the lapse of time between the work

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[3] The compensable condition from the 1996 injury was a disc herniation at L3-4. (Ex. 81-3).

[4] Because Dr. Flemming is the only medical examiner in this record to observe claimant's condition both before and after the October 14, 1998, injury, his opinion regarding a change in that condition is entitled to more weight than the opinions of the other examiners. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416 (1986).

[5] The employer, citing Exhibit 99A, argues that Dr. Flemming diagnosed the L5-S1 disc on or before June 19, 1998, and that as a result, his opinion that the L5-S1 disc relates to claimant's work activities on October 14, 1998, is inconsistent with his own previous findings. We disagree.

Exhibit 99A is a note of Dr. Flemming's telephone conference with claimant's counsel. While the note does mention central herniation at L5-S1, it also mentions comparisons of MRI scans. There are only two MRI scans contained in this record. One is dated February 4, 1998, and indicates the L5-S1 disc is normal. (Ex. 85). The other MRI scan is dated December 16, 1998, which Dr. Flemming read on December 22, 1998, as showing a herniation at L5-S1 with an extruded fragment. (Ex. 108). Because of the dates of the MRI scans, and the references to the scans contained in Exhibit 99A, we conclude that the telephone conference, which is the subject of Exhibit 99A, did not occur on June 19, 1998, but occurred on or after December 22, 1998. Accordingly, we do not find Exhibit 99A reflects an inconsistency or unexplained change of opinion by Dr. Flemming.

[6] The employer argues that Dr. Flemming's opinion is not persuasive because it does not consider claimant's ongoing symptoms from January 1998. We disagree. The opinion from all the medical examiners in this record, including Drs. Fuller and Schilperoort, is that the L5-S1 disc herniation occurred on or after October 14, 1998. The basis of both Fullers and Schilperoorts opinions that claimant's work on October 14, 1998, is not related to the L5-S1 disc is that the disc did not herniate until after that time. Consequently, we conclude, on this record, that claimant's symptoms in January 1998, are unrelated to the L5-S1 disc. Accordingly, Dr. Flemming's opinion is not deficient merely because it does not specifically discuss claimant's symptoms in January 1998.

[7] Specifically, Dr. Flemming was advised that of all the factors that could cause or contribute to a problem, the biggest factor out of all those factors combined on a 51 percent standard is the major contributing cause. (Ex. 130-35). Upon receipt of that definition, Dr. Flemming opined: "I believe that the major cause of the of the reason he herniated his disk was some major tearing of the annulus that occurred with work exposure in October." (Ex. 130-36).

activity and the onset of radicular symptoms. (Ex. 118A- 1,2). Under these circumstances, because he does not explain his reasoning for excluding claimant from the 19 to 20 percent of the population who have slowly herniating discs, we find his opinion is merely an unsupported conclusion and as such, is not persuasive. Accordingly, the ALJ correctly did not rely on it.

The employer also relies on Dr. Schilperoort, who reviewed the records at the employer's request. Dr. Schilperoort found claimant to have an L5-S1 disc herniation with an extruded fragment. (Ex. 123-7). Dr. Schilperoort could not preclude claimant's work from causing the L5-S1 disc condition. (Ex. 129-6). He also indicated that a disc could herniate and not immediately produce neurological findings. (Ex. 129-17). He further indicated that Dr. Flemming's opinion, citing the cause of claimant's escalating symptoms as a migrating disc fragment, was reasonable. (Ex. 129-14). Nevertheless, he opined that claimant's L5-S1 disc herniated after October 22, 1998, but prior to October 28, 1998, and accordingly could not have been the result of work activity on October 14, 1998. (Ex. 123-7). Dr. Schilperoort has excluded, without explanation, the scenario posed by Dr. Flemming, where a tear in the disc annulus occurs and disc material is extruded at a later time. Without such an explanation, his opinion, like Dr. Fuller's is conclusory and not persuasive.

In conclusion, we find no persuasive reason not to defer to Dr. Flemming's well reasoned and persuasive opinion.[8] Consequently we conclude that claimants work activity of October 14, 1998, was the major contributing cause of his disability and his need for treatment for his L5-S1 disc condition.[9]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 11, 2000 is affirmed. For services on review, claimant is awarded a $1,800 attorney fee, payable by the self insured employer.

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[8] The employer argues, citing *Allie v. SAIF*, 79 Or App 284, 287 (1986), that because this claim involves expert analysis, as opposed to expert observation, that Dr. Flemming's opinion is not entitled to any special weight. We find Dr. Flemming's opinion to be the most complete and best reasoned opinion in this record. Accordingly, we find it the most persuasive absent any special weight.

[9] If we assume, as the employer argues, that this claim is an occupational disease claim and not an injury claim, claimant would have to prove that his work activities were the major contributing cause of his combined L5-S1 disc condition and a pathological worsening of the preexisting degenerative condition of the L5-S1 disc. ORS 656.802(2)(b). *See Richard E. Johnson*, 49 Van Natta 282 (1997). Based upon Dr. Flemming's reasoning, which we find persuasive, we would conclude that claimant's work activities, which tore the disc annulus sufficiently to allow the rupture of additional material leading to surgery, pathologically worsened the preexisting condition of the L5-S1 disc. Therefore, whether analyzed as an occupational disease or as an injury, we find the claim compensable.

In the Matter of the Compensation of
QUINA F. TUCKER, Claimant
WCB Case No. 99-08144
ORDER OF ABATEMENT
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

The SAIF Corporation requests that we abate and reconsider our July 5, 2000 Order on Review reversing the ALJ's order that upheld its denial of claimant's medical services claim for a cervical condition.

In order to consider this matter, we withdraw our July 5, 2000 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARSHA E. WESTENBERG, Claimant
WCB Case No. 00-00195
ORDER ON REVIEW
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Kekauoha's order that dismissed her request for hearing based on her failure to appear at hearing. On review, the issue is the propriety of the ALJ's dismissal order.

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

The ALJ dismissed claimant's hearing request pursuant to OAR 438-006-0071(2) when claimant failed appear at the scheduled time and place for hearing.[1] The ALJ observed that, by letter of March 28, 2000, claimant had expressed disagreement with his March 21, 2000 letter that denied her motion for an order compelling discovery and for an extension of time. Noting that claimant had concluded her March 28, 2000 letter by stating that she would not attend the scheduled hearing, the ALJ concluded that claimant had failed to appear based on her disagreement with his ruling on her motions. The ALJ found that this did not justify claimant's failure to appear, nor did it constitute "extraordinary circumstances" justifying postponement or a continuance. Accordingly, the ALJ dismissed the hearing request as having been abandoned.

On review, claimant has submitted a lengthy brief addressing substantive issues that could have been argued had she attended the hearing. Claimant, however, does not address the only issue on review, *i.e.*, whether the ALJ properly dismissed the hearing request pursuant to the above administrative rule. Under these circumstances, we conclude that claimant's failure to attend the scheduled hearing was unjustified. Moreover, we agree with the ALJ that "extraordinary circumstances" did not exist that would justify postponement or continuance of the hearing.

Accordingly, we find that the ALJ properly dismissed claimant's hearing request.[2] Therefore, we affirm.

ORDER

The ALJ's order dated March 31, 2000 is affirmed.

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[1] OAR 438-006-0071(2) provides:

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

[2] In making this finding, we emphasize that claimant should not expect to have her substantive arguments considered on review after having failed to attend a hearing scheduled at her request merely because she disagrees with the ALJ's preliminary rulings. To hold otherwise would be contrary to an orderly administrative process of resolving disputes within the workers' compensation system.

In the Matter of the Compensation of
LINDA K. O'HALLARAN, Claimant
WCB Case No. 99-06679
ORDER ON REVIEW
Donald M. Hooton, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration awarding claimant a penalty under *former* ORS 656.268(4)(g).[1] In her respondent's brief, claimant seeks sanctions under ORS 656.390 for an allegedly "frivolous" request for review and an attorney fee award under ORS 656.382(1) and (2). On review, the issues are penalties, attorney fees and sanctions.

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

Claimant fractured the upper humerus of her left arm on March 24, 1998. In April 1998, claimant was also diagnosed with reflex sympathetic dystrophy (RSD) of the left upper extremity, as well as a brachial plexus injury. (Exs. 8-2, 11-1). The insurer accepted the left humerus fracture on July 10, 1998, after which claimant began treating with Dr. Lorish.

On March 3, 1999, the insurer closed the claim by Notice of Closure that awarded 16 percent unscheduled permanent disability. (Ex. 36). The insurer based the unscheduled award entirely on permanent impairment, finding that claimant had returned to regular work. (Ex. 36-2). Claimant requested reconsideration of the closure notice, including as support for her reconsideration request an affidavit indicating that the employer had modified her job. (Ex. 39).

On April 1, 1999, Dr. Lorish agreed that claimant's diagnosed RSD and brachial plexus conditions were a "direct medical sequelae" of the left humerus fracture. (Ex. 38-2). On June 16, 1999, the insurer accepted the RSD and brachial plexus injury. (Ex. 44). The insurer also stated on June 23, 1999 that it would not object to the newly accepted conditions being part of the reconsideration process. (Ex. 46).

On July 26, 1999, an Order on Reconsideration issued that awarded claimant an additional 23 percent unscheduled permanent disability and 36 percent scheduled permanent disability for injury to the left arm. The reconsideration order also awarded a 25 percent penalty under *former* ORS 656.268(4)(g)[2] because claimant was found to be at least 20 percent disabled and the reconsideration order had increased the permanent disability award by at least 25 percent.[3] The insurer requested hearing contesting the penalty imposed by the Order on Reconsideration.

The ALJ affirmed the penalty. In so doing, the ALJ rejected the insurer's argument that the increased permanent disability award was based on "new information" and that, therefore, the penalty assessment was incorrect. The ALJ reasoned that the alleged "new information" regarding claimant's permanent disability was available to the insurer at claim closure.

On review, the insurer contends that, because the penalty imposed by *former* ORS 656.268(4)(g) only applies to a claim closed by an insurer or self-insured employer, the ALJ incorrectly assessed such a penalty because it did not close the claim with respect to the RSD and brachial plexus conditions, but

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[1] That statute has since been renumbered to ORS 656.268(5)(e).

[2] That statute provides:

[3] "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."

rather the Department did in its reconsideration order. Moreover, the insurer argues that claimant "waived" her right to a penalty by agreeing to have the RSD and brachial plexus injuries rated through the reconsideration order.

The insurer is correct that *former* ORS 656.268(4)(g) applies to a claim closed by a carrier. However, this fact does not change the result in this case because this claim was closed by the carrier on March 3, 1999. The insurer attempts to separate the RSD and brachial plexus portions of the claim from the originally accepted humerus fracture, asserting that the Department, not it, closed the claim with respect to the former conditions. The fact remains, however, that the RSD and brachial plexus injuries would have been rated as direct medical sequelae of the humerus fracture even in the absence of the insurer's "post-closure" acceptance and agreement to have the RSD and brachial plexus conditions rated during the reconsideration process. *See* ORS 656.268(14); (Ex. 46a). Thus, the disputed conditions were part and parcel of the insurer's initial claim closure and, thus, we conclude that *former* ORS 656.268(4)(g) applied to the claim.

We now turn to the insurer's argument that claimant "waived" her right to a penalty under that statute by agreeing to the rating of the "post-closure" accepted conditions during the reconsideration process. We do not find that argument persuasive because the record does not contain evidence that claimant intentionally relinquished her right to a penalty. *See Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 685 (1995) (waiver is "the intentional relinquishment of a known right"). In fact, the evidence is to the contrary. (Ex. 40-12).

The insurer also argues that the penalty should be eliminated because the increase in compensation in the reconsideration order resulted from "new information" obtained after claim closure. The insurer's contention is not persuasive.

First, the "post-closure" accepted conditions were diagnosed and in existence prior to the claim closure. (Exs. 8-2, 11-1). As such, those conditions cannot constitute "new information." Second, claimant unrebutted affidavit indicates that the employer had modified her job. The employer's knowledge of claimant's modified work may be imputed to the insurer and, therefore, claimant's performance of modified work cannot constitute "new information". *See Nix v. SAIF*, 80 Or App 656 (1986), *rev den* 303 Or 158 (1987) (employer's knowledge imputed to insurer). Third, the statute specifically states that "new information" must come from a medical arbiter or from the adoption of a temporary rule. The information that insurer alleges that is "new" does not come from either of those sources. The insurer does not contend otherwise.

Instead, the insurer urges us to examine legislative history to determine the policy behind the 1995 amendments to *former* ORS 656.268(4)(g). We decline to do so inasmuch as the statutory language is clear and unambiguous. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 611 (1993). Moreover, even if we considered the legislative history the insurer cites, it refers to "new information" as coming from a medical arbiter. Accordingly, even with consideration of legislative history, we would still conclude that the "new information" must come from a medical arbiter or from adoption of a temporary rule.

In summary, we conclude that the ALJ properly affirmed the Department's assessment of a 25 percent penalty under *former* ORS 656.268(4)(g). Therefore, we affirm.[4]

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[4] As previously noted, claimant requests sanctions under ORS 656.390 for the insurer's allegedly "frivolous" request for review. We decline to do so in light of the insurer's colorable arguments that the Department's assessment of a penalty was incorrect. In this regard, we note that there was no case precedent directly on point.

Finally, we reject claimant's request for an assessed fee under ORS 656.382(1) and (2). Claimant is not entitled to a fee under subsection (2) because that subsection is conditioned on an award of "compensation." Because a penalty assessment is not an award of "compensation," that subsection is not applicable. *See Nozario N. Solis*, 52 Van Natta 335 (2000) (citing *Saxton v. SAIF*, 80 Or App 631 (1986)). We also decline to award a fee under subsection (1). First, claimant did not raise the issue at hearing and so we are not inclined to address it. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991). Second, because the reconsideration order's penalty assessment does not constitute "compensation," there can be no unreasonable resistance to the payment of compensation, even assuming that the insurer has acted unreasonably.

ORDER

The ALJ's order dated January 5, 2000 is affirmed.

July 31, 2000 Cite as 52 Van Natta 1389 (2000)

In the Matter of the Compensation of
DEBORAH J. PROVOST, Claimant
WCB Case No. 99-04168
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denial of her occupational disease claim for bilateral upper extremity/thoracic outlet syndrome conditions. 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 occupational disease claim, concluding that claimant had failed to satisfy her burden of proof under ORS 656.802(2)(b).[1] Specifically, the ALJ determined that claimant had thoracic outlet syndrome that preexisted her employment as a dental hygienist and that the medical evidence did not establish that claimant's work activities pathologically worsened the preexisting thoracic outlet condition.

On review, claimant contends that the ALJ incorrectly applied the compensability requirements of ORS 656.802(2)(b) because the medical evidence does not establish that the thoracic outlet syndrome preexisted her 13-year employment as a dental hygienist. For the following reasons, we agree with the ALJ's determination that the thoracic outlet syndrome qualifies as a "preexisting condition." Moreover, we agree with the ALJ's finding that claimant failed to sustain her burden of proof under ORS 656.802(2)(b).

At the outset, we note that, to qualify as a preexisting condition, the thoracic outlet syndrome need not have been in existence prior to claimants employment. 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, whichever occurs first. *SAIF v. Cessnun*, 161 Or App 367, 371 (1999).

Here, several examining physicians (Drs. Green, Schilperoort, German and Williams) have opined that the thoracic outlet condition is congenital/developmental in nature. (Exs. 7-4, 12-16, 13-10). In fact, the attending physician, Dr. Young stated that claimant's "thoracic outlet condition is certainly congenital or developmental in its cause."[2] (Ex. 9B). Based on this evidence, we conclude that it is more probable than not that the thoracic outlet condition preceded the date of first treatment in the fall of 1998. Moreover, the preexisting thoracic outlet condition has received treatment from Dr. Young. Therefore, we conclude that it has contributed to claimant's need for treatment. Thus, we find that

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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."

[2] Claimant argues that Dr. Young's statement that the thoracic outlet condition was congenital does not establish that her thoracic outlet syndrome was preexisting. Having reviewed Dr. Young's opinion in its entirety (Ex. 9B), we are persuaded that Dr. Young was referring to claimant's thoracic outlet syndrome when he referred to the thoracic outlet condition as having been congenital or developmental in origin.

claimant's thoracic outlet syndrome constitutes a "preexisting condition" under *Cessnun*. Accordingly, we conclude that claimant's occupational disease claim is based on the worsening of a preexisting disease/condition and, therefore, she must prove that her employment conditions were the major contributing cause of her combined condition and a pathological worsening of the disease. *See* ORS 656.802(2)(b).

Having reviewed this record *de novo*, we conclude that the medical evidence does not establish a pathological worsening of the preexisting thoracic outlet syndrome. Dr. Young opined that claimant's work did not cause the thoracic outlet syndrome but aggravated it. (Ex. 12-1). We find that Dr. Young's opinion at most establishes that claimant's work caused symptoms of the preexisting condition, but did not pathologically worsen it.

For instance, after noting that claimant's condition had improved when she stopped using a certain cleaning device, Dr. Young stated that "this is really important evidence that the job is the major contributing factor to her *symptoms*." *Id.* (emphasis added). In the same report, Dr. Young stated: "Work repetitive stress causes her *symptoms*." (Ex. 12-3, emphasis added).

None of the examining physicians opined that claimant's employment was the major contributing cause of a pathological worsening of the thoracic outlet condition. On this record, we agree with the ALJ that claimant failed to prove a compensable occupational disease claim under ORS 656.802(2)(b). Therefore, we affirm.

ORDER

The ALJ's order dated January 26, 2000 is affirmed.

In the Matter of the Compensation of
PATRICK J. KENNEDY, Claimant
WCB Case No. 99-09988
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Randy Rice, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

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

Claimant, a 48 year-old plumber, injured his low back at work on August 7, 1999, while lifting a cast iron sink. (Ex. 4, Tr. 4). His back tightened up and remained tight. (Tr. 5). Claimant continued to work, but his back and right leg symptoms worsened throughout the month of August. On August 30, 1999, claimant felt the sudden onset of intense back pain after taking a bath. On August 31, 1999, claimant sought treatment with Dr. Bell, a chiropractor. Claimant also treated with Dr. Barr, Dr. Tennant, Dr. Syna, and Dr. Waldram. An MRI performed on September 28, 1999 revealed the presence of degenerative disc disease at L4-5 and L5-S1. (Ex. 9A).

On November 24, 1999, Dr. Woodward examined claimant at the request of the insurer. (Ex. 15). Dr. Woodward concluded that claimant did not have a current diagnosis but that any ongoing back pain was not related to his work activities. (*Id.*) Dr. Tennant concurred with Dr. Woodward. (Ex. 16).

On January 25, 2000, Dr. Bell stated that it was "a strong probability that [claimant's] injury was due to a lifting incident at work." (Ex. 19). On January 26, 2000, Dr. Syna opined that the major contributing cause of claimant's current need for treatment and/or disability was his industrial injury. (Ex. 20). Dr. Waldram essentially deferred to Dr. Syna, but noted his opinion that claimant's L3 radiculopathy was not related to his foraminal narrowing at L4-5 and L5-S1. (Ex. 21).

The ALJ set aside the insurer's denial based on the opinions of treating physicians Drs. Syna, Bell and Waldram. On review, the insurer first contends that claimant did not sustain a "compensable injury" because the August 7, 1999 on-the-job lifting incident did not cause him to seek treatment (until the August 30, 1999 incident after taking a bath). We disagree.

ORS 656.005(7)(a) defines a "compensable injury" as an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death * * *" Claimant sought medical treatment for his low back on August 31, 1999 with Dr. Bell. (Ex. 1). Dr. Bell, along with Dr. Syna, attributed claimant's back injury and resultant medical treatment to his August 7, 1999 lifting incident at work. (Exs. 19, 20). In view of such evidence, we find that claimants August 7, 1999 on-the-job injury "required medical services" consistent with ORS 656.005(7)(a).

The insurer next contends that the ALJ improperly applied a material contributing cause standard, as opposed to the major contributing cause standard, in light of claimant's "preexisting condition" in his low back. We agree with the ALJ that the more persuasive medical evidence indicates that claimant has no preexisting condition that combined with his August 7, 1999 work injury.

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." We cannot infer that an injury has "combined with" a preexisting condition in the absence of a medical opinion to that effect. *See Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Michael D. Riordan*, 50 Van Natta 2375 (1998).

Here, there is no medical evidence that claimant's preexisting degenerative disk disease "combined with" his August 7, 1999 work injury to cause his disability or need for treatment. On the contrary, Dr. Waldram specifically noted that claimant's bilateral foraminal narrowing at L4-5 and L5-S1 was "probably not the explanation" for claimant's L3 radiculopathy condition. (Ex. 21). Consequently, we conclude that the ALJ properly analyzed the case under the "material contributing cause" standard. ORS 656.005(7)(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 $1,500, 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 April 7, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

August 1, 2000 Cite as 52 Van Natta 1391 (2000)

In the Matter of the Compensation of
JOSEPH A. FAIRCHILD, Claimant
WCB Case No. C001712
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Malagon, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On July 17, 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 disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker, insurer or self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on July 17, 2000. The statutory 30th day following the submission is August 16, 2000. Claimant filed his request for disapproval of the disposition on July 25, 2000. Accordingly, we disapprove the disposition. *Id.*

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(5)(k).

IT IS SO ORDERED.

In the Matter of the Compensation of
CURTIS J. MACK, Claimant
WCB Case No. 99-09486
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the insurer's denial of his claim for a left knee injury. On review, the issue is compensability.

We adopt and affirm the order of the ALJ.

ORDER

The ALJ's order dated March 27, 2000 is affirmed.

Board Member Phillips Polich dissenting.

Here, the ALJ found that claimant's knee injury, which occurred while he was playing basketball at work, was not compensable because there was an insufficient connection between work and the basketball activity. In reaching her conclusion, the ALJ relied on the Board's decision in *Michael W. Hardenbrook*, 48 Van Natta 529 (1992). For the following reasons, I dissent from the majority's opinion, as I believe that the facts of this case are distinguishable from *Hardenbrook*.

In *Hardenbrook*, the employer initiated the opportunity for the basketball games on breaks and lunch periods in order to increase productivity and raise employee morale. The claimant's supervisor participated and sometimes encouraged others to play. The claimant testified, however, that he was not required to play but that he did so because he enjoyed the game and found that it relieved the stress and tension of work. *(Id).*

The Board concluded in *Hardenbrook* that the benefit to the employer - improved morale and energy - was incidental when viewed along with the other circumstances of the case. Rather, the Board found that the claimant was engaged in activities primarily for his personal pleasure. Consequently, because there was an insufficient work connection between the injury and the claimant's employment, the Board held that the injury did not arise out of and the in the course of the claimant's employment. *(Id).*

In the present case, however, claimant and his coworkers are firefighters. The employer testified that the firefighters were hired based on certain physical standards and were tested on those standards each year. (Tr. 51). The employer further testified that it had a wellness program at work that required 15 minutes of physical exercise each day. (Tr. 52). Firefighters were permitted to go on walks to satisfy this requirement, but there were times when fire danger was high and the employees were restricted to the compound. (Tr. 52).

Here, as the ALJ noted, the workers were not required to play basketball, but the employer did permit games to be played during regular work hours. Claimant testified that the games were played to keep the workers in shape, to keep up morale, and to break up the monotony of the day. (Tr. 15, 16).

In light of the fact that claimant is a firefighter and the employer requires its employees to participate in a wellness program, I would find that this case is distinguishable from *Hardenbrook*. Here, the record shows that basketball was primarily played to relieve the stress and tension of being confined to the employer's compound during fire season. Consequently, I would conclude that he facts of this case are distinguishable from *Hardenbrook*, in which the claimant was playing basketball primarily for pleasure. Furthermore, I would find a sufficient connection between the basketball activity and claimant's work as a firefighter, which required him to maintain physical fitness while being confined to a compound. Finally, I believe that, because claimant and his coworkers were confined to the compound because of the employer's constraints, relieving stress and tension and building morale is a considerable benefit to the employer. Under such circumstances, I would find that claimant's injury arose out of and in the course of his employment. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363 (1994). Consequently, I dissent from the majority's opinion.

In the Matter of the Compensation of
JOE M. MANN, Claimant
WCB Case No. 98-06650
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Gilroy Law Firm, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the self-insured employer's denials of his right intracerebral hematoma and major depression conditions; and (2) awarded an assessed fee of $7,000.[1] On review, the issues are compensability and attorney fees.

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

ORDER

The ALJ's order dated February 17, 2000 is affirmed.

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[1] Claimant also argues on review that the employer's acceptance of a closed head injury did not reasonably apprise claimant and his medical providers that a "post-concussion syndrome" was encompassed within that acceptance. *See* ORS 262(7)(a). The ALJ, however, resolved that issue in claimant's favor, ordering the employer to specifically accept the "post-concussion syndrome." The employer does not contest that portion of the ALJ's order. Under these circumstances, we do not consider the issue on review.

[2] The ALJ noted that claimant had conceded in closing argument that his claim for the hematoma condition was not compensable. (O&O p. 2). On review, claimant admits that there is no medical evidence in support of his belief that the intracerebral hematoma may have been caused by his compensable injury. In light of claimant's concessions, we conclude that the ALJ properly upheld the employer's denial of this condition.

In the Matter of the Compensation of
RODNEY SULLIVAN, Claimant
Own Motion No. 0269M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's January 26, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from February 19, 1999 through January 7, 2000. SAIF declared claimant medically stationary as of December 22, 1999. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Having received the parties' submissions and respective positions, we proceed with our review.

FINDINGS OF FACT

On June 11, 1996, we issued our Own Motion Order on Reconsideration which authorized the payment of temporary disability compensation beginning the date claimant underwent surgery to correct the varus deformity (lateral wedge osteotomy through triple arthrodesis) with the intent to "unload" the medial compartment of the left knee.

On October 27, 1998, Dr. Ebner, one of claimant's treating physicians, referred claimant to Dr. Woll. Dr. Ebner requested Dr. Wolls opinion regarding problems claimant was having with his left knee and ankle. Although believing that claimant required a high tibial osteotomy or even a debridement procedure for his knee, Dr. Ebner was concerned regarding the effect claimant's misaligned foot would have on his knee. Before proceeding with claimant's knee surgery, Dr. Ebner required Dr. Woll's input regarding treatment for claimant's left foot. After examining claimant, Dr. Woll recommended that claimant undergo a midfoot osteotomy and calcaneal osteotomy to help correct his malunited triple arthrodesis and foot misalignment.

While treating with Dr. Woll for his foot problems, Dr. Woll referred claimant to Dr. Colville for evaluation of his left knee complaints. Dr. Colville opined that, although claimant's options were limited regarding modalities of treatment to relieve his pain and increase his activity and function, arthroscopic debridement might improve his "quality of life." He recommended that claimant finish his treatment for his left foot with Dr. Woll and once he was healed and stationary from that treatment, arthroscopic debridement of the left knee would be considered.

On July 1, 1999, Dr. Neuberg, claimant's attending physician, examined claimant. Dr. Neuberg noted that claimant did not wish to consider surgery on his knee at that time. She recommended that claimant brace his knee and that his workers' compensation claim be closed before considering surgical intervention.[1]

On December 22, 1999, Dr. Woll declared claimant medically stationary as to his foot condition. He stated that claimant did require an orthotic for his foot, but did not anticipate any further surgery. Dr. Woll did not anticipate any further improvement of claimant's foot condition. Additionally, Dr. Woll unequivocally stated that he was not caring for claimant's knee.

In a January 3, 2000 chart note, Dr. Neuberg noted that claimant was seen by Dr. Ayers in regard to his knee problems. She noted that they discussed various treatment options and that claimant was now opting for debridement. On January 20, 2000, Dr. Neuberg concurred with Dr. Woll's December 22, 1999 report.

SAIF closed claimant's claim on January 26, 2000, declaring him medically stationary as of December 22, 1999. Claimant requested review of SAIF's closure on February 7, 2000.

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[1] Since claimant was actively treating for his foot problems, we interpret Dr. Neuberg's reference to closing the workers' compensation claim within the same context of Dr. Colville's recommendation that treatment for claimant's knee be put on hold until his foot problems resolved.

In response to an inquiry from SAIF, on February 11, 2000, Dr. Neuberg concurred that claimant had received a knee brace in January 2000 and recommended referral for an insurer-arranged medical examination (IME) to determine what type of treatment and/or surgery claimant should receive for his knee.

In a March 3, 2000 doctors report to SAIF, Dr. Woll clarified that he had simply declared claimant's left foot medically stationary. He reiterated that he had not evaluated claimant for any left knee complaints.

On March 14, 2000, claimant attended the IME which Dr. Neuberg had recommended. Dr. James, the IME physician, noted Dr. Ayres' December 21, 1999 chart note opining that the best surgical option would be a high tibial osteotomy. After review of the medical record and an examination of claimant, Dr. James concluded that nothing necessarily needed to be done with regard to claimant's left knee. However, if something should be done, Dr. James noted that: (a) claimants best option is to lose weight; (b) injections would reduce symptomatology and are palliative; (c) the possibility of another arthroscopic debridement should not be excluded this would allow the operator to assess the knee joint and would supply added information regarding the potential effectiveness of a high tibial osteotomy; (d) the next step would be to have a valgus producing high tibial osteotomy which is claimants best chance for significant pain reduction; and (e) the last choice would be a total knee replacement. On March 24, 2000, Dr. Neuberg concurred with Dr. James' IME report.

Claimant returned to Dr. Colville on July 11, 2000. Dr. Colville reported that following his recovery from his foot surgery, claimant was examined by Dr. James who recommended consideration of a proximal tibial osteotomy or further conservative care. Dr. Colville concurred with Dr. James that a valgus osteotomy would be helpful for claimant. He recommended that claimant undergo a opening wedge osteotomy as well as an arthroscopic debridement.

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 January 26, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

In support of its closure, SAIF relies on the December 22, 1999 medical report from Dr. Woll and Dr. Neuberg's January 20, 2000 medical report. SAIF contends that at the time it closed claimant's claim, surgery for his left knee had not been recommended. However, on Dr. Neuberg's recommendation and subsequent to the January 26, 2000 claim closure, claimant underwent an IME examination with Dr. James on March 14, 2000. In his report, Dr. James offers several different treatment modalities, one of which is the surgery recommended by Dr. Ebner in October 1998 and endorsed by Dr. Colville in April of 1999.

Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Here, Dr. James has opined that claimant would benefit from a surgery that was first recommended in 1998. That surgery has been recommended by Drs. Colville and Ebner and has been subsequently endorsed by Dr. James and Dr. Neuberg. Further, Dr. James does not indicate that anything has worsened claimant's condition since January 26, 2000. Inasmuch as the record does not suggest that claimant's condition changed between the January 2000 claim closure and Dr. James' March 2000 report, we conclude that Dr. James' March 2000 opinion addresses claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622.

Dr. Colville's opinion that claimant is in need of a tibial osteotomy and arthroscopic debridement has not changed since he first concurred with Dr. Ebner's recommendation in April 1999. Based on the opinions expressed by Drs. Colville, James and Neuberg, we are persuaded that claimant's compensable condition would materially improve with the recommended surgery.

Under such circumstances, we conclude that claimant's condition was not medically stationary on January 26, 2000 when his claim was closed by SAIF. Accordingly, we set aside the Notice of Closure as premature and remand the claim to SAIF for further processing in accordance with law. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
AURELIO ACEVEDO, Claimant
WCB Case No. 99-09280
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that determined that his left thumb injury claim should be classified as "nondisabling." On review, the issue is claim classification.

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

A "disabling compensable injury" entitles the worker to compensation for disability or death, whereas an injury is not disabling if no temporary disability benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury. ORS 656.005(7)(c). Here, claimant's claim is disabling only if there is proof of a reasonable expectation of permanent disability. In construing ORS 656.005(7)(c) and determining whether a compensable injury is disabling, we require expert medical opinion indicating that a permanent disability award is likely or expected. *See, e.g., Thomas G. Dobson*, 50 Van Natta 2390, 2391, *on recon* 51 Van Natta 297 (1999); *Gerasimos Tsirimiagos*, 50 Van Natta 1627 (1998).

Claimant's attending physician, Dr. Stringham, provided the only evidence concerning the expectation of permanent disability for the compensable left thumb injury. Dr. Stringham opined that there was no reduced range of motion, no loss of sensation and no motor loss in the left thumb. Moreover, Dr. Stringham released claimant to the job at injury without restrictions. Dr. Stringham did opine, however, that claimant had "reduced repetitive use of the left thumb by virtue of the injury." (Ex. 16-3).

Having reviewed Dr. Stringham's report, we are not persuaded that it establishes a reasonable expectation of permanent disability. Dr. Stringham did not state that claimant's left thumb condition resulted in permanent disability. Nor did Dr. Stringham indicate permanent disability was reasonably expected. In fact, in light of Dr. Stringham's comments regarding range of motion, sensation, motor function and work restrictions, the preponderance of evidence is that no permanent disability exists or is likely to result from the compensable injury.[1]

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[1] In this regard, we note that the disability "standards" do not allow a "chronic condition" award for the thumb. *See* OAR 436-035-0010(5). Because Dr. Stringham's report does not indicate that repetitive use of the left hand (a body part for which a "chronic condition" award is allowed) is affected by claimant's left thumb injury, we are not persuaded that reduced repetitive use of the left thumb could lead to a permanent disability award under the standards. *See SAIF v. Schiller*, 151 Or App 58, 63 (1997), *rev den* 326 Or 389 (1998) (the Board properly interpreted ORS 656.005(7)(c) to require proof of a current condition that could lead to a ratable impairment under the DCBS's impairment standards, not proof of a condition presently ratable under the standards, in order to reclassify a claim from nondisabling to disabling).

Accordingly, we agree with the ALJ's determination that the claim is "nondisabling."[2] Thus, we affirm.[3]

ORDER

The ALJ's order dated March 11, 2000 is affirmed.

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[2] The ALJ expressed some concerns about which party had the burden of proof, inasmuch as the insurer requested the hearing from an Order on Reconsideration that affirmed a Determination Order finding the claim to be "disabling." *See Lester B. Lewis*, 51 Van Natta 778 (1999). We need not decide, however, which party has the burden of proof. That is, regardless of which party has the burden of proof, we conclude that this record establishes that the proper classification of the claim is "nondisabling."

[3] We do not disagree with the dissent's position that, for a claim to be "disabling," it is not necessary for claimant to have impairment that is currently ratable. We do, however, disagree with the dissent's conclusion that there is a *reasonable likelihood* of permanent disability. That is, viewing Dr. Stringham's opinion as a whole, we do not believe that it establishes a reasonable likelihood that claimant's left thumb conditon could lead to ratable impairment under the Department's impairment standards. This is the appropriate legal standard under *Schiller* and the medical evidence in this case, in our opinion, does not satisfy it.

Board Member Phillips Polich dissenting.

The majority agrees with the ALJ's determination that this claim should be classified as "nondisabling," finding that Dr. Stringham's report does not establish a reasonable expectation of permanent disability. Because I would reach the opposite conclusion, I part company and dissent.

In *SAIF v. Schiller*, 151 Or App 58 (1997), *rev den* 326 Or 389 (1998), the court affirmed the Board's disabling classification finding. In so doing, the court relied on the uncontradicted and credible medical evidence that indicated the claimant's hip strain was reasonably expected to result in permanent disability, as well as the fact that a loss of internal rotation of the hip was a condition recognized by the disability standards. The court explained that the "reasonable expectation" provision of ORS 656.005(7)(c) requires an evidentiary link between the actual, current condition and a potential, statutorily defined condition. The evidentiary burden, according to the *Schiller* court, does not require evidence of a specific and actual impairment as defined by statute or rule, because, under the "reasonable expectation" provision, which concerns an event that has not yet occurred, that kind of proof does not yet exist. The court then held that we properly interpreted ORS 656.005(7)(c) to require proof of a current condition that could lead to a ratable impairment under the Department's impairment standards, not proof of a condition presently ratable under the standards, in order to reclassify a claim from nondisabling to disabling. 151 Or App at 63.

Although the majority cites *Schiller*, in actuality it does not follow that decision. Instead, it concludes that Dr. Stringham's opinion that claimant has a limitation of repetitive use of the thumb does not qualify claimant for a "chronic condition" award under OAR 436-035-0010(5). However, as the *Schiller* court makes clear, evidence of a specific and actual impairment as defined by statute or rule is not required because the "reasonable expectation" provision concerns an event that has not yet occurred. Just because there is no administrative rule that currently allows permanent disability for loss of repetitive use of the thumb does not mean that the claim is necessarily "nondisabling." Indeed, claimant is free to request a special rule to address permanent impairment not addressed by the standards. *See* ORS 656.726(3)(f)(C). Thus, the lack of an administrative rule that currently allows permanent impairment for claimant's "chronic condition" does not foreclose the possibility of future permanent impairment under the standards.[1] In my opinion, we cannot tell from this record whether claimant's permanent impairment is ratable because the record is not yet sufficiently developed with respect to that issue.

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[1] I note the majority states that, for a compensable injury to be "disabling," there must be expert medical opinion indicating that a permanent disability "award" is likely or expected. However, neither ORS 656.005(7)(c) nor the *Schiller* court uses the term "award." Thus, the majority appears to have added a requirement to the statute that does not exist within the statute itself or in applicable case law.

Accordingly, I would conclude, based on Dr. Stringham's report, that claimant may have ratable impairment, even though it may not be currently ratable. Because this is all ORS 656.005(7)(c) requires for a claim to be classified as "disabling," I would find that this record establishes a reasonable likelihood of permanent disability. Therefore, I would hold that this claim should be classified as "disabling." Because the majority concludes otherwise, I dissent.

August 2, 2000 Cite as 52 Van Natta 1398 (2000)

In the Matter of the Compensation of
MARY L. BAKER, Claimant
WCB Case No. 99-08899
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crummé's order that awarded claimant's attorney an assessed attorney fee of $2,000. On review, the issue is attorney fees.

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

Claimant filed a workers' compensation claim for a May 22, 1999 work injury. The insurer did not accept or deny the claim within 90 days and claimant requested a hearing on a "de facto" denial. The insurer filed a response to issues that denied that it had "de facto" denied the claim and also denied that "a condition has been incorrectly omitted (scope of acceptance)." (Ex. 20B). Prior to the hearing, the insurer issued a Notice of Acceptance that accepted claimant's claim for "right shoulder and right knee contusions."

The ALJ found that claimant's attorney was entitled to an attorney fee under ORS 656.386(1)(a) for obtaining a rescission of a "denied claim." The ALJ noted that the insurer's Response to Issues was confusing since it in part denied that a condition had been incorrectly omitted from an acceptance, but no acceptance had ever been issued by the insurer in the claim. The ALJ reasoned: " * * * the most reasonable interpretation of the Response to Issues is that insurer was expressly denying that claimant's claim was compensable. Since insurer had accepted nothing, its denial that a condition had been incorrectly omitted was tantamount to a denial that insurer need accept any condition. Such a denial is, for all intents and purposes, a denial that the claim is compensable." (O & O at 3). On the basis of this reasoning, the ALJ awarded claimant's attorney a $2,000 assessed attorney fee under ORS 656.386(1)(a) for obtaining a rescission of a "denied claim."

On Board review, the insurer argues that claimant's attorney is not entitled to an attorney fee under ORS 656.386(1)(a) because there is no "denied claim." In support of its argument, the insurer cites *Jennifer Pfeiffer*, 52 Van Natta 903 (2000).

In *Pfeiffer*, we found that there was no "denied claim" under ORS 656.386(1)(a) where the insurer's "Response to Issues" denied only that the claimant was entitled to an attorney fee for the reason that "no denial exists."

For purposes of ORS 656.386(1)(a), 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).

We agree with the ALJ that the insurer's "Response to Issues" in this case constitutes a "denied claim." In this regard, by denying that any condition was omitted from a nonexistent Notice of Acceptance, the insurer was, in effect, indicating that claimant's claim did not give rise to an entitlement to compensation. Under such circumstances, there is a "denied claim" warranting an attorney fee. In reaching this conclusion, we find the *Pfeiffer* case to be distinguishable. In *Pfeiffer*, the insurer indicated that "no denial exists" in its Response to Issues. Here, the insurer, as noted above, denied that it had

"de facto" denied the claim and also denied that "a condition has been incorrectly omitted (scope of acceptance)." We find *Pfeiffer* factually distinguishable from the present case, because *Pfeiffer* did not pertain to a denial that a condition had been incorrectly omitted from an acceptance (when no acceptance had ever been issued). Accordingly, we agree with the ALJ that this case involves a "denied claim" that warrants an attorney fee under ORS 656.386(1)(a).

The insurer next argues on review that if there is a "denied claim," the ALJ's award of a $2,000 attorney fee for obtaining rescission of the denial is excessive. We disagree.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-010(4). Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

Claimant's attorney submitted a statement of services to the ALJ indicating that he spent 10 hours on the case. The insurer argues that some of the time was spent on written argument and research regarding the attorney fee issue. Even assuming that only a portion of claimant's attorney's time was spent on the compensability issue prior to the rescission of the denied claim, we find, based on the factors in OAR 438-015-0010(4), that the $2,000 fee awarded by the ALJ was reasonable.

In this regard, in addition to the time factor, the value of the interest and the benefits secured in this case are substantial; *i.e.*, compensability of the claim was established and claimant will now be entitled to medical and other benefits for the claim. In addition, the attorneys involved in the case are skilled and have substantial experience in the area of workers' compensation law. No frivolous issues or defenses were raised. Prior to rescission of the denial, there was at least some risk that claimant's counsel's efforts would go uncompensated.

After considering these factors, in particular, the benefit secured and the value of the interest, we find, based on the factors in OAR 438-015-0010(4) that $2,000 was a reasonable fee for claimant's counsel's services rendered prior to the insurer's rescission of the denied claim.

Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated April 19, 2000 is affirmed.

In the Matter of the Compensation of
BILL OWENS, Claimant
Own Motion No. 00-0222M
OWN MOTION ORDER ON RECONSIDERATION
Daniel Spencer, Claimant Attorney

Claimant seeks Board authorization of an approved fee for attorney's services culminating in our 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 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our 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
GAYLE L. FITZGERALD, Claimant
WCB Case No. 99-09256
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that increased claimant's scheduled permanent disability award for loss of use or function of the right leg (hip) from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to 10 percent (15 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

OAR 436-035-0010(5)(b) provides that a claimant is entitled to a 5 percent scheduled chronic condition impairment value for loss of use or function of the right hip if the preponderance of the medical opinion establishes that, due to a chronic and permanent condition, the claimant is significantly limited in the repetitive use of the right leg (hip).

The ALJ, relying on claimant's lifting limitations for work, as imposed by Dr. Hill, the treating physician, and on claimant's slow healing rate with significant tenderness over the ASIS, right pubic symphysis, right iliopsoas, right hip adductors and greater trochanter, concluded that claimant had established her entitlement to an award for chronic condition impairment.[1] SAIF argues that Dr. Hill's work restrictions, standing alone, are insufficient to establish claimant's entitlement to an award for chronic condition impairment. We agree with SAIF.

OAR 436-035-0007(14) provides that: "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." Here, the medical arbiter report of Dr. Courogen, specifically states: "There are no limitations on repetitive use of the right hip due to the accepted condition." (Ex. 9-2). Because Dr. Hill reports the need for claimant's work restrictions in conjunction with a waxing and waning of symptoms and the possibility of future palliative care, we are unable to determine whether the restrictions reflect his opinion on claimant's ability to repetitively use her right hip, as distinguished from his recommendations to limit use to prevent increased pain or reinjury. *See Maria E. Jimenez-Menera*, 48 Van Natta 2139 (1996).

Consequently, we conclude that the preponderance of medical opinion does not establish a different level of impairment for a chronic condition of claimants right hip than that established by the medical arbiter. Accordingly, claimant is not entitled to an impairment value of 5 percent for a chronic condition. Based on claimant's undisputed loss of right hip range of motion findings, we reinstate and affirm the Order on Reconsideration that awarded claimant 5 percent (7.5 degrees) for loss of use or function of the right leg (hip).

ORDER

The ALJ's order dated April 26, 2000 is modified. In lieu of the ALJ's scheduled permanent disability and "out-of-compensation" attorney fee awards, the November 12, 1999 Order on Reconsideration award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg (hip) is reinstated and affirmed.

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[1] Specifically, Dr. Hill's restrictions were: "Maximum lift of twenty-five pounds; only occasional lift greater than fifteen pounds; bending limited to an occasional basis." (Ex. 6-2).

In the Matter of the Compensation of
DAROLD PERRY, Claimant
WCB Case No. 00-00444
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant's attorney requests review of Administrative Law Judge (ALJ) Nichols' order that denied his request for enforcement of the April 22, 1998 Order on Review concerning an attorney fee.[1] With his reply brief, claimant's attorney has attached two documents not presented at hearing. We treat these documents as a motion for remand for presentation of additional evidence. The SAIF Corporation moves to strike portions of claimant's attorney's reply brief that rely on evidence not in the record and it opposes any motion to remand. On review, the issues are remand, motion to strike, and attorney fees. We deny the motion for remand, grant SAIF's motion to strike in part, and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and repeat them for ease of reference.

Claimant has an accepted claim with SAIF for a 1993 injury. (Ex. 3). In 1997, claimant was involved in litigation to determine whether SAIF, under that claim, or Liberty Northwest Insurance Corporation (Liberty), under a "new injury" claim, should be responsible for claimant's ongoing cervical and low back complaints. After a June 12, 1997 hearing, Liberty was found to be the responsible party. (Ex. 3A). Liberty requested review and the Board reversed, finding SAIF responsible for the "new injury" claim. (Ex. 4). The Board's April 22, 1998 order provided, in part:

> "In lieu of the ALJ's $1,000 assessed fee against Liberty, SAIF shall pay claimant a $1,000 assessed fee for prevailing over its responsibility denial. In addition, claimant's counsel is awarded $1,000 for services related to the compensability dispute, payable by SAIF." (Ex. 4-5).

SAIF appealed the Board's order to the Court of Appeals, but the appeal was subsequently withdrawn and the Board's April 22, 1998 order became final. (Ex. 5).

On December 28, 1999, claimant's attorney wrote to SAIF, seeking payment of the attorney fee that had been awarded by the Boards order. (Ex. 6). On January 4, 2000, SAIF issued a $1,000 check to claimant that was identified as a penalty and a $1,000 check to claimant's attorney. (Exs. 6A, 7).

CONCLUSIONS OF LAW AND OPINION

Motion to Strike / Remand

Our review is limited to the record developed at hearing. ORS 656.295(5). Claimant's attorney, nevertheless, has submitted copies of documents not admitted into evidence with his reply brief. We treat this submission as a motion for remand to the ALJ for further development of the hearings record. *See Judy A. Britton*, 37 Van Natta 1262 (1985). We consider the post-hearing submission for the purpose of determining whether remand is appropriate.

We may remand to the ALJ if we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

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[1] A claimant's attorney has standing to request review on an attorney fee issue. *Mohammad Zarifi*, 42 Van Natta 670 (1990) (citing *Amfac, Inc. v. Garcia-Maciel*, 98 Or App 88 (1989)).

Here, claimant's attorney has included a copy of two recipes, as well as his retainer agreement with claimant. We address each item separately. There is no showing that the copy of the recipes was unobtainable with due diligence at the time of the hearing and that document is not relevant, nor is it reasonably likely to affect the outcome of this case. We deny claimant's attorney's motion to remand concerning the recipes and we grant SAIF's motion to strike that document.

OAR 438-015-0010(1) provides that attorney fees for an attorney representing a claimant "shall be authorized only if an executed retainer agreement has been filed with the Administrative Law Judge *or* Board." (Emphasis supplied). On review, claimant's attorney has filed a retainer agreement with the Board. The retainer agreement was signed by claimant on September 23, 1994. Because OAR 438-015-0010(1) provides that a retainer agreement may be filed with the Board, it is not necessary to remand to the ALJ for consideration of the retainer agreement. We deny SAIF's motion to strike the retainer agreement.

Attorney Fees

Claimant's attorney requested a hearing concerning SAIF's alleged failure to pay an attorney fee pursuant to the April 22, 1998 Order on Review. The ALJ found no case law regarding misdirected assessed attorney fees paid to a claimant. However, the ALJ referred to previous Board cases regarding misdirected approved attorney fees and found them instructive.[2] The ALJ reasoned that claimant did not seek clarification of that portion of the Order on Review that granted claimant an attorney fee. The ALJ noted that claimant's attorney had written to SAIF after the Order on Review had become final, requesting payment of the attorney fee, not attorney "fees." (Ex. 6). The ALJ concluded that claimant's attorney was not without some responsibility for the misdirected fee and, therefore, it would be inappropriate to require SAIF to pay that fee for a second time.

Claimant's attorney argues, among other things, that SAIF has not complied with the April 22, 1998 order because it has not paid an "assessed fee" concerning the responsibility denial. The Board's April 22, 1998 order provided, in part: "In lieu of the ALJ's $1,000 assessed fee against Liberty, SAIF shall pay claimant a $1,000 *assessed fee* for prevailing over its responsibility denial." (Ex. 4-5; emphasis supplied).

On the other hand, SAIF contends that it strictly complied with the Boards order and claimant did not take all reasonable precautions to secure the fee. SAIF asserts that it is "inequitable" for it to make an additional payment to claimant's attorney.

Although the language in the Board's order was incorrect, we do not agree that SAIF "strictly complied" with the Board's April 22, 1998 order. SAIF paid claimant $1,000 for a *penalty* payment (Exs. 6A, 7), despite the fact that the Board had not assessed a penalty. Moreover, the April 22, 1998 order directed SAIF to pay claimant "a $1,000 *assessed fee* for prevailing over its responsibility denial." (Ex. 4-5; emphasis supplied). OAR 438-015-0005(2) defines an "assessed fee" as "an attorney fee *paid to a claimant's attorney* by an insurer or self-insured employer in addition to compensation paid to a claimant." (Emphasis supplied).

At a minimum, the Board's April 22, 1998 order was ambiguous, in that it directed SAIF to pay an "assessed" fee to claimant, which, by definition, must be paid to a claimant's *attorney*. We do not agree that, by making a $1,000 "penalty" payment to claimant, SAIF "strictly" complied with the April 22, 1998 order. SAIF failed to seek clarification of the April 22, 1998 Order on Review and, therefore, SAIF was not without some responsibility for the misdirected fee. Under these circumstances, we do not agree with SAIF that it is inequitable to require SAIF to make an additional payment to claimant's attorney. 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).

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[2] The ALJ found that those cases generally involved a situation in which the insurer paid the entire compensation to the claimant and did not withhold a separate portion for an attorney fee payment directly to the claimant's attorney. The ALJ noted that the Board had addressed such situations in two ways. In those cases in which the claimant's attorney had taken all reasonable precautions to secure payment of the attorney fee, the carrier was ordered to pay the fee to the claimant's attorney. *See, e. g., Ana J. Calles*, 46 Van Natta 2195 (1994). In *Kenneth V. Hambrick*, 43 Van Natta 1636 (1991), however, the ALJ had not ordered payment of an out-of-compensation fee and the claimant failed to timely request correction of the error. Under those circumstances, the carrier was not required to pay an additional fee.

ORDER

The ALJ's order dated April 19, 2000 is reversed. SAIF is directed to pay claimant's attorney a $1,000 assessed fee for services related to prevailing over its 1997 responsibility denials.

In the Matter of the Compensation of
BUDDY S. CARLOW, Claimant
Own Motion No. 99-0055M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's June 5, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from October 22, 1999 through March 17, 2000.[1] SAIF declared claimant medically stationary as of May 17, 2000.

In his request for review, claimant contends that he has suffered a disability, and that closure on this claim is unfair. We interpret such a statement as a contention that claimant was not medically stationary at claim closure.

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

The propriety of the closure turns on whether claimant was medically stationary at the time of the June 5, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a July 7, 2000 letter, 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. Having received that parties' submissions, we proceed with our review.

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

Here, claimant requested review because he still suffers from pain and swelling. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

In a May 17, 2000 doctor's report, Dr. Lantz, claimant's attending physician, opined that claimant was medically stationary. Dr. Lantz noted that claimant had full extension and very good stability to his anterior cruciate ligament. He noted that claimant had a small effusion present, but no varus or valgus instability. Dr. Lantz noted that claimant would have to be careful on uneven or unstable ground, and advised that he may wear a brace when needed. However, Dr. Lantz also noted

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[1] Claimant's March 13, 1984 claim was accepted as a nondisabling claim. This, claimants aggravation rights expired on March 13, 1989. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in December 1998, claimant's claim was under our own motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on February 17, 1999, we issued our own motion order authorizing the payment of temporary disability compensation and noted that when claimant was medically stationary, SAIF should close the claim pursuant to OAR 438-012-0055.

that claimant continues his regular work as a truck driver. This opinion is unrebutted. Thus, even if claimant was contesting his medically stationary date, based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed and that he is not entitled to additional temporary disability.

Claimant also contends that he was told that the surgery he underwent in 1998 would solve his pain. However, he has continued pain and swelling. He notes that he has incurred a limp. Claimant requests a partial disibility [sic] and keeping his claim open during my lifetime of employment. We interpret claimant's request for partial disability as a request for other workers' compensation benefits (permanent disability). We are without authority to award further permanent disability in this claim. Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990). As noted in footnote 1, claimants aggravation rights expired in 1989. Thus, he is not statutorily entitled to a permanent disability award under this reopening of his own motion claim.[2]

In conclusion, based on the uncontroverted medical evidence (*i.e.* the opinion of his attending physician), we find that claimant was medically stationary on the date his claim was closed. Therefore, SAIF's closure was proper.

Accordingly, we affirm SAIF's June 5, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] It appears from claimant's request that his claim remain open during my lifetime of employment, 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 97301
Telephone: 1-800-927-1271

In the Matter of the Compensation of
JUDITH L. CHRASTIL, Claimant
WCB Case No. 99-05329
ORDER ON REVIEW
Mark D. Sherman, Claimant Attorney
Julie Master (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

We adopt and affirm the ALJ's order with the following supplementation to address claimant's argument that SAIF denied only the occurrence of the May 27, 1999 injury. SAIF's denial that claimant's injury did not occur in the course and scope of employment does not prohibit it from defending on the basis of medical causation. *See, e.g., Vernon L. Minor*, 52 Van Natta 320 (2000). Furthermore, we agree with the ALJ that the medical evidence here was not sufficient to carry claimant's burden of proof because it was not based on a complete and accurate history.

ORDER

The ALJ's February 22, 2000 order is affirmed.

In the Matter of the Compensation of
GLEN A. CARR, Claimant
Own Motion No. 00-0026M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer requests that we authorize suspension of claimant's temporary disability benefits under OAR 438-012-0035(5) for failure to seek medical treatment. Based on the following reasoning, we grant the insurer's request.

FINDINGS OF FACT

On August 25, 1989, claimant sustained a compensable injury that ultimately resulted in the amputation of his right leg. Aggravation rights expired on that claim on December 28, 1995.

On December 3, 1999, Dr. Worland, claimant's treating surgeon, requested authorization for outpatient surgery to remove recurrent neuromas of claimant's amputation stump. The insurer authorized the surgery and, on January 18, 2000, recommended that the Board authorize payment of temporary disability benefits in conjunction with this surgery.

On January 19, 2000, Dr. Worland performed the surgery, removing neuromas and bone spurs on the amputation stump.

On February 1, 2000, the Board issued an Own Motion Order that authorized the reopening of the claim to provide temporary total disability benefits beginning the date claimant was hospitalized for surgery. The order directed the insurer to close the claim pursuant to OAR 438-012-0055 when claimant became medically stationary.

On March 20, 2000, the insurer's claims examiner wrote Dr. Worland and asked if claimant had reached medically stationary status following the January 19, 2000 surgery. On March 28, 2000, Dr. Worland's office responded by telephone and stated that they had tried to contact claimant to get him to come in but they could not locate him. Dr. Worland last saw claimant on February 18, 2000.

On March 28, 2000, the insurer sent claimant a letter to his address on Table Rock Road in Medford, Oregon. That letter: (1) stated that Dr. Worland's office confirmed that he was last treated on February 18, 2000; (2) informed claimant that to continue to receive time loss benefits, Oregon Workers' Compensation law and rules require him to remain under medical care and seek reasonable periodic examinations; (3) requested that claimant immediately provide the insurer with an explanation as to why he was no longer under active medical care and whether a reason beyond his control prevented him from receiving treatment; and (4) notified claimant that "[i]f [he did] not provide a valid reason for [his] lack of treatment and verification of time loss authorization [was] not provided by [his] attending physician by 04-11-00, [his] disability benefits [would] cease as of that date."

Claimant did not respond to the insurer's March 28, 2000 letter.

On April 13, 2000, the insurer sent a letter to the Board requesting suspension of claimant's time loss benefits under our Own Motion jurisdiction for failure to seek medical treatment. The insurer sent claimant a copy of this suspension request by regular and certified mail.

On April 18, 2000, we sent claimant and the insurer a letter setting up a briefing schedule regarding the insurer's request for suspension of benefits. Claimant was given 21 days from the date of our letter to respond to the insurer's request, and the insurer was given 14 days from the mailing date of claimant's response to reply. This letter was sent both to claimant's address on Table Rock Road in Medford, Oregon, and to a post office box number in Phoenix, Oregon, a previous address that was in claimant's claim file. Neither letter sent to claimant was returned as undeliverable.

Claimant did not respond to our April 18, 2000 letter.

CONCLUSIONS OF LAW AND OPINION

The insurer requests that we authorize suspension of claimant's temporary disability benefits under our own motion authority pursuant to OAR 438-012-0035(5)[1] for failure to seek medical treatment. Although we provided claimant with the opportunity to do so, he did not respond to the insurer's request for suspension of benefits. Based on the following reasoning, we grant the insurer's request.

Jurisdiction

Because claimant's aggravation rights have expired on his compensable claim, the Board in its own motion authority has exclusive jurisdiction to authorize the reopening and processing of that claim under ORS 656.278 and OAR Chapter 438, Division 012. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). The legislature has provided strict limitations on the Board's own motion authority, however. ORS 656.278(1).[2] In this regard, the Own Motion Board has no jurisdiction over medical service issues or compensability issues, unless those issues involve medical services related to a work injury occurring before 1966. ORS 656.278(1)(b). Nevertheless, the Board's authority extends to enforcing its own motion orders. *Orman v. SAIF*, 131 Or App 653 (1994); *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).

Here, there is no issue regarding the reasonableness and necessity or compensability of any medical service, issues that would not be within our jurisdiction to address under the facts of this post-1966 injury claim. Instead, the issue is the processing of a claim for which aggravation rights have expired, *i.e.*, a claim that is within the Board's own motion jurisdiction under ORS 656.278.

We have previously determined that, where a claim has been reopened under our own motion jurisdiction, a carrier cannot *unilaterally* terminate temporary disability benefits for failure to seek medical treatment. *Robert E. Anderson*, 52 Van Natta 151 (2000). In *Anderson*, the carrier did not request suspension of temporary disability benefits; instead, it unilaterally terminated those benefits based on its assumption that the claimant had failed to seek medical treatment. We held that, although the

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[1] 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 the 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."

[2] 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; 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."

Department has rules that allow such unilateral termination of benefits under ORS 656.268(4)(d)[3] and ORS 656.262(4)(e),[4] there are no similar provisions for unilateral termination of benefits in an Own Motion claim pursuant to ORS 656.278. Rather, we found that, pursuant to OAR 438-012-0035(4),[5] termination of temporary disability benefits in a claim reopened under ORS 656.278 can only occur when the claimant is medically stationary, or when a Claim Disposition Agreement (CDA) extinguishes the claimant's right to further temporary disability benefits, or when termination of such benefits is authorized under ORS 656.268(4)(a) through (c). Because none of those events had occurred, we found that the carrier was not entitled to unilaterally terminate the claimant's temporary disability benefits.

Here, there is no basis for unilateral claim closure or termination of temporary disability benefits under the Own Motion statute and rules. In this regard, because claimant has not returned to his treating physician, there is no evidence regarding his medically stationary status, nor has a CDA terminated claimant's right to further temporary disability benefits, nor have events occurred that would authorize termination of such benefits under ORS 656.268(4)(a) through (c). OAR 438-012-0035(4).

Nevertheless, under OAR 438-012-0035(5), we are authorized to *suspend* the payment of claimant's temporary disability based on his failure to seek medical treatment. In reaching this conclusion, we find instructive ORS 656.012(2)(c), which states that an objective of the Workers' Compensation Law is "[t]o restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable." Requiring workers whose claims have been reopened under ORS 656.278 to seek regular medical care promotes the legislative objective of restoring an injured worker physically and economically to a self-sufficient status as soon as possible and to the greatest extent practicable. ORS 656.012(2)(c). Therefore, although neither ORS 656.278 nor the Board's Own Motion rules allow *unilateral termination* of temporary disability benefits or *claim closure* for failure to seek medical treatment, we are authorized under OAR 438-012-0035(5) to suspend temporary disability benefits for such failure under the appropriate circumstances.

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[3] *Anderson* referred to this statute as ORS 656.268(3)(d). ORS 656.268(3) was renumbered ORS 656.268(4) in 1999 as part of Senate Bill 220. We refer to that statute by its current number. ORS 656.268(4) provides:

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

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

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

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

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

[4] ORS 656.262(4)(e) provides:

"If a worker fails to appear at an appointment with the worker's attending physician, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment. If the worker fails to appear at a rescheduled appointment, the insurer or self-insured employer may suspend payment of temporary disability benefits to the worker until the worker appears at a subsequent rescheduled appointment."

[5] 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)."

In reaching this decision, we find instructive our decisions in *Bill H. Davis*, 47 Van Natta 219 (1995), 47 Van Natta 1448 (1995), 49 Van Natta 337 (1997). In *Davis*, we initially set aside the carrier's closure of an Own Motion claim, finding that the claimant was not medically stationary because a proposed surgery was reasonably expected to materially improve his compensable bladder condition. However, noting that this surgery had been proposed for a period of time, we noted that should the claimant fail to pursue the proposed surgery or decide not to undergo the surgery, the carrier could request suspension of his temporary disability benefits pursuant to OAR 438-012-0035(5).[6] 47 Van Natta at 220. In addition, if the claimant was otherwise medically stationary and refused the proposed surgery, we noted that the carrier could close the claim under the reasoning in *Stephen L. Gilcher*, 43 Van Natta 319, 320 (1991) (where a claimant's medically stationary status is contingent upon undergoing recommended surgery, the claim is not prematurely closed if the claimant refuses surgery).

Almost four months after issuance of the order setting aside its claim closure, the carrier requested that the claimant provide it with information regarding the proposed surgery. 47 Van Natta at 1449. Receiving no response from the claimant, the carrier requested authorization to suspend the claimant's temporary disability benefits pursuant to OAR 438-012-0035(5) for failure to pursue the proposed surgery. Subsequently, the claimant explained the delay in scheduling an upcoming examination with a specialist regarding the bladder surgery. Finding that the claimant was pursuing the proposed surgery, we denied the carrier's request to suspend the claimant's temporary disability benefits. However, we noted that our decision did not preclude the carrier from pursuing the options listed in our earlier order, under the appropriate circumstances. *Id.*

More than a year later, the carrier again requested authorization to suspend the claimant's temporary disability benefits pursuant to OAR 438-012-0035(5) for failure to pursue the proposed surgery. 49 Van Natta at 337. Finding that the medical record established that the proposed surgery was no longer being considered for the compensable bladder condition, we authorized suspension of the claimant's temporary disability benefits pursuant to OAR 438-012-0035(5). 49 Van Natta at 339. We also directed the carrier to reinstate payment of temporary disability benefits if surgery was again recommended. Finally, we directed the carrier to close the claim pursuant to OAR 438-012-0055 when the claimant's compensable was medically stationary. *Id.*

Given our decision in *Davis* that a carrier has the option of requesting suspension of temporary disability benefits under OAR 438-012-0035(5) when a claimant fails to pursue surgery, we find it reasonable, under the appropriate circumstances, to authorize suspension of temporary disability benefits when a claimant fails to seek medical treatment.

Accordingly, based on the above reasoning, we find that we have jurisdiction under our Own Motion authority to suspend temporary disability benefits under OAR 438-012-0035(5) for failure to seek medical treatment.

Suspension of Benefits Under OAR 438-012-0035(5)

Pursuant to OAR 438-012-0035(5), an Own Motion insurer shall not suspend compensation without prior written authorization by the Board. If the insurer believes that temporary disability benefits should be suspended, it must make a written request for such suspension. *Id.* In addition, it must mail copies of that request to the claimant and the claimant's attorney, if any, by certified or registered mail. *Id.*

It is well-established law that notice given by a carrier must be in strict compliance with applicable rules. *See Paniagua v. Liberty Northwest Ins. Corp.*, 122 Or App 288 (1993) (must first determine whether carrier's notice complied with applicable rules); *Annie L. Bounds*, 51 Van Natta 358, 362 (1999) (notice given by a carrier must be in strict compliance with the applicable rule in order for the administrative closure to be proper). When a rule specifically and unambiguously requires the carrier to follow a certain procedure, substantial compliance is not sufficient. *SAIF v. Robertson*, 120 Or App 1 (1993); *Fairlawn Care Center v. Douglas*, 108 Or App 698 (1991); *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986).

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[6] At the time of the first two decisions in *Davis*, the Board's Own Motion suspension rule was numbered OAR 438-12-035(5). By the date of the third order, the rule was renumbered OAR 438-012-0035(5). We refer to the rule by its current number.

Here, the insurer complied with the requirements in OAR 438-012-0035(5). In this regard, the insurer did not unilaterally terminate temporary disability benefits but, instead, requested that the Board suspend such benefits for failure to seek medical treatment. In addition, the insurer mailed a copy of this request to this unrepresented claimant by certified mail.

Furthermore, as noted above, we provided claimant with the opportunity to respond to the insurer's request for suspension of benefits before considering that request. *See Carr v. SAIF*, 65 Or App 110 (1983), *rev dismissed* 297 Or 83 (1984) (where the Workers' Compensation Department terminated the claimant's temporary disability benefits after being advised by carrier that the claimant failed to attend a scheduled medical examination, the claimant's right to continuing benefits was a property interest encompassed by the Fourteenth Amendment, and the claimant was entitled to notice and an opportunity to respond before the Department suspended his compensation pursuant to *former* ORS 656.325). Claimant provided no response.

Claimant has not sought medical treatment since he last saw his treating physician on February 18, 2000. In addition, claimant provided no explanation for his failure to seek medical treatment. Under these circumstances, we find it appropriate to authorize the suspension of claimant's temporary disability benefits effective the date of this order. This suspension shall continue unless and until claimant subsequently seeks medical treatment and the medical evidence establishes that his condition is *not* medically stationary. Should such events occur, the insurer shall reinstate payment of temporary total disability benefits effective the date of that medical treatment.

Furthermore, the insurer remains authorized to close the claim pursuant to the directive in our February 1, 2000 order. That is, when claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

August 3, 2000 Cite as 52 Van Natta 1409 (2000)

In the Matter of the Compensation of
GARY A. CHICCINO, JR., Claimant
WCB Case No. 99-03111
ORDER ON REVIEW
Guy B. Greco, Claimant Attorney
John M. Pitcher, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that awarded: (1) 17 percent (54.4 degrees) unscheduled permanent disability for a cervical condition; (2) 4 percent (7.68 degrees) scheduled permanent disability for loss of use or function of the right arm; and (3) 13 percent (1.3 degrees) scheduled permanent disability for loss of use or function of the left ring finger. Claimant contends that the ALJ erred in precluding him from raising issues not raised in the reconsideration proceeding. Claimant also asserts that the ALJ erred in admitting certain documents at the hearing that were submitted by the insurer during the Directors reconsideration proceeding. Claimant finally contends that the administrative procedures during the reconsideration proceeding violated his rights to procedural due process under the Oregon and United States Constitutions.

On review, the issues are preclusion, evidence, procedural due process, and extent of unscheduled and scheduled permanent disability.

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

We are in receipt of claimant's "Motion to Stay" our decision based on current proceedings at the Department and Hearings Division arising from the insurer's June 19, 2000 Modified Notice of Acceptance and Notice of Closure and alleged *de facto* denial of certain conditions. For the following reasons, we deny claimant's motion.

As an adjudicative body, our function is to resolve disputes brought to us by the litigants. In performing these duties, we apply the relevant statutory, administrative and judicial precedents to the record as it exists at the time of our review. *William M. Beardsley*, 48 Van Natta 2210 (1996). Were we to allow claimant's motion and hold this matter in abeyance pending claimant's request for reconsideration and request for hearing, resolution of this dispute, as well as numerous others, would be deferred for an indeterminate period awaiting a lower forum's decision. We do not consider such an action consistent with our statutory role as a decision-maker. Accordingly, claimant's motion is denied. *See William M. Beardsley*, 48 Van Natta 2210; *Alfonso S. Alvarado*, 43 Van Natta 1303 (1991).

ORDER

The ALJ's order dated March 16, 2000 is affirmed.

In the Matter of the Compensation of
NICHOLAS J. COLOUZIS, Claimant
WCB Case No. TP00001
THIRD PARTY DISTRIBUTION ORDER
Bruce J. Rothman, Attorney
David L. Bussman, Attorney

Reviewed by the Board *en banc*.

Claimant, the personal representative of the estate of Nicholas J. Colouzis, and conservator and *guardian ad litem* for her minor child, has petitioned the Board for resolution of a third party dispute concerning Argonaut Insurance Company's (Argonaut's) entitlement to recovery from a third party claim. Specifically, claimant contends that Argonaut has no lien rights concerning the third party settlement that meets or exceeds $1 million. *See* ORS 656.593(6). For the reasons set forth below, we conclude that Argonaut is entitled to recover its lien of $58,403.89.

FINDINGS OF FACT

The decedent was employed by Midwest Steel Inc. as an ironworker. On July 31, 1997, the parking structure under construction at the Port of Portland's Airport Expansion Project collapsed, resulting in decedent's death. Midwest Steel, as a subcontractor, was insured for Oregon workers' compensation benefits by the Port of Portland's Owner Controlled Insurance Program by Argonaut. (Ex. B).

Claimant, on behalf of herself and her minor child, filed a claim for death benefits. (Ex. C). On September 24, 1997, Argonaut accepted the claims. (Exs. D-2, D-4). Claimant, as personal representative of decedent's estate, initiated a third party claim for wrongful death. In January 2000, claimant entered into a confidential settlement of the third party claim.

Claimant, on behalf of herself and her minor child, has filed a "Notice of Election to Waive Future Benefits Pursuant to ORS 656.593(6)." Claimant asserts that the amount of the third party settlement meets or exceeds the requirement of ORS 656.593(6). The parties agree that the full amount of Argonaut's lien, for compensation paid to date, is $58,403.89. Claimant asserts that no sums have been paid out of the Workers' Benefit Fund, the Consumer and Business Services Fund, or the Self-Insured Employers' Adjustment Reserve.

CONCLUSIONS OF LAW AND OPINION

ORS 656.578 provides that if a worker sustains a compensable injury due to the negligence or wrong of a third party, the worker or beneficiaries shall elect whether to recover damages from the third party. Under ORS 656.580(2), the paying agency has a lien against the cause of action, "which lien shall be preferred to all claims except the cost of recovering such damages." ORS 656.593(1) provides that the proceeds of any damages recovered from the third party by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds.

In 1997, the legislature amended ORS 656.593 by adding subsections 6 and 7. Under ORS 656.593(6), a worker (or the beneficiaries of a worker) who is entitled to payment from a third party judgment or settlement in the amount of $1 million or more may elect to release the paying agency from all "further liability" on the workers' compensation claim, provided that several enumerated conditions are met. Under ORS 656.593(6)(d), one of the conditions is the submission of a settlement stipulation that outlines terms of reimbursement to the paying agency for its incurred expenditures, including those from various funds maintained by the Director of the Department of Consumer and Business Services. ORS 656.593(6)(d) provides that, if the payment of "incurred expenditures" is in dispute, the parties shall submit the matter to the Board for resolution. Under those circumstances, "the release of the claim shall not be final until such time as the order of the board becomes final. In such a case, the only issue to be decided by the board is the amount of incurred expenses by the paying agent."[1]

Claimant argues that, pursuant to ORS 656.593(6), Argonaut has no lien rights with regard to the third party wrongful death settlement. She contends that amendments to ORS 656.593 in 1997 provide a new and different distribution of settlement proceeds. Claimant also argues that the Board may determine only the amount of "incurred expenses" and has no authority to determine whether Argonaut's lien can be enforced.

We first address whether we have jurisdiction in this case. The parties agree that the full amount of Argonaut's lien, for compensation paid to date, is $58,403.89. Argonaut does not dispute claimants assertion that the settlement/release in question meets the conditions set forth in ORS 656.593(6).

In construing ORS 656.593(6), our task is to discern legislative intent. *See* 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*

ORS 656.593 sets out procedures for distributing the proceeds of damages or a settlement recovered in a third-party action. ORS 656.593(1) pertains to damages recovered in a third party action. ORS 656.593(3) pertains to settlements of a third party case. Subsection 6 of ORS 656.593 outlines a different procedure than ORS 656.593(1) or (3). Under ORS 656.593(6), a worker (or the beneficiaries of a worker) who is entitled to receive payment from a third party judgment or settlement in the amount of $1 million or more may elect to release the paying agency from all further liability on the workers' compensation claim, provided that several enumerated conditions are met. ORS 656.593(6) applies "[p]rior to and instead of the distribution of proceeds as described in subsection (1) of ORS 656.593.

ORS 656.593(6) provides:

> "Prior to and instead of the distribution of proceeds as described in subsection (1) of this section, when the worker or the beneficiaries of the worker are entitled to receive payment pursuant to a judgment or a settlement in the third party action in the amount of $1 million or more, the worker or the beneficiaries of the worker may elect to release the paying agency from all further liability on the workers' compensation claim, thereby canceling the lien of the paying agency as to the present value of its reasonably expected future expenditures for workers' compensation and other costs of the worker's claim, if all of the following conditions are met as part of the claim release:
>
> "(a) The worker or the beneficiaries of the worker are represented by an attorney.
>
> "(b) The release of the claim is presented in writing and is filed with the Workers' Compensation Board, with a copy served on the paying agency, including the Department of Consumer and Business Services with respect to its expenditures from the Workers' Benefit Fund, the Consumer and Business Services Fund and the Self-Insured Employer Adjustment Reserve.

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[1] We note that the Board's approval of a stipulation pursuant to ORS 656.593(6) is not required. In the absence of a dispute, a release of a worker's claim is effective if all of the conditions in subsections (a) through (g) of ORS 656.593(6) have been satisfied. One of the conditions is filing the release of the claim with the Board. ORS 656.593(6)(b).

"(c) The claim release specifies that the worker or the beneficiaries of the worker understand that the claim release means that no further benefits of any nature whatsoever shall be paid to the worker or the beneficiaries of the worker.

"(d) The release of the claim is accompanied by a settlement stipulation with the paying agency, outlining terms of reimbursement to the paying agency, covering its incurred expenditures for compensation, first aid or other medical, surgical or hospital service and for expenditures from the Workers' Benefit Fund, the Consumer and Business Services Fund and the Self-Insured Employer Adjustment Reserve, to the date the release becomes final or the order of the board becomes final. If the payment of such incurred expenditures is in dispute, the release of the claim shall be accompanied by a written submission of the dispute by the worker or the beneficiaries of the worker to the board for resolution of the dispute by order of the board under procedures allowing for board resolution under ORS 656.587, in which case the release of the claim shall not be final until such time as the order of the board becomes final. In such a case, the only issue to be decided by the board is the amount of incurred expenses by the paying agent.

"(e) If a service, item or benefit has been provided but a bill for that service, item or benefit has not been received by the paying agency before the release or order becomes final, the reimbursement payment shall cover the bill pursuant to the following process:

"(A) The paying agency may maintain a contingency fund in an amount reasonably sufficient to cover reimbursement for the billing.

"(B) If a dispute arises as to reimbursement for any bill first received by the paying agency not later than 180 days after the date the release or order became final, the dispute shall be resolved by order of the board.

"(C) Any amount remaining in the contingency fund after the 180-day period shall be paid to the worker or the beneficiaries of the worker.

"(D) Any billing for a service, item or benefit that is first received by the paying agency more than 180 days after the date the release or order became final is unenforceable by the person who issued the bill.

"(f) The settlement or judgment proceeds are available for payment or actually have been paid out and are available in a trust fund or similar account, or are available through a legally enforceable structured settlement agreement if sufficient funds are available to make payment to the paying agency.

"(g) The agreed-upon payment to the paying agency, or the payment to the paying agency ordered by the board, is made within 30 days of the filing of the withdrawal of the claim with the board or within 30 days after the board has entered a final order resolving any dispute with the paying agency."

The first sentence of ORS 656.593(6)(d) provides that the release of the claim is accompanied by a settlement stipulation with the paying agency, outlining terms of reimbursement to the paying agency, covering its incurred expenditures for compensation, medical services and other expenditures, to the date the release becomes final or the order of the Board becomes final. The second sentence of ORS 656.593(6)(d) provides:

"If the payment of such incurred expenditures is in dispute, the release of the claim shall be accompanied by a written submission of the dispute by the worker or the beneficiaries of the worker to the board for resolution of the dispute by order of the board under procedures allowing for board resolution under ORS 656.587, in which case the release of the claim shall not be final until such time as the order of the board becomes final. In such a case, the only issue to be decided by the board is the amount of incurred expenses by the paying agent."

We construe the phrase "payment of such incurred expenditures" in the second sentence of subsection (6)(d) of ORS 656.593 with reference to the first sentence of that subsection. That is, the first sentence refers to the terms of reimbursement to the paying agency, covering its incurred expenditures for compensation, medical services and other expenditures. We construe the second sentence of subsection (6)(d), which refers to "the payment of *such* incurred expenditures," as referring to the

reimbursement payment of such incurred expenditures to the paying agency. That construction is consistent with subsection (e) of ORS 656.593(6), which refers to the paying agency's "reimbursement payment." In other words, we construe the second sentence of subsection (6)(d) to mean that, if the reimbursement payment of such incurred expenditures is in dispute, the release of the claim shall be accompanied by a written submission of the dispute by the worker or the beneficiaries of the worker to the Board for resolution of the dispute by order of the Board under procedures allowing for Board resolution under ORS 656.587.

In the present case, the parties agree that the full amount of Argonaut's lien, for compensation paid to date, is $58,403.89. The reimbursement payment of such incurred expenditures is disputed. Furthermore, the "amount of incurred expenses by the paying agency" is disputed in that claimant argues that the "amount" Argonaut is entitled to is zero, whereas Argonaut contends that it is entitled to $58,403.89. Because the fact that the "payment of such incurred expenditures" pursuant to ORS 656.593(6)(d) is in dispute, we find that we have jurisdiction in this case.

Furthermore, another condition that must be met as part of the claim release is explained in ORS 656.593(6)(g), which provides:

> "The agreed-upon payment to the paying agency, or the payment to the paying agency ordered by the board, is made within 30 days of the filing of the withdrawal of the claim with the board or within 30 days after the board has entered a final order resolving any dispute with the paying agency."

Thus, ORS 656.593(6)(g) indicates that the Board may resolve "*any* dispute with the paying agency." (Emphasis supplied). In interpreting a statute, "words of common usage typically should be given their plain, natural, and ordinary meaning." *PGE v. Bureau of Labor and Industries*, 317 Or 606 at 611. We find that the term "any dispute" includes a dispute about a carrier's lien rights. *See SAIF v. Wright*, 312 Or 132, 137 (1991) (the court held that the term "any conflict" in ORS 656.593(3) encompassed the gamut of disputes about distribution of the proceeds). Here, the parties do not agree that a reimbursement payment should be made to Argonaut, as the paying agency. Based on the foregoing reasoning, we conclude that we have jurisdiction in this case.[2]

Next, we address claimant's argument that Argonaut was not a "paying agency" under ORS 656.576. She contends that payments made by Argonaut were not made as a result of an insurance company entering into a workers' compensation insurance contract with the deceased's employer.

ORS 656.576 provides:

> "As used in ORS 656.578 to 656.595, 'paying agency' means the self-insured employer or insurer paying benefits to the worker or beneficiaries."

The decedent was employed by Midwest Steel Inc. At the time of decedent's death, Midwest Steel was insured for Oregon workers' compensation benefits by the Port of Portland's Owner Controlled Insurance Program by Argonaut. (Ex. B). There is no dispute that Argonaut paid benefits to the decedent's beneficiaries. Consequently, we conclude that Argonaut was a "paying agency" under ORS 656.576.

Claimant argues that Argonaut is not entitled to recover its lien because ORS 656.593(6) applies to this case. Claimant contends that ORS 656.593(6) does not provide that a paying agency has a mechanism for recovery of expenditures for past benefits and, therefore, the lien provision in ORS 656.593(1) does not apply.

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[2] In any event, we note that the Board has jurisdiction of matters concerning a claim. ORS 656.704; *SAIF v. Wright*, 312 r at 136. Matters concerning a claim "are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3). The dispute in this case involves a matter concerning a claim, because the amount of compensation to which claimant is entitled is directly in issue. In other words, the more that Argonaut (the paying agency) is entitled to receive, the less that claimant is entitled to retain. *See SAIF v. Wright*, 312 Or at 136 (finding that the Board had jurisdiction to determine whether the carrier was a "paying agency").

Argonaut responds that the only part of the statutory lien recovery mechanism that is impaired is the paying agency's present value of *future* expenses. Argonaut contends that there is no statutory support for claimant's argument that a paying agency's lien for past compensation paid does not apply to settlements under ORS 656.593(6). For the following reasons, we agree with Argonaut.

ORS 656.580(2) provides, in part:

> "The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

ORS 656.593(1) provides:

> "The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section."

The statutory scheme provides that if a claimant elects to proceed against a third party for damages, the paying agency has a "lien" against the cause of action pursuant to ORS 656.580(2). This arrangement shifts the cost of compensating the claimant to the wrongdoer, at least in part, and provides "both the paying agency and the [claimant] some benefit from the third-party claim recovery." *SAIF v. Parker*, 61 Or App 47, 53 (1982). Under ORS 656.580(2), the paying agency's lien "shall be preferred to all claims except the cost of recovering such damages."

Both parties agree that ORS 656.593(6) provides that the paying agency's lien "as to the present value of its reasonably expected future expenditures for workers' compensation" is cancelled. The dispute in this case is whether the paying agency has a lien for compensation it has already paid. For the following reasons, we find that the alternative distribution scheme in ORS 656.593(6) does not extinguish a paying agency's lien rights.

In arguing that Argonaut has no lien rights, claimant relies on the language in ORS 656.593(6) that provides that the lien of the paying agency is cancelled "as to the present value of its reasonably expected future expenditures for workers' compensation and other costs of the worker's claim[.]" According to claimant, there would have been no need for the legislature to add the "other costs" language if the lien cancellation applied only to future expenses.

Subsection 6 of ORS 656.593 applies "[p]rior to and instead of the distribution of proceeds as described in subsection (1) of this section[.]" Thus, ORS 656.593(6) applies instead of the distribution of proceeds in ORS 656.593(1). Claimant reasons that the language of ORS 656.593(1) that provides that "[t]he proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section" does not apply when the distribution of proceeds takes place under ORS 656.593(6) instead.

The problem with claimant's argument is that there is no language in ORS 656.593(6) that indicates any legislative intent to eliminate the paying agency's lien as provided in ORS 656.580(2), which provides that the "paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

In construing statutory language, we are not permitted to omit what has been inserted or insert what has been omitted. ORS 174.010. Furthermore, where there are several provisions, we must, if possible, construe statutes so as to "give effect to all" of its provisions. *Id.* ORS 656.580 applies to the distribution of *all* third party proceeds under ORS 656.593, not just those pursuant to subsections 1 and 3. Claimant's interpretation of ORS 656.593(6) is not persuasive.

Moreover, we are not persuaded by claimant's argument that the language in ORS 656.593(6) referring to "other costs of the worker's claim" encompasses the paying agency's expenditures for past benefits. ORS 656.593(6) provides that the paying agency's lien is cancelled as to the present value of its reasonably expected future expenditures for workers' compensation "and other costs of the worker's claim[.]" Although "costs" are not defined in subsection 6, the language of ORS 656.593(1) supports the conclusion that "costs" do not refer to the paying agency's past expenditures.

In construing a statute, we must consider the context of the statutory provision at issue, which includes other provisions of the same statute. *PGE*, 317 Or at 611. ORS 656.593(1)(c) provides:

> "The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter. Such other costs include expenditures of the Department of Consumer and Business Services from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve and the Workers' Benefit Fund in reimbursement of the costs of the paying agency. Such other costs also include assessments for the Workers' Benefit Fund, and include any compensation which may become payable under ORS 656.273 or 656.278."

ORS 656.593(1)(c) differentiates between a paying agency's right to recover "expenditures for compensation, first aid or other medical, surgical or hospital service" and its right to recover "for the present value of its reasonably to be expected future expenditures for compensation and *other costs of the worker's claim* under this chapter." (Emphasis supplied). Thus, the legislature's use of the term "other costs of the worker's claim" in ORS 656.593(1)(c) means something *other than* the paying agency's right to recover "expenditures for compensation, first aid or other medical, surgical or hospital service[.]" ORS 656.593(1)(c) explains that "[s]uch other costs" include expenditures of the Department of Consumer and Business Services from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve and the Workers' Benefit Fund in reimbursement of the costs of the paying agency, as well as assessments for the Workers' Benefit Fund, and "any compensation which may become payable under ORS 656.273 or 656.278."

The legislature also used the term "other costs of the worker's claim" in ORS 656.593(6). The legislature's "use of the same term throughout a statute indicates that the term has the same meaning throughout the statute." *PGE*, 317 Or at 611. We find no support for claimant's argument that "other costs" in ORS 656.593(6) was intended to include a paying agency's past expenditures for workers' compensation.

In any event, to the extent that the statutory language is ambiguous, the legislative history supports our interpretation of ORS 656.593(6). On May 20, 1997, Kevin Mannix, one of the sponsors of Senate Bill 484, testified before the House Committee on Labor and explained the subsection 6 amendment to ORS 656.593:

> "The main thrust of Senate Bill 484 is to empower a worker who has a third party claim to choose to withdraw that claim or release that claim should the worker decide it's in his financial best interest. It's limited to situations where the worker has been injured by a third party - somebody off the job - and he has succeeded in getting a settlement or judgment against that party of a million dollars or more. The worker may calculate the finances and decide that it's in the worker's best interest for himself and his family financially to say good-bye to his workers' compensation claim in exchange for being able to have no lien on that third party recovery.
>
> "* * * * *
>
> "We've put limitations in the bill which satisfy protecting the interests of the worker against anyone who might try to play fast and loose. The worker has to be represented by counsel. The worker does have to understand that the worker is releasing the claim and it also has to be a situation where the settlement or judgment has already arrived. It's not something they hope to get; it's something that they've got. So it's money in hand.
>
> "*The insurers are treated fairly because they are allowed to get back what they spent. There are protections in the bill to make sure that whatever they did spend on his claim, they will get back, but they will get nothing further.*" Tape Recording, House Committee on Labor, SB 484, May 20, 1997, Tape 83, Side B (comments of Kevin Mannix) (emphasis supplied).

Based on the statutory language, as supported by the legislative history, we conclude that Argonaut has a lien of $58,403.89 for compensation paid to date. *See* ORS 656.580(2).

Alternatively, claimant argues that Argonaut should not be allowed to benefit from its own conduct, and that of its insured's, which caused the death of decedent. Claimant contends that allowance of the lien would be unjust and inequitable.

The Supreme Court rejected a similar argument in *Boldman v. Mt. Hood Chemical Corporation*, 288 Or 121 (1979). The *Boldman* case involved an action for indemnity by Mt. Hood Chemical Corporation as third-party plaintiff against FMC Corporation, third-party defendant. The action arose out of the death of one of FMC's employees. FMC's employee was killed while he was using a chemical sold by Mt. Hood while cleaning grease and dirt from an enclosed cylinder. Workers' compensation benefits were paid to the spouse of the deceased employee. The personal representative subsequently brought an action against Mt. Hood, the supplier of a chemical that caused the employee's death. Mt. Hood filed a third-party complaint seeking indemnity from FMC. Mt. Hood subsequently settled the original claim. The indemnity claim was submitted to a jury, which returned a verdict for Mt. Hood.

Mt. Hood argued, among other things, that it would be inequitable for FMC to have a lien for workers' compensation benefits that were paid by FMC to the widow under ORS 656.593 because FMC's culpability was a cause of the employee's death. The court rejected that argument, holding that, pursuant to ORS 656.593, FMC was entitled to a lien for its compensation payments to the widow. 288 Or at 130. The court said "[w]hether FMC was culpable in causing the death is irrelevant." *Id.*

We reach the same conclusion in this case. Workers' compensation is a no-fault system that compensates a worker for injuries that arise out of and occur in the course of the worker's employment. One objective of the Workers' Compensation Law is to provide fair, adequate and reasonable income benefits to injured workers and their dependents, regardless of fault. *See* ORS 656.012(2)(a) (so stating); *see also Andrews v. Tektronix, Inc.*, 323 Or 154, 159-60 (1996) (fault is irrelevant in Oregon's workers compensation scheme). We conclude that any negligence on behalf of Argonaut or its insured is irrelevant for purposes of analyzing Argonaut's lien rights.

Claimant also contends that Argonaut's entire claim for reimbursement should be disallowed on equitable grounds. Claimant relies on ORS 656.593(3), which provides that the Board may resolve "[a]ny conflict as to what may be a just and proper distribution[.]" Argonaut responds that the "just and proper" language in ORS 656.593(3) does not apply to cases settled under ORS 656.593(6).

ORS 656.593(3) provides:

> "A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

As we discussed earlier, subsection 6 of ORS 656.593 provides for a separate procedure, that applies when a worker (or the beneficiaries of a worker) who is entitled to receive payment from a third party judgment or settlement in the amount of $1 million or more, elects to "release the paying agency from all further liability on the workers' compensation claim, thereby canceling the lien of the paying agency as to the present value of its reasonably expected future expenditures for workers' compensation and other costs of the worker's claim[.]" There is no language in ORS 656.593(6) authorizing the Board to resolve any conflict regarding a "just and proper" distribution. The Workers' Compensation Board is an administrative agency and, as such, it is a creature of statute and does not have the powers of a court of equity. *Oregon Occupational Safety v. Don Whitaker Logging*, 123 Or App 498, 500-01 (1993), *rev den* 318 Or 326 (1994). Consequently, claimant's argument that we have the authority to disallow Argonaut's lien on equitable grounds is not persuasive.

Finally, claimant argues that if the Board permits any reimbursement to Argonaut, the Board should order Argonaut to pay its *pro rata* share of claimant's attorney's fees and costs related to prosecuting the third party action for wrongful death. The Board is limited to the authority conferred by statute. Because we do not have statutory authorization to order Argonaut to pay for part of claimant's

attorney's fees and costs, we reject claimant's request.[3] Any injustice claimant perceives in the statutory scheme is best addressed to the legislature.

In sum, we conclude that Argonaut has a lien for compensation paid to date of $58,403.89. Claimant's counsel is directed to distribute $58,403.89 of the third party settlement proceeds to Argonaut.

IT IS SO ORDERED.

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[3] We note that under ORS 656.593(1) and (3), attorney fees and costs are paid from the proceeds of the third party recovery. Although those subsections do not apply to ORS 656.593(6), they reflect the legislative intent that such fees and costs rest with the third party, not the workers' compensation carrier.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with the majority that we have jurisdiction in this case and that Argonaut is entitled to reimbursement for its lien and all other discussion. I disagree only with the majority's conclusion that Argonaut is not required to pay a share of claimant's attorney fees and costs related to prosecuting this third party action for wrongful death.

By electing to waive future benefits, claimant is providing a tremendous savings to Argonaut of future payments in the approximate amount of $600,000. Claimant points out the majority of other states require a carrier in these circumstances to pay its *pro rata* share of a claimant's attorney fees and costs related to prosecuting a third party action for wrongful death. Claimant's attorneys worked on this third party case for over two years, reviewed tens of thousands of documents, conducted extensive discovery, were involved in over 29 extended depositions, and expended $90,000 in retaining consultants and expert witnesses to prepare for trial. Claimant's attorneys are unable to advise the Board as to the total amount of the contingent attorney fees, however, because that would breach the confidentiality of the settlement agreement.

The record does not reflect that Argonaut has advanced any costs, or paid any attorney fees toward recovering this third party settlement. I agree with claimant that Argonaut should be required to pay a share of claimant's attorney fees and costs related to prosecuting the third party action. I note that the parties stipulated that *all* requirements of ORS 656.593(6) have been met. That would include subsection (6) (d), specifically a settlement stipulation outlining terms of reimbursement to the paying agency. That document is not a part of this record. By concluding that Argonaut is not required to pay a share of claimant's attorney fees, the majority unjustly enriches Argonaut at the expense of claimants, who were required to undertake the burden and expense of litigation. In my opinion, a just and proper distribution of proceeds would allocate some portion of the costs and attorney fees to Argonaut. However, this is an issue that should be negotiated by the parties and be a part of any settlement stipulation outlining terms of reimbursement.

In the Matter of the Compensation of
KEVIN CONNELL, Claimant
WCB Case No. 99-09846
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of his low back degenerative disc disease. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation addressing claimant's contention that the insurer's denial of degenerative disc disease should be set aside with respect to the L 4-5 level. Claimant argues that the insurer "wrongly denied [a] non-existent condition," and, further, that, if that condition does exist, it is compensable as "combined condition" with an accepted L4-5 disc bulge or is part of the disc bulge condition and cannot be "legally denied."

At the outset, we note that the insurer's denied degenerative disc disease in claimant's low back without specifying a particular level. (Ex. 23). We also agree with the ALJ's reasoning that degenerative disc disease exists only at the L2-3 level. Therefore, we find that the insurer's denial only pertains to the L2-3 level. Thus, we disagree with claimant's contention that the insurer wrongly denied a degenerative condition at L4-5.

Claimant, however, also contends that the denial of degenerative disc disease should be set aside with respect to the L2-3 level because the degenerative disease is allegedly part of a compensable "combined condition." Claimant's contention notwithstanding, his examining physician, Dr. Gritzka, testified that the L2-3 degenerative disease had nothing to do with claimant's low back symptoms. (Ex. 25-31; *see also* Ex. 21A-7, 9). Therefore, we are not persuaded that claimant's injury "combined" with the degenerative disease at L2-3 to cause disability or a need for treatment. *See* ORS 656.005(7)(a)(B). Accordingly, we also decline to set aside the insurer's denial on this basis.

ORDER

The ALJ's order dated April 4, 2000 is affirmed.

In the Matter of the Compensation of
TONYA R. GRELL, Claimant
Own Motion No. 98-0312M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's May 5, 2000 Notice of Closure, which closed her claim with an award of temporary disability compensation from July 22, 1998 through December 9, 1999. The insurer declared claimant medically stationary as of April 14, 2000.

In her request for review, claimant requests review of the closure contending that: (1) the insurer-arranged medical examiner (IME) who conducted the examination "did an incompetent job in evaluating my case;" (2) new diagnostic tests demonstrate a worsening of her condition; (3) she continues to experience pain; and (4) her attending physician has recommended further treatment and surgery. We interpret such a statements as a contention that claimant was not medically stationary at claim closure.

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

The propriety of the closure turns on whether claimant was medically stationary at the time of the May 5, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a July 7, 2000 letter, we requested that the insurer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on July 18, 2000; however, no further response has been received from claimant. Therefore, we will proceed with our review.

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

Here, claimant requested review because she continues to experience pain in her wrist and her doctor has recommended further treatment. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

On April 14, 2000, claimant attended an insurer-arranged medical examination (IME) performed by Dr. Barnard. During his physical examination of claimant, Dr. Barnard noted that her range of motion of her fingers and shoulders, sensory examination, reflexes, and strength were all within normal limits. There was no tenderness or swelling along her surgical scars above the wrists. Dr. Barnard noted some tenderness to palpation over the left distal radioulnar joint, but there was not discernible instability. Based on his physical findings and review of the medical record, Dr. Barnard opined that claimant was medically stationary and that there was no evidence that "further treatment will be curative in nature. "

In response, claimant contends that she has continued pain and requires additional treatment to "assist in my pain management." Claimant submits a May 22, 2000 medical report from Dr. Vyhmeister, her attending physician, in support of her contentions. In his report, Dr. Vyhmeister noted claimant's continued pain complaints and reported that diagnostic testing demonstrated that she had left radioulnar joint arthritis. He recommended that claimant continue with therapy once a week and use a heating pad at home. Dr. Vyhmeister agreed that claimant could continue modified duty and scheduled a follow-up visit in four weeks.

However, 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). Here, although Dr. Vyhmeister recommends continued therapy and modified duty, he does not indicate that this continued treatment would materially improve claimant's condition. Also, contrary to claimant's contention, Dr. Vyhmeister has not recommended further surgery.

Thus, based on the medical evidence, we find that claimant was medically stationary on the date her claim was closed.[1] Therefore, we conclude that the insurer's closure was proper.[2]

Accordingly, we affirm the insurer's May 5, 2000 Notice of Closure in its entirety.[3]

IT IS SO ORDERED.

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[1] In reaching this conclusion, we again emphasize that the need for continuing medical treatment to address fluctuating symptoms does not establish that claimant's condition is not medically stationary. *Maarefi*, 69 Or App at 531.

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

[3] In her request for review of the insurer's closure, claimant objects to the manner in which the IME was conducted. It appears from claimant's objections that she is unclear as to her 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, she may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. She may call free of charge at 1-800-927-1271,or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97301

In the Matter of the Compensation of
TRACIE L. SALUSTRO, Claimant
WCB Case No. 99-09527
ORDER ON REVIEW
Heiling & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that dismissed her request for hearing for lack of jurisdiction. The insurer requests sanctions for claimant's allegedly frivolous request for review. On review, the issues are propriety of the dismissal and sanctions.

We decline to impose sanctions and we adopt and affirm the ALJ's order with the following change and supplementation. On page 3, we delete the second paragraph of the "Conclusions of Law and Opinion."

Dismissal

The ALJ found that the insurer prepared and issued a denial letter on March 31, 1999, which was properly addressed and dispatched to claimant's then-address. The certified letter was postmarked March 31, 1999. (Ex. 3A). The ALJ found that the post office left several notices for claimant indicating it was holding a certified letter for her, but the letter was returned to the insurer as "unclaimed." (Ex. 3A, Tr. 47-48). The insurer's claims adjuster who handled claimant's claim testified that she routinely sends the denial letter by both certified and regular mail. (Tr. 45-47). The denial letter sent by regular mail was not returned to the insurer. (Tr. 48).

Claimant filed a request for hearing concerning the insurer's March 31, 1999 denial on December 6, 1999. The ALJ dismissed claimant's request for hearing because she had not requested a hearing within 180 days of the mailing date of the insurer's denial letter.

Claimant argues that the ALJ erred in dismissing her request for hearing. She relies, in part, on the following language in *Norton v. Compensation Department*, 252 Or 75, 78 (1968):

> "It is, of course, conceivable that the mailing of the notice of denial will not bring notice of the denial to the workman within 60 days after the denial or will not bring notice within a reasonably substantial time after the mailing, all through no fault of the workman. What relief can be granted to the workman in such event will have to depend upon the particular circumstances of each case."

In *Wright v. Bekins Moving and Storage Co.*, 97 Or App 45, 48-49, *rev den* 308 Or 466 (1989), the claimant relied on the same language in *Norton* and the court responded:

> "In this case, the notice was correctly addressed and mailed but was not received by claimant. There is no indication that the fact that the notice was not received was due to any fault of claimant or employer. The extenuating circumstance, claimant argues, is that he did not receive the notice. However, if that were considered one of the circumstances contemplated by the dicta in *Norton* and expanded as a principle of law in *Burkholder*, then the statutory period would in effect begin to run from the date that a claimant *received* notice, which is directly contrary to the court's interpretation of the statute in *Norton*." (Emphasis in original).

Compare Burkholder v. SAIF, 11 Or App 334 (1972).[1]

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[1] In *Burkholder*, the insurer mailed the notice of denial to an address at which the claimant had never lived or received mail, even though the correct address was known. Under these circumstances, the court held that there were extenuating circumstances and that the claimant's request for hearing, although filed more than 60 days after the notice was mailed, was nevertheless valid. Here, in contrast, the insurer's denial letter was properly addressed to claimant's address at that time.

In *Norton*, 252 Or at 77, the court interpreted *former* ORS 656.319(2), which provided:

"Notwithstanding the provisions of subsection (1) of this section:

"(a) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless a request for hearing is filed within 60 days *after the claimant was notified of the denial.*" (Emphasis supplied).

In *Wright*, 97 Or App at 47, the court applied *former* ORS 656.319(1), which provided:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day *after the claimant was notified of the denial*; or

"(b) The request is filed not later than the 180th day *after notification of denial* and the claimant establishes at a hearing that there was good cause for failure to file a request by the 60th day *after notification of denial.*" (Emphasis supplied.)

In contrast, a different version of ORS 656.319(1) applies to this case, which provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day *after the mailing of the denial* to the claimant; or

"(b) The request is filed not later than the 180th day after mailing of the denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day *after mailing of the denial.*" (Emphasis supplied).

ORS 656.319 has been amended and no longer provides that a request for hearing is to be filed within 60 days after a claimant is *notified* of the denial. Rather, ORS 656.319(1) provides that a hearing shall not be granted and the claim shall not be enforceable unless a request for hearing is filed not later than the "60th day after the mailing of the denial to the claimant" or the request is filed not later than the "180th day after mailing of the denial" and the claimant establishes at a hearing that there was good cause for failure to file the request by the "60th day after mailing of the denial." Because the current version of ORS 656.319(1) does not require claimant's *notification* of the denial, we find that *Norton* is inapposite.

Here, the insurer mailed the denial letter to claimant at her correct address by certified and regular mail on March 31, 1999. Claimant did not request a hearing within 180 days of the mailing date of the denial letter. Under these circumstances, ORS 656.319(1) provides that a "hearing thereon shall not be granted and the claim shall not be enforceable[.]"

However, claimant relies on ORS 656.262(6)(a) and ORS 656.262(9) to argue that the ALJ erred in dismissing her request for hearing. ORS 656.262(6)(a) provides, in part:

"Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim."

ORS 656.262(9) provides:

"If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Consumer and Business Services denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing pursuant to ORS 656.319."

Although ORS 656.262(6)(a) provides that written notice of the denial shall be "furnished" to the claimant and ORS 656.262(9) provides that written notice of denial shall be "given" to the claimant, neither of those statutes discuss the *timing* of a claimant's request for hearing, which is at issue in this case. In fact, ORS 656.262(9) specifically provides that the worker may request a hearing "*pursuant to ORS 656.319.*" Claimant does not explain why ORS 656.262(6)(a) and ORS 656.262(9) control in this case, rather than ORS 656.319. We find that claimant's reliance on those subsections of ORS 656.262 is misplaced.

Claimant also relies on OAR 438-005-0065, which provides:

> "Notice of denial or other notice from which statutory time runs against a claimant shall be in writing and shall be delivered by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons."

We find that the insurer's notice of denial was "delivered" by certified mail with return receipt requested and, therefore, the insurer complied with OAR 438-005-0065.

Finally, claimant relies on *Bishop v. OBEC Consulting Engineers*, 160 Or App 548 (1999), to argue that the ALJ erred in dismissing her request for hearing. In *Bishop*, the insurer provided notice of the denial to an attorney who did not represent the claimant and failed to deliver notice of the denial by registered or certified mail. One of the issues was whether the claimant's actual knowledge of the insurer's denial terminated his entitlement to interim compensation. The court held that actual notice did not "cure" a failure to furnish notice of denial in the prescribed manner. The court reasoned that the claimant's "actual knowledge" of the denial could not be squared with OAR 438-005-0065, which provides that the notice of denial is effective only when delivered "by registered or certified mail" or "by personal service meeting the requirements for service of a summons." Neither of those occurred in *Bishop*. The court held that the Board erred in determining that the claimant's actual knowledge of the denial terminated his entitlement to interim compensation.

We find that *Bishop* is distinguishable from this case. As the insurer notes, the *Bishop* case addressed the legal significance of a denial and related events that occurred in 1992 and 1993, *before* the 1995 amendments to ORS 656.319(1) that changed the operative date from "notification" of the denial to "mailing."

Furthermore, the facts in *Bishop* are distinguishable. In *Bishop*, the court referred to OAR 438-005-0065, which provides that the notice of denial is effective only when delivered "by registered or certified mail" or "by personal service meeting the requirements for service of a summons." Neither of those requirements occurred in *Bishop*. Here, as discussed above, we find that the insurer's notice of denial was delivered by certified mail with return receipt requested and, therefore, the insurer complied with OAR 438-005-0065.

In sum, we agree with the ALJ that claimant's request for hearing was filed more than 180 days after the mailing of the insurer's denial letter. We find no statutory basis for excusing a request for hearing made more than 180 days from the date of mailing of the denial. *See Wright v. Bekins Moving and Storage Co.*, 97 Or App at 48-49 (there is no statutory basis for adding a third category to ORS 656.319 that excuses a request for hearing made after 180 days from the date of mailing, if there are "extenuating circumstances"); *Anderson v. EBI Companies*, 79 Or App 345, *rev den* 301 Or 445 (1986) (request for hearing filed more than 180 days after the denial was mailed was untimely). We conclude that the ALJ properly dismissed claimant's request for hearing.

Sanctions

The insurer requests sanctions for claimant's counsel's allegedly frivolous request for review. The insurer asserts that sanctions in the amount of approximately $1,200 is appropriate, based on its costs incurred for defending this appeal.

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

We find that claimant has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Although claimant's argument on review did not ultimately prevail, we do not agree that it was "frivolous." *See* ORS 656.390(2); *Bi-Mart Corporation v. Allen*, 164 Or App 288 (1999). Accordingly, we deny the insurer's request for sanctions.

ORDER

The ALJ's order dated April 4, 2000 is affirmed.

August 4, 2000 Cite as 52 Van Natta 1423 (2000)

In the Matter of the Compensation of
CORINNE L. BIRRER, Claimant
Own Motion No. 98-0279M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our January 18, 2000 Own Motion Order Reviewing Carrier Closure, in which we affirmed the insurer's September 13, 1999 Notice of Closure that: (1) declared claimant medically stationary as of November 30, 1998; and (2) awarded temporary disability compensation from September 1, 1998 through November 30, 1998. With her request for reconsideration, claimant submitted a February 15, 2000 report from Dr. McLean, her attending physician. Claimant argues that this report supports her contention that she continued to improve following her November 1998 medical release and, therefore, she was not medically stationary at the time her claim was closed.

On February 17, 2000, we abated our January 18, 2000 order to consider claimant's motion and to allow the insurer an opportunity to respond. Having received the insurer's response and claimant's reply, we proceed with our reconsideration.

Evidentiary Issue

As a preliminary matter, we address an evidentiary issue raised by claimant. With its response to claimant's request for reconsideration, the insurer submitted an April 5, 2000 summary of a March 30, 2000 telephone conversation with Dr. McLean regarding his opinion on claimant's medically stationary status. On April 11, 2000, Dr. McLean agreed that this conversation summary accurately reflected his opinion. Claimant objects to receipt of this report into evidence and demands the opportunity to cross-examine Dr. McLean pursuant to ORS 656.310(2).[1]

In support of her objection, claimant asserts that she is entitled to the last presentation of evidence. Specifically, she cites OAR 438-007-0023, which provides that "[t]he party bearing the burden of proof on an issue in a hearing has the right of first and last presentation of evidence and argument on the issue." This rule applies to procedures before the Hearings Division. Nevertheless, pursuant to OAR 438-012-0060(5), we are authorized to refer Own Motion matters to the Hearings Division for fact-finding hearings. Thus, we treat claimant's contentions regarding ORS 656.310(2) and OAR 438-007-0023 as a request for a fact-finding hearing. Based on the following reasoning, we do not consider a fact-finding hearing to be justified.

---

[1] ORS 656.310(2) provides:

"The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination. This subsection shall also apply to medical or surgical reports from any treating or examining doctor who is not a resident of Oregon, provided that the claimant, self-insured employer or the insurer shall have a reasonable time, but no less than 30 days after receipt of notice that the report will be offered in evidence at a hearing, to cross-examine such doctor by deposition or by written interrogatories to be settled by the Administrative Law Judge."

In her request for reconsideration, claimant conceded that Dr. McLean's February 15, 2000 response to claimant's inquiry about her medically stationary status was not "crystal clear." However, claimant apparently decided not to request further clarification from Dr. McLean regarding that opinion or his later agreement with a summary of a conversation with the insurer. Instead, claimant interpreted McLean's February 15, 2000 opinion as supporting her position that she was not medically stationary at claim closure. Claimant's decision not to request clarification from Dr. McLean or submit other rebuttal evidence does not mean that she was prevented from presenting additional evidence. Rather, the current record supports a conclusion that she did not avail herself of that opportunity.

Referral for a fact-finding hearing is normally made when the disputes are directly attributable to a witness' credibility or reliability (there is a need to develop testimonial and documentary evidence), or when the factual record is insufficiently developed to permit the Board adequate and proper review. *See e.g. Charles Tedrow*, 48 Van Natta 616 (1996).

Here, the matter in dispute is not contingent upon an appraisal of a witness' credibility or reliability. In addition, as summarized below, the factual record is not incomplete. Consequently, we decline to refer this matter to a fact-finding hearing.

All of the evidence regarding claimant's medically stationary status is provided by claimant's treating physician, Dr. McLean. On October 20, 1998, Dr. McLean examined claimant and found that she was doing well after her September 1, 1998 total knee arthroplasty. He released her to return to the "job market" at the end of November. He noted that he wanted to see claimant back in about six months. A separate October 20, 1998 "Clinician's Report of Disability" identified the "clinician" as Dr. McLean and stated that claimant was "release[d] to work," with time loss authorized from September 1, 1998 through November 29, 1998.

On November 9, 1998, claimant was released from physical therapy, with the notation that she was doing well, with excellent knee mobility and activity tolerance.

On April 8, 1999, Dr. McLean examined claimant and noted that she was doing well, although she had some pain when using the accelerator in her car. Claimant had full extension, with flexion to about 110 degrees. He noted that claimant was to return in one year for x-rays.

Subsequently, Dr. McLean completed an 828 form dated August 31, 1999, and indicated that: (1) he had last treated claimant on October 20, 1998;[2] (2) as of November 1998, claimant was released to modified work with permanent restrictions of no heavy lifting, squatting, or kneeling; and (3) claimant was medically stationary as of November 1998.

Based on this 828 form, the insurer closed the claim by Notice of Closure on September 13, 1999. Claimant requested review of the September 13, 1999 Notice of Closure. As noted above, we affirmed that closure on January 18, 2000.

Subsequently, claimant requested reconsideration and submitted a February 15, 2000 opinion from Dr. McLean. That opinion was in response to a February 8, 2000 letter from claimant's attorney in which he provided copies of and summarized claimant's most recent medical documents. [Those documents, in relevant part, are summarized above]. Claimant's attorney also asked Dr. McLean to respond to the following:

> "Other than your note of November 1999,[3] we can see no evidence this lady was medically stationary in November of 1998, only two months[4] after her total knee replacement. There is some indication, however, that she was not medically stationary. Your response to the following question is urgently requested.

---

[2] This is incorrect. As noted above, Dr. McLean subsequently treated claimant on April 8, 1999.

[3] This must be in reference to the 828 form as there is no "note of November 1999" either in the record or summarized in claimant's attorney's letter to Dr. McLean.

[4] Actually, this should be "three months." Claimant underwent surgery on September 1, 1998; therefore, the end of November 1998 would be three months post-surgery.

> "Given that [claimant] was continuing to have complaints and problems in April of 1999, would you agree that she was not yet stationary in November of 1998 and that in all probability was not stationary before April of 1999?" [Footnotes added].

Dr. McLean checked the "no" box, indicating that he did not agree with the above statement, and added: "[Patients] continue to improve for one year after joint replacement - [claimant] was stable in Nov[ember] [19]98 but will improve as noted."

On April 11, 2000, Dr. McLean agreed to the following summary provided by the insurer's attorney of a conversation that took place on March 30, 2000:

> "You stated [claimant] was medically stationary as of November 1998. This is consistent with the 828 Form you previously signed. You noted that most people recover from total knee replacement surgery in about three months, as did [claimant].
>
> "You also clarified your comments in response to [claimant's] attorney's February 8, 2000 letter. In that letter, [claimant's] attorney asked you if you agreed she was not medically stationary before April 1999. At that time you disagreed, and again indicated she was medically stationary as of November 1998. You also wrote that the patient will 'continue to improve for one year.' During our conversation you explained that what you meant was that [claimant] will continue to become more comfortable with her new knee, but that she will not *medically* improve as of November 1998." [Emphasis in original].

We do not find anything new in this last opinion that would be the basis for a fact-finding hearing. Specifically, no new data was provided and/or discussed. Instead, in three separate opinions, Dr. McLean stated that claimant was medically stationary as of November 1998. In addition, Dr. McLean explicitly disagreed with claimant's attorney's theory that claimant was not medically stationary as of November 1998. Dr. McLean's April 11, 2000 opinion is consistent with that disagreement.

The parties are entitled to develop the record. Claimant has availed herself of that opportunity by soliciting and submitting a report from Dr. McLean. The insurer did the same thing by soliciting and submitting a "clarification" opinion from Dr. McLean. As previously noted, the record does not indicate that claimant was prevented from submitting further "clarification/supplementation" opinions. Rather the record suggests that she has not availed herself of that opportunity.

Under such circumstances, we find the record to be adequately developed. Therefore, we need not refer this matter to another forum for taking of further evidence. *See Frank L. Bush*, 48 Van Natta 1293 (1996); *Gary A. Toedtemeier*, 48 Van Natta 1014 (1996).

Medically Stationary Status

Based on the reasoning in our initial order, in addition to the following reasoning, we continue to find that claimant's claim was not prematurely closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the 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 reconsideration, claimant submitted a February 15, 2000 concurrence report from Dr. McLean. In that report, Dr. McLean disagreed with the statement that "[claimant] was not yet medically stationary in November of 1998 and that in all probability was not stationary before April of 1999." He supplemented the report with the following comment: "[patients] continue to improve for one year after

joint replacement - [claimant] was stable in Nov[ember] [19]98 but will improve as noted." Claimant contends that Dr. McLean's comment that she would "improve," demonstrates that she was not medically stationary when her claim was closed.

The insurer submitted an April 11, 2000 "clarifying" conversation summary from Dr. McLean. In that report, Dr. McLean agreed that claimant was medically stationary as of November 1998. He also explained his previous "improve" comment in his February 2000 concurrence report to mean that claimant would become more comfortable with her "new" knee, but that she would *not medically* improve beyond her medically stationary date in November 1998.

As noted above, "medically stationary" is a legal term defined by statute as meaning there is no reasonable expectation of further material improvement from medical treatment or the passage of time. ORS 656.005(17). Therefore, the fact that claimant continued to have discomfort in her knee does not mean that her knee condition was not medically stationary at the time of closure. Instead, the relevant inquiry focuses on whether there is a reasonable expectation of material improvement. Dr. McLean's use of the phrase "will improve" in the February 2000 concurrence report is sufficiently explained in his April 2000 report to mean that claimant would adjust to her new knee with time, but that further material improvement was *not* expected. Contrary to claimant's argument, as noted above, Dr. McLean explicitly disagreed, in his February 2000 concurrence report, that claimant was *not* medically stationary in November 1998 or before April 1999. In addition, his subsequent explanation of his use of the phrase "will improve" in the February 2000 report continues to support a finding that claimant's knee condition was medically stationary at claim closure. Consequently, we continue to conclude that the claim was properly closed.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our January 18, 2000 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.

August 3, 2000 Cite as 52 Van Natta 1426 (2000)

In the Matter of the Compensation of
TRICIA M. JACKSON, Claimant
WCB Case No. 99-07076
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of her claim for a low back injury. On review, the issue is compensability.

We adopt and affirm the order of the ALJ. *See, e.g., Diann C. Harry*, 51 Van Natta 1540 (1999) (Where inconsistencies existed in the record, the Board found that the claimant's contemporaneous reporting in the medical records was more likely accurate than her recollection at hearing).

ORDER

The ALJ's order dated April 13, 2000 is affirmed.

In the Matter of the Compensation of
SALVADOR GUEVARA-MORALES, Claimant
WCB Case No. 99-06605
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Martha Brown's order that affirmed an Order on Reconsideration's award of 8 percent (25.6 degrees) unscheduled permanent disability for claimant's low back injury. In its brief, the employer requests that we take official notice of a March 27, 2000 Opinion and Order issued in WCB Case No. 99-03242, by which the ALJ upheld the employer's denial of compensability and responsibility for claimant's current low back condition. On review, the issues are administrative notice and extent of unscheduled permanent disability.

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

The employer requests that we take administrative notice of a March 27, 2000 Opinion and Order from ALJ Martha Brown regarding the compensability of claimant's current low back condition. Claimant moves to strike portions of the employer's brief that allegedly rely on the March 27, 2000 Opinion and Order.

The employer contends that claimant's new low back injury on September 28, 1998, along with its April 16, 1999 denial of claimant's current lumbar strain under this claim, preclude claimant from being awarded any permanent partial disability on this claim because responsibility for all of claimant's subsequent medical treatment and disability has become the responsibility of the new injury employer under ORS 656.308(1).

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." *See* 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).

However, under ORS 656.283(7), we are statutorily prohibited in "extent" cases from considering "[e]vidence on an issue regarding a notice of closure or determination order" if that evidence was not submitted on reconsideration and made a part of the reconsideration record. *See, e.g., Precision Castparts Corp. v. Plummer*, 140 Or App 227, 231 (1996); *Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996). Therefore, because the March 27, 2000 Opinion and Order was not in existence at the time of the reconsideration proceeding and is not a part of the reconsideration record, we may not consider it as evidence on any issue regarding the Notice of Closure in this case. *See, e.g., Tony D. Houck*, 51 Van Natta 1301 (1999) (Board did not consider an administrative order concerning a medical treatment dispute as evidence because it could have impacted Board's decision about premature closure). Consequently, because no evidence outside the record has been considered, there is no need to strike portions of the employer's brief and claimant's motion to strike 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 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 March 27, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
OSKAR HESS, Claimant
WCB Case No. 99-06658
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
James Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's injury/occupational disease claim for a myocardial infarction; and (2) assessed a 25 percent penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the final two paragraphs.

CONCLUSIONS OF LAW AND OPINION

Claimant, an owner of a business that installs sewer and water lines, filed a claim for a heart attack (myocardial infarction) allegedly the result of mentally stressful work conditions involving a project to connect a commercial building to a sewer line. SAIF denied the claim and claimant requested a hearing.

The ALJ set aside SAIF's denial, finding that claimant had proved that employment events on or about May 24, 1999 were the major contributing cause of his heart attack. In finding that claimant had proved a compensable claim, the ALJ applied the compensability standards of ORS 656.005 and relied on the medical opinion of Dr. Spear, an attending cardiologist, who opined that psychological stress related to claimant's employment precipitated his myocardial infarction. In addition, the ALJ determined that SAIF did not have reasonable doubt about its liability when it issued its denial. Thus, the ALJ assessed a 25 percent penalty for an unreasonable denial.

On review, SAIF contends that the ALJ incorrectly set aside its denial. In making this contention, SAIF asserts that claimant must satisfy the occupational disease/mental disorder requirements in ORS 656.802, citing *SAIF v. Falconer*, 154 Or App 511 (1998).[1] Arguing that Dr. Spear's opinion is insufficient to satisfy claimant's burden of proof, SAIF contends that claimant failed to prove by clear and convincing evidence that his heart attack arose out of his employment. ORS 656.802(3)(d). Further, SAIF argues that claimant failed to establish that the job stressors to which he was exposed were other than those generally inherent in every working situation. ORS 656.802(3)(b).

At the outset, we agree with SAIF that, under *Falconer*, claimant must satisfy the mental disorder requirements of ORS 656.802. This is an occupational disease claim for an alleged mental stress-caused physical condition. Specifically, claimant contends that his physical disorder (heart attack) was caused, at least in part, by factors related to mental stress. ORS 656.802(1)(b) provides that a "mental disorder" includes any physical disorder caused or worsened by mental stress. Therefore, claimant must establish compensability under ORS 656.802(3), the statute pertaining to "mental disorders." *See SAIF v. Falconer*, 154 Or App at 516.[2] We need not address, however, whether the job stressors to which claimant was exposed were other than those generally inherent in every workplace because, even if they were, we find that claimant failed to satisfy the clear and convincing evidence standard.

Subsection (d) of ORS 656.802(3) provides that there must be "clear and convincing evidence" that the mental disorder arose out of and in the course of employment." Accordingly, it must be "highly probable" that the alleged stress-caused disorder (heart attack) arose out claimant's employment. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987). Because of the multiple potential

[1] The *Falconer* court held that a claim for a mental stress-caused physical disorder could be satisfied by diagnosis of stress-caused physical condition that was generally recognized in medical or psychological community. 154 Or App at 517.

[2] Indeed, even claimant concedes as much. (Respondent's Brief Page 2).

causes (*i.e.*, work stress or preexisting coronary artery disease) of claimant's heart attack, 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).

Dr. Spear initially agreed with a statement that claimant's work exposure was the major contributing cause of his heart attack. (Ex. 15-2). Dr. Spear, however, subsequently explained his opinion in a November 18, 1999 narrative report. In that report, Dr. Spear stated:

> "Thus, as the question is asked what is the major cause of a myocardial infarction one must state that the underlying cause is atherosclerotic coronary artery disease. This may or may not make sense to you from a pure anatomic standpoint but that is what is what we consider the major cause of a myocardial infarction." (Ex. 17-1).

It is apparent from the above passage that Dr. Spear believed that the major contributing cause of claimant's heart attack was underlying atherosclerotic coronary artery disease. Dr. Spear's subsequent comments make clear that mental stress related to claimant's employment was, in his opinion, only the "precipitating cause" leading to the heart attack. Dr. Spear explained:

> "From my standpoint there is another way to assess why the plaque ruptured, with the extreme stress that was going on at the time of his acute event [claimant] had arguably been having a coronary spasm that precipitated his myocardial infarction, *thus the stress of his situation at that time precipitated his event.*" *Id.* (emphasis added).

Given the distinction Dr. Spear drew between the major contributing cause of claimant's heart attack (the underlying coronary artery disease) and the precipitating cause of the heart attack (stressful events at work), we are unable to conclude, based on Dr. Spear's report, that it is "highly probable" that work stress was the major contributing cause of claimant's heart attack. *See Worldmark The Club v. Travis*, 161 Or App 644, 650 (1999) (medical opinion that only identified the work injury as a precipitating cause of the condition or need for treatment was not sufficient to establish the work injury as the major contributing cause).

Dr. Toren, an examining cardiologist, provided the only other opinion on the causation issue. Dr. Toren opined that the major cause of claimant's heart attack was the underlying, preexisting arteriosclerotic coronary artery disease. (Ex. 13-1). Dr. Toren noted that diagnostic studies revealed that claimant's heart attack was associated with the rupture of long-standing arteriosclerotic plaque leading to an acute occlusion of a coronary artery. Dr. Toren conceded that extreme emotional stress can be a factor in the onset of a myocardial infarction, but that it would be a minor factor compared to the preexisting coronary artery disease. Opining that no manner of work-related stress would have led to claimant's heart attack without the underlying disease, Dr. Toren concluded that the underlying coronary artery disease was the major factor in the heart attack. *Id.*

Having reviewed the medical evidence *de novo*, we conclude that it does not establish by "clear and convincing" evidence that claimant's heart attack arose out of and in the course of employment. Thus, we reverse the ALJ's decision setting aside SAIF's denial.

Finally, the ALJ assessed a 25 percent penalty, finding that SAIF did not have legitimate doubt regarding its liability when it issued its denial. *See Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). Even assuming that SAIF did not have legitimate doubt regarding its liability when it issued its denial, in light of our decision on the compensability issue, there are no amounts "then due" upon which to base a penalty. ORS 656.262(11). Consequently, a penalty cannot be awarded and it, therefore, follows that the ALJ's penalty assessement must be reversed. Further, because we have concluded that claimant's claim is not compensable, we also do not award a penalty-related attorney fee as there has not been unreasonable resistance to the payment of compensation. *See* ORS 656.382(1).

ORDER

The ALJ's order dated February 25, 2000 is reversed. SAIF's denial is reinstated and upheld. The ALJ's penalty assessment and attorney fee award are also reversed.

In the Matter of the Compensation of
KAREN L. JOHNSON, Claimant
WCB Case No. 99-09441
ORDER ON REVIEW
Thaddeus J. Hette, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mills' order that dismissed her request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

FINDINGS OF FACT

On September 8, 1999, claimant signed a retainer agreement employing her then-attorney of record to represent her in connection with her workers' compensation claim. A provision of that retainer agreement stated that: "Client agrees that Attorney is empowered to perform such services on behalf of client as he deems necessary." On December 1, 1999, claimant, through her then-attorney, requested a hearing regarding a November 15, 1999 denial. A hearing was scheduled for February 24, 2000.

A "Docket Action Worksheet" dated February 23, 2000, indicates that the hearing request was withdrawn. On March 3, 2000, claimant's counsel wrote a letter to the ALJ confirming that claimant had withdrawn her hearing request. The ALJ then dismissed claimant's hearing request by Order of Dismissal of March 20, 2000.

In a letter received by the Board on April 20, 2000, claimant requested review. Claimant stated that she was "intimidated" into withdrawing her hearing request, which she realized was a "very bad mistake." On April 26, 2000, claimant's attorney notified the Board that he no longer represented claimant in connection with her claim.

CONCLUSIONS OF LAW AND OPINION

The sole issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order appropriate.

Where a claimant signs a retainer agreement employing an attorney and giving that attorney authority to act on the claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. *See Arline F. Link*, 52 Van Natta 1032 (2000); *Robert S. Ceballos*, 49 Van Natta 617 (1997); *Gilberto Garcia-Ortega*, 48 Van Natta 2201 (1996). Claimant has the burden of proving that the dismissal order was not appropriate. *Donald J. Murray*, 50 Van Natta 1132, 1133 (1998) (citing *Harris v. SAIF*, 292 Or 683, 690 (1982)) (burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side).

Although claimant avers that she was "intimidated" into withdrawing her hearing request, she provides no specific information regarding this allegation. In any event, the retainer agreement between claimant and her then-attorney authorized that attorney to act on claimant's behalf. Claimant does not assert that her attorney lacked authority to withdraw her hearing request. Nor does she assert that she was not represented by the attorney who withdrew the hearing request at the time in question. *Cf. Silverio Frias, Sr.*, 49 Van Natta 1514, 1515 (1997) (Board vacated ALJ's dismissal order and remanded to the ALJ to determine if the attorney was authorized to withdraw her request for hearing).

Under these circumstances, we find no reason to alter the dismissal order. *See April F. Zamora*, 52 Van Natta 865 (2000) (although the claimant may have been dissatisfied with her attorney's action withdrawing request for review, the Board declined to alter dismissal order); *Steve L. Paul*, 50 Van Natta 1987(1998).[1]

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[1] We note that claimant is presently unrepresented. Because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to: WORKERS' COMPENSATION OMBUDSMAN, DEPT OF CONSUMER & BUSINESS SERVICES, 350 WINTER ST NE, SALEM OR 97301

ORDER

The ALJ's order dated March 20, 2000 is affirmed.

August 4, 2000 Cite as 52 Van Natta 1431 (2000)

In the Matter of the Compensation of
ALICE Z. KULCZYSKI, Claimant
WCB Case No. 99-05744
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) Thye's order that: (1) upheld the self-insured employer's denial of her low back disc herniations; (2) upheld the employer's denial of her low back aggravation claim; and (3) declined to award a penalty for the employer's allegedly unreasonable claim processing. In its brief, the employer moves to strike claimant's references in her "appellant's brief" to testimony given at the hearing, alleging that claimant's observations, explanations, revisions and interpretations contain evidence not admitted into the record. On review, the issues are motion to strike, compensability, aggravation and penalties.

We grant the motion to strike and adopt and affirm the ALJ's order.

Our review must be based on the record certified to us. *See* ORS 656.295(5). Thus, because claimant's brief refers to evidence not offered and admitted at hearing (and therefore not certified to us), we grant the insurer's motion to strike those portions of claimant's brief which refer to such evidence.[1]

ORDER

The ALJ's order dated April 18, 2000 is affirmed.[2]

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[1] To the extent that claimant's submission can be construed as a motion to remand to the ALJ for the taking of additional evidence, we deny such motion. We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing and is likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). In this case, there is no showing that the evidence submitted for the first time on review was unavailable with due diligence at the time of hearing. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome of the case. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. *See* ORS 656.295(5).

[2] We note that claimant is presently unrepresented. Because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927- 1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM OR 97301

In the Matter of the Compensation of
ROBERT E. LANCE, Claimant
WCB Case No. 99-00944
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

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

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

The ALJ set aside the insurer's pre-closure current condition denial on procedural and substantive grounds. Pursuant to *Croman Corporation v. Serrano*, 163 Or App 136 (1999), the ALJ found that the insurer impermissibly issued a "pre-closure" current condition denial because it had never accepted a "combined condition." ORS 656.262(7)(b). On review, the insurer asserts that its denial was proper under our holding in *Tracy A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998). We disagree with the insurer's argument.

We agree with the ALJ that, because the insurer never accepted a "combined condition," ORS 656.262(7)(b) does not apply to allow a pre-closure denial. *Croman Corporation v. Serrano*, 163 Or App at 136; *see Laura Coyle*, 52 Van Natta 1254 n 2 (2000); *Darius McKellips*, 51 Van Natta 2047 (1999).

In *Tracey A. Blamires*, we construed ORS 656.262(7)(b) as providing that, whether or not the carrier has accepted a combined condition, the carrier may issue a "pre-closure" denial whenever the medical evidence establishes that a claimant's accepted injury has combined with a preexisting condition to cause or prolong a claimant's disability or need for treatment. *See Gerry L. Schreiner*, 51 Van Natta 1998 (1999). However, regardless of the rationale expressed in *Tracey A. Blamires* we are bound to follow the Court of Appeals' more recent interpretation of ORS 656.262(7)(b), unless and until the court decides otherwise in *Blamires*.[1]

Although the ALJ set aside the insurer's denial as procedurally invalid, the ALJ proceeded to find claimant's current condition compensable on the merits. In light of our disposition of this case on the above procedural grounds, we decline to reach the merits of the compensability issue. Accordingly, the "Order" portion of the ALJ's order is amended to read "The insurer's denial is set aside as procedurally invalid."

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 March 1, 2000 is affirmed as modified. For services on review, claimant's attorney is awarded $1,250, payable by the insurer.

[1] We accept the insurer's representation that *Blamires* is currently pending at the Court of Appeals.

In the Matter of the Compensation of
RANDY M. PEDERSEN, Claimant
WCB Case No. 99-07412
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Edward J. Harri, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Johnston and Culberson, Inc. (JCI), the statutory processing agent for a non-complying employer, requests review of that portion of Administrative Law Judge (ALJ) Black's order that assessed a 25 percent penalty for JCI's allegedly unreasonable claim processing. Claimant cross-requests review of that portion of the ALJ's order that declined to award interim compensation from December 2, 1998 through July 20, 1999. On review, the issues are penalties and interim compensation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following correction.

Claimant filed a Form 801 on May 5, 1999.

We summarize the facts as follows.

Claimant sustained severe injuries when he fell from a hay loft to the ground on December 2, 1998 when working for the noncomplying employer. He was immediately hospitalized with a fractured back, spinal cord injury and bilateral hemopneumothoraces. A spinal fusion was performed.

Claimant filed a claim on May 5, 1999. After determining that claimant's employer was noncomplying, the Department assigned claimant's claim to JCI on July 20, 1999. By the time of hearing, the claim had not been accepted or denied.

On July 28, 1999, JCI faxed Dr. Peterson a request for medical information. Dr. Peterson's August 4, 1999 reply stated that claimant's work status was "no work" and that claimant's next appointment was sometime around August 15, 1999. On August 18, 1999, JCI paid temporary disability benefits for the period July 20, 1999 through August 11, 1999.

On August 31, 1999, JCI notified claimant that it had no time loss authorization after August 15, 1999 and would, therefore, cease payment of benefits after that date. On September 1, 1999, JCI paid temporary disability benefits for the period August 12, 1999 through August 15, 1999.

On September 7, 1999, JCI again wrote to Dr. Peterson requesting information regarding claimant's medical status and time loss authorization. In a September 17, 1999 letter, Dr. Peterson stated that it was obvious that claimant would have had time loss authorized from the date of injury. Dr. Peterson also stated that claimant would not be able to return to his previous employment, although he felt that claimant was capable of some kind of light to light-medium work and had been since about August 15, 1999. Dr. Peterson reported that claimant had been scheduled for a level II physical capacities evaluation (PCE) and authorized time loss until completion of the PCE.

On September 29, 1999, JCI paid time loss benefits for the period September 17, 1999 through September 22, 1999. No benefits were paid therafter.

On October 6, 1999, JCI wrote to claimant stating that it would close his workers' compensation claim because he had failed to seek treatment for more than 30 days.

CONCLUSIONS OF LAW AND OPINION

Penalty

The ALJ assessed a 25 percent penalty on the amounts of interim compensation due, based on the unpaid periods of time after August 15, 1999 through October 20, 1999. On review, the Workers' Compensation Division (WCD) contends that JCI's failure to pay interim compensation was not wholly

unreasonable and that a reduction of the 25 percent penalty assessed against JCI should be reduced to 5 percent.[1] We disagree.

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). 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).

There is no evidence that claimant's claim had been accepted or denied by the time of the hearing. Therefore, claimant's time loss benefits were in the form of interim compensation. *Jones v. Emanuel Hospital*, 280 Or 147 (1977) (when a claim has neither been accepted nor denied, the benefits for temporary disability that the employer must begin to pay no later than the 14th day after notice of the claim are known as "interim compensation"). A worker is entitled to interim compensation if he has suffered a loss of earnings as a result of a work-related injury. *RSG Forest Products v. Jansen*, 127 Or App 247 (1994).

Here, JCI was obligated to begin payment of interim compensation within 14 days of referral of the claim by the Director, if the attending physician authorized the payment of temporary disability compensation. ORS 656.054(1);[2] ORS 656.262(4)(a). Therefore, JCI's receipt of Dr. Peterson's August 4, 1999 letter authorizing claimant to be off work due to the job-related injury satisfied the requirements of ORS 656.262(4)(a) and triggered JCI's obligation to pay interim compensation pending acceptance or denial of the claim. In that letter, Dr. Peterson indicated that claimant's next appointment would take place on or about August 15, 1999. Dr. Peterson also did not indicate that the "off work" authorization would expire as of the August 15, 1999 examination.

JCI paid claimant interim compensation from July 20, 1999 through August 15, 1999 and ceased payments thereafter because it had learned that claimant did not see Dr. Peterson on August 15, 1999.[3]

ORS 656.262(4)(e) provides:

> "If a worker fails to appear at an appointment with the worker's attending physician, the insurer or self-insured employer shall notify the worker by certified mail that temporary disability benefits may be suspended after the worker fails to appear at a rescheduled appointment."

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[1] WCD participates on Board review pursuant to ORS 656.726(4)(h).

[2] ORS 656.054(1) provides in pertinent part:

> "A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with [Chapter 656]. * * * A claim for compensation made by such a worker shall be processed by the assigned claims agent in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first installment of compensation is to be paid, pursuant to ORS 656.262(4), shall not begin to run until the director has referred the claim to the assigned claims agent."

ORS 656.262(4)(a) provides in pertinent part:

> "The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation."

[3] In its August 31, 1999 letter to claimant notifying him that it was unable to pay benefits after August 15, 1999, JCI stated that it had attempted to obtain information about claimant's medical status from Dr. Peterson, but had been unsuccessful. (Ex. 15).

The statute provides no authority to cease the payment of interim compensation merely because claimant did not attend the August 15, 1999 appointment. Rather, the statute requires JCI to notify claimant *by certified mail* that his temporary disability benefits may be suspended if he failed to appear at a *rescheduled* appointment. Because JCI's letter does not fulfill the statutory requirements, we conclude that JCI had no authority to cease the payment of interim compensation on August 15, 1999.

On September 7, 1999, JCI wrote to Dr. Peterson requesting further information regarding his continuing authorization of time loss, among other things. (Ex. 17). On September 17, 1999, Dr. Peterson responded that he would have authorized time loss from the time of the injury on and that he continued to authorize time loss until a physical capacities examination (PCE) had been completed. (Ex. 18). On September 29, 1999, JCI resumed paying interim compensation benefits effective September 17, 1999.

On September 29, 1999, JCI again wrote to Dr. Peterson. JCI stated that it had learned that claimant had not treated since June 10, 1999 and asked whether it had been at Dr. Peterson's direction. JCI concluded by stating that "it appears that [claimant] is not currently under your care and we are unable to pay any additional [temporary disability] benefits pending clarification." (Ex. 21).

On October 6, 1999, JCI sent claimant a certified letter stating in part:

"To our knowledge, you have not received treatment for your above mentioned injury since June 10, 1999. * * * .

"Oregon law allows an insurer to administratively close a workers' compensation claim when a worker fails to seek treatment beyond 30 days under the following conditions:

"Failure to obtain treatment was without the instruction or approval of your physician; and

"You have been notified that claim closure will result from the failure to obtain treatment.

"If we have not heard from you or your attending physician within 14 days from the date of this letter, we will proceed with the closure of your claim." (Ex. 22).

On the same date JCI sent a similar letter by regular mail to claimant. This letter stated:

"Information in your file indicates you have not been seen by your attending physician, Mark Peterson, MD since June 20, 1999. Information has been requested from Dr. Peterson to clarify your current medical status and determine if any temporary disability benefits are due. Because you have not treated for your injuries in nearly four months, we are unable to pay any additional temporary disability benefits pending a response from Dr. Peterson." (Ex. 23).

JCI unilaterally terminated the payment of interim compensation effective September 22, 1999.

The letters quoted above indicate that JCI apparently terminated claimant's interim compensation based on his failure to seek medical treatment under ORS 656.268(1)(c). ORS 656.268(1)(c) instructs the carrier to close a worker's claim and determine the extent of permanent disability upon the occurrance of certain triggering conditions, one of which is a worker's failure to seek medical treatment for a period of 30 days or to attend a closing examination, unless the worker affirmatively establishes that such failure was attributable to reasons beyond the worker's control. However, this statute does not provide authority to terminate temporary disability benefits and we fail to see how claim closure is appropriate on an unaccepted claim.

We have already addressed the inappropriateness of the termination of interim compensation based on claimant's failure to appear at the August 15, 1999 appointment. *See* ORS 656.262(4)(e). Moreover, claimant's attending physician had verified claimant's inability to work after JCI had requested such verification and had authorized temporary disability compensation to continue until a

PCE was performed.[4] *See* ORS 656.262(4)(d) and ORS 656.262(4)(g). Consequently, on this record, we find no statutory authority for JCI's termination of claimant's interim compensation benefits on September 22, 1999.

Because it is the responsibility of the claim processor to properly apply the law, we conclude that JCI had no legitimate doubt as to its liability.[5] Therefore, its failure to pay interim compensation was unreasonable. Consequently, we decline to reduce the 25 percent penalty assessed by the ALJ.

Interim Compensation from December 2, 1998 through July 20, 1999

The ALJ concluded that, although claimant was entitled to interim compensation due prior to assignment of a claim to the assigned claims agent, such benefits were not payable because there was no authorization of such benefits by the attending physician. On review, claimant asserts that he is entitled to additional interim compensation from the date of injury, December 2, 1998, through July 20, 1999, because the noncomplying employer had notice or knowledge of the claim when it occurred on December 2, 1998, and claimant was hospitalized for more than 14 days thereafter. We disagree.

As discussed in the penalty section above, JCI was obligated to begin payment of interim compensation within 14 days of referral of the claim by the Director. ORS 656.054(1). However, claimant is not entitled to interim compensation commencing with the noncomplying employer's first notice of the claim. *Steven J. Spaur*, 44 Van Natta 2387 (1992), *aff'd per curiam Spaur v. Ashenberner Lumber*, 121 Or App 684 (1993), citing *O'Neall v. Tewell*, 119 Or App 329 (1993) (an assigned claim processing agent for a noncomplying employer is obligated to pay benefits for time loss for the period prior to the time it has notice of the claim only if the claim is ultimately accepted or determined to be compensable).

Here, because the claim had not been accepted by the time of hearing, claimant's entitlement to interim compensation runs from 14 days after the Director referred the claim to JCI.[6]

ORDER

The ALJ's order dated February 15, 2000, as reconsidered February 29, 1999, is affirmed.

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[4] If JCI based its termination of interim compensation on its failure to to receive Dr. Peterson's verification of claimant's inability to work in response to its September 29, 1999 request, it did so in error. Under these circumstances, the controlling statute is ORS 656.262(4)(f), which provides that medical services provided by the attending physician are not compensable until the attending physician submits such verification.

[5] Although it may be confused about the proper application of the law, JCI does not claim that the law is uncertain.

[6] Claimant also argued that it would be a violation of Article I, Section 10 of the Oregon Constitution to preclude claimant from receiving interim compensation for periods before referral. Because claimant did not raise the constitutional issue at hearing, he is barred from raising it on review. *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *Eugenio Gonzalez*, 45 Van Natta 921 (1993).

In the Matter of the Compensation of
MICHAEL STEWART, Claimant
Own Motion No. 99-0199M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Kryger, et al, Claimant Attorneys

Claimant requests review of the self-insured employer's March 22, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from May 21, 1999 through May 25, 1999. The employer declared claimant medically stationary as of September 28, 1999. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 22, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a May 9, 2000 letter, we requested the employer to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. Having received the parties responses we proceed with our review.

Claimant contends that he was not medically stationary when the employer closed his claim because his "knee is a cronic [sic] problem that is probabl[y] going to get worse," and that he has everyday symptoms with his knee and both ankles. Claimant submitted a November 19, 1999 doctors report from Dr. Malkin, one of claimant's treating physicians, wherein a symptomatic posterior tibial tendon strain and sinus tarsi impingement was diagnosed. Dr. Malkin opined that claimant should undergo a fore foot and rear foot reconstruction, but noted that due to current work impediments, claimant was unable to undergo that surgery at that time. In the interim, Dr. Malkin recommended that claimant continue with his anti-inflammatories and shoe inserts.

However, claimant's claim was accepted for a left knee condition. The record does not indicate that an ankle/foot condition has been accepted by the employer. Therefore, unless the employer has accepted an ankle/foot condition, claimant must establish that he was not medically stationary at closure with respect to his accepted knee condition. *Rogers v. Tri-Met*, 75 Or App 470 (1985). Here, Dr. Malkin indicated that claimant requires surgery for his ankle/foot condition. However, he does not relate the possible ankle/foot condition to claimants compensable claim. Additionally, in a February 11, 2000 response to a check-the-box inquiry from the employer, Dr. Malkin specifically states that he cannot comment regarding claimant's compensable knee condition and is silent as to his possible ankle/foot condition.

In addition, although Dr. Gordin, claimant's attending physician, does not specifically state in his September 28, 1999 chart note that claimant was "medically stationary," the use of "magic words" or statutory language is not required. *Liberty Northwest Ins. Corp. v. Cross*, 109 Or App 109 (1991), *rev den* 312 Or 676 (1992), as cited in *U-Haul of Oregon v. Burtis*, 120 Or App 353 (1993); *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412, 417 (1986). In his September 28, 1999 chart note, Dr. Gordin noted that claimant had a full range of motion in his left knee and had regained his quadriceps bulk and strength. He also noted that although claimant had some intermittent swelling and pain, he could find not a "discreet" lesion that would be causing the inflammation. He concluded that claimant would probably have a chronic problem with recurrent inflammation of the left knee. Dr. Gordin noted that claimant was complaining of discomfort in his ankles and for that he was referred to Dr. Malkin. He does not relate claimant's ankle complaints to his compensable knee condition. With regard to claimants left knee condition, Dr. Gordin opined that "at this point I feel I have nothing more to offer."

Based on the uncontroverted medical evidence, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the employer's March 22, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

August 4, 2000 Cite as 52 Van Natta 1438 (2000)

In the Matter of the Compensation of
SHEILA A. LEFORS, Claimant
WCB Case No. 99-07460
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of our May 26, 2000 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that decreased claimant's award of unscheduled permanent disability for a cervical and low back injury from 17 percent (54.4 degrees), as awarded by an Order on Reconsideration, to zero. On June 20, 2000, we withdrew our order to consider claimant's motion for reconsideration. Having received the employers response to claimant's motion, we proceed with our reconsideration.

Claimant contends that we failed to address claimant's cervical impairment or her arguments regarding the instructions that were provided to the medical arbiter panel.

The ALJ addressed claimant's cervical and lumbar impairments in his January 14, 2000 Opinion and Order. We adopted and affirmed the ALJ's order with respect to both impairments. In doing so, we intended for our order and the supplementation to include the cervical spine, as well as the lumbar spine, and amend our order accordingly.

Moreover, by adopting the ALJ's order, we addressed claimant's arguments concerning the medical arbiter panel instructions and we continue to adhere to the conclusions reached in our prior decision. *See, e.g., Jorge Pedraza*, 49 Van Natta 1019 (1997).

Accordingly, on reconsideration, as supplemented, we republish our May 26, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Phillips Polich dissenting,

For the reasons expressed in my previous dissenting opinion, I continue to disagree with the majority's decision.

In the Matter of the Compensation of
GAYLYNN GRANT, Claimant
Own Motion No. 99-0129M
OWN MOTION ORDER
Welch, Bruun & Green, Claimant Attorneys
Ray Myers (Saif), Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for claimant's left shoulder and neck condition. Claimant's aggravation rights expired on February 21, 1997. Although SAIF agreed that claimant's current condition was causally related to the accepted condition, it recommended against reopening the claim for own motion relief on the grounds that surgery or hospitalization was not appropriate for the compensable injury. Pursuant to ORS 656.327, claimant requested the Director to review the requested medical treatment. 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 was 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 was 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 that order.[1] On October 25, 1999, claimant underwent the cervical surgery[2] that was the subject of the dispute in Administrative Order MS 99-384. In addition, MRU abated its order to consider the managed care organization's (MCO's) decision regarding the appropriateness of the proposed treatment. On January 14, 2000, we again postponed action on the own motion matters pending the outcome of the medical services dispute.

On June 28, 2000, the MRU issued an Administrative Order which found that the October 25, 1999 surgery was appropriate medical treatment for claimant's compensable injury. (MTX 00-272). No party requested administrative review of that decision within the requisite 30-day period.

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

Here, the dispute regarding the reasonableness and necessity of claimant's surgery has been resolved. *See* ORS 656.260, and 656.327. The Director has concluded that the October 25, 1999 surgery was appropriate treatment for claimant's compensable injury. Thus, we conclude that claimant's compensable injury has worsened requiring the proposed surgery, and that SAIF is responsible for that surgery. *See Judith R. King*, 48 Van Natta 2403 (1996). Because there are no other issues in dispute, the Board has jurisdiction to authorize the payment of temporary disability compensation in this claim. ORS 656.278(1)(a).

Accordingly, we authorize the reopening of claimant's 1991 industrial injury claim and direct SAIF to provide temporary disability compensation beginning October 25, 1999, the date she was hospitalized for the surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] On May 5, 2000, the Director dismissed SAIF's request for a contested case hearing noting that the MRU had abated its October 7, 1999 order and therefore the issues before it were moot.

[2] This surgery consisted of an anterior cervical diskectomy, foraminotomy, and neural decompression followed by instrumented interbody fusion at C5-6 and C6-7 as recommended by Dr. Brett, claimant's attending physician.

In the Matter of the Compensation of
JUDY A. BELL, Claimant
WCB Case Nos. 99-03656 & 99-02441
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the exception of the ALJ's "Finding of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable injury to her lower back when she lifted a "lexon," or tub, of lettuce at work on February 22, 1998. (Tr. 11). She felt the immediate onset of pain in her low back and down both of her legs. (Tr. 14). The insurer accepted claimant's claim for a disabling lumbar strain. (Ex. 18).

On June 16, 1998, during a medical examination performed at the request of the insurer, claimant experienced the sudden onset of severe left leg pain, extending into her foot. (Tr. 15). A lumbar MRI on June 24, 1998 revealed a large herniated disc at L4-5. (Ex. 23). Claimant was referred to neurosurgeon Dr. Buza. (Ex. 24). On July 16, 1998, Dr. Buza performed surgery directed at the L4-5 disc space. (Ex. 28).

The ALJ set aside the insurer's *de facto* denial of claimant's claim for a herniated disc at L4-5 based on the opinion of her treating physician and surgeon Dr. Buza. Dr. Buza concluded that claimant's February 22, 1998 compensable injury had caused a tear in the annulus surrounding her L4-5 disc, which disc then herniated during her forward flexion maneuver at the June 16, 1998 medical examination. (Ex. 33, 46). In contrast, Dr. Young, a radiologist who performed a file review and review of imaging studies at the insurer's request, concluded that the major contributing cause of claimant's disability and need for treatment for her L4-5 disc herniation condition was preexisting degenerative disease in her lumbar spine. (Ex. 36).

On review, the insurer first contends that the ALJ failed to evaluate claimant's claim as a "consequential condition" under ORS 656.005(7)(a)(A). Under that standard, claimant must prove that her compensable February 22, 1998 injury was the major contributing cause of her L4-5 herniated disc condition. *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Instead of this statute, the ALJ applied the "preexisting condition" standard, which necessitates proof of the treatment or disability for the combined condition on a major contributing cause basis. ORS 656.005(7)(a)(B). *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997). We need not decide this issue, however, as we find that claimant has failed to meet her burden of proof under either standard.

Where the medical evidence is divided, we rely on those opinions that are based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). In addition, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to claimant's treating physician Dr. Buza.

The insurer contends that Dr. Buza is not entitled to the ordinary deference accorded to a treating physician because he did not examine claimant soon after her February 22, 1998 injury. *McIntyre v. Standard Utility Contractors*, 135 Or App 298, 302 (1995). We agree. Dr. Buza did not examine claimant until more than four months after her February 22, 1998 injury. (Ex. 24). In such circumstances, we have declined to accord a treating physician the ordinary deference, and found that physician's opinion less persuasive. *See Carl F. Plumlee*, 52 Van Natta 185 (2000).

Here, there are other reasons for discounting Dr. Buza's opinion. Specifically, Dr. Buza's opinion is inconsistent. In one report and in his deposition, Dr. Buza reasoned that claimant's compensable injury caused a tear in the annulus surrounding her disc at L4-5, which in turn was the major contributing cause of her disc herniation. (Ex. 24-3, 49-23). However, in an earlier letter, Dr. Buza confirmed that claimant suffered from preexisting degenerative disc disease, facet joint disease and a calcified disc at L4-5. (Ex. 42-2). He agreed that claimant had suffered only a strain after her February 22, 1998 work injury. (Ex. 42-1). Dr. Buza further agreed that "any complaints of ongoing back pain * * * relate to the preexisting conditions and not her on-the-job injury and resulting surgery." (Ex. 42-2).

In still another report, Dr. Buza made the internally inconsistent statement that "I agree that the disc bulge and herniation was degenerative in nature, but I believe that a ruptured disc occurring at this same level was caused by trauma." (Ex. 41). Finally, in his deposition, Dr. Buza opined that claimant's torn annulus was the major cause of her need for treatment - a greater factor than her disc disease, the independent medical examination, *and the work injury itself.* (Ex. 49-23). We cannot determine from such a statement that Dr. Buza has offered an opinion that meets claimant's burden of proving that her February 1998 work injury was the major contributing cause of her disability or need for treatment for her low back condition. *See Thomas K. Osborne*, 51 Van Natta 1262 (1999) ("Major contributing cause" means "more than 50 percent" of the cause).

These inconsistencies in Dr. Buza's opinion were never explained. Accordingly, we find Dr. Buza's opinion unpersuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987); *Constance D. Wilbourn*, 51 Van Natta 1541 (1999).

In contrast, we find the opinion of Dr. Young persuasive because it is well-reasoned and based on complete and accurate information. *Miller v. Granite Construction*, 28 Or App 473 (1977). After reviewing claimant's medical records, operative report, and imaging studies, Dr. Young concluded that claimant's foraminal stenosis, scar tissue and a (somewhat calcified) protruding disc were preexisting and degenerative in nature, as opposed to traumatic. (Ex. 36-7). In support of his opinion, Dr. Young explained that calcification of the disc requires many years to develop and that all calcified discs are chronic and long-standing in nature. (Ex. 36-7). Dr. Young reasoned, therefore, that claimant's disc herniation at L4-5 preexisted both her February 22, 1998 work injury and her forward flexion maneuver during the June 16, 1998 insurer-requested medical examination. (Ex. 36-7).

Accordingly, for the reasons stated above, we reverse that portion of the ALJ's order that set aside the insurer's *de facto* denial of claimant's L4-5 herniated disc condition.

ORDER

The ALJ's order dated March 23, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the insurer's *de facto* denial of claimant's L4-5 disc condition is reversed. The ALJ's attorney fee award is also reversed. The remainder of the order is affirmed.

August 9, 2000 Cite as 52 Van Natta 1441 (2000)

In the Matter of the Compensation of
JAMES T. LEE, Claimant
WCB Case No. 98-06593
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) affirmed an Order on Reconsideration award of 19 percent (60.8 degrees) unscheduled permanent disability for claimant's low back condition; and (2) awarded temporary disability benefits from November 11, 1998 through February 9, 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 changes and supplementation. In the fourth paragraph on page 4 of the ALJ's Order on Reconsideration, we change the citation in the first

sentence to "ORS 656.214(2)." In the last paragraph on page 6, we change the first sentence to read: "Under ORS 656.005(12)(a)(B), a chiropractor can function as claimant's attending physician '[f]or a period of 30 days from the date of first visit on the initial claim[.]'" We supplement the ALJ's order to note that we would reach the same conclusion no matter which party has the burden of proof.

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

ORDER

The ALJ's order dated March 21, 2000, as reconsidered April 6, 2000, is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

August 9, 2000 Cite as 52 Van Natta 1442 (2000)

In the Matter of the Compensation of
STEWART C. CORREIA, Claimant
Own Motion No. 00-0239M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his bilateral knee and ankle conditions. Claimant's aggravation rights expired on November 24, 1989. SAIF agrees that claimant's current conditions are causally related to his accepted conditions for which it is responsible. However, SAIF contends that claimant has not met his burden of proof regarding his work force status 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 conditions require surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Here, claimant must prove that he was in the work force on July 3, 2000, the date he was hospitalized for surgery. SAIF's position is that it is unsure whether claimant has met his burden of proof regarding his work force status. However, claimant reported that he received unemployment benefits until a few days after his surgery. In support of his representations, claimant submitted a payment schedule from the Employment Department demonstrating unemployment payments for the period between April 2000 and July 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). The relevant time period for which claimant must establish he was in the work force is the time prior to July 3, 2000, when he was hospitalized for surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

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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).

Here, claimant has established that he received unemployment benefits from April 17, 2000 until July 5, 2000. The receipt of unemployment benefits is *prima facie* evidence that claimant is willing to work and is making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991). Therefore, we find that claimant was in the work force at the time of his current worsening which required surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning July 3, 2000, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

August 9, 2000 Cite as 52 Van Natta 1443 (2000)

In the Matter of the Compensation of
VAN V. HUYNH, Claimant
WCB Case No. 99-09391
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Scheminske, et al, Defense Attorneys
Shelley K. Edling, Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration that awarded 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of claimant's left forearm and 23 percent (34.5 degrees) scheduled permanent disability for loss of use or function of her right forearm. On review, the issue is extent of scheduled permanent disability.[1] We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact, we delete the second sentence and change the third sentence to read: "The employer accepted disabling bilateral tendinitis of the forearms." We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant's accepted condition is bilateral tendinitis of the forearms. (Ex. 11). An August 5, 1999 Notice of Closure awarded 5 percent scheduled permanent disability for loss of use or function of each of claimant's forearms. (Ex. 12). Claimant requested reconsideration. (Ex. 14). Dr. Thomas performed a medical arbiter examination on September 30, 1999. (Ex. 15). A November 5, 1999 Order on Reconsideration awarded 15 percent scheduled permanent disability for loss of use or function of claimant's left forearm and 23 percent scheduled permanent disability for loss of use or function of her right forearm. (Ex. 16). The employer requested a hearing. The ALJ relied on the opinion of Dr. Thomas and affirmed the Order on Reconsideration.

The employer relies on the opinions of Drs. Sohlberg, Kim and Vessely to argue that claimant has no impairment in addition to the chronic condition as determined in the Notice of Closure.[2]

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[1] Although claimant raised a penalty issue at hearing, she did not make any argument on that issue and the ALJ found nothing in the record to warrant a penalty. Because neither party raises this issue on review, we do not address it.

[2] We need not address whether the ALJ properly allocated the the burden of proof to the employer because we would reach the same conclusion no matter which party has the burden of proof.

"Impairment" is established by a preponderance of medical evidence based on objective findings. ORS 656.726(4)(f)(B). 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.[3] *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).

Claimant has a compensable disabling claim for bilateral tendinitis of the forearms. (Ex. 11). Claimant's attending physician at closure was Dr. Sohlberg. In January 1999, Dr. Sohlberg referred claimant for nerve conduction studies of her right upper extremity, which were normal. (Ex. 8). On July 15, 1999, Dr. Sohlberg performed a closing examination and concluded that claimant was medically stationary with no impairment. (Exs. 9, 10). He explained that claimant's wrists and forearms looked normal externally and she had full active motion and 5/5 strength. (Ex. 10). Dr. Sohlberg found that claimant had mild tenderness around the proximal extensor muscles on the right and her sensory exam was intact. (*Id.*) He released claimant to work with restrictions involving no repetitive gripping or twisting and no working with her arms "above the horizontal." (*Id.*) Dr. Sohlberg concluded that claimant's subjective complaints were not matched by the objective findings. (Ex. 9). He explained:

> "It would appear that [claimant] will not be able to return in unrestricted fashion because every time she does the repetitive work, she gets a lot of pain. This has not been supported by objective findings. Basically, I am relying on the patient's report of discomfort to gauge my recommendations." (*Id.*)

Claimant relies instead on the opinion of Dr. Thomas, the medical arbiter, to establish her impairment. Dr. Thomas examined claimant on September 30, 1999 and reported that claimant develops pain in the forearm bilaterally when she uses her hands. (Ex. 15-1). He said claimant had reduced wrist range of motion and she was significantly limited in her ability to use her forearms and hands. (Ex. 15-2). Although Dr. Thomas found that claimant had sensory loss in both hands, he could not identify the specific nerves involved. (*Id.*) In describing the validity of the findings, Dr. Thomas explained:

> "I have no objective reason to state that findings were invalid. She states she has the subjective complaint of pain and there are minimal objective findings. The only real objective finding is the decreased range of motion and the two-point discrimination, which was not symmetrical in the hands." (*Id.*)

On reconsideration, 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). 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 find that a preponderance of the medical opinion establishes a different level of impairment than that reported by Dr. Thomas, the medical arbiter. We find that the opinion of Dr. Thomas is not persuasive because it lacks adequate explanation. Although Dr. Thomas found that claimant had "minimal objective findings," he reported a significant reduction of wrist range of motion and he found that claimant had an abnormal sensory examination. Dr. Thomas did not explain why claimant had such reduced range of motion and abnormal sensory loss in September 1999 when Dr. Sohlberg had reported two months earlier that claimant had full active motion and her sensory exam was intact. Moreover, claimant's January 1999 nerve conduction studies of her right upper extremity were normal. (Ex. 8). Dr. Thomas commented that he had not reviewed that report, although he had seen Dr. Sohlberg's notes that said there was no carpal tunnel syndrome. (Ex. 15-1).

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[3] Although the employer relies on the opinions of Drs. Vessely and Kim, we agree with claimant that neither of those physicians was claimant's attending physician at closure and Dr. Sohlberg did not concur with their reports. Under these circumstances, we do not consider their reports for purposes of rating claimant's permanent disability. *See Tektronix, Inc. v. Watson*, 132 Or App at 483.

In any event, we agree with claimant that the reports from Drs. Vessely and Kim are so distant from claimant's medically stationary date and the date of reconsideration as to be of little value.

We are more persuaded by the opinion of claimant's attending physician, Dr. Sohlberg, who had an opportunity to examine claimant on several occasions. (Ex. 14C). He recommended that claimant avoid certain activities in light of her subjective complaints of pain with repetitive work. (Exs. 9, 10). Claimant argues that Dr. Sohlberg's closing examination was deficient because he did not record any measurement of her range of motion or sensory loss. Dr. Sohlberg reported that claimant had "full active motion" and her sensory exam was "intact." (Ex. 10). Because Dr. Sohlberg did not find any objective findings of permanent impairment, we find that his report was adequately explained. Based on Dr. Sohlberg's report, we conclude that claimant is not entitled to a permanent disability award for reduced range of motion or sensory loss.

The employer does not dispute that claimant is entitled an award of 5 percent chronic condition impairment for each forearm. The medical evidence supports the conclusion that claimant is significantly limited in the repetitive use of each forearm. *See* OAR 436-035-0010(5). Consequently, we reinstate the August 5, 1999 Notice of Closure that awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of each of claimant's forearms. (Ex. 12).

ORDER

The ALJ's order dated March 16, 2000 is modified. In lieu of the ALJ's scheduled permanent disability and out-of-compensation attorney fee awards and the Order on Reconsideration, the August 5, 1999 Notice of Closure is reinstated and affirmed.

Board Member Biehl concurring in part and dissenting in part.

I agree with the portion of the majority opinion that awards claimant 5 percent chronic condition impairment for each arm. I disagree, however, with the majority's conclusion that claimant is not entitled to a scheduled permanent disability award for reduced range of motion or sensory loss. Instead, I would affirm the ALJ's order, which affirmed the Order on Reconsideration award of 15 percent scheduled permanent disability for claimant's left forearm and 23 percent scheduled permanent disability for her right forearm.

In particular, I agree with the ALJ's decision to rely on the opinion of Dr. Thomas, 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. Dr. Thomas carefully documented claimant's ranges of motion and sensory findings. In contrast, Dr. Sohlberg merely explained that claimant's sensory exam was "intact[,]" she had full active motion and her wrists and forearms "look normal externally." (Ex. 10). Moreover, because Dr. Sohlberg referred to claimant's condition as a "strain," it is not clear whether he was aware that her accepted condition was bilateral tendinitis of the forearms.

In this case, the medical arbiter's report provides the most persuasive evaluation of claimant's injury-related impairment. Dr. Thomas found no objective reason to state that claimant's findings were invalid and he specifically noted that her decreased range of motion and the two-point discrimination were objective findings. (Ex. 15-2). Dr. Thomas' report is sufficient to establish that claimant's impairment was due to her compensable condition.

In the Matter of the Compensation of
DWIGHT D. KESTER, Claimant
WCB Case No. 99-07165
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's 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 his "Ultimate Findings of Fact." In addition, we supplement and summarize the ALJ's findings as follows.

On April 26, 1999, claimant, a laborer for a forest products company, allegedly experienced an onset of low back and radiating right buttock and thigh pain after pulling on some lumber. Claimant sought treatment that day from Dr. Farmer, who diagnosed right sciatic nerve irritation. (Ex. 2-1).

Claimant began treating with a nurse practitioner, Ms. Josey, in Dr. Korpa's office on April 28, 1999. There, he was given a diagnosis of "lumbar strain" and "rule out radiculopathy, history of spondylolisthesis." (Ex. 5). Ms. Josey's chart notes document some reduced range of motion and positive straight-leg raising. (Exs. 5, 6). After examining claimant on May 6, 1999, Dr. Korpa diagnosed an acute lumbar strain superimposed on underlying spondylolisthesis. (Ex. 7). Dr. Korpa noted that claimant had been on the job for four days and had not worked for a long time prior to this employment. Claimant also reported that he had gained over 70 pounds in the last year.

On May 14, 1999, claimant told Dr. Korpa that he had been fired because he had not returned to light duty. Claimant requested that he be taken off work and placed on workers compensation because he had no other means by which to live. Dr. Korpa declined to do so because of the lack of any objective symptoms warranting such action. (Ex. 11).

Claimant sought no further treatment until July 7, 1999, when, upon returning to Dr. Korpa's care, he reported that he had been stranded in California after his vehicle had broken down. (Ex. 13). On July 16, 1999, the insurer denied the claim on the ground that claimant's diagnosed lumbar strain was not related to his work activity on or about April 26, 1999. (Ex. 15). Claimant requested a hearing.

In November 1999, Dr. Korpa commented on the cause of claimant's low back condition. Dr. Korpa questioned the validity of claimant's symptoms and complaints because claimant was inconsistent with follow-up care and showed little improvement with the care he did receive. Dr. Korpa also noted that claimant had spondylolisthesis and a prior back claim a number of years ago. (Ex. 15A).

In a subsequent concurrence letter, Dr. Korpa agreed that he could not state to a degree of medical probability that claimant suffered an injury or disease in his brief employment in late April 1999. (Ex. 16). Dr. Korpa noted the following factors in reaching that conclusion: the mechanics and duration of claimant's work did not "add up" to claimant's presenting condition; claimant did not demonstrate any "thoroughly" objective signs of injury or disease; claimant's symptoms were vague and inconsistent; claimant's complaints were more easily explainable by preexisting radiological findings; and the two month break between the May 14, 1999 and July 7, 1999 treatment was not consistent with claimant's July 7, 1999 exaggerated pain complaints and claimant's belief that it had only been a week and one-half between appointments.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial, noting that at no time prior to July 7, 1999 did Dr. Korpa express any doubt that claimant had sustained a work-related injury and had in fact referred to claimant's problems as a "back injury." The ALJ reasoned that, to the extent that Dr. Korpa had subsequently expressed doubts regarding the validity of the claim, it represented a "change of opinion." The ALJ then listed several reasons why Dr. Korpa's "changed" opinion was not persuasive. These included Dr. Korpa's failure to sufficiently consider claimants report of a specific injury event; Dr. Korpa's conclusion that claimant did not demonstrate objective signs of injury was not legally accurate because claimant had demonstrated reduced range of motion and reproducible tenderness; Dr. Korpa

did not explain why he concluded that claimant's symptoms were vague and inconsistent; and finally, Dr. Korpa's statement that claimant's complaints were more easily explainable by preexisting radiological changes was inconsistent with his deposition testimony that claimant's spondylolisthesis was not a significant factor in his complaints.

The ALJ then acknowledged that, even though Dr. Korpa's opinion was not persuasive, claimant had to still produce affirmative evidence supporting the claim. The ALJ determined that there was such evidence, consisting of objective findings to support the initial diagnosis of a "strain;" the history of a specific work event; the immediate medical treatment; the historical evidence that the previous episode of pain had resolved years before; Dr. Korpa's testimony that spondylolisthesis was not a significant part of claimant's complaints; and the fact that there was no evidence of a "combined condition," which allowed the application of a material contributing cause standard. The ALJ also noted that there was no persuasive medical expert stating claimant's injury could not have occurred as reported.

The ALJ then concluded his order by citing the presence of "objective" findings, the existence of a specific work event coincident with the onset of claimants low back symptoms, the provision of immediate medical treatment, evidence that claimant's preexisting condition played no role in claimant's complaints, and the absence of a persuasive negative opinion as to causation. Based on these factors, the ALJ found that a preponderance of evidence established that claimant experienced an incident of injury on April 26, 1999 that was a material contributing cause of his need for treatment.

On review, the insurer contends that the ALJ incorrectly determined that Dr. Korpa had "changed" his opinion, asserting that Dr. Korpa did not express an opinion on the causation issue until he had sufficient data on which to base an opinion and then concluded that claimant's injury claim was not valid. Because Dr. Korpa was the only medical expert to render a causation opinion, and because it could not be reasonably discounted as a "change of opinion," the insurer argues that claimant failed to sustain his burden of proof. For the following reasons, we agree with the insurer that claimant failed to prove a compensable injury claim.

At the outset, we agree with the insurer that Dr. Korpa did not "change" his opinion. Although Dr. Korpa did not initially express doubt regarding the validity of the claim, diagnosed a low back strain and referred to a "back injury," this is not equivalent to an opinion that claimant sustained a compensable work injury. Rather, we interpret Dr. Korpa's initial medical reports as merely reflecting his efforts to treat an alleged injury and not a definitive indication that he believed that claimants symptoms were causally related to his employment activities. Only when Dr. Korpa had received sufficient data on which to make a reasoned conclusion regarding the causation issue did he offer an opinion. That opinion questions the validity of the claim and does not support the compensability of the alleged injury.

Even if we found reasons for discounting Dr. Korpa's "changed" opinion, this would still leave claimant with no affirmative medical opinion supporting compensability. The lack of supporting expert medical opinion is not necessarily fatal to compensability if the causation issue is not complex. However, that is not true in this case.

In *Barnett v. SAIF*, 122 Or App 279 (1993), the court discussed factors for determining whether expert evidence concerning causation is required. Those factors include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. 122 Or App at 283.

We conclude that the situation in this case is complicated. On April 26, 1999, claimant promptly sought medical treatment after allegedly experiencing an onset of low back and lower extremity pain. Claimant attributed the cause to "pulling lumber." (Ex. 1). Although it appears that claimant's symptoms appeared immediately, it is not clear that claimant promptly advised a supervisor about an injury. Claimant did not testify at hearing regarding the incident. However, the form 801 states that "no one was aware of any injury @ work." *Id.* Additionally, claimant apparently was not free from disability of the kind involved. As noted in the medical reports, claimant had suffered from back pain in the past and had preexisting spondylolisthesis. Finally, there is expert medical testimony (Dr. Korpa's) that the alleged precipitating event could not have been the cause of the injury.

After considering the aforementioned factors, we conclude that expert medical opinion regarding causation is required to establish compensability of claimant's low back injury claim. Accordingly,

because the only expert opinion in the record that discusses causation does not confirm that claimant sustained an injury, we conclude that claimant has failed to meet his burden of proof. ORS 656.266.[1] We, therefore, reverse.

ORDER

The ALJ's order dated March 24, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[1] The ALJ cited *Linda J. Collins*, 51 Van Natta 1901 (1999), as supporting his conclusion that claimant did not need expert medical opinion to establish compensability. In *Collins*, the carrier contended that the claimant had not established medical causation because there was no medical evidence relating her thoracolumbar strain to the claimed work incident. We agreed with the ALJ that a physicians reports indicated that he accepted the claimant's history that she strained her back at work. Moreover, we were not persuaded that explicit medical evidence addressing causation was required because it was essentially a "simple case." We reasoned that the claimant's situation was not complex (her condition was not medically complex); her symptoms appeared immediately; she notified her supervisor promptly; she was previously free of mid back disability; and there was no expert evidence that the claimant's injury could not have occurred as she reported it. Under these circumstances, we agreed with the ALJ that the claimant had carried her burden under ORS 656.005(7)(a).

In contrast to *Collins*, where the claimant's history of a work injury was accepted, here Dr. Korpa has not accepted claimant's history that he injured his back at work. Moreover, unlike *Collins*, this is not a simple case. We cannot tell whether claimant promptly notified his supervisor of an injury, although the form 801 implies that he did not. Furthermore, while claimant's symptoms may have appeared immediately, there is expert evidence that questions the validity of the claim. Accordingly, we conclude that *Collins* is distinguishable.

In the Matter of the Compensation of
VAUDA E. NOWOTNY, Claimant
Own Motion No. 00-0189M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Cole, Cary, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

The self-insured employer has submitted a request for temporary disability compensation for claimant's 1991 right back condition. Claimant's aggravation rights expired on September 10, 1997. The employer denied the compensability of claimant's current condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 00-04397). In addition, employer recommends against reopening on the grounds that: (1) the carrier is not responsible for claimant's current condition; and (2) surgery or hospitalization is not reasonable and necessary for the compensable injury.

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. 00-04397 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 approved agreement, the parties should advise us of their respective positions regarding claimant's request for own motion relief.

Finally, we note that the insurer recommends against reopening on the grounds that: (1) claimant's current condition does not require surgery or inpatient hospitalization; and (2) surgery or hospitalization is not reasonable and necessary. Pursuant to ORS 656.327, this medical services issue is within the Director's jurisdiction. Medical Review Case No. 12660 is currently pending before the Director. Therefore, 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNY O. TAYLOR, Claimant
WCB Case No. 99-06801
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Alice Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) directed SAIF to reclassify claimant's bilateral wrist tendonitis condition as disabling; and (2) awarded claimant's counsel an assessed attorney fee for prevailing over SAIF's *de facto* denial of claimant's aggravation claim. On review, the issue are reclassification, aggravation, and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's accepted nondisabling bilateral wrist condition had worsened and directed SAIF to reclassify claimant's claim as disabling. We disagree.

At the outset, we note that claim reclassification was not raised as an issue by either party. Rather, the issue raised was whether claimant had suffered an aggravation of his bilateral wrist condition and whether SAIF should be penalized for its alleged failure to process claimant's aggravation claim. (Tr. 2). In any event, because claimant's claim was in nondisabling status for more than a year after the date of injury, it cannot now be reclassified.[1] ORS 656.277(2); *Shaw v. Paccar Mining*, 161 Or App 60, 65 (1999); *Alacantar-Baca v. Liberty Northwest Insurance Company*, 161 Or App 49, 58-9 (1999). Accordingly, we reverse that portion of the ALJ's order that directed SAIF to reclassify claimant's claim. We now turn to the aggravation issue.[2]

To establish a compensable aggravation, claimant must establish an "actual worsening" of the compensable condition since the last award of compensation. ORS 656.273(1). To prove an aggravation claim, a worker must present medical evidence of a worsening of the compensable condition itself, not merely a worsening of the symptoms related to the underlying condition. *SAIF v. Walker*, 330 Or 102, 110 (2000).

Here, we find no persuasive medical evidence which establishes that claimant's bilateral wrist condition has "actually worsened." Dr. Sandefur, claimant's treating physician, does relate claimant's current condition to the accepted bilateral wrist tendonitis claim.[3] (Ex. 26). However, there is no indication in Dr. Sandefur's report that the underlying wrist condition has worsened. Moreover, Dr. Sandefur concurred with Dr. Button who opined that there was no objective, pathologic worsening of claimant's accepted bilateral wrist condition. (Exs. 29, 30). There is no other medical evidence in the record that establishes that claimant's bilateral wrist condition has worsened.

Under these circumstances, SAIF's *de facto* denial of claimant's claim for aggravation must be upheld.

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[1] This was acknowledged by claimant's counsel at hearing. (Tr. 2).

[2] SAIF argues that claimant did not perfect his aggravation claim as required by ORS 656.273(3). However, this issue is being raised for the first time on Board review. Inasmuch as SAIF did not raise this issue at hearing we decline to address it at this late date. *See Lisa Riley*, 51 Van Natta 1703 (1999) (Board will not address issue of whether a claimant perfected an aggravation claim where that issue was not raised at hearing).

[3] At hearing, the parties agreed that causation was not at issue. (Tr. 2, 3). Consequently, we only address the issue of whether claimant's compensable condition has worsened.

ORDER

The ALJ's order dated January 3, 2000, as amended January 12, 2000, is reversed. The SAIF Corporation's *de facto* denial of claimant's aggravation claim is reinstated and upheld. The ALJ's award of an assessed attorney fee is reversed.

In the Matter of the Compensation of
JOHN G. BACHMAN, JR., Claimant
WCB Case No. 99-09258
ORDER ON REVIEW
John DeWenter, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that declined to award penalties or attorney fees for insurer's allegedly unreasonable claim processing. On review, the issues are penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

We adopt those portions of the ALJ's "Ultimate Findings of Fact" that found: (1) claimant was not terminated for violation of work rules or other disciplinary reasons; and (2) the insurer's failure to pay temporary total disability benefits was incorrect.

We do not adopt the ALJ's "Ultimate Finding of Fact" that the insurer's failure to pay temporary total disability benefits was reasonable.

CONCLUSIONS OF LAW

The ALJ found that the insurer incorrectly refused to pay disability benefits. Nonetheless, in the absence of controlling case authority, the ALJ declined to find such refusal "unreasonable." Consequently, the ALJ concluded that a penalty was not warranted. Based upon the following reasons, we disagree with the ALJ.

Under ORS 656.262(11)(a), if an insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amount then due. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the insurer. *Brown v. Argonaut Ins*, 93 Or App 588, 591 (1988).

Here, the insurer knew that the employer at injury had "laid off" claimant in September 1996 for reasons that did not involve the violation of work rules or other disciplinary reasons. (Ex. 13-1; 18-3; Tr. 10). The insurer also knew that in October 1996, claimant had declined to accept, for reasons not related to his compensable injury, a modified job offer from the employer at injury. (Ex. 8A, 20-2; Tr. 15). The insurer also knew that claimant had returned to the work force, but for a different employer, in October 1998. (Ex. 20-2).

Nevertheless, after the insurer reopened the claim on an aggravation basis in June of 1999, it refused to pay attending physician authorized temporary disability, alleging that claimant had been discharged from the employer at injury for violating a work rule, which the insurer argues relieved it of

paying temporary disability under the terms of ORS 656.325(5)(b).[1] (Ex. 23; 24; 25A). The essence of the insurer's position is that when claimant declined the modified job offer in October 1996, he subsequently "violated a work rule" when he did not show up for work. (Respondent's Brief, 2). This record does not support such a contention. To the contrary, as previously discussed, the record supports a conclusion that claimant had been "laid off" by his employer for reasons that did not involve the violation of a work rule or other disciplinary reason and his subsequent decision to decline to accept a modified job offer did not involve a work rule violation or other disciplinary matter.

Under these circumstances, we conclude that the insurer had no legitimate doubt as to its liability to pay claimant attending physician authorized temporary disability.[2] Consequently, the insurer unreasonably refused to pay compensation under the terms of ORS 656.262(11)(a). Accordingly, we hold that claimant is entitled to a 25 percent penalty pursuant to ORS 656.262(11)(a) based upon the compensation due as a result of the ALJ's order, which we have affirmed. This penalty is to be shared equally by both claimant and his attorney.

The remainder of the ALJ's order is affirmed.[3]

ORDER

The ALJ's order dated March 28, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that declined to assess a penalty is reversed. The insurer is assessed a penalty equal to 25 percent of the compensation due as a result of the ALJ's order to be paid in equal shares to claimant and his counsel. The remainder of the ALJ's order is affirmed.

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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."

[2] Here, the insurer's refusal to pay temporary disability is based upon its allegation that claimant was terminated for violating a work rule; an allegation that was not supported by any fact in the record. Therefore, the conduct here is distinguishable from the conduct in those cases where an insurer has a legitimate doubt regarding the application of facts to case authority, statutory authority, or an administrative regulation. *See Robert A. Rodgers*, 52 Van Natta 1243 (2000); *Gregg A. Karr*, 50 Van Natta 2434 (1998); *Maria R. Porras*, 42 Van Natta 2625 (1990).

[3] Claimant contends he is also entitled to an assessed attorney under ORS 656.382(1). We disagree. The same conduct cannot be the basis for both a penalty under ORS 656.262(11)(a) and an award of attorney fees under ORS 656.382(1). *Corona v. Pacific Resource Recycling*, 125 Or App 47, 50 (1993). We note that claimant's counsel is not entitled to an attorney fee for services on review concerning penalty and attorney fee issues. *Saxton v. SAIF*, 80 Or App 631 (1986), *rev denied* 302 Or 159 (1986).

In the Matter of the Compensation of
JIMMY L. MASSEY, Claimant
Own Motion No. 99-0442M
OWN MOTION ORDER
Richard A. Sly, Claimant Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights expired on July 15, 1987. SAIF initially agreed that claimant's current condition was causally related to the compensable condition, that it was responsible for claimant's current condition and that the proposed surgery or hospitalization was reasonable and necessary. However, SAIF contended that claimant was not in the work force at the time of the current disability.

Following its initial own motion recommendation, SAIF issued a partial denial of claimant's current condition from which claimant timely requested a hearing with the Hearings Division. (WCB Case No. 00-00619). Claimant also requested that the Own Motion matter be placed in abeyance pending the resolution of the litigation before the Hearings Division. On February 22, 2000, we consolidated this Own Motion matter with the pending hearing. If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the accepted injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time his condition worsened.

On May 17, 2000, Administrative Law Judge (ALJ) Hazelett issued an Opinion and Order, which upheld SAIF's partial denial of claimant's L4-5 condition. However, the ALJ noted that SAIF had accepted, as a compensable component of claimants 1980 claim, his current L5-S1 disc condition. Furthermore, the ALJ found that claimant was in the work force at the time his condition worsened. The ALJ's conclusion was based on the following reasoning.

The ALJ found that: (1) claimant left his part-time employment in February 1999 due to increased pain complaints; (2) doctors, who treated claimant in May 1998 and March / April 1999, believed that claimant only required palliative care for his pain complaints and that working would be good therapy for him; (3) no one authorized a release from work when claimant left in February 1999; (4) following claimant's departure from work, in July 1999, evidence arose demonstrating a worsening of claimant's L5-S1 condition requiring surgery; and (5) on August 13, 1999, Dr. Mason, claimant's treating surgeon, recommended surgery at L5-S1. Based on these findings, the ALJ determined that this worsening occurred while claimant was still working and the "worsened symptoms prevented claimant from returning to work." In light of the causal relationship between claimant's compensable L5-S1 condition and the aforementioned "work force" record, the ALJ recommended a finding that claimant was in the work force at the time of the worsening of his L5-S1 condition.

Following the ALJ's May 17, 2000 order, we requested the parties' written positions regarding the ALJ's recommendation. Claimant agreed with the ALJ's reasoning regarding his work force status. SAIF contended that claimant had not demonstrated that he was in the work force at the time of the current worsening. Based on the following reasoning, we agree with SAIF's contention.

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

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

SAIF contended that claimant was not in the work force at the time of the current disability. In response to SAIF's contention, claimant submitted various paystubs dating from September 1998 through February 1999, which he contended, although he was not currently employed, demonstrated his

willingness to work. Based on his paystub submission, we are persuaded that claimant was willing to work and working prior to February 1999.

However, we have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to August 13, 1999, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270 (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).

Claimant indicates that he left work in February of 1999 because of increased pain in the back, left hip, and left leg. He attributes his increased pain to his compensable low back condition. However, claimant does not submit a medical opinion supporting his contentions. The record does not contain medical evidence that claimant was taken off work in February 1999 due to his compensable injury.

In his August 13, 1999 doctor's report, Dr. Mason, claimant's treating surgeon, opined that claimant had reached "a point where he is unable to function in attempting to do any physical activities." We interpret Dr. Mason's statement to mean that claimant was unable to work as of August 13, 1999. As noted above, the date of disability is August 13, 1999, when claimant's condition worsened requiring surgery. Thus, claimant must show that it was futile for him to work and/or seek work *prior* to August 13, 1999.

Although Dr. Mason indicated that claimant was unable to perform many physical activities as of August 1999, he does not address whether it had been futile for claimant to work and/or seek work prior to that time. There is no other medical documentation in the record that addresses claimant's ability to work.[2] Thus, although claimant may have been unable to work at the time of his disability, the medical documentation contained in the record fails to establish that, *prior* to August 13, 1999, claimant was unable to work and that it would have been futile for him to seek work due to his compensable condition.

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

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

IT IS SO ORDERED.

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[1] 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] On November 5, 1999, claimant underwent an insurer-arranged medical examination (IME) with Dr. Dietrich. Dr. Dietrich noted that claimant's inability to work "at a rather sedentary job over a period of 14 years" would not be explainable on the basis of his L5-S1 condition alone. Rather, Dr. Dietrich opined that it was claimant's "apparent lack of motivation to return to gainful employment and prolonged history," that would affect his recovery period after he has the proposed surgery.

In the Matter of the Compensation of
JAMES E. NICKEL, Claimant
WCB Case No. 99-09624
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for bilateral rotator cuff tendinitis and impingement syndrome. On review, the issue is compensability. We reverse that portion of the ALJ's order.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation.[1] In the last paragraph on page 2, we delete the fourth sentence. In the same paragraph, we replace the eighth sentence with the following: "Claimant's work involved some overhead throwing with both arms." We delete the last sentence in that paragraph and insert the following paragraph:

> "On November 12, 1999, Dr. Rask performed surgery on claimant's right shoulder. His post-operative diagnosis was right shoulder impingement syndrome and acromioclavicular joint arthropathy. (Ex. 24). He performed left shoulder surgery on January 14, 2000. (Ex. 30). Dr. Rask explained that claimant's diagnosis of the right and left shoulder was the same: rotator cuff tendinitis with impingement and acromioclavicular joint arthropathy. (Ex. 32)."

We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant challenged SAIF's denial of his occupational disease claim for a bilateral shoulder condition, diagnosed as bilateral rotator cuff tendinitis / impingement syndrome and acromioclavicular joint arthropathy. The ALJ found that claimant had preexisting bilateral "AC" joint degenerative disease in his shoulders. The ALJ reasoned that, for the underlying AC joint degenerative disease to be compensable, claimant must prove that his work was the major contributing cause of a pathological worsening of the condition. The ALJ concluded that the medical evidence was insufficient to establish compensability of the acromioclavicular joint degenerative disease. Neither party contests that portion of the ALJ's order. On the other hand, the ALJ relied on Dr. Rask's opinion and concluded that claimant's work activities were the major contributing cause of his bilateral rotator cuff tendinitis / impingement syndrome.

On review, SAIF argues that the ALJ erred by failing to analyze this as a "combined condition" claim. SAIF contends that there is no persuasive medical evidence that claimant's work activities were the major contributing cause of his bilateral rotator cuff tendinitis/ impingement syndrome.

To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of his bilateral rotator cuff tendinitis/ impingement syndrome. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). For the following reasons, we need not decide whether ORS 656.802(2)(b) applies to this case because we find that Dr. Rask's opinion is insufficient to establish compensability under either standard.

We begin by addressing SAIF's argument that Dr. Rask's opinion is not persuasive because he did not have an accurate understanding of claimant's work activities.

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[1] We modify the ALJ's order to note that Exhibit 10 was also admitted in evidence. (Tr. 1-2).

Claimant worked for the employer as a truck driver/rigger from 1971 to 1980. (Ex. 29-1, Tr. 13, 15). In 1980, claimant left to start his own business, but he had serious heart problems and was off work from 1980 to 1988. (Ex. 29-1; Tr. 16). In December 1988, claimant began working for another company. (Tr. 16).

In July 1990, claimant returned to work for the employer as truck driver/rigger. (Ex. 29-1; Tr. 16). The employer specializes in hauling heavy items such as transformers and turbines. (Tr. 13, 17, 25; Ex. 29). Claimant's job activities at that time involved heavy work, which included lifting and carrying large planks and 8-foot crib ties used to move the heavy items. (Tr. 18-21). Two people at a time would lift steel shoes weighing 300 to 400 pounds. (Tr. 21).

In September 1995, claimant worked as a shop supervisor, which was primarily sedentary work. (Ex. 29-1, Tr. 16, 37). Claimant testified that he did not have shoulder problems before 1999. (Tr. 28, 36).

On April 1, 1999, claimant returned to working as a driver, but did not do much rigging. (Tr. 16, 17, 37). He testified that the employer kept him off the heavy rigging jobs. (Tr. 17, 26). During summer 1999, claimant was involved in five to six week job moving equipment to Hillsboro. (Tr. 29-33). Claimant was required to throw 40-foot nylon slings over 16-foot high loads to tie down the equipment. (Tr. 29, 30). There were six straps per load. (Tr. 31, 32, 39). The crew tried to move four loads per night. (Tr. 32, 39).

Claimant testified that, after about two weeks on this project, his right shoulder became very painful from throwing straps over the loads, so he started using his left shoulder until it became painful as well. (Tr. 32, 33). Claimant's co-workers then threw the straps for him, but claimant continued to do so on occasion when no one was available to help. (Tr. 33). Claimant testified that half-inch chains were used "once in awhile" in moving big forklifts. (Tr. 38-39).

Dr. Rask first examined claimant on August 23, 1999. (Ex. 12). He reported that claimant had experienced shoulder pain since 1990, which was worse in the last 3 to 4 months. (*Id.*) Claimant complained of pain in his anterior and lateral shoulder with popping while throwing the ties over the truck and while lifting overhead. (*Id.*) He diagnosed bilateral impingement syndrome, right worse than left. (*Id.*)

On September 23, 1999, Dr. Rask reported that claimants shoulder condition was likely due to his job, noting that claimant "constantly throws ropes and chains over his load." (Ex. 18). He explained that claimant had no other recreational activities that put stress on his shoulder and, therefore, it was likely a work-related injury. (*Id.*) Dr. Rask wrote to SAIF and explained:

> "[Claimant] has a right rotator cuff tear, impingement and AC joint arthropathy which are the result of his job as a truck driver. This condition is typically caused by the type of work that he does which involves throwing chains and ropes over his load. That is a lot of repetitive over the head motion. He otherwise is involved in no recreational activities which would do this, which makes this with almost certainty a job related injury." (Ex. 19).

On November 12, 1999, Dr. Rask performed surgery on claimant's right shoulder. His post-operative diagnosis was right shoulder impingement syndrome and acromioclavicular joint arthropathy. (Ex. 24). Dr. Rask again reported that claimant's shoulder problem was caused by his work. (Ex. 25). He performed left shoulder surgery on January 14, 2000. (Ex. 30).

On January 19, 2000, Dr. Rask explained that claimant had bilateral rotator cuff tendinitis with impingement and acromioclavicular joint arthropathy. (Ex. 32). He said that claimant did not have a preexisting condition and his work activities were the major contributing cause of his shoulder condition. (*Id.*) Dr. Rask explained:

> "The type of work that [claimant] does is common and typical for his condition. Excessive heavy lifting and throwing chains overhead stresses the rotator cuff and acromioclavicular joint. The type of work he does is a very common and typical etiology for his current shoulder conditions." (*Id.*)

Dr. Rask said that claimant's work caused "a pathologic worsening of a condition and the work was the major contributing cause compared to the normal natural degenerative process." (*Id.*) He concluded that claimant's shoulder conditions were "entirely related to his job as a truck driver and heavy equipment operator." (*Id.*)

On March 1, 2000, Dr. Rask wrote to claimant's attorney and explained:

> "Heavy lifting stresses both the rotator cuff and AC joint because people lift with their arm and their arm is lifted by the rotator cuff partially and the weight of things in people's arms rests on the AC joint. Repetitive work can stretch and/or tear ligaments, tendons and muscles and cause inflammation of the bursal lining. The exertion can break down the joint lining." (Ex. 36-1).

We are not persuaded that Dr. Rask had an accurate understanding of the onset of claimant's shoulder symptoms. Claimant testified that he did not have any shoulder problems until the summer of 1999, when he was involved in moving equipment to Hillsboro and was required to throw 40-foot nylon slings over 16-foot high loads to tie down the equipment. After about two weeks on the project, claimant's right shoulder became very painful, and he used his left shoulder until that became painful as well. (Tr. 32, 33). None of Dr. Rask's reports indicate that he was aware that the onset of claimant's shoulder symptoms occurred during a two-week period in summer of 1999.[2] To the contrary, Dr. Rask's August 23, 1999 chart note said that claimant had experienced shoulder pain since 1990. (Ex. 12).

Dr. Rask apparently relied on claimant's entire work history in assessing causation, despite claimant's testimony that he had not experienced shoulder problems until 1999. (Tr. 28). In September 1999, Dr. Rask reported that claimant "constantly throws ropes and chains over his load." (Ex. 18). He wrote to SAIF and explained that claimant's work required a "lot of repetitive over the head motion." (Ex. 19). On January 19, 2000, Dr. Rask explained that claimant's work involving "[e]xcessive heavy lifting and throwing chains overhead" was a common and typical etiology for his shoulder conditions. (Ex. 32). In March 2000, Dr. Rask indicated that "repetitive overhead motions" and "heavy lifting" were causing the shoulder problems. (Ex. 36).

On January 12, 2000, claimant's attorney wrote to Dr. Rask and provided a summary and photographs of claimant's work activities. (Ex. 29). Claimant's attorney's letter referred to a history recorded by Dr. Rask that claimant had experienced shoulder pain since 1990 and there had been an "aggravation" of his shoulder pain since his return to work as a truck driver in April 1999. (Ex. 29-2). The summary of claimant's work activities made no reference to the fact that the onset of his shoulder symptoms occurred in summer 1999, after a two-week period of throwing 40-foot straps over 16-foot loads. Moreover, claimant testified that the photographs included in the January 12, 2000 letter to Dr. Rask were taken from 1990 to 1994. (Tr. 34, 35). Claimant did not recall having any shoulder problems at that time. (Tr. 36).

We find no evidence that Dr. Rask was aware that the onset of claimant's shoulder symptoms occurred in summer 1999, after a two-week period of throwing 40-foot straps over 16-foot loads. Because we are not persuaded that Dr. Rask had an accurate understanding of the onset of claimant's shoulder symptoms, his causation opinion is entitled to little weight.[3] *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).

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[2] At most, Dr. Rask's November 17, 1999 report said that claimant "sustained a right shoulder rotator cuff tendinitis and impingement syndrome since he started back to work as a truck driver in April of 1999." (Ex. 25). That report, however, provides no explanation of what work activities caused the shoulder condition.

[3] Although the parties litigated this as an occupational disease claim, we note that Dr. Rask's opinion would not be sufficient to establish "major contributing cause" if the claim had been litigated instead as an injury. *See Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984) (the claimant's back trouble coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset").

Moreover, Dr. Rask's opinion that claimant did not have a preexisting degenerative shoulder condition is not persuasive. (Ex. 32). The persuasive medical evidence establishes that claimant had a preexisting degenerative shoulder condition that contributed or predisposed him to disability or a need for treatment. Drs. Duff and Tesar concluded that claimant had preexisting bilateral acromioclavicular joint degenerative disease. (Exs. 21, 34, 37). Dr. Tesar explained that claimant had preexisting degenerative changes in his shoulders in the area of the greater tuberosity and acromioclavicular joint. (Ex. 34-8). Because Dr. Rask did not explain why he believed that claimant did not have a preexisting degenerative shoulder condition, his opinion is not persuasive.

In addition, we agree with SAIF that Dr. Rask did not properly evaluate the relative causes of claimant's shoulder condition. A determination of the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda,* 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). The fact that work activities may be the precipitating cause of a claimant's disability or need for treatment does not necessarily mean that work was the major contributing cause of the condition. *Id.* Dr. Rask opined that claimant was not involved in any recreational activities that involved repetitive overhead motion, "which makes this with almost certainty a job related injury." (Ex. 19). Such "precipitating cause" or "but for" reasoning, without more, does not meet claimant's burden of proving major contributing cause. *See Dietz,* 130 Or App at 401.

None of the other medical opinions support compensability of claimant's bilateral rotator cuff tendinitis/ impingement syndrome. Drs. Duff and Tesar believed that claimant's preexisting degenerative shoulder condition was the major contributing cause of his disability and need for treatment. (Exs. 21, 34, 37). We conclude that the medical evidence is insufficient to establish compensability.

ORDER

The ALJ's order dated April 6, 2000 is reversed in part and affirmed in part. SAIF's denial of claimant's bilateral shoulder condition is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

August 11, 2000 Cite as 52 Van Natta 1457 (2000)

In the Matter of the Compensation of
MARY A. EGBERT, Claimant
WCB Case No. 99-09160
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that declined to assess a penalty or attorney fee for unreasonable claim processing. On review, the issues are penalties and attorney fees.

We adopt and affirm the ALJ's order,[1] with the following supplementation to address claimant's argument on review.

The ALJ concluded that neither a penalty nor an attorney fee was appropriate. On review, claimant contends that she is entitled to an assessed fee under ORS 656.386(1)(b)(B) because the employer did not respond within 30 days to her request to include the right shoulder impingement syndrome and deQuervain's tenosynovitis of the right wrist in its acceptance. *See* ORS 656.262(6)(d). We disagree.

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[1] We substitute the following for the last sentence on page 3: "Consequently, the scope of acceptence includes the more specific diagnoses of right shoulder impingement syndrome and deQuervain's tenosynovitis of the right wrist."

Claimant compensably injured her right shoulder in 1996 at the same employer. Her claim for right rotator cuff tendonitis with impingement syndrome was accepted and processed to closure in February 1998.

On January 19, 1999, Dr. Miller noted that claimant had a history of repetitive use problems with her upper extremities, including a chronic impingement syndrome and tendonitis of the right shoulder. Dr. Miller subsequently diagnosed claimant's overall right arm and shoulder condition as an overuse condition. On April 7, 1999, the employer issued a Notice of Acceptance for a non-disabling "overuse right upper extremity" condition. Claimant was treated for that condition by Dr. Miller, who referred her for an orthopedic consultation.

On May 7, 1999, Dr. Davin, orthopedist, diagnosed biceps tendonitis and deQuervain's tenosynovitis of the first dorsal compartment of the right wrist. In July 1999, Dr. Davin also noted that claimant was still under treatment for an impingement syndrome of the right shoulder by another physician.

On August 23, 1999, claimant requested that the employer accept an impingement syndrome of the right shoulder and deQuervain's tenosynovitis of the right first dorsal compartment of the wrist as part of the January 18, 1999 claim.

On September 2, 1999, within 30 days of claimant's letter, the employer responded to claimant's letter. In this letter, the employer asked claimant to clarify which wrist was involved. The employer also stated that it would be gathering information to determine compensability, and that a decision would be made by November 19, 1999. Claimant contends that this letter does not qualify as a "response," because it was neither an amendment of its acceptance nor a written clarification.

Although the employer did not revise the acceptance notice in this letter, we find that its response qualified as a written clarification, to wit: it was seeking more information regarding claimant's request, and provided a time when its decision would be made. Under the circumstances of this case, we conclude that the employer made a timely response to claimant's request under ORS 656.386(1)(b)(B). Because the employer's claim processing was timely, claimant's attorney is not entitled to a penalty for unreasonable claim processing or an assessed attorney fee for the alleged "de facto" denial.[2]

ORDER

The ALJ's May 9, 2000 order is affirmed.

[2] Because we find that the employer adhered to the more stringent time limit of ORS 656.262(6)(d), we need not address the employer's argument that its response qualified under ORS 656.262(7)(a).

In the Matter of the Compensation of
GARY L. FAGIN, Claimant
WCB Case No. 99-00609
ORDER ON REMAND
Nicholas M. Sencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand. Pursuant to the court's August 10, 2000 order, we have been directed to consider the parties' settlement.

The parties have submitted a "Disputed Claim Settlement" to resolve all issues raised or raisable, in lieu of all prior orders. The parties also agree that the insurer's denial, as set forth in the agreement, "shall forever remain in full force and effect, and that the execution of this document shall constitute a full and final waiver of the claimant's right to challenge or appeal from the denial." Finally, the agreement provides that the "Request for Hearing shall be dismissed with prejudice."

We approve the parties' agreement, thereby fully and finally resolving this dispute, in lieu of all prior orders.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] A provision in the parties' settlement states that a portion of claimant's share of the proceeds shall be provided to "Painters' Trust," a "non-workers' compensation" provider in satisfaction of its lien for previously paid benefits. Inasmuch as the parties' compensability dispute is being resolved by means of a Disputed Claim Settlement (DCS), only medical service providers may be directly reimbursed from the settlement proceeds. ORS 656.313(4)(c). (Health insurance providers may be directly reimbursed by the workers' compensation carrier when "the services are determined to be compensable." ORS 656.313(4)(b).) Nonetheless, because proceeds from a DCS are not considered "compensation," a claimant's assignment of all or a portion of his share of the proceeds is not prohibited by ORS 656.234. *Robert D. Surina*, 40 Van Natta 1855 (1988); *Theodule Lejeune, Jr.*, 40 Van Natta 493 (1988).

Here, we do not interpret the aforementioned settlement provision to represent that a non-workers' compensation insurance carrier will receive reimbursement *directly* from the workers' compensation carrier. Rather, in granting our approval of the settlement, we have interpreted the settlement as stating that claimant has assigned a portion of his share of the settlement proceeds to the non-workers' compensation carrier. Pursuant to *Lejeune* and its progeny, such an assignment is not contrary to ORS 656.234. Finally, because the entities listed as receiving portions of the settlement proceeds are limited to non-workers' compensation carriers and attorneys, we interpret the agreement as effectively providing that no outstanding medical bills from medical service providers were in the insurers possession on the date the settlement terms were agreed on. In light of such circumstances, the proposed settlement is approvable. OAR 438-009-0010(2)(g); *Robert E. Wolford*, 46 Van Natta 522 (1994).

In the Matter of the Compensation of
BETTY O. GUGLIOTTA, Claimant
WCB Case No. 99-02017
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of her occupational disease claim for a right shoulder 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 incorrectly failed to find the opinion of Dr. Galt, the treating physician, persuasive.

Claimant seeks to establish the compensability of a right shoulder condition, diagnosed as impingement syndrome and derangement of the acromioclavicular joint, as an occupational disease. Therefore, she must prove that her work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it.[1] ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

To satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

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[1] Claimant urges us to revisit and change our holding in *Tammy L. Foster*, 52 Van Natta 178 (2000). We decline to do so.

The record establishes that claimant has a preexisting type III acromion condition in her right shoulder. (Ex. 12; 13-4; 13A-1). The record also establishes that claimant has preexisting degenerative changes in her right AC joint. (Ex. 13-4; 17-7). Those preexisting conditions are deemed to be causes in the determination of the major contributing cause of claimant's occupational disease. ORS 656.802(2)(e). Because of the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Drs. Dineen and Schilperoort, who saw claimant at the request of the employer, have opined that the major contributing cause of claimant's right shoulder condition is her preexisting type III acromion coupled with the preexisting degenerative changes in the AC joint. (Ex. 12; 13-5; 14-2; 16-30; 16-41). Dr. Galt, the treating physician, has opined that claimant's work activity is the major cause of claimant's disability and need for treatment, not that her work is the major contributing cause of the shoulder condition (occupational disease) itself.[2] (Ex. 12A, 13A; 15; 17-3).

Accordingly, on this record, we agree with the ALJ that claimant's right shoulder condition is not compensable.

ORDER

The ALJ's order dated March 10, 2000 is affirmed.

[2] We acknowledge that at one point in his deposition Dr. Galt indicated that claimant's impingement syndrome was 51 percent caused by work. (Ex. 17-7). We note that in expressing his opinion at other points in the record, Dr. Galt has been very specific in stating that claimant's work was the major cause of her need for treatment. (Ex. 12A; 13A; 15; 17-3). Accordingly, based upon his previous statements, including other statements in Exhibit 17, we conclude that in answering claimant's counsel's question, as posed in Exhibit 17-7, that Dr. Galt was referring to the major cause of the need for treatment of the impingement condition as opposed to the major cause of the impingement condition itself.

In the Matter of the Compensation of
DENNIS J. NEELEY, Claimant
WCB Case No. 99-01678
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of claimant's post-concussion seizure disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

On September 11, 1995, claimant was compensably injured in a motor vehicle accident. He was treated by Dr. Alanko, who reported severe headaches and episodes of staring, confusion, unsteadiness, difficulty with walking and some blackouts. Dr. Alanko diagnosed a concussion, in addition to thoracic outlet syndrome and multiple strains and contusions. (Ex.4). Claimants blackout spells continued, so Dr.Alanko referred claimant to Dr. Falcon, neurologist, for evaluation.

Dr. Falcon's impression was of a mild head injury. He had no explanation for claimant's transient lapses of awareness. Although he thought that these could represent seizures, Dr. Falcon was also concerned about the possibility of a somatization disorder. Dr. Falcon recommended an inpatient continuous EEG with audio-video monitoring and simultaneous EKG. (Ex.8).

On December 7, 1995, the insurer accepted a disabling concussion and cervical strain.

Claimant continued to complain of passing out spells, which diminished in frequency by January 1996. (Ex.8, 11-3).

On February 8, 1996, claimant was examined by Dr. Rich, neurologist, and Dr. McKillop, orthopedist. The doctors diagnosed claimant with a probable concussion and suspected a somatization disorder. (Ex. 11).

On April 3, 1996, claimant was evaluated by Dr. Holt, psychiatrist. Dr. Holt noted that claimant's blackout spells had diminished to about one per month. (Ex.14-6). Dr. Holt opined that claimant had no diagnosable psychiatric disorder, but did have some orthostatic hypotension aggravated by medication. Dr. Holt also noted that claimant had a past history of alcohol dependency and abuse and that he may over use prescription medications, which probably led to his syncope and "blackouts." Dr. Holt diagnosed Mild Post Concussive Disorder that had essentially abated, and declared claimant medically stationary. (Ex. 14). Dr. Alanko concurred with Dr. Holts opinion. (Ex. 15).

By September 1996, claimant's spells further diminished to dizziness; he had not had a syncopal spell since June 1996. (Ex. 17). On September 24, 1996, Dr. Alanko requested a work hardening program so claimant could return to work. (Ex. 18). When claimant returned to Dr. Alanko for follow up after the work hardening program, he again reported occasional syncopal episodes. Dr.Alanko thought that claimant could not return to his previous job driving a "Cat" (a piece of heavy equipment) because of the syncopal episodes, but that he needed to go to work. (Exs. 19, 32, 33). As of August 1997, claimant continued to report occasional near passing out spells. (Exs. 35, 36).

On July 14 and 15, 1997, claimant was examined by Drs. Holt, Wilson and Phillips for the insurer. (Exs. 37, 38). They found no evidence during their examination to suggest an underlying epileptic seizure disorder and agreed with claimants previous treating physicians, who felt that claimant's spells represented pseudoseizures and were functional. Nevertheless, they recommended inpatient video EEG monitoring to exclude the possibility of epileptic episodes. The doctors also felt that claimant's spells were independent of his injury. (Ex. 38-7). Dr. Alanko concurred with this opinion. (Ex.40).

A September 19, 1997 Determination Order closed the claim with no award of permanent disability.

On January 28, 1998, Dr. Peterson, neurologist, performed an arbiter examination. She recommended further evaluation of claimant's reported dizziness and syncopal episodes. (Ex. 44).

On May 14, 1998, Dr. Alanko reported that claimant's spells were not of cardiac origin. He referred claimant to Dr. Green, neurologist, for further evaluation. (Ex.49).

On July 23, 1998, claimant experienced a spell in Dr. Alanko's office that was witnessed. Dr. Alanko reported that the episode was compatible with a generalized seizure. Claimant reported that he was now experiencing these spells about three times a week. (Ex.52).

In November 1998, Dr. Green advised Dr. Alanko that he had seen claimant in follow up. An MRI of claimant's brain was unremarkable. Dr. Green again recommended inpatient EEG monitoring to rule out epileptic vs. non-epileptic seizures. (Ex. 56).

On January 11, 1999, Dr. Farris, neurologist, and Dr. Davies, clinical psychologist, examined claimant for the insurer. After neuropsychological testing, Dr. Davies reported that claimant tested within normal limits and that there was no evidence during his examination that suggested seizure-like activity. (Ex. 60, 66-32). Dr. Davies noted that there was no evidence of manipulation or secondary gain on neuropsychological testing, but did think that claimant had character pathology and a tendency toward symptom magnification. (Ex 60). Dr. Davies subsequently agreed that his testing did not rule out an organic problem. (Ex. 66-27, -35, -57).

Dr. Farris found that claimant demonstrated excessive pain behavior and found no objective evidence of claimants syncopal episodes. She concluded that claimant's syncopal episodes were related to a personality disorder. Dr. Farris noted evidence in the medical records of alcohol abuse in the past (two DUII's) and opined that alcohol continued to play a role in claimant's present complaints. She also found evidence of manipulation and secondary gain. (Ex.61).

On February 26, 1999, Dr. Green reported that claimant continued to have about one seizure a week that appeared to be tonic clonic in nature. Dr. Green started claimant on a clinical trial of Dilantin. (Ex. 64). Although claimant's seizures initially increased, they improved with an increased dosage of Dilantin. (Exs. 65, 65A, 65B).

In October 1999, claimant was admitted to Oregon Health Sciences University (OHSU) for continuous video EEG monitoring. (Exs. 69, 69a, 69b, 70).

CONCLUSIONS OF LAW AND OPINION

After reviewing the medical evidence, the ALJ concluded that claimant had failed to prove that he has a seizure disorder that is the result of the 1995 MVA. On review, claimant relies on the opinion of Dr. Green to prove compensability of his claim.

Claimant must prove that his September 11, 1995 work injury is at least a material contributing cause of claimant's need for medical treatment or disability for his seizure disorder condition. ORS 656.005(7)(a); *Albany General Hospital v. Gasperino,* 113 Or App 411 (1992). Claimant has the burden of proving the compensability of the disorder by a preponderance of persuasive medical evidence. ORS 656.266.

The cause of claimant's seizure disorder is a complex medical question, the resolution of which requires expert medical opinion. *Barnett v. SAIF,* 122 Or App 279, 283 (1993); *Uris v. Compensation Department,* 247 Or 420 (1967). 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). Finally, 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).

Here, the medical record does not persuasively establish a diagnosis of epilepsy supported by objective findings. (Exs. 38, 60, 61, 66, 67, 69, 69a, 69c, 70). Moreover, Dr. Spencer, neurologist and Assistant Professor of Neurology at OHSU's Epilepsy Center, opined that there was a possibility that the events observed during the testing could represent a psychological or emotional reaction.

Given the uncertainty surrounding the events during the monitoring, and because of claimant's dramatic response to Dilantin treatment, Dr. Spencer recommended continuing that treatment, or, alternatively, of repeating the EEG monitoring in order to record a "full blown" example of claimant's typical clinical episode. (Ex. 70). However, Dr. Spencer did not draw the conclusion that claimant had a seizure disorder, based on the remedial effects of the drug.

The only physician to diagnose frontal lobe epilepsy was Dr. Green, claimant's treating neurologist. He made the diagnosis based solely on claimant's clinical response to Dilantin treatment, noting that ordinarily such a response would rule out malingering or a conversion reaction. (Ex.74). Dr. Green's conclusory opinion, however, did not explain why, in the face of the equivocal report from OHSU, he concluded that claimant actually had a seizure disorder as a result of his 1995 injury. Moreover, Dr. Green did not address whether claimant's documented heavy drinking might have affected his episodes of syncope and blacking out. Because Dr. Green's opinion is conclusory and unexplained, we do not find it persuasive.

Because there is no other expert medical opinion in the record that supports claimant's claim, we conclude that claimant has failed to meet his burden of proof. ORS 656.005(7)(a); ORS 656.266.

ORDER

The ALJ's order dated March 15, 2000 is affirmed.

In the Matter of the Compensation of
STEPHEN T. BROZENE, Claimant
Own Motion No. 00-0225M
OWN MOTION ORDER
Ransom & Gilbertson, Claimant Attorneys

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights expired on November 2, 1998. Although the employer recommends reopening of the claim for the provision of temporary disability compensation, it contends that it is unknown whether claimant was 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.

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

Here, the employer contended that because of claimants out-of-state status and his failure to provide proof of earnings, it is unknown whether he was in the work force at the time of the current worsening. In response to the employer's contention, claimant has submitted a copy of his 1999 tax return and a July 2000 paystub, which demonstrates his continued employment. Based on claimant's submission, we find that he was in the work force at the time of his current worsening which required surgery.[1]

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

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

IT IS SO ORDERED.

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[1] On April 24, 2000, Dr. Gebhard, claimant's attending physician, recommended that claimant undergo a single level anterior stand along femoral ring allograft. 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 and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to April 24, 2000 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).

In the Matter of the Compensation of
COLLEEN M. CONNER, Claimant
WCB Case No. 99-06765
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that increased claimant's unscheduled permanent disability award for a back condition from 3 percent (9.6 degrees), as granted by a Notice of Closure (and affirmed by an Order on Reconsideration), to 6 percent (19.2 degrees). 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

On April 29, 1998, claimant sustained a compensable injury when a bookshelf struck her in the mid-back. The insurer accepted the claim as a "thoracic sprain." Based on the February 2, 1999 closing examination of Dr. Maloney, claimant's attending physician, an April 1, 1999 Notice of Closure awarded 3 percent unscheduled permanent disability for impairment in claimant's thoracic spine. Claimant requested reconsideration.

A medical arbiter examination was performed on July 17, 1999 in connection with the reconsideration proceedings. On August 19, 1999, an Order on Reconsideration affirmed the unscheduled permanent disability award in the Notice of Closure, using the thoracic impairment findings in the arbiters' report. Claimant requested a hearing.

The ALJ modified the reconsideration order to award an additional 3 percent unscheduled permanent disability, for a total unscheduled award of 6 percent. In doing so, the ALJ determined that claimant's unscheduled award should not only be based on impairment in the thoracic spine, but also on left shoulder and cervical impairment documented in Dr. Maloney's report, because impairment in the latter regions were "direct medical sequelae" of the compensable "injury." *See former* ORS 656.268(16).[1]

On review, the insurer contends that the conditions in claimant's left shoulder and cervical regions do not constitute "direct medical sequelae" within the meaning of *former* ORS 656.268(16). The insurer asserts that the issue is not, as the ALJ stated, whether the conditions are direct medical sequelae of the accidental "injury," but rather whether they are the direct medical sequelae of the original accepted "condition." Thus, the insurer contends that the ALJ should not have awarded permanent impairment for cervical and left shoulder conditions because the medical evidence does not establish that they were direct medical sequelae of the accepted thoracic sprain condition. For the following reasons, we agree with the insurer.

In *Julio C. Garcia-Caro*, 50 Van Natta 160 (1998), we held that the accepted condition determines what is included in rating permanent disability of a claim. In that case, the accepted condition was right shoulder tendinitis. We found that, even though the medical evidence established that the claimant suffered a loss of range of motion of the cervical spine, that cervical impairment could not be included in the claimant's permanent disability award unless the carrier had accepted a cervical condition or the record established that the impairment was a direct medical sequelae of the accepted condition. 50 Van Natta at 163.

Similarly, in *Donald D. Davis*, 50 Van Natta 357, *denying recon* 50 Van Natta 682(1998), *aff'd mem* 160 Or App 289 (1999), the claimant had an accepted claim for "left elbow contusion." An Order on Reconsideration awarded permanent disability for an epicondylitis condition, which the Appellate Review Unit determined was a sequelae of the accepted condition. We found that although the medical evidence showed that the claimant's epicondylitis condition was a sequelae of the accidental injury, that condition

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[1] *Former* ORS 656.268(16) provides: "Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied." The statute has been renumbered to ORS 656.268(14).

was not a "direct medical sequelae" of the accepted left elbow contusion. Consequently, the claimant was not entitled to impairment for the epicondylitis condition under *former* ORS 656.268(16).

In this case, as the insurer notes, the accepted condition is a thoracic sprain. The insurer has not accepted (nor does the record reflect that claimant has requested that the insurer accept) any condition involving the left shoulder and cervical spine. Therefore, impairment in those areas is not currently ratable unless claimant can establish that the unaccepted conditions are a direct medical sequelae of the accepted thoracic condition. *See Davis*, 50 Van Natta at 357; *see also Donald A. Westlake*, 50 Van Natta 1213 (1998), *aff'd mem* 162 Or App 298 (1999) (where the medical evidence failed to show that the claimant's distal clavicle condition was accepted or that it constituted direct medical sequelae to the accepted condition of acute impingement syndrome, the claimant was not entitled to a permanent disability award based on the distal clavicle resection). Because the medical record does not establish that the unaccepted conditions in the cervical and left shoulder regions are a direct medical sequelae of the accepted thoracic condition, the ALJ should not have awarded additional unscheduled permanent disability based on the unaccepted conditions.[2]

We acknowledge that, under *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997), we may conclude that certain impairment findings are due to the compensable injury where the medical arbiter rates impairment and describes it as "consistent with" the compensable injury and the record discloses no other possible source of impairment. Nevertheless, in cases such as this, where the medical evidence does not address whether the impairment is consistent with, or does not indicate that the impairment is a direct medical sequelae of, an accepted condition, claimant has not sustained his burden of proof.[3] *See David D. Couture*, 50 Van Natta 1181 (1998) (finding that, in the absence of any evidence that loss of cervical range of motion is consistent with a low back injury, *Danboise* is inapplicable).

ORDER

The ALJ's order dated January 28, 2000 is reversed. The Notice of Closure's and Order on Reconsiderations award of 3 percent (9.6 degrees) unscheduled permanent disability is reinstated and affirmed. The ALJ's out-of-compensation attorney fee award is reversed.

[2] Our holding, however, does not mean that a claim for the unaccepted conditions cannot be made and, if accepted or determined to be compensable, rated for permanent disability in the future. *See* ORS 656.262(6)(d), (7)(a).

[3] Because we are not an agency with specialized medical expertise entitled to take official notice of technical facts within our specialized knowledge, we must have medical evidence that the impairment is consistent with, or a direct sequelae of, the accepted condition. *See SAIF v. Calder*, 157 Or App 224 (1998).

August 15, 2000 Cite as 52 Van Natta 1465 (2000)

In the Matter of the Compensation of
LINDA RATLIFF, Claimant
Own Motion No. 00-0209M
OWN MOTION ORDER OF ABATEMENT
Welch, Bruun, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our July 18, 2000 Own Motion Order, that declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she was in the work force at the time of disability.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The Board implements the following briefing schedule. The insurer's response to claimant's request, including any supporting documents, must be filed within 21 days from the date of this letter. Claimant's reply, including any further supporting documents, must be filed within 14 days from the date of mailing of the insurer's response. (Claimant is reminded to send a copy of any document he files with the Board to the carrier.) Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES H. HAMBLETON, Claimant
WCB Case No. 00-00057
OWN MOTION ORDER
Coughlin, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's claim for a right knee chondral defect. On review, the issue is compensability.

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

We begin with a brief summary of the relevant facts. Claimant felt a pop and soreness in his right knee on September 2, 1999 after engaging in bending and kneeling while working. Claimant did not work the next four days. When he returned to work on September 7, 1999, his knee was feeling better until he felt a sharp pain stepping onto a curb while on a work-related errand. Claimant sought treatment for the right knee with Dr. Sandefur, an orthopedist. Dr. Sandefur believed that claimant had aggravated a preexisting degenerative condition in his right knee.

Claimant filed a claim for the right knee injury and SAIF denied the claim on October 29, 1999. Claimant continued to have problems with the right knee and returned to Dr. Sandefur in December 1999. An MRI was performed. Based on the MRI and his examination, Dr. Sandefur suspected a tear of the medial collateral ligament and a tear of the medial meniscus. (Ex. 10B).

Dr. Sandefur performed arthroscopy surgery on January 19, 2000. The surgery revealed no tears, but did reveal extensive arthritis of the right knee and a chondral defect. (Exs. 12A; 16-4). Dr. McNeill, an orthopedist, examined claimant on behalf of SAIF, on February 22, 2000. Dr. McNeill believed that claimant had sustained a right knee strain on September 7, 1999. He opined that claimant's disability and need for treatment prior to the surgery on January 19, 2000 was 70 percent due to the September 7, 1999 work injury and 30 percent due to the preexisting condition. After the date of the surgery, Dr. McNeill believed that 70 percent of claimant's disability and need for treatment was caused by the preexisting condition.

The ALJ found that claimant's attending physician, Dr. Sandefur, opined that claimant's right chondral defect discovered during surgery was caused solely by the September 2 and September 7, 1999 work incidents. On this basis, the ALJ found that claimant had established compensability of the chondral defect.

On Board review, SAIF argues that the ALJ misstated Dr. Sandefur's opinion by indicating that Dr. Sandefur said that the right chondral defect was "solely" due to the September 2 and September 7, 1999 work incidents. SAIF further argues that Dr. Sandefur noted that claimant had preexisting arthritis and had opined, prior to surgery that claimant had a combined condition. Because Dr. Sandefur did not specify what the major contributing cause of claimant's right chondral defect was, SAIF contends that Dr. Sandefur's opinion is unpersuasive.

Claimant argues that because Dr. Sandefur was aware of the right knee degenerative changes and never opined that there was any connection between the chondral defect and the degenerative changes, there is no combined condition and he need only show that his work injuries were a material factor in the development of the right knee chondral defect. Based on the following reasoning, we affirm the ALJ's order.

When his opinions are read in context, we are persuaded that Dr. Sandefur believed that the September 2 and September 7, 1999 injuries directly caused claimant's chondral defect and that the doctor did not believe, after the surgery, that the preexisting condition combined with the work injuries to cause the defect. In this regard, in his February 2, 2000 chart note following surgery, Dr. Sandefur stated:

> "As I had told him after the surgery, the knee arthroscopy revealed some degenerative arthritis, but there was one small focal area of the medial femoral condyle in which there was a chondral defect; and I believe this was more of an acute injury which could have very well happened at the time of his work injury in September. He states that he has spoken with an attorney about reopening the claim, and I told him the only thing that I believe which probably occurred at the time of the accident was the small chondral defect, which I did shave and smooth out; but the degenerative arthritis was more of a pre-existing condition." (Ex. 12B).

In Exhibit 16, Dr. Sandefur indicated that the surgery revealed extensive degenerative arthritis, but indicated that he believed that the chondral defect revealed at surgery was caused by the acute work injury.

After reading these opinions in the context of this case, we find that Dr. Sandefur believed that the September 1999 injuries directly caused the chondral defect and that the preexisting arthritis did not play a role in the chondral defect. In other words, we find that, at least following surgery, Dr. Sandefur did not believe there was a combined condition involving the preexisting arthritis.[1] Instead, the doctor found two separate conditions: an injury-related chondral defect, and preexisting arthritis that was unrelated to the compensable injury.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, 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 April 24, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,200, to be paid by SAIF.

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[1] SAIF argues that because Dr. Sandefur believed that claimant had a "combined condition" prior to the surgery when he initially suspected that there were tears of the medial collateral ligament and the medial meniscus, he still believed there was a combined condition following the surgery, but involving the chondral defect instead of the tears. We do not find SAIF's argument persuasive. Dr. Sandefur did not find what he expected to find during the surgery. No tear was found at surgery. Instead, he found the chondral defect and was forced to reformulate his opinion to address the actual findings at surgery. As noted above, based on his post-surgery opinions, we are persuaded that the chondral defect was caused directly by the injuries and that there was no "combined" condition involving the arthritis.

In the Matter of the Compensation of
PAUL D. HAMILTON, Claimant
WCB Case No. 99-05803
THIRD ORDER DENYING RECONSIDERATION
Jon C. Correll, Claimant Attorney
Reinisch, et al, Defense Attorneys

On July 7, 2000, we denied claimant's second request for reconsideration of our May 16, 2000 Order on Review that had affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of his injury claim for a neck condition. In reaching our conclusion, we explained that claimant's request for reconsideration was not brought to our attention until after the 30-day statutory appeal period had expired, and, by that time, our authority to further consider our May 16, 2000 order had ended.

We acknowledged in our June 26, 2000 order denying reconsideration that claimant had mailed his initial request for reconsideration to the Board on June 15, 2000, which was within 30 days of our May 16, 2000 Order on Review. However, as we previously explained in our prior decisions, the act of mailing a request for reconsideration of a Board order does not suspend the running of the 30-day

statutory appeal period. Instead, that 30-day appeal period *continues to run unless another Board order issues within the 30-day appeal period* that either withdraws, "stays," reconsiders, or otherwise modifies the initial Board order. Because claimant's request for reconsideration was not brought to our attention until after the 30-day statutory appeal period had expired, our May 16, 2000 order had become final and we no longer had authority to further consider it.[1]

Accordingly, as supplemented herein, we adhere to our July 7, 2000 order that denied claimant's motion for reconsideration.

IT IS SO ORDERED.

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[1] Claimant also states in his request for reconsideration that, if his claim was sent to the Court of Appeals, he requests another appeal on his claim. We have no authority to send a claim to the Court of Appeals. Instead, a party dissatisfied with our May 16, 2000 Order on Review could have appealed that order directly to the Court of Appeals within the statutory 30-day period. We have received no notice that claimant filed a petition for judicial review of our May 16, 2000 order with the Court of Appeals within that period.

We also note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. He may contact the Workers' Compensation Ombudsman, at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT. OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE, ROOM 160
SALEM OR 97301-3878

In the Matter of the Compensation of
GREG HARSHA, Claimant
Own Motion No. 00-0216M
OWN MOTION ORDER
Nicholas M. Sencer, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

The insurer has submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights expired on May 23, 1991. The insurer agrees that claimant's current conditions are causally related to his accepted conditions for which it is responsible. However, the insurer contends that it is unknown whether claimant was 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 conditions require surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Here, claimant must prove that he was in the work force prior to March 17, 2000, the date he was hospitalized for surgery. The insurer's position is that it is unsure whether claimant has met his burden of proof regarding his work force status.

In response, claimant submits copies of: (1) a February 25, 2000 paystub for the pay period ending on February 19, 2000; (2) a February 3, 2000 light duty release form from Dr. Sohlberg; and (3) a February 18, 2000 Short Term Disability form from Dr. Keenan, his attending physician. Claimant contends that these documents demonstrate that he remained employed at a subsequent employer and, although off work previously for an unrelated injury, he returned to work on February 7, 2000. However, he noted that he was unable to complete the workday due to increased back pain.

In the February 18, 2000 Short Term Disability Form, Dr. Keenan found claimant "unable to work" as of February 15, 2000. His primary diagnosis was L5-S1 disc disease and surgery was scheduled for that condition. Claimant underwent the recommended surgery on March 17, 2000. Thus, based on Dr. Keenan's opinion, we find that claimant was unable to work at the time of his current worsening and that, it would have been futile for him to attempt to continue to work due to the compensable low back condition. Thus, the "futility standard" of the third *Dawkins* criterion has been satisfied.

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

Claimant's February 25, 2000 paystub demonstrates that claimant returned to work after he was released to modified duty to begin on February 7, 2000. However, due to increased low back pain, he was unable to make it through his work shift. Despite his inability to finish his work shift, we are persuaded that claimant's attempt to return to work demonstrates his willingness to work.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning March 17, 2000, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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
SHARON M. BATTIN, Claimant
WCB Case No. 99-02619
ORDER OF ABATEMENT
Hilda Galaviz, Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our July 24, 2000 Order on Review that affirmed the Administrative Law Judges (ALJ's) order upholding the self-insured employer's denial of claimant's occupational disease claim for a right carpal tunnel syndrome condition. We have also received the employer's response to claimant's submission.

In order to consider this matter, we withdraw our July 24, 2000 order. After completing our further review, we will issue our Order on Reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLIFFORD M. JAMIESON, Claimant
WCB Case No. 99-09920
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
VavRosky, MacColl, Olson, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's occupational disease claim for bilateral ulnar neuropathy. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinions of Dr. Stigler, consulting neurologist at Kaiser, and Mr. Hollenback, physician's assistant at Kaiser, the ALJ set aside the employer's denial of claimant's occupational disease claim for a bilateral elbow condition, finding that the medical evidence established that claimant's work activities were the major contributing of the occupational disease, ulnar neuropathy. *See* ORS 656.802(2)(a).

On review, the employer argues that the opinions of Dr. Stigler and Mr. Hollenback are insufficient to prove compensability. We agree.

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).

Thus, it is claimant's burden to prove that his employment conditions are the major contributing cause of his bilateral ulnar neuropathy. ORS 656.802(2)(a); ORS 656.266. 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)[2].

A determination of the major contributing cause of claimant's condition requires evaluating the relative contribution of different causes of the disease and explaining why the work exposure contributes more to the claimed condition than all other causes or exposures combined. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995).

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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."

[2] ORS 656.005(7)(a)(B) provides:

"If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

ORS 656.005(24) provides in part:

"'Preexisting condition' means any * * * congenital abnormality * * * that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an * * * occupational disease * * * .

The uncontradicted medical evidence establishes that claimant has a shallow ulnar groove, described by the medical providers as a "congenital defect" or an "anatomic variant." (Exs. 31-1, 32-1, -2). According to Dr. Tahir, claimant's treating neurosurgeon, this preexisting defect was the sole cause of claimant's tardy ulnar nerve palsy because the ulnar nerve was unprotected and the nerve located and dislocated on flexion and extension at the elbow joint. (Ex. 37). Dr. Nolan, surgeon, who examined claimant for the employer, agreed with Dr. Tahir's opinion, but also believed that some of claimant's bilateral symptoms were due in part to an apparent polyneuropathy. (Exs. 25, 39). Mr. Hollenback thought that claimant's shallow ulnar groove predisposed claimant to the development of ulnar neuropathy. (Ex. 33).

In addition, after the first nerve conduction studies, not only Dr. Nolan but other examiners concluded that polyneuropathy was the cause of claimant's ulnar nerve condition. (Exs. 24, 25, 28). Their diagnosis was supported by claimant's widespread distribution of mild abnormalities revealed by the nerve conduction studies and claimant's bilateral foot numbness. (Ex. 24-3). Dr. Nolan and Dr. Bergstrom, who had initially diagnosed claimant's condition as bilateral carpal tunnel syndrome on the basis of his clinical presentation, opined that the polyneuropathy was not related to claimant's work. (Exs. 25, 27).

Because of the number of possible causes, the causation issue presents a complex medical question which must be resolved on the basis of expert medical evidence. *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Uris v. Compensation Department*, 247 Or 420, 424-26 (1965). 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).

Claimant has had injuries and symptoms involving both his right and left elbows for which he has sought medical treatment prior to the onset of his current elbow condition. (Exs. 1, 4, 5, 7, 8, 9, 10). As discussed above, claimant has also been diagnosed with a congenitally anomalous ulnar groove and with polyneuropathy.

Opinions have been rendered on the causation issue by Dr. Tahir; Dr. Nolan; Dr. Stigler, neurologist; Dr. Bergstrom; and Mr. Hollenback.

The only opinions that arguably support compensability are those of Dr. Stigler and Mr. Hollenback. Dr. Stigler repeated claimants nerve conduction studies on December 14, 1999. (Ex. 30). However, he was unable to study all of the muscles in claimant's right arm or any of the left arm, which detracts from his opinion that the nerve conduction studies were consistent with bilateral ulnar neuropathy and not a diffuse polyneuropathy. (Ex. 30-2). In addition, Dr. Stigler did not reexamine claimant after Mr. Hollenback and Dr. Tahir diagnosed the congenital defect and he failed to address the contribution of claimant's shallow ulnar grooves to the development of the ulnar neuropathy. This failure further detracts from the persuasiveness of his opinion, particularly in light of Dr. Tahir's opinion that the congenital defect was the sole cause of claimant's condition. Finally, even though the elbow problems that claimant experienced in 1966, 1970, 1975 and 1993 were remote in time, Dr. Stigler's opinion was specifically based on claimant's "lack of prior treatment, and no prior similar history of symptomatology or complaints regarding his right elbow or either hand." (Ex. 40-1). In light of the fact that claimant has previously experienced symptoms and sought treatment on numerous occasions, we find that Dr. Stigler's opinion is based on an inaccurate and incomplete history. Therefore, we give it little weight.

Mr. Hollenback's opinion is likewise deficient.[3] Mr. Hollenback opined that the major contributing factor for claimant's need for surgery was his keeping his arms bent at the elbows, resting on the elbow and forearm, and constant use of the hands at work. Mr. Hollenback acknowledged that claimant had a predisposition to develop an ulnar problem. He stated that the problem may never have cropped up if claimant had not had the predisposition for it, but if claimant had not been doing the years of work, it probably would not have caused the problem. (Ex. 42). This is not sufficient to support claimant's burden of proof for several reasons.

[3] For the purposes of this analysis, we have assumed, without deciding, that this opinion constitutes medical evidence.

First, although Mr. Hollenback has used "magic words" of major contributing cause, his analysis suggests only that, "but for" claimant's work activities, claimant probably would not have needed surgery. This analysis is insufficient under *Dietz*. Moreover, Mr. Hollenback's opinion shows that he was unaware of any other factors that could have contributed to claimant's condition. Mr. Hollenback's failure to weigh claimant's off-work activities and his prior injuries and conditions renders his opinion unpersuasive for the same reasons that Dr. Stigler's is not persuasive.[4]

In sum, we do not find these opinions, alone or in combination, satisfy claimant's burden of proof. Accordingly, we conclude that claimant failed to establish a compensable occupational disease claim. We, therefore, reverse the ALJ's order.

ORDER

The ALJ's order dated April 13, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[4] Moreover, 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. *Tammy L. Foster*, 52 Van Natta 178 (2000). For that reason, Mr. Hollenback's opinion regarding the cause of claimant's need for surgery is insufficient to establish that claimant's work activities were the major contributing cause of claimant's bilateral ulnar neuropathy condition.

In the Matter of the Compensation of
CLARINDA S. KEYS, Claimant
Own Motion No. 98-0461M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Doblie & Associates, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's May 19, 2000 Notice of Closure which closed her claim with an award of temporary total disability compensation from January 19, 1999 through April 2, 2000 and temporary partial disability compensation from April 3, 2000 through April 25, 2000. The insurer declared claimant medically stationary as of April 25, 2000. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure.

The propriety of the closure turns on whether claimant was medically stationary at the time of the May 19, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 124 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

In a June 14, 2000 letter, we request that the insurer submit copies of materials it considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. Having received the parties' submissions and respective positions, we proceed with our review.

Dr. Breen, claimant's attending physician, examined claimant on April 14, 2000. He noted that claimant was in need of a new orthotic and indicated he would follow-up with her the following week as it was scheduled to "reassess other issues related to [her] laminectomy." On that same date, he completed a "Workers' Compensation Form (WCF)," wherein he indicated that claimant was not medically stationary.

On April 25, 2000, Dr. Jacobs examined claimant. Dr. Jacobs had been concurrently treating claimant with Dr. Breen following her March 1999 surgery. Dr. Jacobs was working on pain management for claimant. He also was monitoring her foot drop and neurogenic problems. At that April 25, 2000 examination, Dr. Jacobs opined that claimant was "stationary at this time with active problems being neurogenic bowel and bladder dysfunction, R[ight] foot drop and chronic neuropath pain from post laminectomy syndrome." He referred claimant back to Dr. Breen and stated that he would see her back as needed. Dr. Jacobs concluded that there was nothing more that could be done regarding her foot drop and bladder dysfunction. On that same date, Dr. Jacobs completed a WCF wherein he indicated that claimant was medically stationary and further treatment would be palliative in nature.

Dr. Breen next examined claimant on May 5, 2000. He noted that claimant's back pain was "manageable" but that claimant was having sympathetic and sensory dysfunction in her perineum that was creating difficult with her bladder function. He noted that they were working on ways to control the dysfunction.

On June 2, 2000, in a follow-up examination, Dr. Breen noted that claimant's symptoms have remained "unchanged." He stated that claimant's back pain were controllable with her use of the TENS unit and that her bladder situation was the same as before. Dr. Breen also commented on claimant's medically stationary status stating that: "I understand there was a mix-up re med stat status. My plan was to attempt a gradual return to work program and make her med state after the maximum work level has been attained. To my knowledge her employer has not yet brought her back, but plans to. I would plan to do closing exam once that has taken place." On that same date, Dr. Breen completed a WCF form indicating that claimant required further treatment and was not medically stationary.

Claimant contends that the insurer should not have relied on Dr. Jacobs' opinion regarding her medically stationary status because he is not her attending physician. Rather, she contends that she was not medically stationary at the time of closure because her attending physician, Dr. Breen, had not declared her medically stationary and had recommended further treatment. In addition, she asserts that because Dr. Breen planned to return her to work on a "gradual basis," and that has yet to occur, she continues to be not medically stationary.

Claimant's apparent reliance that it must be an attending physician who can determine when a claimant is medically stationary is misplaced. It is well settled that for purposes of determining whether a claimant is medically stationary at the time of closure, we rely upon all competent medical evidence and not just the opinion of the attending physician. *See Patricia M. Knupp*, 46 Van Natta 2406 (1994); *Francisco Villagrana*, 45 Van Natta 1504 (1993); *Timothy H. Krushwitz*, 45 Van Natta 158 (1993).

Additionally, 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 addition, we give the most weight to opinions that are both well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In this case, we find Dr. Jacobs' opinion more persuasive. Dr. Jacobs treated claimant concurrently with Dr. Breen following her March 1999 surgery. The record demonstrates that he monitored claimant's progress closely and is very familiar with claimant's condition. Although noting that claimant had remnant symptoms regarding her foot drop and bladder dysfunction, Dr. Jacobs opined that there was no further treatment that would "materially" improve her conditions. He also opined that any further medical treatment would be palliative in nature.

On the other hand, although opining that claimant was not medically stationary, Dr. Breen offers no objective reasons to support his opinion. He agrees with Dr. Jacobs that her condition has remained "unchanged," and does not offer a treatment plan that would "materially" improve claimant's medical condition nor does he opine that her condition would improve with the passage of time.[1]

Further, the definition of medically stationary outlines the criteria by which a physician must determine a claimant's medically stationary status. *See* ORS 656.005(17). Therefore, although Dr. Breen asserts that claimant is not medically stationary because she has not reached her "maximum work level," the pivotal question is whether her condition will improve with further treatment or the passage of time.

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[1] We note that, in the absence of medical evidence providing a reasonable expectation that medical treatment or the passage of time would result in material improvement of claimants condition, the need for continuing medical care in the form of medications and TENS unit does not establish that claimant's condition was not medically stationary. *See Maarefi v. SAIF*, 69 Or App 527, 531 (1984); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

In conclusion, based on Dr. Jacobs' persuasive opinion, we find that claimant was medically stationary on the date her claim was closed. Therefore, the insurer's closure was proper.

Accordingly, we affirm the insurer's May 19, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
CATHY A. McCAUSLAND, Claimant
Own Motion No. 00-0166M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 6, 2000 Notice of Closure, which closed her claim with an award of temporary disability compensation from March 30, 2000 through June 27, 2000.[1] SAIF declared claimant medically stationary as of June 27, 2000.

In her request for review, claimant contends that "this is an apeal [sic]," and that "as of 7-6-00 I feel also that I should of received time loss." We interpret such statements as a contention that claimant was not medically stationary at claim closure.

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

The propriety of the closure turns on whether claimant was medically stationary at the time of the July 6, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

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

Here, claimant requested review because she was currently receiving "shots for pallative [sic] care," and that she would like to "continue receiving this pallative [sic] care." In addition, claimant contends that she should have continued receiving time loss at the time of closure. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

In a June 27, 2000 doctor's report, Dr. Berselli, claimant's attending physician, opined that claimant was medically stationary. Dr. Moore, who performed at Disability Prevention Consultation (DPC) examination on that same date noted that he had confirmed with Dr. Berselli that claimant was medically stationary. He also noted that claimant's active treatment was in the form a recent injection to her shoulder. He concluded that claimant suffered no impairment from her treatment aside from the

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[1] Claimant's December 19, 1976 was accepted as a disabling claim and the first closure was on that same date. Thus, claimant's aggravation rights expired on December 19, 1981. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in March 2000, claimant's claim was under our own motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on May 15, 2000, we issued our own motion order authorizing the payment of temporary disability compensation and noted that when claimant was medically stationary, SAIF should close the claim pursuant to OAR 438-012-0055.

"chronic nature of the condition." These opinions are unrebutted. Thus, even if claimant was contesting her medically stationary date, based on the unconverted medical evidence, we find that claimant was medically stationary on the date her claim was closed and that she is not entitled to additional temporary disability.

Claimant also requests that we consider a "permanent disability of my claim." We interpret claimant's request for "permanent disability" as a request for other workers' compensation benefits. We are without authority to award further permanent disability in this claim. Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990). As noted in footnote 1, claimant's aggravation rights expired in 1981. Thus, she is not entitled to a permanent disability award under this reopening of her own motion claim.

Finally, claimant contends that "this claim should reopen for aggravation of claim also." Claimant should note that if her compensable condition subsequently worsens 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).[2]

In conclusion, based on the uncontroverted medical evidence (*i.e.* the opinion of his attending physician), we find that claimant was medically stationary on the date her claim was closed. Therefore, SAIF's closure was proper.

Accordingly, we affirm SAIF's July 6, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] It appears from claimant's request that her claim be "reopen for aggravation" and her request for "permanent disability," that she may not understand her 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, she 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 97301
Telephone: 1-800-927-1271

August 17, 2000 Cite as 52 Van Natta 1475 (2000)

In the Matter of the Compensation of
JOHN H. ZIMMERMAN, Claimant
WCB Case No. 99-01164
ORDER OF ABATEMENT
James W. Moller, Claimant Attorney
Reinisch, et al, Defense Attorneys
Nicholas M. Sencer, Attorney

The insurer requests reconsideration of our July 19, 2000 Order on Review that affirmed an Administrative Law Judge's order that set aside its denial of claimant's claim for his L3-4 disc herniation and spinal canal stenosis at L3-4. In its request for reconsideration, the insurer contends that we erred in relying on the opinion of Dr. Woodard in determining that claimant had satisfied his burden of proof.

In order to consider the insurer's motion and to allow claimant an opportunity to respond, we abate our July 19, 2000 order. Claimant is granted 14 days from the date of this order to respond to the insurer's motion. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL STEWART, Claimant
Own Motion No. 99-0199M
OWN MOTION ORDER REVIEWING
CARRIER CLOSURE ON RECONSIDERATION

Claimant requests reconsideration of our August 4, 2000 Own Motion Order Reviewing Carrier Closure. Our prior order affirmed the self-insured employer's March 22, 2000 Notice of Closure in its entirety. On reconsideration, we adhere to our prior order, as supplemented below.

In our prior order, we based our findings on Dr. Gordin's September 28, 1999 chart note. In his September 28, 1999 chart note, Dr. Gordin noted that claimant had a full range of motion in his *left knee* and had regained his quadriceps bulk and strength. He also noted that although claimant had some intermittent swelling and pain, he could find not a "discreet" lesion that would be causing the inflammation. He concluded that claimant would probably have a chronic problem with recurrent inflammation of the *left knee*. Dr. Gordin noted that claimant was complaining of discomfort in his ankles and for that he was referred to Dr. Malkin. He did not relate claimant's ankle complaints to his *compensable knee condition*. With regard to claimant's *left knee condition*, Dr. Gordin opined that "at this point I feel I have nothing more to offer." We concluded that Dr. Gordin had declared claimant medically stationary as to his *left knee condition* on that date.

In his request for reconsideration, claimant repeats his contention that he experiences chronic symptoms in both his knee and ankles. He asserts that his ankles "were injured [at] the same time as my left knee, in 1987." Claimant contends that the need for treatment for his *ankle/foot* conditions establishes that he was not medically stationary when the employer closed his claim.

However, as stated in our prior order, the record did not indicate that an *ankle/foot condition* had been *accepted* by the employer. We concluded that, unless the employer had accepted an *ankle/foot condition*, claimant had to establish that he was not medically stationary at closure with respect to his *accepted knee condition*. *Rogers v. Tri-Met*, 75 Or App 470 (1985). As noted above, we concluded that claimant's *left knee condition* was medically stationary when the employer closed his claim on March 22, 2000.

Claimant provides no new argument to dispute our findings in our August 4, 2000 Own Motion Order Reviewing Carrier Closure. In that order, we explained our reasoning supporting our conclusion that claimant was medically stationary when the employer closed his claim. After further consideration, we have nothing to add to our determination that, on this record, claimant was medically stationary when the employer closed his claim on March 22, 2000.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 4, 2000 order, effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.[1]

IT IS SO ORDERED.

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[1] It would appear from his reconsideration request that 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
RUTH TAYLOR, Claimant
WCB Case No. 99-09291
ORDER ON REVIEW
Walsh & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Johnson's order that: (1) found that the Hearings Division had jurisdiction over claimant's request for hearing; and (2) found that claimant was entitled to temporary disability benefits from February 13, 1996 through August 19, 1997. In its appellant's brief, the insurer also contends that the ALJ erred in "reopening" the record to allow further testimony. On review, the issues are jurisdiction, whether the ALJ erred in reopening the record, and temporary disability benefits. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

We adopt the ALJ's "Opinion" on the issue of jurisdiction.

Reopening of record

On review, the insurer argues that the ALJ erred in allowing the record to be "reopened" for further testimony from claimant. Here, claimant had rested and the testimony had been completed. In closing argument, the insurer contended that claimant had not proven that she was entitled to temporary disability benefits because she had not shown a loss of wages due to the injury. In response, claimant's counsel requested permission to call claimant to the stand to testify regarding the issue. The ALJ granted claimant's motion over the insurer's objection.

On review, the insurer argues that the ALJ erred in "reopening" the record. We construe the insurer's argument as a contention that the ALJ abused his discretion by permitting further testimony after closing arguments had been made. *See e.g. Dena M. Calise*, 45 Van Natta 783 (1993).

We need not address whether the ALJ abused his discretion as we find that there is evidence in the documentary record that establishes that claimant had a loss of wages due to the injury which would entitle her to temporary disability benefits. *See* Exs. 24, 30, 41. Consequently, claimant has met her burden of proof in that regard even if the testimony at issue is not considered.

Entitlement to temporary disability benefits

We adopt the ALJ's "Opinion" on this issue.

Claimant's counsel is entitled to an assessed attorney fee for prevailing over the insurer's request for 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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimants respondents brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 17, 2000 is affirmed.

In the Matter of the Compensation of
CHARLES M. HANEY, Claimant
Own Motion No. 98-0360M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's February 1, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from August 18, 1998 through January 28, 2000. SAIF declared claimant medically stationary as of January 28, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

In a June 13, 2000 letter, we implemented a briefing schedule to allow the parties to submit their written positions regarding claimant's request for review of SAIF's closure.[1] Having received the parties' submissions and respective positions, we proceed with our review.

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

The propriety of the closure turns on whether claimant was medically stationary at the time of the February 1, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Claimant contends that he was not medically stationary at the time of closure because he continues have pain and requires further surgery. Claimant submitted a March 30, 2000 doctors report from Dr. Randell and a July 24, 2000 chart note from Dr. Hendrix in support of his contentions.

In his March 30, 2000, Dr. Randell indicated that claimant had continued knee pain with decreased range of motion and stiffness. Although he disagreed that a knee fusion was a viable option for claimant, he did recommend that claimant undergo some physical therapy, a work hardening program and an arthroscopy to assess whether claimant had significant degenerative changes. Dr. Randell opined that a total knee replacement would be a more viable solution than a knee fusion but unless he could prove the need for surgery on objective rather than subjective data, then surgery was not considered at this time.

On June 24, 2000, Dr. Hendrix noted that claimant's condition was "continuing to worsen with time" and that he had not responded to the conservative treatment alternatives. He agreed with Dr. Randell's recommendation that a reasonable treatment alternative would be an arthroscopic evaluation. He also agreed that a total knee replacement and/or knee fusion were not viable options at this time.

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[1] We noted in our request that claimant's March 20, 2000 request was initially interpreted as a request for hearing before the Hearings Division. A hearing was schedule for June 28, 2000 before an Administrative Law Judge (ALJ). Prior to the scheduled hearing date, claimant advised the Hearings Division that he was withdrawing his request for hearing.

On June 8, 2000, the ALJ issued an Order of Dismissal. In that order, the ALJ noted that claimant's initial request was a review of an own motion closure. The ALJ also noted that the Board has exclusive jurisdiction over own motion matters. ORS 656.278(1). Inasmuch as claimant's request for review of the own motion closure had not been referred to the Hearings Division from the Board, the ALJ concluded that the Hearings Division did not have jurisdiction over said issue. Accordingly, the ALJ dismissed claimant's hearing request for lack of jurisdiction and forwarded claimant's request for review of the own motion closure to the Board for further processing.

We further noted that inasmuch as a record was developed before the Hearings Division prior to the hearing dismissal, SAIF and claimant could rely on the documentary evidence submitted at that time.

Although both Drs. Randell and Hendrix recommended, as a possible treatment alternative, that claimant undergo arthroscopic surgery, neither of these reports reference claimant's medically stationary status at the time of the claim closure nor do they imply that he was not medically stationary on February 1, 2000, when SAIF closed his claim. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Rather, Dr. Randell's March 2000 and Dr. Hendrix July 2000 opinions focus on claimant's current need for treatment, not his condition when his claim was closed.

On the other hand, Dr. Funk, who was claimant's attending physician at the time SAIF closed his claim,[2] in response to an inquiry from SAIF, opined that claimant was medically stationary on January 28, 2000. Dr. Funk further opined that claimant would achieve "no further improvement." His opinion is unrebutted.

In conclusion, based on Dr. Funk's opinion, we find that claimant was medically stationary on the date his claim was closed. Therefore, SAIF's closure was proper.

Accordingly, we affirm SAIF's February 1, 2000 Notice of Closure in its entirety.[3]

IT IS SO ORDERED.

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[2] Due to problems inherent in having an "out-of-state" status, throughout claimant's treatment following his 1998 surgery, he has had several attending physicians.

[3] 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
SHERENA M. MEAGHER, Claimant
WCB Case No. 99-08360
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's current condition denial pertaining to claimant's left knee condition, concluding that the denial was procedurally improper. In reaching this conclusion, the ALJ reasoned that the evidence generated in support of the denial suggested a "back-up" denial because it cast doubt on whether claimant's left knee claim was compensable in the first instance. Noting that it was the "law of the case" that claimant had sustained a compensable left knee injury on November 17, 1998, the ALJ further found that the conditions accepted by the employer (left knee strain and left medial meniscus tear) were "combined conditions." As a result, the ALJ determined that the employer's denial should be analyzed under ORS 656.262(6)(c).[1]

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[1] That statute 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."

The ALJ then found that the employer's denial was impermissible under that statute because the employer failed to prove a change in condition or circumstances such that the compensable injury "ceased" to be the major contributing cause of the "combined condition." *See Harry L. Lyda*, 48 Van Natta 1300 (1996), *aff'd State Farm Insurance v. Lyda*, 150 Or App 554 (1997). In making this finding, the ALJ observed that the medical evidence supporting the denial indicated that the injury never was the major contributing cause of claimant's condition, not that circumstances had changed so that the compensable injury was no longer the major cause of the current combined condition.

On review, the employer contends that the ALJ incorrectly set aside its denial on procedural grounds. The employer asserts that its denial was not a "back-up" denial and that the denial was not subject to ORS 656.262(6)(c) because it never accepted a "combined" condition. *See Croman Corp v. Serrano*, 163 Or App 136 (1999). Therefore, the employer argues that the merits of its denial should be reached and that its denial should be upheld under ORS 656.005(7)(a)(B) based on medical evidence from Dr. Farris and Fuller, examining physicians, and Dr. Colville, a former attending physician.

We need not determine whether the ALJ properly set aside the employer's denial on procedural grounds. That is, even assuming that the employer's denial was procedurally correct, we would still set it aside on the merits.

In this regard, we agree with the ALJ that the evidence supporting the employer's current condition denial is directed toward the compensability of the original injury on November 16, 1998, which the employer accepted as a left knee strain and left medial meniscus tear. Dr. Fuller provided the primary evidence in support of the denial. Dr. Fuller opined in several reports that the preexisting arthritis condition was the major contributing cause of claimant's symptoms on November 16, 1998. (Exs. 11-7, 21, 43-3, 44-2, 45-3).[2] However, the compensability of the original injury in November 1998 is not at issue in this case, given that the employer has accepted the injury.[3]

Dr. Colville, claimant's former attending physician, concurred with Dr. Fuller's various reports. (Ex. 47). However, we discount the probative value of Dr. Colville's opinion for the same reason we have discounted Dr. Fuller's. With regard to Dr. Farris' opinion, he noted that claimant did not describe any twisting injury to her knee on November 17, 1998. Dr. Farris concluded that, in the absence of a twisting injury to the left knee, it was medically improbable that claimant would have sustained meniscal tear as a result of the November 17, 1998 injury. (Ex. 29-8). The employer, however, specifically accepted a meniscus tear as compensable. Again, because it addresses the compensability of the initial November 17, 1998 injury claim, we do not find Dr. Fuller's opinion persuasive on the causation issue concerning the current left knee condition.

In contrast to the above evidence, Dr. Puziss, the current attending physician, has opined that the major contributing cause of the current left knee condition is the November 17, 1998 injury, rather than a preexisting arthritis condition. (Ex. 46a). Because Dr. Puziss' opinion is focused on the compensability of the current left knee condition and is well-reasoned and based on an accurate history, we find no persuasive reason not to give greater weight to it. *See Weiland v. SAIF*, 64 Or App 810 (1983).[4]

Accordingly, we find that claimant has sustained her burden of proving that the compensable injury of November 17, 1998 is the major contributing cause of her current left knee condition and need for treatment. Thus, we affirm the ALJ's decision setting aside the employer's denial, although on different grounds.

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[2] Dr. Fuller's opinion is well illustrated by the comment in his December 28, 1999 report that:

"These new records make it clear that she [claimant] sustained no primary or disabling injury on 11/17/98. What she experienced on that day was simply another expression of her chronic rheumatoid arthritis." (Ex. 45-3).

[3] Indeed, the employer states that it has never contended that the accepted conditions in this case are not compensable. (Reply Brief p. 1).

[4] Dr. Puziss stated, however, that, if claimant had a significant problem with the left knee joint prior to the November 17, 1998 injury, then the November 1998 injury would not be the major cause of her knee problems. (Ex. 46A). There is no evidence that claimant received medical treatment for the left knee prior to the November 1998 injury. Therefore, we do not find that Dr. Puziss' caveat detracts from the persuasiveness of his opinion.

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

ORDER

The ALJ's order dated February 25, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the employer.

In the Matter of the Compensation of
MICHAEL L. SPENCER, Claimant
WCB Case No. 99-05588
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's claim for an L4-5 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his low back on February 26, 1998. Claimant was initially treated by Dr. Moore, who sent claimant to physical therapy. Claimant had left sided low back pain that radiated into the left leg. An MRI was performed on March 12, 1998 and read by Dr. Goodman. The MRI showed minimal disc degenerative changes with mild disc bulge at L4-5 without significant central or neural foraminal stenosis. (Ex. 21). The remainder of the lumbar spine appeared normal. The report indicated that no focal disc herniations were identified at any level, but there was a very mild posterior disc bulge at the L4-5 intervertebral disc space. *Id.* In light of the MRI scan and radicular symptoms, Dr. Moore referred claimant to Dr. Amstutz, a neurosurgeon. Dr. Amstutz read the MRI scan as showing an L4-5 disc protrusion that compromised the L4 nerve root. (Ex. 25). Dr. Amstutz recommended epidural steroid injections.

On April 1, 1998, SAIF accepted a lumbar strain. (Ex. 31). EMG studies were performed on April 24, 1998. They showed no evidence of any neurogenic abnormalities in the left lower extremity. (Ex. 35).

Claimant was given caudal epidural injections on May 1, May 22, and June 10, 1998. (Exs. 38; 42).

Claimant was examined, on behalf of SAIF, by Dr. Saviers, a specialist in physical medicine, on June 5, 1998. An EMG study performed by Dr. Saviers showed no evidence of lumbosacral radiculopathy or sciatic neuropathy. (Ex. 44-6).

Claimant was examined by Dr. Schilperoort, an orthopedic surgeon, on SAIF's behalf, on July 13, 1998. Dr. Schilperoort opined that Dr. Amstutz had "over read" the March 12, 1998 MRI scan. Dr. Schilperoort did not believe the scan showed a herniated disc at L4-5. (Ex. 48).

Dr. Mayhall, an orthopedist, performed a records review on behalf of SAIF on October 23, 1998.

Claimant's claim was closed by a Notice of Closure on December 15, 1998 that awarded temporary disability benefits. (Ex. 60).

Claimant's back condition improved and in January 1999, Dr. Amstutz felt that claimant no longer needed a surgeon to oversee his care and recommended that claimant transfer his care to Dr. Saviers.

Dr. Purnell, a radiologist, reviewed claimant's March 12, 1998 MRI scan at SAIF's request.

On May 24, 1999, SAIF issued a denial indicating that there was insufficient evidence that an L4-5 disc herniation existed. (Ex. 66).

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Amstutz' opinion, the ALJ found that claimant had established that he probably sustained an L4-5 disc herniation as a result of the February 26, 1998 compensable injury. SAIF argues that claimant failed to prove the existence of a disc herniation at L4-5. Claimant argues that the ALJ correctly analyzed the medical evidence.

Claimant has the burden of proof to establish that he has a compensable L4-5 disc herniation. ORS 656.266. After reviewing the medical evidence, we find that the evidence does not preponderate in favor of a conclusion that claimant has an L4-5 disc herniation.

In this regard, only Dr. Amstutz asserts that claimant has a herniated disc at L4-5. The remainder of the medical evidence, including the reports of two radiologists who read claimant's MRI, does not establish that claimant has a herniated disc at L4-5.

On March 12, 1998, Dr. Goodman, radiologist, interpreted claimant's MRI to show a very mild posterior disc bulge at L4-5. No focal disc herniations were identified at any level. (Ex. 21).

Dr. Schilperoort, an orthopedist, examined claimant on behalf of SAIF. Dr. Schilperoort opined that Dr. Amstutz "over read" the MRI scan and disagreed with Dr. Amstutz' opinion that the MRI showed a disc herniation. (Ex. 48).

Dr. Amstutz, claimant's treating neurosurgeon, opined that claimant had radiculopathy from a far lateral disc herniation. Dr. Amstutz expressed disagreement with Dr. Schilperoort's report and stated that he did not see any reason to change his diagnosis of radiculopathy from a far lateral disc herniation. (Ex. 52).

Dr. Mayhall, an orthopedist, performed a chart review at SAIF's request. Dr. Mayhall reviewed the MRI scan and opined that there was no evidence of a disc herniation at L4-5. (Ex. 67-2).

Dr. Purnell, a radiologist, reviewed claimant's March 12, 1998 MRI. Dr. Purnell noted a mild circumferential bulge of the annulus fibrosis at L4-5 associated with disc desiccation and mild protrusion of the annular margins into the caudal recesses of the L4 neuroforamina bilaterally, left slightly more prominent than right. Dr. Purnell indicated that this may touch the exiting left L4 nerve root, however, there was preservation of perineural fat and the nerve root sheath was not displaced. Dr. Purnell noted that the significance of this finding was questionable and that clinical correlation was suggested. (Ex. 65).

Dr. Goodman, the radiologist who prepared the March 12, 1998 MRI report, was deposed. Dr. Goodman indicated that it can be difficult to differentiate between disc bulges and herniations and it depended "on the subjective, as most other things in medicine are." (Ex. 68-5). Dr. Goodman indicated, however, that the disc shown on the MRI was "not clearly a herniation." *Id.* Dr. Goodman explained that if a disc presses the nerve root, the fat surrounding the nerve root will be obliterated. Dr. Goodman noted that there was "still good fat" surrounding claimant's L4-5 nerve root. (Ex. 68-10,11).

After reviewing the medical record, we are not persuaded by Dr. Amstutz' lone opinion that the MRI scan establishes a disc herniation. In this regard, neither of the radiologists who reviewed the MRI scan read it as revealing a herniation. Both radiologists noted that the fat surrounding the nerve root was still intact. Orthopedists Schilperoort and Mayhall also reviewed the MRI scan and did not see a herniation. Dr. Amstutz' opinion that the scan shows a herniation is basically unexplained and conclusory. Under such circumstances, and given that the weight of the expert medical evidence is not in agreement with Dr. Amstutz' reading of the MRI, we are not persuaded by Dr. Amstutz' opinion. Instead, based on this record, especially upon the expert opinions of the two radiologists, we conclude that claimant has not established that he suffers from an L4-5 disc herniation.

ORDER

The ALJ's order dated April 7, 2000 is reversed. The ALJ's attorney fee award is also reversed. SAIF's denial is reinstated and upheld.

In the Matter of the Compensation of
PETER VOORHIES, Claimant
Own Motion No. 97-0530M
OWN MOTION ORDER
Sheridan, Bronstein, et al, Defense Attorneys

The insurer requests that we suspend claimant's temporary disability benefits pursuant to OAR 438-012-0035(5) for his failure to attend two closing examinations scheduled with an insurer-arranged medical examiner. Claimant responds that he had "good cause" for failing to attend those closing examinations; therefore, suspension of his temporary disability benefits is not appropriate. Based on the following reasoning, we find that suspension of benefits is not appropriate under the facts of this case.

FINDINGS OF FACT

On January 23, 1982, claimant sustained multiple injuries to his left leg in a compensable motor vehicle accident. His aggravation rights on that claim expired on September 15, 1993.

On November 18, 1996, claimant began treating with Dr. Winquist, M.D., who recommended a total hip replacement. At that time, claimant was residing in Bainbridge Island, Washington. Dr. Winquist's practice is in Seattle, Washington. The insurer sought and received Dr. Winquist's agreement to comply with Oregon Workers' Compensation Law in order to serve as an out-of-state physician. Thereafter, Dr. Winquist became claimant's attending physician.

On January 7, 1997, Dr. Winquist performed the left total hip arthroplasty. The insurer voluntarily reopened the claim. By Own Motion Order dated November 18, 1997, we authorized the reopening of claimant's claim to provide temporary total disability compensation beginning January 7, 1997, the date of surgery.

On May 14, 1998, the insurer issued a Notice of Closure that closed the claim with an award of temporary disability compensation from January 7, 1997 through March 25, 1998. The insurer declared claimant medically stationary as of March 25, 1998, based on Dr. Winquist's affirmative response to a question as to whether claimant was presently medically stationary. Claimant requested review of the claim closure.

On June 10, 1998, Dr. Winquist examined claimant. On August 18, 1998, he withdrew his prior statement that claimant was medically stationary status, explaining that, although claimant required no further treatment/surgery, he was not medically stationary because he continued to make gradual improvement. We found Dr. Winquist's change of opinion persuasive. On October 15, 1998, we set aside the insurer's May 14, 1998 Notice of Closure and directed it to recommence payment of temporary disability benefits. *Peter Voorhies*, 50 Van Natta 2051 (1998).

Subsequently, claimant requested enforcement of our October 15, 1998 order, contending that the insurer had not complied with our order to resume the payment of his temporary disability benefits. On June 8, 1999, we issued an Own Motion Order that: (1) found no valid grounds for the insurer's failure to pay temporary disability benefits as directed by our prior order, directed it to reinstate temporary disability benefits effective March 25, 1998, and to continue payment until such benefits could be lawfully terminated under OAR 438-012-0035(4); and (2) assessed penalties for the insurer's unreasonable refusal to pay compensation. *Peter Voorhies*, 51 Van Natta 920 (1999).

Claimant last saw Dr. Winquist on June 10, 1998. In September 1999, the insurer contacted Dr. Winquist to determine claimant's medically stationary status and to verify his inability to work. Dr. Winquist would not comment on those issues because he had not examined claimant since June 10, 1998. He also stated that he did not perform closing examinations and he would not comment on another doctor's closing examination report because he felt that that would be a conflict of interest with the patient [claimant]. After the insurer corresponded further with Dr. Winquist and reminded him that he had agreed to abide by Oregon Workers' Compensation Law, on December 29, 1999, Dr. Winquist agreed to review a closing examination to be performed by another physician.

By a notice dated January 4, 2000, the insurer informed claimant that an examination was scheduled to be performed by Dr. Reese, orthopedic surgeon, on February 1, 2000. The purpose of the examination was to obtain a closing evaluation. The notice contained a paragraph in capital letters and bold print stating that: (1) claimant must attend this examination and, if he could not attend, he must notify the insurer as soon as possible before the date of the examination; and (2) if he failed to attend

without good reason for not attending, his compensation benefits may be suspended in accordance with the Workers' Compensation Law and rules.

The notice was addressed to both claimant's post office box number and his street address in Bainbridge Island. It was mailed by regular and certified mail. Claimant had no mail receptacle at his street address and received his mail at a post office box. Delivery was delayed because the Bainbridge Island post office attempted to deliver the notice to the street address on the last line above the city and state. Claimant received this notice on January 24, 2000.[1]

By the time claimant received this notice, he had plans to go to Portland to attend to some family matters. He called the Workers' Compensation Ombudsman and was informed that, under OAR 436-060-0095(5), the insurer was required to provide at least ten days notice for an examination.

During the week of January 24, 2000, claimant received a notice from Inland Medical Evaluations (the company that sponsored the examination) providing him with their telephone number and instructing him to call if there were any problems. When claimant called the number provided he was informed that they knew nothing about an examination with Dr. Reese on February 1, 2000. Apparently, the telephone number provided was not the number of the office claimant had been directed to attend the examination. Claimant reached the correct office the day before the appointment and notified them that he would not be attending the examination because the time was not convenient for him.[2] Claimant did not contact the insurer until the day after he had failed to attend the examination.

The insurer rescheduled an examination with Dr. Reese for 10:00 a.m., March 7, 2000, in Everett, Washington. After the examination was rescheduled but before claimant was notified about it, claimant notified the insurer on February 22, 2000, that he had relocated to Palm Desert, California.

By a notice dated February 24, 2000, the insurer informed claimant about the rescheduled appointment with Dr. Reese. This notice was mailed to claimant's Palm Desert address by both regular and certified mail. It was received by the office of the complex in which claimant was living on February 28, and delivered to claimant by the office on February 29, 2000.[3]

This notice informed claimant that the purpose of the examination was to obtain a closing evaluation. It also informed claimant that his claim would not remain open indefinitely for failure to obtain a closing evaluation. The notice contained a paragraph in capital letters and bold print stating that: (1) claimant must attend this examination and, if he could not attend, he must notify the insurer as soon as possible before the date of the examination; and (2) if he failed to attend without good reason for not attending, his compensation benefits may be suspended in accordance with the Workers' Compensation Law and rules.

On February 29, 2000, claimant went to a travel agent to arrange for a ticket. He was told there were no direct flights to Everett, which is north of Seattle. Sea-Tac airport was the closest commercial airport to Everett; and the earliest flight out of Palm Desert would arrive in Seattle at 10:33 a.m.

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[1] We make this finding based on claimant's statement in his May 9, 2000 letter that responded to the insurer's request to suspend benefits. The insurer does not dispute claimant's statement that he received the notice for the first scheduled examination on January 24, 2000. Because the letter was sent by certified mail, the insurer presumably has a return receipt showing the date received. Both scheduled examinations were sent by regular and certified mail. No copy of either return receipt was submitted by the insurer.

[2] We make this finding based on the insurer's statements in its request for suspension and its reply to claimant's response to that request. Claimant does not dispute the insurer's statement that, when he called Inland Medical Evaluations to cancel the scheduled examination, he gave no clear reason for failing to attend the examination other than it was not a convenient time for him.

[3] We make this finding based on claimant's statement in his May 9, 2000 letter that responded to the insurer's request to suspend benefits. The insurer does not dispute claimant's statement that the office received the notice for the rescheduled examination on February 28, 2000, and delivered it to him on February 29, 2000.

Claimant called the claims examiner and explained that he could not leave his wife alone at night because she had started a chemical treatment regime for liver disease that, on occasion, caused her to be violently sick. Claimant suggested that the appointment be rescheduled for midday on March 7, so he could make it to the appointment and back home the same day.

The insurer contacted Inland Medical Evaluations. Three other examinations were scheduled for that date and none of those appointments was able to be rescheduled. As a result, on March 3, 2000, the claims examiner left claimant a telephone message that the March 7, 2000 appointment at 10:30 a.m. had been canceled and she would notify him of a new time. Subsequently, Dr. Reese agreed to stay later than scheduled so that time for claimant could be reserved at the end of the day. As a result, claimant's examination was rescheduled for March 7, 2000, at 3:45 p.m.

On March 3, 2000, the claims examiner informed claimant of this change by a telephone message. On March 4, 2000, claimant received a check from the insurer for $725 to cover the air fare and travel expenses.

Claimant contacted a travel agent and was told that the flight leaving Sea-Tac at 6:49 p.m. was the last flight that would get him home the night of March 7, 2000. The travel agent advised him to arrive at Sea-Tac at least an hour before the flight time. Claimant called Inland Medical Evaluations and was told that a closing examination took from an hour and a quarter to an hour and a half from start to finish. Their best estimate of how long it would take to drive the 40 to 45 miles from their office in Everett to Sea-Tac Airport was possibly an hour and a half or somewhat less. Claimant thought this estimate seemed too optimistic based on his experiences driving in Seattle on Interstate 5 during rush hour traffic. In addition, claimant had to allow time to return the rental car and get transportation from the rental return area to the airport check-in. Without allowing for the recommended hour advance check in time, claimant estimated that he would arrive at the airport at about 7:00 p.m., after the 6:49 p.m. flight departed (allowing an hour and a quarter for the exam, an hour and a half for the trip to the car rental return, and a half an hour from the rental return to the airport).

Inland Medical Evaluations informed the insurer that orthopedic examinations performed by Dr. Reese usually took an hour. The insurer estimated that the 44 miles from Everett to Sea-Tac Airport would take about an hour and a half, allowing for rush hour traffic. Thus, the insurer estimated that claimant would arrive at the airport by 6:15 p.m. - 35 minutes before his 6:49 flight departed.

On March 6, 2000, claimant called Inland Medical Evaluations and advised them he would be unable to attend the examination scheduled for March 7, 2000. After the end of the business day on March 7, 2000, claimant sent a fax to the insurer explaining his reasons for not attending. He returned the $725 check to the insurer.

On March 17, 2000, the insurer requested suspension of claimant's temporary disability benefits pursuant to OAR 438-012-0035(5) for failure to attend two separately scheduled closing examinations.

CONCLUSIONS OF LAW AND OPINION

The insurer requests that we suspend claimant's temporary disability benefits pursuant to OAR 438-012-0035(5) for his failure to attend two closing examinations scheduled with an insurer-arranged medical examiner. 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 the 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."

We conclude that the suspension of claimant's compensation is not warranted under the circumstances of this case. We base this decision on the following reasoning.

We find instructive the Director's rules regarding suspension of compensation for failure to attend a medical examination. *See* OAR 436-060-0095.[4] These rules provide, *inter alia*, the necessary notification requirements that a carrier must satisfy. *See* OAR 436-060-0095(5).[5] In addition, pursuant to OAR 436-060-0095(12), failure to comply with one or more of the requirements addressed in these rules may be grounds for denial of a carrier's request for suspension of benefits. *Sharon S. Webster*, 46 Van Natta 2438 (1994) (Director's order suspending a claimant's permanent total disability benefits reversed because the carrier's notice to the claimant failed to comply with *former* OAR 436-60-095(2)(b) by not providing any information about the "kind of examination").

Here, it is apparent that the insurer attempted to comply with the Director's rules in issuing the notices regarding the two scheduled medical examinations. In this regard, both notices satisfied the requirements of OAR 436-060-0095(5), with the possible exception of the requirement that claimant "be notified in writing of the scheduled medical examination at least 10 days prior to the examination."

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[4] OAR 436-060-0095(1) provides:

"The Division will suspend compensation by order under conditions set forth in this rule. The worker shall have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker refuses or fails to submit to, or otherwise obstructs, a medical examination reasonably requested by the insurer or the Director. Compensation will be suspended until the examination has been completed. The conditions of the examination shall be consistent with conditions described in OAR 436-010-0100. Any action of a friend or family member which obstructs the examination shall be considered an obstruction of the examination by the worker for the purpose of this rule. The Division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination."

[5] OAR 436-060-0095(5) provides:

"(5) If an examination is scheduled by the insurer or by another party at the request of the insurer, the worker and the worker's attorney shall be notified in writing of the scheduled medical examination at least 10 days prior to the examination. The notice sent for each appointment, including those which have been rescheduled, shall contain the following:

"(a) The name of the examiner or facility;

"(b) A specific statement of the purpose for the examination and identification of the medical specialties of the examiners;

"(c) The date, time and place of the examination;

"(d) The first and last name of the attending physician and verification that the attending physician was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician, whichever is appropriate;

"(e) If applicable, confirmation that the Director has approved the examination;

"(f) That the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement shall be made in sufficient time to ensure a timely appearance;

"(g) That an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence; and

"(h) The following notice in prominent or bold face type:

"'You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend or fail to cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060.'"

Claimant argues that the insurer's notice regarding the first medical examination was untimely because he received it less than ten days before the scheduled examination. Citing *Kenneth F. Plummer*, 52 Van Natta 19 (2000), and *Norton v. Compensation Department*, 252 Or 75 (1968), the insurer counters that notification of the medical examination occurred upon mailing, not upon claimant's receipt of the notice. We agree with claimant.

Whether timeliness is determined from the date of mailing or the date of notification is determined by the wording of the applicable statute or rule. *See EBI Ins. Co. v. Chandler*, 112 Or App 275, 277 (1992); ORS 656.289(3) (providing that an order of an Administrative Law Judge (ALJ) is final unless a party requests Board review within 30 days after the ALJ's order is mailed to the parties); ORS 656.295(8) (providing that an order of the Board is final unless a party requests appeals to the Court of Appeals within 30 days after the Board's order is mailed to the parties); ORS 656.319(1)(a) (providing that a request for hearing from a denial of a claim must be filed within 60 days after the mailing of the denial). The cases cited by the insurer dealt with timeliness of hearing requests. In *Norton v. Compensation Department*, 252 Or 75 (1968), the Court reconciled two apparently conflicting statutes (ORS 656.319 and *former* ORS 656.262(8)) and concluded that, with limited exceptions, a claimant had 60 days after *mailing* of the denial to request a hearing.[6]

Here, the issue is not timeliness of a hearing request from a denial of a claim. Instead, the issue is whether claimant timely received notice of the first scheduled medical examination. As discussed above, OAR 436-060-0095(5) provides that claimant "be *notified* in writing of the scheduled medical examination at least 10 days prior to the examination." (Emphasis added). Thus, the applicable rule does *not* state that notification occurs upon mailing of the notice of the medical examination. Instead, under the wording of OAR 436-060-0095(5), notice occurs upon receipt.

Claimant received the notice regarding the first scheduled examination on January 24, 2000, less than ten days before the medical examination scheduled on February 1, 2000. Because claimant had less than the required ten days notice for the first scheduled examination, his failure to attend that examination was not unreasonable.

Regarding the second scheduled examination, claimant apparently waived any objection to timeliness of that notice, contending that, even though he was not given ten days notice, he agreed to attend the second examination, if he could do so and return home on the same day. Although the insurer agreed to pay claimant's expenses for an overnight stay in order for him to attend the examination in Everett, Washington, claimant declined to stay away from home overnight due to his wife's medical treatment for liver disease, which had occasionally made her violently ill in the past.

ORS 656.325(1)(a) provides that, under certain limitations, a worker is required to submit to a medical examination requested by an insurer "at a time reasonably convenient for the worker." *See also* OAR 438-010-0265(6) (insurer medical examinations "shall be at times and intervals reasonably convenient to the worker and shall not delay or interrupt proper treatment of the worker").

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[6] *SAIF v. Edison*, 117 Or App 455, 457 (1992), explained the holding in *Norton* as follows:

"Until 1990, ORS 656.262(8) provided:

'If an insurer * * * denies a claim for compensation, written notice of such denial * * * shall be given to the claimant. * * * *The worker may request a hearing on the denial at any time within 60 days after the mailing of the notice of denial pursuant to ORS 656.319.*' (Emphasis supplied [by the court in *Edison*]).

"ORS 656.319(1)(a) provides:

'A request for hearing is filed not later than the 60th day after the claimant was *notified* of the denial.' (Emphasis supplied [by the court in *Edison*]).

"A potential conflict existed in the statutes as to whether a claimant had 60 days from the date of mailing of the denial, as provided in ORS 656.262(8), or 60 days from the date of receipt of notice of the denial, as suggested in ORS 656.319(1)(a). In *Norton v. Compensation Department*, 252 Or 75, 448 P2d 382 (1968), the Supreme Court reconciled the two statutes by holding that "mailing" as used in ORS 656.262(8) (then numbered ORS 656.262(6)) equals "notice" as used in ORS 656.319(1)(a), concluding that, with limited exceptions, a claimant had 60 days after mailing of the denial to request a hearing."

We find that, under the facts of this case, the time scheduled for the second examination was not "reasonably convenient" for claimant. Given claimant's reasonable need to be home at night and the travel considerations regarding the medical examination scheduled to begin at 3:45 p.m. in Everett, with the return flight scheduled to depart at 6:49 p.m. at Sea-Tac Airport, it was reasonable for claimant to decline to attempt to attend the second medical examination. Thus, we find that suspension of benefits is not appropriate under the circumstances of this case.

That said, we stress that claimant has an obligation to cooperate with the insurer in processing his claim. The insurer notes that claimant has not seen Dr. Winquist since June 10, 1998.[7] Claimant counters that the insurer never required him to return to Dr. Winquist, and he has had no symptoms that required him to seek further treatment from Dr. Winquist.

In *Robert E. Anderson*, 52 Van Natta 151 (2000), we held that a carrier could not unilaterally terminate temporary disability benefits in an open own motion claim for failure to seek medical treatment. In reaching that holding, we found that the provisions under ORS 656.268(4)(d) and 656.262(4)(e) allowing such unilateral termination of benefits for failure to seek treatment did not apply to an own motion claim opened under ORS 656.278. Nevertheless, we held open the possibility of suspension of benefits under OAR 438-012-0035(5) for such failure to seek treatment. There, however, the carrier did not request suspension of benefits but, instead, improperly unilaterally terminated temporary disability benefits.

On the other hand, we recently granted a carrier's request to suspend payment of temporary disability benefits in an Own Motion claim where the claimant failed to seek medical treatment. *Glen A. Carr*, 52 Van Natta 1405 (2000). We found that requiring workers whose claims had been reopened under our Own Motion jurisdiction pursuant to ORS 656.278 to seek regular medical care promoted the legislative objective of restoring an injured worker physically and economically to a self-sufficient status as soon as possible and to the greatest extent practicable. ORS 656.012(2)(c). Therefore, we found it appropriate to authorize suspension of temporary disability benefits for failure to seek medical treatment under the appropriate circumstances.

Finally, although we have concluded that claimant's compensation should not be suspended at this time, we are concerned about the pattern in this case that seems to be emerging. While claimant's failure to attend the closing examinations, when examined separately, seem reasonable, the fact remains that claimant has not attended two closing examinations. Moreover, the insurer's actions, particularly with regard to the second closing examination, indicate an intent to comply with its claims processing duties. If claimant were to miss another examination, without a compelling reason, we may be inclined to authorize a suspension of compensation at that time should such a request be filed. In this regard, our decision today does not preclude the insurer from requesting suspension of benefits under OAR 438-012-0035(5), under the appropriate circumstances.

IT IS SO ORDERED.

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[7] In addition, the insurer notes that Dr. Winquist refused to conduct a closing examination, although he eventually agreed to review another physician's closing examination. ORS 656.005(17) provides that " '[m]edically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." This is fundamentally a medical question. *See, e.g., Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980) (the question of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence). It is well settled that for purposes of determining whether a claimant is medically stationary at the time of closure, we rely upon all competent medical evidence and not just the opinion of the attending physician. See *Verna F. Thomas*, 51 Van Natta 1317 (1999); *Patricia M. Knupp*, 46 Van Natta 2406 (1994); *Francisco Villagrana*, 45 Van Natta 1504 (1993); *Timothy H. Krushwitz*, 45 Van Natta 158 (1993).

In the Matter of the Compensation of
DONNA L. BARTRUFF, Claimant
WCB Case No. 99-04273
ORDER ON REVIEW
Adams, Day & Hill, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
James W. Moller, Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact on page 1, we change the second sentence to refer to a "seven month leave of absence" and we change the date in that sentence to "March 1998." In the second paragraph of the findings of fact on page 1, we change the first sentence to refer to a "seven month leave of absence." In the third full paragraph on page 2, we change the date in the first sentence to "March 1998."

CONCLUSIONS OF LAW AND OPINION

Claimant seeks to establish compensability of her occupational disease claim for bilateral carpal tunnel syndrome (CTS). Under ORS 656.802(2)(a), she must prove that employment conditions were the major contributing cause of the CTS.

The ALJ found that Dr. Thorsett's opinion was not persuasive because he had changed his opinion without explanation. The ALJ was not persuaded that claimant's work was repetitive and he did not believe Dr. Thorsett had adequately explained the nexus between the work activities and CTS. The ALJ concluded that the claim was not compensable.

On review, claimant relies on the opinion of her treating physician, Dr. Thorsett, and contends that her repetitive work activities over the past 11 years are the major contributing cause of her CTS. For the following reasons, we agree with claimant.

Claimant began working for the employer in the "wage match unit" in March 1998. (Tr. 67). Before that, she had been on a leave of absence since mid-August 1997. (*Id.*) She had worked at the "child care unit" before the leave of absence. (Tr. 43).

Claimant's wrist problems initially began while working at the child care unit. (Tr. 50). Her work involved repetitive keyboard activity. (Tr. 50-52). Claimant is right-handed and the pain started in her right wrist. (Tr. 48, 52). On July 7, 1997, claimant sought medical treatment from Dr. Byrkit for right hand pain. (Ex. 1). She told him the discomfort was worse toward the end of the week when she was working on the computer. (*Id.*) He suspected a component of arthritis and prescribed medication and a wrist protector. (*Id.*) In August 1997, Dr. Byrkit suspected CTS. (Ex. 2). Nerve conduction studies were normal and there was no evidence of CTS. (Ex. 3A).

Claimant testified that her wrist pain decreased while she was on a leave of absence from mid-August 1997 until March 8, 1998. (Tr. 61). When she returned to work, she began working four 10-hour shifts per week. (*Id.*) Claimant's supervisor and two coworkers testified that claimant and the other workers in her unit each process 2,200 to 2,500 files per calendar quarter. (Tr. 15, 18, 23). Each case has to be separately processed. (Tr. 18). Processing the cases requires pulling up two to six computer screens. (Tr. 48). In order to pull up a screen, an "ADC" number, a social security number or a name must be typed into the computer. (Tr. 46). Examining the information on each screen generally requires only a few seconds before moving on to the next screen. (Tr. 28, 48). Claimant testified that 75 to 80 percent of her work over the past 11 years had involved keyboarding. (Tr. 44, 53). Two of claimant's coworkers at the wage match unit testified that 85 percent of their work was devoted to keyboarding. (Tr. 19, 23).

After returning to work in March 1998, claimant testified that her wrist problems gradually worsened after about six or seven months. (Tr. 57, 61). On January 4, 1999, she sought medical treatment for pain in her hands and Dr. Byrkit diagnosed probable CTS. (Ex. 4-2). Claimant's studies showed electrophysiologic evidence of bilateral CTS, right worse than left. (Ex. 5). Dr. Thorsett examined claimant in March 1999 and became her attending physician. (Exs. 7, 8). He reported that claimant had a 2 1/2-year history of hand and wrist symptoms. (Ex. 7-1). He noted that the problem seemed to be worse with keyboard-type work and she had been working on a computer for approximately 11 years. (*Id.*) Claimant subsequently had surgery on both hands. (Tr. 62).

In April 1999, SAIF wrote to Dr. Byrkit and asked: "[g]iven [claimant's] history and job duties and off the job exposures what is the major contributing cause of her diagnosed bilateral hand complaints?" (Ex. 9-2). Dr. Byrkit responded: "Unable to quantify specific cause[.]" (*Id.*) On April 8, 1999, Dr. Thorsett concurred with Dr. Byrkit's answer to that question. (Ex. 10).

In a later concurrence report from claimant's attorney, Dr. Thorsett acknowledged that he had reviewed a copy of the medical reports in the exhibit list and had spoken to claimant about the types of repetitive work activities she had performed over the past ten years. (Ex. 14-1). He agreed that it was well demonstrated in the medical literature that repetitive tasks were a risk factor for the development of CTS and that frequent hand/wrist use over a period of time was a factor that must be considered in determining causation of the CTS. (*Id.*) Dr. Thorsett agreed with the following history:

> "The history you obtained from [claimant] is that she has worked for the [employer] for approximately eleven years. During her employment with the [employer] she has mainly functioned as a secretary who performs a variety of repetitive tasks, mainly data entry on a computer. She also performs filing and document review type functions which are repetitive in nature. [Claimant] has explained to you that the majority of her work time is spent in some repetitive keyboarding activity. Your initial report of March 26th, 1999, contains your findings and impression that her symptoms were a result of an overuse type situation." (Ex. 14-2).

Dr. Thorsett had discussed claimant's non-work activities with her and he did not believe she was engaged in any "high risk" repetitive non-work activities. (*Id.*) He agreed that the majority of claimant's job duties involved repetitive work and her off-work activities and other idiopathic risk factors were much less significant. (*Id.*) Based on claimant's 11-year work history, the development of her symptoms, the test results and other clinical findings, Dr. Thorsett agreed that her work activities were the major contributing cause of the CTS. (*Id.*)

SAIF argues that Dr. Thorsett's opinion is not persuasive because he changed his opinion without explanation. SAIF relies on Dr. Thorsett's April 8, 1999 concurrence with Dr. Byrkit's opinion that he was unable to quantify the specific cause of claimant's CTS. (Exs. 9, 10).

At the time he signed the April 8, 1999 concurrence letter (Ex. 10), Dr. Thorsett had only examined claimant on one occasion. (Ex. 7). By the time Dr. Thorsett signed the subsequent concurrence report from claimant's attorney, he had reviewed a copy of the medical reports in the exhibit list and had spoken to claimant about the types of repetitive work activities she had performed over he past ten years. (Ex. 14-1). Thus, although Dr. Thorsett was initially unsure of the major contributing cause of claimant's CTS, he later reviewed additional information about claimant's work activities and additional medical reports to formulate his opinion on causation. *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987) (when there was a reasonable explanation for a change of opinion, medical opinion was persuasive). We are persuaded by Dr. Thorsett's opinion because it is well-reasoned and based on complete and accurate information.

The only contrary opinion on causation is from Dr. Button, who examined claimant on behalf of SAIF. Dr. Button opined that claimant did not "admit to the fact that half of her day is involved in sorting mail, as listed in your covering letter." (Ex. 12-4). There is no evidence to support Dr. Button's comment. Rather, the record establishes that sorting mail is only a small part of claimant's work duties. Dr. Button's opinion is entitled to little weight because he did not have an accurate understanding of claimant's work activities. *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. Button said there were no identifiable preexisting or predisposing conditions commonly associated with CTS. (Ex. 12-4). He explained:

> "I would view [claimant] as falling within the largest utilized statistical category of this being an idopathic condition. It is statistically far more frequent in females vs. males as well as in the middle-aged/aging population of increasing incidence.
>
> "Therefore, the major contributing cause of the condition would indirectly be utilization of the term idiopathic." (*Id.*)

We are not persuaded by Dr. Button's opinion that CTS is "statistically" more frequent in females because it is based on studies which are general in nature rather than specific to claimant. *See Sherman v. Western Employer's Insurance*, 87 Or App 602 (1987) (physician's comments that were general in nature and not addressed to the claimant's situation in particular were not persuasive); *Yolanda Enriquez*, 50 Van Natta 1507 (1998) (medical evidence grounded in statistical analysis was not persuasive because it was not sufficiently directed to the claimant's particular circumstances).

In sum, because we find that Dr. Thorsett's opinion is well-reasoned and consistent with claimant's history (and the contrary opinions unpersuasive), we conclude that her work activities were the major contributing cause of her bilateral CTS.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $6,015, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's affidavit of attorney fees, the hearing record, and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 31, 2000 is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. Claimant's attorney is awarded $6,015 for services at hearing and on review, payable by SAIF.

In the Matter of the Compensation of
JON E. BALL, Claimant
WCB Case No. 99-10202
ORDER ON REVIEW
Heiling & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of his aggravation claim for a cervical condition. In its brief, the employer argues that sanctions should be imposed under ORS 656.390 for an allegedly frivolous appeal. On review, the issues are aggravation and sanctions.

We adopt the ALJ's order with the following supplementation regarding sanctions.

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

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

ORDER

The ALJ's order dated May 5, 2000 is affirmed.

August 18, 2000 Cite as 52 Van Natta 1492 (2000)

In the Matter of the Compensation of
LYNN E. FISHER, Claimant
WCB Case No. 99-05212
ORDER ON REVIEW
Juli Point, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed the SAIF Corporation's request for hearing without prejudice. Claimant also requests an attorney fee under ORS 656.382(2). On review, the issues are propriety of the dismissal and attorney fees. We affirm.

FINDINGS OF FACT

The following procedural history appears from the parties' allegations and briefs on review.

SAIF accepted claimant's "C4-7 disc herniations with spurring & narrowing, lumbar stenosis and L5-S1 slight posterolateral disc bulge, L4-5 disc herniation with spondylolisthesis[.]" The claim was in open status and claimant was receiving temporary disability benefits.

On February 10, 1999, claimant wrote a letter indicating that he had retired and was declining any further vocational services. SAIF submitted a request to the Workers' Compensation Division (WCD) to have claimant's time loss benefits reduced to zero pursuant to OAR 436-060-0105(13) because he had withdrawn from the work force and had declined vocational services. On June 24, 1999, WCD issued an "Order Denying Reduction of Benefits Pursuant to ORS 656.325(4)." The order said that the reduction of benefits under ORS 656.325(4) could be considered only after the claim had been closed and benefits had been awarded. Because claimant's claim remained in open status, WCD found it premature to consider reducing the benefits and, therefore, it denied SAIF's request to reduce claimant's temporary disability benefits to zero.

SAIF requested a hearing concerning WCD's June 24, 1999 order. On March 27, 2000, SAIF wrote to the ALJ, stating that it was withdrawing its request for hearing without prejudice. SAIF requested that the ALJ issue an order of dismissal.

On the following day, claimant's attorney wrote to the ALJ, objecting to a dismissal without prejudice. Claimant's attorney asserted that the order of dismissal should be "with prejudice." Claimant's attorney argued that SAIF had placed claimant's benefits in jeopardy by appealing WCD's June 24, 1999 order and she requested a reasonable attorney fee.

CONCLUSIONS OF LAW AND OPINION

Propriety of Dismissal

The ALJ found that SAIF was requesting dismissal of the request for hearing without prejudice because it was seeking to preserve its ability to appeal any subsequent WCD order that might issue now that the claim had closed. The ALJ dismissed SAIF's request for hearing without prejudice.

On review, claimant contends that SAIF's request for a dismissal of its request for hearing on the procedural time loss issue, together with SAIF's statement to the ALJ that WCD was "right" in its June 24, 1999 order, "should have given rise to a finding on the merits that claimant's right to procedural time loss remains intact via an order of dismissal with prejudice." (Claimant's br. at 5; underline in original).

When a party requesting a hearing moves for dismissal, and there is no cross-request for hearing, the ALJ has discretion to set the terms and conditions of an order of dismissal as he or she deems proper. We will not disturb the terms and conditions imposed by the ALJ except under a showing of an abuse of discretion. *Ronald D. Robinson*, 44 Van Natta 2500, 2501 (1992); *Julie Mayfield*, 42 Van Natta 871 (1990). In the present case, we find no abuse of discretion in the ALJ's reasoning. We are not persuaded that the ALJ erred in dismissing the request for hearing without prejudice.

Attorney Fees

Claimant requested an attorney fee at hearing and argues on review that his attorney is entitled to a reasonable attorney fee under ORS 656.382(2) for "defending against SAIF's attempt to cut off his right to procedural time loss." (Claimant's br. at 6). On the other hand, SAIF contends that, in any event, claimant's attorney is not entitled to an attorney fee under ORS 656.382(2) because the ALJ made no finding on the merits.

ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the Administrative Law Judge, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

An award of attorney fees under ORS 656.382(2) requires that: (1) an employer initiate a request for a hearing to obtain a disallowance or reduction in a claimant's award of compensation; (2) the claimant's attorney perform legal services in defending the compensation award; and (3) the ALJ finds on the merits that the claimant's award of compensation should not be disallowed or reduced. *Strazi v. SAIF*, 109 Or App 105, 107-108 (1991).

Even if we assume that the first two requirements have been satisfied, we agree with SAIF that the third requirement is not satisfied. SAIF withdrew its request for hearing and, therefore, there was no decision on the merits and no finding "that the compensation to a claimant should not be disallowed or reduced" under ORS 656.382(2). Thus, claimant is not entitled to an attorney fee award under ORS 656.382(2). *See Terlouw v. Jesuit Seminary*, 101 Or App 493 (because the Board had dismissed the carrier's appeal without a decision on the merits, there was no authority to award an attorney fee under ORS 656.382(2)), *rev den* 310 Or 282 (1990); *Richard M. Miller*, 49 Van Natta 1239 (1997) (because the ALJ dismissed the hearing request, there was no decision on the merits and no entitlement to a fee under ORS 656.382(2)).

Similarly, the June 24, 1999 WCD order found that SAIF's request to reduce claimant's temporary disability benefits was premature. Even if we assume, without deciding, that ORS 656.382(2) applies to a WCD order, the Director did not make a decision on the merits, so there is no basis for an award of attorney fees under ORS 656.382(2). *See Wise v. Gary-Adams-Trucking*, 106 Or App 654, 656 (1991) (court did not address whether ORS 656.382(2) authorized attorney fee award in a noncomplying employer case because, lacking decision on merits, there was no predicate for a fee award).

ORDER

The ALJ's order dated April 26, 2000 is affirmed.

In the Matter of the Compensation of
THOMAS L. PETERSON, Claimant
WCB Case Nos. 99-04101 & 99-03032
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld Intermountain Claims Inc.'s denial of claimant's "new injury" claim for his current low back condition; and (2) upheld the SAIF Corporation's partial denial of claimant's "consequential condition" claim for the same condition. On review, the issues are compensability and, potentially, responsibility.

We adopt and affirm the order of the ALJ with the following supplementation to address claimant's argument that concurrence letters of Drs. Freeman, Flemming, and Lisk are sufficient to prove that his 1998 work injury is the major contributing cause of his disability or need for treatment for his current low back condition.

On May 1, 1999, Dr. Rosenbaum, who examined claimant at SAIF's request, opined that claimant's work injury of 1998 herniated a disc at L4-5, and thus the 1998 work injury was the major contributing cause of claimant's current disability and need for treatment.[1] (Ex. 46-5,6,7). His opinion regarding the relationship of the L4-5 disc and claimant's work injury of August 1998 was based solely upon a history from claimant; a history that indicated the onset of claimant's back pain and leg numbness was the work injury of August 1998. (Ex. 52-4,5). Subsequently, Dr. Rosenbaum opined that if the history showed the onset of claimant's back pain and leg numbness predated the August 1998 work injury, then his opinion would be that the herniated disc also predated the work injury of August 1998. (Ex. 52-7).

At hearing, claimant testified that two weeks prior to the August 1998 work injury, he experienced low back pain radiating down the back of his right leg with cramps in his calf and thigh and behind the knee together with some numbness. (Tr. 26,27). As a result of claimant's hearing testimony, the ALJ correctly concluded that the opinion expressed by Dr. Rosenbaum in Exhibit 46, was based upon an incorrect history and entitled to little or no weight. *Miller v. Granite Construction Co.*, 28 Or App 473 (1977).

Claimant contends that even though Dr. Rosenbaum had an incorrect history, Drs. Freeman, Flemming, and Lisk had a correct history. Therefore, claimant argues, their concurrences with Dr. Rosenbaum's opinion, as expressed in Exhibit 46, are sufficiently persuasive to meet his burden proof. We disagree.

The concurrences of Drs. Freeman, Flemming, and Lisk are "check-the-box" concurrence letters. Such unexplained reports are generally considered to be conclusory and unpersuasive. *See William F. Gilmore*, 46 Van Natta 999, 1000 (1994). Given their conclusory nature, their concurrence with an opinion that is based upon an incorrect history does little in making their opinions persuasive. Moreover, we note that both Drs. Freeman and Flemming previously indicated that the major contributing cause of claimant's current low back condition is a degenerative condition of spinal stenosis. (Ex. 38, 39). Consequently, their concurrence with Dr. Rosenbaum represents an unexplained changed of opinion, rendering them unpersuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987).

Accordingly, we agree with the conclusion of the ALJ, that on this record, claimant has failed in his burden to prove that the major contributing cause of his current low back condition is his work injury of August 1998.

ORDER

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

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[1] Drs. Freeman, Flemming, and Lisk signed "check-the-box" concurrence letters agreeing with Dr. Rosenbaum's report. (Ex. 48, 49, 50).

In the Matter of the Compensation of
GREG WILLIAMS, Claimant
WCB Case No. 99-10069
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the insurer's denial of his injury claim for a cervical condition. On review, the issue is compensability.

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

Claimant, a laborer-operator for the employer, allegedly suffered an injury on September 20, 1999 when a co-worker struck him in the neck and chest following a heated argument at the end of a work day. (*See* Tr. 10, 11). Claimant did not initially report an injury to the employer, but sought treatment on September 23, 1999 from chiropractor Dr. Moll and Dr. Stringham. (Exs. 3, 4, 17).

In upholding the insurer's denial, the ALJ found that claimant did not meet his burden of proving the compensability of his injury claim because the history upon which his treating physicians relied in reaching an opinion on causation was inconsistent with claimant's testimony and with the testimony of claimant's supervisor and co-worker.

On review, claimant contends that the uncontroverted medical evidence proves that his September 20, 1999 work injury was a material or the major contributing cause of his need for treatment for a cervical condition. In response, the insurer contends that the ALJ's analysis of the medical evidence was correct. In the alternative, the insurer argues that claimant's claim is barred because he was an "active participant" in the conflict with his co-worker that led to his work injury. ORS 656.005(7)(b)(A).[1]

We find that, regardless of whether claimant was an "active participant" in the conflict that resulted in his alleged injury, we agree with the ALJ that claimant did not meet his burden of proving the compensability of his cervical condition with persuasive medical evidence based on objective findings. ORS 656.005(7)(a).

Medical opinions based on an inaccurate history are entitled to little, if any, weight. *Miller v. Granite Construction Co.*, 28 Or App 473 (1977). Claimant relies on the opinions of Dr. Moll and Dr. Stringham to establish his claim. Both of these doctors opined that, based on claimant's history, his September 20, 1999 work injury was the major contributing cause of his disability and need for treatment for his cervical condition. (Exs. 16, 18). However, Dr. Moll is the only physician who stated that claimant had objective findings in support of his injury. Dr. Moll confirmed that claimant had the objective findings of reduced cervical range of motion and muscle spasm. (Exs. 3, 18). Dr. Stringham, in contrast, agreed with the statement that claimant had "no objective findings of injury to either the cervical or chest area." (Ex. 17-1).

However, Dr. Moll based his opinion on causation on the assumption that claimant was struck by a co-worker's fist. (Ex. 18-1). At hearing, claimant's co-worker, Mr. Combs, testified that he pushed claimant in the chest with an open hand, but never struck him. (Tr. 28). Claimant was not sure if Mr. Combs' hand was open or closed (like a fist). (Tr. 24). Based on this discrepancy, as well as other inconsistencies in claimant's history as noted by the ALJ, we affirm the ALJ's order.

ORDER

The ALJ's order dated April 19, 2000 is affirmed.

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[1] ORS 656.005(7)(b)(A) provides: "[A compensable injury does not include] an injury to an active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties." *See Kessen v. Boise Cascade Corp.*, 71 Or App 545 (1984).

In the Matter of the Compensation of
OMAR LALLEY, Claimant
Own Motion No. 00-0235M
OWN MOTION ORDER
Roger Wallingford, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his 1989 heart condition. Claimant's aggravation rights expired on January 22, 1996. The insurer opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition is not causally related to the accepted condition; (2) the insurer is not responsible for claimant's current condition; and (3) 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.*

On July 21, 1999, claimant was hospitalized for a bypass procedure. Therefore, we are persuaded that claimant's current condition worsened requiring surgery. However, the insurer contends that claimant has been treating for a condition diagnosed as coronary artery disease. The insurer further contends that it has not received a formal written request for acceptance or denial of this or any new medical condition. As such, the insurer asserts that "no denial has been issued." As noted above, the insurer contends that claimant's current condition is not causally related to the accepted condition. Claimant has not responded to the insurer's contentions.

Inasmuch as the dispute between the parties regarding the compensability of claimant's current condition remains unresolved, we are not authorized to reopen claimant's 1989 injury claim for the payment of temporary disability benefits. *See* ORS 656.278(1)(a). Should claimant's circumstances change, and the insurer decides to accepted responsibility for claimant's current condition, claimant may again seek own motion relief.[1]

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

IT IS SO ORDERED.

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[1] Inasmuch as we have concluded that the issue regarding the compensability of and/or responsibility for claimant's current condition remains unresolved, we need not address the insurer's contentions regarding claimant's work force status.

In the Matter of the Compensation of
MELVIN J. LUX, Claimant
Own Motion No. 99-0243M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schneider, et al, Claimant Attorneys

Claimant requests review of the self-insured employer's May 12, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from July 12, 1999 through May 4, 2000. The employer declared claimant medically stationary as of May 4, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

FINDING OF FACTS

Claimant sustained a compensable injury to his low back and both knees on January 1, 1980. Claimant's aggravation rights have expired.

On May 12, 1999, Dr. Baldwin, claimant's attending physician, found that claimant's bilateral knee condition was worsening. He opined that claimant required a total knee replacement. On June 18, 1999, the employer submitted an Own Motion recommendation form, identifying the accepted condition as claimant's bilateral knees.

A July 22, 1999 Own Motion Order found that claimant was in the work force at the time of the current disability and authorized reopening of claimant's claim for the provision of temporary disability compensation beginning the date claimant underwent surgery. That order also instructed the employer to close the claim pursuant to OAR 438-012-0055 when claimant was medically stationary.

In a May 4, 2000 doctor's report, Dr. Baldwin reported that claimant's right knee was doing well postoperatively. He opined that "[claimant's] condition his [sic] medically stationary at this time." However, he also noted that claimant's left knee was "slowing him down quite a bit," and that he had experienced a "flare-up" of his low back condition. Dr. Baldwin noted that claimant had an appointment with Dr. Flemming on May 18, 2000 regarding his low back condition. He reported claimant's concern that he may require additional back surgery. Given that he may require back surgery, claimant inquired as to when the next total knee replacement would be scheduled. Dr. Baldwin indicated that if back surgery was required, he would schedule the knee replacement in about three months. If not, he would schedule the total knee surgery "as soon as possible."

Relying on Dr. Baldwin's report, the employer issued its Notice of Closure on May 12, 2000 declaring claimant medically stationary as of May 4, 2000.

Dr. Flemming examined claimant on May 18, 2000, noting that claimant had sciatica and numbness in the left leg and fatigability of the left leg when he walked. Dr. Flemming recommended that claimant undergo a MRI to determine if he had a disc herniation. If the MRI came back positive for a herniation, Dr. Flemming opined that claimant required a decompression of the nerve root with discectomy and possible foraminotomy.

On May 26, 2000, Dr. Flemming noted that the MRI showed foraminal stenosis at L3-4 and L5-S1 with protrusion of disc material. He therefore opined that claimant needed a decompression at L3-4 and L5-S1 for relief of his symptoms.

On June 5, 2000, the employer submitted an Own Motion recommendation to reopen claimant's claim. In answer to Question 13(a), What is the accepted condition(s)?:, this time, the employer replied "low back & bilateral knees."

On June 9, 2000, the Board authorized the reopening of claimant's claim for the provision of temporary disability compensation beginning the date claimant is hospitalized for the recommended low back surgery.

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 May 12, 2000 Notice of Closure, considering claimant's condition at the time of closure and not subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980). In order to be medically stationary, all compensable conditions must be medically stationary. *Rogers v. Tri-Met*, 75 Or App 470 (1985); *Paul E. Voeller, on recon*, 42 Van Natta 1962 (1990).

The employer contends that claimant was medically stationary on May 4, 2000 when Dr. Baldwin declared claimant's right knee condition medically stationary. The employer argues that claimant's low back condition worsened after claimant was declared medically stationary with respect to his right knee condition (the condition for which the claim was reopened in 1999).

The employer's argument does not take into consideration the following two criteria which must be satisfied in order to close the claim: (1) claimant must be medically stationary on the date his claim was closed; and (2) claimant must be medically stationary with respect to *all* compensable conditions on that date.

Here, the employer closed claimant's claim on May 12, 2000, declaring claimant medically stationary from his right knee surgery on May 4, 2000. Therefore, claimant must establish that any of his compensable conditions was not medically stationary on May 12, 2000 (the date of claim closure). *See Rogers v. Tri-Met*, 75 Or App at 470.

In his May 4, 2000 doctor's report, Dr. Baldwin noted that claimant had a "flare-up" of his low back and that he had lost the "strength and ability to lift his left leg." He also noted that claimant was scheduled to see Dr. Flemming for his low back complaints on May 18, 2000. Additionally, Dr. Baldwin discussed the scheduling of a total knee replacement surgery for claimant's *left* knee. That surgery was first recommended in May 1999 when it was decided to first perform claimants *right* knee surgery.

On May 18, 2000, just six days after the employer closed claimant's claim, Dr. Flemming reported that claimant had low back complaints that indicated a possible disc herniation. He opined that if the MRI demonstrated that claimant did indeed have a disc herniation, then claimant would require a decompression surgery. By May 26, 2000, the MRI results confirmed Dr. Flemming's suspicions regarding a disc herniation and he recommended that claimant undergo a decompression at L3-4 and L5-S1.

It is clear from the record that, when the employer issued its Notice of Closure, Dr. Baldwin was recommending further surgery for claimant's compensable *left* knee (the timing of which depended on claimant's need for low back surgery). Under such circumstances, we conclude that claimant's left knee condition was not medically stationary on May 12, 2000, when the employer closed his claim.

Accordingly, we set aside the employer's May 12, 2000 Notice of Closure as premature. The employer is ordered to recommence the payment of temporary disability compensation in this claim, beginning the date the employer previously terminated these benefits.[1]

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the employer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[1] On this date, we have issued our Own Motion Order on Reconsideration in WCB Case No. 00-0191M. That order is issued in response to the employer's June 5, 2000 submission of its recommendation to reopen claimant's claim for the proposed low back surgery. Given our decision that claimant's compensable left knee condition was not medically stationary at the time his claim was closed, the parties request for reopening of this already opened claim is rendered moot. In other words, the insurer is required to process claimant's low back condition under this already reopened claim.

In the Matter of the Compensation of
MELVIN J. LUX, Claimant
Own Motion No. 00-0191M
OWN MOTION ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys

By a "Carrier's Own Motion Recommendation" dated June 5, 2000, the self-insured employer recommended reopening claimant's claim for the payment of temporary disability compensation for his 1980 claim. Pursuant to this request, on June 9, 2000, we issued an Own Motion Order reopening claimant's claim for the requested own motion relief. However, in an order issued on this date, we found the employer's closure of the previous reopening (WCB Case No. 99-0243M) premature and set aside the closure.

After reconsideration, we withdraw our June 9, 2000 Own Motion Order and issue the following order in its place.[1]

Claimant's aggravation rights have expired. After expiration of a claimant's aggravation rights, we may authorize, on our own motion authority, 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 July 22, 1999, as reconsidered on July 29, 1999, we issued an Own Motion Order authorizing the provision of temporary disability compensation beginning the date claimant was hospitalized for a proposed surgery. WCB Case No. 99-0243M. That decision was based on claimant's bilateral knee condition. In addition, we ordered the employer to close the claim under OAR 438-012-0055 when claimant was medically stationary. The employer issued a May 12, 2000 Notice of Closure, declaring claimant medically stationary as of May 4, 2000. However, as noted above, in an order issued on today's date, we set aside the employer's May 12, 2000 Notice of Closure and ordered the employer to recommence the payment of temporary disability compensation in this claim, beginning the date the employer previously terminated those benefits.

As a result of our order in WCB Case No. 99-0243M, we conclude that the claim remains in open status. Therefore, the employer remains obligated to pay temporary disability compensation to claimant as provided by our prior order in WCB Case No. 99-0243M and to continue the payment of those benefits until such compensation can be terminated under OAR 438-012-0055.[2]

In light of such circumstances, the employer's June 5, 2000 recommendation to reopen the claim is moot. In other words, it is unnecessary to reopen a claim that is already open. In reaching this decision, we emphasize that claimant's claim remains open under WCB Case No. 99-0243M, as explained above. That is, as set forth in our order in WCB Case No. 99-0243M, the employer is required to provide compensation and process claimants claim to closure when claimant's bilateral knee and low back conditions become medically stationary.

The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] Based on the situation described in this order, we find extraordinary circumstances to reconsider our June 9, 2000 order. *See* OAR 438-012-0065(3).

[2] With its June 5, 2000 "Carrier's Own Motion Recommendation" form, the employer submitted a May 26, 2000 chart note from Dr. Flemming, who proposed surgery to treat claimant's compensable low back condition. Because claimant's claim remains in open status, benefits related to this surgery shall be processed by the employer under that open claim, without any further action by claimant or the Board.

In the Matter of the Compensation of
JACALYN A. MATHEWS, Claimant
WCB Case Nos. 99-01214 & 99-00820
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Stoel Rives, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld Liberty Northwest's denial of claimant's aggravation claim for a low back condition; and (2) upheld GAB's denial of claimant's "new injury" claim for the same condition. On review, the issues are compensability and, potentially, responsibility.

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

The ALJ found that claimant had not established compensability of her low back condition because the medical evidence established that claimant's current low back condition was now caused in major part by her preexisting low back conditions, including a prior 1982 out-of-state work injury and surgeries.

Claimant argues on review that her 1982 work injury that occurred out-of-state cannot be considered a preexisting condition for purposes of ORS 656.005(7)(a)(B). In support of this argument, claimant relies on *Silveira v. Larch Enterprises*, 133 Or App 297 (1997), and *Andrea E. Henwood*, 52 Van Natta 943 (2000). *Silveira* and *Henwood* hold that for purposes of establishing that an occupational disease is work-related, a claimant may rely on all employments, even those that are not subject to Oregon workers' compensation laws. In the present case, claimant argued that her low back is compensably related to either her 1997 accepted claim with Liberty Northwest or to a new November 11, 1998 incident at GAB's insured. Because both *Silveira* and *Henwood* involve claims for occupational disease, their holdings are inapplicable here since claimant's claims are for an aggravation of the 1997 claim or for a new injury on November 11, 1998.[1]

Claimant also argues that her claim should be analyzed under the "Kearns presumption" of *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984). The "Kearns presumption" applies to determine responsibility between carriers. Here, the dispute is the threshold issue of whether the low back condition is compensable. Responsibility does not become an issue until the claim has been proven compensable. Thus, *Kearns* has no applicability to the compensability determination.

ORDER

The ALJ's order dated January 21, 2000 is affirmed.

[1] On page 13 of her Appellant's Brief, claimant acknowledges that her claim involves successive *injuries* rather than an occupational disease claim. The rationale of *Silveira* does not apply to establishing compensability of injury claims.

In the Matter of the Compensation of
DANIEL M. CAN, Claimant
WCB Case No. 99-06890
ORDER ON RECONSIDERATION
Dennis O'Malley, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

The insurer requests reconsideration of our July 26, 2000 order that affirmed an Administrative Law Judge's (ALJ) order that set aside the insurer's denial of claimant's injury claim for a low back condition. Specifically, the insurer contends that our order failed to properly evaluate the wording of Dr. Waring's opinion as stated in Exhibit 35. The insurer argues that Exhibit 35 represents an unexplained change of opinion on the part of Dr. Waring, rendering his opinion unpersuasive. After considering the employer's arguments, we continue to adhere to our prior order with the following supplementation.

We previously concluded that Dr. Waring used the terms "disc herniation," "degenerative disc disease," "discogenic disease," and "disc disease," interchangeably when referring to claimant's L5-S1 disc. In keeping with that conclusion, we read the pertinent part of Exhibit 35, as follows:

> "I absolutely do not prescribe to the theory set forth in the Independent Medical Evaluation about the patient's **disc herniation** being a preexisting condition, and, even if this were the case, his injury at work was the aggravating circumstance that caused the patient his current disability. . . "[1] (Emphasis added).

Consequently, we interpret Dr. Waring's remarks that the work injury caused the medical condition shown on the MRI as meaning that the work injury caused the L5/S1 disc herniation. We note that our reading of Exhibit 35 is consistent with Dr. Waring's chart notes and consistent with the MRI showing a large disc herniation at L5/S1 and mild disk desiccation with minimal loss of disk space height.[2] (Ex. 19). Accordingly, we do not find that Exhibit 35 represents an unexplained change of opinion on the part of Dr. Waring.

In conclusion, we withdraw our July 26, 2000 order. On reconsideration, as supplemented herein, we republish our July 26, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] This portion of Exhibit 35 literally reads: "I absolutely do not prescribe to the theory set forth in the Independent Medical Evaluation about the patient's disc *disease* being a preexisting condition, and, even if this were the case, his injury at work was the aggravating circumstance that caused the patient his current disability. . . " (Emphasis added.) The insurer argues that the reference to "disc disease" should be read literally, thereby implying that Dr. Waring is of the opinion that claimant's injury caused "disc disease" rather than a disc herniation.

The insurer acknowledges in footnote 1 of its Motion for Abatement and Reconsideration that "Dr. Waring never stated nor would the record support that the injury *caused* the degenerative disc disease. Nevertheless, the insurer urges us to interpret Exhibit 35 in exactly that fashion. We decline to do so because such a reading is inconsistent with Dr. Waring's chart notes and his opinion expressed elsewhere in the record. Moreover, such a reading is inconsistent with Dr. Waring's interchangeable use of the terms "disc herniation," "degenerative disc disease," "discogenic disease," and "disc disease." Finally, our reading of Exhibit 35 recognizes that it was generated as a letter response to refute Dr. Bergquist's opinion that the etiology of disc herniation is degenerative disc disease. (Ex. 26-5).

[2] The MRI is interpreted by Dr. Abvel.

In the Matter of the Compensation of
KENNETH V. FERGUSON, Claimant
Own Motion No. 00-0260M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's left knee condition. Claimant's aggravation rights expired on March 2, 1981. SAIF recommends that we authorize the payment of temporary disability compensation.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, shall close the claim pursuant to OAR 438-012-0055.

Finally, in its recommendation form, the insurer indicates that claimant is represented. Based on such a reference, claimant's attorney may be entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, on this record, we cannot approve such a fee because: (1) no current retainer agreement has been filed with the Board (*see* OAR 438-015-0010(1)); and (2) no evidence demonstrates that claimant's attorney was instrumental in obtaining increased temporary disability compensation OAR 438-015-0080.

In conclusion, because no retainer agreement has been received to date and the record does not establish that claimant's attorney was instrumental in obtaining increased temporary disability compensation, the prerequisite for an award of an out-of-compensation attorney fee have not been met at this time. Consequently, no out-of-compensation attorney fee award has been granted. In the event that a party disagrees with this decision, that party may request reconsideration and submit information that is currently lacking from this record. Because our authority to further consider this matter expires within 30 days of this order, any such reconsideration request must be promptly submitted.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN W. HYATT, Claimant
WCB Case Nos. 99-01329 & 98-04242
ORDER ON RECONSIDERATION
Bruce D. Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

On July 19, 2000, we abated our June 23, 2000 order that reversed in part, affirmed in part and modified in part the Administrative Law Judge's (ALJ's) order setting aside the insurer's denials of claimant's occupational disease and aggravation claims for a left shoulder condition. We took this action to consider claimant's Motion for Reconsideration. We also invited a response from the insurer within 14 days of our Order of Abatement. Having received no response from the insurer, we proceed with our reconsideration.

Our order reinstated the insurer's April 30, 1998 aggravation denial. (Ex. 51). That denial stated, *inter alia*, "* * * your employment at [the employer] is not the major contributing cause of the need for surgery on the left shoulder." (Ex. 51).

Claimant contends that our order should be modified to indicate that either: (1) the portion of the insurer's denial that denied claimant's need for surgery is set aside; or (2) claimant's rights to medical services associated with his occupational disease claim are not affected by the April 30, 1998 denial. In response to claimant's contention, we offer the following clarification.

Our order affirmed that portion of the ALJ's order that held claimant's occupational disease claim compensable. By virtue of that portion of the ALJ's order (and our affirmance of that decision), the insurer's denial of claimant's occupational disease claim has been set aside and the claim has been remanded to the insurer for further processing of the claim as provided by law. Such processing necessarily includes claimant's entitlement to medical services compensably related to his left shoulder occupational disease claim. This claim processing is unaffected by our upholding of insurer's denial of claimant's aggravation claim.

Accordingly, the "Order" portion of our June 23, 2000 order is amended to read:

> "The ALJ's order dated February 22, 2000 is affirmed in part, reversed in part and modified in part. That portion of the order that set aside the insurer's denial of claimant's aggravation claim is reversed. The insurer's April 30, 1998 denial is reinstated and upheld except insofar as it may purport to deny medical services as related to claimant's occupational disease claim. That portion of the ALJ's order that awarded a $7,500 assessed attorney fee is modified. In lieu of the $7,500 award, claimant's attorney is awarded $6,000, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $640, payable by the insurer."

On reconsideration, as supplemented and modified herein, we adhere to and republish our June 23, 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
CHARLES E. JESSE, Claimant
WCB Case No. 99-08069
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) declined his request to direct the SAIF Corporation to amend its acceptance to include headaches; and (2) upheld SAIF's *de facto* denial of his left ulnar neuropathy condition. Claimant moves to strike SAIF's respondent's brief as untimely. On review, the issues are motion to strike, scope of acceptance and compensability.

We grant claimant's motion to strike and we adopt and affirm the ALJ's order with the following change and supplementation. In the third paragraph on page 5, we change the citation in the first sentence to read: "ORS 656.262(6)(d)."

Motion to Strike

Claimant moves to strike SAIF's respondent's brief on the ground that it was untimely filed.

Claimant mailed his opening brief on May 17, 2000. The parties agree that the filing deadline for SAIF's respondent's brief was June 7, 2000. *See* OAR 438-011-0020(2). SAIF mailed its brief on June 9, 2000 and the brief was received by the Board on June 12, 2000. Therefore, SAIF's brief was untimely filed. SAIF asserts that the reason for untimely filing was a clerical error because of a recent transition in personnel. SAIF requests relief from default and an extension to June 9, 2000 to file its respondent's brief.

Ordinarily, the Board will not consider a brief that is untimely filed unless a request for an extension is granted. Extensions of time for filing of briefs are allowed only on written request filed no later than the date the brief is due. OAR 438-011-0020(3). Because SAIF filed its extension request after the due date for its brief, we treat SAIF's request as a motion to waive the Board's briefing rules. *See* OAR 438-011-0030. A motion to waive the rules may be allowed if the Board finds that extraordinary circumstances beyond the control of the moving party justify such action. *Id.* In previous cases, we have held that clerical errors and calendaring errors do not constitute extraordinary circumstances beyond the control of the moving party. *Antonina Gnatiuk*, 50 Van Natta 976 (1998); *Lester E. Saunders*, 46 Van Natta 1153, 1154 (1994). Here, we find no extraordinary circumstances that were beyond the control of SAIF. Accordingly, we grant claimants motion to strike SAIF's untimely filed brief.

ORDER

The ALJ's order dated April 6, 2000 is affirmed.

In the Matter of the Compensation of
BRUCE W. BURROUGHS, Claimant
WCB Case No. 99-06219
ORDER REMANDING
Daniel M. Spencer, Claimant Attorney
Terrall & Terrall, Defense Attorneys

The self-insured employer has requested Board review of Administrative Law Judge (ALJ) Peterson's May 2, 2000 order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral thumb condition; and (2) awarded an assessed attorney fee of $6,000. The following exhibits were received into evidence: Exhibits 1 through 53, 24A, 28A, 28B, 29A, 29AA, 29B, 29C, 30B, 30C, 30D, 31A, 32A.

Following the employer's request for review, the Boards appellate staff discovered that Exhibits 36 through 41 and 43 through 50 were missing from the record. Thereafter, the Board's staff counsel notified the parties' counsels in an effort to reproduce the missing exhibits for inclusion in the record. The parties have been unable to reach an agreement regarding the authentication of any reproduced copies of the missing exhibits.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the ALJ for further evidence taking, correction or other necessary action. *See* ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is warranted. *See Edward R. Schofield*, 50 Van Natta 979 (1998).

Accordingly, the ALJ's May 2, 2000 order is vacated and this matter is remanded to ALJ Peterson with the following instructions. The ALJ shall reopen the record to identify the missing exhibits and to admit copies of the missing exhibits that were admitted at the prior hearing. The parties shall be entitled to present copies of the missing exhibits for admission into the record. That presentation may be achieved in any manner that the ALJ deems achieves substantial justice. After presentation of the documents and identification/admission of the missing exhibits, the ALJ shall reclose the record. Thereafter, the ALJ shall issue a final, appealable Order on Remand addressing the effect, if any, the record presented on remand has had upon his prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY W. KEITH, Claimant
Own Motion No. 00-0257M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Cole, Cary, et al, Claimant Attorneys

The self-insured employer has submitted claimants request for temporary disability compensation for his 1971 cervical claim. Claimant's aggravation rights expired on August 26, 1976. The employer opposes reopening on the following grounds: (1) no surgery or hospitalization has been requested; and (2) claimant was not in the work force at the time of disability.

In addition, a December 3, 1999 Opinion and Order reversed the employer's denial of claimants current cervical condition and need for treatment. Subsequently, we affirmed that Opinion and Order. By letter dated July 17, 2000, claimant's attorney notified the employer's attorney that the employer had acknowledged that claimant's degenerative cervical disc disease is a compensable new medical condition and requested that the employer process that claim. Finally, on August 2, 2000, claimant filed a request for hearing with the Hearings Division and raised the issue of [f]ailure to process [a] new condition. (WCB Case No. 00-05783).

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. 00-05783. 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. 00-05783. 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
QUINA F. TUCKER, Claimant
WCB Case No. 99-08144
ORDER ON RECONSIDERATION
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

On July 28, 2000, we abated our July 5, 2000 order reversing the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's medical services claim for a cervical condition. We took this action to consider SAIF's motion for reconsideration. Having received claimant's response, we now proceed with our reconsideration.

As noted in our previous order, claimant sustained an August 1992 compensable cervical and dorsal injury that SAIF accepted as a "nondisabling" cervical and thoracic "strain." The claim was later reclassified to "disabling" in September 1993. Eventually, in December 1995, the Board approved a Claim Disposition Agreement (CDA), in which claimant released her rights to compensation for "all past, present, and future conditions, except compensable medical services," for a specific sum of money.

In January 1999, claimant sought treatment for neck pain. Dr. Eschelbach, who had previously treated claimant, reported on January 26, 1999 that he had been "retaking care" of claimant since September 1998. Dr. Eschelbach diagnosed an acute flare of cervicodorsal myospasm. In June 1999, Dr. Eschelbach requested approval of palliative care, a request SAIF disapproved in July 1999.

In October 1999, claimant requested a modified Notice of Acceptance to include a C4-5 disc protrusion, ulnar nerve pain, left shoulder pain, cervical dorsal myospasm, and cervical strain. After an examining physician, Dr. Rich, opined that claimant's ongoing symptoms were due to degenerative disc disease, SAIF issued a denial on December 22, 1999 of the conditions asserted to be compensable. SAIF alleged that the August 1992 injury was not the major contributing cause of the disputed conditions or their need for treatment. Claimant requested a hearing.

The issue was framed at hearing as concerning the causal relationship between medical services for claimant's cervical dorsal myospasm and C4-5 disc herniation and her original compensable injury in August 1992. The ALJ upheld SAIF's denial, finding that claimant had failed to establish under ORS 656.005(7)(a)(B) that her 1992 neck injury remained the major contributing cause of the need for treatment of her cervical conditions. Claimant requested Board review.

We determined that the major contributing cause standard of ORS 656.005(7)(a)(B) was not applicable and, therefore, that a material causation standard applied. We then found that a preponderance of the medical evidence proved that claimant's current medical treatment was materially related to the compensable 1992 injury. Therefore, we concluded that this treatment was compensable. Thus, we set aside SAIF's denial and remanded the claim to SAIF for processing.

On reconsideration, SAIF notes that the compensability of left shoulder and ulnar pain was not litigated at hearing and asserts that the medical evidence does not support the compensability of claimant's "pain." SAIF also argues that, of the remaining conditions it denied, only cervical dorsal myospasm is compensably related to the 1992 neck injury. SAIF, therefore, requests that we modify our order to uphold its denial in part and to reverse it only with respect to the cervical dorsal myospasm. Alternatively, SAIF contends that the 1995 CDA bars litigation of the new conditions that claimant asserted were compensable.

Claimant responds that the parties agreed to litigate the relationship of medical services for claimant's diagnosed cervical dorsal myospasm and C4-5 disc herniation and the original compensable injury. Thus, claimant agrees that, to the extent our order overturned SAIF's denial, the conditions actually litigated were limited to the C4-5 disc bulge and cervical dorsal myospasm. According to claimant, our order only means that SAIF's denial of medical treatment was disapproved and that SAIF is required to pay for claimant's medical treatment because that treatment is compensably related to the accepted injury. We agree with claimant.

Because of the parties' CDA, claimant's entitlement to workers compensation benefits was limited to medical services compensably related to the original accepted injury. Claimant, however, was

entitled to establish the compensability of the denied condition(s) on which his medical services claim is based. *See, e.g., John L. Montgomery*, 52 Van Natta 1318 (2000); *Lynn E. Amstutz*, 50 Van Natta 1436 (1996) (claimant not barred from asserting an impingement syndrome is compensably related to the accepted injury in medical services claim); *John L. Partible*, 48 Van Natta 434 (1996) (notwithstanding CDA limiting accepted condition to a cervical strain and disc, claimant may seek medical benefits for thoracic strain under prior accepted claim).

Although SAIF's written denial pertained to several diagnoses/conditions, the parties in effect amended the denial at hearing to limit their dispute to the compensability of medical services based on cervical dorsal myospasm and C 4-5 disc herniation. We set aside SAIF's "amended" denial, finding that claimant's current medical services were materially related to the compensable injury. In other words, when we set aside SAIF's denial (as amended at hearing), we determined that claimant's medical services claim based on the denied conditions (*i.e.* the cervical dorsal myospasm and C 4-5 disc herniation) was compensable.

Accordingly, we reject SAIF's request that we partially uphold its denial of claimant's medical services. We now turn to attorney fees.

Claimant's attorney has requested an assessed fee for services on reconsideration. Inasmuch as we have not reduced claimant's compensation (*i.e.* her compensable medical services), we agree that claimant is entitled to such a fee under ORS 656.382(2).

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

On reconsideration, as supplemented herein, we adhere to and republish our July 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
JOHN L. MONTGOMERY, Claimant
WCB Case No. 99-03372
ORDER OF ABATEMENT
Walsh & Associates, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our July 19, 2000 Order on Review that affirmed an ALJ's order that upheld the SAIF Corporation's denial of his medical services claim for a right knee meniscal tear.

In order to consider this matter, we withdraw our July 19, 2000 order. The SAIF Corporation is granted an opportunity to respond. To be considered, the SAIF Corporation's response must be filed within 14 days from the date of this order. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT WHITTON, Claimant
Own Motion No. 00-0262M
OWN MOTION ORDER
Martin L. Alvey, Claimant Attorney

The insurer has submitted claimant's request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights expired on January 10, 1984. The insurer opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; (2) surgery or hospitalization is not reasonable and necessary; and (3) it is unknown whether claimant is in the work force.

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

On January 13, 1999, Dr. Dupuis, orthopedist, and Dr. Radecki, physiatrist, examined claimant on behalf of the insurer. They concluded that surgery is not indicated at this time. Instead, they felt that claimant had significant mechanical back pain and should be treated for that entity. Dr. Schmidt, M.D., reviewed Drs. Dupuis' and Radecki's report and disagreed with their conclusions. Dr. Schmidt opined that claimant has significant back and left lower extremity pain, with the left lower extremity pain well explained by his L3-L4 disc herniation. Under those circumstances, Dr. Schmidt concluded that surgery was a reasonable option.

The information provided by the insurer indicates that there is a dispute as to whether claimant's low back condition requires surgery. However, the record does not establish that there was a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). The record only establishes that the issue of claimant's need for surgery remains unresolved.

Because the record does not establish that claimant requires surgery or hospitalization, we are not authorized to grant claimant's request to reopen the claim. ORS 656.278(1)(a).

Parenthetically, we note that the insurer contends that it is unknown whether claimant is in the work force. If claimant establishes in the future that his condition requires surgery or hospitalization, he still must establish that he was in the work force at the time of disability to be entitled to temporary disability compensation. *SAIF v. Blakely*, 160 Or App 242 (1999); *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. In addition to any work force evidence submitted, if claimant was *not* working at the time of disability, claimant must submit a sworn affidavit attesting that he was willing to work during the relevant time period.

Accordingly, we deny the request for own motion relief. *Id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES L. BUTLER, Claimant
WCB Case No. 00-01812
ORDER ON REVIEW
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

FINDINGS OF FACT

On October 7, 1999, claimant signed a retainer agreement employing his then-attorney of record to represent him in connection with his workers' compensation claim. A provision of that retainer agreement stated that "[Claimant] authorizes Attorneys to sign [claimant's] name and in all other respects to act for [claimant]."

On March 3, 2000, claimant, through his then-attorney, requested a hearing regarding a February 28, 2000 denial and raised the issues of compensability and claim processing. A hearing was scheduled for June 8, 2000.

On May 31, 2000, claimant, through his then-attorney, withdrew his hearing request. On June 8, 2000, finding that claimant had withdrawn his hearing request, the ALJ dismissed claimant's hearing request.

On July 7, 2000, claimant requested Board review of the ALJ's June 8, 2000 dismissal order. After discussing his injury, his medical treatment, and SAIF's claim processing, claimant asked that he "be treated justly and [ ] be compensated for an on the job injury."

CONCLUSIONS OF LAW AND OPINION

The ALJ dismissed claimant's hearing request. Thus, the sole issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order appropriate.

Where a claimant signs a retainer agreement employing an attorney and giving that attorney authority to act on the claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. *Donald J. Murray*, 50 Van Natta 1132 (1998); *Robert S. Ceballos*, 49 Van Natta 617 (1997).

Claimant has the burden of proving that the dismissal order is not appropriate. *Donald J. Murray, supra*, 50 Van Natta at 1133, citing *Harris v. SAIF*, 292 Or 683, 690 (1982) (burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side). However, claimant makes no argument as to why the dismissal order was not appropriate.

Moreover, the retainer agreement between claimant and his then-attorney authorized that attorney to act on claimant's behalf. Claimant does not assert that his then-attorney did not withdraw his hearing request. Neither does claimant assert that he was not represented by his then-attorney at the time in question. *Cf. Silverio Frias, Sr.*, 49 Van Natta 1514 (1997) (Board vacated ALJ's dismissal order and remanded to the ALJ to determine if the attorney was authorized to withdraw the request for hearing).

Under these circumstances, we find no reason to alter the dismissal order. *Eva F. Gutierrez*, 51 Van Natta 2028 (1999); *William A. Martin*, 46 Van Natta 1704 (1994).

ORDER

The ALJ's order dated June 8, 2000 is affirmed.

In the Matter of the Compensation of
ARK O. GONG, Claimant
WCB Case No. 99-07194
ORDER ON REVIEW
Heiling & Associates, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

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

FINDINGS OF FACT

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

Claimant was examined by Dr. Button on August 18, 1999. (Ex. 25).

CONCLUSIONS OF LAW AND OPINION

On August 26, 1999, the insurer denied claimant's occupational disease claim for right carpel tunnel syndrome on the basis that there was "insufficient evidence that [claimant's] condition is the result of either a work-related injury or disease." (Ex. 26). The ALJ found that Dr. Karty's June 17, 1999 chart note clearly established compensability of the claim. The ALJ found that the insurer's denial was unreasonable and assessed a penalty. On review, the insurer contends that, based on the medical record as a whole, it had "legitimate doubt" about its liability. We agree.

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).

Claimant, age 51, had two neck surgeries prior to the 1997 onset of numbness and pain in his right hand. He sought treatment at Kaiser Permanente for his right hand symptoms on January 20, 1998. He was diagnosed with right CTS, for which Dr. Weinstein performed a release in April 1998. No doctor commented on whether claimant's right CTS condition was related to work. Claimant's symptoms resolved after surgery and he returned to his work as a cook at the employer.

Claimant's symptoms recurred in the late fall of 1998 and he returned to Kaiser. A diagnosis was made of recurrent right carpal tunnel syndrome. On June 16, 1999, claimant's wife asked Dr. Wright whether claimant's condition could be work related. (Ex. 15). Dr. Wright referred claimant to industrial medicine for determination. *Id.* Because claimant's right wrist had been injected and splinted, Dr. Karty was unable to evaluate claimant's wrist directly. Dr. Karty stated: "Dr. Wright's opinion is the symproms [sic] of the right hand are directly related to his work activity, and are not directly related to the previous neck surgery or diagnosis." Dr. Karty reported that claimant's condition was probably greater than 50 percent due to work. (Ex. 16-2). Following claimant's visit to Dr. Karty, an 801 claim form was submitted by the employer. It was not signed by claimant and it listed neither a date of injury nor the body part involved. (Ex. 19).

On August 4, 1999, Dr. Wright again reviewed the records and noted that he could not tell from Dr. Karty's consultation whether Dr. Karty felt claimant's problem was work related. (Ex. 22). Dr. Wright scheduled a second carpal tunnel release forAugust 24, 1999. *Id.*

On August 18, 1999, Dr. Button examined claimant for the insurer. Dr. Button concluded that claimant was asymptomatic with no objective findings of recurrent carpal tunnel sufficient to justify surgery. (Ex. 25). Dr. Button also sought to find out from claimant whether he had ever been told by any physician that his condition was work related, and he was advised by claimant that "no physician has specifically stated that his present condition or need for surgery relates to his work." (Ex. 25-4).

At the time of the insurer's August 23, 1999 denial, it had Dr. Wright's chart note referring claimant to Dr. Karty for Karty's evaluation; Dr. Karty's chart note that mistakenly assumed that Dr. Wright was of the opinion that claimant's symptoms were work related; Dr. Wright's report that he could not tell from Dr. Karty's notes whether claimant's problems were work related, and Dr. Button's report.

Based on these reports, we find that the insurer had a legitimate doubt as to whether claimant's occupational disease claim was compensable. Consequently, we conclude that the insurer's denial was not unreasonable and claimant is not entitled to a penalty.[1]

ORDER

The ALJ's May 8, 2000 order is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty for unreasonable claim processing is reversed. The remainder of the order is affirmed.

[1] Because we find that the insurer's denial was not unreasonable on the merits, we need not address its additional argument regarding its "legitimate doubt" regarding the timeliness of claimant's claim filing.

In the Matter of the Compensation of
MARY C. HAMMOND, Claimant
WCB Case No. 99-09566
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's L4-5 and L5-S1 disc conditions. In its appellant's brief, the employer requests that we hold this case in abeyance pending the appeal of a "companion case." On review, the issues are motion for abeyance and whether the employer may contest the compensability of claimant's L4-5 and L5-S1 disc conditions. We deny the motion for abeyance and affirm on the merits.

We adopt and affirm the order of the ALJ, with the following supplementation. On review, the employer contends that it is proper for us to defer our decision in this matter until a "companion case" with similar issues is decided by the Court of Appeals. Claimant opposes the employers request. Under these circumstances, we deny the employers motion. *See Brent L. Marlatt*, 50 Van Natta 2369 (1998) (in the absence of the parties agreement to do otherwise, motion to hold review in abeyance indefinitely pending resolution of a court appeal denied); *Jerry W. Duede*, 48 Van Natta 413 (1996) (Board declined to hold review in abeyance pending Supreme Court decision, because to do so would be inconsistent with its role as a decision maker or in furthering the dispute resolution process).

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

ORDER

The ALJ's order dated April 26, 2000 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
JAYE E. SANDERS, Claimant
WCB Case No. 99-07869
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for an inhalation exposure. On review, the issue is compensability.

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

The ALJ analyzed the compensability of claimant's respiratory condition as an occupational disease. Finding that the persuasive medical evidence in the record did not establish that claimant's workplace exposure mineral oil was the major contributing cause of her condition, the ALJ concluded that claimant's respiratory condition was not compensable under ORS 656.802.

Claimant contends that the ALJ incorrectly identified the disputed claim in this case as "an upper respiratory condition." At hearing, claimant identified the issue as compensability of claimant's inhalation exposure and need for medical treatment. (Tr. 1). The record shows that, even before the onset of claimant's breathing difficulties, she experienced headaches and nausea that caused her to leave work. (Exs. 4, 10). Accordingly, we agree with claimant that the claim in this case includes headaches and nausea in addition to her respiratory condition.

Claimant further contends that, consistent with the court's reasoning in *Weyerhaeuser v. Woda*, 166 Or App 73, *rev den* 330 Or 361 (2000), which issued subsequent to the ALJ's order, the claim in this case is properly analyzed as an industrial injury rather than an occupational disease. In *Woda*, the court held that even in workplace exposures to dust, fumes, vapors and so forth, determination of whether a given condition is an occupational disease or injury requires examination of whether the symptoms of the condition were sudden or gradual in onset. *Id.* at 81. *See also Jeld-Wen, Inc. v. Molena*, 166 Or App 396 (2000).

We first note that, at hearing, claimant did not assert the compensability of her inhalation exposure as an accidental injury. Instead, claimant agreed with the ALJ that she was making an occupational disease claim and consented to the analysis of her condition under an occupational disease theory. (Tr. 1). Because claimant has raised the accidental injury theory for the first time on review, we are not inclined to consider this argument. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991). On the other hand, we are obligated to apply the appropriate legal standards to determine the compensability of a worker's claim. *Dibrito v. SAIF*, 319 Or 244, 248 (1994). In any event, we need not resolve the question of whether claimant is precluded from raising the accidental injury theory in this case because, even if the claim is analyzed as an injury, we agree with the ALJ that claimant has not sustained her burden of proof.

ORDER

The ALJ's order dated February 4, 2000 is affirmed.

Board Member Phillips Polich concurring in part and dissenting in part.

I concur with that portion of the majoritys opinion that this claim is to be analyzed as an occupational disease. Nevertheless, I respectfully dissent from that portion of the majoritys opinion that claimant has not met her burden to prove a compensable occupational disease. I reason as follows.

Claimant has experienced seasonal allergies since childhood. These allergies result in swollen, watery eyes and a congested nasal passage, but she has never experienced nausea, shortness of breath, or wheezing because of her allergies. She has also been a heavy smoker for about 20 years, but by January 1999, she had reduced her smoking to about five cigarettes a day. She has never experienced shortness of breath or wheezing as a result of her smoking. Claimant has also experienced periodic headaches since 1998. These headaches did not involve any nausea. When claimant was diagnosed with bronchitis in March 1999, she had no breathing difficulties, and, after antibiotic treatment, her symptoms completely resolved.

When claimant arrived at work on or about May 5, 1999, she was immediately subjected to severely noxious fumes. She developed a bad headache and nausea that resulted in repeated episodes of vomiting. This pattern persisted until the end of the week, when she also developed shortness of breath and wheezing. She was temporarily disabled by her symptoms and required medical treatment.

Medical opinions are provided by Dr. Biedenbach, claimant's treating physician for her inhalation-related symptoms, and Dr. Burton, who examined claimant for SAIF.

Dr. Biedenbach has consistently diagnosed claimant's condition as an adverse reaction to fumes from mineral oil. I would rely on the opinion of Dr. Biedenbach, claimant's treating physician, because he is in a more advantageous position to assess the relative contributions to the onset of her condition than Dr. Burton. Dr. Biedenbach first examined claimant within two weeks of the onset of her symptoms. She examined claimant both before and after her late May episode of bronchitis. She was aware of claimant's history of smoking. Her opinion is consistent with claimant's history of symptomatic flare-ups related to claimant's ongoing exposure to the fumes. She had the opportunity to observe claimant's response to different working conditions, including the use or nonuse of a filtered mask.

Moreover, unlike the ALJ, I am not persuaded that Dr. Biedenbach changed her opinion. Dr. Biedenbach was concerned that claimant might have a specific condition chemical pneumonitis as a result of her inhalation exposure. After conferring with the Poison Control Center, Dr. Biedenbach concluded that it was unlikely that claimant had *that* particular condition. Nevertheless, Dr. Biedenbach has consistently reported that claimant's symptoms were caused by her inhalation exposure. For those reasons, I would defer to Dr. Biedenbach as treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983).

In contrast, Dr. Burton did not examine claimant until August 1999. Dr. Burton concluded that there existed no historical or objective data to support a diagnosis of an occupational injury or disease. As the record makes clear, long before the claim was denied, the employer modified its ventilation system to ameliorate the odor problem. But claimant's unrebutted testimony establishes that the air was thick with the smell of the oil, and the record indicated that other employees experienced similar symptoms in response to the noxious odor.

Moreover, Dr. Burton's opinion that claimants wheezing and shortness of breath were caused solely by cigarette smoking does not account for the fact that claimants symptoms improved when she either wore a respirator or was removed from the work place. In addition, Dr. Burton's opinion that claimant's wheezing and shortness of breath were related to infectious bronchitis does not account for the fact that claimant had neither wheezing nor shortness of breath during her documented bouts with bronchitis.

Finally, Dr. Burton's statements concerning workplace inhalation exposures are generalized and at odds with the particulars of this case. Although Dr. Burton's reasoning concerning claimant's smoking and bronchitis may affect claimant's entitlement to benefits during a particular period (*e.g., late May 1999*), his opinion is not sufficiently persuasive in order to defeat the initial compensability of claimants inhalation exposure in early May.

For these reason, I respectfully dissent from that portion of the majority's opinion finding claimant's inhalation exposure noncompensable.

In the Matter of the Compensation of
CHERYL M. GATCHELL, Claimant
WCB Case No. 00-00301
ORDER OF DISMISSAL (REMANDING)
Cole, Cary, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The self-insured employer requested review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's aggravation claim for her left ankle injury. The parties have submitted a joint motion requesting immediate remand to the ALJ.

In support of their motion, the parties stipulate that the ALJ neglected to address the compensability of two specific consequential conditions that the parties had agreed were at issue at the

time of hearing. The parties further represent that the ALJ initially attempted to abate his order to address the oversight, but was prevented from doing so because the insurer's request for review was filed before the issuance of his abatement order. Finally, the parties state that the ALJ has agreed to reconsider the order to formally adjudicate the denied conditions and to make any corrections he deems necessary.

By this order, we have approved the parties' motion. In granting this approval, we find that the uncontested representations contained in the motion establish that this case has been incompletely and insufficiently developed. *See Ronald D. Reynolds*, 51 Van Natta 1552 (1999). Consequently, we conclude that remand is warranted to allow the ALJ an opportunity to consider the compensability of the disputed conditions and correction of his order, which would assist the parties in resolving some of their disagreements. *See* ORS 656.295(5).

Accordingly, the ALJ's order dated July 20, 2000 is vacated. This matter is remanded to ALJ Black for further action consistent with the parties' motion and this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS M. YEOMAN, Claimant
WCB Case No. 99-09148
ORDER ON REVIEW
Max Rae, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that increased claimant's unscheduled permanent disability for a low back injury from 19 percent (60.8 degrees), as awarded by a prior reconsideration order and by a previous Stipulation and Order, to a total of 27 percent (86.4 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 April 14, 2000 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms without opinion the ALJ's order increasing claimant's award of unscheduled permanent disability for his compensable low back injury from 19 to 27 percent. In so doing, it also approves the ALJ's calculation of the adaptability factor, the sole point of contention in this case. Specifically, in calculating the adaptability factor, the ALJ determined that claimant's base functional capacity (BFC) was correctly determined by the SAIF Corporation in its Notice of Closure (that was affirmed by an Order on Reconsideration) as "medium," based on the Dictionary of Occupational Titles (DOT) code for "Supervisor, Horticultural-Specialty Farming." (DOT 405.131-010). Because I agree with claimant that his BFC should be rated as "heavy," I respectfully dissent.

At the outset, I review some of the basic principles involved in determining the adaptability factor. The purpose of assessing base functional capacity or "BFC" is to determine what kind of work the claimant was capable of performing before he or she was hurt so that the claimant can be fully compensated for his or her loss. BFC means an individual's demonstrated physical capacity before the injury or disease. OAR 436-035-0310(3)(a). A determination of the strength requirements of a particular job are based on the ratings found in the DOT. The Board is required to select the DOT code or codes that will encompass the strength requirements of the most physically demanding job claimant has performed in the five years prior to the determination. OAR 436-035-0310(4)(a).

The critical variable is the exertional demands of the claimant's work. Where, as in this case, a combination of codes most accurately describes a worker's duties, the highest strength for the combination of codes shall apply. *Id.* Indeed, where more than one DOT code applies to describe a particular job, the Board has in the past selected a title that does not ignore significant strength requirements. *See Ilene A. Mayfield*, 48 Van Natta 550 (1996); *William L. Knox*, 45 Van Natta 854 (1993).

Here, claimant was injured while working as a landscaper on a job preparing a lawn. While claimant described some of his work as supervisory, it is clear from the record that claimant was working as a landscaper when injured. (Exs. 1, 1A, 6-2, 7-5, 9A, 13). Therefore, even though claimant performed some duties of a supervisor, the description of the job duties in the DOT code on which the ALJ relied (405.131-010) does not adequately reflect claimant's duties as a landscaper. Thus, another DOT code must be used in order to accurately reflect the exertional demands of claimant's work. That code is, as claimant contends, the one used for "landscape gardener" (DOT 408.161-010). It is rated as "heavy" and best reflects the greater exertional demands of landscape work that claimant performed at the time of injury and in the past.

Accordingly, of the DOT codes proposed, only DOT 408.161-010 ("Landscape Gardener") is broad enough to include the heavy activities that claimant's past work demonstrated he was capable of performing. Therefore, I would find that the adaptability factor should be determined using a BFC of "heavy." Because I also agree with claimant that the residual functional capacity (RFC) should be medium/light with "restrictions," based on Dr. Tiley's medical arbiter's report, the transition from a "heavy" BFC to an RFC of medium/light with "restrictions" yields a multiplier of 5. This value times the undisputed value of one for claimant's age and one for the SVP factor results in a product of 10. When added to the undisputed impairment value of 23 percent, claimant's total unscheduled award should be 33 percent.

Because the majority incorrectly affirms the ALJ's lesser award of 27 percent, I must part company with the majority and dissent.

August 23, 2000 Cite as 52 Van Natta 1516 (2000)

In the Matter of the Compensation of
RAYMOND L. HARRIS, Claimant
WCB Case No. 99-09033
ORDER OF ABATEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

On July 27, 2000, we issued an Order on Review that reversed an Administrative Law Judge's order that had affirmed an Order on Reconsideration that had found that claimant's left knee claim was prematurely closed. Announcing that the parties are preparing a settlement to submit for our consideration, claimant seeks abatement of our July 27, 2000 order.

Based on claimant's announcement, we withdraw our July 27, 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 apprised of any future developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
D'ANN ANDERSON-NIXON, Claimant
WCB Case No. 99-01723
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's chronic regional pain syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant had been working as a bartender for approximately one week when she lacerated her right index finger on September 7, 1997. (Ex. 4, Tr. 11). She sought emergency medical treatment and the laceration was repaired. (Ex. 1). She was given a prescription for 30 Percocet to assist with pain control. (Ex. 1-2).

Claimant was referred to Dr. Weirich, who examined her on September 9, 1997. He reported that claimant was nearly out of Percocet, two days after her emergency room visit. (Ex. 2-1). Claimant complained of numbness involving the entire hand with pain radiating to her elbow and shoulder. (Ex. 2-2). Dr. Weirich found that claimant's paresthesias was "puzzling" and he questioned whether she was having some type of hysterical reaction because "having numbness over the entire hand is difficult to achieve without involving three separate nerves." (*Id.*) Claimant was sent to occupational therapy and was given another prescription for Percocet. (*Id.*)

Ms. Anchell, physician's assistant, examined claimant on September 19, 1997, noting that she had been depressed. (Ex. 6-1). Claimant was reluctant to proceed with any type of exercises that might appear painful. (*Id.*) On September 25, 1997, Ms. Anchell said that claimant had requested a refill of Percocet and she had a "frank discussion" with claimant regarding her use of pain medication. (Ex. 6-2).

On October 14, 1997, claimant sought treatment from Dr. Canepa (Exs. 7, 8), and one day later, changed to Dr. Spisak as her attending physician. (Ex. 10).

The insurer accepted a "laceration extensor tendon right index finger." (Ex. 13).

Dr. Spisak referred claimant to Dr. Andersen, who examined her on December 8, 1997. He found no swelling. (Ex. 14-2). He noted that pin sensation was nonphysiologic and there was "ratchety give-way" presentation to manual muscle testing. (Ex. 14-2, -3). He diagnosed "[s]ubjective sensory disturbance and activity intolerance right upper limb without specific organic findings and accompanied by a nonphysiologic sensory examination." (Ex. 14-3). Dr. Andersen commented that it was difficult to explain claimant's current symptoms and activity intolerance given the mechanism of injury and her physical examination. (*Id.*)

On January 5, 1998, Dr. Button examined claimant on behalf of the insurer. (Ex. 15). He diagnosed a healed laceration and "[s]evere functional overlay/symptom magnification." (Ex. 15-3). He noted that this was a relatively minor injury that had been treated appropriately and he concluded that claimant's subjective complaints completely outweighed the objective findings. (Ex. 15-4). He found no rationale for further evaluation or treatment. (*Id.*)

Dr. Spisak referred claimant to Dr. Sager, a rheumatologist. On March 19, 1998, Dr. Sager reported that "[claimant] has the perception of swelling in this [index finger] region, and the perception of a mild degree of swelling across the hand as well as a change of color." (Ex. 19-2). Those changes were not readily apparent to Dr. Sager. (*Id.*) He diagnosed reflex sympathetic dystrophy and recommended a bone scan. (Ex. 19-3). The American Pain Society reclassified the term reflex sympathetic dystrophy in 1993, and replaced it with the term "chronic regional pain syndrome" (CRPS). (Ex. 49-1).

In April 1998, Dr. Nolan examined claimant on behalf of the insurer. (Ex. 23). He diagnosed:

> "Well-healed relatively trivial laceration with minimal extensor tendon involvement, dorsum of the right hand, right index finger. Psychogenic response to the trivial injury noted above with persistent subjective symptomatology of pain, far out of proportion to the magnitude of the objective injury and with continued right hand severe dysfunction, functional or psychogenic in nature." (Ex. 23-3).

Dr. Nolan reported that multiple possible etiologies may lead to the same symptom complex as reflex sympathetic dystrophy. (*Id.*) He concluded that claimant was having a psychogenic response to a trivial hand injury. (Ex. 23-4). Dr. Button agreed with Nolan's opinion. (Ex. 31).

An October 28, 1998 Notice of Closure awarded 52 percent scheduled permanent disability for loss of use or function of claimant's right index finger. (Ex. 38). Claimant requested reconsideration. (Ex. 40). Dr. Gill performed a medical arbiter examination on March 16, 1999 and reported that claimant had an abnormal pain response that "severely" clouded the assessment of residual impairment. (Ex. 45-4). A March 22, 1999 Order on Reconsideration affirmed the scheduled permanent disability award from the Notice of Closure. (Ex. 47).

On February 3, 1999, claimant requested that the insurer accept her chronic regional pain syndrome. (Ex. 42). The insurer denied the claim on February 12, 1999. (Ex. 44).

A February 12, 1999 x-ray of claimant's right hand showed a "well-corticated bony excrescence at the dorsal aspect of the distal wrist." (Ex. 43). A bone scan of claimant's right hand and wrist showed "mild increased uptake[.]" (Ex. 46-2, -3).

On May 20, 1999, Dr. Davies performed a psychological evaluation. (Ex. 48). He reported that claimant presented with a psychological profile consistent with a nonphysiologic symptom magnification syndrome. (Ex. 48-7). Dr. Davies concluded that claimant's ongoing pain complaints were attributable to her psychological makeup, not the work injury. (Ex. 48-9).

CONCLUSIONS OF LAW AND OPINION

Claimant contends that her CRPS is a consequential condition that was caused, in major part, by the September 7, 1997 injury. *See* ORS 56.005(7)(a)(A). The insurer argues that claimant has not established by objective medical evidence that she has CRPS or that the condition is attributable, in major part, to the compensable injury. For the following reasons, we agree with the insurer.

Although claimant urges us to defer to the opinion of Dr. Spisak, her treating physician, we find that the causation dispute involves expert analysis rather than expert external observations. Under those circumstances, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979).

We conclude that Dr. Weirich, who treated claimant two days after the work injury, has provided the most persuasive and well-reasoned opinion. On September 9, 1997, claimant complained to Dr. Weirich of numbness involving the entire hand with pain radiating to her elbow and shoulder. (Ex. 2-2). Dr. Weirich found that claimant's paresthesias was "puzzling" and he questioned whether she was having some type of hysterical reaction because "having numbness over the entire hand is difficult to achieve without involving three separate nerves." (*Id.*) Claimant subsequently sought treatment from other physicians.

In a later report, Dr. Weirich responded to questions from the insurer regarding the diagnosis of CRPS. He said that the hallmark characteristics involve pain and dysfunction out of proportion to that expected from the inciting event. (Ex. 49-1). He explained that the American Pain Society has adopted the following diagnostic criteria for CRPS:

> "A. The syndrome follows an initiating noxious event.
>
> "B. Spontaneous pain or sensitivity exists beyond the territory of a single peripheral nerve and is disproportionate to the inciting event.
>
> "C. There is or has been evidence of edema, skin blood-flow abnormalities, or abnormal sudomotor activity (such as significantly altered sweating) in the region of the pain since the inciting event.

"D. The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction." (Ex. 49-1, -2).

Dr. Weirich reviewed claimant's medical records and found a "suspicious lack of objective evidence" supporting the proposed diagnosis of CRPS. (Ex. 49-3). He felt the most supportive evidence was entirely subjective, *i.e.*, claimant's pain complaints. (*Id.*) Dr. Weirich commented that claimant had required considerable narcotics to repair a simple laceration and had subsequently used a large amount of oral narcotic pain medication as an outpatient. (Ex. 49-3, -4). When he had presented his plan to claimant to wean her to less powerful pain medication, she transferred her medical treatment to other physicians. (Ex. 49-4). Dr. Weirich concluded that, within a reasonable medical probability, claimant did not have CRPS and it was more likely that her pain complaints were psychogenic. (Ex. 49-6). He explained that claimant had never demonstrated any substantial objective evidence of CRPS either by physical examination or imaging studies. (*Id.*)

Dr. Weirich had reviewed claimant's April 9, 1998 bone scan and said that it revealed mild increased uptake, primarily about the right wrist. (Ex. 49-5). He explained that repeat imaging studies on February 12, 1999 revealed a possible bony tumor or arthritic spurring involving the wrist, which was likely the source of the mildly asymmetric radioactive uptake on the April 9, 1998 bone scan. (Ex. 49-6). Dr. Weirich explained:

"In [claimant's] case, I have personally reviewed the 4/9/98 bone scan and the asymmetry of radioactive tracer uptake is mild, and greatest at the wrist joint, where consequent radiographs have noted bony abnormalities consistent with an entirely different process. I do not believe that any of the standard radiographs or the bone scan supports the diagnosis [of] RSD in this patient." (Ex. 49-7).

We are persuaded by Dr. Weirich's opinion because it is well-reasoned and based on accurate and complete information. Dr. Weirich's opinion is supported by Dr. Andersen, who diagnosed "[s]ubjective sensory disturbance and activity intolerance right upper limb without specific organic findings and accompanied by a nonphysiologic sensory examination." (Ex. 14-3). Dr. Weirich's opinion on causation is also supported by Dr. Button, who diagnosed severe functional overlay/symptom magnification (Ex. 15-3), Dr. Nolan, who concluded claimant was having a psychogenic response (Ex. 23-4), Dr. Gill, who concluded she was having an abnormal pain response (Ex. 45-4), and Dr. Davies, who concluded that claimant's ongoing pain complaints were attributable to her psychological makeup. (Ex. 48-9).

Although claimant relies on the opinions of Drs. Sager and Spisak, we are not persuaded by their opinions for several reasons. In diagnosing claimant, Dr. Sager relied on her "perception" of swelling and a change of color, even though those changes were not apparent to him. (Ex. 19-2). Dr. Sager's later reports do not respond adequately to the problems with claimant's diagnosis discussed by Dr. Weirich. In his March 19, 1998 report, Dr. Sager acknowledged that he did not have "considerable experience or expertise" in managing CRPS. (Ex. 19-4). On June 22, 1998, he did not believe that claimant was "overtly malingering[,]" but he recommended that she be evaluated at a chronic pain center "where individuals with *expertise in this matter* might play a central role in determining the proper diagnostic terminology, degree of functional overlay, and proper approach to her rehabilitation." (Ex. 28; emphasis supplied). There is no evidence that Dr. Sager had the opportunity to review Dr. Davies' psychological evaluation, in which Dr. Davies concluded that claimant's pain complaints were attributable to her psychological makeup, not the work injury. (Ex. 48). In light of Dr. Sager's comment that claimant needed to be evaluated by someone with "expertise" in determining the degree of functional overlay, his opinion that claimant has CRPS is not persuasive.

Claimant argues that Dr. Davies' opinion is entitled to little weight because he is not familiar with CRPS. Claimant is correct that Dr. Davies said that he was not familiar with the term "chronic regional pain syndrome." (Ex. 48-9). Nevertheless, Dr. Davies noted that the term had been described by Dr. Spisak as a syndrome that was "strikingly similar to the psychological concepts of a pain disorder with psychological factors." (*Id.*) Despite Dr. Davies' lack of familiarity with the term CRPS, he found that, to a "reasonable psychological certainty[,]" claimant's ongoing pain complaints were attributable to her psychological makeup. (Ex. 48-8). There is no contrary medical evidence presented by an expert in psychology or psychiatry. We agree with the insurer that Dr. Davies has provided a persuasive explanation of claimant's pain complaints.

For the following reasons, we find that Dr. Spisak's opinion is not sufficient to establish that claimant has CRPS. In his June 22, 1998 report, Dr. Spisak deferred to Dr. Sager's opinion that claimant had CRPS, but he noted that the diagnosis was debatable. (Ex. 29). In a later report, Dr. Spisak acknowledged that the diagnosis was "vague" without a clear pathologic correlate. (Ex. 30-1, -2). He noted that he had not treated claimant before the injury and he could not say whether there was a clear history of depressive or psychosomatic illness. (Ex. 30-2). Dr. Spisak felt that a psychiatric examination might be necessary if there was such an issue. (*Id.*) Dr. Spisak subsequently reviewed Dr. Davies' report, but said that he would not specifically address that report because he was "not an expert in this area[.]" (Ex. 50-1). In light of Dr. Spisak's acknowledged lack of expertise, his opinion is not persuasive.

One of the diagnostic criteria of CRPS is that the "diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction." (Ex. 49-1, -2). In this case, the preponderance of medical evidence establishes that the diagnosis of CRPS has not been excluded by the existence of a psychological condition that would account for claimant's pain complaints and dysfunction.

Moreover, Dr. Weirich provided another explanation for claimant's symptoms, *i.e.*, he reviewed claimant's bone scan and imaging studies and found that radiographs had noted bony abnormalities that were consistent with an entirely different process than CRPS. (Ex. 49-7). The February 12, 1999 imaging studies revealed a possible bony tumor or arthritic spurring involving the wrist, which he felt was likely the source of the mildly asymmetric radioactive uptake on the April 9, 1998 bone scan. (Ex. 49-6). He concluded that the bone scan and radiographs did not support the diagnosis of CRPS. (Ex. 49-7).

Dr. Spisak had not reviewed the actual bone scan and there is no evidence whether he had reviewed the imaging studies. (Ex. 50-2). Dr. Spisak noted that the bone scan report mentioned some uptake into the hand, which he felt was objective. (*Id.*) Dr. Spisak opined that the symptoms of the CRPS "have at least been partially met." (*Id.*) Regarding the bony growth condition on claimant's wrist, he felt it was in the exact area of the injury and was caused, in major part, by claimant's injury. (*Id.*) Dr. Spisak concluded that claimant's injury was the major contributing cause of her CRPS. (*Id.*)

Based on Dr. Weirich's report, we find that the presence of a bony abnormality is inconsistent with Dr. Spisak's diagnosis of CRPS. In other words, the diagnosis of CRPS has *not* been excluded by the existence of a bony abnormality in the wrist that would account for claimant's pain complaints and dysfunction. In sum, we find that Dr. Spisak's opinion is not well-reasoned and lacks adequate explanation. We conclude that claimant has not sustained her burden of proving that she has CRPS, or that it was caused, in major part, by the work injury. We therefore reverse the ALJs order.

ORDER

The ALJ's order dated February 23, 2000 is reversed. The insurers denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
JAMES M. EVANS, Claimant
Own Motion No. 99-0152M
OWN MOTION ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our July 27, 2000 Own Motion Order Reviewing Carrier Closure, that affirmed the insurer's April 24, 2000 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. Claimant's reply, including any further supporting documents, must be filed within 14 days from the date of mailing of the insurer's response. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN M. COOPER, Claimant
WCB Case Nos. 99-09605 & 99-05087
ORDER ON REVIEW
Furniss, Shearer & Leineweber, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denials of claimant's injury claim for a right cervical muscle strain with spasm and right superior trapezius muscle strain with spasm. Claimant cross-requests review of that portion of the ALJ's order that upheld SAIF's denial of his current low back 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

February 1999 Cervical Condition

Claimant seeks to establish compensability of an injury sustained in a February 22, 1999 motor vehicle accident (MVA). (Ex.148). On the following day, Dr. Hirsch reported that claimant had decreased cervical range of motion, tenderness and muscle spasm. (Ex. 149). She diagnosed a right cervical muscle strain with spasm and right superior trapezius muscle strain with spasm. (*Id.*)

The ALJ relied on the opinion of Dr. Hirsch and concluded that claimant's February 22, 1999 injury was the major contributing cause of his cervical and trapezius strains.

On review, SAIF argues that Dr. Hirsch's opinion is not sufficient to establish compensability of claimant's cervical/trapezius condition. For the following reasons, we agree with SAIF.

The record establishes that claimant had been treated for neck and shoulder problems before the February 1999 injury. In August 1978, claimant sought medical treatment for headaches, neck and shoulder pain related to a July 1978 injury. (Ex. 3). He was diagnosed with a cervical muscle strain and was hospitalized for cervical traction. (Exs. 6-2, 11).

In August 1979, claimant sought treatment for problems related to a June 1979 MVA. (Ex. 11). He reported daily headaches and chronic neck pain. (Ex. 11-1). Dr. Osborn suspected a chronic pain syndrome. (Ex. 11-2).

In January 1986, Dr. Jaegar reported that claimant had sustained a soft tissue injury in his neck following a whiplash injury related to a December 1985 MVA. (Exs. 18, 21). In April 1986, Dr. Osborn referred to the December 1985 accident, stating that claimant had a musculoskeletal injury to his neck. (Ex. 21).

Claimant was involved in another MVA on January 10, 1995. (Exs. 48, 54). His complaints included neck pain and he was diagnosed with a cervical strain. (Exs. 48, 55). SAIF accepted a disabling cervical and lumbar strain. (Ex. 65). Drs. Dordevich, McCarter and Newman reported that claimant's cervical strain had resolved. (Ex. 72-4). An August 17, 1995 Notice of Closure awarded only temporary disability benefits. (Ex. 91). A December 8, 1995 Order on Reconsideration affirmed the August 17, 1995 Notice of Closure. (Ex. 100).

Dr. Hirsch became claimant's attending physician in January 1996. (Ex. 102). At that time, she indicated that claimant had experienced multiple previous back injuries, but she did not refer to any previous neck problems. In May 1996, however, Dr. Hirsch referred to claimant's "chronic" neck pain and indicated that she needed to review claimant's previous medical records. (Ex. 108). There is no indication whether she reviewed any such records.

On May 6, 1997, claimant was injured when a truck hood disengaged and fell on his neck. (Exs. 110, 111, 113). Dr. Hirsch diagnosed a cervical strain, mild concussion and headaches. (Ex. 112). On June 27, 1997, Drs. Kirschner and Schilperoort examined claimant and reported that his symptoms from the May 1997 incident had resolved without impairment. (Ex. 115-4 to -6). Dr. Hirsch concurred with their report. (Ex. 117). SAIF accepted a nondisabling cervical contusion. (Ex. 116).

On February 4, 1998, Dr. Reddin, chiropractor, reported that claimant had been in a January 29, 1998 MVA and "felt his neck pop" and had an immediate headache. (Ex. 128). She diagnosed a mild acute cervical strain. (*Id.*)

The issue in this case concerns compensability of claimant's February 22, 1999 injury. In light of his previous neck injuries and the multiple possible causes of his 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 279 (1993). Claimant relies on the opinion of his treating physician, Dr. Hirsch, to establish compensability.

The persuasive medical evidence establishes that claimant has a preexisting degenerative cervical condition that combined with the February 1999 injury to cause his disability or need for treatment. Cervical x-rays in May 1997 showed mild degenerative changes at C5-6. (Ex. 109-1). A CT scan showed evidence of a minor incomplete and nondisplaced fracture involving the right lateral mass of C2. (Ex. 109-2). The radiologist felt it showed a chronic healed defect of a prior remote trauma. (*Id.*) Drs. Zivin and Gripekoven found that claimant had preexisting cervical conditions that combined with the February 1999 injury to cause his disability or need for treatment. (Exs. 165-8). Similarly, Drs. Tesar and Wong reported a history of multiple, preexisting cervical injuries. (Ex. 169-4 to -9). They found that claimant's February 1999 strain combined with his preexisting cervical condition to cause his need for treatment. (Ex. 169-10).

Based on these reports, we find that claimant has a combined cervical condition and ORS 656.005(7)(a)(B) applies. Therefore, claimant must prove that the February 1999 work injury was the major contributing cause of the disability and/or need for treatment of the combined condition.

Drs. Zivin and Gripekoven examined claimant on May 25, 1999 and noted that he had previous cervical injuries. (Ex. 165-3). When they questioned claimant, he said he was not claiming any new injuries from the February 1999 injury. (Ex. 165-7). Rather, claimant admitted that all of his symptoms were present prior to that accident. (*Id.*) Drs. Zivin and Gripekoven concluded that claimant did not have new injury, but had experienced a symptomatic flareup of a preexisting condition. (*Id.*) At most, they believed he had experienced a minor soft tissue injury of the cervical spine. (*Id.*) They concluded that claimant's preexisting conditions were the major contributing cause of his need for treatment. (Ex. 165-8). In a later report, Dr. Gripekoven reiterated that opinion. (Ex. 172).

On August 26, 1999, Drs. Tesar and Wong examined claimant and reported a history of multiple, preexisting cervical injuries. (Ex. 169-4 to -9). They concluded that claimant had sustained, at most, a mild cervical strain as a result of the February 1999 accident. (Ex. 169-10). They found that claimant's strain combined with his preexisting cervical condition to cause his need for treatment. (*Id.*) Drs. Tesar and Wong concluded that claimant's preexisting condition was the major cause of his need for treatment and disability, and they noted that the February 1999 MVA was a relatively minor accident. (*Id.*)

The only medical reports supporting compensability are from Dr. Hirsch. On June 12, 1999, Dr. Hirsch reported that the February 22, 1999 injury was the major contributing cause of claimant's neck/trapezius injury and need for treatment. (Ex. 167). She explained:

> "However, it is very difficult in this patient with a long history of chronic neck and back problems to tease out exactly which symptoms may be related to the current motor vehicle accident versus which ones may have been present prior to that time. Clearly this patient has had on-going symptoms prior to this accident, but I have not been treating him for this problem currently or recently prior to the accident for quite some time." (*Id.*)

On August 2, 1999, Dr. Hirsch wrote to SAIF and indicated that claimant's headache and pain were related to the February 22, 1999 MVA. (Ex. 167C).

In a September 1, 1999 chart note, Dr. Hirsch referred to a discussion on causation with SAIF's attorney:

> "The recent IME completed on this patient indicates that he did indeed suffer an injury related to the motor vehicle accident, but that this combined with his previous pre-existing conditions, to result in the need for treatment. I differed with their opinion in that I feel that, although he does have the pre-existing condition of neck pain, I have not actually treated him for this specifically other than related to specific incidences [sic] prior to the date of the MVA and thus feel that greater than 50% of his current need for treatment relates to the MVA dated 2/22/99 and not his pre-existing condition. I agreed that the pre-existing condition makes it difficult to sort this out in a patient with an extensive history of multiple MVAs and others [sic] worker [sic] compensation claims, but have to base my decision on my knowledge of him since I have been seeing him over the past several years." (Ex. 170).

On December 10, 1999, Dr. Hirsch said that the February 22, 1999 MVA was the major contributing cause of claimant's cervical and trapezius strains. (Ex. 173-2). Later in that report, however, Dr. Hirsch explained:

> "With respect to this patient's previous injuries to his neck and low back areas, the patient has had multiple injuries to both areas and chronic symptoms related to both areas. *I find it impossible to separate out which symptoms may have been present prior to each injury and which ones may be related to each injury,* as I can only say that his previous symptoms were always exacerbated by the new injury and sometimes the injury of the neck exacerbated the back and vise [sic] versa. * * *
>
> "As noted above, I feel that my role as a physician is to treat this patient's symptoms when he comes in complaining of such. *I do not feel that it is my role to determine which symptoms may be related to a previous injury,* particularly in a patient who has had as many previous work related and motor vehicle accident related injuries as this patient has. *I find it impossible to provide any reliable estimation of these types of issues from a medical perspective.* I do my best to try to assess the current injury and treat it appropriately and leave these types of decisions to independent medical examiners who have more experience in this area." (Ex. 173-3; emphasis supplied).

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).

Although Dr. Hirsch opined that claimant's February 1999 injury was the major contributing cause of his cervical/trapezius strains, she found it "impossible to separate out which symptoms may have been present prior to each injury and which ones may be related to each injury[.]" (Ex. 173-3). She did not feel it was her role to determine what symptoms were related to a previous injury. (*Id.*) At most, Dr. Hirsch's opinion indicates only a possibility that the February 1999 injury was the major contributing cause of the cervical/trapezius condition. *See Gormley v. SAIF,* 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). Moreover, it is not clear whether she was fully aware of claimant's previous cervical injuries. *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). We find that Dr. Hirsch's opinion is not persuasive because she did not properly evaluate the relative contribution of the preexisting conditions and the work injury and explain why the work injury was the major contributing cause. *See Dietz,* 130 Or App at 401.

In sum, we conclude that the medical evidence fails to establish that the February 22, 1999 injury was the major contributing cause of claimant's disability or need for medical treatment of his right cervical muscle strain with spasm and right superior trapezius muscle strain with spasm.

Current Low Back Condition

We adopt and affirm the portion of the ALJ's order regarding the denial of claimant's current low back condition with the following change and supplementation. In the third full paragraph on page 8, we change the first date in the second sentence to read: "September 9, 1998."

We write to address claimant's argument that *Barrett Business Services v. Morrow*, 164 Or App 628 (1999), applies to this case and, therefore, SAIF continues to be responsible for his current lumbar strain.

The ALJ found that SAIF had not accepted the same condition as the earlier accepted claim and, therefore, ORS 656.308(1) did not apply. The ALJ concluded that claimant failed to prove that the September 9, 1998 injury was the major contributing cause of the need for treatment and disability for his current low back condition.

In *Morrow*, the court held that ORS 656.308(1) applies only when the original compensable injury and the second injury involve the same condition. *Id.* at 636. The court explained that a new compensable injury "involves the same condition" when the new compensable injury encompasses, or has as part of itself, the prior compensable injury. *Id.* at 631. In that circumstance, 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. *Id.* In *Morrow*, there was no dispute that the claimants new compensable strain was the same condition previously accepted by the carrier. *Id.* at 632. In that case, responsibility for the claimants preexisting strain shifted to the second carrier. *Id.*

In the present case, we must determine whether ORS 656.308(1) applies. Claimant has several accepted claims. Before the September 1998 claim, the most recent accepted claim related to claimant's low back involved a January 10, 1995 MVA.[1] (Ex. 54). SAIF accepted a disabling cervical and lumbar strain. (Ex. 65). Claimant was treated conservatively with medication and chiropractic care. (Exs. 55, 56, 59, 66, 69). On March 28, 1995, Drs. Dordevich, McCarter and Newman reported that claimant's cervical and lumbar strains had resolved. (Ex. 72-4). Dr. Lockwood agreed that claimant had not sustained any additional permanent impairment related to the January 10, 1995 injury. (Ex. 88). An August 17, 1995 Notice of Closure awarded only temporary disability benefits. (Ex. 91). A December 8, 1995 Order on Reconsideration affirmed the Notice of Closure. (Ex. 100).

Claimant's September 1998 injury was accepted as a nondisabling acute lumbosacral strain. (Ex. 139). Under ORS 656.308(1), 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).

We find no medical evidence to establish that claimants current back condition involves the same condition as the January 1995 injury. Claimant does not refer to any medical evidence, nor do we find any such evidence, which establishes that his 1995 injury is "within" or "part of" the current low back condition. Rather, the reports from Drs. Dordevich, McCarter, Newman and Lockwood established that claimant's January 1995 cervical and lumbar strains had resolved without impairment. (Exs. 72, 88). Because there is no persuasive evidence that the September 1998 injury involved the 1995 lumbar strain injury, ORS 656.308(1) does not apply. *See McAtee*, 164 Or App at 663 (the claimant's new lumbar strain did not involve the same condition previously accepted); *see also Barrett Business Services v. Morrow*, 164 Or App at 632 n. 1 ("[w]e do not understand how a 1991 strain and a 1994 strain are the same condition").

We examine the other accepted back claims to determine if claimant's current low back condition was previously accepted. *See Fred L. Dobbs*, 50 Van Natta 2293 (1998). On March 30, 1993, claimant injured his back while lifting boxes. (Exs. 23, 24). Dr. Steinhauer diagnosed a lumbosacral strain. (Ex. 27-3). He noted that claimant had sustained many previous back injuries. (*Id.*) Claimant was treated conservatively. SAIF accepted a disabling lumbosacral strain. (Ex. 39).

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[1] Although claimant filed a claim for an August 1997 back injury, that dispute was resolved by a Stipulation and Disputed Claim Settlement Agreement whereby SAIF's denial of that claim remains in effect. (Ex. 133). ORS 656.308(1) does not apply to that claim because it was not accepted. Claimant also filed a claim for a May 6, 1997 injury, but that did not involve his low back. (Exs. 113, 116).

On June 3, 1993, Drs. Tesar and Wilson examined claimant on behalf of SAIF and reported that he had recovered from the lumbosacral strain and had no orthopedic or neurologic abnormalities. (Ex. 37-6). Dr. Steinhauer performed a closing evaluation on July 2, 1993. (Ex. 40). A September 22, 1993 Determination Order awarded 20 percent unscheduled permanent disability for reduced range of motion in claimant's low back. (Ex. 42). There is no medical evidence that establishes that claimants 1993 injury is "within" or "part of" the current low back condition. Rather, the medical evidence establishes that claimant recovered from the 1993 lumbosacral strain. Because there is no persuasive evidence that the September 1998 injury involved the "same condition" as the March 1993 lumbosacral strain, ORS 656.308(1) does not apply. In sum, we agree with the ALJ that ORS 656.308(1) does not apply to this case and we find that claimants reliance on the *Morrow* case is misplaced. Furthermore, we agree with the ALJ that the medical evidence is insufficient to establish that claimant's September 9, 1998 injury is the major contributing cause of his current disability and need for treatment.

ORDER

The ALJ's order dated April 4, 2000 is reversed in part and affirmed in part. That portion of the order that set aside SAIF's denials of claimant's injury claim for a right cervical muscle strain with spasm and right superior trapezius muscle strain with spasm is reversed. SAIF's denials of those conditions are reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

August 25, 2000 Cite as 52 Van Natta 1525 (2000)

In the Matter of the Compensation of
CECIL DUNCAN, Claimant
WCB Case No. C001982
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Margaret F. Weddell, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Member Meyers and Phillips Polich.

On August 16, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, for payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $225 and the total due claimant's attorney is $25. This would equal a total consideration of $250. Contrary to the above mentioned distribution, page 2, number 13 of the agreement recites that claimant's attorney will receive an attorney fee in the amount of $5,625.

Upon review of the document as a whole, we are persuaded that the reference on the second page of the CDA to an attorney fee of $5,625 is a typographical error.[1] Accordingly, we interpret the agreement as providing for a total consideration of $250, with $25 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 $25, 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] In reaching this conclusion, we note that the parties have also entered into a CDA of claimant's April 1995 bilateral shoulder claim that provides for $30,000 in proceeds (less a $5,625 attorney fee). In light of such circumstances, we believe that the reference to a $5,625 attorney fee in this CDA is an inadvertent reference to the other CDA.

In the Matter of the Compensation of
BENJAMIN R. GONZALEZ, JR., Claimant
WCB Case No. 99-05763
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

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

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

On February 4, 1999, while unloading a door weighing between 200 and 400 pounds, claimant was required to support it for less than a minute when the door slid off a cart. We agree with the ALJ's conclusion that Dr. Thayer, consulting orthopedist, provided the most persuasive opinion despite his reference to claimant supporting the door for three to five minutes.

In this regard, by providing a detailed explanation for how the incident physically caused the left carpal tunnel syndrome, we agree with the ALJ that the duration of the incident was less important to Dr. Thayer's opinion than the fact that it happened at all. Dr. Thayer does not state that a duration of three to five minutes was necessary for claimant to be injured; rather, Dr. Thayer globally refers to the incident and discusses how it resulted in carpal tunnel syndrome.

We also find that the rebutting opinions are not persuasive. Examining neurologist, Dr. Rosenbaum, does not address Dr. Thayer's theory of causation and summarily dismisses claimant's work as a factor on the basis that claimant's symptoms developed after he was released from full duty. According to Dr. Rosenbaum, claimant's obesity and diabetes constitute the major contributing cause of the carpal tunnel syndrome. Dr. Thayer adequately addresses this opinion and explains why he did not attribute the condition to these factors.

In sum, we agree with the ALJ that claimant carried his burden of proof, whether under ORS 656.005(7)(a) or 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,437.50, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's brief and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's March 17, 2000 order, as amended March 28, 2000, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,437.50, to be paid by the self-insured employer.

In the Matter of the Compensation of
ROSALYN HICKMON-WILLIAM, Claimant
WCB Case No. 99-06453
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) declined to award temporary total disability benefits from October 22, 1998 through August 30, 1999; and (2) declined to assess penalties or attorney fees for allegedly unreasonable resistance to the payment of compensation. On review, the issues are temporary disability and penalties and attorney fees.

We adopt and affirm the ALJ's order.

ORDER

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

Board Member Phillips Polich dissenting.

I disagree with the majority's decision affirming the ALJ's order that declined to award temporary disability benefits from October 22, 1998 through August 30, 1999.

Although I agree with the ALJ's reasoning that temporary total benefits are not payable pursuant to ORS 656.273(6) from November 22, 1998 through August 30, 1999, I would find that claimant is entitled to temporary *partial* disability benefits (TPD) beginning November 22, 1998. In this regard, I would find, based on the record, that TPD benefits were authorized by Dr. Weintraub and are payable as of the date the insurer had notice of a claim for right cubital tunnel syndrome.

Pursuant to ORS 656.262(4)(a), 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.

Here, the insurer had notice and knowledge of the claim for right cubital tunnel syndrome on November 22, 1998 when Dr. Weintraub attempted to file an aggravation claim on claimant's behalf.[1] Dr. Weintraub had authorized modified work on September 25, 1998 and had opined that the condition was work-related. (Exs. 20; 29). Dr. Weintraub confirmed that claimant had been released to modified work by him throughout the course of the right cubital tunnel claim. (Exs. 29; 31). Under such circumstances, the insurer had notice of the claim as of November 22, 1998 and TPD was authorized by claimant's attending physician. Accordingly, I would conclude that claimant is entitled to TPD benefits from November 22, 1998 until August 30, 1999. *See* ORS 656.262(4)(a).

Claimant also sought penalties and attorney fees for unreasonable refusal to pay compensation. Under ORS 656.262(11)(a), if the insurer unreasonably refuses to pay compensation, the insurer 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).

In this case, I would find that the insurer did not have a legitimate doubt about its liability for TPD. In this regard, the record reflects that the insurer had notice of a claim for the right cubital tunnel syndrome as of November 22, 1998. In addition, the attending physician had restricted claimant to modified work and had causally related the right cubital tunnel condition to the work injury. Under such circumstances, a 25 percent penalty of any amounts "then due" is appropriate.

[1] The aggravation claim submitted on November 22, 1998 provided notice to the insurer of a claim for right cubital tunnel syndrome. Thus, because the insurer had notice of the claim for right cubital tunnel syndrome and because the record establishes that Dr. Weintraub had released claimant to modified work, I would conclude that TPD benefits were payable pursuant to ORS 656.262(4).

In the Matter of the Compensation of
GLEN D. OETKEN, Claimant
WCB Case No. 99-04823
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its partial denial of claimant's injury claim for a cervical condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact with the exception of the ALJ's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial of claimant's cervical disc condition based on the opinion of Dr. Van Pett, claimant's treating surgeon. Dr. Van Pett concluded that claimant's August 31, 1998 work injury was the major contributing cause of claimant's combined cervical condition, including a C5-6 disc herniation. (Exs. 16, 41).

On review, SAIF first contends that the ALJ erred in finding that claimant had a disc herniation at C5-6. In partial support of his conclusion that claimant had a cervical disc herniation, the ALJ referred to a comment by Dr. Matteri, a consulting orthopedic surgeon, that claimant's MRI scan demonstrated a "C5-6 lesion." (Ex. 19). The ALJ then referenced a medical dictionary definition of the term "lesion," and concluded that the definition "supports a finding of a traumatically induced disc." For the following reasons, we agree with SAIF that this inference was improper.

In *SAIF v. Calder*, 157 Or App 224 (1998), the court held that we may consult medical dictionaries to define medical terms. However, the court in *Calder* explained that the Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge. Our findings must be based on medical evidence in the record. *Calder*, 157 Or App at 227; *see John R. Davis*, 52 Van Natta 1278 (2000).

Here, we find that the ALJ impermissibly inferred that the term "lesion" denotes a "traumatically induced disc," in the absence of a medical opinion to that effect. *See Jan M. Hulke*, 50 Van Natta 1393 (1998) (in the absence of medical evidence that the claimant's surgery included arthroplasty, the Board could not award impairment for an arthroplasty procedure based on medical dictionary definitions alone).

Nevertheless, even discounting Dr. Matteri's report, we find that claimant has met his burden of proving the compensability of his combined cervical condition. There is no dispute that claimant suffers from preexisting degenerative disc disease in his cervical spine, and that the degenerative condition combined with his work injury to cause his current need for medical treatment or disability. Therefore, to establish compensability, claimant must prove that his August 31, 1998 work injury is the major contributing cause of his disability and need for treatment for his combined cervical condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon*, 149 Or App 309 (1997).

Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, we generally rely on the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find no persuasive reason not to defer to Dr. Van Pett, claimant's treating surgeon. *Argonaut Insurance Co. v. Mageske*, 93 Or App 698 (1988) (special deference is owed to a treating surgeon due to the unique opportunity to view the claimant's condition firsthand). SAIF contends that Dr. Van Pett's opinion is "unsupported," because, although she initially diagnosed a disc herniation at C5-6 that was "a prominent feature" in claimant's need for treatment and surgery, her operative report did not identify a disc herniation. (Ex. 17). In particular, SAIF notes that, when asked by claimant's counsel

whether, based on her first-hand view at surgery, there was a "small disk herniation at C5-6," Dr. Van Pett responded that "the procedure performed did not allow for visualization of the disc herniation." (Ex. 41).

However, Dr. Van Pett's specific response does not necessarily imply that there was no disc herniation; it establishes only that she was unable to "visualize" a herniation at surgery. Moreover, in Dr. Van Pett's operative report, both her pre-operative and post-operative diagnoses included a "small disk herniation." (Ex. 17). This diagnosis is consistent with Dr. Van Pett's impression during her initial evaluation of claimant: "C5, C6 radiculopathies secondary to a combination of factors - degenerative canal stenosis, osteophytes formation and acute disc herniation at C5/6 level." (Ex. 16-4). These two notations are also consistent with Dr. Van Pett's ultimate conclusion that claimant's August 31, 1998 injury was the major contributing cause of claimant's need for treatment and surgery for his combined cervical condition (including an "acute disc herniation"). (Exs. 16-4, 41).

SAIF next contends that Dr. Van Pett's opinion is unpersuasive because she relied on claimant's "unreliable" reports of symptoms. During her attempted closing examination on March 29, 1999, Dr. Van Pett observed that claimant's complaints of pain "involved almost his whole body and a very significant psychological component." (Ex. 27). However, Dr. Van Pett reached her initial opinion on causation several months before the closing examination, during her first evaluation of claimant. (Ex. 16-4). Importantly, SAIF does not contend that Dr. Van Pett had an inaccurate history of claimant's August 31, 1998 injury or of his symptoms before and after that injury.

Dr. White, a neurosurgeon who performed a records review at the request of SAIF, concluded that no disc herniation was present, either on MRI scan or in Dr. Van Pett's operative report. (Ex. 26-3). Dr. White stated that claimant's surgery was directed strictly at a preexisting degenerative disk disease. (Ex. 26-5). We agree with SAIF that Dr. White's opinion can reasonably be interpreted to state that claimant's compensable injury was not the major contributing cause of his combined cervical condition. *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986) ("magic words" on issue of causation not required). However, like the ALJ, we defer to the opinion of Dr. Van Pett on this issue given her unique position as claimant's treating surgeon. *Argonaut Insurance Co. v. Mageske*, 93 Or App at 702.

SAIF argues that the ALJ erroneously discounted the opinion of Dr. Edmonds, a consulting neurologist. Dr. Edmonds commented that claimant's MRI scan demonstrated "significant cervical spine disease," which was due to degenerative changes. (Ex. 25-3). Dr. Edmonds' opinion is similar to that of Dr. White in this regard, and we agree with SAIF that Dr. Edmonds' report is not supportive of compensability. Nevertheless, we find Dr. Edmonds' opinion less persuasive than that of Dr. Van Pett, for the reason that Dr. Van Pett was claimant's treating surgeon.

Finally, SAIF contends that we should find persuasive the opinions of Drs. Tiley and Morton, who examined claimant at the request of SAIF. These physicians concluded that no disc herniation at C5-6 had ever been identified and agreed with Dr. White that claimant's cervical disc pathology was preexisting. (Ex. 34-9). In finding their opinions unpersuasive, the ALJ reasoned that Drs. Tiley and Morton incorrectly understood that claimant suffered "no significant injuries" on August 31, 1998. (Ex 34-7). By referencing the remainder of their report, we agree with SAIF that Drs. Tiley and Morton were aware of and considered claimant's August 31, 1998 work injury. In particular, these doctors recognized that claimant had sustained a right shoulder strain and labral tear, as well as "minor strains and sprains" secondary to the August 31, 1998 injury. (Ex. 34-7). However, it is not clear that these doctors properly considered claimant's compensable cervical strain condition. (*See* Ex. 7). For that reason, we find their opinion less persuasive.

Moreover, Dr. Pearson, claimant's treating physician, disagreed with Drs. Tiley and Morton and stated his concurrence with Dr. Van Pett's opinion that claimant's work injury caused a disc herniation. (Ex. 36-1). Although Dr. Pearson, by his own admission, is not as qualified as Dr. Van Pett, he was the only physician to examine claimant before and after the injury, and his opinion on causation is therefore persuasive. (Ex. 36). *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986).

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 28, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
RALPH J. RAGEL, Claimant
WCB Case No. 99-09088
ORDER ON REVIEW
John C. Dewenter, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the SAIF Corporation's denial of his claim for left carpal tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated March 24, 2000, as corrected March 27, 2000, is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority's decision to adopt the ALJ's order upholding the denial of claimant's left carpal tunnel syndrome claim. The ALJ found that Dr. Lundsgaard's opinion that claimant had a work-related left carpal tunnel syndrome was unpersuasive because it amounted to an unexplained change of opinion. In this regard, Dr. Lundsgaard had earlier offered opinions that claimant did not have carpal tunnel syndrome on the left.

After reviewing this record, however, I am persuaded that at the time he rendered his earlier opinions, Dr. Lundsgaard had not yet diagnosed claimant's left wrist condition. By the time Dr. Lundsgaard rendered his opinion in Exhibit 23 that claimant had left carpal tunnel syndrome related to his work activities, the diagnosis of the left-sided condition had been made. As Dr. Lundsgaard explained in Exhibit 23, the carpal tunnel syndrome on the left was not intially as severe as the already accepted right sided carpal tunnel syndrome.

There are no contrary medical opinions indicating that claimant's left carpal tunnel syndrome is not compensable. Under such circumstances, I would find Dr. Lundsgaard's opinion sufficient to establish compensability of left carpal tunnel syndrome.

In the Matter of the Compensation of
DALE A. VANORTWICK, Claimant
WCB Case No. 99-08650
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
VavRosky, et al, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's chronic pain syndrome in the lumbar spine. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first full paragraph on page 3, we change the last sentence to read: "Dr. Ramsey, D.C., who provided chiropractic treatment to claimant in conjunction with Dr. Deitchler, believed that claimant's lumbar strain was the major contributing cause of his chronic low back pain. (Ex. 43)." In the third full paragraph on page 3, we change the citations at the end of the paragraph to read: "(Exs. 37, 40, 41)."

In the second full paragraph on page 4, we adopt the first two sentences and replace the remaining sentences in that paragraph with the following:

> "Dr. Jamison agreed with Dr. Woodward's opinion. On the one hand, Drs. Woodward and Jamison believed that claimant's preexisting degenerative disc disease, obesity and deconditioning were the major contributing cause of his ongoing low back pain. On the other hand, Dr. Davis believed that claimant's lumbar strain is the major contributing cause of a chronic pain syndrome."

In the last paragraph beginning on page 7 and continuing on page 8, we change the last portion of the third sentence to delete "as supported by his treating chiropractor Dr. Ramsey."

Finally, we supplement the order to respond to the dissent's argument that Dr. Davis' agreement that "chronic pain syndrome is a recognized DMSO category" lacks adequate explanation. The dissent reasons that "DMSO" is defined as "dimethyl sulfoxide" and Dr. Davis' apparent agreement that claimant's chronic pain syndrome was a recognized "dimethyl sulfoxide" category raises questions regarding the persuasiveness of Dr. Davis opinion.

The issue in this case is compensability of claimant's chronic pain syndrome. Given the context of this case, we find that the reference to a recognized "DMSO" category is a typographical error and should have referred instead to a "DSM" category. The *Diagnostic and Statistical Manual of Mental Disorders*, which is an American Psychiatric Association publication that classifies mental illnesses, is commonly abbreviated as "DSM." *See Stedman's Electronic Medical Dictionary* v. 4.0 (1998).[1] The *Diagnostic and Statistical Manual of Mental Disorders* 458-62 (4th ed 1994) (DSM-IV) includes a discussion of pain disorders. Under these circumstances, we find that it is a reasonable inference that Dr. Davis agreed that chronic pain syndrome was a recognized "DSM" category.

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 $1,840, payable by the self-insured

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[1] The *Diagnostic and Statistical Manual of Mental Disorders* is defined in *Stedman's Electronic Medical Dictionary* as:

"An American Psychiatric Association publication which classifies mental illnesses.

"Currently in its fourth edition (*DSM*-IV) and first published in 1952, the manual provides health practitioners with a comprehensive system for diagnosing mental illnesses based on specific ideational and behavioral symptoms. The *DSM* approach supplants older, less rigorous methods of diagnosis, and as such represents a major step forward for the field of psychiatry. It consists of five axes covering clinical syndromes, developmental and personality disorders, physical disorders, severity of psychosocial stressors, and global assessment of functioning. It is used primarily in the U.S.; elsewhere, the World Health Organization's International Classification of Diseases is preferred." (Emphasis supplied).

employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's affidavit in support of attorney fees), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 25, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,840, payable by the self-insured employer.

Board Member Meyers dissenting.

By adopting and affirming the ALJ's order, the majority concludes that the opinion of Dr. Davis is sufficient to establish compensability of claimant's chronic pain syndrome in the lumbar spine. Because I disagree with the ALJ's and the majority's interpretation of the medical evidence, I respectfully dissent.

I agree with the employer that Dr. Woodward provided a complete and well-reasoned explanation of why claimant did not suffer from chronic pain syndrome. Dr. Woodward said that most authorities consider low back pain to be chronic after six months. (Ex. 37-5). He explained:

> "However, complaints lasting six months do not, of themselves, make a diagnosis of chronic pain syndrome. The diagnosis of chronic pain syndrome is vague and controversial. It is usually used to describe a condition which has been present for many months or a few years unresponsive to narcotic analgesics or customary treatment and associated with depression, dependancy and disability. There is no evidence in the medical records provided to support a diagnosis of chronic pain syndrome. According to Dr. Deitchler, by September 1999, the claimant was working full-time without taking medicine." (*Id.*)

Similarly, Dr. Jamison did not believe claimant suffered from chronic pain syndrome. Rather, he said that claimant's persistent pain that has ensued since his work injury was related to his "morbid obesity and generalized physical deconditioned status." (Ex. 40).

The record establishes that physical therapy helped claimant's low back condition. (Ex. 5). Claimant was prescribed Soma and Vicodin, which apparently helped his condition (Ex. 10), but were voluntarily discontinued. (Ex. 13). An epidural injection on April 7, 1999 provided "some improvement." (Ex. 11). In addition, chiropractic treatments provided "significant improvement." (Ex. 35). At hearing, claimant testified that his current pain medication, Zaltram, had helped and he said that chiropractic treatment had been helpful. (Tr. 9-10). Although Dr. Jayaram counseled claimant that his back pain would not get better unless he lost weight and stopped smoking (Ex. 27-3), it does not appear that claimant followed his advice or returned for further follow up care.

The record clearly establishes claimant was, indeed, responsive to narcotic analgesics and additionally was not disabled. He did return to work. The definition of the condition alleged by claimant has not been met.

Finally, I do not agree that Dr. Davis' opinion is sufficient to establish compensability of claimant's alleged chronic pain syndrome. Although Dr. Davis diagnosed chronic pain syndrome and attributed it to claimant's lumbar strain, he never explained what the condition was, or the basis for his diagnosis or conclusion. In the absence of a well-reasoned explanation for relating claimant's alleged pain syndrome to his accepted lumbar strain, I do not consider Dr. Davis' conclusions to be worthy of probative value. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980).[1] This is particularly the case when

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[1] As an example of this lack of clarity, Dr. Davis signed a concurrence letter from claimant's attorney stating that "chronic pain syndrome is a recognized DMSO category." (Ex. 42-2). "DMSO category" is neither defined nor otherwise explained by any medical expert whose opinion appears in this record. "DMSO" is defined in Dorland's *Illustrated Medical Dictionary* 500 (28th ed. 1994) as "dimethyl sulfoxide." *See SAIF v. Calder*, 157 Or App 224, 227 (1998) (Board may rely on medical dictionaries to define medical terms). An argument could be advanced that the "DMSO" reference was simply a typographical error and that the reference was actually intended to be "DSM-IV," which refers to a classification of mental illnesses and pain disorders. *See Diagnostic and Statistical Manual of Mental Disorders* 458-62 (4th Ed 1994); *Stedman's Electronic Medical Dictionary* v. 4.0 (1998)). Nonetheless, even if it was Dr. Davis' intention for "DMSO"to mean "DSM-IV," such an oversight further illustrates the fundamental lack of foundation provided by Dr. Davis' opinion.

Dr. Davis did not adequately respond to the opinions of Drs. Woodward and Jamison, who either questioned the diagnosis of chronic pain syndrome or attributed claimant's complaints to his preexisting degenerative disc disease, obesity, and deconditioning.

In sum, the record establishes that claimant was working full time and that "narcotic analgesics or customary treatment" were indeed helpful to his condition. Because the ultimate burden of proving the compensability of his claim rests with claimant, I agree with the employer that claimant has failed to prove that he suffers from chronic pain syndrome in the lumbar spine and, in any event, he has not established that it was caused in major part by his lumbar strain. Consequently, I would reverse the ALJ's order and reinstate the employer's denial.

In the Matter of the Compensation of
RICHARD VAUGHN, Claimant
Own Motion No. 99-0254M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights expired on July 24, 1996. The employer issued a denial of the compensability of claimant's current condition on July 1, 1999. Claimant timely appealed that denial. (WCB Case No. 99-05847). In addition, the employer 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 July 1, 1999 denial; however, he failed to appear at the scheduled hearing. The Administrative Law Judge (ALJ) found that there were no extraordinary circumstances for his failure to appear and issued an Order of Dismissal on July 18, 2000. That order has not been appealed. Thus, the current low back condition for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as the employer has not accepted claimant's current condition as compensable. Should claimant's circumstances change and the employer accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN BABCOCK, Claimant
WCB Case No. 99-06533
OWN MOTION ORDER
Mustafa T. Kasubhai, Claimant Attorney
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of his occupational disease claim for his bilateral carpal tunnel syndrome 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 Dr. Casey's opinion is not sufficient to meet claimant's burden of proof. First, in deposition, Dr. Casey agreed that his opinion regarding causation was based on a temporal relationship between the onset of symptoms and the work claimant was performing at the time he experienced such symptoms. (Ex. 17-24, 17-34). However, a temporal relationship analysis is not persuasive. *See Gormley v. SAIF*, 52 Or App 1055 (1981); *Beverly J. Kellow*, 49 Van Natta 741 (1997) (doctor's opinion that the claimant's condition was related to work was not persuasive where the opinion was primarily based on a temporal relationship between the claimant's carpal tunnel symptoms and her work).

Moreover, Dr. Casey reported that, with respect to the etiology of claimant's carpal tunnel syndrome, he believed that the carpal tunnel syndrome was not caused "simply from his diabetes and his smoking * * * ". Because "claimant became symptomatic while doing repetitive activities at work," Dr. Casey believed that the symptoms were related to the activity. (Ex. 14). In a deposition, Dr. Casey again stated that the work activities led to claimant becoming "symptomatic." (Ex. 17-34). There is no discussion by Dr. Casey that establishes that the symptoms in this case are the "disease."[1] *See Teledyne Wah Chang v. Vorderstrasse*, 104 Or App 498, 501 (1990); *Georgia Pacific Corp. v. Warren*, 103 Or App 275, 278 (1990), *rev den* 311 Or 60 (1991). Consequently, a worsening of symptoms alone is not sufficient to prove an occupational disease. *Weller v. Union Carbide*, 288 Or 27 (1980); *Wendy R. Bye*, 49 Van Natta 636 (1997).

Finally, Dr. Casey testified that claimant had been diabetic and a smoker for years, so when claimant gave him a history that it was his work-related activity, Dr. Casey believed that "it was medically probably that it was work-related activity that did that." Dr. Casey first acknowledged that, "one could of course argue that that was simply the straw that broke the camel's back." (Ex. 17-24). Dr. Casey's opinion could be construed as a "precipitating cause" analysis, which would not be sufficient. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (fact that work activities precipitated a claimant's disease does not necessarily mean that work was the major contributing cause of the condition). Even if we do not construe his opinion in that manner, we would nevertheless find that Dr. Casey's opinion does not explain why the work exposure contributed more to the carpal tunnel than the other factors identified as contributors. *Id.; Elizabeth M. Buitron*, 51 Van Natta 1768 (1999).

Consequently, for the above mentioned reasons, we do not find that Dr. Casey's opinion meets claimant's burden of proof. We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated April 25, 2000 is affirmed.

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[1] Dr. Casey also conceded that, in such a case, the first appearance of symptoms does not necessarily establish when the condition actually came into existence. (Ex. 17-25).

In the Matter of the Compensation of
GLENETTE R. WILLIAMS, Claimant
WCB Case Nos. 99-07100 & 99-05568
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its compensability and responsibility denial of claimant's bilateral foot condition issued on behalf of Pendleton Grain Growers (PGG); and (2) upheld the compensability and responsibility denial of the same condition issued by the self-insured employer, Bi-Mart. On review, the issues are compensability and responsibility.[1]

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

In deciding responsibility, the ALJ determined that claimant first sought medical treatment for her bilateral foot condition while employed by PGG. Accordingly, the ALJ assigned initial responsibility to SAIF under *Timm v. Maley*, 125 Or App 396 (1993). The ALJ then noted that SAIF could shift responsibility to Bi-Mart, the self-insured employer, if it could establish that subsequent employment conditions independently contributed to a pathological worsening of the bilateral foot condition. *See Spurlock v. International Paper Co.*, 89 Or App 461 (1988). The ALJ, however, determined that SAIF failed to do so. In making this determination, the ALJ observed that Dr. Carlson, who authored the sole medical opinion addressing "independent contribution," concluded that claimant's work activities for Bi-Mart did not independently contribute to a pathological worsening of the bilateral foot condition.

On review, SAIF contends that, under the court's subsequent decision in *Timm v. Maley*, 134 Or App 245 (1995), we could "infer" that claimant's employment at Bi-Mart caused a worsening of claimant's bilateral foot condition from the fact that claimant's symptoms worsened and she became disabled and developed a new bone spur during her employment at Bi-Mart. We disagree.

In *Maley*, the court held that the Board could reasonably infer that the claimant's condition worsened during the period in which the employer was noncomplying when there was evidence of the dramatic exacerbation of pain, along with evidence that the claimant suffered from a marked limitation in range of motion in her low back, that tenderness had radiated into another area and that the claimant was required to curtail the number of hours she worked. The court also noted that it was not a case in which the treating physician opined that there was only an increase in symptoms. 134 Or App at 249.

If, in this case, the only evidence on whether claimant's employment at Bi-Mart had worsened the bilateral foot condition consisted of the facts SAIF listed, then we might be justified under *Maley* to infer a worsening. However, unlike *Maley*, where the attending physician did not opine that there had only been an increase in symptoms, in this case Dr. Carlson specifically addressed the worsening issue and expressly concluded that claimant's employment at Bi-Mart did not independently contribute to a worsening of the bilateral foot condition. Under these circumstances, we are unwilling to "infer" a worsening from other evidence when there is a medical opinion that directly addresses the relevant issue and indicates that claimant's employment at Bi-Mart did not independently contribute to a worsening of the bilateral foot condtion. *See Industrial Indemnity Co. v. Weaver*, 81 Or App 493, 497 (1986) (concluding that where the medical evidence indicated that the employment had worsened symptoms, but not the underlying condition, the Board did not err in finding that the employment had not caused a worsening of the condition).

On this record, we agree with the ALJ that SAIF failed to shift responsibility to Bi-Mart. Therefore, we affirm.

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[1] Included with claimant's brief was a "Motion for Leave to File Respondent's Brief Beyond the Time Allowed by OAR 438-11." Inasmuch as no party objected to the timeliness of claimant's brief, we have considered it on review.

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

ORDER

The ALJ's order dated April 17, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
JOSHUA G. ZEIGLER, Claimant
WCB Case No. 99-08633
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) denied his request for a continuance of the hearing; and (2) upheld the SAIF Corporation's denial of his occupational disease claim for his right trigger finger and bilateral carpal tunnel syndrome condition. Contending that the ALJ abused his discretion by denying his request for a continuance, claimant seeks remand. On review, the issues are evidence, remand and compensability. We deny the request for remand, and affirm on the merits.

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

On review, claimant argues that the ALJ abused his discretion by denying claimant's motion for a continuance. ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See e.g. Brown v. SAIF*, 51 Or App 389 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

Here, we agree with and adopt the ALJ's reasoning (as set forth on page 1 of the Opinion and Order) regarding his denial of claimant's motion to continue the hearing. Consequently, we find no abuse of discretion on the part of the ALJ, and claimant's request for remand is denied.

ORDER

The ALJ's order dated April 14, 2000 is affirmed.

In the Matter of the Compensation of
ARTHUR R. EVELAND, Claimant
WCB Case No. 99-07883
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant AttorneyS
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its partial denial of claimant's claim for an L2-3 disc herniation. On review, the issue is compensability.

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

On review, SAIF argues that the ALJ should not have deferred to the opinion of claimant's treating surgeon, Dr. Belza. SAIF contends that Dr. Belza incorrectly based his causation opinion on a history of claimant having low back pain only since the February 1999 work incident. SAIF argues that Dr. Belza's opinion is inaccurate because it has not considered claimant's history of prior low back pain. SAIF further contends that Dr. Belza's opinion is not persuasive because it is based on a "precipitating cause" analysis. We disagree.

Dr. Belza specifically noted that claimant had undergone "chiropractic care for muscle strains and aches in his low back for a number of years." (Ex. 37-2). Consequently, we find that Dr. Belza was aware of claimant's past history of treatment for aches and strains. Moreover, in arriving at his opinion regarding causation, Dr. Belza did not solely rely on a precipitating cause analysis. In his final report, Dr. Belza noted that, in addition to the fact that claimant had not had treatment for his back for a year prior to the February 1999 incident, claimant had a "significant event" on that day which caused immediate and severe pain and he then had a progressive worsening of his condition. (Ex. 54).

Dr. Belza had previously explained that the twisting mechanism of the injury in February 1999 was consistent with a diagnosis of a herniated disc. Dr. Belza reported that, unlike claimant's prior soft tissue injuries which resolved without any permanent impairment, the 1999 injury resulted in "persistent radicular symptoms, including left hip and quadriceps weakness, and a sensory deficit in an L2 distribution." (Ex. 50). Finally, Dr. Belza also reviewed claimant's x-rays and MRI scan and considered the contribution of his mild degenerative changes at the lower lumbar levels, but did not find them as significant as the twisting incident. (Ex. 50-2).

Under the circumstances, we conclude that Dr. Belza's opinion is not merely based on a precipitating cause analysis. Rather, Dr. Belza has also considered claimant's history, the mechanism of the injury, claimant's current and past symptoms, his objective findings and the results of his x-rays and MRI scan. Dr. Belza has also weighed any possible contribution from claimant's preexisting condition and has explained why the injury is the major cause of claimant's need for treatment for the combined condition. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995); *Richard C. Purdy*, 49 Van Natta 1272 (1997). Therefore, we agree with the ALJ that Dr. Belza has provided a persuasive opinion and based on that opinion, claimant has met his burden of proof.

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

ORDER

The ALJ's order dated April 26, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,400, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DALE L. HASKINS, Claimant
WCB Case No. 99-06785
ORDER ON REVIEW
Juli Point, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that awarded claimant's counsel an assessed attorney fee of $10,795 for services at hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

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

On November 17, 1999, a hearing was held following claimant's request for hearing concerning SAIF's "current combined condition" denial of his disability and need for treatment for his cervical condition after March 13, 1999. The hearing lasted approximately 4 1/2 hours. Claimant testified at hearing and nine additional witnesses were called to testify on behalf of claimant. Two witnesses testified for SAIF.

Seventy four exhibits were submitted at hearing; eleven of which were generated by claimant's counsel. One deposition of a physician was taken at claimant's request.

Following the hearing, claimant's counsel submitted a statement of services which provided that 63.5 hours had been spent on the case at an hourly rate of $170.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded an attorney fee of $10,795 after considering claimant's counsel's statement of services and the factors set forth in OAR 438-015-0010(4). The ALJ noted that the statement of services had not been rebutted.[1] On review, SAIF contends that the ALJ's attorney fee was excessive. SAIF argues that an assessed fee of $4,000 would be a more appropriate fee in this case.

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4). Those factors are: (1) the time devoted to the case; (2) the complexity of the issue involved; (3) the value of the interest involved; (4) the skill of the attorneys (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

Here, SAIF has provided several reasons for challenging the amount of the ALJ's attorney fee award. First, SAIF contends that the statement of services provides for time spent by claimant's counsel prior to the denial at issue. SAIF contends that several of the entries in the statement of services pertain to time spent on issues unrelated to overturning the denial (such as vocational or termination issues). SAIF also argues that paralegal time has been included in counsel's statement of services at a rate of $170 per hour. Finally, SAIF notes that, while claimant's counsel listed her hourly rate at $170 per hour multiplied by 63 hours in order to reach the total awarded by the ALJ, claimant's counsel also set forth in the statement of services that her customary fee for such cases is $140 per hour. Consequently, SAIF contends that counsel essentially applied a multiplier in this case.

On review, claimant does not dispute the contentions listed by SAIF, although claimant's counsel argues that she does not have paralegal services and is required to perform such work herself. Claimant further argues, however, that if the risk to counsel, the value of the case, and the skill of the attorneys is considered, the case should have actually resulted in a fee higher than the one awarded by the ALJ.

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[1] SAIF filed no objection to claimant's statement of services prior to the issuance of the Opinion and Order.

We conclude that the statement of service time attributed to time not spent in overturning the denial, or in matters not involving this case (such as termination and vocational issues) cannot be considered as a basis for the attorney fee award. Moreover, we have previously held that legal assistant time can only be considered if it represents hours devoted to "research and investigation" which were subject to supervision by an attorney. *See Jamie J. Boldway*, 52 Van Natta 755 (1999); *Candace L. Spears*, 47 Van Natta 2393, 2394 n 1 (1995). Here, some of the services for which a fee is sought consisted of tasks that were secretarial in nature (such as faxing documents). We see no reason to distinguish between a case in which the attorney performed the tasks herself, rather than hiring a paralegal to do so. Because there has been no contention that the "paralegal" services involved research or investigation, we do not include them in our consideration of an attorney fee.

Finally, by listing her customary charge for a non-contingent fee case as $140 in claimants counsels statement of services, and then explaining that workers' compensation cases do not take into account necessary costs, we agree with SAIF that it appears as though a multiplier has been applied in this statement of services to arrive at an hourly rate of $170.[2] To the extent that costs represent the expenses attributable to a claimant's attorney in pursuing denied claims and the risk that an attorney might go uncompensated for those services, such consideration is encompassed within the Board's attorney fee rules. *Boldway*, 52 Van Natta at 756, n 2. However, our consideration of the general contingency factor under OAR 438-015-0010(4)(g) is not by a strict mathematical factor. *Cheryl Mohrbacher*, 50 Van Natta 1826 (1998).

With respect to the remaining factors, we find that the hearing was longer than average and the complexity of the case was above average in terms of the medical evidence. Finally, we agree with the ALJ that claimant's counsel is skilled and experienced, as reflected in the qualifications noted in her statement of services. Moreover, considering the conflicting medical opinions, there was a significant risk that claimant's counsel's efforts might have gone uncompensated.

Based upon application of each of the previously enumerated rule-based factors and considering the parties' arguments, we conclude that $7,000 is a reasonable attorney fee for services at hearing in this case. In reaching this determination, we have primarily considered factor such as the time devoted to the case (as represented by the record, as well as claimant's counsel's statement of services and SAIF's objections), the value of the interest involved, the complexity of the issues, the nature of the proceedings, the skill and standing of claimant's counsel, and the risk that claimant's counsel might go uncompensated. Accordingly, we modify the ALJ's attorney fee award.

ORDER

The ALJ's May 10, 2000 order is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award of $10,795, claimant's counsel is awarded an attorney fee of $7,000 for services at hearing, to be paid by the SAIF Corporation. The remainder of the ALJ's order is affirmed.

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[2] Claimant's counsel is not correct in stating in her statement of services that costs such as traveling to a deposition are not considered in workers' compensation cases. *See, e.g. Marilyn E. Keener*, 49 Van Natta 110, 113 (1997) (attorney's time preparing for, traveling to, and attending depositions considered in assessing a reasonable attorney fee).

In the Matter of the Compensation of
MYRNA GARDNER, Claimant
WCB Case Nos. 99-07634 & 99-04687
ORDER OF ABATEMENT
Stoel Rives, Defense Attorneys

Claimant, *pro se*, requests reconsideration of our July 28, 2000 Order on Review that adopted and affirmed the Administrative Law Judge's order which: (1) upheld the self-insured employer's partial denial of her left ankle pain over dorsum; and (2) reduced her scheduled permanent disability award for the loss of use or function of her left foot (ankle) from 19 percent (25.65 degrees), as awarded by an Order on Reconsideration, to zero.

In order to consider claimant's motion, we withdraw our July 28, 2000 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT A. OLSON, Claimant
WCB Case No. 99-09253
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) directed SAIF to reopen claimant's right knee strain claim for the processing and closure of his "post-closure" accepted right medial meniscus and right patellar displacement conditions under ORS 656.262 and ORS 656.268; (2) set aside SAIF's Own Motion Notice of Claim Closure; (3) awarded claimant temporary disability; (4) assessed a penalty for allegedly unreasonable claim processing; and (5) awarded a carrier-paid attorney fee under ORS 656.386(1). On review, the issues are claim processing, temporary disability, penalties and attorney fees.[1] 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 Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant, a hook tender, originally injured his right knee in a logging accident on June 12, 1975. His claim was accepted by SAIF for an unknown condition (a numerical code) on June 30, 1975. (Ex. 5). On July 8, 1975, claimant underwent surgical removal of the right medial meniscus, the lateral meniscus, and accessory ossification centers of the right patella. (Ex. 6).

Claimant's claim was originally closed by virtue of a December 23, 1975 Determination Order, awarding 10 percent scheduled permanent disability for loss of use or function of the right leg. (Ex. 9). Claimant then had a second surgery for removal of a loose body in his right knee. His claim was reclosed by a Determination Order on December 11, 1980 for a total award of 30 percent (45 degrees) scheduled permanent disability. (Ex. 13).

In January 1999, claimant again sought treatment for his right knee. Claimant's claim was reopened in "Own Motion" status by a February 19, 1999 Own Motion order. (Ex. 39). Claimant did not request review of this order. Dr. Mohler performed a total knee replacement surgery on April 4, 1999. On July 6, 1999, SAIF issued a modified Notice of Acceptance for posttraumatic arthritis of the right knee. (Ex. 28). On September 15, 1999, SAIF issued an Own Motion Notice of Closure awarding temporary disability benefits. (Ex. 30). Claimant appealed this Notice of Closure to the Board.

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[1] 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 or could have a substantial impact on the workers' compensation system. *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. Therefore, claimant's request for oral argument is denied. *See Jeffrey L. Dennis*, 52 Van Natta 344 n4 (2000).

On February 2, 2000, claimant requested the acceptance of a torn right medial meniscus and a right patellar displacement condition. (Ex. 36a). On February 15, 2000, SAIF responded that the existing notices of acceptance "reasonably apprised" claimant of the nature of the compensable conditions, and that all benefits related to the claim would continue to be paid. (Ex. 39). Claimant requested a hearing.

The ALJ directed SAIF to reopen claimant's claim for the processing of the meniscus and patellar conditions. Finding a "de facto" denial of these conditions, the ALJ awarded claimant an assessed attorney fee pursuant to ORS 656.386(1). Relying on *John R. Graham*, 51 Van Natta 1740 (1999), the ALJ also set aside SAIF's September 15, 1999 Own Motion Notice of Closure, awarded claimant temporary disability benefits, and assessed a penalty for SAIF's unreasonable failure to pay these temporary disability benefits.

Claim Processing

The ALJ directed SAIF to reopen claimant's claim for processing of his "post-closure" conditions of right medial meniscus tear and right patellar displacement. On review, SAIF first contends that the Board lacks jurisdiction over claimant's request for hearing regarding reopening of the claim. We disagree. Insofar as claimant's request pertains to SAIF's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ had jurisdiction over the matter. ORS 656.283(7); *Larry L. Ledin*, 52 Van Natta 682, 683 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000).

SAIF next contends that claimant is precluded from seeking that his claim be reopened under ORS 656.262 and ORS 656.268, as opposed to ORS 656.278 (the "Own Motion" statute) because he did not challenge our February 19, 1999 Own Motion order. We disagree.

In *Larry L. Ledin*, 52 Van Natta at 683, we held that the claimant was not barred by an earlier Own Motion order from seeking reopening and processing of his right knee torn meniscus condition. ORS 656.262(7)(c); *see also Craig J. Prince*, 52 Van Natta at 108; *John R. Graham*, 51 Van Natta at 1740. Accordingly, the ALJ correctly decided that claimant was not barred from seeking reopening of his newly accepted conditions because of our earlier Own Motion proceedings.

SAIF next argues that, irrespective of the finality of the Own Motion Closure order, claimant cannot seek benefits beyond what is provided in ORS 656.278 because his aggravation rights have expired. We disagree. In *John R. Graham*, 51 Van Natta at 1744, we held that, where a "new medical condition" claim is accepted after claim closure, the claim must be reopened under ORS 656.262(7)(c) for the payment of benefits (including the payment of temporary disability benefits under ORS 656.262 and claim closure under ORS 656.268) that would have been due if that new medical condition claim had been accepted, even where the claimant's aggravation rights had expired on the original claim. *See also Fleetwood Homes of Oregon v. Vanwechel*, 164 Or App 637, 641 (1999); *Larry L. Ledin*, 52 Van Natta at 684.

Finally, SAIF contends that claimant is barred from requesting a hearing under ORS 656.319(6), which imposes a two year limit on requests for hearing regarding claims processing issues. We disagree. Because SAIF did not raise this issue at hearing, we decline to address it on review. *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

Moreover, the alleged claims processing violation was SAIF's failure to process claimant's February 2, 2000 omitted medical condition claim. (Ex. 36a). The period between the alleged failure to process the medial meniscus and patellar conditions under ORS 656.262(6)(d) and claimant's request for hearing was well within the two year limitation of ORS 656.319(6).

Own Motion Notice of Closure

SAIF next contends that the ALJ erred in declaring null its September 15, 1999 Own Motion Notice of Closure. We agree that the ALJ did not have the authority to alter the Own Motion closure order. In *Larry L. Ledin*, 52 Van Natta 680 n3 (2000) (*Ledin* Own Motion order), a decision issued subsequent to the ALJ's order, we held that, pursuant to ORS 656.278, the Board, not the Hearings Division, has continuing authority to alter Own Motion awards. ORS 656.278(1).

As authority for setting aside SAIF's September 15, 1999 Notice of Closure as a nullity, the ALJ cited to *John R. Graham*, 51 Van Natta at 1745. However, subsequent to the ALJ's order, in *Larry L. Ledin*, we held that an ALJ did not have jurisdiction to review the claimant's request for hearing insofar

as it pertained to an Own Motion order. 52 Van Natta at 683. It follows here that the ALJ did not have the authority to set aside SAIF's September 15, 1999 Own Motion Notice of Closure.

Moreover, the ALJ erred in awarding claimant a specific period of temporary total disability benefits. The payment of temporary disability benefits is a processing obligation of the insurer, and as such, flows directly from an ALJ's order reopening a claim. In other words, unless expressly requested by the parties, it is unnecessary for an ALJ to identify a precise date for commencement and/or termination of the payment of temporary disability benefits.

In any event, the September 15, 1999 Own Motion Notice of Closure has already awarded temporary disability benefits from April 2, 1999 through August 27, 1999.[2] (Ex. 30). Inasmuch as claimant is not entitled to receive more than the statutory sum of benefits for a single period of temporary disability benefits, the temporary disability benefits paid pursuant to the Own Motion Notice of Closure will need to be considered in processing claimant's claim under ORS 656.262 and ORS 262.268. *See Billy W. Washington*, 52 Van Natta 734 n5 (2000).

Accordingly, we reverse that portion of the ALJ's order that awarded a specific period of temporary disability benefits.

Attorney Fee - ORS 656.386(1)

SAIF contends that the ALJ erred in awarding a carrier-paid attorney fee under ORS 656.386(1) for claimant's services in securing the acceptance of claimant's right knee medial meniscus and patellar displacement conditions. We disagree. Here, it is unclear from its original Notice of Acceptance what condition SAIF initially accepted. (Ex. 5). However, on July 6, 1999, SAIF issued a Modified Notice of Acceptance alleging that it had previously accepted claimant's claim for "right knee sprain/stain" and was now broadening its acceptance to include "Post traumatic osteoarthritis of the right knee." (Ex. 28). SAIF never specifically accepted either a medial meniscus or patellar displacement condition.

Nevertheless, SAIF contends that its notices of acceptance "reasonably apprise" claimant and medical providers of the nature of the compensable conditions. ORS 656.262(7)(a). First, we note that claimant's request is properly characterized as an "omitted" medical condition claim under ORS 656.262(6)(d), because the medial meniscus and patellar displacement conditions were in existence at the time of SAIF's initial Notice of Acceptance dated June 30, 1975. (Exs. 4, 5). *Mark A. Baker*, 50 Van Natta 2333 (1998). ORS 656.262(6)(d) does not contain the "reasonably apprises" language of ORS 656.262(7)(a), which applies to "new medical condition" claims. *See Gilbert M. Sanchez*, 51 Van Natta 248 (1999).

Moreover, even if ORS 656.262(7)(a) applies, there is no evidence that claimant or his physicians have been "reasonably apprised" of claimant's right knee conditions. (Tr. 12). Claimant's testimony is not sufficient by itself to satisfy his burden of proving that the Notice of Acceptance should be expanded; the "reasonably apprises" language in ORS 656.262(7)(a) contemplates an objective standard. *Michal A. Fleming*, 52 Van Natta 383 (2000). Nevertheless, there is no medical evidence that the currently accepted conditions of right knee sprain/strain and post-traumatic osteoarthritis encompass either a medial meniscus or patellar displacement condition. *See Cynthia J. Thiesfeld*, 51 Van Natta 984 (1999).

Finally, SAIF argues that, given the unspecific nature of its original Notice of Acceptance, we should look to the contemporaneous medical records to determine what conditions have been accepted, citing to *Timothy Hasty*, 46 Van Natta 1209 (1994). SAIF contends that, because claimant's medial meniscus and patellar displacement conditions were diagnosed at the time of its original Notice of Acceptance, we should find that those conditions were in fact accepted. (*See* Ex. 6). We disagree. Although SAIF's June 30, 1975 Notice of Acceptance is unclear as to what conditions had been accepted at that time, it later issued a modified notice of acceptance representing that it had accepted the conditions of "right knee sprain/strain" and posttraumatic arthritis. (Ex. 28).

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[2] The Own Motion Notice of Closure has been affirmed by a separate Own Motion order issued this date.

Based on SAIF's representation, we find that its 1975 acceptance pertained to claimant's right knee sprain/strain. Consequently, that acceptance (as well as its subsequent acceptance of posttraumatic arthritis) did not encompass claimant's medial meniscus and patellar displacement conditions.

We therefore affirm the portion of the ALJ's order that awarded a $1,000 assessed attorney fee pursuant to ORS 656.386(1) for services in securing the acceptance of claimant's medial meniscus and patellar displacement conditions.

Penalty on TTD

The ALJ assessed a 25 percent penalty on unpaid temporary disability for SAIF's allegedly unreasonable claims processing. ORS 656.262(11). On review, SAIF contends that such a penalty was unwarranted, given its challenge to the existing state of the law regarding reopening of claims when the aggravation rights on an original claim have elapsed. We agree.

Initially, we note that our *Ledin* decision had not yet issued at the time of the ALJ's order. *Ledin* clarified the state of the law regarding jurisdiction and reopening of claims for new conditions accepted after claim closure when the claimant's original claim is in Own Motion status. Considering such circumstances, it was not unreasonable for SAIF to fail to pay temporary disability benefits. In reaching this conclusion, we note that, where the law is in a state of flux, the insurer's colorable interpretation of the law may be objectively reasonable, thus avoiding a penalty for allegedly unreasonable claims processing. *Bertha J. Miner*, 40 Van Natta 518, 519 (1987). Such is the case here. Accordingly, we reverse that portion of the ALJ's order that assessed a penalty on unpaid temporary disability benefits.

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 $2,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the claim processing issues (as represented by claimant's respondent's brief, claimant's attorney's fee request and SAIF's response), the complexity of the claims processing issues, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services on review regarding the temporary disability, Own Motion, penalty and attorney fee issues.

ORDER

The ALJ's order dated April 3, 2000 is reversed in part and affirmed in part. Those portions of the ALJ's order that set aside SAIF's September 15, 1999 Own Motion Notice of Closure, awarded claimant temporary disability, and assessed a penalty are reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $2,500, payable by SAIF.

August 29, 2000 Cite as 52 Van Natta 1543 (2000)

In the Matter of the Compensation of
JIMMY L. MASSEY, Claimant
Own Motion No. 99-0442M
OWN MOTION ORDER OF ABATEMENT
Richard A. Sly, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 10, 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
ROBERT A. OLSON, Claimant
WCB Case No. 99-0065M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests review of the SAIF Corporation's September 15, 1999 Own Motion Notice of Closure that closed his claim with an award of temporary disability from April 2, 1999 through August 27, 1999. SAIF declared claimant medically stationary as of July 2, 1999. Claimant requests that we set aside the closure because he is not yet medically stationary. We affirm SAIF's September 15, 1999 Own Motion Notice of Closure.

FINDINGS OF FACT[1]

On June 12, 1975, claimant compensably injured his right knee while working for SAIF's insured. Claimant sought treatment with Dr. Degge, who diagnosed possible right knee tear of the medial semilunar cartilage, accessory ossification centers, superior lateral pole of the right patella and lateral displacement of the meniscus. On July 8, 1975, Dr. Degge performed a surgery on claimant's right knee for removal of the right medial meniscus, the lateral meniscus, and accessory ossification centers of the patella. (Ex. 6). Claimant's claim was originally closed by virtue of a December 23, 1975 Determination Order, awarding 10 percent scheduled permanent disability for loss of use or function of his right leg. (Ex. 9).

On April 9, 1980, claimant underwent a second surgery for removal of a loose body in his right knee. (Ex. 10). His claim was reclosed by a December 10, 1980 Determination Order for a total award of 30 percent scheduled permanent disability. (Ex. 13).

In January 1999, claimant returned for treatment on his right knee. A February 19, 1999 Own Motion order reopened his claim for the payment of temporary total disability benefits. On April 4, 1999, Dr. Mohler performed a total knee replacement surgery. (Ex. 20).

On July 6, 1999, SAIF issued a modified notice of acceptance which accepted post traumatic osteoarthritis of the right knee. (Ex. 28). On August 26, 1999, after being presented with the definition of "medically stationary," Dr. Mohler stated that claimant became medically stationary on July 2, 1999. (Ex. 29). On September 15, 1999, SAIF issued an Own Motion Notice of Closure awarding temporary total disability benefits through August 26, 1999. (Ex. 30). On October 4, 1999, Dr. Mohler stated that he had misunderstood the interrelation between medically stationary and release to work status and that he was now revising his earlier opinion to state that claimant would not be medically stationary until April 2000. (Ex. 31).

CONCLUSIONS OF LAW AND OPINION

Claimant's "Motion to Strike"

On December 17, 1999, claimant moved to strike SAIF's "unsolicited" December 14, 1999 letter to the Board, contending that the Board never invited argument regarding its Own Motion proceedings. In its December 14, 1999 letter, SAIF contended that claimant's failure to request review of our February 19, 1999 Own Motion order precluded him from arguing that SAIF should process his new medical condition claims. Because we have resolved this issue adversely to SAIF in our "regular jurisdiction" Order on Review issued this date, it is unnecessary to address claimant's "Motion to Strike" SAIF's letter.

Own Motion Notice of Closure

The Board's Own Motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. *Miltenberger v. Howard's Plumbing*, 93 Or App 475, 477 (1988). In

[1] Some of these findings, and the referenced exhibit numbers, are taken from the record of WCB Case No. 99-09253, the separate case decided in our "regular" jurisdiction on today's date.

cases where the aggravation rights have expired, we may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a).[2] In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, there is no dispute that claimant's aggravation rights have expired on his initial injury claim. Moreover, because claimant's condition required surgery, we had the authority to reopen claimant's claim pursuant to ORS 656.278(1)(a) when we issued the February 19, 1999 Own Motion order. Consequently, we had subject matter jurisdiction when we issued the February 19, 1999 Own Motion order authorizing the reopening of the claim and directing SAIF to close the claim under our Own Motion rules when claimant's condition became medically stationary. Thus, our February 19, 1999 Own Motion order was validly issued under ORS 656.278. Accordingly, we now have subject matter jurisdiction to review SAIF's subsequent closure of the claim. We therefore proceed with our review.

A claim may not be closed unless the claimant's condition is medically stationary. ORS 656.268(1); OAR 438-012-055(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. Weyerhaueser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the September 15, 1999 Notice of Closure, considering claimant's condition at the time of closure and not subsequent developments. ORS 656.268(1); *Sullivan v. Argonaut Insurance Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985).

The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980). The only medical evidence regarding claimant's medically stationary status is from Dr. Mohler, who performed claimant's total knee replacement surgery on April 4, 1999.

On June 16, 1999, Dr. Mohler estimated that claimant would be medically stationary in "another six weeks," the time of his next visit. (Ex. 25). On August 26, 1999, Dr. Mohler responded to a letter from SAIF by indicating that claimant became medically stationary on July 2, 1999. (Ex. 29). SAIF's letter provided Dr. Mohler with the definition of "medically stationary" as set forth in the Administrative Rules. (*Id.*)

However, on October 4, 1999, Dr. Mohler stated that "It takes usually one year before patients have reached maximal improvement following total knee replacement." (Ex. 31). Dr. Mohler further stated that he "did not understand the relationship between medically stationary status and return to work," and indicated his belief that "by making [claimant] medically stationary he would be released to work." (*Id.*) In light of that "understanding," Dr. Mohler then revised his earlier statement and stated that claimant "is not medically stationary and will not be so until April 2000." (*Id.*)

Read as a whole, we interpret Dr. Mohler's October 4, 1999 letter to focus on claimant's ability to return to work, rather than on his medically stationary status. Despite Dr. Mohler's purported prior "misunderstanding" as to the interrelation between claimant's medically stationary and return to work status, it appears instead that he has confused the two concepts in his October 4, 1999 letter. "Medically stationary" means that the patient will not experience material improvement through further treatment or the passage of time. ORS 656.005(17). It does not mean the claimant is "released to work." These two concepts are entirely separate in the statute. *See* ORS 656.268(4) (describing circumstances in which claimant's temporary disability benefits can be terminated based on return to work status). It is not clear from Dr. Mohler's October 4, 1999 letter that he believes claimant will not be "medically stationary," as opposed to "not released for work," until April 2000.

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[2] ORS 656.278(1)(a) provides: "(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

> "(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

Moreover, Dr. Mohler's statement that it "usually takes one year before patients have reached maximal improvement following total knee replacement surgery" is general rather than specific to claimant. Dr. Mohler's prediction that claimant will not be medically stationary until April 2000 is also speculative (based on possibilities) rather than based on reasonable medical probability. *Gormley v. SAIF*, 52 Or App 1055 (1981); *John W. Blankenship*, 52 Van Natta 406 (2000). In sum, we do not find that Dr. Mohler's October 4, 1999 letter persuasively establishes a medically stationary date different from July 2, 1999.

On this record, we find that claimant was medically stationary as of July 2, 1999. Nothing in the record indicates that claimant's medically stationary status changed from that date until his claim was closed on September 15, 1999. Therefore, we find that claimant's right knee condition was medically stationary at closure. Accordingly, we affirm SAIF's September 15, 1999 Notice of Closure in its entirety.[3]

IT IS SO ORDERED.

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

In the Matter of the Compensation of
D.A. SAGE, Claimant
WCB Case No. 99-07130
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) declined to admit Exhibits 26 and 27 into evidence; and (2) upheld the insurer's denial of her occupational disease claim for a bilateral eye 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 regarding the evidentiary issue.

After the December 13, 1999 hearing, the record was left open so that the parties could depose Dr. Bilstrom. The deposition occurred on January 14, 2000, with claimant's counsel participating by telephone. The deposition began late due to a clerical error in claimant's attorney's office, so the parties had approximately 50 minutes to question Dr. Bilstrom, rather than the originally allocated one and one-half hours. Although the insurer's attorney completed her questioning, claimant's counsel indicated that she wished to ask additional questions. (Ex. 19-33).

Claimant's attorney requested that the deposition be reconvened. The insurer's counsel stated that she would not object to claimant's counsel obtaining an additional written report from Dr. Bilstrom, but that any reconvening of the deposition would be at claimant's expense. On February 8, 2000, claimant's attorney advised the ALJ that she had written Dr. Bilstrom and requested an additional report.

On February 17, 2000, claimant returned to Dr. Bilstrom to clarify whether her eye condition improved when windows were opened in her office. (Ex. 26). Dr. Bilstrom responded to claimant's request for an additional report with reports dated February 22, 2000 (Ex. 26) and March 3, 2000 (Ex. 27). On March 6, 2000, claimant submitted the proposed exhibits for inclusion into the record.

Unrecorded closing arguments occurred on April 6, 2000. It appears that the disputed exhibits were initially admitted into evidence and that claimant's attorney then presented her closing argument. After that, the insurer's counsel objected to the admission of Exhibits 26 and 27. (recorded closing argument p. 8). The ALJ sustained the insurer's objection and excluded the disputed exhibits from the record.

The parties later reconvened on April 13, 2000 to record arguments on the evidentiary issue. The ALJ adhered to his decision to exclude the disputed exhibits. The ALJ rejected claimant's argument that the insurer's objection to the disputed exhibits was untimely, reasoning that closing argument was the first opportunity for the insurer to present a formal objection and that the two exhibits did not reflect new information, but rather contained facts that could have been presented to Dr. Bilstrom before the hearing. (recorded closing argument p. 9).

On review, claimant contends that the ALJ abused his discretion in declining to admit the disputed exhibits into evidence because the insurer's objections were not made until closing argument. Moreover, claimant emphasizes that the insurer had agreed to allow claimant to obtain an additional written report and only objected because claimant had discussed her condition with Dr. Bilstrom after the deposition and before he submitted his reports.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

We find no abuse of discretion in the ALJs decision to reject the disputed exhibits. Although claimant likens the insurer's objection to the disputed exhibits to raising a "new issue" during closing argument, *see Lawrence E. Millsap*, 46 Van Natta 2112 (1995), the ALJ could reasonably have found that this was the first opportunity in which to formally object to admission of the disputed reports. Moreover, while the insurer agreed to allow claimant to obtain written evidence from Dr. Bilstrom, it did not agree that, as part of that process, claimant could provide additional information to Dr. Bilstrom (after she had already testified at hearing) that was not subject to cross-examination.

In any event, even if we considered the disputed exhibits, we would still affirm the ALJ's determination that claimant failed to prove a compensable occupational disease claim. After reviewing Dr. Bilstrom's deposition testimony, the ALJ determined that claimant did not sustain her burden of proof because Dr. Bilstrom no longer supported his earlier report that implicated claimant's employment as the major factor in causing claimant's bilateral eye condition.[1] Dr. Bilstrom, however, in the disputed reports returned to his prior position after claimant informed him that her eye condition improved when windows were opened at work, but that noise, cold air and wind prevented her from keeping a window open. (Ex. 26, 27).

However, this "post-hearing" information is at odds with claimant's hearing testimony that opening windows at work did not help her condition and that this was true even though at one point she had opened the windows every day (even during the winter). (Tr. 86). Claimant testified that "I still experienced the problem even with the windows open." *Id.*

In light of claimant's hearing testimony, we are not persuaded that the information claimant provided to Dr. Bilstrom after his deposition was accurate. Therefore, we conclude that the "post-deposition" medical evidence from Dr. Bilstrom is insufficient to satisfy claimant's burden of proof, even if we considered it.

ORDER

The ALJ's order dated May 1, 2000 is affirmed.

[1] We agree with the ALJ's reasoning.

In the Matter of the Compensation of
MICHAEL STEWART, Claimant
Own Motion No. 99-0199M
SECOND OWN MOTION ORDER ON RECONSIDERATION

On August 4, 2000, as reconsidered August 15, 2000, we issued an Own Motion Order Reviewing Carrier Closure that affirmed the self-insured employer's March 22, 2000 Notice of Closure in its entirety. In those orders, we explained that: (1) claimant's claim was accepted for a left knee condition; and (2) the record did not indicate that an ankle/foot condition was accepted by the employer. On that basis, we rejected claimant's contention that the need for treatment for his ankle/foot conditions established that he was not medically stationary regarding his accepted left knee condition when the employer closed his claim. Instead, we found that the medical evidence from Dr. Gordin, claimant's attending physician, established that claimant's accepted left knee condition was medically stationary at claim closure.

On August 21, 2000, the Board received an August 16, 2000 correspondence from claimant written at the bottom of a copy of a May 2, 1990 chart note from Dr. Warren, M.D.[1] This chart note states that claimant has been having trouble off and on with his left ankle since he had a twisting injury to it when he fell off machinery at work in November 1987. In his handwritten correspondence, claimant states that he explained all of this in his last hearing before the surgery on his left knee in 1999. We treat this correspondence as a request for reconsideration.

We note that the chart note submitted by claimant is already in the record. We acknowledge that this chart notes mentions that claimant has been having problems with his left ankle since the work injury. Nevertheless, as we noted in our prior orders, there is no evidence in the record that the employer *accepted* any ankle/foot condition. Claimant may pursue compensability of an ankle/foot condition, if he so chooses.[2] However, the issue currently before the Own Motion Board is whether claimants *accepted* condition was medically stationary at claim closure. For the reasons explained in our prior orders, we continue to find that claimant's accepted left knee condition was medically stationary when the employer closed his claim on March 22, 2000.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 4, 2000 and August 15, 2000 orders effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.[3]

IT IS SO ORDERED.

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[1] It is unclear whether claimant mailed a copy of this correspondence to the employer. Therefore, we are enclosing a copy of this correspondence with the employer's copy of this order. Pursuant to OAR 438-012-0016, a copy of any document in an Own Motion proceeding directed to the Board *must* be simultaneously mailed to all other parties. In the future, claimant is reminded to send copies of information sent to the Board to all parties or their attorney.

[2] The Board in its Own Motion jurisdiction does not have the authority to decide compensability issues. *Charles C. Day*, 49 Van Natta 511 (1997); *Bonnie L. Turnbull*, 49 Van Natta 139, *on recon* 49 Van Natta 470 (1997); *Gary L. Martin*, 48 Van Natta 1802 (1996). If claimant contends that his current ankle/foot condition is compensable, he needs to make a claim for that condition to the employer. If claimant objects to the employer's response to such a claim, he may request a hearing before the Hearings Division to decide the compensability issue. If claimant has questions regarding this process, he may contact the Workers' Compensation Ombudsman, as discussed in the footnote below.

[3] 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, as we mentioned in our August 15, 2000 order, it appears that claimant is unclear as to his rights under the Workers' Compensation Law and, therefore, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. He may contact the Workers' Compensation Ombudsman at 1-800-927-1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
350 WINTER ST NE, ROOM 160
SALEM OR 97301-3878

In the Matter of the Compensation of
CARL H. KIMBLE, Claimant
WCB Case No. 99-09828
ORDER ON REVIEW
Scott M. McNutt, Sr., 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 awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist) whereas an Order on Reconsideration had awarded 5 percent (7.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

An Order on Reconsideration issued on December 13, 1999. The Order on Reconsideration awarded 5 percent (7.50 degrees) scheduled permanent disability for the left forearm (wrist). The award was based on lost range of motion and sensory loss. The Order on Reconsideration did not make an award for a chronic condition.

CONCLUSIONS OF LAW AND REASONING

The ALJ found that claimant had a mild but nonetheless significant limitation in repetitive use of his left hand. The ALJ based this conclusion on Dr. Smith's medical arbiter report that found left hand pinch grip weakness and "some mild limitation in the repetitive use" of the left hand for activities requiring grasping heavy objects between the thumb and other fingers. On review, the insurer contends that claimant has not established that he is "significantly limited" in repetitive use of his left hand as required by OAR 436-035-0010(5)(c). We agree.

A worker is entitled to a 5 percent scheduled chronic condition impairment value when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of a body part. OAR 436-035-0010(5)(c). In *Lorraine F. Fortado*, 52 Van Natta 446 (2000), a medical arbiter indicated that the claimant had "some limitation" of ability to repetitively use a body part (right ankle) that was mild. An Order on Reconsideration had awarded permanent disability for a chronic condition. An ALJ had reduced the scheduled award finding that the medical arbiter's report did not establish that the claimant was entitled to a chronic condition award. On review, we agreed with the ALJ and concluded that the medical arbiter's statement that the claimant had "some limitation" in her ability to repetitively use her right ankle that was "mild" in nature did not establish entitlement to a chronic condition award.

Similarly, here, Dr. Smith has stated that claimant has "some mild limitation in repetitive use of his left hand for activities which require grasping heavy objects between his thumb and his other fingers because of weakness of pinch." (Ex. 19). As in *Fortado*, we are not persuaded that "some mild limitation" in repetitive use is sufficient to establish that claimant is *significantly limited* in the repetitive use of his left hand. Accordingly, we conclude that claimant has not established entitlement to an award for a chronic condition. Consequently, we find that the Order on Reconsideration should be affirmed.

ORDER

The ALJ's order dated May 30, 2000 is reversed. The December 13, 1999 Order on Reconsideration is affirmed. The ALJ's out-of-compensation attorney fee award is reversed.

In the Matter of the Compensation of
DEAN M. MOORE, Claimant
WCB Case No. 00-00582
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of his occupational disease claim for a bilateral foot condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has a preexisting pes planus condition (flat feet). He began working as a driver and warehouseman for the employer in July 1995. (Tr. 5). On May 10, 1999, claimant began performing strictly warehouse duties for the employer's Medford office. (Tr. 23). In Medford, claimant worked approximately 60 hours per week. (Tr. 13). For the first month, claimant's job involved working in the "yard," driving a forklift 70 percent of the time. Claimant then began working in the warehouse. He was on his feet 70 percent of the day, walking on concrete, steel grating, gravel and dirt. (Tr. 13).

In June 1999, claimant experienced the onset of pain in his ankles and feet. (Tr. 7). He sought treatment with Dr. Stroot, a podiatrist, on July 1, 1999. (Ex. 3). Dr. Stroot imposed work restrictions of "sit down duty only" and stand/walk limits of five minutes per hour. (*Id.*) Dr. Stroot also prescribed orthotics and recommended a job change. (Ex. 3). After claimant switched to a dispatcher position for the employer, his symptoms improved "50 percent." (Ex. 4).

Claimant filed a claim for a bilateral tarsal tunnel syndrome condition. SAIF sent claimant to be examined by Dr. Williams. (Ex. 11). Dr. Williams diagnosed a congenital pes planus condition along with pain and peripheral nerve irritation at the tarsal tunnel. (Ex. 11-3). He concluded that claimant's pes planus (flat feet) condition would not have developed in the absence of the pes planus condition. (Ex. 11-4).

After reviewing Dr. Williams' report, Dr. Stroot agreed that claimant would not have developed his tarsal tunnel syndrome condition if he were not flat-footed. (Ex. 13).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial based on the opinion of Dr. Williams. The ALJ also discounted the opinion of claimant's treating physician Dr. Stroot, for two reasons. First, the ALJ determined that Dr. Stroot's discounting of claimant's flat feet condition was not persuasive. In doing so, the ALJ reasoned that, if tarsal tunnel does not generally develop in the absence of flat feet, having flat feet must be at least as causative as any work activity. Secondly, the ALJ concluded that Dr. Stroot must have relied on an incorrect history, given Dr. Williams' history of claimant's walking on hard surfaces for four years.

For the following reasons, we find that claimant has established the compensability of his bilateral tarsal tunnel syndrome condition. This is an occupational disease claim. Claimant must prove that his work activity walking on hard surfaces is the major contributing cause of the condition. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).[1]

Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). In addition, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no reasons not to defer to Dr. Stroot.

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[1] Contrary to SAIF's argument, this claim is not based on an alleged worsening of any preexisting condition, which would necessitate proof of a "pathological worsening" of that condition. ORS 656.802(2)(b). In other words, claimant's occupational disease claim is for tarsal tunnel syndrome, not his preexisting pes planus condition.

Dr. Stroot is a board-certified podiatrist. (Ex. 13). He based his opinion on his examinations of claimant and on his review of Dr. Williams' report. Dr. Stroot offered a well-reasoned explanation of the patho-physiological process at work in causing claimant's tarsal tunnel condition. (Ex. 13). Moreover, Dr. Stroot considered the potential impact of claimant's 1992 right leg injury and related infection, diabetes and pes planus conditions. (*Id.*) *See Dietz v. Ramuda*, 130 Or App 397 (1994) (in determining the major contributing cause of a condition, persuasive medical opinion must consider the relative contribution of different causes, and explain why work injury or exposure contributes more to the condition than all other causes combined).

Although Dr. Stroot acknowledged that there was "little or no likelihood" tarsal tunnel syndrome would develop in an individual without either flat feet or excessively pronating feet, this fact does not compel the conclusion that claimant's flat feet condition must be at least "as causative" of his tarsal tunnel condition as his work activity. To the contrary, after considering the contribution of claimant's preexisting flat foot condition (as well as other potentially contributing factors) Dr. Stroot persuasively concluded that claimant's work activity (walking on his employer's hard surfaces) was the major contributing cause of his tarsal tunnel condition. (Ex. 13).

Finally, we find that Dr. Stroot relied on a correct history of claimant's working 10-13 hours per day, five days per week. (Ex. 4-1). There is no indication in Dr. Stroot's chart notes or reports that any specific period of time is required to develop tarsal tunnel syndrome. Although Dr. Stroot reviewed Dr. Williams' report, which contained the erroneous history of claimant's walking on hard surfaces for the past four years, we cannot determine that Dr. Stroot specifically adopted this history as his own. (Ex. 11-1). It appears instead that Dr. Stroot disagreed with Dr. Williams' reasoning and ultimate conclusion regarding the etiology of claimant's tarsal tunnel condition. (*See* Ex. 13-1).

Dr. Williams' report, by contrast, expressly references an incorrect history of claimant's working "for the past four years" as a "warehouseman and yard man." (Ex. 11-1). Even assuming, *arguendo*, that Dr. Williams' opinion would have been unchanged if he understood that claimant had only been working as a warehouseman for the last two months of his employment, we also find Dr. Williams' opinion less well-reasoned than that of Dr. Stroot. Dr. Williams states in conclusory fashion that claimant's tarsal tunnel condition is caused by his pes planus condition, because, if claimant did not have the pes planus condition, he would not have developed tarsal tunnel syndrome. (Ex. 11-4). There is no discussion in Dr. Williams' opinion of the relative contribution of claimant's work activities in comparison to the pes planus condition.

For all of the foregoing reasons, we reverse the ALJ's order upholding SAIF's denial, and remand the claim to SAIF for acceptance and processing according to law.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,100, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, (as represented by the record, claimant's appellate briefs, and claimant's counsel's uncontested attorney fee request), the complexity of the issues, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated May 18, 2000 is reversed. The SAIF Corporation's January 6, 2000 denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant is awarded an assessed fee of $5,100, payable by SAIF.

In the Matter of the Compensation of
ROSEMARY PETERSON, Claimant
WCB Case No. 99-09469
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of the left leg, whereas an Order on Reconsideration had awarded 2 percent (3 degrees). We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction. The medical arbiter's name is Dr. Marble, not Dr. Mason.

CONCLUSIONS OF LAW AND REASONING

Claimant compensably injured her low back on November 1, 1997. The claim was accepted by the SAIF Corporation as a left-sided L5-S1 disc herniation. Dr. Palmer made findings of sensory loss in the left great toe and strength loss in the left leg. Dr. Gehling, claimant's attending physician, concurred with Dr. Palmer's findings.

A Notice of Closure dated July 12, 1999 closed the claim. The Notice of Closure awarded temporary disability benefits, as well as unscheduled permanent disability and an award of 6 percent scheduled permanent disability benefits based on Dr. Palmer's findings of sensory and strength loss in the left leg.

Claimant requested reconsideration of the Notice of Closure and underwent a medical arbiter examination by Dr. Marble. Dr. Marble reported strength loss in both the peroneal musculature and the gastrocnemius muscles on the left. Dr. Marble graded the muscle strength loss as "4.5/5." (Ex. 11-3).

On November 4, 1999, an Order on Reconsideration increased claimant's unscheduled permanent disability award, but reduced claimant's scheduled award, based on Dr. Marbles medical arbiter report, to 2 percent. Claimant requested a hearing, seeking an increased scheduled award.

The ALJ found that the medical arbiter's findings of lost muscle strength in the left leg were sufficient under the standards and used them to rate claimant's muscle strength loss. But the ALJ relied on Dr. Palmer's findings of loss of sensation in the great toe to increase the Order on Reconsideration's scheduled award from 2 percent to 3 percent.

On review, claimant argues that Dr. Marble's findings of lost strength were not reported in the manner required by the disability rating standards. We agree.

Dr. Marble rated claimant's lost muscle strength as "4.5/5." The applicable standards, OAR 436-035-0007(19), (20) and 436-035-0230(8)(a)[1] require that muscle strength loss be reported using the 0 to 5 grading system. The rule does not allow for reporting of muscle strength loss in decimals, however. It is not clear whether Dr. Marble's use of 4.5/5 means 4+/5 (which has a value of 10 percent under the standards) or 5-/5 (which has a value of 5 percent). Moreover, we have previously held that where disability is not reported in the manner required by the standards, we are unable to rely on the findings to award impairment for loss of strength. *See Jose I. Rios*, 52 Van Natta 303 (2000); *Randal W. Piper*, 49 Van Natta 543 (1997); *see also Melody R. Ward*, 52 Van Natta 241 (2000), (Board found no statutory authority for an ALJ to remand to the Director for clarifying report from a medical arbiter who had mistakenly reported a claimant's loss of strength as "4/4" instead of 4/5). Accordingly, because Dr. Marble did not report claimant's impairment in the manner required by the standards, we rely, instead, on the impairment findings of Dr. Palmer, that were ratified by claimant's attending physician.

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[1] The applicable rules are contained in WCD Admin. Orders 99-056; 98-055.

Based on Dr. Palmer's findings, the Notice of Closure found 5 percent impairment for loss of strength in the left leg. In addition, the Notice of Closure also made an award for loss of sensation in the great toe. This converted to 1 percent of the foot. Although the ALJ relied on Dr. Marble's findings regarding loss of strength, he nevertheless relied on Dr. Palmer's findings to conclude that the award for loss of sensation was appropriate. The award for loss of sensation is not challenged by SAIF on review. In addition, neither party contends that the Notice of Closures calculation based on Dr. Palmer's findings was incorrect. (In this regard, SAIF argued only that Dr. Marble's impairment findings were sufficient and should be used). Accordingly, claimant's total scheduled award is 6 percent (9 degrees) for loss of use or function of the left leg, as awarded by the Notice of Closure.[2]

ORDER

The ALJ's order dated March 29, 2000 is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsiderations 2 percent (3 degrees) scheduled permanent disability award for loss of use or function of the left leg, claimant is awarded 4 percent (6 degrees), for the total award of 6 percent (9 degrees) scheduled permanent disability for the left leg. Claimant is awarded 25 percent of the "increased" compensation created by this order (the 3 percent increase between the ALJ's award and this award), not to exceed $6,000. If any portion of this "increased" compensation has been previously paid to claimant, claimant's counsel may seek recovery of the attorney fee granted in this order pursuant to the procedures set forth in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *affd on other grounds Volk v. America West Airlines*, 135 Or App 565 (1995).

[2] Claimant also seeks an award for a chronic condition under OAR 436-035-0010(5) based on claimant's altered gait. The medical evidence does not establish that claimant's altered gait causes her to be "significantly limited in the repetitive use" of her left leg as the rule requires.

In the Matter of the Compensation of
KENNETH V. FERGUSON, Claimant
Own Motion No. 00-0260M
OWN MOTION ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant seeks Board authorization of an approved fee for attorney's services culminating in our August 23, 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 August 23, 2000 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our August 23, 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
GARY L. CHENEY, Claimant
WCB Case No. 99-02593
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral carpal tunnel syndrome. In his brief, claimant moves for remand for further evidence taking before a different ALJ. On review, the issues are remand and compensability.

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

Here, claimant argues that the ALJ unreasonably limited his testimony to work activities only up to the date of filing of the 801 form, insisted that certain documents (driver manifests) be marked as exhibits, and declined to admit a videotape into evidence.

With regard to claimant's argument that his testimony was limited, the transcript reflects that claimant was allowed to make an offer of proof regarding his work activities after the date the claim was filed. Thus, the testimony is available for review by an appellate body and there is no need for remand to obtain the testimony.

Regarding the marking of manifests as exhibits, the employer's attorney objected when claimant asked to use one of the manifests (which had not been disclosed to the carrier or offered into evidence) in testifying. (Tr. I, 25). Claimant did not offer the manifests or intend that they be offered into evidence. The ALJ marked the manifests as exhibits, so they could be identified for purposes of ruling on the objection. (Tr. 30). In any case, the decision to mark the exhibits did not result in any evidence being kept out of the record.

Finally, claimant argues that the ALJ should have admitted a videotape into evidence. The employers counsel objected to the videotape on the ground that it had not been disclosed as required by the administrative rules. The videotape was prepared by claimant and depicted his work activities. Claimant's counsel argued at the hearing that the videotape was not subject to the discovery rules because it had not been in her possession. (Tr. 53).

OAR 438-007-0015 requires *claimants*, as well as persons acting on behalf of claimants, to furnish discoverable material in accordance with the rules. OAR 438-007-0015(4)[1] requires disclosure of material within 7 days of receipt. Because claimant did not disclose the videotape within 7 days of receipt as required by the rules, we find no error in the ALJ's decision not to admit it into evidence.

Here, there is no contention that the videotape was disclosed in a timely fashion. Under such circumstances, the ALJ did not err in declining to admit the videotape.

Finally, even assuming that the ALJ's rulings were incorrect, we conclude that remand would not be appropriate. We may remand to the ALJ if we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

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[1] OAR 438-007-0015(4) provides: "Documents acquired after the initial exchanges shall be provided to the insurer(s) and the claimant within seven days after the disclosing party's receipt of the documents."

Here, neither claimant's testimony regarding work activities after filing of the claim nor the videotape are reasonably likely to affect the outcome of the case. In this regard, the ALJ found the opinion of claimant's treating physician, Dr. Lipp, unpersuasive on the ground that his opinion was lacking in explanation and analysis and because he had an inaccurate understanding of claimants history. Claimant's lay testimony in this case does not affect the persuasiveness of that medical opinion. In addition, for the same reasons, the videotape of claimant performing his work (which the medical experts did not see) is also not reasonably likely to affect the outcome of this case. Thus, we deny the motion to remand.[2]

Regarding the merits, we adopt the ALJ's conclusion and reasoning with the following modification. On page 5 of the ALJ's order, we delete the fourth and fifth sentences in the second full paragraph.

ORDER

The ALJ's order dated May 18, 2000 is affirmed.

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[2] We note that claimant argues that he did not receive a fair and just hearing and seeks remand to a different ALJ. To the extent that claimant felt during the hearing that the ALJ was unfair, the time to object and request a change of ALJ was at the hearing. *See* OAR 438-007-0095(2). Claimant's request for remand to a different ALJ is neither timely nor in accordance with the applicable administrative rule. *See Willie C. Johnson*, 48 Van Natta 2451 (1996). In any case, because our review of the record is *de novo*, we are statutorily authorized to make our own appraisal of the documentary and testimonial evidence. *Id.* Therefore, we find no compelling reason to remand for proceedings before a new ALJ.

August 30, 2000 Cite as 52 Van Natta 1555 (2000)

In the Matter of the Compensation of
ALAN KUCERA, Claimant
Own Motion No. 00-0268M
OWN MOTION ORDER
Martin J. McKeown, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's right wrist, right forearm condition. Claimant's aggravation rights expired on October 5, 1993. The insurer recommends that we authorize the payment of temporary disability compensation.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery.

Claimant's condition worsened and his claim is reopened within the time for appeal of a July 6, 2000 Notice of Closure issued pursuant to ORS 656.268. Thus, when appropriate, this claim must be closed under ORS 656.268 rather than ORS 656.278. *See Carter v. SAIF*, 52 Or App 1027 (1981); *Coombs v. SAIF*, 39 Or App 293 (1979). Therefore, when claimant is medically stationary, the insurer shall close the claim pursuant to ORS 656.268 rather than under OAR 438-012-0055.

Finally, in its recommendation form, the insurer indicates that claimant is represented. Based on such a reference, claimant's attorney may be entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, on this record, we cannot approve such a fee because: (1) no current retainer agreement has been filed with the Board (*see* OAR 438-015-0010(1)); and (2) no evidence demonstrates that claimant's attorney was instrumental in obtaining increased temporary disability compensation OAR 438-015-0080.

In conclusion, because no retainer agreement has been received to date and the record does not establish that claimant's attorney was instrumental in obtaining increased temporary disability compensation, the prerequisite for an award of an out-of-compensation attorney fee have not been met at this time. Consequently, no out-of-compensation attorney fee award has been granted. In the event that a party disagrees with this decision, that party may request reconsideration and submit information that is currently lacking from this record. Because our authority to further consider this matter expires within 30 days of this order, any such reconsideration request must be promptly submitted.

IT IS SO ORDERED.

August 31, 2000 Cite as 52 Van Natta 1556 (2000)

In the Matter of the Compensation of
DEWEY C. HARVEY, Claimant
WCB Case No. 99-06867
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that: (1) increased claimant's unscheduled permanent disability from 20 percent (64 degrees), as awarded by an Order on Reconsideration, to 23 percent (73.6 degrees); and (2) affirmed the reconsideration order's 7 percent (10.5 degrees) scheduled permanent disability award for the loss of use or function of the left leg. On review, the issues are extent of unscheduled and scheduled permanent disability.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

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

Claimant compensably injured his low back in 1991 when a different carrier was on the risk. He was diagnosed with herniated discs on the right at L4-5 and L5-S1. A microlumbar diskectomy and foraminotomy was performed at L4-5 on the right. The prior carrier issued a Notice of Closure that awarded 16 percent unscheduled permanent disability for claimant's low back injury.

In 1998, claimant compensably injured his low back when the current insurer was on the risk. The insurer accepted a left L4-5 disc herniation combined with a preexisting right L4-5 disc herniation and preexisting noncompensable degenerative disc disease. Laminectomy and diskectomy surgery was performed at L4-5 on the left. In his closing examination report, Dr. Palmer stated that he would apportion claimant's current condition as 60 percent due to the present injury and 40 percent to preexisting disc disease. The claim was closed by a Determination Order that awarded 7 percent unscheduled permanent disability for the low back and 4 percent scheduled permanent disability for loss of use or function of the left leg. Claimant requested reconsideration and appointment of a medical arbiter.

The arbiter, Dr. Carpenter, noted that the compensable injury remained the major cause of claimant's current condition. (Ex. 56-4). Dr. Carpenter estimated that 60 percent of claimant's impairment in the low back was due to the "accepted condition" of left L4-5 disk herniation and "40 % due to his previous degenerative non-compensable disk disease." *Id.*

An Order on Reconsideration increased the unscheduled permanent disability award for the low back to 20 percent and the scheduled permanent disability award for the left leg to 7 percent. Pursuant to OAR 436-035-0007(2), the appellate reviewer apportioned claimant's lost range of motion in the lumbar spine as assigned by the arbiter. The insurer requested a hearing on both unscheduled and scheduled permanent disability.

The ALJ applied OAR 436-035-0007(4)(c) to determine the extent of permanent disability for claimant's combined condition, rather than apportionment under OAR 436-035-0007(2), as urged by the insurer. The ALJ increased claimant's unscheduled permanent disability to 23 percent.

On review, the insurer argues that the rule relied on by the ALJ is inconsistent with OAR 656.214(5) and, therefore, should be held invalid.[1] Specifically, the insurer argues that the rule that provides for rating the total accepted combined condition violates the statute that requires a rating of disability for permanent loss of earning capacity due to the compensable injury. Having reviewed the rule in question, we conclude that it is not inconsistent with the statute.

ORS 656.214(5) provides:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury."

OAR 436-035-0007(4)(c) provides:

> "Where a worker's compensable condition *combines with a preexisting condition*, pursuant to ORS 656.005(7), the current disability resulting from the total accepted combined condition shall be rated *as long as the compensable condition remains the major contributing cause of the accepted combined condition, i.e.*, a major contributing cause denial has not been issued pursuant to ORS 656.262(7)(b). Apportionment is not appropriate." (Emphasis supplied.)

Here, the insurer accepted a combined condition; *i.e.*, a left L4-5 disc herniation combined with a preexisting right L4-5 disc herniation and preexisting degenerative disc disease. The insurer did not issue a written denial of the combined condition under ORS 656.262(7)(b). Therefore, the entire combined condition remains the accepted condition. *See SAIF v. Belden*, 155 Or App 568, 576-75 (1998); *compare Kenneth R. Reed*, 49 Van Natta 2129 (1997) (because the carrier did not accept a "combined condition," the preexisting condition was not considered in rating the claimant's disability).[2] Consequently, because the entire accepted combined condition is due to the compensable injury, the rule is not inconsistent with the statute.[3]

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[1] In *Schultz v. Springfield Forest Products*, 151 Or App 727 (1997), the court held that the Board had the authority to review the validity of a Director's rule to determine if it is consistent with applicable statutes.

[2] We acknowledge that the treating surgeon and the arbiter divided impairment between the injury and the preexisting disease. However, the "combined condition" accepted by the insurer included both the injury and the preexisting disease. Therefore, in the absence of a pre-closure denial, the entire "combined condition" was ratable.

[3] The insurer cites *Nomeland v. City of Portland*, 106 Or App 77, 78 (1991), for the proposition that, when it is possible to segregate a claimant's disability that preexisted his employment from that caused by the employment, the employer is responsible only for the disability caused by the employment. The insurer's reliance on *Nomeland* is misplaced.

The issue in *Nomeland* was how to treat the claimant's scheduled condition, a documented, preemployment hearing loss, in calculating the extent of his disability. In contrast to claimant's low back condition in this case, an unscheduled condition subject to he provisions of ORS 656.214(5), hearing loss is a scheduled disability and subject to the provisions of ORS 656.214(2). The *Nomeland* court applied ORS 656.214(2) and the pertinent rule, *former* OAR 436-30-360(2), which is specific to the calculation of disability due to hearing loss and provides for an offset "by pre-existing hearing loss if previously compensated, presbycusis, or if supporting evidence such as base-line or pre-exposure audiograms are provided." The *Nomeland* court held that the claimant's preexisting hearing loss, as determined by a preemployment audiogram, should be offset from the claimant's total hearing loss in determining the benefits to which he is entitled.

Here, in contrast to *Nomeland*, the issue is calculation of unscheduled permanent disability where a carrier has accepted a combined condition and has closed the claim without issuing a denial of the combined condition prior to closure. ORS 656.214(5) provides:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section [inapplicable here], the criteria for rating of disability shall be the permanent loss of earning capacity *due to the compensable injury*."

The compensable injury in this case is claimant's combined condition (a left L4-5 disc herniation combined with a preexisting right L4-5 disc herniation and preexisting noncompensable degenerative disc disease). Because the insurer did not take advantage of the ability to deny a combined condition prior to claim closure if it ceased to be the major contributing cause of the worker's need for treatment or disability, claimant's loss of earning capacity is "due to" the compensable combined condition.

The insurer next argues that the ALJ erred in finding that claimant was not previously awarded an impairment value for his prior surgery. The insurer contends that, because claimant had surgery at L4-5 on the right and received a 16 percent unscheduled permanent disability award for his previous injury, we should infer that claimant was awarded permanent disability for the surgery and offset that award against the present award. We do not agree.

The applicable rule is OAR 436-035-0007(6)(c), which provides in pertinent part:

> "For unscheduled disability, a worker is not entitled to be doubly compensated for a permanent loss of earning capacity in an unscheduled body part which would have resulted from the current injury or disease but which had already been produced by an earlier injury or disease and had been compensated by a prior award. * * * Only that portion of lost earning capacity not present prior to the current injury or disease shall be awarded. The following factors shall be considered when determining the extent of the current disability award:
>
> "* * * * *
>
> "(D) The extent to which the current loss of earning capacity includes impairment and social vocational factors from a prior injury or disease which were still present at the time of the current injury or disease. After considering and comparing the claims, any ratable permanent partial disability in the current claim for loss of earning capacity caused by the current injury or disease, (which would not have been present at the time of the current injury or disease) shall be granted."

Here, there is no evidence that the current loss of earning capacity includes the impairment factor from the prior surgery. Even assuming (but not deciding) that claimant had been awarded 9 percent for the prior surgery, we do not find that the current loss of earning capacity includes any impairment value from that prior surgery. The 9 percent value awarded by the ALJ for claimant's low back surgery in the current claim (a *left* L4-5 laminectomy and diskectomy) is for a new condition caused by the current injury. Accordingly, after considering and comparing the claims, we agree that the ALJ was correct in granting a 9 percent impairment value for the new surgery. No offset for the prior surgery is appropriate. OAR 436-035-0007(6)(c)(D).

Scheduled Permanent Disability

The ALJ also declined to apportion claimant's 7 percent award for scheduled disability for the same reasons he declined to apportion claimant's unscheduled disability award. We agree that claimant is entitled to the 7 percent award for the loss of use or function of his left leg, but for different reasons.

Claimant has a strength loss of 4/5 in the left quadriceps, tibialis anteriors and extensor halluces due to the accepted L4-5 disc herniation. (Ex. 56-3). 4/5 strength is graded as 20 percent. OAR 436-035-0007(19). This value is multiplied by the value of 37 percent assigned to the L5 nerve root, for a value of 7.4 percent. OAR 436-035-0230(8)(a). This value is rounded to arrive at a value of 7 percent. OAR 436-035-0007(15). Finally, because claimant has not previously received a disability award for the left leg, the full value for this impairment is given. OAR 436-035-0007(6)(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 $1,500, 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 April 6, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
DAVID W. KELLER, Claimant
WCB Case No. 99-06413
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) declined claimant's motion to reopen the record for rebuttal evidence; and (2) upheld the SAIF Corporation's denial of his injury claim for a hernia 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.

Claimant challenges the ALJ's decision to deny his request to reopen the record for the taking of additional rebuttal evidence. Claimant contends that the record should have been reopened given the "surprising" deposition testimony by Dr. Yarusso. For the following reasons, we find no abuse of discretion in the ALJ's ruling.

The ALJ is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); *Armstrong v. SAIF*, 67 Or App 498 (1984). The ALJ has broad discretion with regard to the admissibility of evidence at hearing. *Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *Jesus M. Delatorre*, 51 Van Natta 728 (1999); *James D. Brusseau II*, 43 Van Natta 541 (1991). Specifically, when an ALJ leaves the record open for a limited purpose, it is within the ALJ's discretion to exclude evidence that does not comport with that purpose. *Clifford L. Conradi*, 46 Van Natta 854 (1994).

Here, claimant stipulated at hearing that the "sole reason" the record was being left open was for the "post-hearing" depositions of Drs. Heinonen and Yarusso. (Tr. 2). Moreover, claimant agreed that the record could be closed after these depositions. (Tr. 3). Although claimant contends that he was "surprised" by the deposition testimony of Dr. Yarusso, claimant does not contend that any new issues arose out of the deposition. *See William E. Sanders*, 43 Van Natta 558, 559-560 (1990) (No abuse of discretion found when the ALJ declined to reopen the record for rebuttal evidence where, among other reasons, a deposition uncovered no additional issues). Under these circumstances, we find no abuse of discretion in the ALJ's decision to decline to reopen the record for additional rebuttal evidence.

Furthermore, we agree with the ALJ that on this record claimant failed to meet his burden of proving the compensability of his hernia condition through Dr. Graham, who offered the only arguably supportive medical opinion for claimant.

ORDER

The ALJ's order dated April 18, 2000 is affirmed.

In the Matter of the Compensation of
BOBBY A. BRADBURRY, Claimant
WCB Case Nos. 99-07212 & 99-04471
ORDER ON REVIEW
Preston, Bunnell & Stone, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Liberty Northwest Insurance Corporation (Liberty) requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its responsibility denial of claimant's right knee condition beginning April 24, 1999 and thereafter; and (2) set aside the SAIF Corporation's denial of claimant's "new injury" claim for the same condition from January 29, 1999 through April 23, 1999. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

On April 14, 1977, claimant injured his right knee while working for Liberty's insured. (Exs. 1, 2, 3). Claimant's "801" form said he had twisted his knee. (Ex. 3). Although there is no formal acceptance in the record, Liberty indicated on the "801" form that it had accepted the injury claim. (*Id.*) Likewise, a May 20, 1977 "802" form indicated the claim had been accepted. (Ex. 11). An arthrogram showed a posteriomedial horizontal meniscal tear. (Exs. 5, 6). In May 1977, Dr. Wells performed an arthroscopy followed by a medial arthrotomy, and excision of a torn medial meniscus and suprapatellar plica. (Exs. 9, 10). He diagnosed a "horizontal tear, posterior medial meniscus and suprapatellar plica." (*Id.*)

On September 6, 1977, Dr. Wells felt that claimant's right knee impairment was 15 percent. (Ex. 13). One week later, however, claimant reported additional knee symptoms and Dr. Wells recommended another arthroscopy. (Ex. 14). Dr. Wells found diffuse synovitis involving the suprapatellar joint. (Ex. 15). He recommended that the claim be reopened. (Ex. 16). A February 27, 1978 Determination Order awarded 15 percent scheduled permanent disability for loss of use or function of claimant's right leg. (Ex. 19).

Claimant sought treatment from Dr. Wells in October 1978, complaining of popping, catching and pain in his right knee. (Ex. 23). Dr. Wells performed an arthroscopy, which showed chondromalacia of the anteromedial pole of the patella. (Exs. 25, 27). He diagnosed "[c]hondromalacia, anterior medial pole of the patella, status post medial meniscectomy and mild chondromalacia with mild to moderate amount of intra-articular fibrinous debris." (Ex. 25). A December 22, 1978 Determination Order awarded additional temporary disability and found that claimant's permanent disability was the same as the previous Determination Order. (Ex. 26). A March 23, 1979 Opinion and Order increased claimant's right leg disability to 30 percent, and the Board affirmed. (Exs. 30, 34).

In May 1979, claimant sought medical treatment from Dr. Burr. (Ex. 31). He performed an arthrogram, which showed regeneration of the medial meniscus. (Exs. 33, 35, 37). Dr. Burr performed surgery to excise the medial meniscus, and he diagnosed "[p]atellar compression syndrome with recurrent remnant, medial meniscus and regeneration." (Exs. 37, 38). Dr. Burr believed that the surgery was related to the April 1977 injury. (Ex. 39). In February 1980, Liberty reopened the claim as an aggravation. (Ex. 40).

In August 1980, Dr. Anderson treated claimant for right knee pain and diagnosed probable chondromalacia of the patella and medial femoral condyle. (Ex. 41-5). A December 3, 1980 Determination Order awarded additional temporary disability benefits, but did not award any additional permanent disability. (Ex. 43).

In July 1982, Dr. Burr requested claim reopening for an arthroscopy. (Ex. 45). In August 1982, Dr. Burr performed a "[p]es anserine transfer" of the right knee with incidental arthrotomy. (Exs. 47, 48). His diagnoses were "[s]tatus postoperative medial meniscectomy" and "[a]nteromedial rotatory instability, with laxity, anterior cruciat[e] ligament, right knee." (Ex. 47). Liberty accepted an aggravation claim and a September 27, 1983 Determination Order awarded additional temporary disability, but no additional permanent disability. (Exs. 49, 51). A stipulated order approved on May 29, 1984 increased claimant's permanent disability for loss of use or function of his right leg to 55 percent. (Ex. 52).

In June 1983, claimant began working for SAIF's insured as a correctional officer. (Tr. 13). He worked in a variety of positions. Claimant testified that, after beginning that job, he did not have any right knee problems and was able to perform his job duties without problems until January 1999. (Tr. 14).

In January 1999, claimant was working in the upholstery shop as a security officer and that position involved walking, sitting and standing. (Tr. 24). On January 29, 1999, he stepped on a piece of wood and twisted his right knee. (Tr. 15, Ex. 55). He experienced immediate pain and reported the injury to a supervisor. (Tr. 15, 16). On February 15, 1999, he sought treatment from Dr. Orwick, who reported that claimant was "feeling fine now and there never was any swelling." (Ex. 54). Dr. Orwick noted that claimant did not think it was anything serious. (*Id.*) He found that claimant had no effusion and full range of motion and was walking without a limp. (*Id.*)

On March 17, 1999, claimant was transferred to work in the cell housing units, also called the "general population." (Tr. 21-22). That position required walking five to ten miles a day and walking up and down stairs. (Tr. 19, 20). He had not worked in that position for about five years. (Tr. 22). On April 2, 1999, claimant returned to Dr. Orwick because of worsened knee pain, which had resulted from the additional walking in the new position. (Tr. 25-26, Ex. 56). Dr. Orwick felt that claimant had a sprain, as well as degenerative arthritis of the medial joint compartment. (Ex. 56).

Claimant was referred to Dr. Becker, who felt that claimant might have a tear of the posterior horn of the medial meniscus. (Ex. 60). At that time, he had not reviewed claimant's previous surgical records. (Ex. 63). On June 9, 1999, Dr. Becker performed an arthroscopy and diagnosed grade III chondromalacia of the posterior medial compartment with a very small area of Grade IV on the posterior medial tibial articular surface, as well as juxtaarticular synovitis along the medial femoral condyle. (Ex. 68).

On May 21, 1999, SAIF issued a disclaimer of responsibility and claim denial. (Ex. 64). SAIF asserted, among other things, that there was insufficient evidence to establish compensability of the claim. (Ex. 64-1). Liberty denied responsibility of claimant's right knee condition on September 1, 1999. (Ex. 72). Claimant requested a hearing on both denials.

On October 19, 1999, Dr. Bald performed a chart review on behalf of Liberty. (Ex. 75). The parties subsequently deposed Dr. Bald. (Ex. 76).

CONCLUSIONS OF LAW AND OPINION

At hearing, SAIF's attorney said it had issued a denial of compensability and responsibility and explained that, for SAIF to be responsible, claimant must have sustained a new compensable injury. (Tr. 1). The ALJ and the parties agreed that, for SAIF to be responsible, the claim must be compensable to SAIF as a new injury. (Tr. 2). On the other hand, Liberty had denied only responsibility. (Tr. 3). The ALJ's order indicates that the parties agreed at closing arguments that responsibility was the only issue and that claimant's attorney was entitled to an assessed attorney fee of $1,000, payable by Liberty.

The ALJ found that claimant had experienced a compensable right knee strain as a result of the January 29, 1999 injury at SAIF's insured. He found that the right knee strain combined with the preexisting right knee condition to cause or prolong claimant's disability and need for treatment, including the June 1999 surgery. The ALJ concluded that the January 1999 injury was the major contributing cause of claimant's disability and need for treatment from January 29, 1999 through April 23, 1999 and he set aside SAIF's denial for that time period. The ALJ determined that claimant's 1977 injury at Liberty's insured was the major contributing cause of his disability and need for treatment after April 23, 1999.

On review, Liberty agrees that it is responsible for claimant's knee condition beginning on September 9, 1999. Liberty argues, however, that the ALJ erred in finding that it was responsible for claimant's condition from April 24, 1999 through September 8, 1999. Liberty contends that claimant's June 1999 surgery was related to the January 29, 1999 injury with SAIF's insured and, therefore, Liberty did not become responsible for claimant's condition until he was medically stationary from the surgery. Liberty relies on Dr. Bald's opinion.

SAIF does not dispute the ALJ's conclusion that claimant experienced a compensable right knee strain as a result of the January 29, 1999 injury. SAIF agrees with the ALJ that its responsibility for claimant's knee strain ended on April 23, 1999, when the strain resolved and after that time, Liberty was responsible because claimant's preexisting condition became the major contributing cause of his knee condition. On review, SAIF asserts: "[t]his is a dispute between carriers that is based on actual causation, rather than the application of particular rules for assigning responsibility." (SAIF's br. at 2). SAIF relies on Dr. Bald's opinion to support its position.

Neither Liberty nor SAIF have explained whether or not ORS 656.308(1) is applicable to this case. Under ORS 656.295(6), we have *de novo* review authority and may reverse or modify the ALJ's order or make any disposition of the case that we deem appropriate. *See Precision Castparts Corp. v. Lewis*, 115 Or App 732, 735 (1992) (Board was not confined on review to issues raised by the parties and had the authority to address any issue that was before the referee); *Destael v. Nicolai Co.*, 80 Or App 596, 600-01 (1986) (Board has *de novo* review and was free to make any disposition of the case it deemed appropriate). Our first task is to determine which provisions of the Workers' Compensation Law are applicable. *DiBrito v. SAIF*, 319 Or 244, 248 (1994).

Because claimant has a previously accepted claim involving his right knee, we begin by determining whether ORS 656.308(1)[1] applies to this case. In *Barrett Business Services v. Morrow*, 164 Or App 628 (1999), the court held that ORS 656.308(1) applies only when the original compensable injury and the second 631. In that circumstance, 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. *Id.* at 632.

Liberty's September 1, 1999 denial of claimant's current right knee condition said that the April 1977 claim had been accepted for a "right knee sprain and right medial meniscus tear resulting in a medial arthrotomy and eniscectomy." (Ex. 72). However, there is no formal acceptance from Liberty in the record. The scope of acceptance is a factual determination. *SAIF v. Tull*, 113 Or App 449 (1992). When the carrier does not identify the specific condition accepted, we look to contemporaneous medical records to determine what condition was accepted. *See, e.g., Verna M. Bolin*, 51 Van Natta 1949 (1999); *Fred L. Dobbs*, 50 Van Natta 2293 (1998).

Claimant was injured on April 14, 1977 when he twisted his knee at work. (Exs. 2, 3). Although there is no formal acceptance in the record, Liberty indicated on the "801" form that it had accepted the injury claim. (Ex. 3). Likewise, a May 20, 1977 "802" form indicated the claim had been accepted. (Ex. 11). We examine the contemporaneous medical records to determine the causes of claimant's knee symptoms. In May 1977, Dr. Wells performed an arthroscopy followed by a medial arthrotomy, and excision of a torn medial meniscus and suprapatellar plica. (Exs. 9, 10). He diagnosed a "horizontal tear, posterior medial meniscus and suprapatellar plica." (*Id.*) Because the medical reports at the time of Liberty's acceptance indicated that claimant's right knee condition involved a horizontal tear of the posterior medial meniscus and suprapatellar plica, we find that Liberty accepted those conditions. Claimant had several additional surgeries related to the accepted injury. (Exs. 15, 25, 37, 38, 47, 48).

Dr. Becker, claimant's treating physician, diagnosed the following knee conditions after performing surgery on June 9, 1999:

> "Chondromalacia, posterior medial compartment Grade III with one very, very small area of Grade IV on the posterior medial tibial articular surface, having had a previous medial meniscectomy. He has some juxtaarticular synovitis along the medial femoral condyle as well." (Ex. 68).

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[1] 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."

Dr. Becker had previously indicated that, if claimant had a previous medial meniscectomy (which was confirmed at surgery), that would be a "heavy contributor" and would be, by far, the major contributing cause of his current knee condition. (Ex. 63-1, -2). In a later report, Dr. Becker agreed that claimant's preexisting conditions had combined with his work exposure at SAIF's insured. (Ex. 70). He also agreed that claimant's preexisting condition was the major contributing cause of the disability or need for medical treatment of the right knee and he noted that the current "majority problem" was the residual from the old meniscal tear. (*Id.*)

Dr. Bald performed a chart review on behalf of Liberty and diagnosed a right knee strain, as well as progressive medial compartment degenerative arthritic condition with medial compartment chondromalacia. (Ex. 75-4). Dr. Bald said that the arthritic condition with chondromalacia was a direct result of claimant's 1977 injury and subsequent surgeries. (*Id.*)

Under ORS 656.308(1), 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). The opinions of Drs. Becker and Bald establish that the new right knee condition has the earlier injury accepted by Liberty within or as part of itself. *Compare McAtee*, 164 Or App at 661 (because the claimant's earlier accepted claims were for a herniated disc and degenerative changes and the new compensable injury was a lumbar strain, the new injury did not involve the same conditions earlier accepted). Moreover, even if we assume, without deciding, that claimant sustained a right knee strain as a result of the January 1999 injury, we find that the right knee condition resulting from the January 1999 injury involved the same condition previously accepted by Liberty.

We conclude that claimant's current right knee condition involves the "same condition" as those previously accepted by Liberty. Under ORS 656.308(1), Liberty 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." Thus, the next question is whether claimant sustained a "new compensable injury" in January 1999. ORS 656.308(1) provides, in part:

> "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."

Both Dr. Becker and Dr. Bald agreed that claimant's preexisting right knee conditions combined with his work at SAIF's insured to cause his disability and need for medical treatment. (Exs. 70, 76-7). Consequently, we find that ORS 656.005(7)(a)(B) applies and SAIF is responsible for claimant's knee condition only if the January 1999 injury constitutes the major contributing cause of his disability or need for treatment for the combined condition. *See SAIF v. Britton*, 145 Or App 288, 291-92 (1996).

As we discussed above, Dr. Becker indicated before claimant's June 1999 surgery that, if he had had a previous medial meniscectomy, that would be a "heavy contributor" and would be, by far, the major contributing cause of his current knee condition. (Ex. 63-1, -2). Dr. Becker subsequently determined that claimant indeed had a previous medial meniscectomy. (Ex. 68). In a later report, he agreed that claimant's preexisting condition was the major contributing cause of the disability or need for medical treatment of the right knee and he noted that the current "majority problem" was the residual from the old meniscal tear. (Ex. 70).

In contrast, Dr. Bald's opinion is confusing because he differentiated between the major contributing cause of the decision to perform surgery and the major contributing cause of claimant's overall disability and need for treatment. In his October 19, 1999 report, he concluded that the January 1999 incident was "by far" the major contributing cause of claimant's acute symptoms and need for treatment between January 29, 1999 and September 9, 1999. (Ex. 75-5). He explained that claimant's acute knee condition, *i.e.*, a right knee strain, had resolved and had been declared medically stationary on September 8, 1999. (Ex. 75-4). He felt that claimant's current, ongoing right knee condition, *i.e.*, degenerative arthritis of the medial compartment, was causally related to the April 14, 1977 injury and sequelae. (Ex. 75-5).

In a deposition, Dr. Bald agreed that the pathology identified at claimant's June 1999 surgery was the same pathology he had *before* the January 29, 1999 injury. (Ex. 76-6). Dr. Bald believed that the January 1999 incident had caused a right knee strain, which combined with his preexisting condition to cause or prolong his disability or need for treatment. (Ex. 76-6, -7). He opined that the strain was the major contributing cause until September 9, 1999, which allowed some recovery time from the June 1999

surgery. (Ex. 76-16, -17). Nevertheless, Dr. Bald said that the surgery was not required for the knee strain (Ex. 76-20), and the arthroscopy found no evidence of residual problems from a strain. (Ex. 76-17). He also said that the surgery confirmed that the January 1999 injury had not caused any mechanical abnormality in the knee. (Ex. 76-20). Dr. Bald acknowledged that, at the time of surgery, the major contributing cause of claimant's condition was the preexisting degenerative disease. (Ex. 76-21, -22, -25, -33, -34).

In discussing causation, Dr. Bald focused on the *decision* to perform the arthroscopy and said that was made because of the injury, not the degenerative condition. (Ex. 76-28, -29). He explained:

> "And you know, I hate to sound like a broken record, but the decision making regarding the need for surgical treatment was made because of the injury and the possibility of something correctable mechanically in the knee, and therefore, in my opinion should be covered as part of the injury.
>
> "The fact that nothing was found doesn't mean that the clinical suspicion wasn't there. * * *
>
> "* * * * *
>
> "And in my opinion, the surgery was caused by the injury, the need for surgery was caused by the injury, even though the doctor didn't find anything, and that you have to give the guy a reasonable recovery time from the surgery." (Exs. 76-37, -38).

The issue in this case is whether claimant's January 1999 injury at SAIF's insured was the major contributing cause of his disability or need for treatment for the combined condition. Although claimant's arthroscopy was part of his medical treatment for the combined condition, the major cause of the *decision* to perform the June 1999 arthroscopy is not part of the determination. Rather, 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.*

In light of Dr. Bald's focus on the reason for performing claimant's June 1999 surgery, rather than the major contributing cause of the overall disability and need for treatment, we are not persuaded by Dr. Bald's opinion that claimant's January 1999 injury was the major contributing cause of his disability or need for treatment. To the contrary, Dr. Bald agreed that the pathology identified at claimant's June 1999 surgery was the same pathology he had *before* the January 29, 1999 injury. (Ex. 76-6). He explained that the surgery was not required for the knee strain (Ex. 76-20), and the arthroscopy found no evidence of residual problems from a strain. (Ex. 76-17, -20). Moreover, Dr. Bald acknowledged that, at the time of surgery, the major contributing cause of claimant's condition was the preexisting degenerative disease. (Ex. 76-21, -22, -25, -33, -34). Dr. Bald did not explain what medical treatment, if any, was directed to the right knee strain. We find that Dr. Bald's opinion is not sufficient to establish that claimant sustained a "new compensable injury" involving the same condition previously accepted by Liberty.

We conclude that Dr. Becker's opinion on causation is the most persuasive. As discussed earlier, Dr. Becker agreed that claimant's preexisting condition, which was related to his 1977 injury and sequelae, was the major contributing cause of his disability or need for medical treatment of the current right knee condition. Thus, under ORS 656.308(1), Liberty remains responsible for future compensable medical services and disability relating to the compensable condition. Consequently, we set aside Liberty's responsibility denial of claimant's current right knee condition.[2] Furthermore, we uphold SAIF's denial of claimant's right knee condition.

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[2] In any event, we note that, if claimant had experienced a new compensable injury involving the same condition as the previous compensable injury, responsibility for the entire preexisting condition would shift forward and would not shift back. In *Barrett Business Services v. Morrow*, 164 Or App at 635, the court held that the statutory language in ORS 656.308(1) did not support the carrier'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.

ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances. The ALJ said that all parties agreed at closing arguments that claimant's attorney was entitled to an assessed attorney fee of $1,000, payable by Liberty. Based on the foregoing reasoning, we agree that the attorney fee is payable by Liberty. Claimant is not entitled to an attorney fee on Board review, because no brief was submitted. *Shirley M. Brown*, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated April 12, 2000 is reversed in part and affirmed in part. The portion of the ALJ's order that set aside SAIF's denial as to a right knee combined condition from January 29, 1999 through April 23, 1999 is reversed. SAIF's compensability and responsibility denial is reinstated and upheld. Liberty's responsibility denial is set aside, and the claim is remanded to Liberty for further processing according to law. The remainder of the ALJ's order in affirmed.

August 30, 2000 Cite as 52 Van Natta 1565 (2000)

In the Matter of the Compensation of
RODNEY D. SULLIVAN, Claimant
Own Motion No. 96-0269M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our August 1, 2000 Own Motion Order, that set aside the January 26, 2000 Notice of Closure as premature.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUSTIN T. FOLLETT, Claimant
WCB Case Nos. 99-06110 & 99-04145
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) dismissed his request for hearing concerning a March 26, 1999 denial of his left sacroiliac strain, iliolumbar strain and spondylolisthesis conditions issued by Wausau Insurance Companies (Wausau) with prejudice; (2) upheld Wausau's August 16, 1999 compensability and responsibility denial of claimant's "new injury" claim for spondylolisthesis, spondylosis S1 and spinal stenosis as barred by claim preclusion; and (3) upheld Travelers Insurance Company's (Travelers) compensability and responsibility denial of claimant's aggravation claim for the same conditions. On review, the issues are the propriety of the dismissal order, claim preclusion, compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. On page 2, we change the stipulation of the parties to note that the employer's insurance coverage changed on January 1, 1999 from Travelers to Wausau. (Tr. 6).

CONCLUSIONS OF LAW AND OPINION

Wausau's March 26, 1999 Denial

The ALJ found that claimant had received, read and understood Wausau's March 26, 1999 denial, but had not requested a hearing within 60 days. The ALJ found that claimant failed to establish good cause for failing to timely request a hearing.

On review, claimant asserts that Wausau's March 26, 1999 was a denial of responsibility only. He contends that he has demonstrated good cause for not filing a request for hearing within sixty days after the March 26, 1999 denial. He asserts that his failure to request a hearing constitutes either mistake or excusable neglect. He argues that, by pursuing a claim against Travelers, he has demonstrated reasonable diligence.

Claimant did not file a request for hearing of Wausau's March 26, 1999 denial until August 5, 1999, which was more than 60 days, but less than 180 days after Wausau's denial. A request for a hearing must be filed not later than the 60th day after the mailing of the denial to the claimant. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if the claimant establishes good cause for the late filing. ORS 656.319(1)(b). Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). "Good cause" means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B(1). *Hempel v. SAIF*, 100 Or App 68, 70 (1990).

On February 1, 1999, claimant signed an 801 form concerning a January 14, 1999 injury at Wausau's insured. (Ex. 14). Claimant indicated he had experienced severe low back pain while tying a rope around some racks. (*Id.*) Claimant signed an 827 form on January 15, 1999 related to the same injury. (Ex. 11).

On March 26, 1999, Wausau indicated it had received claimant's claim for a condition related to a January 14, 1999 injury, which was diagnosed as left sacroiliac strain, iliolumbar strain and spondylolisthesis. (Ex. 19). Wausau denied responsibility and said that the diagnosed conditions may be related to a prior claim with Travelers. (*Id.*)

Claimant testified that he received the March 26, 1999 denial and signed for it. (Tr. 15, 34, Ex. 20). He read the letter and understood that he had 60 days to appeal the denial. (Tr. 35). He did not request a hearing within 60 days to contest the March 26, 1999 denial. (Tr. 15). Claimant explained that, because Wausau's letter said it was not responsible for his condition, he went to his doctor and they sent the claim forms to Travelers. (*Id.*)

In previous cases, we have held that a claimant's misunderstanding of a carrier's claim processing actions generally does not establish "good cause" in the absence of evidence that the claimant was misled by the carrier. *See, e.g., Jack L. Barbee*, 48 Van Natta 1855 (1996) (the claimant's mistaken belief that the claim would be covered by another carrier did not constitute good cause); *Randall Davis*, 48 Van Natta 369 (the claimant's mistaken understanding that his claim would be processed as part of another claim did not constitute good cause), *aff'd mem Davis v. Kendall Ford*, 144 Or App 192 (1996); *Roger Eli*, 47 Van Natta 1938 (1995) (the claimant's erroneous belief that claim would be covered by one of two carriers did not establish good cause where record did not indicate that either carrier misled the claimant), *aff'd mem Eli v. Selectemp*, 140 Or App 644 (1996).

In this case, we find no evidence that either carrier misled claimant. We conclude that claimant has not demonstrated good cause for his failure to request a hearing within sixty days after Wausau's March 26, 1999 denial. *See* ORS 656.319(1)(b). Wausau's March 26, 1999 denial is final as a matter of law.

Claim Preclusion

The ALJ agreed with Wausau that claim preclusion barred claimant's June 1999 claim for the same condition that had been denied on March 26, 1999. The ALJ found no persuasive evidence that claimant's back condition had changed since March 1999 and, therefore, claimant was barred from asserting Wausau was responsible for his low back condition. In addition, the ALJ found that the medical evidence did not establish that the 1996 injury with Travelers was the major contributing cause of claimant's current low back condition and need for treatment.

Claimant argues that Wausau's August 16, 1999 denial denied additional conditions that were not previously ripe for litigation. According to claimant, he did not have to litigate compensability or responsibility of the spondylosis S1 or spinal stenosis conditions until Wausau issued the August 16, 1999 denial and, therefore, those conditions were not time-barred. He contends that the only conditions at issue as a result of the March 26, 1999 denial were left sacroiliac strain, iliolumbar strain and spondylolisthesis.

Wausau's March 26, 1999 letter denied responsibility for claimant's condition related to a January 14, 1999 injury, which was diagnosed as left sacroiliac strain, iliolumbar strain and spondylolisthesis. (Ex. 19). On June 2, 1999, claimant's attorney wrote to Wausau regarding a claim for spondylosis S1 with secondary Grade 1 spondylolisthesis and spinal stenosis" as either an aggravation of the April 1997 injury or as a "new injury" on January 14, 1999. (Ex. 29). On August 16, 1999, Wausau said it had received claimant's new injury claim for spondylosis S1 with grade one spondylolisthesis and spinal stenosis. (Ex. 33). Wausau indicated that it had already denied responsibility for spondylolisthesis on March 26, 1999 and it was supplementing the denial to include a denial of compensability of spondylolisthesis. (*Id.*) In addition, Wausau denied compensability and responsibility for claimants spondylosis S1 and spinal stenosis. (*Id.*)

The doctrine of claim preclusion applies in workers' compensation cases when there is an opportunity to litigate an issue before a final determination and the party against whom the doctrine could be applied fails to litigate the issue. *Drews v. EBI Companies*, 310 Or 134, 140, 142 (1990).

We first address the claim preclusion issue concerning the spondylolisthesis condition. Wausau denied responsibility for claimant's spondylolisthesis on March 26, 1999. (Ex. 19). Claimant could have, but did not, challenge that denial. The claim for spondylolisthesis was not a "new medical condition" claim under ORS 656.262(7)(a) or an "omitted" condition under ORS 656.262(6)(d). *See Eugene J. Senger*, 52 Van Natta 1324 (2000); *compare Olive M. Bonham*, 51 Van Natta 1710 (1999) (ORS 656.262(7)(a), which allowed the claimant to "initiate a new medical condition claim at any time" created an exception to claim preclusion); *Wallace M. Prince*, 52 Van Natta 45 (2000) (claim preclusion did not apply to claim

under ORS 656.262(6)(d)). Wausau's March 26, 1999 denial became final for the purposes of claim preclusion when claimant did not timely request a hearing. *See* ORS 656.319; *Popoff v. Newberrys*, 117 Or App 242, 244 (1992) (the claimant's failure to request a hearing on the denial barred her from asserting later claims for medical services). Claimant is precluded from litigating a claim for his spondylolisthesis condition against Wausau.

We next address the claim preclusion issue as it pertains to claimant's spondylosis S1 and spinal stenosis conditions. Wausau did not deny compensability or responsibility of the spondylosis S1 and spinal stenosis conditions in the March 26, 1999 denial. Claimant argues that he did not have to litigate compensability or responsibility of the spondylosis S1or spinal stenosis conditions until Wausau issued the August 16, 1999 denial and, therefore, those conditions are not time-barred. Wausau responds that the record does not show that any new medical conditions arose since the March 26, 1999 denial and, therefore, claimant is barred from asserting that Wausau is responsible for his current low back condition.

> "Claim preclusion bars litigation of a claim based on the same factual transaction [that] was or could have been litigated between the parties 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). However,
>
> "[a]lthough a claimant may be barred from presenting new evidence relating to the same condition, he may renew a request for medical services if his condition has changed *and* the request is supported by new facts that could not have been presented earlier."

Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 564 (1989), *rev den* 309 Or 645 (1990) (emphasis in original); *see also Liberty Northwest Ins. Corp. v. Rector*, 151 Or App 693 (1997) (claim was not precluded because the claimant's condition had changed).

Claimant's June 1999 claim for a low back condition was an initial claim for compensation related to a January 14, 1999 injury, not a "new medical condition" claim under ORS 656.262(7)(a) or an "omitted" condition under ORS 656.262(6)(d). Therefore, the claim preclusion exceptions related to those statutes do not apply. *See Eugene J. Senger*, 52 Van Natta at 1324.

We first determine whether claimant's spondylosis S1 and spinal stenosis could have been litigated in connection with Wausau's March 26, 1999 denial. On February 26, 1999, Dr. Fulper explained that claimant had "[s]pondylosis S1 with secondary grade 1 spondylolisthesis" and "[p]ositional spinal stenosis related" to that condition. (Ex. 16-2). Thus, claimant had been diagnosed with "spondylosis S1" and "spinal stenosis" before Wausau issued its March 26, 1999 denial.[1]

We find no medical evidence to establish that claimant's spondylosis or stenosis conditions were different or had changed from his condition at the time of Wausau's March 26, 1999 denial. Rather, we agree with the ALJ that the medical evidence establishes that, before and after the March 26, 1999 denial, claimant has been seeking medical treatment for the same problem in his back. *See, e.g., Margaret R. Jones*, 45 Van Natta 1249 (1993); *Johnny J. Forrest*, 45 Van Natta 1798 (1993). Under these circumstances, we conclude that claimant's current "spondylosis S1" and "spinal stenosis" conditions are based on the same factual transaction involved in Wausau's March 26, 1999 denial. Based on the doctrine of claim preclusion, we conclude that claimant is barred from litigating his "spondylosis S1" or "spinal stenosis" conditions with Wausau.

Compensability and Responsibility

Alternatively, even if we assume that claimant's current low back condition claim against Wausau is not barred by claim preclusion, we find that Wausau is not responsible for claimant's current back condition. Furthermore, we agree with the ALJ that the medical evidence does not establish that the 1996 injury with Travelers was the major contributing cause of claimant's current low back condition and need for treatment.

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[1] We note that Dr. Fulper's diagnosis of "[s]pondylosis S1" on February 26, 1999 may have been a typographical error. In the same report, he explained that imaging studies showed a "bilateral spondylolysis involving S1" (Ex. 16-1), and Dr. Fulper's January 15, 1999 report referred to spondylolysis, rather than spondylosis. (Ex.12).

There are two work-related back injuries involved in this case. In December 1996, claimant was working in the warehouse for Travelers' insured when a box fell and he hyperextended his back while attempting to catch it. (Ex. 3, Tr. 10-11). Claimant first sought medical treatment on April 16, 1997. (Ex. 1). Travelers accepted a nondisabling lumbar strain. (Ex. 9).

On January 14, 1999, claimant was pulling a rope in an effort to tie down racks of product when he experienced severe pain in his lower back. (Ex. 14). At that time, he working for Wausau's insured. Claimant has filed claims with Wausau and Travelers.

At hearing, claimant sought to establish compensability of his L5-S1 spondylisthesis and spondylolysis, as well as an L3-4 herniated disc and L4-5 herniated disc. (Tr. 1, 7). He relies on the opinions of Drs. Fulper and Flemming to establish compensability of his current low back condition. We address each condition in turn.

L5-S1 Spondylisthesis

Claimant contends that his spondylolisthesis at L5-S1 is compensable, based on the opinions of Drs. Fulper and Flemming.[2] "Spondylolisthesis" is defined as "forward displacement (olisthy) of one vertebra over another * * * usually due to a developmental defect in the pars interarticularis." Dorland's *Illustrated Medical Dictionary* 1563 (28th ed. 1994).

The medical evidence establishes that claimant's spondylolisthesis at L5-S1 preexisted the December 1996 and January 1999 injuries. (Exs. 32-1, 36-2, 37-12, 37-32). Dr. Flemming explained that claimant had spondylolisthesis since he was much younger, but that condition was made symptomatic by the December 1996 injury. (Ex. 37-11). He also agreed that claimant's work activities combined with the preexisting spondylolisthesis to cause his back pain. (Ex. 37-45). Based on Dr. Flemming's opinion, we find that the December 1996 injury and other work activities combined with the preexisting spondylolisthesis to cause claimant's disability or need for treatment. Therefore, ORS 656.005(7)(a)(B) applies and claimant must establish that the December 1996 injury was the major contributing cause of his disability or need for treatment of his back condition.

Dr. Flemming's opinion indicates that, at most, the December 1996 injury made the spondylolisthesis symptomatic. (Exs. 34, 36-2, 36-3, 37-11, 37-25, 37-28). There is no evidence that Dr. Flemming believed either of claimant's injuries were the major contributing cause of the spondylolisthesis. In addition, Dr. Flemming did not believe claimant's spondylolisthesis had been pathologically worsened by either of the work injuries. (Ex. 37-28, -34, -35). Dr. Flemming's opinion is not sufficient to establish compensability of claimant's spondylolisthesis.

The only medical evidence that supports claimant's position is from Dr. Fulper. He agreed that claimant had a pars defect with grade I spondylolisthesis that preexisted the December 1996 injury. (Ex. 32-1). On the other hand, Dr. Fulper said that claimant "may have developed his spondylolisthesis from his December 1996 hyperextension injury." (Ex. 32-2). He did not explain how claimant could have "developed" the spondylolisthesis in December 1996 if that condition preexisted the injury.

Furthermore, we find that Dr. Fulper's opinion is not persuasive because he did not properly evaluate the relative contribution of the preexisting condition and the work injury and explain why the injury was the major contributing cause of the L5-S1 spondylolisthesis. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Dr. Fulper explained: "Because [claimant] states he has had ongoing problems with back pain since that [December 1996] injury, I believe this injury is the major contributing cause of his present need for medical treatment. (Ex. 32-2). We find that Dr. Fulper's opinion establishes only that the work injury was the precipitating cause of claimant's spondylolisthesis symptoms. Such an opinion is insufficient to establish compensability. *See Dietz*, 130 Or App at 401 (fact that work activities precipitated a claimant's injury does not necessarily mean that work was the major contributing cause of the condition).

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[2] Although claimant raised the issue of compensability of his spondylolysis condition at hearing (Tr. 1, 7), he does not raise that issue on review. Dr. Flemming explained that spondylolysis is a defect in the bone that allows the spondylolisthesis to occur. (Ex. 37-19, -33). In claimant's case, Dr. Flemming diagnosed the spondylolisis and spondylolisthesis together. (Exs. 26-2, 36-1, 37-19). Similarly, Dr. Fulper said that claimant had "bilateral spondylolysis involving S1, with an associated grade I spondylolisthesis[.]" (Ex. 16-1). Based on these medical reports, we do not address compensability of a separate spondylolysis condition.

L3-4 Herniated Disc

We first address Wausau's argument that claimant has never made a valid claim for spinal stenosis at L3-4 or a herniated disc at that level. Wausau contends that, although claimants attorney mentioned the L3-4 herniated disc in opening statement, there has been no written claim for that condition.

At hearing, claimant's attorney characterized the issues as compensability of L5-S1 spondylisthesis and spondylolysis, as well as an L3-4 herniated disc and L4-5 herniated disc. (Tr. 1, 7). Neither carrier objected to claimant's characterization of the issues. The medical evidence discusses causation of the L5-S1 spondylolisthesis, the L4-5 herniated disk and the L3-4 herniated disk and the ALJ made findings regarding compensability of all three conditions.

Because Wausau did not object at hearing to the characterization of the issues as including an L3-4 disc condition and proceeded to litigate compensability and responsibility of that condition, we find that Wausau has waived any potential procedural challenge to claimant's characterization of the issues litigated. *See Thomas v. SAIF*, 64 Or App 193 (1983); *see also Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue). Therefore, we proceed to the merits.

Claimant relies on the opinions of Drs. Fulper and Flemming to establish compensability of his L3-4 disc herniation.

We are not persuaded by the opinion of Dr. Fulper because his opinion is inconsistent and lacks adequate explanation. Dr. Fulper diagnosed claimant with a lumbar strain on April 16, 1997, and he noted that claimant had "probably centrally bulged his L3, 4 disk." (Ex. 1). In his later reports in 1997, however, he diagnosed only a lumbar strain and spondylolosis. (Exs. 5, 8, 10). Although Dr. Fulper treated claimant for the January 14, 1999 injury, his chart notes did not refer to an L3-4 disk problem. Dr. Fulper's first mention of that condition was on August 15, 1999, when he responded to questions from claimant's attorney. (Ex. 32).

In the first part of his August 15, 1999 report, Dr. Fulper said that claimant "may have sustained a disk herniation from the January 1999 workplace event." (Ex. 32-1). Later in the report, he said that claimant had probably herniated his L3-4 disk from the January 1999 injury. (Ex. 32-2). In the same report, however, Dr. Fulper said that claimant's December 1996 injury was the major contributing cause of his present need for medical treatment. (*Id.*) He noted that Dr. Flemming had said that the disk had a "high signal intensity and hence may represent a recent event." (Ex. 32-2, -3). Because Dr. Fulper has attributed claimant's L3-4 disk herniation to both the December 1996 incident and the January 1999 injury, his opinion is entitled to little weight.

Claimant also relies on the opinion of Dr. Flemming. 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, Dr. Flemming examined claimant on only one occasion and met with him twice to discuss the imaging studies and treatment options. (Ex. 37-30, -31). Under these circumstances, Dr. Flemming's opinion is not entitled to any particular deference.

For the following reasons, we are not persuaded by Dr. Flemming's opinion regarding causation of claimant's L3-4 disk herniation. We agree with Wausau that Dr. Flemming's opinion is not persuasive because he did not have an accurate history of claimant's back symptoms. Claimant testified that, between December 1996 and January 1999, his back pain ranged between a level of five and eight, based on a scale of one to ten, with ten being the worst pain. (Tr. 29, 43, 44). He said that his back pain never went below "five." (Tr. 42, 43). Claimant said his back pain was a seven or eight between January and April 1999. (Tr. 29, 30, 45).

Dr. Flemming first examined claimant on May 14, 1999. (Ex. 26). He reported that claimant's back pain after the December 1996 injury had eventually improved and he had returned to work. (Ex. 26-1). Claimant told Dr. Flemming that his pain had "never been completely gone but it was tolerable."

(*Id.*) In a deposition, Wausau's attorney asked Dr. Flemming about his understanding of claimant's back symptoms after the 1996 injury and before the January 1999 incident. (Ex. 37-49). Dr. Flemming understood that claimant had intermittent back pain since the 1996 event. (*Id.*) He believed that claimant had back episodes "that he got over and got better" and, since the 1999 injury, claimant had pain in the range of six to eight out of ten, which had not gone away. (Ex. 37-51, -52). Dr. Flemming agreed that the history was quite significant in forming his opinion on causation of the L3-4 disk. (Ex. 37-52).

Wausau's attorney asked Dr. Flemming what his opinion would be if claimant had experienced pain in the range of five to eight out of ten since 1996. (Ex. 37-51). Dr. Flemming and Wausau engaged in the following colloquy:

> "A. [Dr. Flemming]: Then I would say his pain is probably related to all the different areas in his back, spondylolisthesis, degenerative changes, and whatever else is going on at the L3-4 level.
>
> "Q. [Wausau]: Would it still be advisable to --
>
> ""A. [Dr. Flemming]: I am not following you, I guess. *Because my understanding by his history is totally different than what you are proposing here.* His history is that he had episodes of pain in the back that he got over and got better, and since the most recent injury in '99 he has had this six to eight pain that has not gone away despite fairly active conservative treatment including injections, time, therapy, medications? Is that wrong?" (Ex. 37-51, -52; emphasis supplied).

Based on claimant's testimony, we find that Dr. Flemming had an inaccurate understanding of his back symptoms between the December 1996 injury and the January 1999 injury. Because his opinion was based on an inaccurate history, we do not find Dr. Flemming'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).

Moreover, we find that Dr. Flemming's opinion regarding causation of the L3-4 disk herniation was inconsistent and was couched in terms of possibility rather than probability. In *Gormley v. SAIF*, 52 Or App 1055, 1060 (1981), the court found that the doctors' use of the words "could," "can," "it is reasonable to assume" and "we would like to assume" worked against a finding of medical causation in terms of probability. The *Gormley* court concluded that, because the claimant could not prove more than just the possibility of a causal connection, she failed to carry her burden of proof.

In a report to Travelers, Dr. Flemming agreed that the January 1999 injury was the major contributing cause of the L3-4 herniation. (Ex. 35-3). In a "check-the-box" letter from claimant's attorney, however, Dr. Flemming agreed that claimant probably herniated the L3-4 disc in early 1997 when the stack of boxes fell on his back. (Ex. 36-3). Dr. Flemming did not explain his change of opinion.

In a deposition, Dr. Flemming agreed that the January 1999 injury was the major contributing cause of claimant's L3-4 herniation. (Ex. 37-6). He said his "gut feeling" was that claimant probably herniated his disk at that time. (Ex. 37-8, -9). When he was asked if his opinion was based on a reasonable medical probability (Ex. 37-8), Dr. Flemming responded:

> "Well, you guys use the term 'probability' for indicating a greater than 50-percent chance; 'possibility' indicating less than 50-percent chance. That is my understanding of the definition of 'probability' versus 'possibility.' *I would say it is possible, it may be probable, but I have no way of knowing.*" (Ex. 37-9; emphasis supplied).

Dr. Flemming's opinion that the 1999 injury "may be" the probable cause of the L3-4 disk herniation is not sufficient because it suggests only a possibility of a causal connection. *See Gormley*, 52 Or App at 1060. Dr. Flemming also said that "you could make the *assumption* that with [the 1999 injury], he herniated his disk, more likely, than strained his spondylolisthesis." (Ex. 37-11; emphasis supplied). Later in the deposition, Dr. Flemming was again asked about causation of the L3-4 disk herniation. He responded:

> "As I said earlier, I think from the mechanism of injury and the history of his pain, that is a reasonable *assumption* that pulling the rope caused the disk herniation at L3-4." (Ex. 37-29; emphasis supplied).

In addition, Dr. Flemming could not specify the source of claimant's back pain. He explained that claimant's back pain could be caused by the L3-4 herniation, the L4-5 degenerative changes and bulging disk, or the spondylolisthesis. (Ex. 37-12, -40). He said there was "no real way of telling" which accident caused which disk problem. (Ex. 37-40, -41). Dr. Flemming agreed that claimant "may" have injured the L3-4 disk in December 1996, but he was not certain. (Ex. 37-17). Although Dr. Flemming felt that the L3-4 disk herniation had occurred within the year before May 1999 because of the higher signal intensity on the MRI, he said that a person can herniate a disk "doing anything" and can even wake up with a herniated disk. (Ex. 37-40, -41).

Based on the foregoing reasons, we conclude that Dr. Flemming's opinion is not sufficient to establish compensability of the L3-4 disk herniation. There are no other medical opinions that support compensability of the L3-4 disk herniation.

L4-5 Herniated Disc

Claimant's May 3, 1999 CT showed a small bulge of the L4-5 disc centrally. (Ex. 23). A May 19, 1999 MRI showed spur formation and/or a small disc bulge at the L4-5 disc centrally. (Ex. 27). The only medical evidence regarding claimant's L4-5 disc is from Dr. Flemming.

Dr. Flemming explained that the MRI and CT scan showed claimant had "quite severe degeneration" of the L4-5 disc. (Ex. 28). In an August 27, 1999 letter to Travelers, Dr. Flemming explained that claimant had "quite significant" degeneration at L4-5, which preexisted the January 1999 injury. (Ex. 34). Dr. Flemming explained that the 1996 injury apparently made claimant's degenerative disk changes at L4-5 symptomatic to some degree, but he still continued to work at a fairly vigorous job. (*Id.*)

In a deposition, Dr. Flemming said that claimant had a "bad disk at the L4-5 level that is bulging and degenerating." (Ex. 37-11). Dr. Flemming agreed that claimant's degenerative disk disease at L4-5 probably preexisted the 1996 injury. (Ex. 37-12). He explained that claimant's L3-4, L4-5 and L5-S1 disks were all degenerated. (Ex. 37-13). He agreed that claimant's genetic predisposition was the major contributing cause of the L4-5 bulging disk. (Ex. 37-14, -15). Later in the deposition, Dr. Flemming said he did not have an opinion to a "medical certainty" as to the cause of the L4-5 herniation, although he felt it was more of a degenerative herniation rather than an acute event. (Ex. 37-35, -36). He said there was no real way of telling which incident caused which disk problem. (Ex. 37-41).

We conclude that Dr. Flemming's opinion is not sufficient to establish that claimant's L4-5 disc condition is related to either of his work injuries.

ORDER

The ALJ's order dated April 7, 2000 is affirmed.

August 31, 2000 Cite as 52 Van Natta 1572 (2000)

In the Matter of the Compensation of
ROBERT E. LANCE, Claimant
WCB Case No. 99-00944
ORDER OF ABATEMENT
Bottini Bottini & Oswald, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

On August 3, 2000, we affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's current low back condition. Announcing that the parties have scheduled a mediation session in the hopes of resolving this dispute, the insurer seeks abatement of our decision.

Based on the insurer's representation, we withdraw our August 3, 2000 order. Any proposed settlement should be submitted for our consideration. Should a settlement prove to be unattainable, we will republish our August 3, 2000 order. Meanwhile, the parties are requested to keep the Board apprised of any further developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
CAMILLA S. KOSMOSKI, Claimant
WCB Case No. 99-09855
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) directed it to process claimant's "new medical condition" claim under ORS 656.262 and ORS 656.268; (2) assessed a penalty pursuant to ORS 656.268(5)(d)[1] for SAIF's allegedly unreasonable failure to close the claim; and (3) awarded a $2,000 attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable claim processing. In its brief, SAIF contends that neither the ALJ nor the Board have jurisdiction over this matter. On review, the issues are jurisdiction, claim processing, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Claimant compensably injured her left shoulder and right elbow in August 1994. SAIF accepted a nondisabling left shoulder sprain and a right elbow strain. A July 8, 1996 Notice of Closure advised claimant that her aggravation rights would end on August 20, 1999.

On September 14, 1999, claimant's counsel requested that SAIF expand its acceptance to include: shoulder adhesive capsulitis; tenosynovitis, bicipital left; and tendinitis and impingement syndrome. On October 8, 1999, SAIF modified its acceptance to include these additional medical conditions.

On November 2, 1999, claimant's counsel wrote to SAIF, requesting that it close the claim for the new medical conditions within 10 days. SAIF did not close the claim. Instead, SAIF recommended to the Board that claimant's claim not be reopened for time loss benefits under Own Motion.

On November 24, 1999, the Board, under its Own Motion jurisdiction, issued an order denying claimant's request for Own Motion relief. Claimant requested reconsideration of the Own Motion order, requesting the Board to order SAIF to "reopen the new conditions and issue the appropriate closure" pursuant to *John R. Graham*, 51 Van Natta 1740 (1999), and *John R. Graham*, 51 Van Natta 1746 (1999). The Board issued an Own Motion Order on Reconsideration on February 9, 2000, holding that claimant did 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) and that it was without authority in its Own Motion capacity to direct a carrier to process a claim under ORS 656.262(7)(c).

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[1] The ALJ applied *former* ORS 656.268(4)(f). Effective October 23, 1999, that statute was renumbered ORS 656.268(5)(d) with no change in text. Or Laws 1999, ch 313, sec 4. Claimant's written request that SAIF close the claim was dated November 2, 1999. Therefore, we cite to the renumbered statute.

On December 4, 1999, claimant requested a hearing, seeking an order requiring SAIF to reopen and process her "new medical condition" claim to closure under ORS 656.262(7)(c). The ALJ remanded claimant's "new medical condition" claim to SAIF for processing under ORS 656.262, ORS 656.268 and any other applicable provisions.

On review, SAIF contends that, because aggravation rights have run on claimant's injury, sole jurisdiction over the claim processing issue lies with the Board in its Own Motion capacity. We disagree.

We previously addressed the bifurcated authority of the Board in *John R. Graham*, 51 Van Natta 1740 (1999), 51 Van Natta 1746 (1999), and in *Craig J. Prince*, 52 Van Natta 108 (2000). In *Graham*, 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 *Prince*, we determined that the Board's authority under its "Own Motion" capacity is strictly limited by the provisions of ORS 656.278 and that those provisions do not include the authority to direct a carrier to process a claim under ORS 656.262(7)(c). 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.*

Consequently, because the claim processing arguments raised by claimant in this case involve a "matter concerning a claim," the Hearings Division and the Board have jurisdiction. *See also Larry L. Ledin*, 52 Van Natta 682 (2000) (discussing Board's bifurcated authority and concluding that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268 even when the claimant's original claim is in Own Motion status).[2]

Claim Processing

We adopt and affirm the ALJ's order on this issue.[3] *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 at 1745 (1999) (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). *See also Johansen v. SAIF*, 158 Or App 672, 680-81, *on recon* 160 Or App 579, (ORS 656.262(7)(a) gives no indication of an intention to exclude the new medical condition claim from the processing requirements for claims

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[2] In light of the Board's bifurcated authority discussed above, we agree with SAIF that the Board has no authority to award benefits under ORS 656.262 and 656.268 under its Own Motion jurisdiction. *Independent Paper Stock v. Wincer*, 100 Or App 625, 627-628 (1990). Similarly, we agree with SAIF that the Board's Hearings Division lacks original jurisdiction to enforce a Board's Own Motion order, *Orman v. SAIF*, 131 Or App 653, 656-657 (1994), and that the Board under its Own Motion jurisdiction has no authority to order vocational assistance, *Harsh v. Harsco Corp.*, 123 Or App 383 (1993).

However, under the procedural posture of this case, SAIF's reliance on those cases is misplaced. The issues in this case are claim processing under ORS 656.262(7)(c) and claim closure under ORS 656.268, which arise under the Hearings Division's jurisdiction over "matters concerning a claim," and not under the Board's Own Motion jurisdiction.

[3] SAIF also argues on page 12 of its appellant's brief that any claim that it failed to process the new conditions after acceptance is barred after two years are not inclined to consider it on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). In any case, SAIF litigated its alleged failure to process the claim at the hearing without objection. Under such circumstances, we find that SAIF has waived any potential procedural challenge to claimant's request for hearing. *Thomas v. SAIF*, 64 Or App 193 (1983); *Ezra J. Tolman*, 52 Van Natta 310 (2000). Moreover, even if we were to consider SAIF's contention, we would reject it because the period between the alleged failure to process the claim under ORS 656.262(7)(c) and the request for hearing in this case was less than four months, well within the two year statutory period allowed under ORS 656.319(6). *Robert A. Olson*, 52 Van Natta 1540 (2000).

generally that are provided in ORS 656.262 and ORS 656.268 * * * * * [A] new medical condition claim must be processed as any other claim), *rev den* 329 Or 527 (1999).[4]

Penalty and Attorney Fees

The ALJ assessed a penalty under ORS 656.268(5)(d) (to be shared equally by claimant and her counsel) and an attorney fee under ORS 656.382(1), based on SAIF's allegedly unreasonable refusal to close claimant's "new medical condition" claim. Based on the following reasoning, we reverse.

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).

Claimant's request that SAIF close the claim was made on November 2, 1999. On November 24, 1999, the Board, under its Own Motion jurisdiction, issued an order denying claimant's request for Own Motion relief based on the lack of surgery or other treatment requiring hospitalization. Claimant requested reconsideration, citing *Graham*, which had issued on October 14, 1999. As discussed above, we determined in *Graham* that, where a new medical condition claim is accepted after claim closure, the claim qualifies for reopening for the payment of benefits that would have been due if that new medical condition had been accepted. *Graham* supports the proposition that this entitlement extends to claims for medical conditions that are made after aggravation rights have expired on the original claim. However, *Graham* does not address the preclusive effect, if any, of an unappealed Own Motion order that allegedly involves the "new medical condition."

On December 16, 1999, claimant requested a hearing, challenging SAIF's failure to close his new medical condition claim. On February 9, 2000, in response to claimant's motion for reconsideration, the Board issued an Own Motion Order again denying reopening based on the lack of surgery or inpatient hospitalization. Citing *Craig J. Prince*, 52 Van Natta 108 (2000), the Board further stated that it was without authority in its Own Motion capacity to direct a carrier to process a claim under ORS 656.262(7)(c). The Board's Own Motion order was not appealed. The hearing in this case was held on March 14, 2000. On April 14, 2000, following the hearing and the ALJ's order, the Board issued *Larry L. Ledin*, 52 Van Natta 682 (2000). In *Ledin*, the Board held that a carrier was responsible for the processing of a new medical condition under ORS 656.262(7)(d) (for closure under ORS 656.268) even when the claim had been previously reopened under ORS 656.278 for allegedly the same condition by a final, unappealed Own Motion order.

Consequently, it was not until issuance of the *Ledin* decision that it became clear that, notwithstanding the submission of an Own Motion recommendation (and issuance of an unappealed Own Motion order), a carrier was still obligated to reopen, process, and close a claim for a new medical condition pursuant to ORS 656.262 and ORS 656.268. Because the *Ledin* holding issued after SAIFs claim processing actions, SAIF had a legitimate doubt regarding its liability for the processing of the new condition claim pursuant to ORS 656.262 and ORS 656.268 and, as such, it was not unreasonable for SAIF to refuse to close the claim under ORS 656.268. Accordingly, we reverse that portion of the ALJ's order that assessed a penalty and attorney fee for SAIF's refusal to close claimant's new medical condition claim under ORS 656.268.

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[4] On review, SAIF contends that *John R. Graham* and *Johansen v. SAIF* were wrongly decided. SAIF notes that the Board's decision in *Graham* is pending review before the Court of Appeals. However, because the court has not yet reached a decision regarding *Graham*, that case remains good law, and we continue to apply it on review. Moreover, we are bound by precedent, which includes the *Johansen* decision.

SAIF also argues that, where a claim has previously been determined for benefits, claim preclusion bars the award of further benefits under ORS 656.262 and 656.268 unless there is an express statutory provision that allows further benefits after claim closure. SAIF contends that, because claimant's aggravation rights have expired in this case, the only applicable legislative exception to the claim preclusion doctrine is ORS 656.278, which limits the benefits available to claimant. Because this argument is merely another challenge to the Board's holding in *Graham*, we decline to address it.

Claimant is entitled to an attorney fee for her counsel's services on review regarding the claim processing 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 counsel's services on review concerning the claim processing issue is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 27, 2000 is affirmed in part and reversed in part. The ALJ's penalty and attorney fee assessments are reversed. The remainder of the ALJ's order is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
LORRAINE W. DAHL, Claimant
WCB Case No. 99-04622
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Fulsher's order that upheld the self-insured employer's denial of her 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.

Claimant is a 52 year-old directory assistance operator. Approximately three years prior to the hearing, she changed from a "toll operator" position at the employer to her current position. Herjob requires her to use a computer keyboard all day. After one year of performing her directory assistance operator duties, claimant experienced the onset of symptoms in her right shoulder. In February 1999, claimant sought treatment with Dr. Stringham and filed a claim for an occupational disease involving her right shoulder. The employer denied claimant's claim on the basis that her condition was not worsened by, nor did it arise out of, or in the course of, her employment. (Ex. 6).

The ALJ upheld the employer's denial, finding that claimant had not met her burden of proving the compensability of her right shoulder tendinitis/bursitis condition through the opinion of her treating physician, Dr. Stringham. The ALJ reasoned that, at most, Dr. Stringham's opinion established that claimant's work activities as a directory operator were the major contributing cause of claimant's right shoulder symptoms. (*See* Exs. 9, 9D). On review, claimant contends that the ALJ erred in failing to rely on Dr. Stringham.

This is an occupational disease claim under ORS 656.802. Claimant must therefore prove that her work activities are the major contributing cause of her right shoulder tendinitis condition itself, rather than just of the disability and need for treatment for her right shoulder condition. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). Here, we agree with the ALJ that Dr. Stringham's opinion establishes only that claimant's work activity was the major contributing cause of her right shoulder symptoms, as opposed to the disease itself. (Ex. 9). Under those circumstances, claimant has failed in her burden of proof. *Robinson v. SAIF*, 147 Or App 157 (1997), *Salvador Padilla*, 51 Van Natta 1693 (1999).

Because claimant has not met her burden of proof through the opinion of Dr. Stringham, it is unnecessary to discuss claimant's contentions regarding the persuasiveness of Dr. Schilperoort's opinion or the accuracy of the videotape allegedly depicting claimant's work activities, upon which Dr. Schilperoort relied. *See Connie J. Barrs, on recon*, 51 Van Natta 1500 (1999) (if medical opinions supporting compensability are insufficient to meet the claimant's burden of proof, the claimant's claim fails, regardless of persuasiveness of countervailing opinions).

ORDER

The ALJ's order dated March 31, 2000 is affirmed.

September 1, 2000 Cite as 52 Van Natta 1577 (2000)

In the Matter of the Compensation of
RENEE E. GREEN, Claimant
WCB Case No. 00-00117
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Livesely's order that: (1) found that claimant's claim was not barred as untimely filed; and (2) set aside the insurer's denial of claimant's injury claim for an L5-S1 disc herniation. On review, the issues are timeliness and compensability.

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

Claimant worked as a cook in the employer's residential care facility. On September 26, 1999, claimant filed a workers' compensation claim alleging that she injured a disc in her low back on March 4, 1999. She alleged that, on that date, she unloaded freight and then bent over to get a mixing bowl out of the cupboard and felt a pull and low back pain. Claimant was ultimately diagnosed with a herniated disc at L5-S1. Dr. Goodwin performed surgery on the disc in October 1999.

The insurer denied the claim on December 17, 1999 on the grounds that the injury did not occur within the course and scope of employment and that the claim was not reported to the employer within 90 days of the alleged injury.

The ALJ found that the employer had knowledge of the injury within 90 days and that notice of the claim was given within one year. On this basis, the ALJ concluded that the claim was not time-barred under ORS 656.265(4).[1] Addressing the merits, the ALJ found that claimant had established compensability of her claim.

The insurer argues on review that claimant's claim was untimely because she failed to establish that the employer had knowledge of the claim within the initial 90 days following the injury. *See Jeffery E. Henderson*, 50 Van Natta 2340, 2342 (1998) (under ORS 656.265(4), the employer must have had knowledge of the injury within 90 days after the alleged injury date). In *Argonaut Insurance v. Mock*, 95 Or App 1 (1989), the court discussed what constitutes "knowledge of the injury" for purposes of ORS 656.265(4):

> "'[K]nowledge of the injury' must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate." *Id.* at 5. (Emphasis added.)

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[1] ORS 656.265(4) provides, in relevant part: "Failure to give notice a required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and * * * (a) The employer had knowledge of the injury or death * * *."

Here, claimant's supervisor, Ms. Hoover, gave a recorded statement to the insurer in which she stated that claimant had mentioned that her back hurt and that she might have pulled something putting away freight at work or that the back started hurting after unloading the freight. (Ex. 21A-8, 18). Ms. Hoover believed that the conversation took place between March 4th and April 5th. (Ex. 21A-18). Ms. Hoover also believed that claimant had mentioned her back hurting in a conversation with claimant, herself and Ms. Herring.

At the hearing, Ms. Hoover testified that claimant told her sometime between March 1999 and June 1999 that her back hurt, but that claimant did not mention anything specific that caused the back pain. (Tr. 56-57). Ms. Hoover did testify, however, that claimant mentioned that her back might have been hurt putting freight away, but Ms. Hoover could not remember when the conversation took place. Ms. Hoover also recalled a conversation between claimant, herself and Ms. Herring in which claimant said that her back was really hurting and that Ms. Herring had said "Oh, you just don't take enough breaks." (Tr. 57).

Ms. Herring, the owner of the residential care facility where claimant worked, testified that she was not aware that claimant was having problems with her back between March 1999 and the summer of 1999.

Ms. Rollins, the administrator who was hired by the employer in April 1999, testified that she was aware that claimant had pain, but testified that she was not aware that claimant was claiming that the back pain was caused by work until September 1999 when claimant filed a workers' compensation claim. (Tr. 51).

Although Ms. Hoover's testimony and statement are somewhat scattered and confusing, we are persuaded that she was aware that claimant had back pain between March 1999 and roughly early April 1999 (within 90 days of the alleged injury), and that the pain may have been caused by unloading freight at work.[2] Under such circumstances, we are persuaded that the employer, through Ms. Hoover, had enough knowledge of claimant's back injury to lead it to conclude that workers' compensation liability was a possibility and that further investigation was appropriate.

With regard to the merits, we agree with the ALJ that claimant has established compensability of her claim. We find no reason not to defer to the opinion of claimant's surgeon, Dr. Goodwin. *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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 4, 2000 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, payable by insurer.

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[2] With regard to when the conversation between Ms. Hoover and claimant took place, we rely on Ms. Hoover's investigative statement which was made closer in time to the events following the injury.

In the Matter of the Compensation of
BONNIE J. WOOLNER, Claimant
WCB Case Nos. 99-04302, 99-02707 7 98-09381
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of chronic muscle tightness/myofascial pain syndrome in claimant's neck. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the employer's denial of her current right shoulder condition; (2) upheld the employer's denial of her occupational disease claim for right shoulder and neck conditions; (3) upheld the employer's denial of chronic muscle tightness/myofascial pain syndrome in claimant's right shoulder; (4) set aside a March 22, 1999 Order on Reconsideration that determined that a January 4, 1999 Notice of Closure had prematurely closed her claim; and (5) set aside as "moot" an August 9, 1999 Order on Reconsideration awarding 24 percent (76.8 degrees) unscheduled permanent disability. On review, the issues are compensability, premature claim closure and extent of unscheduled permanent disability. We reverse in part, affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

Current Condition Denial

As a result of claimant's compensable May 29, 1996 injury, the employer accepted "multidirectional instability" of the right shoulder and a "cervical strain." (Exs. 24, 33, 58). Prior to claim closure on January 4, 1999, the employer denied claimant's current right shoulder condition on November 25, 1998. (Ex. 58). Claimant requested a hearing contesting the denial.

The ALJ determined, based on the medical evidence, that the compensable injury had combined with preexisting bilateral multidirectional shoulder instability to cause a need for treatment. Concluding that the employer had, therefore, accepted a "combined condition," the ALJ upheld the employer's denial, finding that, at the time the denial was issued, the compensable injury was no longer the major contributing cause of the need for treatment. *See* ORS 656.005(7)(a)(B).

On review, claimant contends that the current condition denial should be set aside on procedural and substantive grounds. The employer responds that the current condition denial was appropriate procedurally, as well as substantively, because the "preclosure" denial was required by ORS 656.262(7)(b) when the medical evidence indicated that the accepted injury was no longer the major contributing cause of claimant's "combined condition."[1] For the following reasons, we conclude that the employer's current condition denial was an invalid "preclosure" denial.

In *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998), we construed ORS 656.262(7)(b) as providing that, whether or not the carrier has accepted a combined condition, the carrier may avail itself of the "preclosure" denial procedure of that statute whenever the medical evidence establishes that a claimant's accepted injury has combined with a preexisting condition to cause or prolong disability or a need for treatment on an open claim. However, the Court of Appeals has since concluded that, in order for a carrier to properly issue a "preclosure" denial under ORS 656.262(6)(c) and ORS 656.262(7)(b), the carrier must have accepted a combined condition. *Croman Corp. v. Serrano*, 163 Or App 136 (1999).

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[1] Under ORS 656.262(7)(b), after a worker's claim has been accepted, the carrier "must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

Here, the employer expressly accepted "multidirectional instability" of the right shoulder, but it did not accept a "combined condition." Because the employer did not accept a combined condition, it may not properly issue a "preclosure" denial under ORS 656.262(6)(c) or ORS 656.262(7)(b). Accordingly, we reverse that portion of the ALJ's order that upheld the employer's denial.[2]

Occupational Disease Claim

We adopt the ALJ's reasoning on this issue.

Denial of Chronic Muscle Tightness/Myofascial Pain Syndrome

On April 2, 1999, the employer denied claimant's request that it accept chronic muscle tightness and myofascial pain syndrome in the neck and shoulder areas. The denial stated that medical evidence from the attending physician indicated that claimants compensable injury was not the major contributing cause of the claimed conditions. (Ex. 71).

The ALJ analyzed the neck and shoulder areas separately. The ALJ first determined that, with respect to the cervical area, the employer's denial should be set aside. The ALJ reasoned that, since there was no "combined condition," a material causation standard applied. *See Albany General Hospital v. Gasperino*, 113 Or App 411, 414 (1992).

After reviewing the medical evidence, the ALJ determined that claimant had proved that the compensable injury was a material contributing cause of claimant's cervical muscle tightness/myofascial syndrome. Alternatively, the ALJ determined that cervical muscle tightness was the condition the employer originally accepted and that, therefore, the April 2, 1999 denial was an invalid "back-up" denial with respect to the cervical condition.

The ALJ then proceeded to determine the compensability of the disputed condition with respect to the right shoulder. The ALJ upheld the employer's denial with regard to the right shoulder, finding that the medical evidence did not establish to a degree of medical probability that the muscle tightness/myofascial pain condition in the right shoulder was compensable.

On review, the employer contends that the ALJ improperly applied a material contributing cause standard. Noting that claimant had conceded that she was making a consequential condition claim, the employer asserts that compensability should be determined under the major contributing cause standard of ORS 656.005(7)(a)(A). Moreover, when that standard is applied, the employer argues that claimant failed to establish the compensability of her chronic muscle tightness/myofascial pain condition.

At the outset, we conclude that the compensability standard in ORS 656.005(7)(a)(A) applies. As the employer notes, claimant conceded this was a consequential condition claim in her written closing argument. (Page 6). Moreover, on review, claimant also describes the muscle tightness/myofascial pain condition as a "consequential condition." (Claimant's Brief p. 9). Finally, the ALJ described the employer's denial of the chronic muscle tightness/myofascial condition as a "consequential" condition denial. (O&O p. 4). Therefore, we find that, under ORS 656.005(7)(a)(A), claimant must prove that the compensable injury is the major contributing cause of the consequential muscle tightness/myofascial syndrome in claimant's cervical spine and right shoulder.

On June 15, 1998, Dr. Sullivan, claimant's attending physician, opined that claimant's cervical strain and an "unspecified" shoulder problem were directly related to the compensable May 1996 injury. Dr. Sullivan further opined that these conditions caused muscle tightness associated with pain. (Ex. 44). In September 1998, Dr. Sullivan diagnosed "chronic myofascial syndrome," which the medical evidence indicates is synonymous with chronic muscle tightness. (Ex. 68). Dr. Sullivan agreed on March 19, 1999 in a concurrence letter from the employer's counsel that claimant was susceptible to "pain and tightness" when she engaged in certain activities or experienced tension. Dr. Sullivan, however, agreed that the symptoms of pain and tightness were primarily due to particular activities or tension-producing factors at the time they occurred and that claimant's original May 1996 injury was not the major contributing cause of these symptoms or claimant's need for treatment. (Ex. 68).

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[2] Moreover, we note that, at the time the current condition denial was issued, there was neither ongoing treatment nor any request for further medical services related to claimant's right shoulder condition. Accordingly, we also conclude that the employer's November 1998 current condition denial was an improper prospective denial of claimant's right shoulder condition. *See Elizabeth Markuson*, 52 Van Natta 781 (2000); *Jose D. Rodriguez*, 49 Van Natta 703, 704 (1997).

In September 1999, Dr. Sullivan later responded to a concurrence letter from claimant's attorney. In that letter, Dr. Sullivan agreed that claimant had developed a chronic neck strain due to her compensable injury and that this was "somewhat" synonymous with myofascial pain syndrome. Dr. Sullivan further agreed that, when he concurred with the letter from the employer's counsel, he had not intended to discount or dismiss the role of the original injury. Dr. Sullivan agreed that, while claimant's current symptoms may be caused by tension producing activities, claimant's chronic cervical strain was directly related to the compensable injury and that the original injury remained the major contributing cause of the chronic cervical neck condition. (Ex. 81).

The parties then deposed Dr. Sullivan, who, in response to questioning by the employer's counsel, testified that his March 1999 concurrence letter accurately reflected his opinion and the activities that precipitated claimant's symptoms are the major contributing cause of the need for treatment. (Ex. 82-5, 6). Yet, at another point, Dr. Sullivan testified that the September 1999 concurrence letter accurately reflected his opinion. (Ex. 82-10).

Having reviewed Dr. Sullivan's opinion as a whole, we do not find that it proves that claimant's compensable injury is the major contributing cause of the consequential chronic muscle tightness/myofascial pain syndrome condition. While Dr. Sullivan clearly believes that claimant's original injury remains the major contributing cause of claimant's cervical strain (which remains accepted), he has indicated the major factor in claimant's muscle tightness condition are the activities that produce the symptoms of that condition, not the compensable injury. Accordingly, we conclude that claimant has failed to establish the compensability of his consequential condition claim for chronic muscle tightness/myofascial pain syndrome in the cervical spine and right shoulder.[3] Thus, we reverse the ALJ's decision setting aside the employer's denial to the extent that it denied cervical muscle tightness/myofascial pain syndrome. Because of this decision, we likewise reverse the ALJ's $1,000 attorney fee award.

Premature Claim Closure

The ALJ determined that the January 4, 1999 Notice of Closure was not prematurely issued. The ALJ reasoned that the medical evidence established that claimant's compensable right shoulder and cervical conditions were medically stationary prior to claim closure. We agree with the ALJ's evaluation of the medical evidence that indicated that claimant's compensable conditions were medically stationary prior to claim closure. Accordingly, we reinstate the Notice of Closure.[4]

We also take this opportunity to address the Department's procedural objections to the employer's January 4, 1999 claim closure. The Department objected to the January 1999 closure notice because adequate closing information was not obtained pursuant to OAR 436-030-0020(1) through (4). However, the Department is not authorized to set aside a carrier's closure notice as premature on the basis that the carrier did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4). *See Ball v. The Halton Company*, 167 Or App 468 (2000).

Finally, the Department noted that, in November 1998, the employer had issued a major contributing cause denial prior to claim closure but did not comply with OAR 436-030-0034(4), which requires notice to the worker that claim closure may result from the issuance of the major contributing cause denial. However, based on our finding that claimants accepted conditions were medically stationary at the time of the January 1999 claim closure, we find OAR 436-030-0034(4)(a) inapplicable because this rule only applies if the claimants condition is not medically stationary. *Timothy R. Sowell*, 52 Van Natta 112, 113 n. 3 (2000).

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[3] We also reject the ALJ's determination that the portion of the employer's April 2, 1999 denial that denied cervical muscle tightness was a "back-up" denial. The employer accepted a cervical "strain," a condition distinct and separate from the cervical muscle tightness claimant alleged was compensable. Moreover, the record does not establish that the employer was attempting to the deny the compensability of the original cervical strain injury.

[4] We take this action as the ALJ did not reinstate the January 4, 1999 closure notice despite determining that the March 22, 1999 reconsideration order incorrectly set it aside as premature.

Unscheduled Permanent Disability

After the Department set aside the January 1999 Notice of Closure as premature, the employer reclosed the claim by Notice of Closure dated March 31, 1999, that also awarded no permanent disability. Claimant requested reconsideration of that closure notice. As part of the reconsideration proceedings, a medical arbiter panel consisting of Drs. Coulter and Tiley examined claimant on June 23, 1999. Although they initially acknowledged that the accepted conditions were "multidirectional instability, right shoulder and cervical strain," at another point they described the accepted conditions (incorrectly) as "right shoulder strain, multidirectional instability, and cervical strain." (Ex. 79-7).

Based on the arbiter's range of motion findings in the shoulder and cervical spine, an Order on Reconsideration dated August 9, 1999 determined that claimant had 8 percent impairment in the right shoulder and 11 percent in the cervical spine. Combining those values, the appellate unit reviewer determined that claimant's total impairment value was 18 percent. Adding this value to the product (6) of the age and education values times the adaptability factor, the Order on Reconsideration awarded a total of 24 percent unscheduled permanent disability. (Ex. 80-3). The employer contested the unscheduled award before the ALJ.

The ALJ declined to reach the merits of the unscheduled permanent disability issue. Noting that he had set aside the employer's denial of claimant's cervical muscle tightness, the ALJ observed that a new closure would have to occur with respect to that condition. Acknowledging that it was not appropriate to delay determination of the permanent disability pending the reopening of the claim for processing of the cervical condition, the ALJ, nevertheless, found it reasonable that closure of the additional claim could be accomplished and a medical arbiter appointed to resolve the extent of disability issues at one time. Accordingly, the ALJ set aside the August 1999 reconsideration order as "moot."

Although claimant contends that the reconsideration order's permanent disability award was correct, neither she nor the employer address the ALJ's reasoning for not addressing the permanent disability issue. Nevertheless, we find that the ALJ should have decided the merits of the permanent disability issue based on the accepted conditions at claim closure (mutidirectional instability of the right shoulder and cervical strain) even though he had determined that the cervical muscle tightness condition was also compensable and that the claim would require reopening for processing of that condition. *See Verna C. Flescher (FKA Lowell)*, 50 Van Natta 1105, 1111 n. 2 (1998), *aff'd mem* 159 Or App 426 (1999); *James L. Mack*, 50 Van Natta 338, 339 (1998). In *Anthony J. Telesmanich*, 49 Van Natta 49, 51 (1997), *on recon* 49 Van Natta 166 (1997), we held that, where the carrier has accepted additional conditions after issuance of an Order on Reconsideration, the proper procedure at hearing on the Order on Reconsideration is to rate the conditions accepted at the time of the Order on Reconsideration and remand the later accepted conditions to the carrier for processing according to law. *See also* ORS 656.262(7)(c); *Bernard G. Hunt*, 49 Van Natta 223 (1997). Therefore, in rating permanent disability under the current statutory scheme, the focus is on accepted conditions at the time of claim closure and reconsideration. *See Janet R. Christensen*, 50 Van Natta 1152 (1998) (evaluation of conditions ordered accepted after claim closure must await the reopening and processing of the claim for that new condition).

In light of the above precedent, we rate permanent disability based on the accepted multidirectional instability and cervical strain conditions. Based on the following reasoning, we agree with the employer that the reconsideration order incorrectly awarded unscheduled permanent disability.

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).

In this case, we do not find the arbiters' report to be well-reasoned. First, the arbiter panel described the accepted conditions inaccurately. As previously noted, the accepted conditions at the time of claim closure were multidirectional instability of the right shoulder and cervical strain. The Coulter/Tiley panel, however, described the accepted conditions as right shoulder strain, multidirectional instability and cervical strain. (Ex. 79-7). In light of the erroneous inclusion of a right shoulder strain among the accepted conditions, we do not find persuasive the arbiters' conclusion that restrictions on right shoulder range of motion were related to the accepted conditions.

Apart from its misidentification of the accepted conditions, we also find the medical arbiters' report to be conclusory and to suffer from its failure to explain why its impairment findings were injury related when the employer had denied chronic muscle tightness/myofascial pain syndrome in the neck and shoulder areas, a denial we have now upheld in its entirety.

In summary, we do not find the medical arbiters' report well reasoned or persuasive. Instead, we rely on the medical opinion of the attending physician at closure, Dr. Sullivan. (Ex. R 47). He opined that claimant had no permanent impairment in the shoulder and cervical region attributable to the compensable injury. (Ex. R46).

Accordingly, we conclude that this record fails to establish that claimant sustained permanent impairment due to the compensable injury. Therefore, we find the Order on Reconsideration incorrectly awarded unscheduled permanent disability. Consequently, we reverse the award of unscheduled permanent disability in the August 9, 1999 Order on Reconsideration.

Attorney Fees

Because we have reversed the ALJ's decision upholding the employer's current condition denial, claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding this 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 with respect to the employer's "current condition" denial is $2,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's 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 March 13, 2000 is reversed in part, modified in part and affirmed in part. Those portions of the ALJ's order that upheld the employer's "current condition" denial, set aside the employer's denial of chronic muscle tightness and myofascial pain syndrome in the cervical spine, set aside the August 9, 1999 Order on Reconsideration as "moot" and remanded the claim "back to the parties" to arrange the appointment of a medical arbiter are reversed. The November 25, 1998 "current condition" denial is set aside and the claim is remanded to the employer for processing in accordance with law. The employer's April 2, 1999 denial of chronic muscle tightness and myofascial pain syndrome in claimant's neck is reinstated and the denial is upheld in its entirety. The ALJ's $1,000 assessed fee is reversed. The August 9, 1999 Order on Reconsideration is reinstated, [and] claimant's award of 24 percent (76.8 degrees) unscheduled permanent disability is reversed The January 4, 1999 Notice of Closure is reinstated and affirmed. The remainder of the ALJ's order is affirmed. For services at hearing and on review regarding the current condition denial, claimant's counsel is awarded an assessed fee of $2,000, to be paid by the employer.

In the Matter of the Compensation of
RAYMOND L. HARRIS, Claimant
WCB Case No. 99-09033
ORDER ON RECONSIDERATION
Swanson, Thomas & Coon, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

On August 23, 2000, we abated our July 27, 2000 order that reversed an Administrative Law Judge's (ALJ's) order affirming an Order on Reconsideration that found claimant's left knee claim was prematurely closed. We took this action to consider the parties' settlement.

The parties have submitted a "Disputed Claim Settlement" that is designed to resolve disputes pending in this case, as well as disputes pending before the Hearings Division in WCB Case No. 00-03153. Those portions of the settlement pertaining to disputes pending before the Hearings Division have received approval from the ALJ. Pursuant to the settlement, "claimant agrees that his claim shall remain in denied status, and that all requests for hearing shall be dismissed with prejudice." The

settlement further provides that the Notice of Closure, Order on Reconsideration, and Opinion and Order should be vacated as moot. Finally, the self-insured employer agrees that "its Request for Board Review shall be dismissed, in accordance with this settlement agreement."

We have approved those portions of the parties' settlement that pertain to this case, thereby resolving the parties' dispute, in lieu of all prior orders. Accordingly, on reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT V. MASSEY, Claimant
WCB Case No. 99-08236
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for his neck, right shoulder and low back condition. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant contends that, pursuant to the court's holding in *SAIF v. Danboise*, 147 Or App 550 (1997), he is entitled to an award of permanent disability because the range of motion findings in this case have not been attributed to any other cause and they are consistent with claimant's injury. We disagree.

Here, claimant's range of motion findings are not necessarily consistent with his injury. Dr. Sacamano, who examined claimant on behalf of the employer, found loss of range of motion. However, Dr. Sacamano also noted that the accepted injuries would not have any "residual effect[...]" Dr. Sacamano further found that there was no evidence of permanent impairment based on purely objective findings. (Ex. 39). Moreover, Dr. Sacamano did cite to other possible non-injury related causes regarding claimant's findings. (Ex. 39-4; 39-5). Consequently, we do not find *Danboise* applicable and we agree with the ALJ that claimant has not established entitlement to an award of permanent disability.

ORDER

The ALJ's order dated March 1, 2000 is affirmed.

In the Matter of the Compensation of
ISMAEL PANTOJA, Claimant
WCB Case Nos. 98-09601 & 98-04597
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Mannix, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation, as the insurer of C&H Reforesters (SAIF/C&H), requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that awarded an assessed fee of $5,000 for claimant's attorney's services in prevailing over its compensability and responsibility denials regarding claimant's low back injury claim. In his brief on review, claimant requests that we increase the assessed attorney fee to $7,500. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF/C&H requests a reduction of the ALJ's award of a total assessed attorney fee of $5,000, contending that a total fee in the range of $3,000 to $3,500 would be appropriate for claimant's attorney's services at hearing. Claimant requests that the total fee be increased to $7,500. Claimant's attorney does not submit a statement of services to support this requested increase, although he estimates that he "spent no less than 40 hours handling the denied compensability/responsibility claim from the time of the initial Request for Hearing through the hearing on the merits."

Following a hearing on the merits, claimant finally prevailed against SAIF/C&H's denials of compensability and responsibility. Claimant's attorney is entitled to an assessed fee for his services in prevailing against those denials. ORS 656.386(1); 656.308(2)(d).

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-010(4). Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

A hearing on the merits convened that lasted over two hours.[1] The hearing transcript regarding the compensability and responsibility issues is approximately 54 pages. Claimant and another witness testified on his behalf, two witnesses testified on behalf of SAIF/C&H, and three witnesses testified on behalf of SAIF/Washburn. The record consists of 43 exhibits, 18 of which were submitted by claimant's attorney. Based on compensability and responsibility disputes generally litigated before this forum, we find the issues presented in this case were of average complexity. The value of the interest involved and the benefit secured for claimant are material, however, because SAIF/C&H has been directed to accept the denied back injury claim, which was diagnosed as cervical, thoracic, and lumbar strains. The attorneys involved in this matter are skilled litigators with substantial experience in workers' compensation law. Furthermore, there was a risk that claimant's counsel might go uncompensated, given the circumstances of claimant's report of the injury, his continuing to work for C&H for almost two weeks following the injury, and his failure to mention the injury when he resigned from C&H.

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[1] In evaluating the extent of claimant's counsel's services at hearing, we have accorded minimal weight to services expended during the "failure to appear/show cause" hearing phases of this litigation. In reaching this determination, we note that neither party has contested the ALJ's conclusion that claimant's failure to receive notice of the March 30, 1999 scheduled hearing was attributable to his counsel's providing the Hearings Division with an inaccurate address.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), including the complexity of the legal issues involved, the value of the interest involved, and the risk claimant's attorney might go uncompensated, we find that $4,000 is a reasonable fee for claimant's counsel's services at hearing regarding the compensability issue. Considering these same factors regarding the responsibility issue, we find that $1,000 is a reasonable fee for prevailing on that issue. Therefore, we agree with the ALJ's total assessed attorney fee award of $5,000.

ORDER

The ALJ's order dated March 24, 2000, as reconsidered April 26, 2000, is affirmed.

In the Matter of the Compensation of
JOHN H. ZIMMERMAN, Claimant
WCB Case No. 99-01164
ORDER ON RECONSIDERATION
James W. Moller, Claimant Attorney
Reinisch, et al, Defense Attorneys
Nicholas M. Sencer, Defense Attorney

On August 17, 2000, we abated our July 19, 2000 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's claim for his L3-4 disc herniation and spinal canal stenosis at L3-4. We took this action to consider the insurer's motion for reconsideration. Having received claimant's response, we now proceed with our reconsideration.

The insurer again contends that Dr. Woodward's opinion is not persuasive. The insurer acknowledges that Dr. Woodward agreed in deposition with claimant's attorney that the 1978 injury and the 1979 and 1981 surgeries were the major cause of claimant's need for treatment. However, the insurer contends that such a statement is inconsistent with Dr. Woodward's testimony that the noncompensable 1969 surgery was an "integral component" of the major contributing cause equation. Consequently, the insurer argues that, at best, the evidence is in equipoise and claimant cannot prevail.

The insurer also contends that, while Dr. Woodward testified that age-related degenerative conditions were a minor contributing factor, his opinion was based on studies of the population at large, rather than on the particulars involved in this case. Under such circumstances, the insurer argues that Dr. Woodward's opinion is not persuasive.

After considering the insurer's arguments and claimant's response, we continue to conclude that claimant has met his burden of proof. Dr. Woodward specifically considered the effects of the noncompensable 1969 surgery and reiterated his opinion that the 1978 injury and following surgeries were the major contributing cause of claimant's need for treatment in 1998. (Ex. 118-24). Moreover, while Dr. Woodward may have referenced a general study, the record indicates that he was aware of the "particulars" of this case and the details of claimant's history and condition.

Claimant's attorney has requested an assessed fee for services on reconsideration. Inasmuch as we have not reduced claimant's compensation, we agree that claimant is entitled to such a fee under ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the insurer's reconsideration request and counsel's stated hours), the complexity of the issue and the value of the interest involved.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our July 19, 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
TERRY L. ANTHONEY, Claimant
WCB Case No. 99-08306
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the finding that in 1976 claimant had a fusion at L4-5. Instead, we find that claimant's 1976 surgery involved laminectomy, excision of the disc, and fusion at L5-S1. (Ex. 0A-3; 0A-10; 0A-11).

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's order with the following supplementation to address claimant's contention that the ALJ incorrectly failed to find Dr. Bert's opinion persuasive.

The ALJ found that claimants work incident of June 1999, combined with claimant's preexisting low back problems to cause claimant's current disability or need for treatment. Consequently, the ALJ determined that: (1) claimant's current low back condition is a combined condition under the terms of ORS 656.005(7)(a)(B); and, (2) the "major contributing cause" standard applies to this claim. Neither party objects to the ALJ's determinations.

Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department,* 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his work incident of June 1999 contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF,* 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda,* 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Dietz,* 130 Or App at 401; *see also Robinson v. SAIF,* 147 Or App 157, 162 (1997); *Elaine M. Baxter,* 51 Van Natta 1898 (1999).

Here, Dr. Bert, claimant's treating physician, opined that the lifting incident at work in June 1999 resulted in a free disc fragment becoming lodged in the neural foramina at L5-S1, thereby causing claimant's current disability or need for treatment. (Ex. 12-1). Dr. Bert's opinion is based upon his own review of MRI films from 1997 and 1999, as well as claimant's history of being symptom free for about a two year period prior to the work incident of June 1999.[1] We interpret Dr. Bert's opinion as supporting a conclusion that the work incident of June 1999 is the precipitating cause, but not necessarily the major contributing cause, of claimant's current disability or need for treatment.

[1] We note that Dr. Bert's opinion is also based upon his belief that claimant's L5-S1 interbody space retains enough motion, despite a previous fusion at that level, that herniation of additional disc material can occur. (Ex. 12-2). We note further that Dr. Schilperoort, an employer-arranged medical examiner, disputes this belief. (Ex. 10-10).

We acknowledge claimant's argument that Dr. Bert's opinion considers claimant's past medical history, the prior surgeries and claimant's recovery therefrom, as well as the MRI studies. We further acknowledge that Dr. Bert has also considered the types of surgical procedures used in 1976. However, Dr. Bert does not evaluate the relative contributions of claimant's previous L5-S1 fusion, the preexisting state of the disc material at that level, and the 1999 work incident with regard to the free disc fragment that he opines is the cause of claimant's current disability or need for treatment. Without such an evaluation, his opinion that the 1999 work incident is the major contributing cause of claimant's current disability or need for treatment is merely an unsupported conclusion; as such, it is unpersuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

In conclusion, we find that claimant has established that the 1999 work incident precipitated his current disability or need for treatment. However, based on this record, claimant has not established that the 1999 work incident is the major contributing cause of his current disability or need for treatment for his combined condition. Accordingly, we agree with the ALJ that claimant has failed to establish the compensability of his low back condition. *See* ORS 656.266; ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated May 23, 2000 is affirmed.

In the Matter of the Compensation of
DONALD E. BALLINGER, Claimant
WCB Case No. 99-09473
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Fulsher's order that set aside its denial of claimant's right knee injury claim. On review, the issue is compensability.

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

The ALJ set aside SAIF's denial, finding that claimant had proved a compensable right knee injury claim under ORS 656.005(7)(a)(B). In so finding, the ALJ determined that the medical opinion of the attending physician, Dr. Farris, who attributed claimant's need for treatment, including arthroscopic surgery, in major part to a September 29, 1999 injury, was more persuasive than that of an examining physician, Dr. Marble.

On review, SAIF contends that Dr. Farris' opinion is not persuasive because he engaged in an improper "precipitating cause" analysis and relied on an inaccurate history that claimant "twisted" his right knee during the September 1999 incident of injury. Moreover, SAIF asserts that Dr. Marble's opinion is more persuasive because he explained why the allegedly minor work incident of stepping up a stair was not the major contributing cause of claimant's need for treatment when compared to preexisting degeneration in claimant's right knee. For the following reasons, we do not find SAIF's contentions persuasive.

Dr. Farris treated claimant's right knee condition both before and after the September 29, 1999 incident of injury. He was, therefore, in an advantageous position in which to determine the major cause of claimant's need for treatment. *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). Furthermore, like the ALJ, we are persuaded that Dr. Farris sufficiently weighed the contribution of claimant's preexisting degenerative condition versus that of the September 29, 1999 incident. (Ex. 30-3). Moreover, Dr. Farris had the additional advantage of having performed the surgery on claimant's right knee that revealed findings of an acute injury to the right knee. *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).[1] Accordingly, like the ALJ, we, too, find Dr. Farris' opinion persuasive.

We acknowledge Dr. Farris' history that claimant had "twisted" his right knee during the injury incident even though claimant did not testify in accordance with that history. (Tr. 12). Despite the apparent inaccuracy in Dr. Farris' history, our review of his opinion does not reveal that the exact mechanism of injury was important in his causation opinion. Rather it appears that Dr. Farris' surgical findings that indicated an acute injury had occurred were the important factor in determining the major cause of claimant's right knee condition.[2] (Ex. 30-3). The fact that the exact mechanism of injury was not crucial in determining causation also distinguishes the case on which SAIF relies, *Michael A. McGarvey*, 52 Van Natta 1014, 1015 (2000), where, in contrast to this case, two physicians stressed the importance of an accurate history of the mechanism of injury from the claimant and based their opinions on the claimant's history of being asymptomatic prior to the injury and sustaining a distinct twisting injury to his knee while stepping off a curb at work.[3]

Finally, we do not find Dr. Marble's opinion persuasive on the causation issue. Dr. Marble concluded that the "major contributing cause of [claimant's] *current* right knee condition is the pre-existing degenerative disease." (Ex. 23-5, emphasis added). However, we agree with claimant that this opinion, directed toward the compensabilty of the *current* right knee condition, is not directly relevant to whether claimant initially sustained a compensable right knee injury.

In conclusion, we agree with the ALJ that claimant proved that a compensable right knee injury occurred in September 1999. Thus, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 April 19, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

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[1] Citing *Jeffrey S. Declue*, 50 Van Natta 2315 (1998), SAIF argues that there is no indication that Dr. Farris' observation of the interior of claimant's knee put him in a better position to offer a causation opinion. Unlike *Declue*, however, where the physician who performed the claimant's surgery did not relate any surgical observations to his causation opinion, here Dr. Farris described his surgical findings and how they indicated that an acute injury had occurred. These findings of an acute injury in turn played a substantial role in Dr. Farris' determination that the September 29, 1999 injury was the major contributing cause of claimant's right knee condition and need for treatment. (Ex. 30-3).

[2] In any event, we note that Dr. Farris reviewed Dr. Marble's report in which the latter doctor specifically stated that claimant did not describe a "twisting" event. (Exs. 23-2, 30-1). Thus, Dr. Farris had access to an accurate history regarding the mechanism of injury.

[3] SAIF also notes Dr. Farris' statement that claimant was functioning "reasonably well" prior to the September 29, 1999 incident (Ex. 30-3) and asserts that Dr. Farris' opinion cannot be persuasive when Dr. Farris himself had reported on September 16, 1999 that claimant had "severe discomfort" in both knees. (Ex. 2). While Dr. Farris' assessment of claimant's pre-injury condition is troubling in light of his September 16, 1999 chart note, the fact remains that no physician was in a better position to assess the causation of claimant's "post-September 29, 1999" right knee condition than Dr. Farris, who treated claimant both before and after the alleged injury and performed the surgery on claimant's right knee. Accordingly, we conclude that it was appropriate for the ALJ to give greater weight to Dr. Farris' causation opinion.

In the Matter of the Compensation of
MONICA A. LAWRENCE, Claimant
WCB Case No. 99-05641
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's injury claim for a left elbow condition; and (2) assessed a penalty for allegedly unreasonable claims processing. The employer also contends that the ALJ improperly declined to admit certain exhibits and testimony into evidence. On review, the issues are the propriety of the evidentiary rulings, compensability, and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." We do not adopt the ALJ's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that Dr. Wenner's opinion, as the treating physician, was sufficient to establish medical causation of claimant's left elbow epicondylitis condition. The employer argues that Dr. Dineen's opinion persuasively established that claimant's left elbow condition was not caused by the work incident.[1] We agree with the employer's contention.[2]

To establish that her left elbow epicondylitis is compensable, claimant must prove that her work injury is a material contributing cause of the disability or need for treatment of that elbow condition. *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

Because of the possible alternative causes of claimant's epicondylitis condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). Because the question before us requires expert medical analysis rather than expert observation, Dr. Wenner, as the attending physician is entitled to no special deference. *See Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979).

Dr. Dineen, who examined claimant on behalf of the employer, has opined that the single activity of throwing a 20-30 pound object into a bin was not sufficient to cause claimant's left elbow condition. (Ex. 22-7). Dr. Dineen has further opined that epicondylitis is not generally caused by a single incident, but rather caused by repetitive motion, and can originate from the multiple activities of daily living. (Ex. 27-6, 7; Ex. 37-2, 3).

Dr. Wenner, the attending physician, agrees that epicondylitis often develops after prolonged repetitive activities, but also believes it can develop following an acute activity such as the work event described by claimant. (Ex. 39-1). Although Dr. Wenner has opined that claimant's single work activity of throwing a trash bag into a bin is the cause of her elbow condition, he does not explain his reasoning for identifying the work incident, as opposed to the repetitive activities of daily living, as the cause of claimant's epicondylitis. Because his opinion lacks such an explanation, it is merely an unsupported conclusion, and as such we find that it is not persuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

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[1] Dr. Dineen saw claimant at the request of the employer. Both doctors agree that claimant has epicondylitis of the left elbow. (Ex. 27-5; 28; 32). The doctors disagree as to the cause of the epicondylitis.

[2] The employer contends that the ALJ improperly declined to admit Exhibit 8A, a trespass and harassment warning from the employer to claimant. The employer further contends that the ALJ improperly declined to allow certain witnesses to testify about claimant's attempts to obtain statements from them dealing with the safe/unsafe nature of a trash compactor, where claimant's injury apparently occurred. Because we are upholding the employer's denial based on the current record, we need not address the employer's contentions regarding the propriety of the ALJ's evidentiary hearing.

Because Dr. Wenner's opinion is the only medical evidence that supports the compensability of claimant's injury, it follows that claimant has not established that her left elbow condition is compensable.[3] ORS 656.266; ORS 656.005(7)(a). In light of this conclusion, it is unnecessary to resolve the question posed by the dissent regarding the probative value of Dr. Dineen's opinion. In other words, even if Dr. Dineen's opinion is conclusory and unpersuasive, Dr. Wenner's unpersuasive opinion is insufficient to prove the compensability of claimant's condition. Accordingly, the self-insured employer's denial is reinstated and upheld.

Penalties

Relying on ORS 656.262(11), the ALJ assessed a penalty of 25 percent of the amounts due claimant for the self-insured employer's failure to timely accept or deny the claim as provided in ORS 656.262(6)(a). Because we have upheld and reinstated the self-insured employer's claim denial, there are no amounts then due upon which to base a penalty. *See Weyerhaeuser Co. v. Knapp*, 100 Or App 462, 464 (1990) ("amounts then due" for unreasonable denial are amount due when the denial is set aside). Accordingly, the ALJ's award of a penalty is reversed.

ORDER

The ALJ's order dated April 10, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's awards of penalties and an assessed attorney fee are reversed.

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[3] Because we have decided that claimant's left elbow condition is not compensable based upon our evaluation of the medical evidence, we do not address the employer's arguments that claimant is not credible.

Board Member Biehl dissenting.

I disagree with the majority's conclusion that claimant has failed to establish the compensability of her left elbow condition. Therefore, I respectfully dissent.

I disagree with the majority that the resolution of the medical question before us involves only expert analysis. In my view, resolution of this matter involves both expert analysis and expert observation. Consequently, I find no persuasive reason to abandon our general practice of evaluating medical opinions by deferring to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

I further disagree with the majority that Dr. Wenner's opinion is unsupported and conclusory. Dr. Wenner has been the claimant's treating physician since May 14, 1999. (Ex. 23). The history he had in rendering his opinion on causation, was the same as that given by claimant at hearing and as described in the accident investigation report. (Tr. 14-15; Ex. 1A, 39-1). In rendering his opinion he also took note that claimant's elbow pain started immediately after the act of throwing the trash bag into a bin. (Ex. 39-1). Because the medical record establishes that significant elbow activity can result in the immediate onset of epicondylitis type symptoms, and because claimant's elbow pain started immediately after the act of throwing the trash bag into a bin, I conclude that Dr. Wenner need not offer additional reasoning for excluding the activities of daily living as a cause of claimant's elbow condition. Consequently, I find Dr. Wenner's opinion to be well reasoned and persuasive.

In contrast, I find Dr. Dineen's opinion to be conclusory and not persuasive. Specifically, I find that Dr. Dineen's opinion that the single activity of throwing a 20-30 pound object into a bin is not the cause of claimant's elbow left elbow condition (Ex. 22-7; 37-3) is based upon a belief that epicondylitis is not generally caused by a single incident, but rather caused by repetitive motion.[1] (Ex. 37-2; 37-3). I conclude from his use of the term generally, that he cannot rule out a single acute incident as a cause of epicondylitis. I note further that Dr. Dineen has indicated that the onset of elbow symptoms like claimant's are usually spontaneous, and if there is a significant strain, symptoms would be immediate.[2]

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[1] In contrast, Dr. Wenner has stated that while epicondylitis often develops after prolonged activities, it is not uncommon to see it develop after acute injuries like the one described by claimant. (Ex. 39-1).

[2] Dr. Dineen was specifically referring to extensor and flexor strains, which he also indicated are synonymous with epicondylitis.

(Ex. 37-3). Because claimant's elbow symptoms appeared immediately following her activity of throwing a trash bag into a compactor, I consider Dr. Dineen's opinion that claimant's work was not a cause of her left elbow condition, without further explanation, to be an unsupported conclusion and as such, is not persuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980). Accordingly, I conclude that the ALJ correctly did not rely on it.

In conclusion, I find no persuasive reason not to defer to the opinion of Dr. Wenner. Consequently, I would affirm the ALJ's order that set aside the employer's denial of the claim.

Because I would affirm the ALJ's order and set aside the employer's denial of the claim, I would also affirm the ALJ's assessed penalty of 25 percent of the amounts due claimant for the self-insured employer's failure to timely accept or deny the claim as provided in ORS 656.262(6)(a). Accordingly, I offer this dissenting opinion.

In the Matter of the Compensation of
JOE M. MANN, Claimant
WCB Case No. 99-06806
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Gilroy Law Firm, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that affirmed an Order on Reconsideration that awarded no temporary or permanent disability benefits. In his brief, claimant requests that this case be consolidated with his appeal in WCB Case No. 98-06650. On review, the issues are consolidation, temporary disability, permanent total disability, and extent of unscheduled permanent disability for claimant's post-traumatic headache condition.

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

Consolidation

Asserting that he has requested Board review of an ALJ's order in WCB Case No. 98-06650 that: (1) directed the employer to modify its Notice of Acceptance to include post-concussion syndrome; (2) set aside the employer's denial after August 23, 1996 of claimant's accepted dementia condition; and (3) upheld the employer's denial of depression and intercerebral hematoma; claimant seeks consolidation of this case with his appeal in WCB Case No. 98-06650.

We previously issued an Order on Review in WCB Case No. 98-06650 on August 1, 2000.[1] Consequently, claimant's request for consolidation has become moot. Moreover, while this case involves the extent of temporary and permanent disability resulting from an appeal of an Order on Reconsideration, in WCB Case No. 98-06650, the issue is compensability of new medical conditions. These issues are separate and distinct from one another and a decision in WCB Case No. 98-06650 is not dependent upon our or the ALJ's decision in this case. *See James Mack*, 50 Van Natta 338 (1998) (evaluation of a "post-closure" accepted condition must await the reopening and processing of the claim for that new condition). 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). Therefore, even if we had not already issued our order in WCB Case No. 98-06650, administrative efficiency would not be served by consolidated review. Accordingly, we conclude that there is no compelling reason to review the two cases together.

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[1] As a general rule, we 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).

Permanent Total Disability

Claimant argues that his preexisting psychiatric disorder must be considered in evaluating his permanent total disability status. In determining whether a claimant is permanently and totally disabled, only disability that preexisted or was caused by the compensable injury may be considered. ORS 656.206(1)(a); *Nyre v. F & R Leasing*, 106 Or App 74 (1991).

Here, even if Dr. Syna correctly concluded that claimant's underlying psychiatric disorder made him unsuitable for gainful work, there is no evidence that claimant was disabled by this condition prior to his January 13, 1995 injury. *Elder v. Rosboro Lumber Co.*, 106 Or App 16 (1991). Moreover, non-injury related disability that a claimant suffers after his on-the-job injury is not considered for purposes of permanent total disability. *Emmons v. SAIF*, 34 Or App 603 (1978). Because claimant has not established that his preexisting psychiatric disorder was disabling prior to his injury, his present disabling mental condition is not cognizable as a preexisting disability that may be considered for entitlement to permanent total disability benefits.[2]

ORDER

The ALJ's order dated May 9, 2000 is affirmed.

[2] We also note that claimant has failed to establish that he was willing to work, a finding that is a prerequisite to entitlement to permanent total disablity benefits. ORS 656.206(3); *Champion International v. Sinclair*, 106 Or App 423 (1991) (citing *SAIF v. Stephen*, 308 Or 31 (1989)). Thus, even if claimant is unable to work, his claim would fail because he has not carried his burden to prove he was willing to work.

September 7, 2000 Cite as 52 Van Natta 1593 (2000)

In the Matter of the Compensation of
CHRIS R. RILEY, Claimant
WCB Case No. 99-08876
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) upheld the insurer's partial denial of claimant's head injury claim; (2) upheld the insurer's denial of claimant's psychological condition claim; (3) declined to award penalties and attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties and attorney fees.

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

ORDER

The ALJ's May 5, 2000 order is affirmed.

[1] In his brief, claimant contends that the diagnostic medical services provided for his noncompensable head injury are compensable. Because claimant did not raise the medical services issue at hearing, we decline to address that issue on review. *Fister v. Smith Hills Health Care*, 149 Or App 214 (1997); *Janice A. Talevich*, 48 Van Natta 2318, 2319 (1996) (declining to consider "back-up" denial issue raised for first time on review).

In the Matter of the Compensation of
ZEBEDEE MATHEWS, Claimant
WCB Case No. 99-05021
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that awarded claimant 33 percent (105.6 degrees) unscheduled permanent disability for a cervical condition, whereas an Order on Reconsideration had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

In early 1998, claimant injured his neck when he was lifting a heavy panel of aluminum. (Exs. 4, 6). He sought medical treatment on April 16, 1998, after he began to notice numbness and a feeling of weakness in his right hand. (Ex. 4). Claimant was diagnosed with a neck strain with right hand weakness and paresthesias and he was referred to a neurosurgeon. (Ex. 4-2). Dr. Rosenbaum recommended conservative treatment. (Ex. 5).

In June 1998, Dr. Ward became claimant's attending physician. (Ex. 7). Claimant was treated conservatively and was placed on modified duty. (Ex. 8). His June 1998 cervical x-rays showed disc space narrowing at C6-7. (Ex. 9). Dr. Ward diagnosed a work-related cervical strain and non-work related, preexisting C6-7 degenerative disc disease and degenerative joint disease. (Ex. 10-2). In June and July 1998, claimant performed sedentary job duties, but was anxious to return to regular work. (Exs. 11, 13, 14).

The insurer accepted a disabling cervical strain on July 15, 1998. (Ex. 15).

On July 17, 1998, Dr. Ward reported that claimant needed more physical therapy and his degenerative condition was prolonging his recovery. (Ex. 16). Dr. Ward noted, however, that claimant's work limitations were imposed because of the cervical strain. (*Id.*)

On September 1, 1998, Dr. Ward performed a "closing" examination and reported that claimant had no permanent impairment. (Ex. 19-3). He commented that claimant's restrictions and cervical range of motion were most likely due to the non-work related C6-7 degenerative condition. (Ex. 19-3). An October 5, 1998 Determination Order awarded only temporary disability benefits. (Ex. 21).

Claimant returned to Dr. Ward on October 8, 1998, complaining of a significant increase in cervical symptoms after stacking pieces of aluminum. (Ex. 22). Dr. Ward signed an aggravation claim form. (Ex. 23). A cervical MRI showed prominent degenerative changes at C6-7. (Ex. 24). Dr. Ward diagnosed a work-related cervical strain with exacerbation, as well as non-work related C6-7 degenerative disc disease and degenerative joint disease. (Exs. 22, 26, 28). The insurer accepted claimant's aggravation claim. (Ex. 31).

On October 29, 1998, Dr. Ward reported that claimant was performing modified light duty and was tolerating the job well. (Ex. 28). He doubted that claimant would be able to return to his regular job without restrictions "due to the non-work related diagnoses and the exacerbation of 9/20/98[.]" (Ex. 28-2).

At the next exam on November 16, 1998, Dr. Ward performed another "closing" examination. (Ex. 29). He said that claimant had been transferred to a job where he operated a machine standing or sitting at a table. (Ex. 29-1). He had developed low back discomfort and was temporarily working at a job that primarily involved sitting. (*Id.*) Dr. Ward said that claimant continued to have stiffness and discomfort in the posterior neck into the right trapezius area and his pain was increased by neck extension and repetitive neck flexion. (*Id.*) He reported that claimant's restrictions of cervical range of motion and work restrictions were due to the non-work related C6-7 degenerative condition. (Ex. 29-2). He anticipated that the restrictions would "hopefully" improve and resolve, as long as claimant worked within restrictions and avoided exacerbating activities. (*Id.*)

A January 7, 1999 Determination Order awarded only temporary disability benefits. (Ex. 33). Claimant requested reconsideration. (Ex. 35). Dr. Gibbs performed a medical arbiter examination on April 27, 1999. (Ex. 36). A May 27, 1999 Order on Reconsideration affirmed the Determination Order. (Ex. 37).

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on the opinion of Dr. Gibbs and concluded that claimant was entitled to an unscheduled permanent disability award of 33 percent for his cervical condition.

The insurer argues that the preponderance of medical evidence establishes that claimant is not entitled to an award of unscheduled permanent disability. Alternatively, the insurer contends that apportionment of permanent disability is appropriate in this case.

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). 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).

After reviewing the record, we find that Dr. Gibbs, the medical arbiter, has provided the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. On April 27, 1999, Dr. Gibbs reported that claimant was working full-time, but his job duties had been modified so that he no longer had to lift overhead. (Ex. 36-2). Claimant continued to have chronic neck pain. (*Id.*) Dr. Gibbs said that claimant had no prior neck injuries and had not experienced problems with chronic neck pain before the work injury. (*Id.*) He found that claimant had reduced cervical range of motion and the findings were valid. (Ex. 36-3, -4).

Dr. Gibbs noted that claimant's C6-7 degenerative changes were preexisting, but were completely asymptomatic until the work injury. (Ex. 36-3). He explained that claimant's chronic symptoms were due to a combination of cervical strain caused directly by the 1998 injury and an exacerbation of previously asymptomatic cervical degenerative changes. (*Id.*) Dr. Gibbs found that 75 percent of claimant's findings were due to the accepted cervical strain. (*Id.*) He concluded that claimant should have restrictions on lifting more than 45 pounds on a frequent basis and he was permanently precluded from overhead activities. (Ex. 36-4).

We are persuaded by Dr. Gibbs' well-reasoned report of claimant's impairment. In addition, we rely on Dr. Gibbs' report because we find that the time gap between Dr. Ward's closing examination (November 16, 1998) and Dr. Gibbs' April 27, 1999 report (*i.e.*, five months) was significant. *See, e.g., Kelly J. Zanni*, 50 Van Natta 1188 (1998) (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); *Ronald L. Tipton*, 48 Van Natta 2521, 2522 n. 5 (1996).

Furthermore, we do not agree with the insurer that the preponderance of medical opinion establishes a different level of impairment. Although the insurer relies on the opinion of Dr. Ward, we find that his reports are inconsistent and lack adequate explanation.

Dr. Ward diagnosed a work-related cervical strain and non-work related C6-7 degenerative disc disease and degenerative facet disease. (Ex. 29). On July 17, 1998, Dr. Ward said that claimant was not to perform overhead lifting more than 35 pounds or repetitive side bending of the neck. (Ex. 16). Dr. Ward explained that claimant's work limitations were imposed "because of the cervical strain." (*Id.*) Although Dr. Ward's July 17, 1998 work restrictions were imposed because of claimant's cervical strain (Ex. 16), he reported on September 1, 1998 that the restrictions and cervical range of motion were due to the non-work related C6-7 degenerative condition. (Ex. 19-3). Dr. Ward did not explain why claimant's work restrictions were now due to the degenerative condition, rather than the cervical strain.

Claimant had a significant increase in cervical symptoms in September 1998 and the insurer reopened the claim. (Exs. 22, 31). One month later, on October 29, 1998, Dr. Ward reported that claimant was performing modified light duty and was tolerating the job well. (Ex. 28). Nevertheless, he doubted that claimant would be able to return to his regular job without restrictions "due to the non-work related diagnoses and the exacerbation of 9/20/98[.]" (Ex. 28-2). On November 16, 1998, Dr. Ward

reported that claimant had work restrictions, but they were due to the non-work related diagnoses. (Ex. 29-2). Dr. Ward did not explain why claimant's October 1998 work restrictions were related in part to the aggravation, but the November 16, 1998 work restrictions were *not* related to the aggravation.

Dr. Ward had initially reported that claimant was performing "very heavy" work at the time of injury (Exs. 8, 13), and had no prior neck or shoulder trauma. (Ex. 8). Similarly, Drs. Rosenbaum and Gibbs reported no prior history of neck or arm symptoms. (Exs. 5-1, 36-2). In his November 1998 closing examination, Dr. Ward said that claimant was performing modified work, but continued to have stiffness and discomfort in his neck and right trapezius area and his pain was increased by neck extension and repetitive neck flexion. (Ex. 29-1). Dr. Ward explained that claimant had work restrictions of occasional neck extension, occasional neck bending, and lifting and carrying maximum 50 pounds and he "hoped" they would improve and resolve "as long as he works within the restrictions and avoids exacerbating activities." (Ex. 29-2).

Dr. Ward's conclusion that claimant's work restrictions and symptoms were now entirely due to his preexisting, previously asymptomatic cervical degenerative condition lacks adequate explanation, particularly since he had reported in July 1998 that the work restrictions were imposed because of the cervical strain (Ex. 16), and he reported in October 1998 that the work restrictions were due in part to the September 1998 aggravation. (Ex. 28). We are not persuaded by Dr. Ward's opinion.

We rely on Dr. Gibbs' report to determine claimant's impairment. Based on Dr. Gibbs' report and OAR 436-035-0360(13), (14), (15), and (16), claimant has the following range of motion losses in the cervical spine:

flexion	22 degrees	=	3.8%
extension	12 degrees	=	5.04%
right lateral flexion	14 degrees	=	2.13%
left lateral flexion	23 degrees	=	1.47%
right rotation	72 degrees	=	0.40%
left rotation	76 degrees	=	0.20%

The impairment values for loss of range of motion in the cervical spine are added for a total impairment value of 13.04 percent, which is rounded down to 13 percent. *See* OAR 436-035-0007(15).

The insurer's alternative argument is that apportionment is appropriate. The insurer relies on Dr. Gibbs' opinion that 75 percent of claimant's findings were due to the accepted cervical strain (Ex. 36-3), and it reasons that claimant is entitled to, at most, 75 percent of the 13 percent impairment. The insurer asserts that no combined condition was accepted. Citing OAR 436-035-0007(2), the insurer argues that the strain is properly analyzed as "superimposed" on the degenerative disc disease.

On the other hand, claimant contends that apportionment is not appropriate here because the insurer has not issued a major contributing cause denial. Claimant relies on OAR 436-035-0007(4)(c) and argues that rule applies because he has a "preexisting condition."

OAR 436-035-0007(4) provides, in part:

"Where a worker has a preexisting condition, the following applies:

"* * * * *

"* * * * *

"(c) Where a worker's compensable condition combines with a preexisting condition, pursuant to ORS 656.005(7), the current disability resulting from the total accepted combined condition shall be rated in accordance with these rules as long as the compensable condition remains the major contributing cause of the accepted combined condition, *i.e.*, a major contributing cause denial has not been issued pursuant to ORS 656.262(7)(b). Apportionment of disability is not appropriate."

There is no dispute that claimant has a preexisting cervical degenerative disc disease. Thus, he has a "preexisting condition" for purposes of OAR 436-035-0007(4). Nevertheless, claimant does not have an "accepted combined condition" as required under OAR 436-035-0007(4)(c). The insurer accepted a "cervical strain" on July 15, 1998. (Ex. 15). At that time, Dr. Ward had diagnosed a work-related cervical strain and preexisting, non-work related C6-7 degenerative disc disease and degenerative joint disease. (Exs. 10, 11, 13, 14). Despite the diagnosis of a degenerative cervical condition, the insurer accepted only a "cervical strain." Under these circumstances, we are not persuaded that the insurer accepted a combined condition.[1] *Compare Dewey C. Harvey*, 52 Van Natta 1556 (2000) (where the insurer accepted a left L4-5 disc herniation combined with a preexisting right L4-5 disc herniation and preexisting degenerative disc disease, the entire accepted combined condition was rated as permanent disability due to the compensable injury). Therefore, we do not agree with claimant that OAR 436-035-0007(4)(c) applies to this case.

Next, we address the insurer's argument that OAR 436-035-0007(2) applies to this case. OAR 436-035-0007(2) provides, in part:

> "Where a worker has a superimposed condition, only disability due to the compensable condition shall be rated as long as the compensable condition is medically stationary and remains the major contributing cause of the overall condition. Then, apportionment is appropriate."

The term "superimposed condition" means "a *condition that arises after the compensable injury or disease* which contributes to the worker's overall disability or need for treatment but is not the result of the original injury or disease." OAR 436-035-0005(14)[2] (emphasis supplied).

The medical evidence establishes that claimant's C6-7 degenerative disc disease and degenerative facet disease preexisted the 1998 work injury. (Exs. 10-2, 30-1, 36-3). Although the degenerative condition contributed to claimant's disability and need for treatment, it was asymptomatic before the work injury. Thus, the degenerative condition arguably "arose" after the compensable injury. *See Jack B. Roy*, 50 Van Natta 1029 (1998) (because the claimant's condition involved a "reinjury" after the compensable injury, the claim involved a "superimposed condition" within the meaning of *former* OAR 436-035-0007).

We need not determine whether OAR 436-035-0007(2) applies because we find that, in any event, ORS 436-035-0007(1) is applicable. ORS 436-035-0007(1) provides, in part:

> "Except for sections (4) and (5) of this rule, a worker is entitled to a value under these rules for those findings of impairment that are permanent and were caused by the compensable injury or disease including the compensable condition, a consequential condition and direct medical sequelea [sic]. *Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules.*" (Emphasis supplied).

In determining claimant's impairment, we are relying on Dr. Gibbs' opinion. Dr. Gibbs concluded that approximately 75 percent of claimant's "signs and symptoms" were due to the accepted condition of cervical strain. (Ex. 36-3). Based on Dr. Gibbs' opinion, we conclude that claimant's impairment is 75 percent of 13 percent, *i.e.*, 9.75 percent, which is rounded for a total of 10 percent impairment.

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[1] *See, e.g., Kenneth R. Reed*, 49 Van Natta 2129 (1997) (because the carrier did not accept a "combined condition," the preexisting condition was not considered in rating the claimant's disability); *Dorothy M. Harris*, 49 Van Natta 1348 (1997) (because a combined condition was not accepted, the carrier was not required to issue a "major contributing cause" denial under ORS 656.262(7)(b) before it could argue that part of the claimant's impairment was related to a noncompensable condition); *Robin W. Spivey*, 48 Van Natta 2363 (1996) (because the accepted condition did not involve a combined condition, ORS 656.262(7)(b) did not apply and the carrier was not obligated to issue a denial before closing the claim).

[2] The definitions in OAR 436-035-0005 apply in OAR 436-035-0001 through 436-035-0500, unless the context requires otherwise. OAR 436-035-0005(1).

We now assemble the appropriate factors relating to claimant's unscheduled permanent disability. The parties agree that claimant is entitled to a value of "1" for age and "1" for education. *See* OAR 436-035-0290(2); 436-035-0300(2)(b). The Specific Vocational Preparation (SVP) value is based on claimant's work as an anodizer/laborer. Dictionary of Occupational Titles (DOT) 500.682-010/500.686-010. Claimant's highest SVP is "4," which has a value of "3." OAR 436-035-0300(3) and (4).

Claimant's adaptability is measured by comparing his Base Functional Capacity (BFC) to his maximum Residual Functional Capacity (RFC). OAR 436-035-0310(2). We agree with the ALJ that the applicable DOT codes 500.682-010/500.686-010 have a strength of "heavy." Thus, claimant's BFC is "heavy." The medical arbiter concluded that claimant was restricted to lifting no more than 45 pounds on a frequent basis and was permanently precluded from overhead activities. (Ex. 36-4). We agree with the ALJ that claimant's RFC is "medium/light." *See* OAR 436-035-0310(3)(g). Comparing claimant's BFC of "heavy" with his RFC of "medium/light" results in an adaptability factor of "4." OAR 436-035-0310(6).

We now assemble the factors for claimant's unscheduled permanent disability. The values of age (1) and education (4) are added for a total of 5. OAR 436-035-0280(4). The value for adaptability (4) is multiplied by the value for age/education (5) for a total of (20). OAR 436-035-0280(6). This value (20) is added to the impairment value (10) for a total of 30 percent unscheduled permanent disability.

ORDER

The ALJ's order dated April 13, 2000 is modified. In lieu of the ALJ's order and in addition to the Order on Reconsideration, claimant is awarded 30 percent (96 degrees) unscheduled permanent disability for his cervical condition. The ALJ's out-of-compensation attorney fee is modified accordingly.

September 7, 2000 Cite as 52 Van Natta 1598 (2000)

In the Matter of the Compensation of
NITA C. WENDT, Claimant
WCB Case No. 99-09970
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Schwabe, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of her occupational disease claim for a right shoulder condition. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 2, 2000 is affirmed.

Member Phillips Polich dissenting.

Because I believe that the ALJ overlooked key testimony regarding claimant's raising and lowering of the deli van doors, I respectfully dissent from the portion of the majority's order that affirms the ALJ's order upholding the insurer's denial of claimant's right shoulder rotator cuff tear condition.

This case involves a long-time (more than 11 years) employee of the employer's mobile catering service. Claimant is five feet, five inches tall. Her job requires her to drive vans to various sites. The employer has two vans - a smaller "cold truck" and a larger "hot truck," with heavier doors. After July 1999, claimant began driving the hot truck. Taking an average of her testimony and that of her supervisor, claimant makes between 14 and 20 stops per day. Each stop involves opening and closing the van's doors. The "hot truck" doors weigh 150 pounds. Although the van is equipped with shocks that assist the doors in their upward movement after the initial pull, these same shocks also act to hold the door open (above claimant's head). (Tr. 9, 12). I believe the majority and the ALJ ignore the effort required of a five-foot-five woman in repetitively reaching overhead to close the door while overcoming the effect of these shocks.

The ALJ found the medical opinions in this case, which uniformly support compensability, unpersuasive because they relied on an inaccurate history of "overhead lifting." In my view, claimant's job does indeed involve significant overhead "lifting" as described above. Moreover, Dr. Arbeene, who examined claimant on behalf of the insurer, concluded that claimant's "repetitive overhead *reaching*" was the major contributing cause of her rotator cuff tear. (Ex. 15-7). Claimant's treating physician, Dr. Rabie, related claimant's complaints to the overhead lifting *and pulling* of the heavy doors. (Ex. 24-2). This history is consistent with the testimony at hearing. I would have set aside the insurer's denial.

For those reasons, I respectfully dissent.

September 7, 2000 Cite as 52 Van Natta 1599 (2000)

In the Matter of the Compensation of
WILLIAM H. McCORMICK, SR., Claimant
WCB Case Nos. 00-01706 & 99-05930
ORDER ON REVIEW
Preston, Bunnell & Stone, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) found that claimant had timely filed a request for hearing on the employer's denial of claimant's low back injury claim; and (2) set aside the denial. On review, the issues are timeliness and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's July 26, 1999 request for hearing was a timely appeal of the employer's July 20, 1999 denial of claimant's low back claim. The employer argues that, because claimant's request for hearing specifically referred to his knee claim rather than his back claim, and because claimant did not file a request for hearing on his back claim within the statutory period, his request for hearing was untimely under ORS 656.319(1)(a) and OAR 438-005-0070, and should have been dismissed by the ALJ. Claimant argues that his request for hearing referred to the correct date of the employer's denial and was, therefore, sufficient under ORS 656.319(1)(a). We need not resolve this question because, even if claimant's hearing request was timely filed, we would uphold the employers denial. Our decision is based on the following reasoning.

Relying on the opinion of Dr. Treible, claimant's treating surgeon, the ALJ concluded that claimant had established compensability of his L5-S1 herniated disk. The employer contends that Dr. Treible's opinion is not persuasive because it is conclusory and unexplained, and that Dr.Woodward's opinion should be relied on. We agree that Dr. Treible's opinion is not persuasive, for the following reasons.

Claimant must prove by a preponderance of the persuasive medical evidence that his September 11, 1995 work injury is the major contributing cause of his need for medical treatment or disability of his L5-S1 herniated disc condition. ORS 656.005(7)(a)(B); ORS 656.266.

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, including the precipitating cause, and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Whether a preexisting condition or an on-the-job injury is the major contributing cause of a worker's condition is a complex medical question that requires expert testimony. *See Uris v. Compensation Department*, 247 Or 420, 424-26 (1967).

Claimant has a long history of chronic back pain, dating from at least 1990. In 1992, he was involved in a motor vehicle accident that involved his low back, and for which he had physical therapy. He also received chiropractic treatment from December 1993 until March 1996, which was often directed to his low back pain complaints.

On December 18, 1995, claimant sustained a compensable low back injury. X-rays of the low back were normal and a January 1996 MRI that showed a mild disc bulge at L5-S1 without nerve root involvement was interpreted as a normal study. The claim was accepted as a lumbosacral strain. In March 1996, after conservative treatment, claimant was released to regular work and overtime, if available. The claim was closed in October 1996 with no permanent disability award.

In December 1997, claimant filed a claim for a back injury after he was hit by a dolly at work. There is no evidence that he received medical treatment for this incident.

A few weeks prior to June 25, 1999, claimant strained his back when he was performing his regular sanding work. (Ex. 62-6 through -9). Claimant missed four days of work and treated with Dr. Harris, chiropractor, after which he returned to his regular work. (Ex. 62-10).

On June 25, 1999, claimant sought treatment for a sharp, sudden pain in his low back after a work incident in which he bent over to pick up a bracket. Dr. Harris diagnosed a lumbar strain, but suspected a herniated disc. An MRI revealed moderate desiccation of the L5-S1 intervertebral disc with mild narrowing of the disc space, and a small central L5-S1 herniated disc beneath the posterior longitudinal ligament, which effaced but did not appear to produce posterior displacement of the right S1 nerve root.

On July 12, 1999, Mr. Rosborough, physician's assistant in Dr. Trieble's office, diagnosed a small herniated disc, effacing the S1 nerve root, but without a radicular component. Subsequently, when claimant's condition failed to improve, Dr. Treible performed an epidural cortisone injection, which did not alleviate claimant's symptoms. On September 23, 1999, Dr. Treible performed an anterior lumbar diskectomy and interbody fusion for degenerative disk disease, L5-S1, with central herniated nucleus pulposus. (Ex. 69).

The only opinion arguably supporting claimant's claim is that of Dr. Treible. Dr. Treible signed a concurrence letter written by claimant's attorney. In that letter, he agreed that claimant did not suffer any permanent impairment to his low back as a result of his 1995 low back strain. He based his opinion on Dr. Noall's finding of no evidence of underlying disc pathology and a normal 1996 MRI. He also based his opinion on claimant's return to work in March 1997 and that he had no disabling low back problems until the 1999 work incident. Dr. Treible affirmed that the 1999 MRI demonstrated a new injury to the disc that was different from that on the 1996 MRI.

Dr. Trieble also agreed that the June 1999 injury was the major contributing cause of any combined condition resulting from that injury, because claimant had gone back to his regular work for over two years before the June 1999 incident triggered claimant's herniated disc.

Dr. Treible further agreed that, even if claimant's herniated disc was a combined condition and that the 1995 injury was the major contributing cause of the 1999 herniated disc, the major contributing cause of the need for surgery was the 1999 work injury.

In addition, Dr. Treible agreed that prior to the July 1999 injury, claimant's disc was functionally adequate, "herniated or not," and immediately after the June 1999 injury, the disc's functional capacity substantially deteriorated, as indicated by claimant's complaints and clinical testing.

However, Dr. Treible did not evaluate the relative contributions of claimant's longstanding low back condition, the June 1999 work incident and the degenerative disc condition at L5-S1 that he diagnosed at the time of surgery. Moreover, Dr. Treible had an incomplete history of claimant's longstanding back pain.[1] Consequently, Dr. Treible's opinion is insufficient for us to find it persuasive, particularly in light of Dr. Woodward's contrary opinion that was based on claimant's complete medical history. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1997). Consequently, we conclude that claimant has not established the compensability of his L5-S1 herniated disc.

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[1] Claimant did not disclose any prior medical history in his initial visit with Physician Assistant Rosborough, and there is no indication that Dr. Treible was aware of claimant's chiropractic treatment, his motor vehicle accident, or the 1997 back injury.

ORDER

The ALJ's May 1, 2000 order is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
JANET L. SCHELL, Claimant
WCB Case No. 99-08997
ORDER ON REVIEW
Brothers & Ash, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for a right elbow condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for left elbow epicondylitis. The ALJ set aside the insurer's denial of right elbow epicondylitis after finding that claimant's treating physician, Dr. Thayer, carried claimant's burden of proving compensability. The insurer challenges that conclusion.

The insurer first asserts that the ALJ inappropriately limited his analysis to deciding whether or not claimant had a "diagnosable condition." As the insurer notes, its denial stated that claimant had not contracted "any diagnosable condition from your work activities at [the employer]." Consistent with the denial of causation, the ALJ applied ORS 656.802(2)(a) and decided whether the persuasive medical evidence satisfied this statute. Thus, we disagree with the insurer that the ALJ based his decision only on whether or not there was a "diagnosable condition."

The insurer further disputes the ALJs finding that Dr. Thayer provided the most reliable opinion. The record contains numerous opinions concerning causation.

Examining orthopedic surgeon, Dr. Courogen, found a history of right elbow epicondylitis but reported that there "are no valid objective physical findings today to support any diagnosable condition[.]" (Ex. 33-5). Dr. Courogen also thought that ranges of motion were "not valid," noting that claimant exhibited "gross inconsistencies" in comparison to motion observed before the examination. (*Id.*) Finally, Dr. Courogen reported that the absence of improvement between the time claimant stopped work in June and the examination in November was not consistent "with any tissue injury or orthopedic condition of which I am aware." (*Id.* at 6).

Dr. Courogen provided a subsequent report stating that he found Dr. Thayer's diagnosis of epicondylitis was "not tenable, especially on the basis of absolutely no improvement after four and one-half months of total inactivity." (Ex. 38-2). Based on viewing a videotape of claimant performing her job, Dr. Courogen further commented that it did not "even remotely suggest overuse activity." (*Id.*)

Examining orthopedist, Dr. McKillop, agreed with Dr. Courogen that there was "evidence of a nonorganic condition" and that claimant displayed "significant functional overlay." (Ex. 37A-10, 37A-11). Dr. McKillop also stated that the "examination shows very little and certainly does not answer any questions as to etiology." (*Id.* at 11).

Dr. Stewart saw claimant on referral from Dr. Thayer. He concurred with Dr. Courogen's report and stated that he also had looked at the videotape and thought that the activities depicted were unlikely to cause lateral epicondylitis, noting that at best some motions could possibly aggravate this condition. (Ex. 39A). Dr. Stewart thought that claimant "had lateral elbow pain of unclear etiology[.]" (*Id.*)

After viewing the videotape, Dr. Thayer first reported that "it is possible that this type of work could provoke epicondylitis" and that "it would be probable retrospectively if this was the case from my history and examination." (Ex. 30).

Dr. Thayer's final report reiterated his diagnosis of claimant's right elbow pain as lateral epicondylitis. (Ex. 40-1). Dr. Thayer thought that the condition "would appear to be related, clearly by history to her work in the office, and that relationship to me would make it the major contributing cause for her elbow problem on the right[.]" (*Id.*) Dr. Thayer further stated that the videotape showed

> "elbow use and techniques which are not common due to the size of the object she was copying. As I stated [previously], her exposure at this job and her development of symptoms is related by time. I have no reason to believe that she has any medical problems that would cause this, and her leisure time activities were virtually none. For that reason, I believe that that job would account for her right elbow pain." (*Id.* at 2).

We defer to the treating physician absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Furthermore, causation cannot be inferred from temporal relationship alone. *Allie v. SAIF*, 79 Or App 284 (1986). In other words, a persuasive medical opinion must also be well-reasoned. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

Here, we find that Dr. Thayer's opinion is solely based on a temporal relationship between the onset of claimant's symptoms and her work. Although Dr. Thayer comments that claimant's work activities could provoke epicondylitis, he does not explain why those motions were the major contributing cause of claimant's condition.[1] Furthermore, he does not respond to Dr. Courogen's point that claimant's failure to improve after leaving work was not consistent with a tissue injury. Dr. Thayer also did not rebut or respond to findings from Dr. Courogen, Dr. McKillop, and Dr. Stewart showing inconsistencies and pain behavior.

In sum, because Dr. Thayer's opinion was not well-reasoned and based only on a temporal relationship, we find persuasive reasons not to defer to his opinion. Because the record contains no other opinions supporting causation, we further conclude that claimant failed to carry her burden of proving that her employment activities were the major contributing cause of her right elbow condition. *See* ORS 656.802(2)(a).

ORDER

The ALJ's February 24, 2000 order is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

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[1] We need not decide whether the videotape accurately depicted claimant's work because, even assuming its accuracy, because Dr. Thayer did not explain why those activities caused claimant's condition, her claim fails.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not carry her burden of proof and I would affirm the ALJ's order. Thus, I dissent.

First, claimant worked for the employer for five years and was promoted at least once. The ALJ explicitly found her credible. Thus, based on her truthful and unrebutted testimony, claimant clearly showed that she performed intensive and repetitive hand and arm activities, followed by the onset of pain in both arms and hands.

As the ALJ notes, a videotape of the job was not consistent with claimant's credible testimony and, thus, did not accurately depict the work activities. Because both Dr. Courogen and Dr. Stewart relied in part on deciding that the videotape did not show activities that were likely to cause epicondylitis, their opinions should be rejected as unreliable.

In contrast, claimant's treating physician, Dr. Thayer, recognized the deficiency of the videotape and based his opinion on an accurate understanding of claimants work activities. For this reason, and as the treating physician, Dr. Thayer's opinion is entitled to the most weight.

Finally, I disagree with the majority's construction of the employer's denial. Because the denial was for "any diagnosable condition," I would find it limited to only whether claimant has a "diagnosable condition." As the ALJ explained, every physician provided a diagnosis, thereby rebutting the basis of the denial.

In any case, whether or not limited only to a "diagnosable condition," I would affirm the ALJ's order concluding that claimant carried her burden or proof.

September 7, 2000 Cite as 52 Van Natta 1603 (2000)

In the Matter of the Compensation of
LOREN E. WEIDEMAN, Claimant
WCB Case Nos. 99-08376 & 99-05835
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney
VavRosky, Maccoll, Olson, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The City of Eugene (Eugene), a self-insured employer, requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its compensability/responsibility denial of claimant's medical services claim for a left ankle condition; and (2) upheld SIMS, Inc.'s compensability/ responsibility denial of claimant's "new injury" claim for the same condition. Claimant cross requests review, contending he is entitled to temporary disability and a larger attorney fee than awarded by the ALJ.[1] On review, the issues are compensability, responsibility, and attorney fees.

We adopt and affirm the order of the ALJ with the following supplement to address the Eugene's contentions that: (1) claimant's left ankle condition is not compensable; and (2) if the ankle condition is compensable, SIMS is responsible.

Compensability

The ALJ relied upon the opinions of Drs. Garber and Bills to conclude that claimant's 1987 compensable left ankle injury was the major contributing cause of claimant's current left ankle condition and his need for a 1999 surgery.[2] Eugene contends that: (1) the ALJ incorrectly relied on the opinions of Drs. Garber and Bills; and (2) the opinions of Drs. Lundsgaard and Filarski, who believe that the 1987 compensable injury (for which Eugene is responsible) is not the major contributing cause of claimant's current left ankle condition, are more persuasive.[3] We disagree with Eugene's contentions.

Because of the possible alternative causes for claimant's current left ankle condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

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[1] On review, we will not address claimant's entitlement to temporary disability. Claimant's entitlement to temporary disability will be addressed pursuant to the Board's Own Motion authority under ORS 656.278.

[2] Dr. Garber initially saw claimant at the request of Eugene; he later performed claimant's 1999 surgery. (Ex. 33, 36). Dr. Bills was claimant's attending physician before claimant became Dr. Garber's patient. (Ex. 28, 29).

[3] Dr. Lundsgaard was claimant's attending physician for the 1987 ankle surgery. (Ex. 15). Dr. Filarski, performed a records review at Eugene's request. (Ex. 54).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986).

The medical record establishes that claimant had a history of ankle sprains that predate the 1984 injury with Eugene. (Ex. 4). The record also establishes that the time of 1984 injury, the 1984 injury was the most severe sprain claimant had experienced for many years. (Ex. 4). The record also establishes the degree of laxity of claimant's left ankle after the 1984 injury was "somewhat lax" (Ex. 8), and further establishes that the degree of laxity of the ankle after the 1987 injury (also with Eugene) was significantly lax.[4] (Ex. 11-2). The medical record contains no description or measurement of the laxity of claimant's ankle before the 1984 injury.

Both Drs. Lundsgaard and Filarski have opined that claimant's 1987 work injury is a cause of his current condition and need for surgery, but not the major contributing cause. (Ex. 23, 54). The basis for their opinions is the degree of laxity in claimant's ankle that they attribute to problems that preexist both the 1984 and 1987 compensable left ankle injuries. (Ex. 23, 54). Their opinions do not describe or compare the laxity, if any, of claimant's ankle as it existed prior to the 1984 injury with what the medical record establishes as the degree of laxity existing in the ankle after both the 1984 and 1987 injuries. Without such a description or comparison, their opinions are mere conclusions and as such are not persuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980)

In contrast, Drs. Garber and Bills take into account claimant's ankle sprains before 1984, the laxity as described after the 1984 injury and the laxity recorded after the 1987 injury in advancing their opinions that the work injury of 1987 is the major contributing cause of claimant's current left ankle condition and the need for the 1999 ligament reconstruction surgery. Because their opinions do not speculate on the degree of laxity in claimant's ankle prior to 1984, we find their opinions to be better reasoned and based upon a more history. Consequently, we find their opinions persuasive. *Somers v. SAIF*, 77 Or App 259 (1986). Accordingly, we agree with the ALJ's determination that claimant's current left ankle condition is compensable as to Eugene.

Responsibility

Responsibility for claimant's current left ankle conditions remains with the City of Eugene unless the record establishes that claimant suffered either a new compensable injury or a new occupational disease. ORS 656.308(1). The record does not establish that claimant suffered either a new compensable injury or new occupational disease involving his left ankle since the start of his October 1992 employment with the City of Ontario. Accordingly, we conclude that the City of Eugene remains responsible for claimant's current left ankle condition.

Attorney Fees

The ALJ awarded claimant an assessed fee in the amount of $2,500 under ORS 656.386(1), and an additional fee of $1,000 under ORS 656.308(2)(d). Claimant challenges only the amount awarded pursuant to ORS 656.386(1).

With his respondent/cross-appellant brief, claimant submitted an affidavit of counsel, as support for his contention that the ALJ should have awarded a larger attorney fee. Eugene objects to the submission of the affidavit of counsel as untimely.

OAR 438-015-0029 allows, on Board review, a claimant's attorney to file a request for a specific fee for services at the hearing level and/or for services on Board review. *William F. Davis*, 51 Van Natta 257 (1998). Such a request is timely filed if it is filed within 14 days from the filing of the last appellate brief under OAR 438-011-0020. OAR 438-015-0029(2)(b). Here, claimant's request was filed contemporaneously with his respondent/cross-appellants brief. Consequently, the request was timely filed.

For services at hearing pursuant to ORS 656.386(1), claimant's counsel requests a fee in the amount of $4,560. Claimant's counsel spent 30.4 hours on the case. However, time devoted to the case

[4] Dr. Lundsgaard described the laxity as Grade III. (Ex. 14).

is but one factor we consider in determining a reasonable attorney fee. OAR 438-015-0010(4) instead requires consideration of numerous other factors, 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 the 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). 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).

The hearing transcript consists of 31 pages; claimant was the only witness. The record consists of 54 exhibits, including 2 medical report/letters concerning compensability that were submitted by claimant. No depositions were taken. We find the legal and medical issues, when compared to compensability disputes generally presented to the Hearings Division, to be of average complexity. We find the value of the claim and the benefits secured, including claimant's 1999 surgery, to be average. 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 $2,500 is a reasonable attorney fee under ORS 656.386(1), for services at the hearings level regarding the compensability issue. We reach this conclusion because of factors such as the time devoted to the issue, the value of the interest involved, the complexity of the issue, and the risk that claimant's counsel might go uncompensated. Accordingly, we affirm the ALJ's attorney fee award in view of the factors in OAR 438-015-0010(4).

Claimant's attorney is entitled to an assessed fee for services on review. 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 of the left ankle condition is $1,200, to be paid by Eugene. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and his counsel's request), the complexity of the issue, and the value of the interest involved.[5]

ORDER

The ALJ's order dated April 18, 2000 is affirmed. For services on review, claimant is awarded an $1,200 fee, payable by Eugene.

[5] We have not considered any time devoted to the responsibility, temporary disability or attorney fee issues.

September 7, 2000 Cite as 52 Van Natta 1605 (2000)

In the Matter of the Compensation of
LOREN E. WEIDEMAN, Claimant
Own Motion No. 99-0259M
OWN MOTION ORDER
Coughlin, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney
VavRosky, et al, Defense Attorneys

The self-insured employer submitted claimant's request for temporary disability compensation for his left ankle condition. Claimant's aggravation rights on that claim expired on November 2, 1993. On July 6, 1999, the employer denied the compensability of claimant's current left ankle condition. Claimant requested a hearing. (WCB Case No. 99-05835). In addition, the employer opposed reopening of claimant's claim on the grounds that: (1) it was not responsible for claimant's current condition; and (2) surgery or hospitalization was not reasonable and necessary for claimant's accepted condition. The Board postponed action on the own motion matter pending resolution of the litigation pending before the Hearings Division.

By Opinion and Order dated April 18, 2000, Administrative Law Judge (ALJ) Menashe set aside the employer's July 6, 1999 denial. The employer requested Board review of ALJ Menashe's order, and, by an order issued on today's date, we have affirmed ALJ Menashe's order.

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

On April 5, 1999, claimant underwent an Evans procedure left ankle surgery. Thus, we are persuaded that claimant's compensable injury worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1987 injury claim to provide temporary disability compensation beginning April 5, 1999, the date claimant was hospitalized for surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the employer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
BOBBY A. BRADBURRY, Claimant
WCB Case Nos. 99-07212 & 99-04471
CORRECTED ORDER ON REVIEW
Preston, Bunnell & Stone, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Julie Masters (Saif), Defense Attorney

It has come to our attention that our September 1, 2000 Order on Review contains a clerical error. Specifically, an incomplete sentence appears on the top portion of page 6 of our order. To correct this oversight, we replace the first five lines appearing on page 6 of our September 1, 2000 order with the following lines:

> "ORS 656.308(1) applies only when the original compensable injury and the second injury involve the same condition. *Id.* at 636. The court explained that a new compensable injury involves the same condition when the new compensable injury encompasses, or has as part of itself, the prior compensable injury. *Id.* at 631. In that circumstance, 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. *Id.* at 632."

Accordingly, we withdraw our September 1, 2000 order. As corrected herein, we republish our September 1, 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
JON S. HALL, Claimant
WCB Case No. 99-03316
ORDER ON REVIEW
Gatti, Gatti, et al, 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) Johnson's order that set aside its denial of claimant's abdominal hernia claim. The employer also challenges the ALJ's admission of certain exhibits. On review, the issues are evidence and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Evidence

The employer first contends that the ALJ erred in allowing Exhibits 13A, 19A, 22A, all authored by Dr. Forsythe. Specifically, the employer reiterates its argument at hearing that submission of the documents was not timely and contravened claimant's prior statement that he would not rely on Dr. Forsythe's opinion.

The ALJ found the evidence relevant and admitted the reports. The ALJ also allowed the employer an opportunity to continue the hearing to depose Dr. Forsythe. Following the hearing, the employer notified the ALJ that it did not wish to depose Dr. Forsythe.

Under OAR 438-007-0018(4), the ALJ may admit additional evidence that was not disclosed as required by OAR 438-007-0015; in making this decision, the ALJ must determine if material prejudice has resulted from the untimely disclosure and, if so, whether there is good cause that outweighs any prejudice. Following a finding of material prejudice, the ALJ may exclude the evidence or continue the hearing for any action that would cure the material prejudice. We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *affd mem* 133 Or App 258 (1995).

Here, at hearing, the employer objected to the documents because, based on claimant's prior statement that he would not rely on Dr. Forsythe's opinion, it had decided not to depose the physician. Although such information could be the basis for the ALJ finding that the employer was materially prejudiced by the late submission, the ALJ continued the hearing to allow the employer to depose Dr. Forsythe, thus allowing the employer to cure any material prejudice. Therefore, we find no abuse of discretion by the ALJ in admitting the disputed exhibits.

Compensability

In November 1995, claimant underwent surgery for diverticulitis, leaving an incisional scar on his abdomen. On March 8, 1999, while working, claimant felt an acute onset of abdominal pain at the incision site and was diagnosed with an incisional hernia.

As explained by the ALJ, the record contains several opinions concerning the major contributing cause of claimant's hernia condition. Claimant relies on Dr. Forsythe and Dr. Ryan, both of whom treated claimant. Dr. Braun, who reviewed the records, found that preexisting factors outweighed the work incident.

We first agree with the ALJ that Dr. Forsythe's opinion is not sufficiently well reasoned to be persuasive. Namely, Dr. Forsythe does not discuss or weigh the other contributing factors recognized by Dr. Ryan and Dr. Braun and summarily attributes the condition to the work incident. Thus, we do not rely on Dr. Forsythe's opinion. *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).

Dr. Ryan performed claimant's 1995 surgery and operated on his incisional hernia. Dr. Ryan first indicated that work activities were the major contributing cause of claimant's hernia. (Ex. 13). Dr. Ryan then reported that claimant had a "pre-existing condition" from the incision from the 1995 surgery, potentially making this "an area of weakness under excessive stress." (*Id.*) The report further explained that "extra force" was applied to the abdomen during the March 1999 event and that the stresses were a "major cause" of the hernia. (*Id.*)

Dr. Ryan was then deposed. He reiterated that the work incident combined with the preexisting weakness from the incision to cause the hernia. (Ex. 24-11). Dr. Ryan discussed additional causal factors, including obesity and diabetes. (*Id.* at 12-13). With regard to the work incident, Dr. Ryan described it as "a significant thing," " a noticeable contributor," and agreed that it was "the most major contributing factor." (*Id.* at 15, 16, 23).

Dr. Ryan also subsequently agreed, however, that he was "speculating" in finding that the work incident was the major contributing cause. (*Id.* at 27). Dr. Ryan then estimated that obesity contributed twenty-five percent; diabetes contributed "maybe say 5 or 10 percent"; and the prior surgery contributed approximately thirty to forty percent. (*Id.* at 32). Dr. Ryan then agreed that adding these figures showed that they outweighed the work incident. (*Id.* at 33). Dr. Ryan disagreed, however, that the work incident was about twenty-five to forty percent the cause, stating that it "was the significant event." (*Id.*)

We find Dr. Ryan's opinion confusing and inconsistent. Although Dr. Ryan considered the work incident an important factor in causing the hernia, he did not consistently characterize it as the major contributing cause. On the contrary, Dr. Ryan conceded that he was "speculating" in finding it to be the major contributing cause and agreed that, when he approximated the percentage of contribution from other factors, they outweighed the work incident. In short, because portions of Dr. Ryan's opinion support claimant's assertion that the work incident was the major contributing cause of the need for treatment and other portions supports the employer's position that preexisting factors contributed more than the work event, we find that it is not sufficiently reliable to carry claimant's burden of proof.

Because the remaining opinion from Dr. Braun also does not support causation, we conclude that claimant did not prove compensability. *See* ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated March 2, 2000 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

Board Member Phillips Polich affirming in part and dissenting in part.

I agree with that portion of the majority's order finding no abuse of discretion by the ALJ in admitting the exhibits. I dissent, however, from the majority's decision that claimant failed to prove compensability of his abdominal hernia.

The majority relies upon that portion of Dr. Ryan's deposition when he was asked by the employer's counsel to assign percentages to each potential contributor and, when totaled, the nonwork factors outweighed the work incident. First, I find it inappropriate to apply a mathematical formula to determine compensability. Such a method does little to decide whether a physician's opinion is persuasive.

Furthermore, Dr. Ryan indicated that assigning such percentages was speculative and followed this exchange by stating that the work injury was "the significant event." Consequently, I find that this portion of the deposition does not represent Dr. Ryan's complete opinion and give it less weight than his ultimate conclusion that the major contributing cause of claimant's hernia was the work injury.

The remaining portion of Dr. Ryan's opinion also supports compensability. Dr. Ryan carefully considered each of the potentially contributing factors of claimants hernia, including the incision from the prior surgery, any subsequent infection, obesity, smoking, diabetes, and the work incident, and repeatedly found that the major contributing cause of the hernia was the March 1999 work incident. Dr. Ryan was the only physician to consider all factors as required by *Dietz v. Ramuda.*

Specifically, with regard to the incision, Dr. Ryan indicated that such condition "had some potential weakness" and that very few of his patients developed incisional hernias. In discussing the diabetes, Dr. Ryan concluded that he could not be sure whether the condition was a contributing factor and, if it was, the contribution was minor. Because claimant does not smoke, there was no contribution from smoking. Finally, although conceding claimant was "not the trimmest fellow," obesity was not a significant factor.

Thus, a careful review of Dr. Ryan's opinion shows that the surgery resulted in a weakened area but the hernia was not "incisional," and claimant's diabetes and weight were factors but not "significant." After careful evaluation of all factors, Dr. Ryan concluded that the work injury was the major contributing cause of the abdominal hernia.

Thus, based on the Dr. Ryan's entire opinion, I would conclude that claimant carried his burden of proof.

September 8, 2000 Cite as 52 Van Natta 1609 (2000)

In the Matter of the Compensation of
ALVIN VAN ARNAM, Deceased, Claimant
WCB Case No. C001879
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On August 4, 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 (the beneficiary of the deceased worker) released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker (the workers beneficiaries), the insurer or the self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on August 4, 2000. The statutory 30th day following the submission is September 5, 2000. Claimant filed her request for disapproval of the disposition on August 28, 2000. Accordingly, we disapprove the disposition. *Id.*

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(5)(k).

IT IS SO ORDERED.

In the Matter of the Compensation of
LEAH M. HALLGARTH, Claimant
WCB Case Nos. 99-04974 & 99-03306
ORDER ON REVIEW
Robert A. Baron (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation denials of claimant's injury claims for her left shoulder condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation to address claimant's contentions that: (1) she does not have a preexisting condition in her left shoulder; and (2) Dr. Goodwin, not Dr. Anrooy, is her attending physician.

Claimant seeks to establish the compensability of her left shoulder condition, diagnosed as left shoulder pain/strain/subluxation. (Ex. 2; 3; 7C; 8; 12A-3). To establish that her left shoulder problem is compensable as an injury, claimant must prove that her work activity was a material contributing cause of the disability or need for treatment of that shoulder condition. *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). If however, her left shoulder problem combined with a preexisting condition, the left shoulder problem is compensable only if the work activity was the major contributing cause of the disability or need for treatment for the "combined" shoulder condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 106 (1997), *affd as modified on recon*, 149 Or App 309, 315 (1997), *rev denied*, 326 OR 389 (1998).

The medical record establishes that claimant had prior problems with her left shoulder in 1990. (Ex. A; B; D). Claimant contends that her prior shoulder problem was a mild strain, which completely resolved years ago. She further contends that her prior shoulder problem plays no role in her current shoulder condition. In contrast, SAIF contends that claimant's 1990 left shoulder problem represents a preexisting condition, and that this preexisting condition, not claimant's work activities, is the major contributing cause of claimant's current disability or need for treatment of the left shoulder. Because of the possible alternative causes of claimant's current left shoulder condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Dr. Van Anrooy, a consulting orthopedist, opined that: (1) claimant has ligamentous laxity in her left shoulder; and (2) the work activities, as described by claimant were not consistent with causing a shoulder instability (laxity) problem. (Ex. 9; 11-5; 11-26). Consequently, he opined that claimant's left shoulder problems were not work related. (Ex. 9; 11-39).

Dr. Anderson, a SAIF-arranged examiner, opined that claimant appeared to have a preexisting shoulder instability problem, but he could not determine if claimant's current symptoms were related to her work activities. (Ex. 8-3).

Dr. Vadja, the initial attending physician, appears to support claimant's contention that the 1990 injury was a discrete event, but he does not express an opinion regarding the cause of claimant's current left shoulder problem. (Ex. 2A; 6B; 13).

Dr. Goodwin, the current attending physician, while finding no instability in claimant's left shoulder, expresses no opinion regarding the cause of the current left shoulder problem. (Ex. 12A-3).

Claimant has the burden of establishing the compensability of her left shoulder condition. ORS 656.266. Based upon this record, we conclude that claimant has failed to establish that her work activities are a material contributing cause of her current disability or need for treatment of her left

shoulder condition.[1] Accordingly, on this record, we agree with the ALJ that claimant has failed to establish the compensability of her left shoulder condition.[2]

ORDER

The ALJ's order dated April 3, 2000 is affirmed.

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[1] In determining that claimant has failed to establish the compensability of her left shoulder condition under the material contributing cause standard, we necessarily determine that she has also failed to establish the compensability of that condition under the major contributing cause standard.

[2] It appears that claimant is not clear as to what medical evidence she needs to present to establish a compensable 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. Inasmuch as claimant is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. She may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

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

In the Matter of the Compensation of
HAROLD L. AVERY, Claimant
Own Motion No. 66-0475M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On August 30, 2000, the SAIF Corporation submitted its request to reopen claimant's claim under our own motion jurisdiction to provide reimbursement for diagnostic medical services to determine the compensability of requested medical services as they relate to his compensable October 6, 1948 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 medical services an integral part of a medical service provided to an injured worker. As such, we conclude the diagnostic medical services qualify as compensation under ORS 656.005(8) and ORS 656.625.

Accordingly, we find that the requested medical file review is reasonable and necessary and is justified by special circumstances. Therefore, we authorize SAIF's request for reimbursement for the costs of diagnostic medical services. By this order, the claim is again closed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DARLEEN J. WEISS, Claimant
WCB Case No. 99-10012
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Biehl and Bock.

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

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

The ALJ found that claimant established a sufficient causal connection between her work activity and the injury to find that the incident occurred in the course and scope of employment. The employer argues that claimant was injured while engaging in a personal activity and the injury did not arise out of the course and scope of employment.

There is no dispute that claimant was in the course and scope of employment when the injury occurred. The only dispute is whether the injury arose out of claimant's employment.

Claimant works for the employer as a fee taker at the employer's recycling center. She injured her left knee during her shift while unloading her own old rototiller into the metal recycling area. The employer has a policy that encourages employees to help customers unload recycling. The employer also has a policy prohibiting employees from engaging in personal business on company time. Claimant's supervisor, however, testified that the policy against engaging in personal business had not been brought to claimant's attention. When the injury occurred, claimant was in an area of the recycle center where she was required to work from time to time.

The "arising out of" element of the work-connection test requires that a causal link exist between the worker's injury and her employment. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525-26 (1996). The work-connection test may be satisfied if the factors supporting one prong of the statutory test are minimal while the factors supporting the other prong are many. *Id* at 531. The totality of the circumstances surrounding the injury determines compensability. *SAIF v. Fortson*, 155 Or App 586, 591 (1998).

In *Fortson*, the claimant was injured when he fell into a dumpster to get a crate for his personal use. The employer had a policy that allowed employees to salvage material from plant grounds if permission and a pass were first obtained from the employer. The claimant had obtained the permission and pass and was injured looking for the crate in a dumpster. After considering the totality of the circumstances, the court concluded that the claimant's injury arose out of the course and scope of the claimant's employment.

In this case, we are persuaded that claimant's injury has a stronger work connection than the injury in *Fortson*. In this regard, the area where claimant was injured was an area where she might normally work, whereas the claimant in *Fortson* did not normally work near the dumpster. In addition, here, the risk of unloading recyclable material was a normal risk of claimant's job since the employer has a policy that encouraged employees to assist members of the public in unloading their recycling. Moreover, claimant twisted her knee on uneven ground and gravel near the metal recycling bin. Finally, the employer's policy against engaging in personal business on company time has not been brought to claimant's attention. In light of the totality of the circumstances, we are persuaded that claimant's injury arose out of the course and scope of her employment.

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

ORDER

The ALJ's order dated April 10, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by the employer.

September 11, 2000 Cite as 52 Van Natta 1613 (2000)

In the Matter of the Compensation of
DONALD J. WHISENANT, Claimant
WCB Case No. 99-07729
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our May 8, 2000 order that reversed those portions of Administrative Law Judge (ALJ) Thye's order that: (1) awarded temporary total disability (TTD) for the period from October 31, 1998 through November 2, 1998 and temporary partial disability (TPD) for the period from November 3, 1998 through May 4, 1999; (2) assessed a penalty for the self-insured employer's allegedly unreasonable failure to pay temporary disability; and (3) awarded 11 percent (14.85 degrees) scheduled permanent partial disability for loss of use or function of claimant's right foot, whereas an Order on Reconsideration had awarded 8 percent (10.8 degrees). On June 2, 2000, we abated our order to consider claimant's motion for reconsideration and granted the employer an opportunity to respond. Having received the employer's response, we proceed with our reconsideration and replace our prior order with the following order.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following exception, supplementation, and summary. We do not adopt the ALJ's finding of ultimate fact regarding claimant's entitlement to increased scheduled permanent disability benefits.

On September 11, 1998, claimant sustained a laceration and nondisplaced fracture of the fifth toe of his right foot while working in the employer's warehouse. That same day, claimant was treated in the emergency room. The claim was accepted for a right foot strain and crush injury.

On September 15, 1998, claimant began treating with Dr. Sauvain, M.D., who continued to recommend crutches and light duty, seated work. (Ex. 3). She referred claimant to Dr. Mozena, a podiatrist, and left it up to Dr. Mozena to determine who would continue to treat claimant's foot injury.

On September 18, 1998, Dr. Mozena began treating claimant. On September 24, 1998, Dr. Mozena removed the stitches in claimant's laceration and applied a cast to his foot. Light duty, seated work was ordered continued until October 30, 1998, when Dr. Mozena released claimant "back to full duty" with the use of over-the-counter arch supports pending receipt of fitted orthotic devices.

The employer terminated claimant a week after he sustained his foot injury. As of October 31, 1998, the employer stopped paying TTD. It did not begin paying TPD. On November 3, 1998, claimant began working at a fast food restaurant.

On November 12, 1998, claimant returned to Dr. Sauvain, who noted that claimant had difficulties tolerating standing for more than two to three hours per day because of right foot pain. Dr. Sauvain continued claimant on light duty. (Ex. 9).

On November 24, 1998, claimant received his fitted orthotic devices from Dr. Mozena. On February 16, 1999, claimant reported to Dr. Mozena that he was working as a manager in a fast food restaurant, which required him to stand on hard surfaces 35 to 40 hours a week. Dr. Mozena prescribed treatment, including physical therapy, and advised claimant to seek work that did not require being on his feet so much.

On March 17, 1999, Dr. Sauvain performed a closing examination. (Ex. 14). At that time, claimant continued to work as a manager in a fast food restaurant. Dr. Sauvain, in consultation with

Dr. Mozena, concluded that claimant's initial injuries were medically stationary and, considering his continuing to work in a primarily weight bearing occupation, his compensatory fascial right foot pain was also medically stationary. (Ex. 14). She noted that, if claimant were to be employed in an occupation requiring him to be on his feet less than 50 percent of the time, his fascial right foot pain would probably resolve. She expected that claimant would be able to return to work as a warehouseman within six months to a year, *i.e.*, sometime in late 1999 or 2000. (Ex. 14-3).

On May 4, 1999, the claim was closed by a Determination Order that declared claimant medically stationary as of March 17, 1999, and awarded: (1) temporary disability benefits from September 11, 1998 through October 30, 1998; and (2) 3 percent (4.05 degrees) scheduled permanent disability benefits for loss of use or function of the right foot. (Ex. 16). Claimant requested reconsideration and appointment of a medical arbiter.

On August 25, 1999, Dr. Berselli, M.D., examined claimant in his capacity as medical arbiter. (Ex. 18A).

On September 28, 1999, an Order on Reconsideration affirmed the medically stationary date and temporary disability benefit award and increased the scheduled permanent disability benefit award to 8 percent (10.8 degrees). (Ex. 19). Claimant requested a hearing.

On December 15, 1999, ALJ Thye issued an order that affirmed the medically stationary date. That order also: (1) awarded TTD for the period from October 31, 1998 through November 2, 1998 and TPD for the period from November 3, 1998 through May 4, 1999; (2) assessed a penalty for the employer's allegedly unreasonable failure to pay temporary disability; and (3) increased the scheduled permanent disability award to 11 percent (14.85 degrees) for loss of use or function of claimant's right foot. The employer requested review of those portions of the ALJ's order addressing these last three issues.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

The ALJ awarded claimant 5 percent scheduled permanent disability for loss of dorsiflexion in his right ankle and lost right toe joint range of motion. In making this award, the ALJ declined to compare claimant's lost range of motion with the contralateral joints of the left ankle and toes because claimant had reported a previous laceration in the dorsum of his left foot resulting in residual dysesthesia. On review, relying on *Lopez v. Agripac, Inc.*, 154 Or App 149, *rev den* 327 Or 583 (1998), we determined that the Order on Reconsideration properly evaluated claimant's scheduled permanent disability based on comparisons with his contralateral joints because there was no medical evidence of injury to the contralateral joints.

On reconsideration, claimant argues that the ALJ properly awarded permanent disability for loss of dorsiflexion in claimant's right ankle and lost right toe joint range of motion without comparison to the contralateral joints, because claimant told the medical arbiter that he previously lacerated the dorsum of his left foot. Thus, because his left *foot* had a prior history of injury, claimant contends that we erred in concluding that his right ankle and toe joint range of motion should be evaluated by comparison with their contralateral (left) joints, under OAR 436-005-0007(23).

After further consideration of claimant's argument, we continue to reject it for the reasons explained in our prior order. On reconsideration, we assume for the sake of argument that claimant's reporting to the arbiter (and the arbiter's notation that claimant had a scar on the dorsum of his left foot) would be sufficient medical evidence to establish a "history of injury or disease" to claimant's left *foot*. However, absent medical evidence indicating that claimant's prior left *foot* laceration included injury or disease to his left *ankle* or *toe joint*, we continue to conclude that the standards require evaluating claimant's right ankle and toe joints by comparing them to the contralateral *joints*. *See Lopez v. Agripac, Inc.*, 154 Or App at 154 (contralateral joint comparison required under OAR 436-005-0007(23) where there is no documented medical evidence of injury to the contralateral joints).

Temporary Disability

The employer does not dispute the payment of TTD benefits from September 11, 1998 through October 30, 1998. Instead, the employer argues that it was entitled to stop all temporary disability

benefits after October 30, 1998, the date Dr. Mozena, claimant's treating podiatrist, released him "back to full duty." The employer also argues that termination of temporary disability benefits was supported by Dr. Sauvain's November 12, 1998 notation that claimant had returned to "a regular job in a fast food restaurant on November 3, 1998." The employer notes that claimant continued in that job, or a similar job, through the date of claim closure on May 4, 1999. Finally, the employer argues that claimant was not entitled to temporary disability benefits after October 30, 1998, "because no attending physician authorized temporary disability (total or partial) after October 30, 1998, the last date for which temporary disability was paid." On reconsideration, we disagree with the employer's contentions.

On September 15, 1998, Dr. Sauvain released claimant to light duty work. (Ex. 3-2). Contrary to the employer's argument, Dr. Sauvain did not report on November 12, 1998 that claimant had returned to "a regular job" in a fast food restaurant on November 3, 1998. Instead, in her November 12, 1998 chart note, Dr. Sauvain stated that claimant began working at a fast food restaurant on November 3, 1998, and he "has been on light duty because of his right foot." (Ex. 9-1). In addition, Dr. Sauvain noted that claimant had difficulties tolerating standing for more than two to three hours because of pain and continued claimant on light duty. (Ex. 9). Thus, Dr. Sauvain expressly released claimant to ongoing light duty. Furthermore, Dr. Sauvain's light duty work release had not changed at the time she conducted claimant's closing examination on March 17, 1999. (Ex. 14). Moreover, at that time, Dr. Sauvain recommended that claimant not stand more than four hours in an eight hour work day, and restricted his climbing, crouching, and crawling to one-third of the time or less. (Ex. 14-3). Finally, at no time did Dr. Sauvain release claimant to regular work. Under these circumstances, we find that Dr. Sauvain released claimant to light duty work.

Therefore, the employer is mistaken in its contention that "claimant was not entitled to temporary disability benefits, because no attending physician authorized temporary disability (total or partial) after October 30, 1998." To the contrary, Dr. Sauvain authorized ongoing light duty during this period. (Exs. 3, 9, 14).

The employer relied on Dr. Mozena's October 30, 1998 release to "full duty" to terminate claimant's TTD benefits. For the following reasons, we find that the employer's reliance on Dr. Mozena's work release is misplaced.

ORS 656.262(4) provides, in material part, that temporary disability compensation shall be paid if authorized by the attending physician. ORS 656.262(4)(a) and (h). The statute further provides that temporary disability compensation is not due 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." ORS 656.262(4)(g) (emphasis added). Thus, only the attending physician is qualified to authorize payment of and termination of temporary disability benefits.

An "attending physician" is defined as: (1) a medical doctor or a doctor of osteopathy licensed under ORS 677.100 to 677.228; (2) an oral or maxillofacial surgeon; or (3) a chiropractor for the first 30 days from the date of first visit on an initial claim or for 12 visits, whichever first occurs. ORS 656.005(12)(b). As the ALJ found, a podiatrist is licensed under ORS 677.805 *et seq.* Therefore, as a podiatrist, Dr. Mozena does not qualify to serve as claimant's attending physician. Instead, Dr. Sauvain is claimant's attending physician. Furthermore, as discussed above, Dr. Sauvain continued to authorize light duty work. Thus, Dr. Mozena's release to "full duty" did not provide the employer a basis to terminate temporary disability benefits.

The employer also argues that it was entitled to terminate temporary disability benefits under the reasoning in *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, *rev dismissed* 329 Or 503 (1999). We disagree.

In *Bundy*, the court reversed our decision in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), that held that the 14-day limitation on "retroactive" temporary disability authorization from an attending physician set forth in ORS 656.262(4)(g), was not applicable to "substantive" temporary disability awarded at the time of claim closure. After reviewing the legislative history of ORS 656.262(4), the court concluded that the statute's reference to ORS 656.268 was intended to limit the award of retroactive time loss to 14 days regardless of whether the claim was open or pending closure.

As noted above, ORS 656.262(4)(g) provides that temporary disability is not due and payable "pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability

or for any period of time not authorized by the attending physician." 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." In *Bundy*, the court held that this section applies to the substantive entitlement to benefits at claim closure as well as the procedural obligation to pay temporary disability while the claim is open.

Nevertheless, Dr. Sauvain's release to light duty was not a retroactive release. Instead, it was a contemporaneous, ongoing release. Therefore, the limitation on retroactive authorization of temporary disability benefits does not apply.

By the same token, *Douglas R. Hart*, 51 Van Natta 1856 (1999), is distinguishable. In *Hart*, we adopted and affirmed an ALJ's order that: (1) relied on our decision in *Kenneth P. Bundy*, 48 Van Natta at 2501, to conclude that the claimant's "substantive" entitlement to temporary disability benefits was not contingent on a contemporaneous authorization of time loss from an attending physician; and (2) awarded temporary disability based on a retroactive opinion from the attending physician. Citing *Fred Meyer, Inc. v. Bundy*, the court reversed and remanded our decision. *SAIF v. Hart*, 162 Or App 297 (1999). On remand, we determined that, because the record did not contain a contemporaneous authorization of time loss from an attending physician for the period in question, the claimant was not entitled to temporary disability benefits for that period. 51 Van Natta at 1857.

Here, as discussed above, because the podiatrist had no authority to terminate claimant's temporary disability, Dr. Sauvain's ongoing authorization for temporary disability continued. Therefore, unlike *Bundy* and *Hart*, claimant's attending physician provided a contemporaneous authorization of temporary disability.

However, ORS 656.268(4) provides that temporary total disability may be terminated: (1) when the worker returns to regular or modified work; (2) when the attending physician releases the worker to regular work; (3) when the worker is released to modified work, such work is offered in writing, and the worker fails to begin such employment; or (4) upon the occurrence of any event that causes temporary disability compensation to be lawfully terminated under ORS 656.262(4) or other provisions of this chapter. ORS 656.268(4)(a), (b), (c), (d).

The only basis for termination of TTD benefits under the facts of this case is claimant's return to modified employment on November 3, 1998, the date he began working for another employer (a fast food restaurant). ORS 656.268(4)(a). In this regard, claimant's at-injury job consisted of warehouse work, not fast food work. *Compare John McConnell*, 45 Van Natta 1197 (1993) (a return to regular employment the worker had at the time of disability constituted return to "regular employment" within the meaning of *former* ORS 656.268(3)(a) [now ORS 656.268(4)(a)]). Furthermore, claimant was restricted to light duty at the time he began working in a fast food restaurant. *See Gary D. Smith*, 45 Van Natta 298 (1993) (a restriction on a worker's ability to perform his or her regular work is not a release to return to regular work). Thus, we find that claimant returned to "modified employment," not "regular employment." Therefore, claimant is entitled to TPD benefits effective November 3, 1998.

The ALJ awarded TTD benefits from October 31, 1998 through November 2, 1998, and TPD benefits from November 3, 1998 through May 4, 1998, the date the claim was closed by Determination Order. While we agree with the award of TTD benefits, we award TPD benefits from November 3, 1998 through March 17, 1999, the date claimants condition became medically stationary. *See Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992) (court held that a worker is substantively entitled to temporary disability benefits only until the condition is medically stationary, and that the Board has no authority to award temporary disability benefits beyond the medically stationary date); OAR 436-030-0036(2) (worker not entitled to award of temporary disability for any period in which worker is medically stationary) (WCD Admin. Order 97-065, effective 1/15/98).

Penalty

The ALJ found that the employer's failure to pay TTD benefits through November 2, 1998, and TPD benefits thereafter (assuming any were due) was unreasonable on the basis that Dr. Mozena's regular work release was not legally sufficient. Therefore, the ALJ assessed a penalty of 25 percent on any amounts of temporary disability then due. We agree.

A carrier is liable for a penalty of up to 25 percent of the amounts then due when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

The employer argues that nothing in the record suggested that Dr. Mozena's work release was legally insufficient until the ALJ declared it to be so. Therefore, the employer argues, its reliance on Dr. Mozena's release to terminate claimant's temporary disability benefits was not unreasonable. We disagree.

The carrier is responsible for processing claims and providing compensation for a worker. ORS 656.262(1). That responsibility includes knowledge of the relevant law. As explained above, by statute, only an attending physician may authorize or terminate temporary disability and, also by statute, a podiatrist is not qualified to serve as an attending physician. Therefore, it was unreasonable for the employer to rely on a statement from claimant's treating podiatrist, a person unqualified to serve as the attending physician, to terminate temporary disability.

Accordingly, we assess a penalty of 25 percent of the amounts then due regarding our award of TTD benefits from October 31, 1998 through November 2, 1998, and TPD benefits from November 3, 1998 through March 17, 1999.

Attorney Fees

The ALJ awarded out-of-compensation attorney fees of 25 percent of the increased temporary disability benefits and 25 percent of the increased scheduled permanent disability benefits awarded by his order. Our order today eliminates the ALJ's scheduled permanent disability award and reduces the temporary disability benefits award. The ALJs out-of-compensation attorney fee award is reduced accordingly.

Because we have reduced claimant's compensation awarded by the ALJ's order, he is not entitled to an assessed attorney fee pursuant to ORS 656.382(2).

ORDER

In lieu of our May 8, 2000 order, the ALJ's December 15, 1999 is affirmed in part, reversed in part, and modified in part. That portion of the order that awarded 11 percent (14.85 degrees) scheduled permanent disability for loss of use or function of claimant's right foot is reversed. In lieu of the ALJ's award, the Order on Reconsideration that awarded claimant 8 percent (10.8 degrees) scheduled permanent disability for loss of use or function of claimant's right foot is affirmed. In lieu of the ALJ's temporary disability awards and in addition to the Order on Reconsideration's awards, claimant is awarded temporary total disability benefits from October 31, 1998 through November 2, 1998, and temporary partial disability benefits from November 3, 1998 through March 17, 1999. The ALJ's out-of-compensation attorney fee award is modified accordingly. In lieu of the ALJ's penalty assessment, the employer shall pay claimant a penalty of 25 percent of all temporary disability payable as a result of this order, one half of which shall be paid to claimant's attorney in lieu of an attorney fee. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with the majority's reasoning and conclusions regarding the temporary disability and penalty issues. However, because I would affirm the ALJ's decision regarding the scheduled permanent disability issue, I respectfully dissent from the majority's opinion regarding that issue.

In this regard, given the history of injury to claimant's contralateral (left) foot, comparison of range of motion findings with the left foot is not appropriate. Therefore, claimant's range of motion finding is 6 percent, which combined with the undisputed 5 percent loss of repetitive use results in a total impairment of the right foot of 11 percent.

In the Matter of the Compensation of
TROY D. BRENNER, Claimant
WCB Case No. 00-00644
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Bostwick, 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 upheld the insurer's denial of his claim for a back and right hip condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ, with the following supplementation. We disagree with the dissent's contention that claimant's fall was due to tripping over boxes at work. Although one co-worker testified that she believed that is what happened to claimant, the first reports from co-workers were taken by the emergency service providers. Those providers noted that claimant's co-workers reported that they saw claimant "fuzz out," then stumble backwards and fall over some boxes." The emergency report further states that claimant had "no recollection of the syncopal spell." (Ex. 2-1). Consequently, if this case was to be resolved by lay testimony, the evidence regarding the fall is, at best, in equipoise.

However, we agree with the ALJ's deference to the expert medical evidence in this case. Drs. Jacobson and Price, who treated claimant in the emergency room following the fall, reported that claimant was "discussing something with his co-workers when he acutely lost consciousness." The doctors further reported that claimant "had no forewarning" and the doctors described the incident as "a syncopal spell." (Ex. 2-1). On the same day, claimant was examined by Dr. Muench who noted that claimant had "a history of falling a lot." Dr. Muench also reported that claimant had a new onset of right lower extremity weakness "following a complete loss of consciousness this morning." (Ex. 5-2).

Consequently, in light of the expert medical evidence in this case, which is unrebutted, we conclude that claimant has not established that his fall was due to merely tripping over boxes at work. Therefore, we agree with the ALJ's conclusion that claimant has not met his burden of proof. ORS 656.266.

ORDER

The ALJ's order dated May 11, 2000 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the ALJ and the majority's conclusion that this case involves an "unexplained fall," and that claimant has failed to rule out idiopathic causes. Claimant's co-worker, Ms. Rawlins, testified that she witnessed the incident at work. Ms. Rawlins saw claimant back up and trip over some boxes, which caused him to fall and strike his head. (Tr. 3). Ms. Rawlins also saw claimant's face immediately before the fall and did not see any sign of loss of consciousness, syncope or dizziness. (Tr. 10).

Ms. Rawlins' testimony is consistent with the report taken by the ambulance service that transported claimant after his fall. That report indicates that the last thing claimant remembered was leaning against a wall. Claimant also reported that "there was a pile of boxes there that he may have tripped over." (Ex. 1-1).

While I acknowledge that there is evidence in the record showing that claimant had previously fallen on occasion due to his paraplegia, claimant testified that he had only previously fainted on one occasion, and that was not related to his paraplegia condition. Consequently, any medical opinions that attribute claimant's fall to a syncopal episode are based merely on speculation.

Therefore, based on the credible testimony of claimant and his co-worker, which has not been rebutted, I would conclude that claimant's injuries at work were sustained because he tripped over boxes and fell. Any opinions or reports that claimant fainted and fell due to an idiopathic cause are purely speculative and should not be given weight.

In the Matter of the Compensation of
WILLIE D. CASHMERE III, Claimant
WCB Case No. 99-02499
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Martha Brown's order that set aside its denial of claimant's occupational disease claim for a bilateral hearing loss 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 summarize the relevant facts as follows. Claimant is a 39 year-old forklift operator. He started working for the employer in November 1991. (Tr. 5). His prior work environments had not been noisy. His current job exposes him to loud noises from several sources, most notably a "palletizer" machine, buzzers and conveyor belts. (Tr. 13). Claimant did not use hearing protection until the fall of 1998. (Tr. 12). Before November 1991, claimant attended at least one live music concert, but has not done so since. Claimant occasionally mows his lawn and uses power tools. (Tr. 9, 10).

In November 1991, claimant had some hearing loss, albeit not "ratable," as verified on an audiogram performed on November 4, 1991. (Ex. 3). Audiograms taken from July 1993 through March 1997 revealed fairly stable hearing levels. (Ex. 6). However, audiograms taken in October and November 1998 revealed greatly increased hearing loss. (Exs. 10, 11). Claimant sought treatment with Dr. Roberts and filed a claim for bilateral hearing loss, which was denied by the employer.

This is an occupational disease claim under ORS 656.802. Because the parties agree that claimant had some preexisting hearing loss, claimant must prove that his workplace noise exposure is the major contributing cause of the combined hearing loss condition and pathological worsening of the condition. ORS 656.802(2)(b); *Richard E. Johnson*, 49 Van Natta 282, 283 (1997).

Where the medical evidence is divided, we rely on those medical opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Generally, we give deference to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983).

The ALJ set aside the employer's denial based on the opinion of claimant's treating physician, Dr. Roberts. Dr. Roberts concluded that claimant's exposure to loud noises at work was the major contributing cause of a pathological worsening of his bilateral hearing loss condition. (Ex. 15-29).

Dr. Hodgson, who performed an examination of claimant on behalf of the employer, initially agreed that claimant's hearing loss was typical of that seen in loud noise exposure cases, and that excessive noise exposure was the "most likely major contributing factor" to claimant's hearing loss. (Ex. 11-4, -5). However, after being provided with further information as to the "tolerable" noise levels in claimant's workplace, Dr. Hodgson stated that these levels were not sufficient to cause claimant's increased hearing loss and the hearing loss was therefore "idiopathic." (Ex. 12).

The employer first contends that the evidence does not support claimant's theory of increased production in 1997 and 1998 which would explain his dramatic loss of hearing during that relatively short period of time. The employer references statistics from 1997 and 1998, asserting that production levels "remained the same as in previous years." (*See* Ex. 16-1). We disagree.

Although production levels from 1997 to 1998 were virtually unchanged, claimant testified that production levels increased after *1996*. (Tr. 16). Claimant also stated that in 1995 he started working "swing" shift, which had greater production levels than the "grave yard" shift he had previously been working. (Tr. 17). Moreover, claimant's supervisor confirmed that production levels had increased "in

recent years," with more palletizers and conveyor belts creating more overall noise in the workplace. (Tr. 34-35).[1]

The employer next contends that Dr. Roberts' opinion is not persuasive because he relied on an inaccurate history of claimant's noise exposure at work. Specifically, the employer contends that Dr. Roberts mistakenly believed that claimant worked consistent 12-hour days, whereas claimant actually worked eight-hour days, with only occasional overtime. (Tr. 21). However, at deposition, Dr. Roberts opined that, even assuming an eight-hour per day, five-day week, claimant's exposure to workplace noise was the "most significant factor" in the progression of his hearing loss condition. (Ex. 15-28). Moreover, Dr. Roberts stated that working a 12-hour shift would only increase the impact of claimant's workplace noise exposure. (Ex. 15-33). We are therefore satisfied that Dr. Roberts relied on an accurate history in rendering his opinion on causation.

In contrast, we find Dr. Hodgson's opinion less persuasive, because it was based on incomplete information. Although Dr. Hodgson eventually concluded that claimant's hearing loss condition was "idiopathic," based on the "tolerable" noise levels represented in the 1996 noise level survey, he was never afforded the opportunity to review the March 1999 "Noise Exposure Assessment." (Ex. 14). Furthermore, Dr. Hodgson agreed with Dr. Roberts that presbycusis played no causative role in claimant's hearing loss and that claimant's "decidedly notched" pattern of hearing loss is typical of a "noise-induced" hearing loss. (Ex. 11-4, -6).

For all of the above reasons, we agree with the ALJ that claimant met his burden of proving that his work exposure was the major contributing cause of a pathological worsening of his bilateral hearing loss condition. 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 $1,500, 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 16, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the employer.

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[1] Although it had access to such statistics (Tr. 34), the employer did not submit statistics from 1991 through 1996 which, when compared to the 1997-1999 statistics, would contradict the testimony of claimant and his supervisor. *See* ORS 10.095(8); *Roberts v. SAIF*, 18 Or App 590, 593 (1974) (if weaker and less satisfactory evidence is offered when it appears that stronger and more satisfactory was within the power of the party, the evidence offered should be viewed with distrust); *cf. Ragie D. Duncan*, 52 Van Natta 1 (2000) (unexplained failure to call witnesses the claimant identified as corroborative of his injury construed against the claimant).

In the Matter of the Compensation of
SHARON L. SHELNUTT, Claimant
WCB Case No. C002125
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Steven M. Schoenfeld, Claimant Attorney
Wallace, Klor & Mann PC, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

On September 5, 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.

On page 2, the CDA indicates that the accepted conditions subject to the CDA are "Low back strain and cervical strain *with no claim being made for aggravation or worsening of underlying degenerative disc disease.*" (Emphasis supplied).

The function of a claim disposition agreement is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. *See* ORS 656.236(1). It is not the function of a CDA to accomplish claim processing functions under ORS 656.262 or otherwise resolve compensability issues. *See Lynda J. Thomas*, 45 Van Natta 894 (1993). There are other procedural avenues available to the parties to accomplish these objectives, such as stipulations. *See Frederick M. Peterson*, 43 Van Natta 1067 (1991).

Here, we do not interpret the CDA as accomplishing a claim processing function. Rather, we interpret the CDA as clarifying the conditions that have already been accepted. Under such circumstances, we do not find that the CDA was intended to deny or withdraw an aggravation claim or to carry out any other claim processing function.

Under such circumstances, we conclude that the agreement, as interpreted herein, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $437.50, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. CORUM, Claimant
WCB Case No. 97-10164
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's left wrist and ankle injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant alleges that he slipped and fell at work on November 5, 1997. Claimant has many previous injuries, including numerous low back injuries dating to 1979. Several months before November 1997, claimant fractured his left foot.

The ALJ concluded that claimant carried his burden of proving that the November 1997 work injury was a material contributing cause of left wrist, ankle and foot strains. The insurer contends that the medical evidence is not adequate to prove compensability. The insurer further argues that claimant is not credible and his testimony was not sufficiently persuasive to show legal causation.

Claimant's treating physician, Dr. Feldstein, concurred with a letter from the insurer's attorney stating that, "based on your examination and [claimant's] history, the only injuries materially caused by the fall of November 5, 1997, if it occurred, would be to his left wrist and left ankle." (Ex. 79).

Dr. Feldstein concurred with a second letter from the insurer's attorney stating that information about prior injuries would assist her in assessing and treating claimants injuries. (Ex. 82). The letter further stated that, because claimant, "in fact, suffered prior injuries to all of the above body parts, it would not possible for you to render a meaningful opinion on the cause of [claimant's] alleged injuries of November 5, 1997." (*Id.*)

Finally, Dr. Feldstein reported to claimant's attorney that she saw claimant "on two occasions and do not have any wish to review prior records [concerning past injuries]." (Ex. 83-1). Dr. Feldstein also noted that claimant "alleges he slipped and fell on the floor on November 5, 1997, injurying [sic] his left hand and wrist" and that she had "no reason to dispute that." (*Id.*)

Dr. Feldstein further stated that a bone scan was consistent with degenerative joint disease in the left foot and this "could explain some of the findings in [claimant's] left foot." (Ex. 1-2). According to Dr. Feldstein, however, in the absence of "an extensive review of [claimant's] prior records, I cannot say how the new injury affected [claimant.]" (*Id.* at 2).

Examining orthopedic surgeon, Dr. Woodward, found that, although claimant complained of "widespread pain * * * the objective findings have been slight consisting of stiffness and tenderness." (Ex. 74-5). Dr. Woodward further reported that, "[o]n the basis of the examination today and the medical history and the x-ray reports in the medical record, I am unable to come up with a realistic orthopedic diagnosis." (*Id.*)

We agree with the insurer that the medical evidence is not sufficient to prove that claimant compensably injured his left wrist and ankle. First, Dr. Feldstein indicated that, in view of claimant's prior injuries, she could not provide a "meaningful" opinion concerning causation. Although she provided a subsequent report, at best it merely declines to dispute claimant's allegation that he sustained injuries in a November 1997 slip and fall. In other words, Dr. Feldstein does not provide any affirmative medical evidence that a November 1997 fall at work was a material contributing cause of left wrist and ankle injuries.

Moreover, even if we construed Dr. Feldstein's report as supporting medical causation, it provides no reasoning to support the conclusion. We find such an absence undermines the persuasiveness of Dr. Feldstein's opinion in light of Dr. Woodward's opinion that claimant has no "realistic orthopedic diagnosis."

Thus, having found that claimant did not carry his burden of proving medical causation, we conclude that claimant did not establish compensability.

ORDER

The ALJ's February 24, 2000 order is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

In the Matter of the Compensation of
ROSEMARY PETERSON, Claimant
WCB Case No. 99-09469
CORRECTED ORDER ON REVIEW
Coughlin, Leuenberger & Moon PC, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

It has come to our attention that our August 30, 2000 Order on Review contains a clerical error. Specifically, the language in the Order section suggested that the out-of-compensation attorney fee from our increased permanent disability award was payable to claimant, rather than to claimant's attorney.

In light of these circumstances, we withdraw our prior order and replace the Order section with the following language:

ORDER

"The ALJ's order dated March 29, 2000 is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsiderations 2 percent (3 degrees) scheduled permanent disability award for loss of use or function of the left leg, claimant is awarded 4 percent (6 degrees), for the total award of 6 percent (9 degrees) scheduled permanent disability for the left leg. Claimant's attorney is awarded 25 percent of the "increased" compensation created by this order (the 3 percent increase between the ALJ's award and this award), not to exceed $6,000. If any portion of this "increased" compensation has been previously paid to claimant, claimant's counsel may seek recovery of the attorney fee granted in this order pursuant to the procedures set forth 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)."

Accordingly, as supplemented and modified herein, we republish our August 30, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

In the Matter of the Compensation of
CHRISTINA A. FOSTER, Claimant
WCB Case No. 98-09971
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) concluded that a prior stipulation did not encompass the insurer's denial of claimant's degenerative and combined conditions; (2) set aside the insurer's partial denial of claimant's combined condition as an impermissible pre-closure denial; (3) set aside the insurer's denial of claimant's degenerative condition; and (4) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are the preclusive effect of a prior stipulation, compensability, and penalties. We reverse.

FINDINGS OF FACT

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

Claimant has a long history of back pain. On May 21, 1998, when she was working for the employer as a licensed practical nurse, she injured her low back in a lifting incident. She was diagnosed with a low back strain and preexisting degenerative changes at L5-S1 and L4-5. (Exs. 2 through 8). On August 18, 1998, the insurer denied claimant's low back strain injury claim.

Subsequent to the denial, Dr. Kitchel diagnosed a lumbar strain with accompanying lumbar radiculitis and preexisting lumbar degenerative disc disease. (Ex. 13). On November 19, 1998, Dr. Wilson opined that claimant's low back strain had resolved, that claimant was medically stationary on August 25, 1998, and since that time the major need for treatment was due to claimant's radiculitis of the L-5 nerve root. Dr. Wilson thought that claimant had a minor injury that combined with a significant preexisting back condition that required medical treatment. (Ex. 15). On December 8, 1998, the insurer accepted a disabling lumbar strain.

On December 11, 1998, the insurer, relying on Dr. Wilson's opinion, partially denied claimant's "degenerative condition" and "combined condition." On December 15, 1998, the insurer issued an Updated Notice of Acceptance that listed the accepted condition as "disabling lumbar strain." The claim was closed by a December 18, 1998 Notice of Closure.

On December 22, 1998, claimant filed a request for hearing on the December 11, 1998 denial.

On January 12, 1999, a prior ALJ signed a Stipulation and Order in WCB Case No. 98-07142, prepared by the insurer, memorializing the parties' agreement.

CONCLUSIONS OF LAW AND OPINION

Relying on extrinsic evidence, the ALJ found that neither the parties nor the stipulation contemplated settlement of the insurer's December 11, 1998 denial. The ALJ therefore concluded that claimant's hearing request was not barred.

On review, the insurer contends that the Stipulation is not ambiguous and that extrinsic evidence should not have been relied on by the ALJ. Specifically, the insurer contends that the language of the document demonstrates a clear intent to dispose of the issues raised by the insurers August 18, 1998 denial of claimants low back injury, as well as any other issues that had been asserted or could have been asserted.

In contrast, claimant contends that the agreement is ambiguous, as it contains no mention of any combined condition or any condition other than claimant's lumbar strain. We disagree with claimant.

The terms of a written agreement to settle a workers' compensation claim are interpreted using the standard rules of contract construction. *See Trevitts v. Hoffman-Marmolejo*, 138 Or App 455, 459 (1996); *Good Samaritan Hospital v. Stoddard*, 126 Or App 69 (applying law of contracts to workers' compensation settlement agreement), *rev den* 319 Or 572 (1994). If such an agreement is unambiguous, the interpretation of the agreement is a question of law to be decided by a court based on an examination of the terms of the agreement as a whole. *Pollock v. Tri-Met, Inc.*, 144 Or App 431, 435 (1996). The construction to be given such an agreement is to render, if possible, all of its provisions harmonious and to carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement. *Id.*

Generally, contract interpretation consists of two steps. First, a determination is made as to whether, as a matter of law, the terms of the agreement are ambiguous. *Timberline Equip. v. St. Paul Fire and Mar. Ins.*, 281 Or 639, 643 (1978); *Taylor v. Cabax Saw Mill*, 142 Or App 121 (1996). A contract is not ambiguous if it has only one sensible and reasonable interpretation; it is ambiguous if there is more than one sensible and reasonable interpretation. *P & C Construction Co. v. American Diversified*, 101 Or App 51, 56 (1990); *D & D Co. v. Kaufman*, 139 Or App 459 (1996). In deciding whether an ambiguity exists we are not limited to mere text and context but may consider parol and other evidence. *Abercrombie v. Hayden Corp.*, 320 Or 279, 292 (1994). Only if the terms are ambiguous do we proceed to the second step: the "determination of the 'objectively reasonable construction of the terms' in the light of the parties' intentions and other extrinsic evidence." *Taylor v. Cabax Saw Mill*, 142 Or App at 125 (quoting *Williams v. Wise*, 139 Or App 276, 281 (1996)).

The stipulation approved on January 12, 1999 carried WCB Case No. 98-07142 which apparently corresponded to claimants hearing request from the insurers August 18, 1998 denial. The stipulation provides in relevant part:

> "Claimant filed a claim on or about May 22, 1998, alleging injury to her low back, sustained on May 20, 1998.
>
> "[The insurer] denied claimant's claim on August 18, 1998.
>
> "Claimant filed a Request for Hearing to appeal the denial and raise other issues.
>
> "The parties agree to settle all issues raised or raisable as of the time this Stipulation is approved by the administrative law judge as follows:
>
> "[The insurer] rescinds its denial, agrees to accept claimant's claim for lumbar strain, and to pay compensation according to law.
>
> "Claimant's attorney is allowed a fee of $2,000.00 for prevailing on a denied claim, payable in addition to compensation.
>
> "* * * * *
>
> "The request for hearing is dismissed with prejudice.
>
> "* * * * *

> "IT IS SO ORDERED, and it is further ordered, the claimant's Request for Hearing and all issues raised or raisable as of the time this Stipulation is approved by the administrative law judge are hereby dismissed with prejudice." (Ex. 22)

The phrase in question states that "all issues raised or raisable as of the time this Stipulation is approved by the administrative law judge are hereby dismissed with prejudice." That language is unequivocal and has a definite sense: it purports to encompass all issues raisable as of January 12, 1999, the date the administrative law judge approved the stipulation, and to dismiss those issues with prejudice. Giving these words their ordinary and usual meaning, we find that this clause encompasses *all* issues, not just the issue of the August 18, 1999 denial. Accordingly, we conclude that this clause unambiguously establishes that the issues raised by the December 11, 1999 denial were encompassed by its terms.

Because we have found that the terms of the stipulation are not ambiguous, interpreting the stipulation is a matter of law. *Good Samaritan Hospital v. Stoddard*, 126 Or App 69, 72, *rev den* 319 Or 572 (1994). The question is whether the insurer's partial denial of claimant's combined and preexisting conditions could have been negotiated before approval of the stipulation. *Id.* At 73. We conclude that the answer is "yes."

The record establishes that before the parties entered into the January 12, 1999 stipulation, claimant had been diagnosed with a preexisting degenerative condition in her low back. Dr. Wilson opined that claimant's low back strain had combined with her preexisting low back condition. Dr. Wilson also opined that claimant's low back strain had resolved by August 25, 1998 and that, since that time, the major contributing cause of claimant's need for treatment was the preexisting condition that was causing radiculitis of the L-5 nerve root. Moreover, the insurer's December 11, 1998 partial denial of claimant's combined and preexisting conditions had issued prior to the parties' January 12, 1999 stipulation. In that stipulation, claimant agreed that all issues raised or raisable by the time of the ALJs January 12, 1999 approval of the parties stipulation were dismissed with prejudice.

Because claimant's combined and preexisting conditions had been diagnosed and identified as related to her injury and denied before the stipulation, we conclude that compensability of these conditions was an issue that could have been negotiated before approval of the January 12, 1999 stipulation. *See Good Samaritan Hospital v. Stoddard*, 126 Or App 69, 72, *rev den* 319 Or 572 (1994); *Marti J. Coleman*, 51 Van Natta 819 (1999). Consequently, we conclude that claimant's request for hearing on the December 11, 1999 partial denial of these conditions is barred by the stipulation.[1] Therefore, we reverse the ALJ's order.

ORDER

The ALJ's order dated April 26, 2000 is reversed. The insurer's partial denial of claimant's combined and degenerative conditions is reinstated and upheld. The ALJ's penalty and attorney fee awards are also reversed.

---

[1] We contrast this case with *Pollack v. Tri-Met, Inc.*, 144 Or App 431 (1996). In *Pollack*, the court did not address whether the agreement was ambiguous because the Board did not conclude whether it was or not. Here, that issue is directly before us, and we have concluded that the agreement is not ambiguous. Consequently, we agree with the insurer that *Pollack* does not govern here.

Board Member Phillips Polich dissenting.

Unlike the majority, I would find that the "raised or raisable" language is ambiguous. The final paragraph in the stipulation dismissed with prejudice all issues raised or raisable as of the time the Stipulation is approved by the ALJ, *i.e.*, as of January 12, 1999. In the context of the entire agreement, "issues" refers necessarily to matters relating to the broader subject of the settlement. *See Liberty Northwest Ins. v. Bowen*, 152 Or App 549, 553 (1998). However, the agreement does not specify what "raised or raisable" issues are deemed settled under the agreement. While the insurer asserts that the parties agreed to settle all issues that could have been raised prior to the date of the agreement, including issues not related to claimant's hearing request from the August 18, 1998 denial in WCB Case No. 98-07142, the agreement itself does not state that intention. The "raised or raisable issues" language, when read harmoniously with the provisions addressing claimant's hearing request, could reasonably be interpreted as stating an intention to settle all "raised or raisable issues relating to claimant's hearing request, *i.e.*, issues arising from the first denial that predated the insurer's December 18, 1998 denial.

Because the agreement does not clarify whether the parties intended to settle only "raised or raisable" issues relating to the hearing request, or whether they intended to settle all "raised or raisable" issues that arose prior to the date of the agreement, I would find that the language of the agreement is ambiguous and would rely on the parties' stipulations and other evidence surrounding the disputed provision.

Claimant's attorney stipulated that he had no intention to resolve the December 11, 1998 partial denial at the time he negotiated a settlement of the August 18, 1998 denial. The evidence establishes that the partial denial was not in existence at the time the insurer issued its December 8, 1998 acceptance and that the insurer's attorney was not aware of the denial during negotiations. Moreover, I agree with the ALJ that the insurer's December 9, 1998 note establishes the parameters of the parties' agreement. The fact that claimant's attorney requested a hearing on the December 11, 1998 denial that issued subsequent to the parties' agreement further supports his stipulation that he did not contemplate that the denial be included within the settlement agreement.

Consequently, for these reasons, I respectfully dissent.

In the Matter of the Compensation of
HIDI L. HARI, Claimant
WCB Case No. 99-05101
ORDER ON REVIEW
Walsh & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the self-insured employer's denial of claimant's claim for a mental stress condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation. We agree with the ALJ's statement that, although this is a tragic case, the law in its current state requires this outcome. However, we are not certain that, in enacting ORS 656.005(7)(a)(B), the legislature foresaw the result that has occurred here. Specifically, we acknowledge that claimant had a preexisting bipolar disorder prior to the work incident. In comparison to the extreme circumstances to which claimant was subjected and the severity of her resulting psychological condition following the incident, however, claimant's prior condition was mild. Nevertheless, the doctors in this case have found that claimant's psychological conditions "combined" and that the work incident was essentially a precipitating cause of her subsequent disability and need for treatment.

Although the facts of this case are far more extreme and troublesome than a typical "combined condition" case involving a physical condition, the law does not distinguish between the two and claimant cannot obtain the benefits to which she ordinarily would be entitled. It is certainly disheartening to find a case in which a worker was fulfilling the obligations of her job under such dangerous circumstances, but has been subsequently left without benefits. However, under the current law and based on the expert opinions in this case, the unfortunate result for claimant is that her claim is not compensable.

ORDER

The ALJ's order dated May 3, 2000 is affirmed.

Board Member Phillips Polich dissenting.

I would find that, based on the opinion of the experts in this case, claimant has met her burden of proof. Claimant does have a preexisting bipolar disorder. With respect to claimant's current condition, her treating psychiatrist, Dr. Broskie, reported that the condition consists of a bipolar condition, posttraumatic stress disorder, and a chronic physical pain condition. Nevertheless, Dr. Broskie has also persuasively testified that the aforementioned conditions are "three separate diagnoses"

and she agreed that they represented "three separate conditions." (Ex. 53-16, 17). More specifically, Dr. Broskie agreed that the bipolar illness and the posttraumatic stress disorder were "two separate psychological conditions." (Ex. 53-20, 21, 22). Dr. Broskie explained that, with regard to the posttraumatic stress disorder, the only significant cause was the event at work involving gunfire and the deceased police officer. (Ex. 53-23).

Consequently, because the expert opinion of claimant's treating doctor establishes that the posttraumatic condition is separable from the bipolar disorder, and because the work incident is the major contributing cause of the condition, I would find that the condition is compensable. *See, e.g., Colin J. McIntosh*, 47 Van Natta 1965 (1995) (the Board found that the medical evidence established that the claimant's depression condition was compensable, despite a preexisting and contributing, but noncompensable posttraumatic stress disorder condition).

In the Matter of the Compensation of
JON O. NORSTADT, Claimant
WCB Case No. 99-10123
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) Johnson's order that dismissed his hearing request seeking claim reclassification. On review, the issues are jurisdiction and claim reclassification.

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

Claimant argues that the 1999 amendments to ORS 656.277 contained in SB 220 apply retroactively to his claim. *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 as provided in former ORS 656.277). Or Laws 1999, ch 313, Sec. 3(2) (SB220, Sec. 3). However, the legislature did not express any intention that the amended statute be applied retroactively. *See Kempf v. Carpenters and Joiners Union*, 229 Or 337, 343 (1961) (it is a general rule that statutes will be construed to operate prospectively unless an intent to the contrary clearly appears). Thus, we conclude that *amended* ORS 656.277 does not apply retroactively to claimant's claim. *Nga H. Burson*, 52 Van Natta 860, 861 n 2 (2000); *John B. Shaw, Sr.*, 52 Van Natta 63, 64 n 4 (2000).

Here, as the ALJ explained, because claimant's request for reclassification under *former* ORS 656.277[1] was made more than one year after the date of injury, it must be made as a claim for aggravation under ORS 656.273. *Alcantar-Baca v. Liberty Northwest Ins. Corp.*, 161 Or App 49 (1999); *John B. Shaw, Sr.*, 52 Van Natta at 64. Because claimant's aggravation rights on his claim have expired, we lack jurisdiction to consider his aggravation claim. Accordingly, the ALJ properly dismissed claimant's hearing request.

ORDER

The ALJ's order dated June 8, 2000 is affirmed.

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[1] *Former* ORS 656.277 provides, in part: "(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."

In the Matter of the Compensation of
ANGEL J. RODRIGUEZ, Claimant
Own Motion No. 00-0175M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

On July 13, 2000, we issued an Own Motion Order denying claimant's request for temporary disability compensation for his 1977 left knee claim. Although the SAIF Corporation opposed authorizing reopening the claim for payment of temporary disability compensation on several grounds,[1] we decided the issue on the ground that claimant had not established that his compensable condition required surgery or hospitalization. In a letter dated August 21, 2000, and received by the Board on August 28, 2000, claimant states that "[t]his is my formal request to reopen the claim for temporary disability compensation." We treat this letter as a request to reconsider our June 13, 2000 order. Based on the following reasoning, we deny claimant's request for reconsideration.

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).

Claimant requested reconsideration of our July 13, 2000 Own Motion Order after 30 days but within 60 days from the mailing date of that order. Therefore, in order for us to have authority to consider claimant's request for reconsideration, he must establish good cause or extraordinary circumstances for his untimely request for reconsideration.

We note that the return address on the envelope containing claimant's August 21, 2000 letter is different from the address we used in mailing prior correspondence to claimant, including his copy of the July 13, 2000 Own Motion Order. However, none of this prior correspondence, including the July 2000 order, was returned to us as undeliverable. In addition, claimant provides no reason for his failure to request reconsideration within 30 days after the mailing date of our July 2000 order. Without persuasive argument and/or evidence establishing good cause for his failure to timely request reconsideration, we conclude that claimant has failed to meet his burden of proving good cause or extraordinary circumstances. Therefore, we deny his request for reconsideration.

In any event, even if we considered claimant's recent submission, we would not alter our prior decision that declined to reopen the claim. We base this conclusion on the following reasoning.

With his August 21, 2000 letter, claimant submits copies of paycheck stubs dated July 31, and August 15, 2000, and W-2 income tax forms for 1998 and 1999. In addition, he provides the names and telephone numbers of his current physicians and invites us to call them and request any information we might need.

We note that in a May 26, 2000 letter to claimant, we requested information regarding claimant's work force status and noted that copies of paycheck stubs and income tax forms could establish that claimant was in the work force at the time of disability. In addition, we also requested medical documentation regarding whether claimant's condition required surgery and/or hospitalization. We requested that claimant provide the requested information within 14 days from the date of our letter. When no response was forthcoming, we issued our July 13, 2000 Own Motion Order denying reopening on the ground that the need for surgery and/or hospitalization had not been established.

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[1] Specifically, SAIF contended that: (1) claimant's current condition did not require surgery and/or hospitalization; (2) the current condition was not causally related to the accepted condition; (3) SAIF was not responsible for claimant's current condition; (4) surgery or hospitalization was not reasonable and necessary for the compensable injury; and (5) claimant was not in the work force at the time of the current disability.

It appears that claimant's August 21, 2000 letter and attachments attempt to provide the information requested in our May 26, 2000 letter. Although the copies of the paycheck stubs and tax forms establish that claimant remains in the work force, the references to claimant's physicians do not establish that his compensable left knee injury requires surgery or hospitalization.

As we explained in our July 13, 2000 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). 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). Thus, if claimant's compensable condition has not worsened requiring surgery or hospitalization, we *cannot* reopen the claim for payment of temporary disability compensation.

In addition, it is claimant's burden to prove entitlement to benefits.[2] ORS 656.266. In other words, claimant must prove that his compensable condition has worsened requiring surgery or hospitalization. Furthermore, because this is a medical question, medical evidence must be submitted that proves a worsening of the compensable condition requiring surgery or hospitalization. Claimant's statement that he needs/requests surgery is not sufficient to meet his burden of proof.

Here, because claimant has failed to prove that his compensable condition requires surgery or hospitalization,[3] 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.[4] ORS 656.278(1)(a).

Accordingly, claimant's request for reconsideration is denied. The issuance of this order neither "stays" our prior orders nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986); *Fisher v. SAIF*, 76 Or App 656 (1985).

IT IS SO ORDERED.

---

[2] We note that claimant has provided us with the names and telephone numbers of his physicians and invites us to call these physicians and obtain the information we need. However, the Workers' Compensation Board is an adjudicative body of the State of Oregon. In that role, the Board addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial body. Thus, we cannot grant claimant's request to develop the record for him.

[3] As noted above, SAIF also contends that claimant's current condition is not causally related to the accepted condition and that it is not responsible for claimant's current condition. As we noted in our July 13, 2000 order, the issue of whether claimant's current condition is compensable is not determinative under the circumstances of this case. In other words, because the record does not establish that claimant's current condition requires surgery or hospitalization, claimant is not entitled to temporary disability benefits at this time. ORS 656.278(1)(a).

[4] 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, Room 160
Salem, OR 97301-3878
Telephone: 1-800-927-1271

In the Matter of the Compensation of
DAVID A. RUDDOCK, Claimant
WCB Case No. 99-03581
ORDER ON REVIEW
Mustafa Kasubhai PC, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's L5-S1 disc condition; and (2) awarded a $4,500 attorney fee. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of facts with the following change. In the third paragraph on page 3, we delete the citation after the second sentence.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that he has sustained a compensable L5-S1 disc herniation. The ALJ found that, although claimant had preexisting conditions, they did not combine with the injury to the L5-S1 disc and, therefore, claimant was required to prove only that his injury was a material contributing cause of the L5-S1 herniation. The ALJ relied on Dr. Wenner's opinion to establish compensability.

The employer argues that claimant had a preexisting degenerative condition at L5-S1 that contributed to the L5-S1 herniation. The employer contends that, assuming this case is properly analyzed as an injury, ORS 656.005(7)(a)(B) applies.

Claimant has injured his back on several previous occasions. Because of the number of possible causes of his herniated disc, this case presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). 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)).

ORS 656.005(7)(a)(B) provides that if an injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable if the work injury was the major contributing cause of the disability and/or need for treatment of the combined condition. In *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999), the court held that a "combined condition" under ORS 56.005(7)(a)(B) may constitute either an integration of two conditions or the close relationship of those conditions, without integration. In other words, in order for there to be a "combined condition," there must be two conditions that merge or exist harmoniously. *Luckhurst v. Bank of America*, 167 Or App 11 (2000).

A March 11, 1999 MRI of claimant's lumbar spine showed a large herniated disk on the left at L5-S1. (Ex. 59). The radiologist reported that the lumbar disks are normal except for desiccation and narrowing at L5-S1. (*Id.*)

Claimant's attending physician, Dr. Wenner, agreed that the March 1999 MRI showed that the lumbar discs were normal except for some dessication and narrowing. (Ex. 86-1). Dr. Wenner agreed that there was "no significant degenerative process that would have played a role" in claimant's herniated disc. (*Id.*) We are not persuaded by Dr. Wenner's opinion because it lacks adequate explanation. Moreover, the issue is whether claimant had a preexisting back condition that combined with his work injury to cause or prolong his disability or need for treatment. Whether or not claimant had a "significant" degenerative condition is not at issue.

In contrast, we are persuaded by Dr. Zivin's well-reasoned opinion. He examined claimant and reviewed the March 1999 MRI. (Ex. 83-4). Dr. Zivin explained:

> "There are degenerative disc signals of mild degree at all levels. The disc at L5-S1 is moderately narrowed and associated with degenerative spurring; there is a moderate to large disc herniation in the left lateral recess which appears to abut the S1 nerve root. In addition, the canal itself appears to be congenitally shallow at L3-4 and to a greater extent L4-5 short pedicles and flattened canal. There are [sic] very minor degree of facet hypertrophy apparent." (*Id.*)

Dr. Zivin diagnosed degenerative disc disease at L5-S1 and a herniation at L5-S1, as well as some degree of congenital spinal stenosis at L4-5 and L3-4. (*Id.*) He explained that the development of an "acute and 'soft' disc herniation as in [claimant's] case [was] based upon development of a flabbiness and fraying of he annular ligament that degenerative disc material finally is squeezed into the epidural space[.]". (Ex. 83-8). His opinion indicates that claimant's degenerative condition at L5-S1 preexisted the 1999 work activities. He believed that claimant's L5-S1 disc herniation was caused by his underlying degenerative disc disease. (Ex. 84).

We rely on Dr. Zivin's well-reasoned opinion to find that claimant had two conditions that "merge[d] or exist[ed] harmoniously." Dr. Zivin found that claimant had degenerative disc disease at L5-S1 and a herniation at L5-S1 and he believed that the herniation resulted from the degenerative disc disease. (Exs. 83-4, 84). We find that claimant had a "combined condition" and ORS 656.005(7)(a)(B) applies. Therefore, claimant must establish that the 1999 injury was the major contributing cause of his disability or need for treatment of his combined L5-S1 disc condition. We find no such medical evidence in the record. Dr. Wenner agreed that claimant's slipping and twisting activities were "at least the material contributing cause of [his] L5-S1 herniated disc." (Ex. 86-2). Claimant has not sustained his burden of proof under ORS 656.005(7)(a)(B).

Moreover, we find that, for the following reasons, Dr. Wenner's opinion is not sufficient to establish compensability. On March 18, 1999, Dr. Wenner signed an aggravation claim form, which indicated claimant's condition was related to an October 1995 work injury. (Ex. 65). In a later opinion, however, he agreed that claimant's slipping and twisting activities in 1999 were a material contributing cause of the L5-S1 herniated disc. (Ex. 86-2). Because Dr. Wenner provided no explanation for his apparent change of opinion, his opinion is not persuasive. *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 addition, we find that Dr. Wenner's opinion on causation does not support an injury theory. Dr. Wenner's concurrence letter from claimant's attorney said that claimant's low back problems occurred during the winter of 1999, after several weeks of slipping and losing his footing. (Ex. 86-1). Dr. Wenner agreed that the slipping and twisting activities were a material cause of the L5-S1 disc herniation. (Ex. 86-2). Dr. Wenner's concurrence letter did not attribute claimant's L5-S1 disc herniation to a specific event. Rather, he attributed his back condition to several weeks of work activities.

An occupational disease stems from conditions that develop gradually over time. ORS 656.802; *Mathel v. Josephine County*, 319 Or 235, 240 (1994). In contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999); *Valtinson v. SAIF*, 56 Or App 184, 188 (1982).

Dr. Wenner's opinion on causation indicates that claimant's back symptoms related to a condition that developed gradually over several weeks. Based on Dr. Wenner's understanding, the onset of claimant's symptoms did not correspond to a specific "event." *Compare Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983) (the claimant's back trouble was unexpected and coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset"), *rev den* 296 Or 350 (1984). Although Dr. Wenner's opinion supports an occupational disease theory, it is not sufficient to establish causation under that theory.

Furthermore, we note that Dr. Zivin said that the gradual onset of symptoms in spring 1999 without a particular inciting event depicted the natural progression of degenerative disc problems. (Ex.

83-4). We conclude that claimant has failed to sustain his burden of proving compensability of his L5-S1 disc herniation.[1]

ORDER

The ALJ's order dated April 21, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[1] In light of our conclusion, it is not necessary to address the issue of claimant's credibility. Furthermore, we need not address the employer's argument that the ALJ's attorney fee award was excessive.

In the Matter of the Compensation of
RODNEY A. BLACK, Claimant
WCB Case No. 99-03659
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its denial of claimant's current cervical condition; and (2) set aside its denial of claimant's headache and myofascial trigger point conditions. In its reply brief, the insurer objects to claimant's counsel's requested assessed fee for services on review, asserting that it is excessive. On review, the issues are compensability 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."

CONCLUSIONS OF LAW AND OPINION

Current Condition Denial

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

Denial of Trigger Point and Headache Condition

The ALJ set aside the insurer's denial of claimant's trigger point and headache conditions, applying ORS 656.005(7)(a)(B). In so doing, the ALJ determined that claimant had proved that his compensable May 1998 injury, accepted as a cervical contusion/strain, was the major contributing cause of the need for treatment of the disputed conditions. The ALJ relied on the medical opinion of claimant's most recent attending physician, Dr. Lee, over that of claimant's previous treating physician, Dr. Lawlor.

On review, the insurer contends that the ALJ should not have deferred to Dr. Lee's opinion and that, instead, the ALJ should have found the medical opinion of Dr. Lawlor the most persuasive. For the following reasons, we agree with the insurer's contentions.

At the outset, we note that there is some disagreement regarding the appropriate legal standard of compensability. As previously noted, the ALJ applied the major contributing cause standard in ORS 656.005(7)(a)(B). Claimant, on the other hand, asserts that a material contributing cause standard should apply because the medical evidence does not establish that his compensable cervical strain combined with the trigger point and headache conditions. Lastly, the insurer suggests that the consequential condition standard of ORS 656.005(7)(a)(A) should be applied because the trigger point and headache conditions are "consequential conditions" of the accepted cervical strain. We need not decide the issue, however, because, regardless of whether a major or material contributing cause standard applies, we conclude that claimant failed to prove the compensability of the disputed conditions or of their need for treatment.

Because of the multiple number of possible causes of claimant's trigger point and headache conditions, 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). Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

In this case, claimant's two attending physicians, Drs. Lawlor and Lee, have opposing viewpoints regarding the cause of claimant's trigger point and headache conditions. Dr. Lawlor, who began treating claimant less than a month after claimant's compensable May 15, 1998 cervical injury, opined in October 1998 that claimant's cervical injury had resolved and that any residual pain should be attributed to underlying, preexisting degenerative spine disease. (Ex. 28-1). In her November 1999 deposition, Dr. Lawlor explained that her opinion that claimant's compensable cervical strain had resolved was based on medical literature indicating that spinal strains, in the presence of underlying degenerative disease, generally resolve within 12 weeks. (Ex. 63-9).

On the other hand, Dr. Lee began treating claimant in December 1998. He was the physician who diagnosed the headache and trigger point conditions. Dr. Lee opined in January 1999 that claimant had trigger points in the neck and upper trunk area and that most of claimants headaches were due to referred pain pattern from the activation of the trigger points. (Ex. 48). Dr. Lee opined that the compensable injury was the major contributing cause of the trigger point/headache conditions. (Ex. 60-1). He specifically disagreed with Dr. Lawlor's opinion that claimant's current need for treatment was due to preexisting degenerative changes.

As between the two medical opinions, we agree with the insurer that Dr. Lawlor's opinion is more persuasive. First, Dr. Lee did not begin treating claimant for over six months after the compensable injury. In contrast, Dr Lawlor began treating claimant less than a month after the compensable injury. *See McIntyre v. Standard Utility Contractors, Inc.*, 135 Or App 298, 302 (1995) ("a treating physician's opinion [] is less persuasive when the physician did not examine the claimant immediately following the injury"). Indeed, Dr. Lee conceded in his deposition that Dr. Lawlor was in a better position to determine whether claimant's cervical condition had resolved. (Ex. 62-7, page 25). In addition, Dr. Lee expressed some hesitancy in expressing opinions to a degree of medical probability in the deposition because he had not followed claimant right after the compensable injury. (Ex. 62-6, page 24).

In addition to Dr. Lee's lack of perspective, his opinion also suffers from the fact that it is largely based on a temporal relationship between claimant's trigger points and headaches and the compensable injury. Dr. Lee testified that the main reason for concluding that claimant's headaches were due to the work injury was that claimant did not report that he had them prior to the compensable injury. (Ex. 62-3, page 11). Such an opinion is unpersuasive. *See Allie v. SAIF*, 79 Or App 284, 288 (1986) (causation cannot be inferred from temporal relationship alone).

Claimant contends that Dr. Lawlor's opinion is unpersuasive because it was based on the probable course of cervical strains and fails to address claimant's particular circumstances. *See Jackie T. Ganer*, 50 Van Natta 2189, 2191 (1998); *Sueyen A. Yang*, 48 Van Natta 1626, 1628 (1996). However, unlike those cases where we have discounted medical opinions for not sufficiently considering a claimant's particular circumstances, here, we find that Dr. Lawlor did apply her understanding of the probable course of cervical strains to the particular claimant for whom she provided medical treatment contemporaneously with the injury. In other words, we are persuaded that Dr. Lawlor used her general knowledge regarding the usual course of a strain condition and applied it within the context of her contemporaneous treatment of claimant. Accordingly, we do not find that Dr. Lawlor's opinion should be discounted for lack of consideration of claimant's specific circumstances.

Accordingly, because it is the product of a superior perspective and well-reasoned, we find that Dr. Lawlor's opinion is the most persuasive in this record. Therefore, we reverse the ALJ's decision setting aside the insurer's denial of claimant's trigger point and headache conditions.

Attorney Fees

The ALJ awarded a $4,000 assessed fee for claimant's attorney's services in setting aside the insurer's denial of claimant's current condition and of the headache/trigger point conditions. Inasmuch as we have reinstated the denial of the latter conditions, it follows that the ALJ's assessed fee should be modified.

After considering the factors set forth 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 current condition denial is $2,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review because we have affirmed the ALJ's decision setting aside the "current condition" denial. ORS 656.382(2). *See Laura Maderos*, 48 Van Natta 538, *on recon* 48 Van Natta 838 (1996) (even though overall compensation reduced on review, attorney fee awarded pursuant to ORS 656.382(2) because compensation was not reduced with respect to a particular condition). Claimant's attorney has requested a fee of $3,608, to which the insurer has objected. We agree with the insurer that the requested fee is excessive in light of the fact that we reinstated its denial of the trigger point/headache 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 on review with respect to the "current condition" is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 28, 2000 is reversed in part, affirmed in part, and modified in part. That portion of the ALJ's order that set aside the insurer's denial of the trigger point/headache condition is reversed. The insurer's denial of those conditions is reinstated and upheld. The ALJ's attorney fee award is also modified. In lieu of the ALJ's award, claimant is awarded a $2,000 fee for services at hearing, to be paid by the insurer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
JAMES A. POELWIJK, Claimant
Own Motion No. 92-0427M
ORDER POSTPONING ACTION
ON REQUEST FOR REVIEW OF CARRIER CLOSURE

Claimant requests review of the self-insured employer's February 4, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from August 17, 1992 through February 3, 2000. The employer declared claimant medically stationary as of February 3, 2000. Claimant contends he is entitled to additional benefits, as he was not medically stationary at the time his claim was closed.

Claimant contends that he was not medically stationary at the time his claim was closed because he needs further treatment in the form of either a medication pump, which would materially improve his functional status, or a lumbar fusion. The employer is presently disputing the reasonableness and necessity of the recommended surgery. Additionally, the employer contends that claimant's medication pump is palliative at this point and surgery does not appear to be a valid option for decreasing claimant's pain or improving his condition. Pursuant to ORS 656.327, these medical services issues are within the Director's jurisdiction. Claimant requested Director's review of the requested medical treatment. (MRU Case No. 6964). Should the Director find that either treatment is both reasonable and necessary to materially improve claimant's compensable condition, that finding could have an effect on the Board's review of the carrier's closure of the claim.

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 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
DANIEL B. COVERT, Claimant
WCB Case No. 00-01535
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that modified an Order on Reconsideration to award temporary total disability benefits from March 2, 1998 through March 10, 1999. On review, the issue is temporary total disability.

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

The ALJ noted that SAIF, as the party appealing the Order on Reconsiderations award of temporary disability benefits, bore the burden of proof. The Order on Reconsideration had awarded temporary disability benefits from April 24, 1997 through March 10, 1999. Concluding that there was no evidence that claimant's then-attending physician authorized temporary disability benefits after December 23, 1996, the ALJ found that SAIF had proved that claimant was not entitled to temporary disability benefits from April 24, 1997 through March 1, 1998. However, the ALJ concluded that SAIF had failed to establish that claimant's attending physician did not authorize temporary disability benefits from March 2, 1998 through March 10, 1999.

On review, SAIF asserts its disagreement with our decision in *Roberto Rodriguez*, 46 Van Natta 1722 (1992), and argues that we relied upon ORS 656.283(7)[1] in reaching our decision in *Rodriguez* and that that statute is applicable only to permanent disability awards and not to temporary disability benefits. On this basis, SAIF argues that the burden of proof was incorrectly applied to it in this case that involves temporary disability benefits.

In *Rodriguez*, however, we also relied on *Harris v. SAIF*, 292 Or 683, 690 (1982), which states the general rule that the burden of proof is upon the proponent of a fact or position. Consistent with that general rule, SAIF, as the party that appealed the Order on Reconsideration, has the burden to establish that the temporary disability award was incorrect. We note that we have previously declined to revisit *Rodriguez* and have relied on it as precedent. *See e.g., Lori L. Kowalewski*, 51 Van Natta 13 (1999). We continue to take that approach in this case.

SAIF argues that, on June 11, 1998, Dr. Rosenbaum replied to questions posed by SAIF's claims adjuster, who had asked whether claimant was released to regular work for his sciatica. Dr. Rosenbaum indicated that he had not seen claimant since March 2, 1998 and could not assess whether claimant could perform regular work. SAIF argues that there is no affirmative authorization for temporary disability after the June 11, 1998 communication with Dr. Rosenbaum. We disagree, however, because Dr. Rosenbaum did not withdraw his March 2, 1998 authorization or otherwise indicate that temporary disability benefits were no longer authorized.

SAIF also argues that temporary disability should be cut off on July 14, 1998. On that date, SAIF asserts that Dr. Rosenbaum saw claimant, but did not state either that claimant was unable to work or that he was released from regular work. In addition, SAIF argues that Dr. Rosenbaum was relinquishing his role as the attending physician and ending his treatment of claimant because the doctor indicated that claimant would likely select a new physician. Again, Dr. Rosenbaum did not withdraw his earlier off work release. Under such circumstances, for the reasons set forth in the ALJ's order, we agree that SAIF has not met its burden to establish that claimant's attending physician did not authorize temporary disability benefits.

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[1] ORS 656.283(7), provides, in part, that: "* * * nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Claimant's counsel has submitted a statement of services indicating that he spent 7 hours on the case and requesting a fee of $1,600. Claimant seeks a fee for services not only for the temporary disability issue raised by SAIF, but also for the scheduled permanent disability issue that was not raised on appeal by SAIF. Claimant also requests that we take into account the additional factor of the "extreme financial burden" placed on claimant by having compensation withheld pending the appeal by SAIF.

SAIF has responded to claimant's counsel's statement of services, noting that it did not appeal on the issue of permanent disability and only appealed the issue of temporary disability benefits from March 2, 1998 through March 10, 1999. SAIF further contends that the requested $1,600 fee is excessive and asserts that a fee of $1,050 based on an hourly rate of $150 is reasonable.

Because the issue of scheduled permanent disability was not raised on Board review, claimant's attorney did not provide any services on Board review regarding that issue and consequently is not entitled to a fee for the permanent disability issue. We further note that the factors to be considered in awarding a reasonable fee are set out in OAR 438-015-0010(4). Thus, we are not at liberty to consider factors not set forth in that rule.

The factors to be considered in determining a reasonable attorney fee are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

Here, claimant's counsel spent 7 hours on the issue of temporary disability benefits. The value of the interest and the benefits secured are limited. The issue is of average complexity. There was some risk that claimant's attorney might go uncompensated. There were no frivolous issues or defenses.

After considering the factors, claimant's attorney's statement of services, SAIF's objection and claimant's attorneys response, we find that a reasonable fee for claimant's attorney's services on review is $1,050, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorneys statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 16, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,050, payable by SAIF.

In the Matter of the Compensation of
GREG HARSHA, Claimant
Own Motion No. 00-0216M
OWN MOTION ORDER ON RECONSIDERATION
Nicholas M. Sencer, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

The insurer requests reconsideration of our August 15, 2000 Own Motion Order that authorized the reopening of claimant's low back injury claim for temporary disability compensation beginning March 17, 2000, the date he was hospitalized for surgery. In its request for reconsideration, the insurer contends that claimant has a separate disabling wrist injury claim with another carrier that is open and will result in overlapping periods of time loss. The insurer asks that we give our permission for it to petition the Compliance Division for a pro rata distribution of payments between the two claims. Although we need not give our permission for such a petition, we provide the following clarification.

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, the insurer 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).

Accordingly, we withdraw our August 15, 2000 order. On reconsideration, as supplemented herein, we republish our August 15, 2000 Own Motion Order. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

September 14, 2000 Cite as 52 Van Natta 1637 (2000)

In the Matter of the Compensation of
WILLIAM HARDIN, Claimant
WCB Case No. TP-00007
THIRD PARTY DISTRIBUTION ORDER
Popick & Merkel, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation, as paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. *See* ORS 656.593(3). Specifically, the dispute pertains to the amount of SAIF's "just and proper" share of the settlement proceeds. We conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

Claimant was compensably injured on September 8, 1999 in an accident. SAIF accepted a disabling claim for second degree burns of claimant's forearms. (Ex. 2).

Claimant retained an attorney to pursue a third party lawsuit against the party responsible for the accident. Claimant's attorney, on claimant's behalf, filed a notice with SAIF of claimant's election to proceed personally against the third party. (Ex. 4). The notice stated that SAIF, as the paying agency, had a lien on the third party cause of action and any third party recovery. (*Id.*) The notice further stated that SAIF was to be paid its actual claim costs. (*Id.*)

On January 26, 2000, SAIF's third party adjuster notified claimant's attorney that it had a lien on the third party claim, and that any settlement required SAIF's prior written approval. (Ex. 5). On April 13, 2000, SAIF's adjuster wrote to claimant's attorney, stating that its lien was $303.96. (Ex. 6).

On or about May 8, 2000, the third party claim was settled for $1,850. (Ex. 7). On May 23, 2000, claimant's attorney sent SAIF's adjuster a check for $202.64. (Ex. 8). Claimant's attorney said that the check was "in payment of SAIF's lien on this case less attorneys fees (33 1/3%)." (*Id.*)

SAIF's adjuster wrote to claimant's attorney on May 25, 2000, returning the check and asking that he reissue it in the full amount of SAIF's lien of $303.96. (Ex. 8).

On June 6, 2000, claimant's attorney responded to SAIF's adjuster as follows:

> "We have settled this claim and completed our work on the matter. We distributed funds to our client in the good faith belief that we were paying your lien in full. I am returning your check to you since we are not holding any additional funds for [claimant]. You may wish to contact him directly if you wish to make an issue of the balance of SAIF's claimed lien since we have completed our work on this file." (Ex. 10).

On June 14, 2000, SAIF's attorney requested that claimant's attorney pay the balance of its lien. (Ex. 11). When no payment was forthcoming, SAIF petitioned the Board for resolution of the dispute.

After receiving SAIF's petition, we granted claimant's counsel an opportunity to respond. Specifically, claimant's counsel was given 21 days to file his response, including any supporting evidence. The 21-day period has expired without claimant's counsel's response. We proceed with our review.

CONCLUSIONS OF LAW AND OPINION

If a worker is compensably injured due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third party. ORS 656.578. The proceeds of any damages recovered from the third party by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant was compensably injured as a result of the negligence or wrong of a third party. The claim was accepted by SAIF, which has provided compensation. Because SAIF has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576.

ORS 656.580(2) provides that the paying agency has a lien against the cause of action as provided by ORS 656.591 or ORS 656.593. When claimant obtained a settlement with the third party, the settlement became subject to SAIF's "just and proper" share of the proceeds under ORS 656.593(3). We proceed to a determination of a "just and proper" distribution.

In *Urness v. Liberty Northwest Ins. Corp.*, 130 Or App 454 (1994), the court held that "ad hoc" distributions are contemplated by ORS 656.593(3) and, therefore, it was improper for the Board to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes. *Id.* at 458. The court held that each case should be judged on its own merits when determining a "just and proper" distribution. *Id.*

Here, SAIF contends that it is entitled to full reimbursement of its $303.96 in actual claim costs from the third-party settlement proceeds. Claimant has not contested SAIF's assertion that it has incurred $303.96 in actual claim costs. Moreover, claimant's attorney's notice of the election to proceed against the third party stated, in part: "SAIF is to be paid its actual claim costs." (Ex. 4).

In previous cases where a paying agency has incurred expenditures for compensation attributable to an accepted injury claim and the claimant has not challenged the payment of those benefits, we have found it "just and proper" for a paying agency to receive reimbursement for such claim costs. *See, e.g., Susan R. Hollander*, 51 Van Natta 1502 (1999).

We find that SAIF's expenditures in this case constitute "compensation" that has previously been provided to claimant. In light of such circumstances, as well as claimant's attorney's prior notice that said SAIF would be paid its actual claim costs, we conclude that it is "just and proper" for SAIF to receive full reimbursement for these expenses from claimant's third party settlement. *See* ORS 656.593(3). Accordingly, we conclude that SAIF's "just and proper" share of the third party settlement is $303.96.

Instead of distributing $303.96 to SAIF in full satisfaction of its lien, claimant's counsel sent SAIF a check for $202.64, asserting that it was "in payment of SAIF's lien on this case less attorneys fees (33 1/3%)." (Ex. 8).

Under ORS 656.593(1)(a), a claimant's attorney fees in a third party recovery are initially deducted from the recovery and distributed to the attorney. Following the distribution of attorney fees and litigation costs to claimant's attorney, the remaining balance of the third party recovery is distributed among claimant (1/3 share) and the paying agency (to the extent of its lien). There is no statutory provision that permits a claimant's attorney to reduce the recovery of the carrier's lien by an additional attorney fee. *See Hollander*, 51 Van Natta at 1502 (the claimant's counsel was not entitled to an additional one-third "pro rata" attorney fee deducted from the paying agency's lien); *Dennis Youngstrom*, 47 Van Natta 1622 (1995) (the claimant's attorney was not entitled to deduct one-fourth of the paying agency's share of a third party recovery for an additional attorney fee); *Sheri L. Cody*, 44 Van Natta 2254 (1992) (the claimant's attorney was not entitled to deduct one-third of the carrier's lien for a "standard attorney fee").

We find that claimant's attorney's unauthorized action in declining to reimburse SAIF for the full amount of its lien is contrary to the statutory distribution scheme as set forth in ORS 656.593(1). Furthermore, based on claimant's attorney's notice stating that SAIF would be paid its actual claim costs, we conclude that it is "just and proper" for SAIF to receive full reimbursement for these expenses from claimant's third party settlement. *See* ORS 656.593(3). In similar cases, we have held that the paying agency may recover its unpaid lien from claimant's attorney. *Hollander*, 51 Van Natta at 1502; *Youngstrom*, 47 Van Natta at 1622. We reach the same conclusion in this case. Claimant's attorney is jointly and severally responsible for remedying this situation. Accordingly, claimant and/or claimant's attorney are directed to pay SAIF $101.32 in full satisfaction of SAIF's lien.[1]

IT IS SO ORDERED.

[1] We note that the parties do not dispute that SAIF is entitled to $202.64 in satisfaction of its lien. The affidavit from SAIF's third party claims adjuster indicates that she is holding a $202.64 check from claimant's attorney pending the outcome of these proceedings. (Ex. 1). SAIF is entitled to $303.96 as a "just and proper" share of the third party settlement.

In the Matter of the Compensation of
DAWN C. WHITUS, Claimant
WCB Case No. 99-02417
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition.[1] On review, the issue is compensability.

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

The ALJ set aside the employer's denial based on the opinion of claimant's treating physician, Dr. Stringham. The employer contends that the ALJ erred in failing to apply ORS 656.802(2)(b), because claimant had right shoulder problems preexisting her claim. We disagree.

In an occupational disease claim, a claimant must prove that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). In addition, 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."

Relying on *SAIF v. Cessnun*, 161 Or App 367 (1999), the ALJ found that claimant's claim was not "based on a worsening of a preexisting disease or condition." The ALJ reasoned that a preexisting condition must precede the work exposure giving rise to the claim, and "a portion of a compensable condition cannot be its own preexisting condition." The ALJ cited *Cessnun*, 161 Or App at 375, and *The New Portland Meadows v. Dieringer*, 153 Or App 383, 387-388 (1998).

[1] The employer's denial denied compensability of a right shoulder condition only. (Ex. 19). At hearing, the parties agreed to litigate the compensability of claimant's right shoulder condition, preserving the issue of compensability of her left shoulder condition for a later hearing. (Tr. 5). However, the ALJ's order lists the issue as "compensability of claimant's *bilateral* shoulder condition." We accordingly modify the ALJ's order to reflect that the issue was compensability of claimant's right shoulder condition.

We agree with the employer that *Dieringer* did not hold that a preexisting condition must predate the claimant's *employment*. *See Cessnun*, 161 Or App at 375. Rather, the question is whether the preexisting condition preceded the date the disease "became manifest," which means the date that the claimant either became disabled or first sought treatment. ORS 656.005(24); *Cessnun*, 161 Or App at 374; *Betti A. Haley*, 51 Van Natta 1786 (1999). Notwithstanding this modification of the ALJs statutory analysis, we conclude that the more persuasive medical evidence proves that claimant does not have a preexisting right shoulder condition.

Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). We generally rely on the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reason not to defer to Dr. Stringham on the issue of whether claimant has a "preexisting condition."

Dr. Schilperoort, who examined claimant at the request of the employer, concluded that claimant's (unidentified) motor vehicle accident caused her right shoulder adhesive capsulitis condition. (Ex. 31-4). However, we agree with the ALJ that the record does not establish that any of claimant's motor vehicle accidents resulted in a significant injury to her right shoulder. (Exs. 8, 10). This conclusion is based on the opinion offered by claimant's attending physician, Dr. Stringham, who stated that claimant's motor vehicle accidents had little relevance to her current right shoulder (bursitis/adhesive capsulitis) condition. (Ex. 30-28, -31). We consider this opinion to be well-reasoned, particularly because Dr. Stringham further explained his reasoning at a deposition after receiving new information about the motor vehicle accidents. Inasmuch as the opinion from claimant's attending physician was based on complete and accurate information, we find it to be persuasive.

The employer argues that Dr. Stringham relied on an inaccurate history of claimant's prior motor vehicle accidents.[2] We disagree. Dr. Stringham correctly understood that claimant was involved in three motor vehicle accidents, including an April 1994 accident in which her right shoulder hit the steering wheel, and an April 1998 accident in which she sought treatment for her right shoulder. (Exs. 10, 30-27, -28). Dr. Stringham stated, however, that his review of the medical records indicated that claimant's right shoulder was not a "major factor" in the 1998 motor vehicle accident, although claimant had some treatment for right shoulder symptoms after the accident. (Ex. 30-28). When presented with new information about the April 1994 injury, Dr. Stringham discounted the impact of the accident on claimant's right shoulder condition unless it was shown to be a "significant injury." (Ex. 30-31). We are therefore satisfied that Dr. Stringham relied on a correct history in rendering his opinion.

Dr. Schilperoort's opinion, by contrast, is conclusory and does not explain how the prior motor vehicle accidents could have caused or contributed to claimant's current shoulder condition. In light of such circumstances, we are not persuaded that claimant had a "preexisting condition" that preceded the date of the manifestation of her shoulder condition. Therefore, we agree with the ALJ that claimant need not satisfy the more stringent requirement of proving a "pathological worsening" of a preexisting condition under ORS 656.802(2)(b). *Ron L. Merwin*, 49 Van Natta 1801 (1997).

Finally, the employer contends that claimant proved, at most, that her work activities caused an increase in her right shoulder symptoms, as opposed to the condition itself. *Kathy J. Heitz*, 51 Van Natta 1023 (1999); *Peggy Shipman*, 51 Van Natta 827 (1999). We disagree.[3] Although Dr. Stringham initially stated in his first deposition that claimant's work activity caused muscle tension which caused her right shoulder symptoms, he later concluded that claimant's work activity was the major contributing cause of her right shoulder condition. (Ex. 30-42, -54). This later opinion is consistent with Dr. Stringham's April 10, 1999 letter, in which he opined that claimant's work activity was the major contributing cause of her current right shoulder condition and need for treatment. (Ex. 27).

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[2] The employer contends that Dr. Poulson also relied on an incorrect history. However, the ALJ specifically discounted Dr. Poulson's opinion, and did not rely on his opinion in setting aside the denial. (*O&O* at 5).

[3] We also reject the employer's assertion that claimant must prove "an actual worsening" of the compensable condition. That is the standard for aggravation claims. ORS 656.273(1); *SAIF v. Walker*, 330 Or 102 (2000).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 5, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the employer.

In the Matter of the Compensation of
RICHARD H. CALKINS, Claimant
WCB Case No. 00-01048
ORDER ON REVIEW
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Otto's order that dismissed his request for hearing. On review, the issue is the propriety of the dismissal. We affirm.

FINDINGS OF FACT

On January 31, 2000, claimant signed an attorney retainer agreement employing his former attorney of record to represent him in connection with a workers' compensation claim against the self-insured employer. The retainer agreement provided, in part: "Client agrees that Attorney is empowered to perform such services on behalf of Client as he deems necessary."

On February 7, 2000, claimant's former attorney filed a request for hearing on his behalf regarding the employer's January 24, 2000 denial, raising the issue of compensability. A hearing was scheduled for May 3, 2000. The employer responded to the request for hearing on March 21, 2000.

On May 2, 2000, claimant's former attorney wrote to the ALJ, stating: "[t]his will confirm that the claimant has withdrawn his request for hearing in the above-referenced matter." The employer's attorney wrote to the ALJ on May 4, 2000, indicating that claimant's attorney had advised that he was withdrawing claimant's request for hearing. The employer requested that the ALJ issue an order of dismissal with prejudice. The ALJ issued an order of dismissal.

CONCLUSIONS OF LAW AND OPINION

Claimant, *pro se*, requests review of the ALJ's order of dismissal, asserting that his attorney was "no longer an interested party to this matter, which is one of the reasons for the decision to withdraw in the first place." Claimant requested an opportunity to present evidence before the ALJ.

The employer argues that claimant's former attorney was acting pursuant to the authority given him by the retainer agreement when he withdrew claimant's request for hearing. The employer contends that there is no legal basis for reversing the ALJ's order of dismissal.

Claimant has the burden of proving that the dismissal order was not appropriate. *Donald J. Murray*, 50 Van Natta 1132 (1998). Where a claimant signs a retainer agreement employing an attorney and giving that attorney authority to act on the claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. *See, e.g., Loy W. Williams*, 52 Van Natta 754 (2000); *Wilson O. Santamaria*, 52 Van Natta 657 (2000).

Here, claimant does not dispute his former attorney's authority to act on his behalf. Furthermore, he does not 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.[1]

Furthermore, because we find the ALJ's dismissal order proper, claimant's request for an opportunity to present evidence before the ALJ is rendered moot. *See Rachelle M. Rock*, 50 Van Natta 1168 (1998); *compare Silverio Frias, Sr.*, 49 Van Natta 1514 (1997) (remand allowed for development of record on issue of whether the claimant's former attorney had authority to act on the claimant's behalf at the time the former attorney withdrew the claimant's hearing request).

ORDER

The ALJ's order dated May 11, 2000 is affirmed.

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[1] Because claimant is presently unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, at (503)-378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE, ROOM 160
SALEM OR 97310-3878

In the Matter of the Compensation of
RICHARD J. HATFIELD, Claimant
WCB Case No. 99-03963
ORDER ON REVIEW
Scott M. McNutt, Jr., Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the insurer's denial of claimant's low back injury claim; and (2) upheld the insurer's denial of claimant's claim for an L4-5 disc condition. On review, the issue is compensability.

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

On review, claimant argues that the ALJ erred by not accepting the opinion of his treating surgeon, Dr. Zelaya. Claimant contends that he had only a minimal preexisting condition and that Dr. Zelaya was accurate in his belief that claimant's previous back problems had resolved. Claimant further contends that Dr. Zelaya's opinion regarding the degree of contribution from the work exposure is persuasive. We disagree.

First, the record establishes that claimant had more than a minimal preexisting condition. For example, in 1978, claimant injured his low back and later developed pain which radiated into both legs. (Ex. I). Claimant testified that the pain took a "couple of years" to resolve. Claimant continued to experience back pain while working over cars and in May 1996, he sought treatment following a "sudden onset" of lumbosacral pain. (Ex. 1). In November 1996, claimant was involved in a motor vehicle accident and was treated for low back and hip pain. (Ex. 2). Films taken in 1996 after the accident showed loss of intervertebral disk space at L5-S1. (Ex. 24). Finally, a CT scan taken in 1999 showed degenerative disc disease at L5-S1, in addition to a disc protrusion at L4-5. (Ex. 15).

Accordingly, we conclude that the medical record and claimant's history supports the opinions of claimant's treating doctor, Dr. Ackerman, and Dr. Zivin, who examined claimant on behalf of the

insurer. Those doctors both found that claimant had a preexisting condition and that, based on that history, the preexisting condition was the major cause of claimant's current disability and need for treatment. (Exs. 44, 50).

Finally, for the remaining reasons set forth in the ALJ's order, we agree that Dr. Zelaya's opinion is conclusory and not persuasive. Therefore, claimant has not met his burden of proof. The ALJ's order is affirmed.

ORDER

The ALJ's order dated May 12, 2000 is affirmed.

In the Matter of the Compensation of
LINDA RATLIFF, Claimant
Own Motion No. 00-0209M
OWN MOTION ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requested reconsideration of our July 18, 2000 Own Motion Order which declined to reopen her 1991 industrial injury claim for the payment of temporary disability compensation because she failed to establish that she remained in the work force when her compensable condition worsened requiring surgery or hospitalization. With her request for reconsideration, claimant submitted an affidavit in support of her contention that she was in the work force at the time of disability.

On August 15, 2000, we abated our July 18, 2000 order and allowed the insurer 21 days in which to file a response to the motion. As no response has been received, we will proceed with our review. On reconsideration, we withdraw our prior order, and issue the following order in its place.

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

We have previously found that the "time of disability" for the purpose of determining whether claimant is in the work force, under the Boards own motion jurisdiction, is the date of surgery or inpatient hospitalization.[1] *Fred Vioen*, 48 Van Natta 2100 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Furthermore, the relevant time period for which claimant must establish she was in the work force is the time prior to June 16, 2000, when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App at 414; *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

The insurer contends that claimant was not in the work force at the time of disability relying on an August 18, 1999 chart note from Dr. Puziss, claimant's attending physician, wherein Dr. Puziss noted that claimant had not "worked since October of last year."

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

However, as noted above, the "time of disability" is June 16, 2000, when claimant's condition worsened requiring surgery. Thus, claimant must establish that she was in the work force prior to June 16, 2000.

In order to satisfy the second *Dawkins* criterion, claimant must show that, although she is not working, she is willing to work and was seeking work. Claimant submitted an affidavit, which outlines her current work history and work search. Claimant attests that: "My last job was as a bartender at the Royal Inn in Troutdale. I worked there between September 1999 and February 2000. I was laid off for lack of work. In March and April of 2000 I applied for a job at Sharis, International House of Pancakes, and A&W Restaurant but I was not hired. * * * From February 2000 to May 2000 I was willing to work and had sought work at the places listed above as well as other places that I dont remember." Claimant's assertions are unchallenged.

Based on claimant's unrebutted affidavit, we find that she has demonstrated her willingness to work. Additionally, claimant's statement demonstrates that she has made a reasonable effort to seek work. Thus, based on this record, we conclude that claimant has established that she was willing to work and was making a reasonable effort to find work at the time of her current worsening.

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

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARINDA S. KEYS, Claimant
Own Motion No. 98-0461M
OWN MOTION ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
Liberty Northwest Insurance Corp., Insurance Carrier

Claimant requests reconsideration of our August 15, 2000 Own Motion Order, that affirmed the insurer's May 19, 2000 Notice of Closure. Claimant further requests that a briefing schedule be established.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY A. FRANCISCO, Claimant
WCB Case No. 00-01086
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

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

Findings of Fact

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

Conclusions of Law and Opinion

The issue in this case is whether claimant sustained an "actual worsening" of her compensable low back condition arising from an accepted injury of January 28, 1993. The compensable injury, accepted as an L3-4 disc herniation, was closed in April 1993, with claimant eventually receiving 39 percent unscheduled and 7 percent scheduled permanent disability in an October 1995 Order on Reconsideration.

In April 1999, claimant sought further treatment from Dr. Heusch, who had previously performed surgery at the L3-4 level in February 1993. Dr. Heusch filed an aggravation claim on claimant's behalf that was denied on December 22, 1999, on the ground that the accepted L3-4 disc herniation had not worsened. (Ex. 23). Claimant requested a hearing from the denial.

The ALJ set aside the denial, finding that the opinion of a consulting orthopedic surgeon, Dr. Keenen, satisfied claimant's burden of proving a compensable worsening. The ALJ noted that Dr. Keenen had diagnosed degenerative disc disease at L3-4, L4-5, and L5-S1 and opined that claimant's increased symptoms were the result of a material worsening of the underlying disc disease. Although acknowledging that Dr. Keenen had not expressly stated that the L3-4 disc disease had worsened, the ALJ nevertheless concluded that his opinion as a whole "infers that claimant has sustained a post-closure worsening of the degenerative disease at all three levels of [claimant's] lumbar spine."

On review, the insurer contends that the ALJ incorrectly set aside its denial based on medical evidence of a worsening of degenerative disc disease in the lumbar spine, when claimant's burden was to prove to an actual worsening of the compensable condition, the L3-4 disc herniation. Noting that there is no evidence that the accepted disc herniation had worsened, the insurer argues that Dr. Keenen's opinion is not a proper basis for overturning its denial. For the following reasons, we agree with the insurer that claimant failed to establish a compensable aggravation claim.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an "actual worsening" of the compensable condition supported by objective findings. Two elements are necessary under the statute to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995); *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)).[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 injury, the insurer accepted an L3-4 disc herniation. The medical record does not establish that the accepted disc herniation condition has worsened. Instead, the medical evidence indicates that claimants current condition consists of multi-

[1] The insurer does not contend that claimant failed to prove diminished earning capacity.

level degenerative disc disease that preexisted the compensable 1993 injury. (Exs. 17-6, 18, 22-2, 25-6). 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 preexisting degenerative disc disease is a compensable condition.[2] *Id.*

Dr. Keenen opined that claimant had three-level lumbar disc disease that had materially worsened. However, he never attributed the degenerative disc disease to the compensable injury. (Ex. 22). An examining physician, Dr. Fuller, also diagnosed three levels of possible degenerative disc disease, but he, like Dr. Keenen, did not attribute the degenerative disc disease to the compensable injury. (Ex. 17).[3]

The final medical opinion is from Dr. Heusch. Dr. Heusch concluded that the degenerative changes in claimant's low back were "secondary" to the original injury, but that claimant's obesity was also a factor. (Ex. 24). We do not find that this opinion establishes that the degenerative changes in claimant's low back are a compensable condition. Dr. Heusch never explained in what way the preexisting degenerative condition was "secondary" to the original injury, nor did he precisely allocate the amount of contribution of the compensable injury to the degenerative condition, as opposed to claimant's obesity. *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).

Accordingly, on this record, we conclude that claimant failed to prove an "actual worsening" of the compensable low back condition. Therefore, we reverse the ALJ's order.

Order

The ALJ's order dated June 6, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] The ALJ stated that the insurer did not choose to litigate the aggravation claim on causation grounds. However, it does not appear that the insurer conceded that claimant's preexisting degenerative disease is compensable. The applicable case law is clear that, if the worsened condition at issue in the aggravation claim is not the accepted condition, then claimant must establish that it is a compensable condition. *See Carl F. Plumlee*, 52 Van Natta 185 (2000) (citing *Gloria T. Olson*).

[3] Dr. Fuller deferred answering the insurer's inquiry regarding claimant's current low back condition pending a discogram. (Ex. 17-7). However, it does not appear that the discogram was ever performed. (Ex. 22-2).

September 18, 2000 Cite as 52 Van Natta 1646 (2000)

In the Matter of the Compensation of
BRUCE W. BURROUGHS, Claimant
WCB Case No. 99-06219
INTERIM ORDER VACATING ORDER REMANDING
Daniel M. Spencer, Claimant Attorney
Terrall & Terrall, Defense Attorneys

On August 24, 2000, we issued an order vacating Administrative Law Judge (ALJ) Peterson's May 2, 2000 order that: (1) set aside the self-insured employer's denial of claimant's occupational disease claim for a bilateral thumb condition; and (2) awarded an assessed attorney fee of $6,000. We took this action because the appellate record did not include several admitted exhibits that were missing from the record and were otherwise unreproducible by the parties. (Exhibits 36 through 41 and 43 through 50).

The missing exhibits have been subsequently located in the Board's Appellate Section. Under such circumstances, it is unnecessary to remand this matter to the ALJ. Therefore, we vacate our August 24, 2000 order and implement the following briefing schedule.[1]

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[1] Copies of the transcript have been included with the parties' attorneys copies of this Board order.

The employer's appellant's brief must be filed within 21 days from the date of this order. Claimant's respondent's brief must be filed within 21 days from the date of mailing of the employer's appellant's brief. The employer's reply brief must be filed within 14 days from the date of mailing of claimant's brief. Thereafter, the Board will proceed with its review.

IT IS SO ORDERED.

In the Matter of the Compensation of
SCOTT L. JELI, Claimant
WCB Case No. 99-07131
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Meyers.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denials of claimant's L4-5 herniated disc condition;[1] and (2) awarded a $7,000 assessed attorney fee under ORS 656.386(1). In his respondent's brief, claimant contends that the ALJ erred in finding that the insurer's "pre-closure" denial was valid. On review, the issues are compensability, the validity of the insurer's denial, and attorney fees.[2] We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW

Compensability

We adopt and affirm this portion of the ALJ's order with the following supplement to address the insurer's contention that the ALJ incorrectly relied upon the medical opinion of Dr. Gritzka, as supported by Dr. Hill, rather than the opinions of Drs. Colletti and Neumann.

The parties do not contest the ALJ's conclusion that the compensability of claimant's herniated L4-5 disc condition is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that the low back condition is compensable, claimant must show that his work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 106 (1997), *aff'd as modified on recon*, 149 Or App 309, 315 (1997), *rev den*, 326 Or 389 (1998). Because of claimant's preexisting condition and the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to his need for medical treatment or disability for the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

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[1] By stipulation, the parties agreed that the insurer's denials encompassed claimant's L5-S1 disc condition, even though that condition is not specifically listed as a denied condition. (Tr. 5). As a result of that stipulation, the ALJ determined the compensability of the L5-S1 disc condition. Accordingly, our review will also include the compensability of the L5-S1 disc condition.

[2] Because we conclude that claimant's L4-5 and L5-S1 disc herniations are compensable, we do not address claimant's contention that the insurer's "pre-closure" denial of that condition was procedurally invalid.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986).

Dr. Coletti, an orthopedic surgeon who performed an insurer-arranged medical exam, diagnosed claimant's medical problems as: (1) L4-5 disc herniation with degenerative disease; (2) post lumbar laminectomy and disc excision; and (3) lumbar sprain. (Ex. 25-5). He attributed the L4-5 disc herniation with associated disc disease, as well as the laminectomy and disc excision to a preexisting problem that required surgery in 1989. (Ex. 25-5). He attributed the lumbar strain to claimant's 1999 lifting incident at work. (Ex. 25-5). He then opined that claimant had incurred no new pathologic change as a result of the 1999 work incident and that the major cause of claimants disability and need for treatment was the preexisting problem at L4-5. (Ex. 25-6, 7, 9).

Subsequent to Dr. Coletti's examination, claimant had a discogram performed by Dr. Slack. The discogram, as interpreted by Dr. Slack, showed a posterior annular fissure with epidural leak at L4-5 and a posterior annular tear of L5-S1. (Ex. 31-2). Dr. Coletti was unaware of the results of the discogram; and consequently unaware of what appears to be new pathology at both L4-5 and L5-S1.[3] Because Dr. Coletti's opinion that claimant incurred no new disc pathology as a result of the 1999 lifting incident at work is based upon incomplete information, we conclude that his opinion is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998). Accordingly, the ALJ correctly did not rely upon it.

The insurer also relies on Dr. Neumann, an orthopedist, who performed an insurer-arranged exam. Dr. Neumann diagnosed: (1) degenerative disc disease; (2) congenital spinal stenosis; (3) post lumbar laminectomy and disc excision at L4-5; and (4) lumbar sprain.[4] (Ex. 29-4). Dr. Neumann attributed the lumbar sprain to claimant's 1999 work incident and attributed his other diagnoses to preexisting conditions. (Ex. 29-4). Dr. Neumann also recommended that claimant have a discogram to determine if claimant could benefit from epidural steroid treatment. (Ex. 29-6). In recommending the discogram, Dr. Neumann opined that if intradiscal pathology was present, he would relate that pathology to the 1999 work incident. (Ex. 29-4).

Later, upon reviewing Dr. Slack's discogram report and acknowledging Dr. Slack's findings of intradiscal pathology, Dr. Neumann opined that claimant would benefit from epidural steroid treatment.[5] (Ex. 33-2). He also opined, in an apparent reversal of his prior opinion regarding causation, that the work injury of 1999 resulted in a sprain/strain superimposed upon preexisting degenerative disc disease. (Ex.33-1). We conclude from the express language used by Dr. Neumann in recommending the discogram, (*i.e.* to determine whether claimant would benefit from epidural steroid treatment) that his purpose in determining the existence of intradiscal pathology was to explore treatment options, not to establish the causation of such pathology, which he had opined would be related to claimants 1999 work incident. (Ex. 29-4, 6). Dr. Neumann does not explain the reason for his change of opinion regarding the causation of the intradiscal pathology. Because Dr. Slack's report expresses no opinion regarding the cause of the intradiscal pathology, we cannot conclude that Dr. Neumann's review of the report adequately explains his change of opinion. Therefore, because Dr. Neumann's change of opinion is not explained, his opinion is not persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987); *Blakely v. SAIF*, 89 Or App 653, 656, *rev den*, 305 Or 972 (1988). Accordingly, the ALJ correctly did not rely upon it.

In contrast to the opinions of Drs. Coletti and Neumann, is the opinion of Dr. Gritzka, an orthopedic surgeon. Dr. Gritzka examined claimant, and reviewed all the medical records, including the MRI films of February 1999, and the discogram by Dr. Slack. (Ex. 49). Based upon his record review, his examination of claimant, and his analysis of the mechanism of injury, he opined that: (1) claimant had incurred a centrally herniated disc at L5-S1, and a recurrent herniated disc at L4-5 with recent rupture of the L4-5 annulus fibrosis; (2) claimant's primary symptomatology was the result of the L5-S1

[3] Dr. Gritzka has opined that this is new disc pathology. (Ex. 49-11).

[4] Dr. Neumann, like Dr. Coletti, examined claimant before the discogram by Dr. Slack was performed.

[5] We note that Dr. Neumann reviewed Dr. Slack's report, but not the films of the discogram itself. (Ex. 33-1).

disc herniation; (3) the L5-S1 disc herniation was caused by the sudden compressive loads exerted on claimant's lumbar spine from the 1999 work incident; (4) the rupture of the L4-5 annulus fibrosis was caused by the sudden compressive loads exerted on claimant's lumbar spine from the 1999 work incident; (6) the 1999 work incident was the sole cause of the L5-S1 disc herniation; and (7) the 1999 work incident was the major cause of the pathological worsening of the L4-5 disc. (Ex. 49-9, 10, 11). Attending physician, Dr. Hill, a neurosurgeon, concurred with Dr. Gritzka. (Ex. 50).

The insurer contends that Dr. Gritzka's opinion is not persuasive because: (1) it is based upon possibilities instead of probabilities;[6] and (2) it does not evaluate the relative contributions of all the potential causes of claimant's L4-5 and L5-S1 disc conditions. We disagree with each of the insurer's contentions.

We acknowledge that Dr. Gritzka does not expressly list the individual contribution of claimant's preexisting degenerative changes at both L4-5 and L5-S1 when he opined that the work injury of 1999 was the major contributing cause of the pathological worsening of the L4-5 disc and the sole cause of the L5-S1 disc herniation. However, he did expressly state that in rendering his opinion that he took into account all factors contributing to claimant's current condition, including claimant's work activity, prior surgery, age, and genetics. (Ex. 49-11). Consequently, based upon Dr. Gritzka's expressed statement that he considered all factors contributing to claimant's current condition, his extensive explanation of the forces of the work injury acting upon the discs, his thorough review of the complete medical record including claimant's history, and his review of the diagnostic tests, we conclude that he necessarily considered and evaluated the relative contributions of all the possible causes for claimant's disc conditions in rendering his overall opinion. Accordingly, we find Dr. Gritzka's opinion persuasive.

In conclusion, based upon Dr. Gritzka's well reasoned and persuasive opinion, as concurred in by Dr. Hill, we find that claimant's work injury of 1999 was the major contributing cause of his disability and need for treatment of claimant's L4-5 and L5-S1 disc herniations. Consequently, we affirm the ALJ's order that set aside the insurer's denials of those conditions.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the L4-5 and L5-S1 herniated disc conditions is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.[7]

Attorney Fee

The ALJ awarded claimant an assessed attorney fee of $3,500 for overturning the denial of the L4-5 disc herniation. The ALJ also awarded claimant an assessed attorney fee of $3,500 for overturning the insurer's current condition denial.

The insurer contends that the ALJ's total attorney fee award of $7,000 was excessive. Rather the insurer suggests that a total fee of $2,500 is more appropriate. (Appellant's Brief, p. 9).

Claimant is entitled to a fee for services devoted to overcoming the insurer's denial of his L4-5 disc herniation and the denial of his current condition. *See* ORS 656.386(1). Specifically, claimant had to litigate two denials: (1) a formal written denial of the L4-5 disc herniation; and (2) a formal written denial of his current condition, consisting of the accepted lumbar strain combined with preexisting multi-level degenerative disc disease, congenitally stenotic lumbar canal, and prior lumbar surgery.[8] Each denial involved separate and complex medical issues.

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[6] his argument comes from Dr. Gritzka's use of the words "I think . . . probably" in a portion of his lengthy analysis. (Ex. 49-10). We note that Dr. Gritzka uses the word "probably," not "possibly." We note further that his overall opinion is expressed in terms of "medical probability." (Ex. 49-9). Under these circumstances, we conclude that his opinion is based upon reasonable medical probability.

[7] In reaching this conclusion, we do not consider time devoted to the procedural issue or the attorney fee issue.

[8] The current condition denial included language indicating that the accepted lumbar strain condition was no longer the major contributing cause of his current condition.

In determining a reasonable attorney fee, we consider such factors as time devoted to the case, the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefits secured, and risk that an attorney's efforts may go uncompensated. OAR 438-015-0010(4); *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).

When compared to compensability disputes generally presented to this forum, the value of the claim and the benefits secured are about average. Although the hearing was relatively short,[9] the medical issues presented are more complex than those generally litigated in the Hearings Division. Moreover, claimant's attorney generated substantial medical evidence in support of the claims in the face of similar medical evidence generated by the insurer to defeat the claims. 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 considerable 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 $7,000 is a reasonable attorney fee for services at the hearings level in this case. We reach this conclusion particularly 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. Accordingly, we affirm the ALJ's attorney fee award in view of the factors in OAR 438-015-0010(4).

ORDER

The ALJ's order dated May 4, 2000 is affirmed. For services on review regarding the compensability issue, claimant's counsel is awarded an $2,000 attorney fee, payable by the insurer.

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[9] The hearing transcript consists of 43 pages. The hearing itself took two hours plus the time devoted to closing arguments, which were not recorded. The hearing record consists of 50 exhibits, most of which are medical records. Claimant's counsel generated 10 exhibits, several of which were essential to establishing the compensability of the claim.

In the Matter of the Compensation of
NANCY J. NELSON, Claimant
WCB Case No. 99-07561
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Fulsher's order that upheld the insurer's denial of claimant's right shoulder rotator cuff tear condition under both an injury theory and an occupational disease theory. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 5, 2000 is affirmed.

Board Member Phillips Polich dissenting.

Because I find that claimant has met her burden of proof to establish a compensable occupational disease claim, I must respectfully dissent from the majority's opinion.

First, there is no persuasive evidence that claimant had any preexisting right shoulder condition. Claimant testified that, prior to March 14, 1999, she had no prior right shoulder symptoms and no medical treatment for her right shoulder. (Tr. 32, 33). In addition, various diagnostic tests showed no

evidence of preexisting conditions or degenerative changes in claimant's right shoulder. (Exs. 6, 7, 14-2, 19-6). Moreover, Dr. Mandiberg, claimant's treating orthopedist, did not find any preexisting condition in claimant's right shoulder. As Dr. Mandiberg notes, examining physician Dr. Strum does not explain his opinion that claimant has a preexisting right shoulder condition. Finally, as noted above, the diagnostic tests do not support a finding that claimant has a preexisting right shoulder condition. Therefore, I would find that claimant had no preexisting right shoulder condition.

Accordingly, under ORS 656.802(2)(a), claimant must prove that employment conditions were the major contributing cause of her right shoulder rotator cuff tear. I find that the opinion of Dr. Mandiberg meets claimant's burden of proof. (Exs. 15, 17).

Dr. Mandiberg first examined claimant on July 29, 1999, and had a "lengthy visit" with her, including discussing her work activities and shoulder condition. (Ex. 9). Thus, Dr. Mandiberg was familiar with claimant's work activities. Dr. Mandiberg opines that claimant's right rotator cuff tear condition is caused by her work activities as a waitress. (Exs. 15, 17).

Dr. Mandiberg's opinion is well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259 (1986) (generally, most weight is given to opinions that are both well reasoned and based on complete information). In addition, as claimant's treating physician, Dr. Mandiberg's opinion should be deferred to absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). There are no persuasive reasons not to defer to Dr. Mandiberg's opinion. Therefore, I would find that claimant has met her burden of proving a compensable occupational disease claim. Because the majority holds otherwise, I respectfully dissent.

In the Matter of the Compensation of
KEVIN E. THOMPSON, Claimant
WCB Case No. 00-00375
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) found that his claim had not been prematurely closed; (2) affirmed the Order on Reconsideration's medically stationary date; and (3) declined to award temporary disability benefits. Alternatively, claimant contends that he is entitled to an award of permanent disability. On review, the issues are premature closure, medically stationary date, temporary disability benefits and, alternatively, extent of permanent disability.

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

On review, claimant argues that his claim was closed based on an independent medical examination dated May 27, 1999. Claimant notes that the report was not sent to his treating doctor, Dr. Preston, for a concurrence. Consequently, claimant contends that the closure was not proper.

SAIF is correct, however, that we have previously rejected a similar argument. In *William M. Heck*, 48 Van Natta 1072 (1996), the claimant contended that his claim was improperly closed because his attending physician was not asked to respond to a report generated by an insurer-arranged examiner. However, in *Heck*, we held that nothing restricted consideration of opinions regarding medically stationary status to those opinions rendered by attending physicians.

Consequently, in the present case, we do not find that the ALJ erred by relying on the May 1999 report in determining claimant's medically stationary status. Moreover, for the reasons expressed by the ALJ, we agree that claimant has not met his burden of proving that he was not medically stationary at the time of claim closure.

ORDER

The ALJ's order dated June 15, 2000 is affirmed.

September 18, 2000 Cite as 52 Van Natta 1652 (2000)

In the Matter of the Compensation of
JANET E. WHITTY, Claimant
WCB Case No. 99-07693
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of her claim for an upper back injury. On review, the issue is compensability.

We adopt and affirm the order of the ALJ, with the following supplementation.[1] On review, claimant contends that the ALJ erroneously analyzed this case as a "combined condition" case. We disagree.

Claimant's treating doctor, Dr. Peterson, reported that claimant had a preexisting degenerative condition. Dr. Peterson opined that claimant's need for treatment was due to a "combination of cervical stenosis with acute cervical disc herniation superimposed." Dr. Peterson further stated that he felt that claimant's condition was "due to a combination of both the degenerative cervical stenosis and an acute cervical disc herniation at C6-C7." (Ex. 20). Dr. Mayhall, who examined claimant on behalf of SAIF, also stated that claimant had a preexisting condition, and if claimant did have a work incident, it "could have combined with the preexisting condition to cause or prolong the need for treatment." (Ex. 21-4).

After considering the expert opinions in this case, we conclude that this matter should be analyzed pursuant to ORS 656.005(7)(a)(B). Moreover, for the reasons stated in the ALJ's order, we agree that claimant has not met her burden of proof with regard to "medical causation." Therefore, we affirm the ALJ's order.

ORDER

The ALJ's order dated April 28, 2000 is affirmed.

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[1] We do not adopt the ALJ's finding that claimant's orthopedic surgeon, Dr. Peterson, is not board certified. We agree with claimant that there is no evidence regarding Dr. Peterson's status in the record.

In the Matter of the Compensation of
MYRNA GARDNER, Claimant
WCB Case Nos. 99-07634 & 99-04687
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Stoel Rives LLP, Defense Attorney

On August 25, 2000, we abated our July 28, 2000 order that adopted and affirmed the Administrative Law Judge's order which: (1) upheld the self-insured employer's partial denial of her left ankle pain over dorsum; and (2) reduced her scheduled permanent disability award for the loss of use or function of her left foot (ankle) from 19 percent (25.65 degrees), as awarded by an Order on Reconsideration, to zero. We took this action to consider claimant's motion for reconsideration. Having received the employer's response, we now proceed with our reconsideration.

Claimant contends that our order should be reversed to set aside the employer's partial denial of her left ankle pain over dorsum. With her brief, claimant has attached several documents in support of her argument. The first document is a release to modified work by Dr. Grossenbacher dated March 22, 1999; the second is a letter from Dr. Grossenbacher dated March 29, 1999; and the third document is a copy of the second page of the September 20, 1999 Order on Reconsideration on which claimant has highlighted one sentence regarding an award of temporary disability.

Our review must be based on the record certified to us. *See* ORS 656.295(5). Because claimant's brief refers to evidence not offered and admitted at hearing (and therefore not certified to us), we construe her submissions as a motion to remand to the ALJ for the taking of additional evidence. We deny such motion.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing and is likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

In this case, there is no showing that the evidence submitted for the first time on review was unavailable with due diligence at the time of hearing. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome of the case. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. *See* ORS 656.295(5).

The ALJ concluded in her January 14, 2000 Opinion and Order that the persuasive medical evidence provided by Dr. Thrall, claimant's attending physician, establishes that claimant's current pain over dorsum condition is not related to the accepted ankle sprain condition. We adopted and affirmed the ALJ's order with respect to both impairments. By adopting the ALJ's order, we addressed claimant's arguments concerning the compensability of the pain over dorsum condition and we continue to adhere to the conclusions reached in our prior decision. *See, e.g., Jorge Pedraza*, 49 Van Natta 1019 (1997).

Accordingly, on reconsideration, as supplemented herein, we republish our July 28, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.[1]

IT IS SO ORDERED.

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[1] We note that claimant is presently unrepresented. Because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM, OR 97301

Board Member Phillips Polich dissenting.

For the reasons expressed in my previous dissenting opinion, I continue to disagree with the majority's decision.

In the Matter of the Compensation of
JUANA M. LOPEZ, Claimant
WCB Case No. 99-09380
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mongrain's order that affirmed an Order on Reconsideration that awarded no additional scheduled permanent disability for the loss of use or function of claimant's right ankle beyond the 30 percent (40.5 degrees) she had received in previous awards. On review, the insurer renews its argument that claimant's request for hearing was untimely. With her request for review, claimant has attached a medical report. We treat claimant's submission as a motion to remand to the ALJ for the taking of additional evidence. On review, the issues are remand, dismissal, and potentially, extent of scheduled permanent disability.

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

Claimant has provided a "Return to Work Recommendation/Restrictions" report from Dr. Sampson in support of her claim that she is entitled to additional permanent disability for her right ankle condition. Because this medical report was not presented as evidence at the hearing, we treat this submission 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). In addition, to merit remand, it must clearly be 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).

Because this is an "extent" proceeding, the ALJ is limited to the record developed at reconsideration before the Department. ORS 656.268(7)(h); ORS 656.283(7). Accordingly, because the medical report submitted by claimant was not in the reconsideration record, neither the ALJ nor the Board can consider it. *Douglas D. Power*, 52 Van Natta 107 (2000); *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 this document would not affect the outcome of this case. *Compton v. Weyerhaeuser*, 301 Or at 646.[1]

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[1] On review, the insurer raises a procedural issue, contending that claimant's request for hearing from the October 29, 1999 Order on Reconsideration was untimely. We disagree.

The Order on Reconsideration issued on October 29, 1999. Thirty days from October 29, 1999 is November 28, 1999, which is a Sunday. ORS 174.120; *Anita L. Clifton*, 43 Van Natta 1921, 1922 (1991). Claimant's request for hearing was mailed by certified mail to the Board on Monday, November 29, 1999. Thus, the hearing request was "filed" on November 29, 1999. *See* OAR 438-005-0046(1)(b). Claimant's request for hearing was therefore made within 30 days after the mailing date of the October 29, 1999 Order on Reconsideration (Ex. 77) and the request was timely filed. ORS 656.268(6)(g); ORS 656.319(4).

Turning to the substantive issue raised by claimant's hearing request, we agree with the ALJ that, on this record, claimant is not entitled to additional permanent disability.

ORDER

The ALJ's order dated May 2, 2000 is affirmed.

September 19, 2000 Cite as 52 Van Natta 1655 (2000)

In the Matter of the Compensation of
DEAN M. MOORE, Claimant
WCB Case No. 00-00582
ORDER ON RECONSIDERATION
Bischoff, Strooband & Ousey, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our August 30, 2000 Order on Review that awarded claimant a $5,100 assessed attorney fee for services at hearing and on review for finally prevailing over SAIF's denial of claimant's occupational disease claim for a bilateral foot condition. ORS 656.386(1). On reconsideration, SAIF contends that the attorney fee for services at hearing and on Board review should be reduced to $3,500. We disagree.

Initially, we note that the Board's record does not contain SAIF's April 20, 2000 letter to the ALJ in which it contested claimant's counsel's requested attorney fee for services at hearing. Moreover, we note that SAIF did not object to claimant's counsel's requested fee for services on review. Accordingly, in our prior order, we stated that claimant's counsel's requested attorney fee was "uncontested."

In any event, we disagree with SAIF's contentions on reconsideration. SAIF contends that an attorney fee of $3,500 for services both at hearing and on review is more reasonable, in light of the size of the record (number of exhibits, length of transcript) and the "uncomplicated" nature of the proceedings. However, this factor is just one of several under OAR 438-015-0010(4) that are considered in setting the amount of a reasonable attorney fee under ORS 656.386(1). On reconsideration, we adhere to our award of $5,100 for claimant's attorney's services at hearing and on review. In making this determination, we have considered all of the factors in OAR 438-015-0010(4). Particularly, in a case such as this where claimant did not prevail at hearing and the medical opinions are in conflict, we have considered the risk of claimant's counsel going uncompensated, as well as the complexity of the issue and the value of the interest involved.

Accordingly, we withdraw our August 30, 2000 order. On reconsideration, as supplemented herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LUZVIMINDA P. ANONUEVO, Claimant
WCB Case No. 99-08839
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration which awarded 10 percent (32 degrees) unscheduled permanent disability for a right shoulder condition. On review the issue is unscheduled permanent disability.

We adopt and affirm the ALJ's order with a supplement to address claimant's contentions that: (1) she is entitled to an impairment value for loss of range of motion of the right shoulder; and (2) she entitled to an award for social/vocational factors.

The ALJ relied on the medical arbiter panel's opinion and concluded that claimant was not entitled to an increase in physical impairment for loss of range of motion in her shoulder. The ALJ further determined that claimant had been released to her regular work and, therefore declined to consider social/vocational factors in rating the extent of her unscheduled permanent disability. *See* ORS 656.726(4)(f)(D)(ii).

We evaluate claimant's disability as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence. OAR 436-035-0007(14). Here, a medical arbiter panel consisting of Drs. Bald, Murray, and Woodward, found that claimant had restricted ranges of motion of the right shoulder, but opined that their findings were not attributable to the accepted condition or its surgical treatment.[1] (Ex. 16-3).

Dr. Strum, who examined claimant at the self-insured employer's request, found restricted ranges of motion in claimant's shoulder that he opined were the result of the compensable injury. (Ex. 6-5). Attending physician, Dr. Neitling, concurred with Dr. Strum. (Ex. 9). Consequently, Dr. Strum's impairment findings can be used to rate impairment provided the findings are valid. *Tektronix, Inc. v. Watson*, 132 Or App 483, 486 (1995).

However, Dr. Strum expressly indicated his range of motion findings were not valid for impairment rating purposes. (Ex. 6-5). He based his opinion on the discrepancy between claimant's active and passive ranges of motion as well as her diffuse giveway in musculature in the upper extremity not involved in her impingement problems.[2] (Ex. 6-5). Because Dr. Strum has provided a written opinion based upon sound medical principles explaining why his impairment findings are invalid, those findings cannot be used to rate claimant's impairment. OAR 436-035-0007(28); *Labor Force of Oregon v. Frierson*, 169 Or App 573 (2000).

Consequently, we conclude that the medical evidence does not establish claimant is entitled to an impairment value for lost range of motion of her right shoulder as a result of her compensable injury. Accordingly, on this record, we agree with the ALJ's determination that claimant is not entitled to permanent impairment based upon loss of range of motion of her right shoulder.

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[1] Claimant contends that because the medical arbiter panel did not opine that its range of motion measurements were invalid, those range of motion measurements must be used for rating purposes. We disagree with claimant's contention. Because the medical arbiter panel opined that claimant's restricted ranges of motion were not attributable to the compensable injury, the measurements cannot be used to establish impairment even if the measurements are valid. ORS 656.214(5); OAR 436-035-0320(2).

[2] Based upon Dr. Strum's "discrepancy" explanation, we disagree with claimant's contention that Dr. Strum's findings should be disregarded.

Claimant contends that she is entitled to an award for social/vocational values because she is not released for regular work. Specifically, she asserts that she cannot work the 12 hour shift that her regular work requires.[3]

The medical arbiter panel opined that claimant has no permanent restrictions attributable to the accepted condition on the number of hours she could work. (Ex. 16-3). In contrast, Dr. Neitling has restricted claimant to work no more than 8 hours per day. (Ex. 14). However, Dr. Neitling also appears to have concurred with those portions of Dr. Strum's opinion and the results of the physical capacity test, both of which indicate that claimant is not restricted from working her normal shift. (Ex. 6-5; 8; 9).

Finally, because the medical arbiter's opinion, the opinion of Dr. Strum, the physical capacities test, and Dr. Neitling's concurrence all appear to agree that claimant can work her regular shift without restriction, we conclude that the preponderance of evidence does not establish that claimant is entitled to have her social/vocational factors considered in a determination of the extent of her unscheduled permanent disability. *See* ORS 656.726(4)(f)(D)(ii). Accordingly, we agree with the ALJ's conclusion that claimant has been released for regular duty work and is not entitled to an award for social/vocational values.

ORDER

The ALJ's order dated April 4, 2000 is affirmed.

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[3] Claimant's regular work appears to require a shift of 11.5 hours per day for three calendar days followed by three days off. This is then followed by four calendar days with a work shift of 11.5 hours, with the next four days off. (Ex. 8).

Board Chair Bock specially concurring.

I agree with the conclusion that claimant has been released for regular duty work and is not entitled to an award for social/vocational factors. I write separately to address the dissent's contention that we should give more weight to Dr. Neitling's opinion regarding claimant's ability to return to regular work, as expressed in Exhibit 14, than we do to his concurrence with the opinions of Dr. Strum and the medical arbiter panel on this same issue. (Ex. 9).

While Dr. Neitling's concurrence with Dr. Strum and the physical capacity test is a "check-the-box" type of concurrence, he did expressly indicate that based upon Dr. Strum's objective examination, the conclusions reached by Dr. Strum are reasonable. (Ex. 9). He also indicated that Dr. Strum's conclusions were consistent with the physical capacity exam. (Ex. 9). In light of this, I am unable to determine whether the restrictions he recites in Exhibit 14 reflect his opinion that claimant is unable to perform her regular work, as distinguished from a recommendation to limit her work hours to prevent increased pain. *See Gayle L. Fitzgerald*, 52 Van Natta 1400 (2000); *Maria E. Jimenez-Menera*, 48 Van Natta 2139 (1996). Accordingly, I give Exhibit 14 little weight.

Board Member Phillips Polich concurring in part and dissenting in part.

I agree with the majority that claimant is not entitled to permanent impairment based upon loss of range of motion of her right shoulder. However, I disagree with the majority's conclusion that claimant has been released for regular duty work and is not entitled to an award for social/vocational values.

On June 17, 1999, Dr. Neitling released claimant for work with the following restrictions: (1) no repetitive use of the right hand or arm; (2) no use of right arm in horizontal or overhead positions; (3) limit lifting to 2 to 3 pounds on occasional basis; and (4) no work of more than 8 hours per shift. (Ex. 14). He further indicated those restrictions were permanent.[1] (Ex. 14). Because Dr. Neitling is

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[1] I acknowledge that Dr. Neilting appears to have concurred with the portions of Dr. Strum's report and the physical capacity test that indicate claimant is not restricted from working her normal shift. However, those concurrences are "check-the-box" type concurrences, which we generally consider to be unpersuasive. *See William F. Gilmore*, 46 Van Natta 999, 1000 (1994). Consequently, I give much more weight to the specific restrictions listed in Exhibit 14 than I do to his "check-the-box" concurrences.

claimant's attending physician, and because I find no persuasive reason not to defer to his opinion, I give his opinion regarding claimants ability to return to regular work more weight than I do the opinions of Dr. Strum and the medical arbiter panel. *See Weiland v. SAIF*, 64 Or App 810 (1983). Consequently, I conclude that claimant has not been released for return to her regular work. Having concluded that claimant has not been released to regular work, I find she has established an entitlement to an award for social/vocational values. Accordingly, I would so modify the ALJ's order.

September 19, 2000 Cite as 52 Van Natta 1658 (2000)

In the Matter of the Compensation of
CRAIG J. PRINCE, Claimant
WCB Case No. 99-0186M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Scott McNutt, Sr., Claimant Attorney
Reinisch, et al, Defense Attorneys

Pursuant to our January 26, 2000 Own Motion Order on Reconsideration, we postponed action regarding a request that we exercise our authority under ORS 656.278 to authorize temporary disability compensation under claimant's 1999 low back claim. We took this action to await resolution of litigation that would soon be pending before the Hearings Division arising from claimant's contention that the insurer was obligated to reopen and process his current condition under ORS 656.262(7)(c) to closure under ORS 656.268.

This date, we have affirmed an Administrative Law Judge's (ALJ's) order that directed the insurer to reopen the claim and process claimant's L4-5 and L5-S1 disc conditions under ORS 656.262(7)(c) to closure under ORS 656.268. The ALJ further recommended that, in light of such a determination, we decline to reopen the claim under ORS 656.278.

Because we have affirmed the ALJ's order regarding the processing of claimant's claim for his current low back conditions, we also share the ALJ's reasoning that we decline to exercise our Own Motion authority to reopen the claim under ORS 656.278. Nonetheless, in denying the request for Own Motion relief, we reiterate the ALJ's comments that, in the event that any temporary disability benefits were previously paid pursuant to our June 21, 1999 Own Motion Order, any such payments may be offset against any temporary disability due for the same period under the claim reopened pursuant to ORS 656.262(7)(c) for processing to closure under ORS 656.268. *See Billy W. Washington*, 52 Van Natta 734, 737 n. 5 (2000).

IT IS SO ORDERED.

In the Matter of the Compensation of
FRED A. COX, Claimant
WCB Case No. 00-01542
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeed, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that affirmed a Director's order reclassifying claimant's claim to disabling. On review, the issue is reclassification. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the second sentence of the ALJ's ultimate findings of fact. We supplement and summarize the facts as follows.

Claimant was compensably injured on November 16, 1998, while working for the employer as a construction superintendent. Dr. Ramsthel, claimant's then-treating physician, released claimant to modified work. (Exs. 91, 92). On December 7, 1998, Dr. Ramsthel released claimant to regular work. (Exs. 93, 94).

On December 9, 1998, the insurer accepted a nondisabling lumbosacral strain.

On December 14, 1998, claimant's pain increased and, on January 5, 1999, Dr. Ramsthel placed claimant on light duty at claimant's discretion. (Exs. 95, 96, 97). On February 16, 1999, Dr. Ramsthel released claimant to regular work, and, on March 12, 1999, declared claimant medically stationary. (Ex. 105). On April 16, 1999, Dr. Ramsthel wrote to the insurer, stating that claimant's condition had completely resolved, with no impairment or disability. (Ex. 108).

On November 1, 1999, claimant reinjured his low back while raking leaves. He was diagnosed by Dr. McMillan with a low back sprain or strain with sacroiliac joint pain on the right. (Ex. 112). Dr. McMillan submitted a form 827 to the insurer that authorized modified work from November 1, 1999 through November 12, 1999. (Ex. 113).

On November 4, 1999, claimant wrote to the insurer and the Workers' Compensation Division asking each to reclassify his claim as disabling. (Exs. 113A, 133B). These requests for reclassification were received on November 5, 1999. On November 16, 1999, the insurer denied claimant's aggravation claim. (Ex. 117).

Dr. McMillan referred claimant to Dr. Rodriguez, osteopath, for further evaluation of claimant's low back and sacroiliac joint pain. (Ex. 115). Dr. Rodriguez took claimant off work from November 15 through November 22, 1999. (Exs. 116, 118). On November 23, 1999, a Determination Order ordered that claimant's accepted lumbosacral strain claim remain classified as "nondisabling." (Ex. 119).

On December 17, 1999, Dr. McMillan wrote a letter to claimant's attorney regarding claimant's November 16, 1998 injury. (Ex. 121).

On January 26, 1999, Drs. Williams and Scheinberg examined claimant for the insurer. (Ex. 123). Dr. McMillan and Dr. Rodriguez each concurred with Drs. Williams' and Scheinberg's opinion. (Exs. 124, 125).

On February 17, 2000, a Directors Classification Review and Order reclassified claimant's claim to "disabling." The insurer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant's low back strain injury claim should be classified as "disabling." In affirming the Director's order, the ALJ relied on Dr. Ramsthel's authorizations of

modified work and range of motion measurements taken on April 19, 1999, even though Dr. Ramsthel explicitly found claimant medically stationary and without permanent impairment regarding the lumbosacral strain injury. The ALJ also relied on Dr. McMillan's authorization of modified work, and Dr. Rodriguez' taking claimant off work in November 1999 to conclude that claimant had established that some temporary disability compensation may be due and payable. On review, the insurer contends that the record does not contain evidence that temporary disability benefits are due and payable or the requisite expert medical opinion to establish a reasonable expectation of permanent disability. We agree and reverse.

A "disabling compensable injury" entitles the worker to compensation for disability or death, whereas an injury is not disabling if no temporary disability benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury. ORS 656.005(7)(c). In *Karren S. Maldonado*, 47 Van Natta 1535 (1995), we held that to establish a disabling injury under ORS 656.005(7)(c), it is not enough that a claimant be limited to modified work; there must be entitlement to temporary disability benefits or a reasonable expectation of permanent disability. Moreover, in construing ORS 656.005(7)(c) and determining whether a compensable injury is disabling, we require expert medical opinion indicating that a permanent disability award is likely or expected. *See, e.g., Thomas G. Dobson*, 50 Van Natta 2390, 2391, *on recon* 51 Van Natta 297 (1999); *Gerasimos Tsirimiagos*, 50 Van Natta 1627 (1998).

Here, no temporary disability was authorized. Because temporary disability benefits were not due and payable, claimant's claim is not disabling under ORS 656.005(7)(c) unless there is a reasonable expectation of permanent disability. As noted above, Dr. Ramsthel declared claimant medically stationary without permanent impairment in April 1999. Moreover, none of claimant's subsequent treating or examining physicians indicated that a permanent disability award was likely or expected. *See* Exs. 121, 123, 124, 125. Consequently, the preponderance of the evidence is that no permanent disability exists or is likely to result from the compensable injury.

ORDER

The ALJ's June 2, 2000 order is reversed in part and affirmed in part. That portion of the order that affirmed the Director's order is reversed. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

September 19, 2000 Cite as 52 Van Natta 1660 (2000)

In the Matter of the Compensation of
CHARLES M. HANEY, Claimant
Own Motion No. 98-0360M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 15, 2000 Own Motion Order, that affirmed the SAIF Corporation's February 1, 2000 Notice of Closure in its entirety.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The Board implements the following briefing schedule. Claimant is requested to submit medical evidence supporting his request within 30 days of the date of this order. SAIF's response to claimant's evidence, including any supporting documents, must be filed within 30 days from the date of mailing of claimants evidence. Claimant's reply, including any further supporting documents, must be filed within 14 days from the date of mailing of SAIF's response. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL A. HOLTE, Claimant
WCB Case No. 00-00690
ORDER ON REVIEW
Ernest M. Jenks, 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) Hazelett's order that set aside its denial of claimant's occupational disease claim for left rotator cuff tendinitis and impingement syndrome. In his brief, claimant requests a penalty for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

Claimant has experienced recurrent right shoulder pain for a number of years which has been relieved with cortisone shots. (Exs. 1; 3; 8-1, -2; 9-2, -3). For about two and a half years, claimant had been operating a front-end loader for the employer about seven and a half hours a day, five days a week. Steering the loader required repetitive use of his left arm, using a steering knob on an 18-inch steering wheel located at about chest level. (Tr. 11,12, 15; Ex. 7).

Claimant's symptoms in the left shoulder developed about the third week in November 1999. (Tr. 15). It began as an ache and soreness starting midmorning and worsening as the work day progressed. (Tr. 15; 16; Exs. 8-1; 9-3). Claimant continued to perform work activities for another three weeks during which time his condition worsened. (Tr. 15). In December 1999, claimant sought treatment from Dr. Pausig for bilateral shoulder pain. (Ex. 1). Dr. Pausig referred him to Dr. Rask, orthopedic surgeon, who diagnosed bilateral rotator cuff tendinitis and impingement syndrome. Dr. Rask treated the left shoulder conservatively. (Ex. 2). On December 29, 1999, claimant filed a claim for his left shoulder. (Ex. 5). On January 14, 2000, the insurer denied the claim. (Ex. 6).

On January 17, 1999, Dr. Rask found that claimant had a type III acromion in the left shoulder. (Ex. 7). Conservative treatment was unsuccessful, and Dr. Rask subsequently performed arthroscopic surgery. (Ex. 7B; Tr. 16).

On February 29, 2000, Dr. Bald examined claimant for the insurer. (Ex. 9).

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's opinion on this issue[1], with the following supplementation to address the insurer's contention that the ALJ incorrectly failed to find the opinion of Dr. Bald, the examining physician, more persuasive than that of Dr. Rask.

Claimant seeks to establish the compensability of a right shoulder condition, diagnosed as rotator cuff tendinitis and impingement syndrome, as an occupational disease. Therefore, he must prove that his work activities are the major contributing cause of the disease. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

To satisfy the "major contributing cause" standard, claimant must establish that his work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

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[1] We do not adopt the second sentence of the third full paragraph on page 4.

The record establishes that claimant has a preexisting type III acromion condition in his left shoulder. (Ex. 7). This preexisting condition is deemed to be a cause in determining the major contributing cause of claimant's occupational disease. ORS 656.802(2)(e). Because of the possible alternative causes for claimant's condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Dr. Bald, who saw claimant at the request of the insurer, opined that the major contributing cause of claimant's bilateral shoulder condition was the result of a combination of non-work-related factors, including his type III acromion. (Ex. 9-6). Dr. Bald thought that claimant had a bilateral idiopathic impingement syndrome that developed as the result of the type II and III acromions and was most apparent in the left shoulder. (Ex. 9-6). Dr. Bald explained that elevation of claimant's arm caused the rotator cuff tendon to rub on the undersurface of the acromion, creating an impingement syndrome. (Ex. 9-7).

Although Dr. Bald felt that claimant's work activities involving his upper extremities were unlikely to result in a chronic rotator cuff condition, he did not identify any non-work-related elevation of the left arm that might have contributed to the combination of non-work-related factors and the type III acromion that he posited in his report.[2] Moreover, although claimant reported to Dr. Bald that he did not have any left shoulder problems until November 1999 (but had right shoulder symptoms since 1992), Dr. Bald did not provide any reasoning regarding the time difference in the onset of claimant's left and right shoulder conditions.

Finally, Dr. Bald stated,

> "There is a high degree of association between the development of rotator cuff tendinitis and impingement with particularly a type III acromion. This type of acromial configuration effectively reduces the available space in the subacromial region and has a high degree of association with this type of impingement type syndrome."

We are not persuaded by Dr. Bald's opinion regarding the "high degree of association" between the development of rotator cuff tendinitis and impingement syndrome" because it is not specific to claimant. *See Sherman v. Western Employer's Insurance*, 87 Or App 602 (1987) (physician's comments that were general in nature and not addressed to the claimant's situation in particular were not persuasive); *Yolanda Enriquez*, 50 Van Natta 1507 (1998) (medical evidence grounded in statistical analysis was not persuasive because it was not sufficiently directed to the claimant's particular circumstances).

In contrast, Dr. Rask, claimant's treating physician, opined that claimant's work activities are the major cause of claimant's left shoulder condition. In rendering his opinion, Dr. Rask took into consideration that claimant's work activities correlated directly with the development of his symptoms, that claimant had had no left shoulder off work accidents or injuries, and that claimant's household activities were not a significant contributing factor in the development of his condition. Dr. Rask also evaluated the contribution of claimant's preexisting degenerative process in the shoulder, which he found to be minimal.

In sum, because we find that Dr. Rask's opinion is well-reasoned and consistent with claimant's history (and the contrary opinion unpersuasive), we conclude that his work activities were the major contributing cause of his bilateral CTS.

Penalties

Claimant contends that a penalty should be assessed for the insurer's allegedly unreasonable denial. We disagree.

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[2] Dr. Bald mentioned claimant's dirt bike riding, stating that that type of activity, if performed to excess, could result in aggravation of shoulder symtomatology. However, Dr. Bald also specifically established that claimant does not ride a dirt bike regularly or repetitively, and does not ride hard, vigorously or competitively. (Ex. 9-9). Under these circumstances, this medical evidence is insufficient to establish that claimant's dirt bike riding was a significant causative factor in this case.

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 to it at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Claimant sought treatment from Dr. Pausig on December 15, 1999. Dr. Pausig diagnosed left shoulder biceps tendinitis/bursitis and stated: "Nothing that he did brought this on. Classic presentation." (Ex. 1). After ruling out calcific tendinitis, Dr. Pausig referred claimant to Dr. Rask. (Exs. 1, 2). Dr. Rask reported:

> "[Claimant] has been complaining of bilateral shoulder pain for 8-9 years. It first started with his right shoulder, later his left. * * * No specific injury but he thinks it may have occurred when he was lifting something at work or when he was coaching Little League and was demonstrating pitching techniques."

Dr. Rask diagnosed bilateral shoulder rotator cuff tendinitis and impingement syndrome. (Ex.3). On December 29, 1999, Dr. Rask submitted a Form 827 on which claimant described "[n]o accident, gradually got more painfull [sic] over time." (Ex. 4). On January 14, 2000, the insurer issued a denial of claimant's left shoulder condition on the basis that there was insufficient evidence that claimant's condition was related to his work activity at the employer. (Ex. 6).

Based on the contemporaneous medical reports, we find that the insurer had a legitimate doubt as to whether claimant's occupational disease claim was compensable. Consequently, we conclude that the insurer's denial was 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 $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's reply brief), the complexity of the issue, and the value of the interest involved.[3]

ORDER

The ALJ's order dated May 24, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

[3] Finally, we do not award an attorney fee for claimant's counsel's services on review regarding the penalty issue.

In the Matter of the Compensation of
MICHAEL C. MARTIN, Claimant
WCB Case No. 99-02901
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Bruce M. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of his injury claim for an inguinal hernia condition. On review, the issue is compensability.

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

The record establishes that: (1) claimant has undergone surgery for inguinal hernias on two occasions before his work incident in January 1999; and (2) claimant had an off-the-job abdominal injury about a week-and-a-half prior to his January 1999 work incident. (Ex. 3-1; 5B-9). The record further establishes that the prior surgeries and the prior off-the-job injury contributed in some fashion to claimants current condition. (Ex. 5-3; 8-2). Accordingly, we conclude that claimant's right inguinal hernia condition, is a combined condition under the terms of ORS 656.005(7)(a)(B). We note that neither party argues otherwise.

In order to establish that his inguinal hernia condition is compensable, claimant must show that his work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 106 (1997), *aff'd as modified on recon*, 149 Or App 309, 315 (1997), *rev den*, 326 Or 389 (1998). Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). To satisfy the "major contributing cause" standard, claimant must establish that his work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's inguinal hernia condition and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Claimant has been seen by two doctors who have rendered opinions on causation: (1) Dr. Bernardo, the attending physician; and (2) Dr. Braun, a SAIF-arranged medical examiner. Dr. Bernardo opined that claimant's disability and need for treatment of the inguinal hernia condition was related to the work incident of January 1999. (Ex. 3-2). Dr. Bernardo offered no opinion as to the major contributing cause of claimant's disability or need for treatment for the inguinal hernia condition. Consequently, Dr. Bernardo's opinion does not establish that claimant's inguinal hernia condition is compensable under ORS 656.005(7)(a)(B).

Dr. Braun initially opined that claimant's work incident of January 1999 was the major contributing cause of claimant's disability and need for treatment of his inguinal hernia condition. (Ex. 5-3). In rendering that opinion, Dr. Braun was unaware of claimant's earlier off-the-job abdominal injury. (Ex. 5-1). Because Dr. Braun's initial opinion was based upon incomplete information his initial opinion is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Later, upon learning of claimant's off-the-job abdominal injury, Dr. Braun opined that the off-the-job injury was the major contributing cause of claimant's disability and need for treatment of his inguinal hernia condition. (Ex. 8-2).

We acknowledge claimant's argument that Dr. Braun's change of opinion is based upon an incorrect history; a history that failed to accurately indicate the off-the-job abdominal injury was left sided and not right sided. Nevertheless, the record does not contain a medical opinion that: (1) has a correct history; (2) evaluates the relative contributions of the different causes of claimant's inguinal hernia condition; and (3) persuasively explains that claimant's work incident of January 1999 was the major contributing cause of claimant's disability and need for treatment of his inguinal hernia condition. Accordingly, we conclude that claimant has failed to establish the compensability of his inguinal hernia condition.

ORDER

The ALJ's order dated June 2, 2000 is affirmed.

In the Matter of the Compensation of
DUANE J. PIXLER, Claimant
WCB Case No. 99-10090
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich, and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration reclassifying claimant's claim as disabling. On review, the issue is claim processing.

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

The ALJ affirmed the Order on Reconsideration finding claimant's claim "disabling" because the medical evidence indicated that claimant has a reasonable expectation of permanent impairment due to his accepted injury. ORS 656.005(7)(c); *Gerasimos Tsirimiagos*, 50 Van Natta 1627 (1998). On review, the insurer argues that the more persuasive medical evidence proves that, if claimant has a reasonable expectation of permanent impairment, it is related to his noncompensable L4-5 herniated disc condition. *See Rosa Cazares*, 48 Van Natta 1007 (1996). We disagree with the insurer's contentions.

A "disabling compensable injury" is "an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury." ORS 656.005(7)(c). To qualify for "disabling" status, a claimant need not demonstrate a "specific and actual" impairment, but rather merely a "reasonable expectation" of permanent impairment. *SAIF v. Schiller*, 151 Or App 58, 62 (1998). We agree with the ALJ that claimant has a reasonable expectation of permanent impairment due to his compensable injury.

Claimant's treating physician, Dr. Puziss, concluded that it was "virtually impossible" for claimant not to have sustained permanent impairment from his compensable injury. (Ex. 34-2). Dr. Puziss reasoned that claimant's injury had caused a lumbar strain and disc bulge, that claimant had "ongoing evidence for impairment" and that his injury was "partially disabling." (Ex. 23-2).

In contrast, Drs. Gripekoven and Yerby, who examined claimant at the request of the insurer, stated that claimant was medically stationary with no permanent impairment regarding his low back condition, although he may experience some "waxing and waning" of symptoms due to a (non work-related) degenerative process. (Ex. 31-8). Dr. Puziss criticized these examiners' opinions, reasoning that the term "waxing and waning" contemplates a permanent condition.[1] (Ex. 34).

The insurer contends that Dr. Puziss relates any permanent impairment to the noncompensable L4-5 disc herniation condition. (Ex. 32, 34). However, Dr. Puziss stated that claimant's low back pain was caused by a "small annular tear causing some bulging and/or herniation of the left L4-5 disc." (Ex. 32-2). The insurer has accepted, among other conditions, a "bulging L4-5 disc." (Ex. 25). Dr. Puziss' opinion therefore, while not relating a specific impairment to the disc bulge condition, establishes a *reasonable expectation* of permanent impairment due to the accepted disc bulge condition, separate from the noncompensable disc herniation condition. (Exs. 23, 32-2); *SAIF v. Schiller*, 151 Or App at 62.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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.

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[1] *Cf.* ORS 656.273(8) (In an aggravation claim, "waxing and waning of symptoms" must be more than that which was "contemplated by the previous permanent disability award."). We emphasize, however, that we find Dr. Puziss' opinion persuasive not on the basis of his understanding of the term "waxing and waning," but because of his position as claimant's treating physician. Dr. Puziss' opinion relates claimant's permanent impairment at least in part to his compensable low back strain and disc bulge conditions.

ORDER

The ALJ's order dated April 7, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
JOHN J. WISEMAN, Claimant
WCB Case No. 99-06689
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that dismissed his hearing request as untimely. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

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

The insurer issued two denials, one dated August 18, 1999, and another one dated September 29, 1999, and a partial denial dated November 30, 1999. (Exs. 54, 55, 58). The first two denials were set aside by the insurer's December 1, 1999 Notice of Acceptance. Thus, only the November 30, 1999 partial denial is potentially at issue.

Claimant has been represented by three attorneys regarding workers' compensation matters. Claimant was attempting to file a malpractice action against his first attorney regarding a workers' compensation matter.

Claimant's second attorney requested a hearing regarding the two earlier denials. That hearing was scheduled for November 22, 1999.

On November 3, 1999, claimant's second attorney withdrew from representing claimant because she did not handle malpractice claims. That same date, she requested postponement of the November 22, 1999 hearing, noting that claimant needed time to consult with and retain another attorney. Claimant had no communication with his second attorney after she withdrew from representing him. Claimant immediately began seeking another attorney.

On December 1, 1999, the insurer mailed by certified mail the November 30, 1999 partial denial. (Ex. 58A-1). On December 2, 1999, claimant's wife signed the certified mail receipt. (Ex. 58A-2; Tr. 13). She gave the partial denial to claimant that night. (Tr. 17). Claimant recalled receiving the denial and reading it "many times," although he did not understand it. (Tr. 23-24). The partial denial contained appeal rights that notified claimant of the deadline to request a hearing. (Ex. 58-2).

After receiving the partial denial, claimant called the insurer and asked what the denial meant. He was told that he needed an attorney to look it over for him. (Tr. 32). On January 13, 2000, claimant met with an attorney and gave him all of his workers' compensation records, which included the November 30, 1999 partial denial. Claimant asked the attorney to look over the records quickly. (Tr. 30-31). At that time, claimant was within the 60 day period within which to timely request a hearing on the November 30, 1999 partial denial.

On February 14, 2000, claimant and this new attorney signed a retainer agreement. Claimant's new attorney filed a hearing request on the November 30, 1999 partial denial on February 15, 2000, more than 60 days after the insurer mailed the denial.

CONCLUSIONS OF LAW AND OPINION

It is undisputed that claimant requested a hearing from the insurer's November 30, 1999 partial denial more than 60 days and less than 180 days after the mailing of the denial. Consequently, the hearing request confers jurisdiction only if claimant had "good cause" for the late filing. ORS 656.319(1); *Tracie L. Salustro*, 52 Van Natta 1420 (2000). Based on the following reasoning, we find that claimant failed to prove "good cause" for his late filing.

Mistake, inadvertence, surprise or excusable neglect, as those terms are used in ORCP 71B(1), constitute "good cause." *Hempel v. SAIF*, 100 Or App 68, 70 (1990); *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986). Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1984). Lack of diligence does not constitute good cause. *Id.*

Claimant argues that he was confused by the November 30, 1999 partial denial because he had previously received two denials regarding his claim. He contends that he did not understand the contents of the partial denial.

Confusion regarding the contents of a denial does not, without reasonable diligence, constitute good cause. *See Debra A. Gould*, 47 Van Natta 1072 (1995) (a claimant confused by a carrier's simultaneous denial of a condition as a new occupational disease and reopening of an accepted claim did not have good cause for untimely hearing request, because there was no evidence that the claimant had exercised any diligence in resolving confusion); *Mary M. Schultz*, 45 Van Natta 571 (1993) (confusion regarding status of claim caused by receipt of interim compensation insufficient to prove good cause; further, lack of diligence in clearing up confusion also prevented finding of good cause); *see also Tuan A. Ho*, 45 Van Natta 2413 (1993) (claimant's inability to read English did not establish good cause in the absence of reasonable diligence). Thus, claimant's contention that the partial denial was confusing does not meet his burden of proving "good cause."

Claimant also argues that *Voorhies v. Wood, Tatum, Moser*, 81 Or App 336 (1985), *rev den* 302 Or 342 (1986), supports a finding that he has established "good cause." In making this argument, claimant repeatedly notes that the insurer's representative did not advise him about the importance of appealing the partial denial within 60 days. Instead, when claimant asked the insurer's representative what the partial denial meant, he was told that he needed to get an attorney to look it over for him. (Tr. 32). We do not find claimant's reliance on *Voorhies* persuasive.

In *Voorhies*, "good cause" was established where a claims supervisor erroneously advised a claimant that mailing of a request for hearing on the 60th day would protect his rights. Prior to receiving this advice, the claimant was prepared to hand-carry his request for hearing to the Hearings Division on the 60th day. Thus, under the reasoning in *Voorhies*, reliance on a misleading statement of an insurer's representative can constitute good cause. Nonetheless, here, there is no evidence that the insurer's representative made any misleading statement to claimant. Instead, the insurer's representative advised claimant to get an attorney to look over the partial denial. Therefore, *Voorhies* does not support claimant's position.

Finally, claimant contends that he was confused regarding the postponement process, contending that he thought his second attorney's request to postpone the scheduled hearing also handled the November 30, 1999 partial denial. We do not find this argument persuasive.

Claimant's second attorney withdrew from representing him almost a month before the partial denial was issued. Moreover, there is no evidence that claimant's second attorney was aware of the partial denial. In this regard, claimant acknowledged that he had no contact with his second attorney after she withdrew her representation. Thus, claimant made no effort to confirm his assumption that the partial denial was somehow being handled by his former attorney.

In addition, although claimant turned over his workers' compensation records to his current attorney within the 60 day period to timely request a hearing on the partial denial, the hearing request was not filed until after the 60 day period had expired. While the neglect of an attorney's employee who is not responsible for handling hearing requests may be excusable neglect, *see Ogden Aviation v. Lay*, 142 Or App 469 (1996), neglect by an attorney or by an attorney's employee who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. *See Sekermestrovich v. SAIF*, 280 Or 723, 727 (1977); *EBI Companies v. Lorence*, 72 Or App 75, 78 (1985).

In *Ogden*, a case relied on by claimant, good cause had been established by the claimant because the failure to timely file the hearing request was attributable to a legal secretary not regularly charged with filing hearing requests. Here, however, there is no evidence as to whose neglect in claimant's attorney's office caused the untimely filing. Therefore, we cannot determine if the untimely request was caused by the excusable neglect of an employee not responsible for handling hearing requests or the inexcusable neglect of the attorney or an attorney's employee who is responsible for filing hearing requests. *See Melba J. Culver*, 50 Van Natta 2028 (1998). Thus, we find *Ogden* distinguishable.

Based on all of the above reasoning, we conclude that claimant failed to establish good cause. Accordingly, we affirm the ALJ's decision dismissing claimant's hearing request.

ORDER

The ALJ's order dated March 31, 2000 is affirmed.

September 21, 2000 Cite as 52 Van Natta 1668 (2000)

In the Matter of the Compensation of
LELA SEWARD-DOUGLAS, Claimant
Own Motion No. 00-0275M
OWN MOTION ORDER
Ronald Fontana, Claimant Attorney
Fremont Industrial Indemnity, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's right wrist condition. Claimant's aggravation rights expired on July 27, 1995. The insurer recommends that we authorize the payment of temporary disability compensation.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning 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, in its recommendation form, the insurer indicates that claimant is represented. Based on such a reference, claimant's attorney may be entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, on this record, we cannot approve such a fee because: (1) no current retainer agreement has been filed with the Board (*see* OAR 438-015-0010(1)); and (2) no evidence demonstrates that claimant's attorney was instrumental in obtaining increased temporary disability compensation OAR 438-015-0080.

In conclusion, because no retainer agreement has been received to date and the record does not establish that claimant's attorney was instrumental in obtaining increased temporary disability compensation, the prerequisite for an award of an out-of-compensation attorney fee have not been met at this time. Consequently, no out-of-compensation attorney fee award has been granted. In the event that a party disagrees with this decision, that party may request reconsideration and submit information that is currently lacking from this record. Because our authority to further consider this matter expires within 30 days of this order, any such reconsideration request must be promptly submitted.

IT IS SO ORDERED.

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in the Matter of the Compensation of
QUINA F. TUCKER, Claimant
WCB Case No. 99-08144
SECOND ORDER ON RECONSIDERATION
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

The SAIF Corporation again requests reconsideration of our July 5, 2000 Order on Review, as reconsidered on August 24, 2000, that reversed the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's medical services claim for a cervical condition. For the following reasons, we do not find SAIF's most recent reconsideration request persuasive.

In its first reconsideration request, SAIF requested that we modify our order to uphold its denial in part and to reverse it only with respect to cervical dorsal myospasm. We rejected SAIF's request, noting that, although SAIF's written denial pertained to several diagnoses/conditions, the parties, in effect, amended the denial at hearing to limit their dispute to the compensability of medical services based on cervical dorsal myospasm and C4-5 disc herniation. We emphasized that, when we set aside SAIF's "amended" denial, we found that claimant's current medical services were materially related to the compensable injury. In other words, when we set aside SAIF's denial (as amended at hearing), we determined that claimant's medical services claim based on the denied conditions (*i.e.* the cervical dorsal myospasm and C4-5 disc herniation) was compensable.

Asserting that the issue tried at hearing was the compensability of conditions for which claimant requested acceptance, and not medical services, SAIF contends that we lacked jurisdiction to decide the compensability of medical services because it had issued a July 2, 1999 denial of palliative care that was not contested and became final by operation of law.

If medical treatment was denied on other than causation grounds, our order should not be interpreted as addressing such issues because, with respect to medical services, we only have jurisdiction over causation disputes. *See* ORS 656.704(3)(b); *Vicki L. Mangum*, 52 Van Natta 1006 (2000). To the extent that SAIF is arguing that medical services were not at issue in this case, we disagree. For instance, in its respondent's brief, SAIF described the issue as "the causal relationship between claimant's need for treatment of her neck condition and her accepted claim." (Respondent's Brief page 2).

SAIF also objects to our first reconsideration order, arguing that it is inconsistent with our original order. Specifically, SAIF states that our reconsideration order republished our original order which provided that SAIF's denial was set aside. SAIF argues this is inconsistent with our reconsideration order that indicated that only medical services are compensable. We disagree with SAIF's contention.

As previously noted, SAIF, in effect, amended its written denial to limit the dispute to compensability of medical services based on cervical dorsal myospasm and C4-5 disc herniation. When we set aside SAIF's amended denial in our original order and subsequently republished that order in our first reconsideration order, we held that claimant's current medical services for those disputed specific conditions were compensable. We perceive no inconsistency in our prior orders.

Accordingly, we withdraw our July 5, 2000 and August 24, 2000 orders. On reconsideration, as clarified and supplemented herein, we adhere to and republish our July 5, 2000 and August 24, 2000 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
SHERRY A. GOMES, Claimant
WCB Case No. 99-07107
ORDER ON REVIEW (REMANDING)
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Black's order that dismissed her 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 September 8, 1999, claimant's former attorney requested a hearing and one was scheduled for December 7, 1999. The hearing was cancelled when the case was reported as settled. The settlement, however, was never executed and claimant's former attorney subsequently withdrew as counsel. The case was rescheduled for hearing on May 22, 2000.

On May 22, 2000, the ALJ convened the hearing, but claimant did not appear. On May 25, 2000, the ALJ issued an Order of Dismissal, stating that the Request for Hearing was dismissed as abandoned under OAR 438-006-0071(2). The ALJ, however, gave claimant 30 days from the date of his order to request abatement and reconsideration should she believe that "extraordinary circumstances" prevented her attendance at the hearing.

On June 26, 2000, the Board received a letter from claimant. Claimant stated that she "was not able to attend the hearing due to the fact I am incapacitated." Claimant further stated that she was living in California and unable to make any prolonged trips. Therefore, she alleged that she was unable to defend herself.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant 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, in her letter, claimant explains her failure to appear as being due to incapacity. Therefore, we find that claimant's letter following the Order of Dismissal constitutes a motion for postponement. 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 May 25, 2000 order is vacated. This matter is remanded to ALJ Black 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

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[1] We note that the ALJ's order that both dismissed the hearing request and gave claimant an opportunity to request abatement and reconsideration was appropriate here, where claimant did not appear at a scheduled hearing and no communication regarding the non-appearance was received. Nevertheless, to avoid confusion and conflict with the 30-day appeal period, the "show cause" period might have been reduced to a period less than 30 days. *See Teresa Marion*, 50 Van Natta. 1165, 1166 n.1 (1998); *Brent Harper*, 50 Van Natta 499, 500 n.2 (1998).

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.[2]

IT IS SO ORDERED.

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[2] Inasmuch as claimant is presently unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. She may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271, or write to:

WORKERS'COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE ROOM 160
SALEM OR 97301-3878

In the Matter of the Compensation of
JAMES A. HANSON, Claimant
WCB Case No. 00-01150
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration that awarded 21 percent (31.50 degrees) scheduled permanent disability for loss of use or function of the right wrist. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on the findings of the medical arbiter panel to conclude that claimant's lost range of motion in the left wrist was due to and consistent with the accepted conditions. On this basis, the ALJ affirmed the Order on Reconsideration's award of 21 percent scheduled permanent disability benefits based on the medical arbiter panel's findings.

On review, SAIF argues that the medical arbiter panel's range of motion findings should not have been used to rate claimant's scheduled permanent disability because the arbiters stated that the loss of range of motion was "greater than would be expected from the accepted conditions." Instead, SAIF seeks reinstatement of the 13 percent scheduled permanent disability awarded by a September 3, 1999 Notice of Closure, as amended on September 29, 1999.

In reporting claimant's findings of lost range of motion, the medical arbiter panel stated:

"The examinee's loss of range of motion of the wrist on flexion, extension, radial and ulnar deviation is greater than would be expected from the accepted conditions.

"We compared our results with those reported on December 14, 1996 by Dr. Neumann, et al. The examinee has considerable reduced range of motion on the right today when compared to that reported then. Since that time the examinee has undergone a debridement of the triangular fibrocartilage. If this had been the cause of his symptoms, his range of motion would be expected to be improved and not reduced. We do not regard the loss of range of motion found today as being due to the accepted conditions. Thus, we do not believe there is objective evidence of worsening."

In determining that the medical arbiter panel's range of motion findings should be used, the ALJ relied on *SAIF v. Danboise*, 147 Or App 550, 553, *rev den* 325 Or 438 (1997), to conclude that claimant's range of motion loss should be rated because it was consistent with the accepted condition. In *Danboise*, the court held that:

> "when the record discloses no other possible source of impairment, medical evidence that rates the impairment and describes it as 'consistent with' the compensable injury supports a finding that the impairment is due to the compensable injury."

The issue in *Danboise* was whether the claimant had established that his neck impairment was due to the compensable injury. Although the medical evidence described the claimant's impairment as "consistent with" the compensable injury rather than "due to" that injury, the court affirmed the Board's award of unscheduled permanent partial disability.

Here, in contrast to *Danboise*, the medical arbiter panel did not describe claimant's impairment as consistent with the accepted condition. To the contrary, the arbiter panel suggested that the impairment was inconsistent with the accepted condition and that the findings were not regarded as being "due to" the accepted condition. Under such circumstances, *Danboise* does not apply. *See Synndrah R. Spillers*, 52 Van Natta 714 (2000); *Kenneth W. Emerson*, 51 Van Natta 654, 655 (1999).[1]

Because the medical arbiter panel reported that the range of motion findings were not due to the accepted condition, we rely, instead, on the physical capacity evaluation findings that were ratified by the attending physician, Dr. Zirschky. There is no contention that the 13 percent (24.96 degrees) awarded by the Notice of Closure based on those findings was incorrectly calculated. Under such circumstances, we conclude that the 13 percent scheduled permanent disability awarded by the Notice of Closure should be reinstated.

ORDER

The ALJ's order dated May 22, 2000, is reversed. The Order on Reconsideration is modified to affirm the Notice of Closure award of 13 percent (24.96 degrees) scheduled permanent disability benefits. The ALJ's attorney fee award is also reversed.

[1] Claimant also cites to OAR 436-035-0007(28) and argues that the medical arbiters must provide a written opinion, based on sound medical principles, explaining why the findings are invalid. Here, the medical arbiters did not report that the findings were invalid. Instead, they reported that the impairment was not due to the injury. Thus, OAR 436-035-0007(28) is not applicable.

In the Matter of the Compensation of
ALAN KUCERA, Claimant
Own Motion No. 00-0268M
OWN MOTION ORDER OF ABATEMENT
Martin J. McKeown, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer requests reconsideration of our August 30, 2000 Own Motion Order, that authorized reopening of this claim for the payment of temporary disability compensation. However, the Board noted that, when claimant is medically stationary, this claim must be closed under ORS 656.268. The insurer contends that, when appropriate, this claim should be closed under OAR 438-012-0055 and ORS 656.278.

In light of such circumstances, the following briefing schedule shall be implemented. The insurer shall have 14 days from the date of this order to file its opening brief. Claimant shall have 14 days from the date of mailing of the insurer's brief to file his response. The insurer shall then have 7 days from the date of mailing of claimant's response to file its reply. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUDITH A. JOHN, Claimant
WCB Case No. 99-10078
ORDER ON REVIEW
Terral & Terrall, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of her occupational disease claim for a bilateral carpal tunnel syndrome condition. Along with her brief, claimant submits additional evidence, which we treat as a motion for remand. On review, the issues are remand and compensability.[1]

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

Enclosed with claimant's brief are numerous documents, some of which were neither submitted nor admitted at hearing. These include a report from claimant's treating surgeon, Dr. Becker, and a letter from claimant's former attorney concerning a conversation with another physician, both of which were generated after the ALJ's order. Claimant also submits documents that were in existence at the time of the hearing, including a "Fitness for Duty" form; medical reports from 1997 and 1998; and medical information from the internet.

Because our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand the case to the ALJ. *See Judy A. Britton*, 37 Van Natta 1262 (1985). We remand only if the record is improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Specifically, to merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Claimant has not established, or even contended, that the "Fitness for Duty" form, 1997 and 1998 medical reports, and internet information were not obtainable with due diligence. Furthermore, because the documents do not relate specifically to the cause of claimant's carpal tunnel syndrome condition, we conclude that admission of the evidence would not affect the outcome of the case.

Although the remaining reports were generated after the hearing, they essentially reiterate the medical opinions already in the record. In particular, the report from Dr. Becker contains the same reasoning and conclusion contained in Exhibit 14 and the letter from claimant's former attorney (even if we assume it would be admissible) provides the opinion from Dr. Tsang contained in Exhibit 13.

Because Dr. Tsang does not support a causal relationship between claimant's condition and her work activities, admission of the letter from claimant's former attorney would not affect the outcome. Dr. Becker's report continues to have the same defects explained by the ALJ that render his opinion insufficient to carry claimant's burden of proof. Thus, admission of his post-hearing report also would not affect the outcome.

In sum, we conclude there is no compelling reason to remand the case to the ALJ for admission of the submitted documents. Thus, we deny the motion to remand.

ORDER

The ALJ's order dated April 17, 2000 is affirmed.

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[1] In its brief, the employer expresses confusion concerning the filing date of its brief because it did not receive copies of anything filed by claimant. It asks that the Board consider its brief as timely filed.

Because claimant apparently did not provide the employer or its counsel with a copy of her appellant's brief, we find extraordinary circumstances to warrant acceptance of the employer's respondent's brief. *See* OAR 438-011-0030 (Board may waive its rules when it finds extraordinary circumstances beyond a party's control that warrants such an action). A copy of claimant's appellant's brief and submission have been included with the employer's counsel's copy of this order.

In the Matter of the Compensation of
SHARON M. BATTIN, Claimant
WCB Case No. 99-02619
ORDER ON RECONSIDERATION
Hilda Galaviz, Claimant Attorney
Reinisch, et al, Defense Attorneys

On August 17, 2000, we abated our July 24, 2000 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order upholding the self-insured employer's denial of claimant's occupational disease claim for a right carpal tunnel syndrome condition. We did so to address claimant's request for reconsideration. We have also received the employer's response to claimant's submission. After completing our reconsideration, we provide the following order.

At hearing, claimant submitted proposed Exhibit 15, a medical report to which claimant's treating surgeon, Dr. Hubbard, responded. The employer objected to admission of the document and also asserted that it would seek a continuance if it was admitted. The ALJ found that claimant did not act with "due diligence" in obtaining the report and sustained the employer's objection. On review, claimant challenged the ALJ's ruling and moved to remand the case for admission of the document.

In our initial order, we found that it was not necessary to address this issue because, whether or not we considered proposed Exhibit 15, we concluded that claimant did not carry her burden of proving compensability. Specifically, we found that remand was not warranted because the report did not provide an opinion from Dr. Hubbard that claimant's entire work history was the major contributing cause of her right carpal tunnel syndrome, as required under the last injurious exposure rule.

In moving for reconsideration, claimant argues that, because claimant was not asking to reopen the record for admission of the document (since the record had not yet closed), the Board "should have simply determined whether the developments[.]" Claimant also objects to the Board's analysis of proposed Exhibit 15, contending that our discussion "appears to punish the claimant because she did not ask the question using magic words and phrases[.]"

Relying on our analysis of proposed Exhibit 15, the employer responds the Board appropriately declined to remand the case because admission of the document was not reasonably likely to affect the outcome.

Claimant essentially asserts that, if the ALJ abused her discretion in not admitting the report, we need not resort to deciding whether or not admission of the document would have an effect on the outcome if the report is material and relevant. That is, according to claimant, if the ALJ improperly declined to admit the report, remand is warranted.

Claimant's position is contrary to prior holdings. *E.g., Nancy A. Nielsen*, 52 Van Natta 333 (2000) (not necessary to decide whether the ALJ improperly declined to admit several documents because even if considered the claimant did not prove compensability); *Carol D. Courtright*, 50 Van Natta 1770 (1998) (same). Furthermore, we are not persuaded that we should deviate from that approach in this case. In particular, we find such an analysis consistent with the court's construction of ORS 656.295(5) that remand is warranted when there is a compelling reason, which includes the reasonable likelihood that admission of additional evidence will affect the outcome of the case. *See SAIF v. Avery*, 167 Or App 327, 332-33 (2000) (outlining Board's two-step process under ORS 656.295(5) for remand).

Thus, consistent with our prior caselaw, in deciding whether to remand this case under ORS 656.295(5) for admission of proposed Exhibit 15, we consider whether there is a compelling reason, including whether its admission is reasonably likely to affect the outcome of the case. We continue to adhere to our analysis of proposed Exhibit 15 and conclusion that its admission is not reasonably likely to affect the outcome.

On reconsideration, as supplemented and modified herein, we adhere to and republish our July 24, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILL D. FASCHING, Claimant
WCB Case No. 00-00726
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Otto's order that affirmed an Order on Reconsideration award of 16 percent (51.2 degrees) unscheduled permanent disability for claimant's cervical and thoracic condition. On review the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following changes and supplementation. On page 2, we change the first full paragraph to read: "Claimant sought medical treatment from Dr. Ackerman, who diagnosed a cervical strain, a C6-7 disc herniation and disc bulges at C4-5 and C5-6. (Ex. 3-1)." At the end of the second full paragraph on page 2, we change the citations to read: "(Exs. 5, 6)." We delete the third paragraph on page 3. We delete the first paragraph on page 5 and provide the following supplementation.

SAIF argues that the ALJ erred in holding that it had the burden of proof regarding the extent of claimant's unscheduled permanent disability. We need not address that issue because we would reach the same result no matter which party has the burden of proof.

SAIF contends that the ALJ erred by relying on the medical arbiter's report to determine claimant's unscheduled permanent disability. According to SAIF, the medical arbiter failed to limit his findings to the accepted strains. We disagree.

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).

SAIF accepted cervical and thoracic strains resulting from claimant's February 1999 injury. (Ex. 8). On October 15, 1999, SAIF modified its acceptance to refer to a combined cervical and thoracic condition. (Ex. 10). Thereafter, SAIF denied compensability of claimant's current condition on the basis that his work injury was no longer the major contributing cause of his combined condition and need for treatment. (Ex. 11). That denial became final as a matter of law.

SAIF relies primarily on the July 6, 1999 report from Drs. Hamby and Williams to establish claimant's impairment. Drs. Hamby and Williams said that claimant's current complaints were related to preexisting cervical degenerative arthritis and he did not have any impairment attributable to the work incident. (Ex. 4-8, -9). Drs. Ackerman and Wong concurred with their report. (Exs. 5, 6).

On *de novo* review, we conclude that the report from the medical arbiter, Dr. Thompson, provides the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. We agree with the ALJ that Dr. Thompson clearly distinguished the strain conditions from claimant's preexisting degenerative changes in the cervical spine. Dr. Thompson was informed that claimant's accepted conditions were cervical and thoracic strains and he was instructed to describe objective findings of permanent impairment resulting from the accepted conditions. (Ex. 9). Dr. Thompson specifically noted that the cervical degenerative changes were not due to the work incident. (Ex. 12-6). He also expressly found that claimant's pain complaints were consistent with the accepted cervical and thoracic strains. (*Id.*) Based on Dr. Thompson's report, we agree with the ALJ that claimant is entitled to a 16 percent unscheduled permanent disability award for his cervical and thoracic condition. We are not persuaded that a preponderance of medical opinion establishes a different level of impairment. Furthermore, we note that Dr. Thompson's December 8, 1999 report provided more current evidence of claimant's disability as of January 13, 2000, the issuance date of the reconsideration 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 $1,400, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's statement of services[1] and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 6, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,400, payable by SAIF.

[1] Claimant's attorney's statement of services requests an attorney fee of $1,400 "for services at hearing and before the Board." Because claimant's attorney was awarded an attorney fee for services at hearing, we assume that the statement of services refers only to services devoted to the case on Board review.

In the Matter of the Compensation of
KATHLEEN E. HILL, Claimant
WCB Case No. 00-00262
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
J. Keene, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration setting aside a Notice of Closure for a bilateral wrist condition claim as premature. On review, the issue is premature closure.

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

The ALJ affirmed the Order on Reconsideration on two bases. First, the ALJ concluded that the employer had not complied with OAR 436-030-0035(5)[1] and, therefore, the Notice of Closure should be set aside. Alternatively, the ALJ found that the preponderance of medical opinion proved that claimant was not medically stationary.

On review, the employer first contends that the ALJ erred in considering an issue not "raised" at the reconsideration proceeding nor argued at hearing. The employer contends that claimant did not raise the specific issue of the procedural propriety of the claim closure, *i.e.*, failure to comply with OAR 436-030-0035(5). The employer also argues that the Department did not have the authority to require that claimant's attending physician concur with the insurer-arranged closing examination, or even to require a closing examination at all, citing *Ball v. The Halton Co.*, 167 Or App 468 (2000). We need not decide these issues, however, as we agree with the ALJ's alternative finding that claimant's accepted condition is not medically stationary.

The employer contends that claimant's attending physician, Dr. Young, made an unexplained change in opinion on the issue of claimant's medically stationary status, and that his opinion is therefore unpersuasive. We disagree.

Where there is a conflict in medical opinions as to whether the claimant's compensable condition is medically stationary, we give more weight to those opinions that are based on an accurate history, on

[1] OAR 436-030-0035(5) provides, In pertinent part, "Notwithstanding sections (1) through (4) of this rule, OAR 436-035-0007 requires the attending physician's concurrence or comments when the attending physician arranges, or refers the worker for, a closing examination with another physician to determine the extent of impairment, or when the insurer refers a worker for an insurer medical examination. * * *"

the most objective findings, on sound medical principles, and clear and concise reasoning. OAR 436-030-0035(2); *Anselmo Enriquez, Jr.*, 51 Van Natta 304 (1999). Where there is no preponderance of medical opinion stating whether a worker is medically stationary, deference is generally given to the opinion of the attending physician. OAR 436-030-0035(3).

Although Dr. Young originally concurred with the finding of Drs. Gripekoven and Williams that claimant's carpal tunnel condition was medically stationary, three days later he stated instead that claimant was not medically stationary with regard to her left carpal tunnel condition. (Exs. 38, 40). Dr. Young's change of opinion was not unexplained, however. In the interim, between his two reports, Dr. Young examined claimant and performed multiple range of motion tests. (Ex. 39). Dr. Young based his new opinion that claimant's condition was not medically stationary on the specific objective finding of loss of range of motion in her left wrist, which he expected to improve with the therapy claimant was currently receiving. (Ex. 40). Under these circumstances, we find Dr. Young's opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (a physician's change in opinion, if adequately explained, can still be persuasive).

Finally, we acknowledge that the mere fact that claimant continues to seek treatment does not mean that she is not medically stationary. *See Maarefi v. SAIF*, 69 Or App 527 (1984); *Caroline S. Nordyke*, 52 Van Natta 61 (2000).

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. *Carolyn S. Nordyke*, 52 Van Natta at 62; *Lois Brimblecom*, 48 Van Natta 2312 (1996). Here, we find that Dr. Young's opinion establishes a reasonable expectation that claimant's carpal tunnel condition (specifically, range of motion in her left wrist) will improve with ongoing therapy. (Ex. 40). On this record, we agree that claimant's accepted condition is not medically stationary. The Notice of Closure was properly set aside as premature.

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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated April 6, 2000 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
RICHARD J. JAMES, Claimant
WCB Case No. 99-06602
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Scheminske, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

CIGNA Insurance Company[1] requests review of those portions of Administrative Law Judge (ALJ) Johnson's order that: (1) denied its motion to dismiss claimant's request for hearing; (2) set aside its denial of claimant's occupational disease claim for a bilateral wrist condition; (3) upheld AIG Insurance Company's denial of claimant's occupational disease claim for the same condition; and (4) awarded an assessed attorney fee. On review, the issues are claim preclusion, and potentially, responsibility and attorney fees.

[1] Now known as "ACE-USA."

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

The ALJ denied CIGNA's motion to dismiss claimant's request for hearing based on the alleged preclusive effect of its earlier denial of claimant's "withdrawn" claim for the same condition. (Ex. 6). On review, CIGNA contends that claimant's current claim is barred, because he never requested a hearing from that denial, which became final by operation of law. ORS 656.319(1). We disagree.

In *Troy M. Garner*, 48 Van Natta 1594 (1996), the claimant filed a hearing loss claim. The claimant subsequently withdrew that claim. The employer then issued a denial based on the claimant's claim withdrawal. The claimant did not file a request for hearing from that denial. 48 Van Natta at 1595. The claimant later filed a second claim for bilateral hearing loss, which the employer denied. When the claimant appealed that denial, the employer argued that the claimant's claim was precluded by the failure to contest the first denial.

In *Garner*, we held that the claimant was not barred from proceeding on his second hearing loss claim by the earlier unappealed denial. We reasoned that when the claimant withdrew his claim, there was no claim outstanding and, because the denial issued in the absence of a claim, it was void and without legal effect. *Id. See also William C. Becker*, 47 Van Natta 1933 (1995) (a denial issued in response to a withdrawn claim is a nullity and without legal effect).

CIGNA cites to *Sweeden v. City of Eugene*, 95 Or App 577 (1989), for the proposition that a denial that has become final by operation of law is not subject to challenge, regardless of the merits of the denial. We find *Sweeden* distinguishable because it did not involve a "withdrawn" claim. As we noted above, a denial issued in response to a withdrawn claim is null and void, and without legal effect. *William C. Becker*, 47 Van Natta at 1933; *Larry J. Bergquist*, 46 Van Natta 2397 (1994); *William F. Hamilton*, 41 Van Natta 2195 (1989).

Similarly, we find *Gonzalez v. Schrock Cabinet Co.*, 168 Or App 36 (2000), cited by CIGNA, distinguishable. In *Gonzalez*, the court held that an ALJ's order finding the claimant was entitled to vocational assistance was voidable and was valid until the Board dismissed the request for review for lack of jurisdiction, based on legislative changes which took effect during the pendency of the employer's request for review. *Id.* The employer analogizes to *Gonzalez* and argues that its denial of claimant's claim was valid unless and until the claimant requested a hearing to have it set aside. However, *Gonzalez* involved a "voidable" order issued by an ALJ, as opposed to a "null and void" denial, as here. *Id.* 42, 43. Because the ALJ's order in *Gonzalez* was merely "voidable," it was necessary for the employer to pursue an appeal of the order. In contrast, a null and void denial is invalid *ab initio*. *William C. Becker*, 47 Van Natta at 1933.

Responsibility

We agree with the ALJ's determination that CIGNA, having been assigned initial responsibility for claimant's carpal tunnel condition, did not prove that claimant's work for the employer while AIG was on the risk actually contributed to a worsening of his underlying condition. *See Boise Cascade Corp. v. Starbuck*, 296 Or 238, 243 (1984); *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992); *John W. Blankenship*, 52 Van Natta 406 n1 (2000). We adopt and affirm the ALJ's reasoning on this issue.

Attorney Fees

CIGNA contends that the $5,000 attorney fee awarded by the ALJ's order should be reduced. We disagree.[2] Initially, we note that the ALJ did not distinguish between attorney fees awarded for the compensability issue as opposed to the responsibility issue. Pursuant to ORS 656.308(2)(d), absent a finding of extraordinary circumstances, claimant is limited to $1,000 for prevailing over CIGNA's responsibility denial. *Brett S. Huston*, 51 Van Natta 1790 (1999). Because the ALJ did not apportion the award, we find that $1,000 of the award represents a reasonable fee for services at the hearings level devoted to the responsibility issue.

[2] We are authorized to review the amount of attorney fees awarded, notwithstanding CIGNA's failure to object to claimant's counsel's statement of services at hearing. (0&0 at 1). *Hays v. Tillamook County General Hospital*, 160 Or App 55 (1999).

Turning to the compensability portion of the award, under ORS 656.386(1), we find that $4,000 is a reasonable fee for claimant's attorney's services at hearing. In reaching this conclusion, we particularly rely on claimant's attorney's statement of services and the various factors in the administrative rule as detailed in the ALJ's order. *See* OAR 438-015-0010(4); *Schoch v. Leupold & Stevens*, 162 Or App 242 (1999).

Finally, CIGNA contends that AIG Insurance Company should be required to "share" a portion of the attorney fee payable under ORS 656.386(1). We disagree.

In *Safeway Stores v. Hayes*, 119 Or App 319, 323 (1993), the court held that an attorney fee under ORS 656.386(1) may be awarded against a non-responsible carrier only where the responsible carrier has denied responsibility only (because the *non-responsible* carrier, by also denying compensability, has placed the claimant's compensation at risk). *See also Terry J. Rasmussen*, 51 Van Natta 1287 (1999). Here, in light of CIGNA's "claim preclusion" arguments, we are persuaded that it contested not only its responsibility for the claim, but also the compensability of the claim. Accordingly, because claimant has prevailed over both of these contentions, we conclude that CIGNA is liable for claimant's attorney fee awards under both ORS 656.386(1) and ORS 656.308(2)(d).

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 CIGNA. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services regarding the responsibility and attorney fee issues. *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Douglas L. Wilson*, 51 Van Natta 1473 (1999).

ORDER

The ALJ's order dated June 2, 2000 is affirmed. For services on review, claimant's attorney is awarded $800, payable by CIGNA.

In the Matter of the Compensation of
VIKKI A. CUELLAR, Claimant
WCB Case No. 99-09215
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Edward J. Harri, Attorney

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

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that affirmed an Order on Reconsideration award of 17 percent (54.4 degrees) unscheduled permanent disability for claimant's cervical and left shoulder conditions. Claimant cross-requests review of that portion of the ALJ's order that reduced her 5 percent (9.6 degrees) scheduled permanent disability award for loss of use or function of her left arm, as awarded in an Order on Reconsideration, to zero. On review, the issues are extent of unscheduled permanent disability and scheduled permanent disability. We modify in part, reverse in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

We adopt and affirm that portion of the ALJ's order finding that Dr. Weller, the medical arbiter, provided the most thorough, complete and well-reasoned evaluation of claimant's impairment. We also

adopt and affirm that portion of the ALJ's order that found claimant had an impairment value of 3 percent for her reduced cervical range of motion. For the following reasons, however, we the ALJ's finding of 6 percent impairment for loss of shoulder strength.[1]

Dr. Weller found that claimant had some reduced strength in her shoulder. (Ex. 27-3, -4). She explained:

> "There was some weakness noted on manual muscle testing with 4/5 strength in external rotation of the left shoulder. However, there was pain associated and it was my impression that the weakness is not due to any muscle or nerve injury, but rather to associated pain." (Ex. 27-4).

The ALJ relied on anatomy texts to find that the infraspinatus and teres minor muscles affect rotation at the shoulder. The ALJ found that the intraspinatus muscle is innervated by the suprascapular nerve and the teres minor muscle is innervated by the axillary nerve. The ALJ concluded that claimant was entitled to 6 percent impairment for reduced left shoulder strength.

The insurer relies on *Anthony W. Abshire*, 52 Van Natta 204, *on recon* 52 Van Natta 635 (2000), to argue that claimant is not entitled to an award for reduced left shoulder strength.

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

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

OAR 436-035-0330(19) provides:

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

OAR 436-035-0007(19)(b) 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.

Here, although Dr. Weller found that claimant had 4/5 strength in external rotation of the left shoulder, she explained there was pain associated with that finding and it was her impression that the weakness was "*not* due to any muscle or nerve injury, but rather to associated pain." (Ex. 27-4; emphasis added).

We acknowledge that OAR 436-035-0320(3) provides that pain is considered in impairment values to the extent that it results in measurable impairment. The problem for claimant is that OAR 436-035-0330(17) refers to "[i]njuries to a unilateral specific named peripheral nerve" and OAR 436-035-0330(19) states that loss of strength should be valued "as if the nerve supplying (innervating) the weakened muscle was impaired." In other words, an award of impairment for loss of shoulder strength requires an injury to a nerve, or a weakened muscle. In this case, Dr. Weller expressly stated that she did not believe claimant's weakness was due to a muscle or nerve injury. Under these circumstances, we conclude that claimant is not entitled to an award for loss of shoulder strength. *See Anthony W. Abshire*, 52 Van Natta at 635 (record contained no information from which to conclude the claimant had strength loss attributable to either a nerve injury or a specific impaired muscle in the shoulder); *compare Victor M. Bardales*, 52 Van Natta 925 (2000) (physician specifically described the affected areas of loss of shoulder strength).

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[1] We also modify the ALJ's order to note that we would reach the same result no matter which party has the burden of proof.

In sum, we find that claimant has an impairment value of 3 percent for her cervical condition. The parties did not dispute the 8 percent total value that the Order on Reconsideration assigned to claimant's age, education and adaptability. Therefore, we conclude that claimant's impairment value of 3 percent and value for age, education and adaptability provide for an unscheduled permanent disability award of 11 percent. *See* OAR 436-035-0280.

Scheduled Permanent DisabiliLy

The Order on Reconsideration relied on Dr. Weller's opinion to find that claimant was entitled to a 5 percent scheduled permanent disability award for loss of use or function of the left arm. (Ex. 28). Relying on *Richard O. Burke*, 50 Van Natta 1177 (1998), the ALJ found that where, as here, a worker's limited ability to use an arm is due to symptoms in the shoulder as distinct from the arm, the worker is not entitled to a separate scheduled chronic condition value for the arm. The ALJ reasoned that claimant was significantly limited in the repetitive use of her left shoulder and although that limitation affected the use of her left arm for overhead activities, the pain symptoms causing the limitation were in her left shoulder rather than in her left arm. The ALJ eliminated claimant's scheduled permanent disability award.

Claimant cross-requests review of that portion of the ALJ's order, arguing that the 5 percent scheduled permanent disability award should be reinstated. She contends that *Burke* is distinguishable because Dr. Weller made findings related to her left arm.

In *Richard O. Burke*, 50 Van Natta at 1177, the claimant injured his left scapula and shoulder. The medical arbiter found that the claimant sustained a partial loss in ability to repetitively use his left shoulder. The arbiter also found that the claimant should not work at or above shoulder level and that he was permanently precluded from frequently reaching, pushing or pulling more than 30 pounds with his left upper extremity. We found that, although the claimant had established a permanent partial inability to repetitively use his left shoulder and restrictions on the use of his left upper extremity, the medical evidence did not identify any symptoms causing loss of function of the left arm, or a chronic condition of the left arm, as distinguished from the left shoulder. Under those circumstances,, we concluded that the claimant was not entitled to a separate scheduled permanent disability award for his left arm.

We reached a similar conclusion in *William L. Fischbach*, 48 Van Natta 1233 (1996). In that case, the medical arbiter did not report any arm symptoms flowing from the claimant's left shoulder injury. Rather, the arbiter explained that the claimant experienced snapping in the left shoulder with awkward motions and difficulty using his left arm overhead because of easy shoulder fatiguability. The arbiter did not identify any symptoms causing loss of function to the claimant's left arm. Under those circumstances, we concluded that the claimant was not entitled to a separate scheduled permanent disability award for a chronic condition of a scheduled member. *See also Kim S. Anderson*, 48 Van Natta 1876 (1996) (medical evidence failed to establish inability to repetitively use the claimant's arm, as distinguished from shoulder).

Under OAR 436-035-0010(5), a worker is entitled to a 5 percent scheduled chronic condition impairment value when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of specified body parts, including the forearm or the arm.

Here, claimant has an accepted left trapezius strain, left cervical strain and thoracic strain. (Exs. 10, 14, 25A). Dr. Weller reported that claimant had intermittent pain in the left posterior shoulder and shoulder blade area. (Ex. 27-1). During the examination, Dr. Weller found tenderness with palpation in the left upper trapezius and levator scapula. (Ex. 27-2). She noted that claimant had pain with sustained overhead hold of the left arm. (Ex. 27-3). Regarding claimant's residual functional capacity, Dr. Weller explained:

> "It is my impression that [claimant] would not have any restrictions in her ability to lift or carry objects due to her above noted work injuries. However, I would recommend against working with the left arm overhead in a sustained or repetitive fashion[.]" (*Id.*)

Later in the report, Dr. Weller recommended that claimant avoid frequent lifting above her shoulder or sustained work that would require her to work at or above the shoulder level. (Ex. 27-4).

Although Dr. Weller said that claimant had "pain with sustained overhead hold of the left arm" (Ex. 27-3), she did not explain the location of the pain. During the examination, Dr. Weller referred to tenderness in the shoulder area and did not report any symptoms with the left arm. She recommended restrictions for frequent lifting above the shoulder or sustained work at or above the shoulder level. Although Dr. Weller recommended against working with the left arm "overhead," she did not restrict the use of the left arm in general. We find that the medical evidence does not identify any symptoms causing loss of use or function of the left arm, or a chronic condition of the left arm, as distinguished from the left shoulder. *See Richard O. Burke*, 50 Van Natta at 1177; *William L. Fischbach*, 48 Van Natta at 1233. Under these circumstances, we agree with the ALJ that claimant was not entitled to a scheduled permanent disability award for loss of use or function of her left arm.

Attorney Fee

The ALJ awarded claimant's attorney a $1,875 attorney fee pursuant to ORS 656.382(2) for defending against the insurer's challenge to the unscheduled award for impairment for claimant's neck and left shoulder. On review, we have reduced claimant's unscheduled permanent disability award to 11 percent. Under these circumstances, claimant's attorney is not entitled to an attorney fee under ORS 656.382(2).

ORDER

The ALJ's order dated May 4, 2000 is modified in part, reversed in part, and affirmed in part. In lieu of the ALJ's award and the Order on Reconsideration award, claimant is awarded 11 percent (35.2 degrees) unscheduled permanent disability for her cervical condition. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

Board Member Phillips Polich, concurring in part and dissenting in part.

I agree with the majority that claimant is not entitled to a scheduled permanent disability award for loss of use or function of her left arm. I disagree, however, with the majority's conclusion that claimant's unscheduled permanent disability award should be reduced. Therefore, I dissent from that portion of the majority's opinion.

The ALJ properly affirmed the Order on Reconsideration award of 17 percent unscheduled permanent disability for the cervical and left shoulder conditions. The majority erroneously concludes that an award of impairment for loss of shoulder strength requires an injury to a nerve, or a weakened muscle. OAR 436-035-0330(19) provides that valid loss of strength to an unscheduled body part or area shall be valued "*as if* the nerve supplying (innervating) the weakened muscle was impaired." (Emphasis supplied). The rule's reference to "as if" does not require actual injury to the nerve. *See Gevers v. Roadrunner Construction*, 156 Or App 168, 172 (1998) (*former* OAR 436-35-350(5) did not require a showing of nerve damage for a loss of shoulder strength to be ratable). Rather, that term is merely descriptive of new impairment to be evaluated.

The ALJ correctly determined that Dr. Weller's finding that claimant had 4/5 strength in external rotation of the shoulder provided verifiable, objective, measurable impairment meeting the requirements of OAR 436-035-0320(3) and OAR 436-035-0330(19). The ALJ properly relied on medical texts to find that the infraspinatus muscle is innervated by the suprascapular nerve and the teres minor muscle is innervated by the axillary nerve. Claimant is entitled to a 17 percent unscheduled permanent disability award. The majority errs by concluding otherwise.

In the Matter of the Compensation of
GERALD W. HARTUNG, Claimant
WCB Case No. 00-01107
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Kekauoha's order that affirmed the Order on Reconsideration award of 15 percent (28.8 degrees) scheduled permanent disability for loss of use or function of the right arm. On review, the issue is extent of scheduled permanent disability.

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

The ALJ affirmed the Order on Reconsideration award based on the findings of the medical arbiter, Dr. Thomas. On review, the employer contends that Dr. Thomas' findings are less persuasive than those of Dr. Jones, with which claimant's attending physician concurred, because Dr. Thomas did not rely on a complete and accurate history. Specifically, the employer asserts that Dr. Thomas' report does not reveal that he reviewed claimant's medical records. (Ex. 24). We agree with the ALJ's decision to rely on Dr. Thomas' findings.

Medical findings of impairment must be made by claimant's attending physician at the time of claim closure, or the medical arbiter. ORS 656.245(2)(b)(B); ORS 656.268 (7); *Lopez v. Agripac, Inc.*, 154 Or App 149, 155 (1998). Impairment findings from non-attending physicians may be considered only if the findings are ratified by the attending physician at the time of claim closure. *Koitzsch v. Liberty Northwest Insurance Corp.*, 125 Or App 666 (1994); *Adam J. Delfel*, 50 Van Natta 1041 (1998).

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 438-035-0007(14); *Lorenzo K. Kimball*, 52 Van Natta 411 (2000). We rely on the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. *Kenneth W Matlack*, 46 Van Natta 1631 (1994).

Here, Dr. Thomas recited several key pieces of claimant's medical history in his medical arbiter report. (Ex. 24-1). Although the portion of Dr. Thomas' written report regarding claimant's history was not exhaustive, we are satisfied that Dr. Thomas reviewed claimant's medical records in conjunction with his examination in light of his reference to some of these reports.

Moreover, we agree with the ALJ that the medical arbiter's findings on impairment are more persuasive than those of Dr. Jones. In this regard, we note that the medical arbiter examination was completed five months after Dr. Jones' closing examination, and just 19 days before issuance of the Order on Reconsideration. (Exs. 13, 24, 25). Where the medical arbiter examination is substantially closer in time to the Order on Reconsideration, we have accorded the arbiter examination greater probative value on the issue of the claimant's permanent impairment. ORS 656.283(7) ("[e]valuation of the worker's disability by the Administrative Law Judge shall be as of the date of the issuance of the reconsideration order."); *Lorenzo K. Kimball*, 52 Van Natta at 413 (five month gap between closing examination (PCE) and medical arbiter examination found "significant"); *Kelly J. Zanni*, 50 Van Natta 1188 (1998).

Next, the employer contends that claimant's impairment is not related to the accepted injury, but instead to functional overlay and/or secondary gain, as described by Dr. Jones and Dr. Fuller, who also performed an examination at the request of the employer. We disagree.

First, we note that the medical arbiter letter from the Department specifically instructed Dr. Thomas to "describe any objective findings of impairment resulting from the accepted condition(s) * * * " (Ex. 23A). Furthermore, with regard to the "chronic condition" award, Dr. Thomas expressly stated that claimant "is significantly limited in the ability to repetitively use the [right] elbow due to diagnosed condition arising out of accepted condition." (Ex. 24A). Moreover, the validity of range of motion testing must be determined by the medical examiner performing the tests. *Tat Hueng*, 50 Van Natta 2205 (1998); *Teri S. Callahan*, 49 Van Natta 548, 549 (1997). Here, Dr. Thomas expressly stated that claimant's findings were valid and straightforward. (Ex. 24-2). Implicit in such an express statement is that Dr. Thomas did not consider claimant's impairment findings to be invalid or otherwise unreliable.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,700, payable by the self-insured employer. Idn reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and uncontested attorney fee request), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated April 28, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,700, payable by the self-insured employer.

In the Matter of the Compensation of
VIVIAN K. HEWITT, Claimant
WCB Case No. 99-08581
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
J. Keene, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration that awarded 5 percent (7.5 degrees) scheduled permanent disability bilaterally for loss of use or function of the left and right forearms, whereas a Notice of Closure awarded no permanent disability. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ order with the following supplementation. On review, the employer repeats its argument that the medical arbiter's report does not support a finding of impairment. We disagree.

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. That is the case here.

The medical arbiter stated that the "ongoing symptoms that [claimant] complains of do seem to have a mild component of de Quervain's tenosynovitis and some dorsal wrist symptoms." (Ex. 48-2). The medical arbiter felt that those symptoms may need separate evaluation and potential treatment, which he stated was unrelated to her accepted bilateral carpal tunnel syndrome claim. However, the only "ongoing symptoms" claimant complained of was some aching in her wrists. (Ex. 48-1). We agree with the ALJ that this was what the medical arbiter was referring to in the above quoted statement.

The medical arbiter clearly understood that the "accepted conditions" were limited to "bilateral carpal tunnel syndrome." (Ex. 48). He measured decreased ranges of motion in claimant's wrists and explicitly found that those "measurements" were "valid and consistent with the accepted conditions." (Ex. 48-2). Thus, the medical arbiter did not relate claimant's loss of range of motion to any other cause; instead, he found it consistent with the accepted bilateral carpal tunnel syndrome condition. Accordingly, we agree with the ALJ that claimant is entitled to arating for her loss of range of motion. *Danboise*, 147 Or App at 553.

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 $1,225, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 24, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,225, payable by the employer directly to claimant's attorney.

In the Matter of the Compensation of
LEE J. JOHNSON, Claimant
WCB Case No. 99-08305
ORDER ON REVIEW
Gayle A. Shields, Claimant Attorney
Cobb & Woodworth, Defense Attorneys
Robert G. Dolton, Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) directed it to pay claimant $13,548.03 as ordered by a June 17, 1999 Order on Reconsideration; and (2) assessed a 25 percent penalty against the insurer for its allegedly unreasonable failure to comply with the June 17, 1999 Order on Reconsideration. On review, the issues are claim processing and penalties.

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

Claimant has an accepted May 1, 1989 neck/right shoulder injury claim. The claim was closed on December 4, 1991 with an award of 57 percent (182.4 degrees) unscheduled permanent disability.

The carrier issued a denial of claimant's right shoulder condition in 1993. The denial was ultimately set aside after litigation and the claim was closed by a Notice of Closure on March 19, 1999. The Notice of Closure provided that the total unscheduled award to date was 69 percent equal to 220.8 degrees. Claimant requested reconsideration and a June 17, 1999 Order on Reconsideration increased claimant's award to 71 percent equal to 227.20 degrees. The "Order" section of the Order on Reconsideration provided, in relevant part:

> "The department orders that the worker is entitled to an increase in the award of permanent partial disability.
>
> "The total unscheduled award to date is 71 percent equal to 227.20 degrees.
>
> "The insurer is ordered to pay the worker $13,548.03. This amount is in addition to that awarded by the Notice of Closure dated Mar. 19, 1999."

Claimant filed a request for hearing regarding the Order on Reconsideration, but subsequently withdrew the request. The order has become final. The insurer calculated that it owed claimant $8,857.66.

Claimant requested a hearing seeking enforcement of the Order on Reconsideration. The ALJ found that the insurer was required to comply with the Order on Reconsideration's directive to pay claimant $13,548.03 in addition to the Notice of Closure award. In addition, the ALJ assessed a penalty against the insurer pursuant to ORS 656.262(11)(a).

On Board review, the insurer agrees that the total award to claimant is 71 percent (227.2 degrees), but argues that the Order on Reconsideration contains an error directing it to pay more than is owed. Specifically, the insurer argues that the Order on Reconsideration contains a direct contradiction in the order portion of the document because it "orders an award of 71% unscheduled PPD, a 2% increase ($2224.06) over the Notice of Closure, but orders payment of $13,548.03, more than the Notice of Closure award." (App. Br. at 2). On this basis, the insurer argues that the order is internally inconsistent and ambiguous and is therefore distinguishable from *Steven L. Walter*, 48 Van Natta 1532 (1996), the case relied upon by the ALJ.

In *Walter*, the carrier argued that its failure to pay an Order on Reconsideration award was not unreasonable because the Department's order was internally inconsistent and in error. We disagreed, noting that the order wag enforceable, even if it was wrong. We further noted that, considering the order's clear directive (to pay an award of $2,982.70 in addition to any previous award), no contextual inconsistency elsewhere in the order reasonably supported noncompliance. Based on this reasoning, we assessed a penalty against the carrier for failing to comply with the Order on Reconsideration.

The insurer argues that *Vega v. Express Services*, 144 Or App 602 (1996), *rev den* 325 Or 446 (1997), rather than *Walter*, controls. In *Vega*, the Workers' Compensation Division issued an Order on Reconsideration that awarded 14 percent equal to 21 degrees scheduled permanent disability and ordered the carrier to pay $6,405 in addition to any previous awards.

The claimant filed a request for hearing on the reconsideration order. On the same day, the carrier contacted the Department and requested clarification. The carrier paid an additional $3,202.50 pursuant to the order, but pointed out to the Department that while the order increased the award by seven percent, which would entitle the claimant to an additional $3,202.50, the order provided that the carrier was to pay the claimant an additional $6,405. The carrier was told that the Department would correct the order. The Department subsequently issued a corrected order.

After the hearing, the ALJ issued an order that set aside the Department's corrected order on the ground that the Department lacked authority to correct the order after a request for hearing had been filed. The ALJ also concluded that the claimant was substantively entitled only to a total award of 14 percent and that the Order on Reconsideration would be corrected to award only an additional $3,202.50. The ALJ also imposed a penalty on the carrier for unreasonably failing to pay the amount ordered by the reconsideration order. Both parties requested Board review of the ALJ's order and the Board affirmed.

The carrier appealed to the Court of Appeals. The court relied upon *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992), and held that the carrier was not obligated to pay the claimant the disputed $3,202.50. The court reasoned that:

> "Claimant does have a substantive right under ORS 656.214 to be compensated for his injury, but, in the absence of statutory authority providing otherwise, the right extends only to the actual amount of the award deemed appropriate for the degree of his injury. That statute does not provide a right either substantively or procedurally, to receive an award in excess of that provided by the statute. Nor does ORS 656.295, the statute under which claimant requested a hearing, provide a substantive right to payment regardless of the ultimate outcome of an administrative appeal. The Board's conclusion that the employer was not obligated to pay the overpayment was correct." 144 Or App at 607.

As the ALJ noted, the distinction between the present case and *Vega* is that the Order on Reconsideration at issue in this case has become final by operation of law. The order at issue in *Vega* was appealed and the ALJ had authority to correct the error in the award. The insurer's remedy in this case was either to bring the error to the Department's attention or to timely request a hearing so that the error could be corrected. Although the insurer argues that the order is ambiguous, the order language clearly states: "The insurer is ordered to pay the worker $13,548.03. This amount is in addition to that awarded by the Notice of Closure dated Mar. 19, 1999." Such language is not ambiguous and although the order was apparently wrong, it is a final order and we lack authority to alter it.

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).

The court in *Vega* found that a penalty was not warranted, because the evidence in the record did not support the Board's assumption that the employer knew that the claimant's request for a hearing preceded its request to the Department for a corrected order.

Here, unlike in *Vega*, the insurer had not taken any action to correct the order. Based on our reasoning in *Walter*, we agree with the ALJ's decision to assess a penalty against the insurer for a failure to comply with the Order on Reconsideration. The insurer's remedy was to appeal the order or bring the error to the Department's attention. By failing to take either of these actions, there is no legitimate doubt regarding its liability to pay the Order on Reconsideration 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 $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the claim processing issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's counsel is not entitled to an attorney fee for services on review concerning penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986), *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated February 15, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the insurer.

In the Matter of the Compensation of
JOHN L. MONTGOMERY, Claimant
WCB Case No. 99-03372
ORDER ON RECONSIDERATION
Walsh & Associates, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

On August 18, 2000, we abated our July 19, 2000 order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's medical services claim for a right knee meniscal tear. We took this action to consider claimant's motion for reconsideration. Having received SAIF's response we now proceed with our reconsideration.

As noted in our previous order, claimant sustained an August 1994 compensable low back injury that SAIF accepted as a lumbar strain/sprain. Claimant was treated for low back and ongoing right leg symptoms and, in September 1995, low back surgery was performed. In February 1996, claimant was diagnosed with osteoarthritis in the right hip. The claim was closed in April 1996, with an award of 34 percent unscheduled permanent disability.

In mid-1996, claimant was examined for ongoing back and right leg pain, and, in August 1996, SAIF denied compensability of claimant's current low back and right hip condition. In January 1997, the parties entered into a CDA concerning claimant's August 1994 claim, in which claimant released his rights to compensation arising out of the claim, except for medical services.

In March 1998, claimant was diagnosed with a torn medial meniscus in the right knee and authorization for surgery was requested. In December 1998, claimant's attorney requested that SAIF amend its acceptance of the 1994 claim to include the torn right medial meniscus. SAIF denied the claim.

The ALJ concluded that claimant was barred from establishing the compensability of the right medial meniscus tear by the August 1996 CDA and upheld SAIF's denial without addressing the merits of the claim.

In our prior order, we concluded that claimant was not barred from arguing that his condition was compensably related to the 1994 claim in order to establish a right to future medical services for that condition. But, on the merits, we concluded that claimant's tom right medial meniscus was not compensable. We determined that the contemporaneous medical records contained no reports of claimant having a right knee injury, bruising or swelling. Instead, contemporaneous medical reports involved radiating pain in the back and side of claimant's right leg that claimant's physicians related to the low back injury and which improved as a result of the surgery.

Claimant made no right knee complaints until January 1995; right knee arthritis was noted during a July 1995 examination. Claimant did not seek treatment for his right knee until 1998, when, for the first time, he attributed his right knee complaints to the August 1994 injury. We concluded that the contemporaneous medical reports were more persuasive in establishing causation than the 1998 medical report that relied on claimant's belated report of a severe right knee injury in 1994. Consequently, we found that claimant failed tc prove compensability of his right knee condition.

Claimant requests that we remand the case to the ALJ for a determination of claimant's credibility. Specifically, claimant contends that, because the ALJ did not reach the merits of the compensability issue, he did not make a credibility finding. For the following reasons, we deny claimant's request.

We may remand a case to the ALJ if we determine that the case has been improperly, incompletely, or insufficiently developed. ORS 656.295(5). However, our review is de *novo* and, although we generally defer to the ALJ's demeanor-based credibility finding, we are equally qualified to make our own determination of credibility based on the substance of a witness' testimony. *Erck v. Brown Oldsmobile*, 311 Or 519, 528 (1991); *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

As explained above, after our *de novo* review of the record, we concluded that claimant failed to prove compensability because there is an absence of persuasive medical evidence establishing causation. Therefore, whether or not claimant was a credible witness, he did not carry his burden of proof. Consequently, we find no compelling reason to remand to the ALJ to determine credibility. *See* ORS 656.295(5); *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986) (in order to warrant remand, there must be a compelling reason established for doing so, including a reasonable likelihood that the evidence souglit to be admitted on remand will affect the outcome of the hearing); *Samantha L. Spencer*, 49 Van Natta 280 (1997) (same).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 19, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Phillips Polich dissenting in part.

For reasons expressed in my previous opinion dissenting from the majority's decision that claimant failed to prove compensability of his right knee injury, I continue to dissent.

In the Matter of the Compensation of
DAVE R. OUZOUNIAN, Claimant
WCB Case No. 99-09951
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that awarded 18 percent (51.6 degrees) unscheduled permanent disability for a respiratory injury, whereas an Order on Reconsideration awarded no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disabil'

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

On April 23, 1997, claimant was exposed to chlorine gas at work. There is no dispute that this exposure injured claimant's lungs/respiratory system. The dispute is whether this injury resulted in any ratable unscheduled permanent disability under the standards.

By the time claimant had become medically stationary, he had returned to his at-injury job. The employer argues that, because claimant returned to his at-injury job, he failed to prove any loss of earning capacity and, thus, was not entitled to an award of unscheduled permanent disability. We disagree.

The statutory provisions regarding the rating of unscheduled permanent disability directly oppose the employer's argument. In this regard, ORS 656.214(5) provides, in relevant part: (1) the criteria for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury; and (2) earning capacity is to be calculated using the standards specified in ORS 656.726(4)(f).

ORS 656.726(4)(f) provides, in part, that the criteria for evaluating disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job. ORS 656.726(4)(f)(A). Nevertheless, pursuant to ORS 656.726(4)(f)(D)(i), where, as here, a worker returns to regular work at the at-injury job, impairment is the only factor considered in rating disability under ORS 656.214(5). Thus, by statute, claimant is entitled to a rating under the standards for any impairment due to the work injury.

The employer also argues that claimant failed to prove any impairment under the relevant rules. For the reasons explained by the ALJ, we disagree. In addition, we add the following reasoning.

The standards regarding rating of impairment to the respiratory system are found at OAR 436-035-0385. *See* WCD Admin. Order 98-055 (eff. 7/1/98). In addition, OAR 436-035-0007(7) provides:

> "Except as otherwise required by these rules, methods used by the examiner for making findings of impairment shall be the methods described in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev. 1990,** and shall be reported by the physician in the form and format required by these rules." (Emphasis in original).

OAR 436-035-0385(2) provides that lung impairment shall be determined according to four classes. The parties dispute whether claimant's lung impairment comes within Class 1, which results in no impairment, or Class 2, which results in 18 percent impairment. OAR 436-035-0385(2) defines "Class 1" as: "FVC greater than or equal to 80% of predicted, *and* FEV1 greater than or equal to 80% of predicted, *and* FEV1/FVC greater than or equal to 70%, *and* Dco greater than or equal to 80% of predicted; *or* VO2 Max greater than 25 ml/(kg x min)."[1] (Emphasis added). OAR 436-035-0385(2) defines "Class 2" as: "FVC between 60% and 79% of predicted, *or* FEV1 between 60% and 79% of predicted, *or* FEV1/FVC between 60% and 69%, *or* Dco between 60% and 79% of predicted, *or* VO2 Max greater than or equal to 20 ml/(kg x min) and less than or equal to 25 ml/(kg x min)." (Emphasis added).

The employer argues that reports from the medical arbiter, Dr. Keppel, M.D., support a finding that claimant comes within "Class 1". We disagree.

First, we agree with the ALJ's reasoning and conclusion that claimant's VO2 Max is 20.6, the measurement taken at his "anaerobic threshold," during claimant's August 7, 1998 pulmonary function tests performed by Dr. Schaumberg. (Ex. 5A). Dr. Schaumberg also measured claimant's FEVI/FVC ratio at 68 percent. (Ex. 5A-2).

Dr. Keppel relied on Dr. Schaumberg's pulmonary function tests in reaching his conclusions. (Ex. 10). In addition, Dr. Keppel measured claimant's FVC at 5.27 on the first measurement, and 4.68, 4.65, and 4.63 on the next three measurements, a pattern seen where one gets some bronchospasm with the first deep breath. (Ex. 8-2). Dr. Keppel measured claimant's FEV1 as 3.60 on the best effort, which was 83 percent of predicted, similar to claimant's previous tests. (*Id.*). Dr. Keppel did not calculate the FEV1/FVC ratio, nor did he measure claimant's VO2 Max. (Exs. 8, 9, 10).

Dr. Keppel concluded that, although claimant's exposure to irritants left him with some airway irritability, claimant remained in "Class 1." (Ex. 10). In reaching this conclusion, Dr. Keppel relied on the FEV1 and FVC measurements, noting that both were greater than 80 percent of predicted. (Exs. 9-2, 10). The employer argues that FEV1 and FVC values of 80 percent of predicted would necessarily result in a FEV1/FVC ratio greater than 80 percent, which would put claimant in Class 1. We disagree.

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[1] OAR 436-035-0385(1)(a) through (d) provide the following definitions: FVC is Forced Vital Capacity, FEV1 is Forced Expiratory Volume in the first second, Dco refers to diffusing capacity of carbon monoxide, and VO2 Max is Measured Exercise Capacity.

The rules do not provide any exception to using the *AMA Guides* regarding the method of making findings of respiratory impairment; therefore, we use the methodology provided by the *AAM Guides*. OAR 436-035-0007(7). The *AMA Guides* establish that FEV1 and FVC are ineasured in liters, and provide charts showing the predicted "normal" values for men and women. *See AMA Guides*, pages 118, 120. This is the way Drs. Schaumberg and Keppel measured claimant's FEV1 and FVC. (Exs. 5A, 8-2). The *AMA Guides* also provide that the person's FVC and FEV1 results are compared to these predicted "normal" values. *See AMA Guides*, page 120. It is this comparison that Dr. Keppel was making when he stated claimant's FEV1 and FVC measurements were greater than 80 percent of "predicted." However, these comparisons (ratios) of the worker's performance to predicted "normal" performances in FVC and FEV1 tests are not used to calculate the FEV1/FVC ratio. Instead, the actual FEV1 and FVC measurements are used to calculate the FEV1/FVC ratio. *See AMA Guides*, pages 123-25. Using this methodology, we calculate claimant's FEV1/FVC ratio as 68 percent using Dr. Keppel's measurements for those values. [3.6 (FEV1) divided by 5.27[2] (FVC) =.68]. Thus, both Drs. Keppel's and Schaumberg's measurements result in a FEV1/FVC ratio of 68 percent. If the FEV1/FVC ratio is less than 70 percent, Class 1 does not apply; Class 2 applies instead. OAR 436-035-0385(2). Accordingly, we agree with the ALJ that claimant has Class 2 lung impairment, which entitles him to 18 percent unscheduled permanent disability.

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

ORDER

The ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid directly to claimant's attorney by the employer.

[2] The spirogram indicating the best effort should be used to calculate the FVC and FEV1. *AMA Guides*, page 120.

In the Matter of the Compensation of
DONNA M. RUSSELL, Claimant
WCB Case No. 99-05129
ORDER ON REVIEW
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed her request for hearing as untimely.[1] On review, the issue is propriety of the dismissal order.

We adopt and affirm the ALJ's order with the following change and supplementation. In the last paragraph on page 1, we change the second sentence to read: "She prepared a request for hearing regarding the employer's denial on June 24, 1999, which was received on June 28, 1999."

Claimant signed an "801 " form on January 25, 1999 regarding an injury that day when she fell on ice in the parking lot. (Ex. 60). On January 28, 1999, the employer wrote to claimant and told her they were deferring acceptance or denial of her claim until it received the necessary medical information and completed an investigation. (Ex. 68-3). On March 1, 1999, the employer wrote to claimant, stating it had no indication that she had received medical services regarding her January 25, 1999 injury. (Ex. 68-4). The employer asked claimant to advise them of the name of her attending physician. (*Id.*) On April 14, 1999, the employer denied the claim on the basis that it had not received medical documentation to support the claim. (Exs. 61, 68-5).

[1] We note that claimant was represented at hearing.

Claimant's request for hearing of the employer's April 14, 1999 denial was filed more than 60 days, but less than 180 days after the employer's denial. A request for a hearing must be filed not later than the 60th day after the mailing of the denial to the claimant. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if the claimant establishes good cause for the late filing. ORS 656.319(1)(b). Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). "Good cause" means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B(1). *Hempel v. SAIF*, 100 Or App 68, 70 (1990).

On review, claimant asserts that she failed to request a hearing within 60 days of the employer's denial because she believed that the employer had received the necessary medical documentation and that would take care of the reason for the denial. Another reason she did not request a hearing within 60 days was because the employer's denial referred to an expedited hearing, which she did not believe was necessary. Claimant contends that she has shown diligence by attempting for several months to have the necessary medical records sent to the employer.

At hearing, claimant acknowledged receiving the March 1, 1999 letter from the employer regarding the lack of medical documentation. (Tr. 5). She called the person that wrote the letter and spoke to her. (*Id.*) She testified that when she went in to see Dr. Bert, she asked them to send the medical records to the employer. (Tr. 5-6). Claimant reasoned that, because the employer had apparently issued the denial because it had not received any medical records, and she had asked Dr. Bert's office to send such records to the employer, that would take care of the denial. (Tr. 7).

The record indicates that Dr. Bert formally evaluated claimant's left knee on June 2, 1999. (Ex. 63). Dr. Bert said that claimant had fallen on the ice on January 25, 1999 and he noted that she had "chatted with me in the hospital and we decided to wait this out to see if it would settle down." (*Id.*) Claimant was next examined by Dr. Bert on June 23, 1999 for a follow-up visit. (Ex. 65).

Claimant testified that when she went to visit Dr. Bert on June 23, 1999, she found out that his office had mistakenly sent her medical records to another insurance company, rather than the employer. (Tr. 6). Claimant prepared a letter requesting a hearing on the following day, which was postmarked on June 25, 1999.

In previous cases, we have held that a claimant's misunderstanding of a carrier's claim processing actions generally does not establish "good cause" in the absence of evidence that the claimant was misled by the carrier. *See, e.g., John Wiseman*, 52 Van Natta 1666 (2000) (the claimant's contention that the partial denial was confusing did not meet his burden of proving "good cause"); *Vickie Hillard*, 51 Van Natta 1994 (1999) (the claimant's mistaken belief that her claim had been accepted, based on the scheduling of a second independent medical examination, did not constitute "good cause"); *Edward J Andrews*, 51 Van Natta 226, *recon* 51 Van Natta 377 (1999) (the claimant's mistaken belief that the carrier would rescind its denial and accept his claim once he attended an independent medical examination did not constitute "good cause").

Here, we agree with the ALJ that it was necessary for claimant to timely file a request for hearing concerning the employer's denial in order to keep her claim viable. Claimant was under the mistaken impression that Dr. Bert's forwarding medical records to the employer would take care of her claim and she did not have to file a request for hearing of the denial. Even if the employer had received the necessary documentation in a timely manner, however, that would not nullify or somehow eradicate the denial. We agree with the ALJ that claimant's failure t1h seek legal advice earlier did not constitute the type of diligence required to establish "good cause." We find no evidence that the employer misled claimant. We conclude that claimant has not demonstrated "good cause" for her failure to request a hearing within sixty days after the employer's denial. *See* ORS 656.319(1)(b). The employer's denial is final as a matter of law.

ORDER

The ALJ's order dated June 8, 2000 is affirmed.

In the Matter of the Compensation of
HERIBERTO SILVA, Claimant
WCB Case No. 99-039
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) awarded a $6,500 attorney fee. Claimant cross-requests review, requesting an increased attorney fee award. On review the issues are aggravation and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. At the end of the second paragraph of the findings of fact on page 2, we add the following sentence: "The insurer accepted a disabling lumbosacral strain. (Ex. 3)." In the first paragraph on page 3, we change the fourth sentence to read: "An October 26, 1995 lumbar MRI did not show any significant interval changes from the July 1994 MRI. (Ex. 12)."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on November 8, 1993, while he was lifting a casting. (Exs. 1, 2). The insurer accepted a disabling lumbosacral strain. (Ex. 3).

On July 11, 1994, Dr. Laycoe performed a closing examination. He reported that claimant had continued pain in the right thigh and calf. (Ex. 4-1). He noted that claimant's neurological exam "continues to show an absent right ankle reflex[.]" (*Id.*) Dr. Laycoe found reduced lumbar range of motion, and reported that the sensory exam was decreased in the S1 distribution of the right leg. (*Id.*) He explained:

> "Because of the continuation of neurological symptoms in the right leg, a followup MRI scan was performed 7/6/94. The scan did not show any significant changes from the previous exam. The principle finding was a degenerative signal change at L5-S1 with some diffuse bulging but no definite neural impingement. There was some degenerative change in the facet at L5-S1." (Ex. 4-2).

Claimant's diagnosed condition was a "low back strain with radiculitis in the right leg with residuals." (*Id.*) Dr. Laycoe released claimant to his regular job, but said that his physical capacities required some modifications. (*Id.*) He noted that claimant's symptoms had remained constant without any waxing and waning and he did not anticipate that claimant would require future medical treatment. (Ex. 4-3).

An August 8, 1994 Determination Order awarded 18 percent unscheduled permanent disability, based on reduced lumbar range of motion. (Ex. 5).

On February 27, 1995, claimant sought treatment from Dr. Laycoe for back and right leg pain. (Ex. 9). Dr. Laycoe reported that claimant's "objective findings continue to be identical to those previously seen, that being zero to trace ankle reflex on the right." (*Id.*) He concluded that claimant's condition remained the same and he presented with chronic pain syndrome. (*Id.*) He noted that claimant had a workup for sciatica in the past without finding a documentable source or surgical entity. (*Id.*)

In September 1995, Dr. Laycoe again treated claimant for low back pain and sciatica. (Ex. 11). Claimant's right ankle reflex was "1+." (*Id.*) An October 1995 lumbar MRI did not show any significant changes from the previous MRI. (Ex. 12). Dr. Laycoe did not recommend any additional treatment. (Exs. 13, 14). On November 21, 1995, claimant had a trace right ankle reflex. (Ex. 14).

Claimant returned to Dr. Laycoe in October 1996, complaining of low back and right leg pain. (Ex. 15). Dr. Laycoe reported that claimant's right ankle reflex was absent. (*Id.*) Claimant was treated with physical therapy and he was on light duty for two weeks. (Exs. 16, 17, 18).

Claimant has filed two aggravation claims. Dr. Laycoe signed an aggravation claim form on January 19, 1999, but did not authorize time loss. (Ex. 21). Dr. Laycoe had examined claimant on January 14, 1999 and reported that he continued to have the same symptoms in the right low back and right leg, but it had been worse in the last three months. (Ex. 20). He said that claimant walked with a limp and had decreased mobility in his back. (*Id.*) He noted that claimant's right ankle reflex was absent. (*Id.*) Dr. Laycoe explained that claimant had continued sciatic and low back pain secondary to the 1993 injury. (*Id.*) He recommended EMG studies and another MRI. (*Id.*)

On March 4, 1999, Dr. Laycoe reported that the MRI did not show any new lesions. (Ex. 26). He diagnosed chronic sciatica in the right leg, but he did not recommend surgery. (*Id.*)

On April 13, 1999, the insurer denied claimant's first aggravation claim on the basis that the medical evidence failed to establish that the accepted lumbosacral strain had compensably worsened. (Ex. 27).

Claimant began treating with Dr. Fisher on May 13, 1999. (Ex. 28). He initially diagnosed back pain and degenerative disc disease. (*Id.*) He recommended physical therapy and referred claimant to a neurosurgeon. (Exs. 28, 30). Dr. Markham examined claimant and recommended a lumbar myelogram. (Ex. 33). The myelogram did not show a right-sided lesion. (Exs. 41, 42).

On June 2, 1999, Dr. Fisher signed an aggravation form. (Ex. 36). He authorized time loss and described claimant's limitations as no lifting or walking. (*Id.*)

On October 18, 1999, the insurer denied claimant's second aggravation claim, again asserting that the medical evidence failed to establish that the accepted lumbosacral strain had worsened. (Ex. 71). Claimant requested a hearing on both denials.

The ALJ relied on Dr. Fisher's opinion and found that claimant had established an actual worsening of the compensable condition since the last arrangement of compensation. The ALJ also found that the worsening was more than the waxing and waning symptoms of the condition contemplated by the previous permanent disability award.

The insurer argues that the medical evidence is not sufficient to establish an actual worsening of claimant's accepted lumbosacral strain. Among other things, the insurer contends that, although Dr. Fisher said that the cause of claimant's allegedly worsened condition was degenerative disc disease, arthritis and nerve compression, claimant has not filed a claim for those conditions.

Claimant relies on Dr. Fisher's opinion to establish his aggravation claim. He contends that, although Dr. Fisher used diagnoses and nomenclature different than that of the accepted claim, that does not mean that the treatment was not with reference to the accepted injury. Claimant contends that his radicular symptoms have been present since the beginning of the claim and, therefore, Dr. Fisher is referring to the same right leg radiculopathy that has been present since the initial injury.

To begin, we clarify the issues litigated at hearing. At the beginning of the hearing, the insurer's attorney asked the ALJ to focus on the fact that the accepted condition was a lumbosacral strain. (Tr. 5). The insurer's attorney noted that a number of other conditions were mentioned in the medical record. (*Id.*) The insurer's attorney said that the parties had discussed the scope of the acceptance and whether other conditions might be claimed, but the decision was made to make claims for no other conditions and to proceed on an aggravation theory only. (*Id.*) Claimant's attorney commented that claimant was not waiving any rights with respect to an additional claim. (*Id.*)

Based on the parties' discussion at the beginning of the hearing, we find that the parties litigated only an aggravation claim, not a new injury claim. *Compare Angela L. Gates*, 52 Van Natta 1037 (2000) (although the medical evidence was not sufficient to establish an aggravation, the claimant did establish compensability of a new injury). We do not address compensability of any other conditions.

ORS 656.273(1) provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings."

In *SAIF v. Walker*, 330 Or 102 (2000), the Supreme Court examined the legal standard for an aggravation. The court held that:

> "[E]vidence of worsened symptoms, while relevant, is not sufficient by itself to meet the proof standard created by ORS 656.273(1) (1995). However, * * * a physician may rely upon that kind of evidence in determining whether the compensable condition has worsened and in opining on that question to the factfinder or to the Board. In other words, the 'medical evidence * * * supported by objective findings'that is required under ORS 656.273(1) (1995) and (3) to prove an 'actual worsening of the compensable condition' may include a physician's written report commenting that the worker's worsened symptoms demonstrate the existence of a worsened condition." *Id.* at 118.

In *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995), we held that ORS 656.273(1) requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening," and (2) a compensable condition. Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury." *Id.* If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7). *Id.*

Here, the insurer accepted a lumbosacral strain. (Ex. 3). Thus, to prove an aggravation, claimant must establish an actual worsening of the lumbosacral strain supported by objective findings.

Dr. Laycoe treated claimant after the November 1993 injury and was his attending physician until May 13, 1999, when claimant began treating with Dr. Fisher. Dr. Laycoe signed an aggravation form in January 1999. (Ex. 21). On February 18, 1999, Dr. Laycoe said that claimant's diagnosis was "lumbosacral sprain/strain with chronic low back pain and right leg pain." (Ex. 22). Although Dr. Laycoe diagnosed claimant with a lumbosacral sprain/strain, he could not find any objective evidence of worsening. (*Id.*) He said that claimant possibly had a waxing and waning of symptoms. (*Id.*) In a later report, Dr. Laycoe explained that a recent MRI did not show any new lesions. (Ex. 26). Dr. Laycoe's opinion is not sufficient to establish that claimant had an actual worsening of the compensable lumbosacral strain.

Claimant relies on Dr. Fisher's opinion to establish an aggravation. However, we find no evidence that Dr. Fisher has diagnosed claimant's current back condition as a lumbosacral strain. Instead, Dr. Fisher has diagnosed claimant's current back condition as degenerative disc disease (Exs. 28, 29, 34, 37, 44-2), neuritic pain (Ex. 44-1), lower motor neuron lesion -- disc (Ex. 47), low back pain with spasm -- sacral nerve impingement syndrome (Ex. 55), "DJD" (Ex. 58), sacral nerve impingement syndrome (Exs. 64-2, 72-2), "HNP * * * nerve compression" (Ex. 78A), nerve compression syndrome (Ex. 80), and sciatic nerve compression syndrome (Ex. 82). In a post-hearing deposition, Dr. Fisher said that his current diagnosis of claimant's low back condition was "degenerative disk disease -- arthritis in the low back -- and he has nerve compression[.]" (Ex. 84-8 -17). He explained that the x-rays showed arthritis and "fairly significant" degenerative changes. (Ex. 84-8).

Dr. Fisher did not indicate that claimant's current low back condition was a lumbosacral strain or a worsening of a lumbosacral strain. Therefore, his opinion is not sufficient to establish that claimant had an actual worsening of the compensable lumbosacral strain. *See, e.g., Roland A. Walker*, 52 Van Natta 1018 (2000) (although a medical opinion indicated that the claimant's degenerative condition at L5-S1 had worsened, that did not establish an "actual worsening" of the compensable L5-S1 disc herniation). We find no medical opinion supporting claimant's assertion that Dr. Fisher's diagnoses are merely different nomenclature from the accepted claim.

In addition, we note that Dr. Fisher had an inaccurate understanding of claimant's previously accepted condition. In a deposition, Dr. Fisher said that he understood that claimant's nerve compression was an accepted condition in 1993. (Ex. 84-12). Because Dr. Fisher's understanding was inaccurate, we do not find his opinion persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473,

476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive). Furthermore, Dr. Fisher testified that it generally takes two to six weeks for a soft tissue injury in the back to heal. (Ex. 84-17). His opinion does not support a conclusion that claimant continues to have a lumbosacral strain. We conclude that the medical evidence is not sufficient to establish an "actual worsening" of the compensable lumbosacral strain.[1]

ORDER

The ALJ's order dated June 2, 2000 is reversed. The insurer's denial of claimant's aggravation claim is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] Because the parties agreed to litigate only an aggravation claim, we do not address compensability of any other conditions. In light of our conclusion that claimant has not established an "actual worsening," we need not address the insurer's argument that the ALJ awarded an excessive attorney fee. Likewise, it is not necessary to address claimant's contention that the attorney fee should be increased.

In the Matter of the Compensation of
CHARLOTTE L. VALDIVIA, Claimant
Own Motion No. 00-0234M
OWN MOTION ORDER
Swanson, Thomas & Coon, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her 1986 claim. Claimant's aggravation rights expired on April 15, 1991. SAIF opposes authorization for temporary disability compensation, contending that claimant has withdrawn from the work force.

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

On December 20, 1999, Dr. Woll, claimant's attending physician, requested surgery authorization for the left foot. On this record, 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." *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 "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction, is the date she enters the hospital for the proposed surgery and/or inpatient hospitalization.[1] *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 December 20, 1999, when her condition worsened requiring that surgery. *See generally Wausau Ins. v. Morris*, 103 Or App 270, 273 (1990); *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability compensation at the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

SAIF contends that claimant has not returned to work following a September 8, 1999 claim closure.[2] Claimant contends that, although she was not working at the time of her current worsening, she was willing to work and was seeking work within her limitations. Claimant submitted a January 27, 2000 affidavit and September 1, 2000 affidavit in support of her contentions.

In her January 2000 affidavit, claimant contends that the 1997 reopening was for a worsening to her *right* foot. She explains that when her claim was closed in September 1999, her doctor had indicated to her that she was going to require surgery to her *left* foot and that such surgery was eminent. Accordingly, she did not seek work from September 9 through December 2, 1999 expecting to undergo surgery "any day now." When authorization for the requested surgery on her *left* foot was not forthcoming, claimant outlined an extensive job search beginning December 2, 1999.

Claimant also attested that she had been willing to work since her September 1999 release and would have sought work, but she "thought the treatment for [her] compensable injury (the upcoming surgery) made ajob search futile." In her September 1, 2000 affidavit, claimant attests that: "I was willing to work, and had I known it would take SAIF from Sept. 15 to Dec. 10 to authorize my request for surgery, and that they would then deny disability payments during the recovery period, I would have begun seeking work on Sept. 16th of 1999." Based on claimant's affidavits, we find that she was willing to seek employment.

However, in order to prove that she is a member of the work force, claimant must also satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Based on the following, we find that, at the time of her disability, claimant was willing to work and seeking work.

As noted above, the relevant time period to determine whether claimant was in the work force is at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). On this record, claimant's condition worsened requiring surgery on her left foot on December 20, 1999, which is the date of disability.[3]

In order to satisfy the second *Dawkins* criterion, claimant must show that, although she is not working, she is willing to work and was seeking work. Claimant's two affidavits outline her work history and work search. Claimant attested that she began to look for employment on December 2, 1999. In her January 27, 2000 affidavit, she lists, in detail, several of the places of employment where she sought work between December 2, 1999 and January 27, 2000. In her September 1, 2000 affidavit, she attests that she has been employed since March 2000. Claimant's assertions are unchallenged.

Based on claimant's unrebutted affidavits, we find that she has demonstrated her willingness to work. Additionally, claimant's statements demonstrate that she has made a reasonable effort to seek work. Thus, based on this record, we conclude that claimant has established that she was willing to work and was making a reasonable effort to find work at the time of her current worsening.

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

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

[3] Although claimant attested in her affidavits that surgery for her left foot was pending at the time SAIF closed her claim in September 1999, the medical documentation contained in the record demonstrate that surgery for her left foot was first requested on December 20, 1999.

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
MARSHA E. WESTENBERG, Claimant
WCB Case No. 00-00195
ORDER DENYING RECONSIDERATION
Hoffman, Hart & Wagner, Defense Attorneys

On July 28, 2000, we affirmed the Administrative Law Judge's (ALJ's) March 31, 2000 order that dismissed claimant's request for hearing based on her failure to appear at hearing. On August 27, 2000, claimant, *pro se*, filed a petition for judicial review of our decision. On September 5, 2000, the Board submitted the appellate record to the court.

Claimant wrote the Board on September 12, 2000, alleging that "at least 167 missing multiple page attachments" were absent from the appellate record.[1] In a September 15, 2000 response to claimant's letter from the Board's staff counsel, claimant was advised that the proposed exhibits were not included in the appellate record because they had not been admitted into evidence because the hearing was never held. If the court decided that the unadmitted exhibits should be produced, the Board's staff counsel responded that the unadmitted, proposed exhibits would be forwarded to the court.

On September 20, 2000, the Board received a copy of claimant's September 19, 2000 letter to the court. In that letter, claimant noted that the appellate record did not contain a March 6, 2000 letter that she wrote to the ALJ concerning her request to "reset" the hearing before the ALJ, as well as a March 3, 2000 letter that the employer had apparently written to the ALJ regarding the hearing issues. Claimant requested that the court require the Board to produce the entire record upon which we based our order concerning the dismissal of her hearing request.

We treat claimant's September 19, 2000 letter as a request for reconsideration of our July 28, 2000 order. As previously noted, claimant has requested judicial review of our July 28, 2000 Order on Review. ORS 656.295(8). Furthermore, the 30-day period within which to withdraw and reconsider our order has expired. Thus, jurisdiction of this matter rests with the court. ORS 656.295(8); ORS 656.298(1); *Haskell Corporation v. Filippi*, 152 Or App 117 (1998); *SAIF v. Fisher*, 100 Or App 288 (1990). Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. *See* ORS 183.482(6); ORAP 4.35; *Glen D. Roles*, 43 Van Natta 278 (1991). This authority is rarely exercised. *See Carole A. VanLanen*, 45 Van Natta 178 (1993). For the following reasons, we deny claimant's motion for reconsideration.

At the outset, we note that the letters to which claimant refers are not contained in the record, although claimant has attached a copy of the March 6, 2000 letter to her September 19, 2000 letter. Therefore, claimant's September 19, 2000 letter is, in effect, a motion for remand for consideration of the March 6, 2000 letter.

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), *Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). We examine the proposed evidence only to determine if remand would be appropriate.

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[1] The self-insured employer's counsel has advised the Board that it does not have a copy of claimant's September 12 letter. We have included a copy of that letter with this order.

Prior to entering his order dismissing claimant's hearing request, the ALJ had written the parties on March 21, 2000 to address claimant's pre-hearing request for an order compelling discovery and a postponement of the hearing scheduled for March 31, 2000.

In that letter, the ALJ had noted that the case concerned an appeal of an Order on Reconsideration. Therefore, the ALJ observed that any evidence that was not contained in the Department's reconsideration record was not admissible at hearing under ORS 656.283(7). Thus, the ALJ stated that claimant's remedy for any alleged discovery violation was to obtain a certified copy of the reconsideration record and if, after obtaining the record, she discovered material that was not properly discovered, she could then seek the remedies listed in OAR 438-007-0015(8). Finally, observing that claimant had ample time to obtain the Department's certified reconsideration record to prove her case, the ALJ determined that there were no "extraordinary circumstances" to justify a postponement of the March 31, 2000 hearing. Accordingly, the ALJ advised claimant to be prepared to prove her case at the hearing that was limited to review of an Order on Reconsideration dated December 3, 1999.

By letter of March 28, 2000, claimant objected to the ALJ's ruling arm concluded by stating that she would not attend the scheduled hearing. When claimant did not attend the March 31, 2000 hearing, the ALJ dismissed the hearing request, finding no justification for claimant's failure to appear and no "extraordinary circumstances" to justify a postponement or a continuance.

The question now is whether we should remand to the ALJ to consider the March 6, 2000 letter that is not contained in the record and that was apparently not considered by the ALJ.[2] That letter indicates that claimant desired a postponement of the scheduled hearing because she was still seeking discovery from the employer and because the employer had not responded to her suggestion to pursue mediation. Moreover, claimant noted that she was involved in litigation before the Ninth Circuit Court of Appeals and, because briefs were due around the time of the scheduled hearing, her attention was directed to the briefing deadline.

Having considered claimant's letter, we do not find that it is likely to affect the outcome of the case. That is, we do not find that it justifies claimant's failure to appear at the hearing, nor does it contain information that would constitute "extraordinary circumstances" sufficient to justify a postponement or a continuance of the March 31, 2000 hearing. Specifically, the ALJ's "pre-hearing" March 21, 2000 letter adequately addressed claimant's concerns regarding discovery. Moreover, claimant's "pre-hearing" reference to the possibility of mediation does not excuse claimant's failure to appear at the scheduled hearing, nor does it justify a delay of the scheduled hearing. Finally, the fact that claimant was involved in litigation in another forum also does not excuse her failure to attend the hearing scheduled at her request or constitute extraordinary circumstances justifying a postponement or a continuance of that requested hearing. In this regard, claimant's "attention" to the Ninth Circuit's briefing schedule does not establish that there was a scheduled proceeding that conflicted with the March 31, 2000 hearing. *See* OAR 438-006-0081(3).

Accordingly, because the previously unconsidered correspondence is not likely to affect the outcome of the case, claimant's motion for remand and reconsideration is denied.[3] The issuance of this order neither "stays" our prior order nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986).

IT IS SO ORDERED.

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[2] The ALJ did not refer to this letter in his March 21, 2000 letter.

[3] Claimant did not provide a copy of the employer's March 3, 2000 letter. Inasmuch as that letter was submitted by the employer, it is doubtful that it contains information justifying *claimant's* failure to appear at the hearing. Moreover, claimant does not assert that the employer's letter supports her contentions that the ALJ improperly denied her postponement requests. Therefore, we conclude that consideration of this letter would also be unlikely to affect the outcome of the case, *i.e.* whether the ALJ properly dismissed claimant's hearing request.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

Cite as 330 Or 554 (2000) August 24, 2000

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Milan F. Shubert, Claimant.

MILAN F. SHUBERT, Petitioner on Review,
v.
BLUE CHIPS and SAIF CORPORATION, Respondents on Review.
(WCB 94-08858; CA A89283; SC S45040)

On review from the Court of Appeals.*
Argued and submitted March 5, 1999.
Meagan A. Flynn, Portland, argued the cause for petitioner on review. With her on the brief were Robert W. Pardington and Pozzi, Wilson, Atchison, LLP, Portland.
Julene M. Quinn, Salem, argued the cause and filed the brief for respondents on review.
Before Carson, Chief Justice, and Gillette, Van Hoomissen, and Durham, Justices.**
GILLETTE, J.
The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed and the case is remanded to the Workers' Compensation Board with instructions to remand the case to the Director of the Department of Consumer and Business Services for further proceedings.

*Judicial review from the Workers' Compensation Board. 151 Or App 710, 951 P2d 172 (1997).

**Kulongoski, Leeson, and Riggs, JJ., did not participate in the consideration or decision of this case.

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330 Or 556> In this workers' compensation case, claimant seeks review of a Court of Appeals decision affirming the denial of his claim for an additional award of permanent partial disability (PPD) for a shoulder condition. The denial was based on a temporary administrative rule that assigned a value of zero to any disability attributable to certain surgical procedures that claimant had undergone. Claimant asserts that the rule is inconsistent with ORS 656.726(4)(f)(C),[1] the statute under which it was adopted. The Court of Appeals held that claimant's argument was not well taken. *Shubert v. Blue Chips*, 151 Or App 710, 951 P2d 172 (1997). For the reasons that follow, we reverse the decision of the Court of Appeals.

The following facts are supported by substantial evidence in the record. *See* ORS 183.482(8)(c) (setting out "substantial evidence" standard). Claimant injured his shoulder in a 1987 industrial accident and received workers' compensation benefits, including a PPD award. Several years later, claimant underwent a procedure called a "Bristow" surgery to repair his shoulder. After that surgery, claimant's original PPD award was adjusted upward to 17 percent.

Claimant continued to have problems with his shoulder. Eventually, claimant's treating physician determined that those continuing problems were being caused by a screw that had been inserted in claimant's shoulder during the Bristow surgery. The doctor recommended additional surgery to remove the screw. Claimant followed that recommendation and simultaneously filed an aggravation claim, which was closed by a July 30, 1991, determination order. That order did not award claimant any additional PPD.

Claimant sought reconsideration of the determination order and, in particular, its failure to award additional PPD. Claimant argued that he never had been compensated for the residual impairment attributable to the Bristow and **<330 Or 556/557>** screw removal surgeries, and that the Director of the Department of Consumer and Business Services (the Director and the Department, respectively) should adopt a temporary rule evaluating that residual impairment under ORS 656.726(4)(f)(C).[2] That statute provides:

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[1] At the time that this case began, the statute was numbered ORS 656.726(3)(f)(C). In 1999, the legislature renumbered the statute. Or Laws 1999, ch 876, section 9. No change was made to the text. We use the present statutory citation for convenience.

[2] ORS 656.726(4)(f)(C) modifies and further defines the authority granted to the Director by ORS 656.726(4)(f) to "provide standards for disabilities."

> "When, upon reconsideration of a determination order or notice of closure * * * it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, * * * the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment."

Claimant enclosed a medical report by a Dr. Brenneke with his reconsideration request. The report assigned a residual impairment value of 10 percent to the two surgeries, without identifying or describing the nature of the impairment. Claimant also enclosed a letter from his treating physician concurring in Brenneke's report. However, without addressing claimant's request for a temporary rule, the Department affirmed its previous "no PPD" order.

A workers' compensation administrative law judge (ALJ) affirmed the Department's order, holding that a temporary rule was not required. However, on further review, the Workers' Compensation Board (Board) concluded that, under ORS 656.726(4)(f)(C), a temporary rule *was* required. Based on Brenneke's report, the Board stated in its opinion that "claimant ha[d] suffered permanent impairment as a result of the surgical repair of a compensable subluxing shoulder condition" and that the "surgical procedure and resulting impairment [had not] been addressed by the applicable standards." Accordingly, the Board remanded to the Director for the adoption of a temporary rule to address the residual effects of claimant's shoulder surgery.

On remand, the Director adopted a temporary rule that stated, in part:

> "This worker underwent Bristow repair and malleolar screw removal in the left shoulder. * * * Bristow repair of a **<330 Or 557/558>** dislocated shoulder improves the function of the shoulder and reduces the chance of dislocation. Removal of the screw fixation device does not result in recognized loss of shoulder function. In this case, the impairment value for these procedures shall be a value of zero."

Claimant challenged that temporary rule before the Hearings Division, arguing that, under ORS 656.726(4)(f)(C), the Director could not adopt a temporary rule that assigned an impairment value of zero to the effects of his surgeries. To do so, claimant argued, effectively would ignore what claimant believed already had been decided by the Board -- that the surgeries had resulted in impairment that must be "accommodated" under ORS 656.726(4)(f)(C). However, the ALJ and, later, the Board, held that it was for the Director to adopt disability standards under ORS 656.726(4)(f)(C) and that neither the Hearings Division nor the Board could "correct" the Director's actions in that regard. The Board held, moreover, that the temporary rule was not inconsistent with the statute:

> "Here, pursuant to our remand order, the Director found that claimant's left shoulder [surgeries were] not addressed by the standards. Our order did not determine whether or not claimant had a rat[e]able impairment as a result of the surgery, but merely determined that the surgical procedure was not addressed by the Director's 'standards' * * *.
>
> "As a result of our order, the Director promulgated a temporary rule * * * which addressed the surgery. Applying the temporary rule, the Director found that claimant was not entitled to an impairment value for the surgical procedure. This action was within the Director's authority pursuant to ORS 656.726([4])(f)(C)."

On claimant's petition for judicial review of the Board's decision, a divided Court of Appeals affirmed. The court's majority agreed with the Board that the Board had no authority to substitute its own views regarding disability standards for those of the Director. *Shubert*, 151 Or at 714-15. It also agreed that the Board had not found that claimant's surgery had resulted in permanent impairment and that the Director's rule, assigning the surgeries an **<330 Or 558/559>** impairment rating of zero, was not inconsistent with the findings that the Board had made. *Id.* at 715-16. We allowed claimant's petition for review.

Before this court, claimant argues, as he did below, that a "zero" impairment rating inherently is contrary to the policy expressed in ORS 656.726(4)(f)(C). Taking his cue from the Court of Appeals'

dissent, claimant focuses on the direction in ORS 656.726(4)(f)(C) that the existing rules be amended to "accommodate" the impairment at issue. Claimant explains that a zero impairment rule cannot be reconciled with the concept of accommodation, because such a rule essentially denies that any impairment or, at least, any impairment that also is a disability, exists.[3]

Claimant contends that the fact that the Director adopted a rule to address claimant's condition at all establishes that that condition is a disability and, therefore, a ratable impairment. That is so, claimant argues, because the Director is authorized to adopt a temporary rule only when the Director finds that the condition at issue is a disability, *i.e.*, an impairment that merits a disability award -- and, by inference, a positive impairment value -- that is not addressed by existing standards. Therefore, claimant concludes, a zero impairment rule is inherently inconsistent with ORS 656.726(4)(f)(C), because it denies the very fact under which the Director's authority to adopt a temporary rule under ORS 656.726(4)(f)(C) arose in the first place.

We are not persuaded by that logic. ORS 656.726(4)(f)(C) requires the Director to adopt a temporary rule when "it is found that a worker's disability is not addressed by [existing] standards." But "disability" cannot be "found" in the way that an ordinary fact would be found. Rather, disability is a legal conclusion that arises out of the medical fact of impairment in combination with pertinent legal criteria. *See Russell v. SAIF*, 281 Or 353, 357 n 4, <330 Or 559/560> 574 P2d 653 (1978) (law concerns disability that results from impairment, a medical concept); *see also* ORS 656.726(4)(f)(A) (criteria for evaluation of disability shall be permanent impairment modified by factors of age, education, and adaptability). If the Director concludes that the condition at issue is not an impairment (or, at least, not one that is entitled to a positive impairment rating), then the condition is not a disability and no temporary rule is required by ORS 656.726(4)(f)(C). However, the Director nevertheless might wish to explain his or her thinking in that regard. At least in theory, the Director can do so in two ways. First, the Director simply might announce that no temporary rule is required, because he or she has concluded that the condition at issue is not a disability. Alternatively, the Director could adopt a temporary rule that assigns to the condition an impairment value of zero. Either way, the Director would be announcing a legal conclusion that he or she must make to determine his or her obligations under ORS 656.726(4)(f)(C). Either way, the courts then could review the conclusion for legal error. We see nothing in either the wording or the logic of the statute that would preclude the Director from announcing his or her choice through the temporary rule device.

Claimant also argues that the temporary rule is contrary to ORS 656.726(4)(f)(C), because it purports to assign an impairment value to a surgical procedure *qua* procedure, rather than to the specific impairment that claimant suffered as a result of that procedure. Claimant notes that, by its express terms, ORS 656.726(4)(f)(C) contemplates case-specific accommodation of *the worker's* impairment. Claimant further notes that the clear purpose of ORS 656.726(4)(f)(C) is to ensure that claimants with atypical disabilities receive consideration, even if the existing disability standards do not address their particular conditions. Claimant contends that the present rule addresses the screw removal procedure as a categorical matter and, therefore, is responsive neither to the express words of the statute nor to its purpose.

We agree with claimant that, if the Director finds that a worker suffers from an impairment that results in disability and that that disability is not addressed by existing standards, then the Director must promulgate a rule that <330 Or 560/561> addresses the worker's particular impairment. The Director cannot escape that duty by, for example, making some categorical pronouncement about the ordinary and expected effects of the event that caused the impairment.

We now apply the foregoing principle to the rule adopted by the Director in the present case. The Director's response to claimant's condition turned on the following two sentences: "Bristow repair of a dislocated shoulder improves the function of the shoulder and reduces the chance of dislocation. Removal of the screw fixation device does not result in recognized loss of shoulder function." The first

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[3] The Court of Appeals' majority declined to address that particular point, stating that it had not been argued on review. *Shubert*, 151 Or App at 717 n 4. We disagree. Claimant argued to the Board and to the Court of Appeals that a temporary rule cannot, consistent with ORS 656.726(4)(f)(C), assign an impairment value of zero to a disability, the existence of which necessarily has been established as a precondition for adoption of the rule.

sentence is a general observation about the intent of performing a Bristow repair; it does not purport to address claimant's particular circumstance at all. When considered with that first sentence, the second sentence also turns out to be an abstract statement: Its use of the present tense (repair "does not result" in recognized loss of shoulder function) demonstrates that the sentence purports to be a generalized statement concerning the expected medical outcome of the procedure. That sentence is not a response either to the specific surgery that claimant underwent or to the sequellae of that surgery.

The Director's failure to address claimant's personal circumstances, as opposed to the generality of circumstances attendant upon the two kinds of surgeries, means that the Director's temporary rule was unresponsive as a matter of law. The Director thus has not yet performed the function contemplated by ORS 656.726(4)(f)(C) with respect to claimant's condition. The contrary conclusions of the Court of Appeals and the Board were in error.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed and the case is remanded to the Workers' Compensation Board with instructions to remand the case to the Director of the Department of Consumer and Business Services for further proceedings.

Cite as 168 Or App 579 (2000) June 28, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Billy M. Mohr, Claimant.
BILLY M. MOHR, Petitioner,
v.
BARRETT BUSINESS SERVICES, Respondent.
(97-04178; CA A103884)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 27, 1999.
Gerald A. Martin argued the cause for petitioner. With him on the brief was Francis & Martin.
William J. Blitz argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
ARMSTRONG, J.
Affirmed.
*Kistler, J., *vice* Warren, S.J.

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168 Or App 581> Claimant seeks review of an order of the Workers' Compensation Board in which the Board held that claimant was not entitled to compensation for the medical services that he received after he experienced pain in his arm while at work. He assigns error to the Board's determination that he did not show a sufficient connection between his workplace injury and the medical treatment to entitle him to compensation. We affirm.

Claimant worked as a long-haul trucker for employer. In the course of transcontinental runs, he would sometimes stop at his residence to refresh himself. Before setting off again, he would inspect the truck, checking the oil, coolant, belts, tires, and lights. During one of those inspections, when claimant attempted to open the 400-pound fiberglass hood of the truck to check the oil and water, he experienced extreme pain in his right arm where the biceps is attached to the elbow joint. Claimant went inside his house and attempted to contact his employer. He was unable to do so until the following day. He also did not seek medical attention until the next day, when he saw a physician's assistant.

When employer's agent came to pick up the truck, he noted that claimant's arm had a scoop-like dent in it at the dorsal surface of the elbow. Moreover, the physician's assistant whom claimant visited observed slight ecchymosis on claimant's right arm.[1] Claimant also reported that his right arm had reduced strength and that he felt tingling in the fingers. The physician's assistant diagnosed a sprain and referred claimant for physical therapy. However, when claimant attempted to attend physical therapy, he was turned away because of the poor condition of his arm. Claimant then went to see Dr. Jacobson, who diagnosed an acute rupture of the distal biceps tendon and recommended surgery. When Jacobson performed the surgery, he discovered that the rupture of the tendon was actually quite old and that, because of extensive scarring, it could not be repaired by surgery. He found no evidence of a recent injury to claimant's **<168 Or App 581/582>** arm and stated that, in his opinion, "[Claimant's] employment activities * * * were not the cause of his need for surgery and treatment * * *."

Claimant sought compensation from employer for the surgery. Employer denied the claim, and the Administrative Law Judge (ALJ) upheld the denial, concluding that claimant had failed to meet his burden to show a sufficient connection between his workplace injury and the medical services that he received. The ALJ also suggested that claimant had not met his burden to show an on-the-job injury in the first instance. The Board adopted the ALJ's order. Claimant assigns error to the Board's determination that he is not entitled to compensation, arguing that the Board's holding is not supported by substantial evidence and that the Board erred in not awarding compensation for the diagnostic medical services that he received.

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[1] "[E]cchymosis" is a "[a] purplish patch caused by extravasation of blood into the skin." *Stedman's Medical Dictionary*, 437 (23d ed 1976).

Two statutes bear on the compensability of the medical services provided to claimant. First, ORS 656.005(7)(a) defines "compensable injury" and addresses the compensability of preexisting conditions:

> "A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "* * * * *
>
> "(B) If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

In *SAIF v. Nehl*, 149 Or App 309, 312, 942 P2d 859 (1997), *rev den* 326 Or 389 (1998), we interpreted ORS 656.005(7)(a)(B) to require the factfinder to weigh the "extent of claimant's preexisting condition * * * against the extent of his on-the-job **<168 Or App 582/583>** injury in determining which of the two is the primary cause of his need for treatment of the combined condition." We further clarified that "a claimant needs to establish more than the fact that a work injury *precipitates* a claimant's need for treatment in order to establish the compensability of his combined condition." *Id.* at 313 (citations omitted; emphasis in original).

ORS 656.245 addresses the compensability of medical services. It provides in part:

> "(1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires * * *. In addition, for consequential and combined conditions described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury."

Under ORS 656.005(7)(a), a claimant has the burden to show that the claimant suffered an accidental injury at work that required medical services or resulted in disability. Additionally, a claimant who has a preexisting condition must also show that the "compensable 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." ORS 656.005(7)(a)(B). Finally, under ORS 656.245(1)(a), the claimant must show that the medical expenses he seeks to recover were directed to a medical condition "caused in major part" by the compensable injury.

After examining the record, we conclude that the Board's findings that claimant did not meet those burdens are supported by substantial evidence. Jacobson discovered evidence of a preexisting condition during surgery. The evidence is conflicting as to whether claimant's workplace incident or his preexisting condition was the primary cause of his disability and need for treatment. While claimant did allege that he felt extreme pain in his arm during and immediately after the workplace incident, Jacobson, who performed the surgery, could find no evidence of a recent injury to claimant's arm. Moreover, the record does not disclose whether **<168 Or App 583/584>** some of claimant's other symptoms, such as ecchymosis and the dent in his arm, were preexisting or arose only after the workplace incident. Claimant had the burden to show that the workplace incident was the primary cause of his need for the medical services for which he seeks compensation. The Board could have reasonably relied on Jacobson's report in concluding that claimant had not met that burden. As such, its denial is supported by substantial evidence.

Claimant nonetheless argues, based on our decision in *Brooks v. D & R Timber*, 55 Or App 688, 639 P2d 700 (1982), that the aborted surgery to repair the biceps tendon is a compensable diagnostic procedure, notwithstanding the fact that the surgery revealed a noncompensable preexisting condition. Claimant misreads *Brooks*. In *Brooks*, the claimant had sustained an injury when a choker hook struck his

left knee. The claimant's doctor suspected that the injury may have caused a tear in the meniscus of the knee. The doctor performed an arthroscopy on the claimant's knee to determine the nature of his injury. Instead of a torn meniscus, the surgery revealed a synovial plica, or a fold in the membrane that lines the knee joint. The claimant's doctor was uncertain as to whether the workplace injury caused the synovial plica but concluded that it was probably idiopathic. After the conclusion of the arthroscopy, the doctor made a separate incision to repair the folded membrane. The ALJ awarded compensation for the entire surgery, but the Board reversed, concluding that, while the claimant had sustained a compensable injury, the surgery was not compensable. We reversed in part, holding that the arthroscopy was compensable, because the claimant had established that the blow to his "knee directly resulted in the need for exploratory surgery," but that the surgery to repair the synovial plica was not. *Brooks*, 55 Or App at 692. *See also Counts v. International Paper Co.*, 146 Or App 768, 770, 934 P2d 526 (1997).

This case differs from *Brooks* in several important respects. First, whether claimant sustained an on-the-job injury is itself subject to reasonable dispute in this case, whereas in *Brooks*, at least at the appellate level, it was undisputed that the claimant had suffered such an injury. *Brooks*, 55 Or App at 691. Moreover, in *Brooks*, the claimant had shown that his injury directly resulted in his need for <168 Or App 584/585> exploratory surgery. Because we have upheld the Board's determination that claimant did not establish that his workplace incident was the primary cause of his need for medical services, *Brooks* is of little assistance to claimant. Finally and most importantly, the arthroscopy at issue in *Brooks* was diagnostic in nature. In contrast, in this case, the stated purpose of the surgery was not to diagnose but rather to repair an acute rupture of the tendon. When the doctor performed the surgery, he realized that the rupture was preexisting and could not be repaired. He then proceeded to explore the extent of the preexisting injury. Based on that evidence, it was reasonable for the Board to conclude that the services provided to claimant were not sufficiently related to his workplace incident to entitle him to compensation under *Brooks*.

Affirmed.

Cite as 168 Or App 649 (2000) June 28, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Veronica M. Strackbein,

VERONICA M. STRACKBEIN, Petitioner,
v.
SAIF CORPORATION and HARSCH INVESTMENT, Respondents.
(WCB 96-03694, 96-08239; CA A99635 (Control), A100449)

Judicial review from Workers' Compensation Board.
Argued and submitted January 28, 1999.
Darris K. Rowell argued the cause and filed the brief for petitioner.
Julene M. Quinn argued the cause and filed the brief for respondents.
Before Landau, Presiding Judge, and Deits, Chief Judge,* and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

*Deits, C. J., *vice* Warden, S. J.

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168 Or App 651> In these consolidated petitions for review, claimant challenges two separate orders of the Workers' Compensation Board. The first order reversed administrative law judge (ALJ) Herman's order awarding claimant permanent total disability (PTD). According to the Board, claimant was not entitled to any additional permanent disability. The second Board order reinstated SAIF's denial of a post-concussive syndrome (PCS). We review both orders for substantial evidence. ORS 656.298(7); ORS 183.482(8)(c). *Hurlburt v. Tecton Laminates Corp.*, 135 Or App 202, 203, 897 P2d 347 (1995); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205-06, 752 P2d 312 (1988), and we affirm.

In September 1985, claimant was injured in a motor vehicle accident that occurred during the course and scope of her employment. SAIF accepted a cervical and lumbar strain. The claim was closed and claimant was eventually awarded 15 percent permanent partial disability (PPD). An October 1992 order required that the claim be reopened and that SAIF accept an inner ear concussion syndrome and an adjustment reaction with anxiety and depression. SAIF's denial of several other related conditions was affirmed. The claim was closed in November 1995 without an award of additional permanent disability. Claimant requested reconsideration but was not awarded any additional permanent disability.

At the hearing, Herman awarded claimant PTD, relying on one of the attending physician's opinion that claimant's current disability was due to the compensable injury and the conditions SAIF was ordered to accept.[1] SAIF requested Board review. The Board reversed, stating that it was not persuaded by the attending physician's opinion that claimant's current disability was due to the compensable conditions. Accordingly, the Board reinstated the reconsideration order awarding claimant no additional permanent disability.

168 Or App 652> Claimant requested reconsideration and asked that the Board take administrative notice of a subsequent order by ALJ Galton that held that claimant's PCS was compensable.[2] Claimant argued to the Board that the law of the case doctrine applied. According to claimant, the Board was precluded from discounting the attending physicians' opinions because Galton concluded that claimant's PCS was compensable. The Board held that the law of the case doctrine did not apply, because Galton's order finding that claimant's PCS was compensable was not yet final. In addition, the Board noted that the compensable inner ear syndrome was not the same condition as the PCS. The Board relied on one of the attending physician's opinion that the inner ear syndrome had resolved and that claimant's current disability was due to the PCS.

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[1] The parties expressly preserved the right to litigate the compensability of claimant's PCS. Shortly after the hearing, SAIF denied that claimant's PCS was compensable. The second Board order on review concerns this denial.

[2] While the appeal of claimant's PTD was pending before the Board, Galton set aside SAIF's denial of claimant's PCS.

Meanwhile, in May 1996, claimant asked SAIF to accept the PCS and, in August 1996, SAIF denied that condition. As previously indicated, Galton set aside the denial, concluding that Herman's order, finding that claimant's current disability was compensable, precluded him from affirming the denial. In addition, Galton concluded, after his *de novo* review of the evidence, that claimant's PCS condition was compensable.

SAIF asked the Board to review and to take administrative notice of the Board's prior order that claimant's current disability was not due to the compensable injury. It argued that the Board should apply the law of the case doctrine to that order, even though it was not final because a petition for judicial review had been filed. The Board concluded, based on the law of the case doctrine, that claimant's PCS condition was not compensable. In a footnote, the Board stated that, in any event, claimant did not prove the compensability of the PCS condition. The Board concluded that neither attending physician's opinion was persuasive.

We do not address the parties' arguments concerning the Board's application, or refusal to apply, the law of the case doctrine. Rather, we decide these cases based on the **<168 Or App 652/653>** Board's alternate grounds that claimant did not establish she was entitled to an award of PTD and that she did not establish that her PCS was compensable.

The issue in the first Board order is whether claimant is PTD due to her compensable conditions and any preexisting disability. ORS 656.206(1)(a). We review for substantial evidence. *Hurlburt*, 135 Or App at 203. The primary issue before the Board was whether claimant's current disability was due to her compensable injury. Dr. Tobin stated that claimant's current disability was due to the compensable conditions. The Board discounted Tobin's opinion because she did not explain how claimant's injury in 1985 was still the cause of claimant's symptoms more than ten years later. Nor, according to the Board, did Tobin explain the impact of claimant's denied conditions on her current disability. Next, the Board also considered the medical arbiter's report. The Board concluded that the medical arbiter's report established that claimant's current disability is not due to her compensable injuries. Substantial evidence supports the Board's order that claimant is not entitled to PTD benefits.

In her second assignment of error, claimant argues that the Board erred in affirming SAIF'S denial of the PCS. Claimant does not dispute that there is divided medical evidence concerning the compensability of the PCS. Rather, she argues that the Board erred in concluding that claimant's current condition was not the same condition that SAIF was ordered to accept in October 1992. In October 1992, SAIF was ordered to accept an inner ear syndrome. The Board relied on Tobin's opinion that the inner ear syndrome resolved and that claimant's current disability was due to the PCS. Based on that opinion, there is substantial evidence in the record to support the finding that claimant's current condition is not the same as her inner ear syndrome.

Affirmed.

Cite as 169 Or App 208 (2000) July 26, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James E. Tapp, Claimant.

AGRICOMP INSURANCE and CRB MANUFACTURING, Petitioners,
v.
JAMES E. TAPP, LIBERTY NORTHWEST INSURANCE/CRB MANUFACTURING and SAIF CORPORATION/CRB MANUFACTURING, Respondents.
(WCB Nos. 97-07116, 97-05315, 97-05314; CA A102426)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 5, 1999.
Richard D. Barber, Jr., argued the cause for petitioners. With him on the brief was Sheridan and Bronstein.
Alexander D. Libmann argued the cause and filed the brief for respondent Liberty Northwest Insurance/CRB Manufacturing.
David L. Runner, Appellate Counsel, argued the cause for respondent SAIF Corporation/CRB Manufacturing.
John M. Oswald waived appearance for respondent James E. Tapp.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Kistler, Judge.
DEITS, C. J.
Affirmed.
*Deits, C. J., *vice* Armstrong, Judge.

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169 Or App 210> Petitioner PAULA Insurance (PAULA)[1] seeks review of an order of the Workers' Compensation Board that applied the last injurious exposure rule (LIER) to assign PAULA responsibility for claimant's left-side carpel tunnel syndrome (CTS). We affirm.

Claimant began working for CRB Manufacturing in 1968. He worked elsewhere from 1972 to 1975, but returned to CRB in 1975 and has worked there since that time. Throughout his employment with CRB, claimant has been a punch press operator. The parties acknowledge that claimant suffers from bilateral CTS, an occupational disease, caused by his work for CRB. Because the compensability of claimant's condition is acknowledged, the only issue here is responsibility. An order pursuant to ORS 656.308(1)[2] was not entered and, consequently, the LIER applies in assigning responsibility. *SAIF v. Yokum*, 132 Or App 18, 24-25, 887 P2d 380 (1994).

Three insurers covered CRB during the period in question: (1) from July 1, 1988, to June 30, 1996, Liberty Northwest Insurance Corporation was CRB's insurer; (2) from July 1, 1996, to December 31, 1996, SAIF Corporation was the insurer; and (3) from January 1, 1997, to the time of the hearing, PAULA was CRB's insurer. All of the insurers denied responsibility for claimant's condition. A hearing was held to determine responsibility and the administrative law judge (ALJ) assigned responsibility for claimant's right CTS to Liberty[3] and his left CTS to PAULA. The Board affirmed the ALJ's order. Liberty has not sought **<169 Or App 210/211>** review of the Board's order. Therefore, the only issue before us is responsibility for claimant's left CTS.

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[1] PAULA Insurance was formerly known as Agricomp Insurance.

[2] ORS 656.308(1) provides in part:

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

[3] The ALJ and the Board found the triggering date for the right-side CTS to have occurred in 1991 because, after the visit to Dr. Ebert, claimant began to wear a splint on his right wrist.

In 1991, claimant sought treatment for recurrent headaches and pain in his left eye from Dr. Ebert, a neurologist. As part of Ebert's investigation of claimant's headaches and eye pain, he asked claimant if he had experienced any wrist pain. Claimant responded that for a number of years he had been experiencing numbness and tingling in his hands. Ebert then performed nerve conduction tests on both wrists and formally diagnosed "right carpal tunnel syndrome." His only medical recommendation with respect to claimant's hands was surgical decompression of the right hand. The Board found that claimant did not expressly request treatment for the symptoms in his left wrist. It further found that Ebert did not diagnose left CTS or recommend or provide treatment for that condition. Ebert described the recommended surgery to claimant's right wrist as elective, and claimant did not pursue it at that time. Between 1991 and 1997, claimant used splints and anti-inflammatories to counter the continuing pain, primarily in his right wrist.

In April 1997, claimant sought treatment for his worsening hand and wrist pain. Claimant was referred to Dr. Brett, a neurologist, who diagnosed "work-related bilateral median nerve entrapment and carpal tunnel syndrome (worse on the right)" and recommended right carpal tunnel release. Brett also noted that left carpal tunnel release would eventually be required. However, Dr. Woods, who performed nerve conduction tests at Brett's request, diagnosed abnormalities on claimant's right side "commonly secondary to carpal tunnel syndrome" but no "electrophysiologic evidence of a left carpal tunnel syndrome." Claimant had right carpal tunnel release surgery on May 13, 1997.

PAULA assigns error to the Board's assignment of initial responsibility for claimant's left CTS to PAULA. Under the LIER, initial or presumptive responsibility for a condition is assigned to the last period of employment where conditions could have caused claimant's disability. *Bracke v. Baza'r*, 293 Or 239, 248-49, 646 P2d 1330 (1982). The onset of disability is the "triggering date" for determining the last potentially causal employment. If the claimant receives **<169 Or App 211/212>** treatment, before experiencing time loss due to the condition, the date of the first medical treatment is the triggering date that dictates which period of employment is assigned initial responsibility for the treatment. *Reynolds Metals v. Rogers*, 157 Or App 147, 153, 967 P2d 1251 (1998), *rev den* 328 Or 365 (1999). PAULA argues that Liberty should have been assigned initial responsibility for the left CTS because the "triggering date" here was Ebert's 1991 *treatment* of claimant's left wrist.

The question that is critical in resolving which insurer should be assigned initial responsibility for the left CTS is whether what occurred in 1991, relating to claimant's left wrist, constituted "treatment" for purposes of the LIER. PAULA contends that, in concluding that the events of 1991 relating to claimant's left wrist *did not* constitute treatment for the purposes of the LIER, the Board incorrectly applied the rule of law established in *SAIF v. Kelly*, 130 Or App 185, 880 P2d 970 (1994). The *Kelly* rule provides that, "in assigning responsibility under the [LIER], the dispositive date is the date claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later." *Id.* at 188.

Admittedly, there is not complete clarity in the case law as to what constitutes *treatment* for purposes of assigning initial responsibility under the LIER. We have articulated the standard for determining the triggering date in different terms. The triggering date has been described as "the date claimant first sought treatment for symptoms, even if not correctly diagnosed until later." *Kelly*, 130 Or App at 188; *SAIF v. Carey*, 63 Or App 68, 70, 662 P2d 781 (1983). Alternatively, the triggering date has been described as "the date that the claimant first began to receive treatment." *Timm v. Maley*, 125 Or App 396, 401, 865 P2d 1315 (1993), *rev den* 319 Or 81 (1994).

The above-described standards are not simply alternative ways of saying the same thing. It is apparent that application of these two standards for determining the triggering date will not always result in the same date. However, the objective in designating a triggering date is to identify a point when a condition generally becomes a disability. As we **<169 Or App 212/213>** explained in *Carey*, "[t]he date when a claimant first sought medical treatment, at least in most cases, has some objective relationship to the date when the claimant's condition became a disability, because it is usually documented." 63 Or App at 70. Because both the date that a claimant first *seeks* medical treatment and the date that the claimant first *receives* treatment generally have an objective relationship to when the claimant's condition becomes a disability, we believe that it is appropriate to designate a triggering date based on either event, whichever occurs first.

Applying the above standards to this case, we agree with the Board's conclusion that the triggering date for assignment of responsibility for claimant's left CTS did not occur until 1997. The Board correctly articulated the test for assigning initial responsibility. It explained that, under the LIER,

the triggering date here would not be the onset of the disability, but rather the date upon which claimant first "sought treatment." The ALJ found that claimant neither sought nor received treatment for his left CTS in 1991. The ALJ explained:

> "In 1991, claimant reported to neurologist John P. Ebert, M.D., for treatment of severe recurring headaches and pain in his left eye. He did not complain of, nor seek care for, hand or wrist problems. The doctor tested claimant's wrists as part of the overall test in regards to claimant's headache problems. The doctor reported, 'Nerve conduction study demonstrated a moderate right carpal tunnel syndrome with low amplitude and temporal dispersion of the motor response.' When the doctor inquired about any history of wrist problems, claimant told the doctor that for eight or nine years he had been having bilateral numbness and tingling when the weather was cold, particularly in the right hand. Dr. Ebert diagnosed possible right carpal tunnel syndrome and suggested surgical decompression of the carpal tunnel problem. Claimant did not have any left-sided problems at that time, though Dr. Ebert's nerve conduction studies were performed on each wrist." (Citations to exhibits omitted.)

On review, the Board adopted the ALJ's finding with one correction:

> **169 Or App 214>** "Claimant did relate a prior history of left hand/wrist numbness and tingling when he was examined by Dr. Ebert in 1991. However, claimant did not expressly request treatment for his left-sided symptoms; and Dr. Ebert did not diagnose left carpal tunnel syndrome or recommend or provide treatment for that condition."

As mentioned above, PAULA's complaint is that the Board did not apply the rule of law established in *SAIF v. Kelly*, that, even when the condition is not correctly diagnosed until later, the dispositive date is the date that the claimant first sought treatment for the symptoms. PAULA asserts that the Board's conclusion that claimant did not seek treatment in 1991 was improperly based on its finding that claimant did not "expressly request treatment" at that time. However, while the Board made a finding of fact that claimant did not expressly request treatment at that time, the Board does not appear to attach the same significance to that finding that PAULA does. In view of the Board's accurate discussion of the test for determining initial responsibility, and its other findings with respect to the medical treatment claimant received in 1991, we do not believe that the Board *required* claimant to have "expressly requested treatment" as a prerequisite to establishing the trigger date under *Kelly*. Rather, the fact that claimant had not "expressly requested treatment" for his left CTS in 1991 appears to be one factor that the Board considered in reaching its determination of when claimant first sought medical treatment. The Board also found that Ebert's testing of claimant's wrists was "part of the overall test in regards to claimant's headache problems" and that "[c]laimant did not have any left-sided problems at that time, though Dr. Ebert's nerve conduction studies were performed on each wrist." An express request for treatment is not required under *Kelly*, and we do not believe the Board required one from claimant here.

In view of the Board's findings, we agree with its conclusion that claimant neither sought nor received treatment for his left CTS in 1991. In circumstances such as this--when a claimant does not seek treatment for a condition, and the symptoms are simply noted incidentally as part of an examination for another condition, but are not diagnosed or **<169 Or App 214/215>** treated in any other way--the date of the medical examination generally would not have a sufficient objective relationship to the date of disability to make it an appropriate triggering date for assignment of initial responsibility under the LIER.

PAULA's second assignment of error is that substantial evidence does not exist to support the Board's finding that claimant did not receive treatment for his left wrist[4] in 1991. It argues that the uncontroverted evidence indicates that claimant did receive treatment for both wrists in 1991 and that a reasonable person could not come to a different conclusion. "Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that

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[4] As noted in respondent's brief, PAULA makes this argument regarding both wrists. We assume that PAULA means claimant's left wrist.

finding." ORS 183.482(8)(c). There is evidence in the record that Ebert tested claimant's wrist as part of his investigation of claimant's headache and eye problems. There is also evidence that Ebert did not diagnose or treat the left wrist in any way. A reasonable person could have found, from the evidence in this case, that claimant did not *receive treatment* for left CTS in 1991. The underlying premise of PAULA's argument appears to be that testing a claimant's symptoms always constitutes medical treatment. That premise is incorrect. Under some circumstances, such as these, where the testing is incidental to the investigation of a separate medical condition and the testing results in no diagnosis or treatment, the testing itself is not treatment for purposes of assignment of initial responsibility under the LIER. We conclude that there was substantial evidence to support the Board's findings and that the Board did not err in assigning initial responsibility for claimant's left CTS to PAULA.

Affirmed.

Cite as 169 Or App 231 (2000) July 26, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James E. Clemons, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
JAMES E. CLEMONS, Respondent.
(97-00968; CA A101296)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 16, 1999.
Charles E. Bolen argued the cause for appellant. With him on the brief was Hornecker, Cowling, Hassen & Heysell.
Benton Flaxel argued the cause for respondent. With him on the brief was Flaxel & Nylander.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded.

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169 Or App 233> Employer Roseburg Forest Products (employer) seeks review of an order of the Workers' Compensation Board affirming an administrative law judge's (ALJ) award of scheduled and unscheduled disability for claimant's accepted claim of "left-sided sciatica." We reverse and remand.

In May 1996, claimant experienced pain and numbness along the left posterior lateral thigh, calf, and foot while driving a forklift at work. Dr. Brazer examined claimant and diagnosed left-sided sciatica. Brazer prescribed rest and anti-inflammatories, and the condition improved within a few days. Brazer recommended that claimant have an MRI to rule out a herniated disc. The MRI showed no significant disc bulging or herniation, and an x-ray showed mild degenerative changes in claimant's back. After the MRI, Brazer diagnosed "left sciatica with no evidence of disk herniation."

On June 5, 1996, claimant saw Dr. Keizer, an orthopedist, and reported a continuation of leg symptoms and pain in his low back. Keizer diagnosed "mild degenerative osteoarthritis of the lumbar spine, symptomatic." Claimant had some physical therapy, and his condition began to improve. Claimant also underwent an independent medical examination, and the diagnosis was sciatica and mild degenerative disc disease. On June 18, 1996, Dr. Bert, claimant's attending physician, examined claimant and diagnosed "mild sciatica, resolving." Bert released claimant for work on June 24, 1996.

On October 14, 1996, employer accepted a claim for "left-sided sciatica," and also closed the claim with an award for temporary total disability but without an award of permanent disability. Claimant sought reconsideration, objecting to the impairment findings used to rate his disability. Dr. Smith, a medical arbiter, was asked to describe "any objective findings of permanent impairment **resulting from the accepted injury**" including ranges of motion and muscle strength. (Bold and underscoring in original.) In his report, the arbiter noted "slight loss of strength of inversion and eversion of the left ankle and foot estimated at 4+/5. The **<169 Or App 233/234>** nerve root involved is L5." The arbiter also noted that range-of-motion measurements did not meet the American Medical Association's (AMA) validity requirements but concluded that "the measurements themselves are accurate and could be used to determine impairment."

Based on the arbiter's report, the Department of Consumer and Business Services awarded scheduled disability for claimant's loss of foot strength and unscheduled disability for his loss of range of motion. On review by the hearings division, the ALJ affirmed the award of scheduled disability, reasoning that the foot disability was a "medical sequel[a]" to the original accepted condition of "left-sided sciatica" and was therefore compensable under ORS 656.268(16) (1997).[1] In affirming the award of

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[1] ORS 656.268(16) (1997) provided:

"Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

unscheduled disability, the ALJ relied on the opinion of the medical arbiter as to loss of range of motion. The Board affirmed the ALJ, accepting with supplementation the ALJ's order.

Employer contends initially that because claimant did not specifically assert an entitlement to scheduled permanent partial disability for loss of left foot strength in his request for reconsideration, the Department lacked jurisdiction to consider the matter. We reject that contention. The Board has long held that, in the reconsideration process, the Department is not limited to deciding only those issues raised by the parties but must make its award based on the evidence before it. *Darlene K. Bentley*, 45 Van Natta 1719, 1799 (1993). That view reflects a correct understanding of the Department's obligation under ORS 656.268(5) and (6) (1997),[2] to examine the medical and vocational reports and **<169 Or App 234/235>** award further compensation, if appropriate. Unlike ORS 656.268(8), relating to the hearing process, ORS 656.268(5) and (6) (1997) contain no restriction on the Department's authority to consider issues not raised by the parties. The Board did not err in determining that the Department could consider and award benefits for claimant's scheduled disability.

On the merits, employer asserts, among other issues, that its acceptance did not encompass the conditions for which the Board awarded scheduled and unscheduled permanent disability. The scope of employer's acceptance is a question of fact. *See Granner v. Fairview Center*, 147 Or App 406, 935 P2d 1252 (1997). We discuss first the scheduled disability award for the left foot. The foot weakness was first measured and noted by the medical arbiter, who also was of the opinion that the cause of claimant's left foot weakness is the nerve root involvement at L5. The ALJ said that, in the absence of a specific denial of L5-S1 nerve root injury, the question was whether the foot weakness was a direct medical sequela of the accepted sciatica. Relying on the explanation provided by the independent medical examiners, the ALJ said that sciatica

> "is a syndrome characterized by pain radiating from the back into the buttock and into the lower extremity along its posterior or lateral aspect. The term also refers to pain anywhere along the course of the sciatic nerve. *Dorland's Medical Dictionary* (27th ed 1988). The sciatic nerve is a bundle of nerves which travels through the buttock and down the back of the thigh before splitting at the knee."

169 Or App 236> The ALJ found that, although only the medical arbiter had measured the foot weakness, there was other medical evidence of a neurological disturbance in the lower leg. She concluded that employer had failed to carry its burden of proof under ORS 656.283(7)[3] to negate a relationship between the accepted sciatica and the neurological symptoms in the foot.

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[2] ORS 656.268(5) and (6) (1997) provided, in part:

"(5)(a) Within 10 working days after the department receives the medical and vocational reports relating to an accepted disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the supervision of the Director of the Department of Consumer and Business Services. If necessary the department may require additional medical or other information with respect to the claim, and may postpone the determination for not more than 60 additional days.

"* * * * *

"(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.

"(b) 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."

[3] ORS 656.283(7) provides in part:

"[N]othing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

The same medical report on which the ALJ relied for the definition of sciatica explains that a diagnosis of sciatica can, but need not, involve the nerve root, *i.e.*, the place of origin of the sciatic nerve in the low back. As that medical report explained, symptoms of sciatica can occur at any point along the nerve, including in the foot after the nerve splits at the knee. Employer's acceptance is for "left-sided sciatica." The scope of an acceptance is an issue of fact which we review for substantial evidence. ORS 183.482(8). We conclude that the medical report, which explains that a diagnosis of sciatica can involve symptoms at any point along the nerve, constitutes substantial evidence to support the Board's finding that claimant's neurological symptoms, including his foot weakness, were a part of the accepted condition.

The final issue is whether the Board could use range-of-motion findings that did not meet AMA validity criteria to determine claimant's unscheduled permanent partial disability. Dr. Smith took a series of measurements to determine claimant's range of motion. He reported that "[t]he relationship between total sacral motion and straight leg raising does not meet the AMA validity requirements." He concluded, "Despite this, I believe that the measurements themselves are accurate and could be used to determine impairment."[4]

The ALJ ruled that Smith's measurements could be used even though they did not comply with the AMA validity requirements. She explained:

> "Dr. Smith administered the test only three times rather than the allowable six times. That may be explained by his conclusion that despite the fact that the AMA validity requirements were not met, his measurements were accurate and usable for determining impairment * * *. Following promulgation of OAR 436-035-0007(27) which became effective February 17, 1996, that appears to be sufficient. *Justeen L. Parker*, 49 Van Natta 334, 335 (1997).
>
> "In order to be insufficient under the governing rule for rating permanent disability, even though the doctor acknowledges that the measurements do not comply with AMA standards, they are to be used to rate impairment unless the physician 'provides a written opinion, based on sound medical principles, explaining why the findings are invalid.' OAR 436-035-0007(27). Without that explanation, the measurements are technically adequate for purposes of rating permanent disability."

The Board adopted the ALJ's reasoning.

On review, employer argues that the Board misinterpreted OAR 436-035-0007(27) (1996). That rule provided:

> "Validity shall be established for findings of impairment according to the criterion noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990,** unless the validity criterion for a particular finding is not addressed in this reference or is not pertinent to these rules. Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid. **<169 Or App 237/238>** When findings are determined invalid, the findings shall receive a value of zero."

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[4] According to an interpretative bulletin issued by the Workers' Compensation Division, the AMA guidelines provide that "reproducibility of abnormal motion is currently the only known criterion for validating optimum effort. The examiner must take at least three consecutive measurements of mobility which must fall within plus or minus ten percent or five degrees (whichever is greater) in order to be consistent." Workers' Compensation Bulletin No. 242, at 2 (Feb 1, 1995). The bulletin also states that "measurements of true lumbar flexion are invalid if the tightest straight leg raising (SLR) angle is not equal to or within 10 degrees of the sum of the lumbar extension and flexion measured at midstream." *Id.* at 7.

In this case, Smith took three consecutive measurements of various movements. Those measurements appear to meet the first AMA criterion for validity. Smith reported, however, that his measurements did not meet the second criterion. Neither the parties nor the Board discusses whether the failure to meet the second criterion invalidates all or only some of Smith's findings of impairment.

OAR 436-035-0007(27) (1996) (bold in original).[5] The question the rule presents is how the standard for validity set out in the first sentence relates to the determination whether a finding of impairment is ratable, which the second sentence contemplates. Employer argues that the rule does not permit the Board to rate findings of impairment that are not valid under the AMA criteria; in other words, a determination that a finding of impairment is valid under the AMA criteria is a necessary prerequisite to a determination that the finding is ratable. Claimant urges us to adopt the Board's interpretation of the rule.[6] Under that interpretation, the fact that a finding of impairment is not valid under the AMA criteria is immaterial to the question whether it is ratable. Rather, as the ALJ explained, findings of impairment "are to be used to rate impairment unless the physician 'provides a written opinion, based on sound medical principles, explaining why the findings are invalid.'"

Claimant's interpretation is at odds with the text of the rule. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 612 n 4, 859 P2d 1143 (1993) (methodology for statutory construction applies to administrative rules). Under claimant's interpretation, a finding of impairment that is not valid under the AMA criteria is presumed to be ratable unless the physician provides a written opinion explaining why the finding is invalid. It is difficult, however, to understand why the rule would specify a criterion for determining when findings of impairment are valid and then direct that that criterion be ignored unless the physician has instructed otherwise. Claimant's interpretation would effectively read the first sentence out of the rule.

169 Or App 239> Employer's interpretation fits more closely with both the text and context of the rule. Under its interpretation, validity under the AMA is a necessary, but not the only, prerequisite for determining that a finding of impairment is "ratable." That interpretation gives effect to the first sentence in the rule. It is also consistent with the phrase, "determined to be ratable *pursuant to these rules*," in the second sentence. (Emphasis added.) As that phrase makes clear, the question whether a finding of impairment is ratable is not limited to the question whether it is valid under the AMA criteria. Rather, other rules may require consideration of additional factors in determining whether a finding of impairment is ratable. *See, e.g.*, OAR 436-005-0007(2)(a) (when there is a superimposed condition, "[o]nly the portion of those findings that are due to the compensable condition shall receive a value"); OAR 436-035-350(1)(a)(2) (specifying how subsequent surgeries on vertebrae should be rated).

Although the text and context of the rule fit better with employer's position than claimant's, we cannot say that the text and context are unambiguous. The parties have not identified any legislative history that would shed light on the rule's meaning, and we are aware of none. We are thus left to maxims of construction, but those maxims do not provide a clear answer. Employer's interpretation produces an incongruity but not an absurdity.[7] *Cf. Young v. State of Oregon*, 161 Or App 32, 38, 983 P2d 1044 (1999) (explaining role of the "absurd result" maxim). Claimant's interpretation, on the other hand, effectively reduces the first sentence in the rule to a nullity; if claimant were correct, validity would not be established by the AMA criteria, contrary to the explicit statement in the rule. We conclude that the better answer is to interpret the rule in a way that will not reduce an integral part of the rule to a nullity and that fits more closely with both the text and context of the rule. *See* ORS 174.010; *State* **<169 Or App 239/240>** *v. Cook*, 163 Or App 578, 586, 989 P2d 474 (1999). We accordingly hold that under OAR 436-035-0007(27) (1996), if a finding of impairment does not comply with the AMA criteria, it may not be used to rate a claimant's impairment. We reverse the Board's order and remand for further proceedings consistent with this decision.

Reversed and remanded.

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[5] The rule was amended in 1997, but the amended rule does not apply to this claim because the claim was closed before the amended rule's effective date. OAR 436-035-0003(1).

[6] The rule was promulgated by the Workers' Compensation Division of the Department of Consumer and Business Services. Because the Board was not interpreting its own rule, we do not defer to its interpretation. *See Don't Waste Oregon Com. v. Energy Facility Siting*, 320 Or 132, 142, 881 P2d 119 (1994).

[7] If a determination that findings are ratable requires a determination that findings are valid under the AMA criteria, then the second sentence permits a physician to explain why findings that do comply with AMA criteria are nonetheless invalid, but the rule does not permit a physician to explain why findings that do not comply with AMA criteria are nonetheless valid. We note that the rule has since been amended to permit a physician to explain why a finding of impairment that does not comply with the AMA criteria is nonetheless valid. That amendment, however, does not apply to this case. *See* n 5 above.

Cite as 169 Or App 329 (2000) August 9, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Shawn L. Rhoades, Claimant.

SHAWN L. RHOADES, Petitioner,
v.
SANDY RURAL FIRE PROTECTION DISTRICT 72 and SAIF CORPORATION, Respondents.
(97-08354; CA A104640)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 14, 1999.
Mark W. Potter argued the cause and filed the brief for petitioner.
Julene Marian Quinn argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Affirmed.

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169 Or App 331> Claimant seeks review of a Workers' Compensation Board order dismissing his request for a hearing. The Board held that claimant had not shown good cause for filing his request more than 60 days after SAIF denied his claim. We affirm.

Claimant is a volunteer firefighter for employer, Sandy Rural Fire Protection District 72. He was responding to employer's call when he slipped and injured his knee.[1] Claimant filed a workers' compensation claim on November 22, 1996. SAIF denied his claim because the injury did not occur within the course and scope of employment. SAIF mailed its denial on April 21, 1997, to both claimant and employer. Claimant spoke with the fire chief about the denial. The fire chief told claimant that he would either take care of the matter with SAIF or appeal the denial on claimant's behalf, a course of action that the fire chief had taken when other employees' claims had been denied.

The fire chief was away on vacation in May 1997. After returning from vacation, the fire chief retired on June 15, 1997. The fire chief did not appeal or otherwise resolve the denial before he retired. On June 20, 1997, the 60-day period in which to file a request for hearing expired. On July 3, 1997, SAIF sent a letter to employer, stating that the denial was final because it had not been appealed within 60 days. After discussing the issue at a board meeting, employer helped claimant prepare his request for a hearing. That request was filed on October 14, 1997, more than 60 but less than 180 days after SAIF mailed the denial.

The Board dismissed claimant's appeal because he had failed to establish good cause for his late filing. *See* ORS 656.319(1)(b). The Board found, as the ALJ had, that employer was not acting as the insurer's agent. It compared this case instead to *Mendoza v. SAIF*, 123 Or App 349, 859 P2d 582 (1993), *rev den* 318 Or 326 (1994), in which we upheld the Board's determination **<169 Or App 331/332>** that when the person charged with responsibility for filing a hearing request fails to do so in a timely manner, that person's actions are attributed to claimant. The Board reasoned that: (1) in light of the arrangement between claimant and the fire chief, the fire chief was the person charged with responsibility for filing the request; (2) the fire chief had not delegated that responsibility to anyone else; and (3) claimant had failed to establish that the fire chief's failure to file the request within 60 days constituted excusable neglect. The Board explained:

> "Assuming that the employer was acting as claimant's agent for purposes of filing the hearing request, claimant's testimony indicates that [the fire chief] was responsible for filing the hearing request. There is no evidence that [the fire chief] delegated that responsibility to anyone else. Based on [the executive secretary's] testimony, the only explanation for [the fire chief's] failure to file the request for hearing was that he was gone in May 1997. However, that explanation only pertains to part of the 60[-]day time period following SAIF's denial. There is no explanation in the record as to why the request for hearing was not filed during the remaining [part of the 60-day period] after SAIF's April 21, 1997 denial."

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[1] As long as the volunteers intend to respond to the call, employer considers them employees and on the job from the time they receive a call until they return home.

The Board accordingly found that the evidence did not support claimant's argument (and the ALJ's conclusion) that the turnover of employer's personnel caused the failure to file a timely hearing request. Because claimant had not established good cause for his late filing, the Board dismissed his request for a hearing.

In *Ogden Aviation v. Lay*, 142 Or App 469, 921 P2d 1321 (1996), we clarified our standard of review in these sorts of cases:

> "Our review here, thus, is to see whether the agency's determination of 'good cause' is within 'the range of discretion delegated to' the Board by ORS 656.319(1). ORS 183.482(8)(b). The Supreme Court considered the contours of that policy in *Sekermestrovich [v. SAIF*, 280 Or 723, 573 P2d 275 (1977)]. It construed 'good cause' as meaning 'mistake, inadvertence, surprise or excusable neglect,' as found in *former* ORS 18.160, 280 Or at 726-27, and held that [the] **<169 Or App 332/333>** negligence of an attorney is not good cause unless the attorney's reason for failing to file would be good cause if attributed to the claimant."

Id. at 476 (footnotes omitted). *Ogden* reaffirmed that the legislature delegated the Board authority to determine, within statutory limits, when a claimant's failure to file a timely request for hearing constitutes good cause. *See id.* at 476-77. Our inquiry is whether the Board's decision that a claimant has or has not established good cause falls within the Board's delegated range of authority. *See id.* at 476.

On review, claimant advances essentially three reasons why the Board erred. First, he argues that when a claimant relies on a non-lawyer to file his or her claim, the Board should test the non-lawyer's actions under a more lenient standard than when a claimant relies on an attorney. The Board, however, declined to draw that distinction. Rather, the relevant question, according to the Board, is whether the person who failed to file the hearing request was charged with the responsibility for doing so, not whether that person was or was not an attorney. If the person was charged with the responsibility for filing the request, that person's actions will be attributed to the claimant.

The Board's order follows our decision in *Mendoza*.[2] In that case, we upheld the Board's determination that a legal assistant's negligence was attributable to the claimant because the assistant had been charged with responsibility for filing the request. 123 Or App at 352. That was so even though the legal assistant was a lay person, and not an attorney. It may have been within the Board's authority to draw the distinction claimant urges, but *Mendoza* makes clear that it is also within the Board's authority to hold a claimant responsible for the acts of his or her agent whenever that agent is charged with the responsibility for filing the hearing request. *Compare Ogden*, 142 Or App at 478 (upholding **<169 Or App 333/334>** Board's determination that where attorney's legal assistant was not charged with responsibility for filing hearing requests, that assistant's negligence was not attributable to the claimant).

Claimant advances a second argument. Relying on *Voorheis v. Wood, Tatum, Mosser*, 81 Or App 336, 725 P2d 405, *rev den* 302 Or 342 (1986), he argues that because he reasonably relied on employer's representation that it would file his hearing request, he has established good cause. *Voorheis* did not hold, however, that whenever a claimant reasonably relies on another person to file his or her request for a hearing, the claimant's reasonable reliance constitutes good cause. That would be inconsistent with the Supreme Court's decision in *Sekermestrovich*, as well as our decision in *Mendoza*. Those cases establish that when an agent is charged with responsibility for filing a request for hearing, the agent's actions may be attributed to the claimant without regard to the reasonableness of the claimant's reliance on the agent. As the Board explained, good cause existed in *Voorheis* because the claimant in that case

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[2] Claimant bases his argument on *Berwick v. AFSD*, 74 Or App 460, 703 P2d 994, *rev den* 300 Or 332 (1985). *Berwick*, however, requires that hearings officers "'must be especially diligent in ensuring that favorable as well as unfavorable facts and circumstances are elicited.'" 74 Or App at 467 (quoting *Rosa v. Weinberger*, 381 F Supp 377, 381 (ED NY 1974)). It does not limit the Board's authority to hold attorney and non-attorneys who undertake to file hearing requests to the same standard.

reasonably relied on the *insurer's* representation, and the insurer was not the claimant's agent. Here, the Board's order is based on the premise that employer was acting as claimant's agent.[3]

Finally, claimant argues that the Board erred in finding that he had failed to establish that the fire chief's negligent failure to file the request was not excusable. He argues that the ALJ correctly determined that the failure was due to turnover in the office and that the Board erred in not accepting that finding. There is substantial evidence, however, to support the Board's conclusion that employer's failure to file a timely request for hearing was not caused by turnover of employer's personnel. Claimant does not argue, and we find **<169 Or App 334/335>** no evidence, that anyone other than the fire chief was responsible for filing the request for hearing. Claimant offers no explanation, other than personnel turnover, for why the fire chief failed to file the claim either before he left on vacation in May or after he returned. Also, with the exception of the fire chief, the personnel turnover claimant relies on either occurred before his claim was denied or after the 60-day period to file a request for hearing had expired.[4] We need not decide whether the evidence would have permitted the Board to adopt the ALJ's finding that the failure to file was caused by turnover in the office. It is sufficient to say that substantial evidence permitted the Board to reach a different conclusion. We accordingly affirm the Board's order.

Affirmed.

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[3] Both the Administrative Law Judge and the Board recognized that an employer may be an insurer's agent, which could make *Voorheis* applicable to this case. The ALJ, however, found that the employer in this case was not acting as SAIF's agent. Claimant did not challenge that finding on appeal to the Board. The Board agreed with the ALJ's finding that employer was not acting as SAIF's agent in this case, and claimant has not challenged that finding in this court. Similarly, claimant has not challenged the Board's premise that employer was his agent for the purpose of filing his hearing request. Rather, he has affirmatively argued before us that employer "was [claimant's] agent for the purpose of filing an appeal."

[4] Employer's secretary resigned in October 1996. A new secretary began working in December 1996. SAIF mailed the denial on April 21, 1997. The fire chief retired on June 15, 1997. On June 20, 1997, the 60-day period to file a request for hearing ran. On June 30, 1997, more than 60 days after the denial was mailed, employer's new board took office.

Cite as 169 Or App 345 (2000) August 23, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Pedro Frias, Claimant.

SAIF CORPORATION and J & R CONTRACTORS, INC., Petitioners,
v.
PEDRO FRIAS, Respondent.
(97-03188; CA A101756)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 26, 1999.
David L. Runner argued the cause and filed the brief for petitioners.
Joseph A. DiBartolomeo argued the cause for respondent. With him on the brief was Lavis & DiBartolomeo.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
ARMSTRONG, J.
Reversed and remanded.

*Kistler, J., *vice* Warren, P.J., retired.

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169 Or App 347> Employer seeks review of an order of the Workers' Compensation Board awarding claimant temporary disability benefits. Employer assigns error to the Board's exclusion of periods during which employer had no work for claimant from the calculation of claimant's average weekly wage. OAR 436-060-0025(5)(a)(A). We review for errors of law and reverse.

Most of the relevant facts are not in dispute. Claimant was employed as a construction worker for employer. The hours claimant worked were somewhat irregular. After he had been working for employer for about seven months, claimant slipped and fell from a roof while at work. The fall caused a fracture of one of his thoracic vertebrae, and claimant submitted a claim for temporary disability compensation. Employer accepted the claim.

Originally, employer calculated claimant's time loss rate based on a 40-hour work week. Because claimant's hourly wage was $12, his average weekly wage under employer's initial calculation was $480.[1] Apparently, employer initially assumed that claimant worked all 52 weeks of the year, which would make his yearly gross income $24,960. However, a few months after the initial acceptance, employer notified claimant that it had determined that he was entitled to a lower level of benefits than he had been receiving. Part of the reason for the change was employer's realization that claimant had been employed for only part of the year, from May through the beginning of December, during which he had earned only $9,300 in gross wages. Employer divided that gross income by the number of weeks that claimant had worked for employer, which employer calculated to be 31.6 weeks, to produce an average weekly wage of $294.30 rather than $480. In calculating the number of weeks that claimant had worked for employer, employer included in the calculation two time periods in which it had **<169 Or App 347/348>** no work for claimant and one in which claimant was on vacation.[2] Including the vacation period and the two periods in which employer had no work for claimant as part of claimant's employment reduced claimant's average weekly wage, because claimant earned no wages during those periods.

Claimant sought a hearing to challenge the reduction in his benefits. His principal contention at the hearing was that the periods during which he did no work for employer should be excluded under OAR 436-060-0025(5)(a)(A) from the calculation of his average weekly wage, because those periods constituted extended gaps in his employment.[3] The administrative law judge (ALJ) agreed with

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[1] Under ORS 656.210(1), temporary total disability compensation is set at 66 percent of a claimant's wages, but no more than the average weekly wage for all workers. *See* ORS 656.211. Hence, the temporary disability compensation paid to claimant would have been less than the $480 that employer had calculated his average weekly wage to be.

[2] The vacation period was followed directly by a period in which employer had no work for claimant. For convenience, we refer to the vacation period and the period that followed as two separate periods in which claimant did no work for employer.

[3] *See* 169 Or App at 349 for the text of OAR 436-060-0025(5)(a)(A).

claimant and ordered employer to recalculate claimant's temporary disability benefits based on an employment period that excluded the weeks in which claimant did no work for employer. Employer sought review, and the Workers' Compensation Board affirmed the ALJ, noting that, cumulatively, the gaps in claimant's employment amounted to 15 percent of his total employment and concluding that the gaps were therefore "extended."[4]

On review, employer argues that the Board erred in concluding that the two periods during which employer had no work for claimant were "extended gaps" under OAR 436-060-0025(5)(a)(A) and therefore subject to exclusion from claimant's weekly wage calculation. Employer challenges the Board's method of determining whether the gaps in a claimant's employment are extended. To do so, the Board adds up all the gaps during the preceding year (or during a worker's employment if less than a year) and then compares the sum to the span of the preceding year (or to the period of employment). If the sum of the gaps comprises a sufficiently high percentage of the whole, then the Board deems the gaps **<169 Or App 348/349>** "extended" and does not include them in the weekly wage calculation. Apparently, the Board does not have a set cutoff below which it will not consider a sum of gaps to be extended; it simply makes the determination on a case-by-case basis in light of the percentages that it has previously viewed as extended.

If employer's position on appeal were accepted, claimant's average weekly wage would be $325.17, based on employer's stipulation to the Board that the vacation period was an extended gap. Under that stipulation, the vacation period of three weeks would be subtracted from the 31.6 total weeks of employment, leaving 28.6 weeks of employment. The gross earnings of $9,300 would then be divided by 28.6, making claimant's average weekly wage $325.17. On the other hand, if we accepted claimant's view that all of the periods of non-work constitute an extended gap, his average weekly wage would be $394.07 ($9,300 in gross wages divided by 23.6 weeks of employment).

OAR 436-060-0025(5)(a)(A) provides in part:

> "(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *
>
> "(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:
>
> "(A) Insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks."

OAR 436-060-0025 was promulgated by the Director of the Department of Consumer and Business Services (Director). We previously held that an earlier, similar version of the rule comported with the legislative intent of ORS 656.210(2)(b)(A) that "'[t]he benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury.'" *Hadley v. Cody Hindman Logging*, 144 Or App 157, 160-61, **<169 Or App 349/350>** 925 P2d 158 (1996) (quoting ORS 656.210(2)(b)(A)) (emphasis omitted). As we explained in *Hadley*, the Board's function in reviewing cases to which OAR 436-060-0025 applies is to "apply the methods prescribed by the Director in accordance with the intent of the legislature." *Id.* at 162. ORS 656.210(2) delegates no authority to the Board to do otherwise. *Id.* at 161.

We interpret administrative rules according to their plain meaning, considering the text of the rule in context. *SAIF v. Fitzsimmons*, 159 Or App 464, 468, 978 P2d 404 (1999), *rev den* 329 Or 589 (2000). The dispute in this case centers on the meaning of the term "extended gaps."[5] "Gap" means "a

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[4] Employer stipulated to the Board and to the ALJ after the hearing that the vacation period was an extended gap. Therefore, the vacation period is not included in the Board's calculation of the percentage of claimant's employment comprised of gaps.

[5] The Board assumed without deciding that the rule requires an evaluation of whether "extended gaps" exist even when an employee has been employed for fewer than 52 weeks in total. Based on the wording of the rule, we conclude that the rule does require such an analysis.

break in continuity: INTERVAL, HIATUS." *Webster's Third New Int'l Dictionary*, 935 (unabridged ed 1993). "Extended" means "drawn out in length," "lengthy," "protracted," or "prolonged." *Id.* at 804. Finally, "drawn-out" means "stretched to great or greater length * * * [;] made to seem or be longer than desirable or normal." *Id.* at 687.

To begin with, we note that nothing in the rule suggests that the gaps in a claimant's employment, whether extended or not, should be added up and evaluated as a sum. Indeed, the definition of "gap" indicates that it refers to a discrete time period; the fact that "gap" refers to a discrete time period suggests that each gap should be evaluated separately to determine whether it is extended. A contrary reading has the potential to allow the exclusion of all gaps, whether extended or not, simply because a claimant's employment happens to have had numerous gaps, the sum of which is substantial.[6] Such a reading clearly broadens the rule beyond its **<169 Or App 350/351>** plain meaning, because the rule directs that only extended gaps be excluded. Moreover, when the sum of the gaps is evaluated instead of each individual gap, "extended" loses its meaning. It is difficult or impossible to discern what could be meant by a "drawn out or prolonged" sum because those words, which properly define "extended," are clearly temporal concepts, whereas "sum" is a quantitative concept. Because "gap" is a temporal concept, as is "extended," the phrase "extended gap" makes sense, but the phrase "extended sum" does not. The use of the modifier "any" before the phrase "extended gaps" reinforces the view that "gaps" are discrete events. Again, excluding other gaps if their sum is substantial does more than the rule directs because it fails to focus on whether each gap is extended in deciding whether to exclude it; thus "any gaps" could be excluded under the Board's interpretation rather than only "any extended gaps," as the rule directs.

Our reading of the text of the rule is supported by its context as well. The context of a rule includes other subsections of the same rule as well as other related rules. *Fitzsimmons*, 159 Or App at 468. OAR 436-060-0025(5)(m) explains how to calculate average wages for workers who have cyclic schedules:

> "For workers with cyclic schedules, insurers shall average the hours of the entire cycle to determine the weekly wage. For purposes of temporary disability payments, the cycle shall be considered to have no scheduled days off. For example: A worker who works ten hours for seven days, has seven scheduled days off, then repeats the schedule, is considered to have a 14[-]day cycle. The weekly wage and payment schedule would be based on 35 hours a week with no scheduled days off. "

For workers with cyclic schedules, subsection (5)(m) requires that regular time off be included in the weekly wage calculation. Thus, if a person works two weeks out of every five, the three weeks the person does not work are not excluded from the calculation as an extended gap. Instead, the three weeks off are included in the weekly average; that practice brings the claimant's weekly wage down to its actual average over the regular five-week period. In contrast, the Board's interpretation of subsection (5)(a)(A) paradoxically treats workers **<169 Or App 351/352>** "employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages" more favorably than those with cyclic schedules are treated under subsection (5)(m). The Board's interpretation of subsection (5)(a)(A) has that result because it potentially excludes all of the workers' time off due to lack of work or other reasons from the calculation of their weekly wages whenever the sum of those spans of non-work is substantial or "extended." We can discern no basis for treating those with irregular employment schedules more favorably than those with cyclic schedules. Thus, as part of the context of subsection (5)(a)(A), subsection (5)(m) supports our conclusion that the Board's practice of adding up all of the gaps in a claimant's employment and then determining whether the sum is extended is erroneous.

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[6] Interpreting subsection (5)(a)(A) as the Board does also has the questionable result of making the issue of whether a gap is extended depend on the length of the employment relationship. For instance, a gap of a week in a four-week employment relationship would comprise 25 percent of the employment period and therefore would be subject to exclusion under the Board's analysis, whereas a gap of a week in a one-year relationship would comprise less than two percent of the employment period and thus presumably would not be extended. Although it is possible that the length of the employment could be a relevant factor in determining whether a gap is extended, we see nothing in the wording of the rule to indicate that that determination should turn solely on the length of the relationship, as it does under the Board's current analysis.

In *Hadley*, we held that the Board's interpretation of an earlier version of OAR 436-060-0025(5)(a)(A) improperly added a requirement to the rule. *Hadley*, 144 Or App at 162. The Board's interpretation of the rule in *Hadley* required a claimant to show a change in the character of the employment relationship in order to establish an extended gap. Noting that the Board had no policy-making authority with respect to OAR 436-060-0025(5)(a)(A), we held "that the Board's interpretation constituted an unauthorized limitation on the director's authority * * * to prescribe methods for establishing wages at the time of injury." *Id.* In this case, rather than improperly narrowing the rule, the Board has improperly broadened it. The Director has specified that only extended gaps be excluded from the calculation of a claimant's average weekly wage. Nevertheless, the Board has interpreted the rule in such a way that it potentially excludes all gaps, provided that their sum is substantial. The Board has no more authority to broaden the rule beyond its terms than it does to narrow it. Its interpretation of OAR 436-060-0025(5)(a)(A) exceeds its authority.

Having rejected the Board's practice of adding up all the gaps in a claimant's employment and then determining whether their sum is substantial, we now turn to a closer evaluation of the meaning of the term "extended gap." It is clear from the dictionary definitions of "extended" that a gap must be lengthy in order to be subject to exclusion under OAR 436-060-0025(5)(a)(A). *See* 169 Or App at 350. However, **<169 Or App 352/353>** as employer correctly points out, it can be difficult to judge whether a gap is lengthy without looking at the particular circumstances of each employment relationship. The definition of "drawn-out" as "longer than desirable or normal" supports employer's argument that "extended gap" is, in some sense, a relative term and that whether a gap of a certain length is extended will depend in part on the circumstances of the employment relationship. We therefore conclude that the determination of whether a gap is extended must be made in light of its length and of the circumstances of the individual employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship.

Because we conclude that the Board's practice of evaluating gaps cumulatively does not comport with the language of OAR 436-060-0025(5)(a)(A), we reverse and remand for a reevaluation of whether the gaps in claimant's employment were extended.

Reversed and remanded.

Cite as 169 Or App 354 (2000) August 23, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ROY L. STAMP, dba Blue Mountain Pools, Petitioner,
v.
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondent.
(INS 95-06-013; CA A102274)

En Banc*
Judicial Review from Department of Consumer and Business Services.
Argued and submitted April 6, 1999; resubmitted en banc June 7, 2000.
Gary G. Linkous argued the cause and filed the brief for petitioner.
Denise Fjordbeck, Assistant Attorney General, argued the cause for respondent.
With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
Before Deits, Chief Judge, Edmonds, De Muniz, Landau, Haselton, Armstrong, Linder, Wollheim, and Brewer, Judges.
WOLLHEIM, J.
Affirmed.
Edmonds, J., dissenting.

*Kistler, J., not participating.

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169 Or App 356> Petitioner seeks judicial review of a final order of the Department of Consumer and Business Services (DCBS) upholding a workers' compensation premium audit billing for the period October 1, 1993 through September 30, 1994. At issue is whether petitioner's brother, an independent contractor registered with the Construction Contractor's Board (CCB), was an employee of petitioner. If petitioner's brother was an employee, then petitioner was liable to pay workers' compensation premiums. We review the findings of fact for substantial evidence and review the conclusions of law to determine if they are correct as a matter of law. *Oregon Drywall Systems v. Natl. Council on Comp. Ins.*, 153 Or App 662, 666, 958 P2d 195 (1998). We affirm.

The facts are uncontested. Roy Stamp, petitioner, builds swimming pools under the business name Blue Mountain Pools (Blue Mountain).[1] During the audit period, Roy used Gary Stamp exclusively for the tile work on the 19 pools constructed by Blue Mountain. Roy's work constituted roughly 90 percent of Gary's income for that period. Gary performed only three jobs for persons other than Roy during that time. At one point prior to the audit period, Gary went commercial fishing, but he then returned and continued to work on Roy's pools. Roy generally paid Gary after completion of the work and the pay was based on the amount of tile laid. However, Roy on occasion paid Gary an advance for materials or travel, and, in one instance, loaned Gary money that was then deducted from a subsequent invoice. On several projects, Gary hired an assistant.

SAIF provided workers' compensation insurance for Blue Mountain. SAIF conducted a premium audit of Blue Mountain and concluded that Roy was responsible for providing workers' compensation coverage for Gary and his employee. SAIF billed Blue Mountain accordingly. Roy appealed that billing.

169 Or App 356> A hearings officer concluded that Gary was Roy's employee during the audit period. The hearings officer's proposed order stated five ultimate findings of fact: (1) Roy did not direct or control the day-to-day work of Gary; (2) Roy retained the right to direct or control the day-to-day work of Gary; (3) Gary provided all of his own tools and equipment for performing the work; (4) Gary was paid on an hourly basis and on the basis of the amount of material installed; and (5) Gary had one employee while working on jobs for Roy but did not obtain workers' compensation coverage until May 24, 1994. The hearings officer then applied the "right to control" test and the "nature of the work" test to reach the conclusion that Gary was Roy's employee.

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[1] Petitioner's brother is Gary Stamp and conducts business under the name Style Tile. For purposes of clarity, throughout this opinion we shall refer to them as Roy and Gary.

The four factors to be considered when applying the right to control test include: (1) direct evidence of the right to, or exercise of, control; (2) the furnishing of tools and equipment; (3) the method of payment; and (4) the right to fire. *Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 475, 879 P2d 1319, *rev den* 320 Or 453 (1994).

Applying the right to control factor, the hearings officer first concluded that, although Roy did not direct or control the day-to-day activities of Gary, Roy did retain the *right* to control Gary's work. The hearings officer relied on a range of evidence in reaching that conclusion. The hearings officer found that Roy was responsible for assigning Gary work, that Roy directed when and where Gary worked, and that, during the audit period, Gary worked almost exclusively for Roy, and Roy used Gary exclusively for the tile work on all the swimming pools constructed by Roy. The hearings officer also noted that Gary performed his work consistently with a work order and to Roy's expectations about the quality of work. Additional evidence cited by the hearings officer included the fact that contractors or homeowners dealt primarily with Roy instead of Gary, that they contacted Roy when there was a problem with Gary's work, and that they did not bargain about the price of the tile work with Gary. The hearings officer also explained that the testimony of both Roy and Gary convinced the hearings officer that Roy **<169 Or App 357/358>** retained the right to instruct Gary on how a job was to be performed. The hearings officer concluded that the right to control factor indicated that Gary was an employee.

Addressing the second factor, the hearings officer found that Gary provided all of his own tools and equipment and concluded that that factor supported an independent contractor status. That conclusion is not challenged by petitioner.

The hearings officer concluded that the third factor was neutral because Gary was typically paid on the basis of the amount of materials installed. *See Henn v. SAIF*, 60 Or App 587, 592, 654 P2d 1129 (1982), *rev den* 294 Or 536 (1983) (citing 1C Larson, *Workmen's Compensation Law*, section 44.33(b) (1978) ("When payment is by quantity or percentage, the method of payment test * * * largely cancels itself out and becomes neutral.")).

Finally, the hearings officer concluded that the fourth factor, the right to fire, was neutral if not indicative of employee status. Because Roy and Gary never used written contracts, there was little evidence before the hearings officer concerning that factor.

After completing the analysis of the right to control test factors, the hearings officer did not indicate whether he ultimately concluded that those factors indicated employee status or independent contractor status or whether the test was inconclusive. Instead, the hearings officer immediately proceeded to the relative nature of the work test.

The relative nature of the work test consists of two elements. The first is the character of the person's work or business--its skill, status as a separate enterprise, and the extent to which it may be expected to carry the burden of its accidents itself. *Woody v. Waibel*, 276 Or 189, 195, 554 P2d 492 (1976) (citing 1A Larson's, *Workmen's Compensation Law*, section 43.52 (1973)). The hearings officer noted that Gary's skills were the product of apprenticeship training and that he relied on his brother for his livelihood. The hearings officer also interpreted Gary's commercial fishing trips to Alaska before the audit period as an indication of Gary's reliance on **<169 Or App 358/359>** Roy's business as opposed to an indication of Gary's independence.

The second nature of the work test element is the relation of a person's work to the employer's business--how much it is a regular part of the employer's regular work, whether it is continuous or intermittent, and whether it is of sufficient duration to be the hiring of continuing services rather than contracting for a particular job. *Id.* The hearings officer noted that Gary's work was integral to the building of Roy's pools and that Roy kept Gary more or less fully employed during the audit period. Although Roy arranged with Gary to perform each job, the hearings officer concluded that the relationship was in the nature of the hiring of continuing services. The hearings officer concluded that Gary was an employee under the relative nature of the work test.

The hearings officer then conducted an analysis under ORS 656.029 (governing workers' compensation coverage for individuals who perform labor under a contract) and ORS 656.027(7) (the sole

proprietor exemption to "worker" status).[2] Finally, the hearings officer calculated the payroll amount subject to a new billing assessing a workers' compensation premium and ordered SAIF to withdraw its prior audit billing and issue a new billing.

Roy appealed and DCBS affirmed the proposed order.

On review here, petitioner argues that Gary was not Roy's employee, that the hearings officer improperly applied the "right to control" test and the "nature of the work" test, and that there was no substantial evidence to conclude that Roy had paid Gary any wages. Therefore, petitioner concludes that DCBS improperly upheld the premium audit billing.

We follow the methodology set forth in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 872 P2d 1 (1994), to determine whether an individual is a "subject worker" under the workers' compensation law. We must **<169 Or App 359/360>** first determine whether the individual is a "worker" as defined under ORS 656.005(30). To make that determination, we apply the "right to control" test. If, and only if, that test is inconclusive, we apply the "relative nature of the work" test.[3] If the person is determined to be a worker under either test, we must then determine whether that person is a subject worker or is excluded from subject status by one of the subsections under ORS 656.027. If the person is a subject worker and is not excluded, the worker is subject to the workers' compensation laws and the employer must pay premiums for that worker. *Id.* at 630-31.

Petitioner first argues that there was no substantial evidence to find that Gary was a "worker" or a "subject worker." ORS 656.005(30) defines a worker as "any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *." The evidence demonstrates that Gary furnished services to Roy for remuneration. The only issue here is whether Gary was under Roy's direction and control. To resolve that issue, we apply the right to control test.

As explained above, the right to control test consists of analyzing four factors. No single factor is dispositive in all instances. However, a single factor that indicates an employer-employee relationship may constitute proof of an employment relationship whereas contrary evidence, indicating independent contractor status, is, at best, mildly persuasive and may have no effect at all to a determination of worker status. *See Cy Investment, Inc. v. Natl. Council on Comp. Ins.*, 128 Or App 579, 584, 876 P2d 805 (1994).

The first factor in the right to control test is evidence of the right to exercise, or actual exercise of, control. In reaching the conclusion that this factor indicated an employee status, the hearings officer relied on the evidence regarding the assignment of work, the performance and quality control **<169 Or App 360/361>** of that work, and the party held responsible for the work. The hearings officer also stated that he based his conclusion on the oral testimony of both Roy and Gary. That testimony includes, among other things, statements that, during the audit period, Gary never turned down a Blue

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[2] All statutory references are to the statutes in effect during the audit period unless otherwise noted.

[3] Petitioner is correct that the hearings officer incorrectly applied the two tests when he immediately proceeded from the first test to the second. The hearings officer should have made an explicit determination that the right to control test was inconclusive about Gary's worker status before proceeding with the relative nature of the work test. We conclude that the hearings officer misconstrued and misapplied the two tests.

Mountain project,[4] and that Roy told SAIF that he wanted to keep Gary so <169 Or App 361/362> busy that Gary would not have time to work for others.[5] We conclude that the evidence that the hearings officer explicitly and implicitly relied on addresses the nature of Roy and Gary's relationship, indicates that Roy was "in charge" and indicates that Roy had a right to control Gary's work.

This is not the first instance that we have looked at similar evidence and reached the conclusion that it indicated a right to control. In *HDG Enterprises Inc. v. Natl. Council on Comp. Ins.*, 121 Or App 513, 520, 856 P2d 1037 (1993), we reversed a Department of Insurance and Finance (DIF) conclusion that the right to control test was inconclusive. Specifically, we did not agree with DIF's conclusion that the first factor--the control factor--was neutral. We concluded that the "employer had the right to exercise significant control" over floor covering installers. *Id.* at 518. Among other facts, DIF found (1) that the employer directed the time and place of installation; (2) that the installation was in accordance with specifications furnished by employer; (3) that written agreements indicated the degree of control the employer could exercise; (4) that the employer was specific about the nature and quality of the finished product desired; (5) that the employer did not physically supervise the installation; and (6) that it was the employer to whom customers turned if there was a problem with the quality of the installation. *Id.* Each of those facts was relevant to the right to control factor. Each of those facts, with the exception of written agreements, is present in the case before us now. Because of the presence here of similar facts

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[4] The dissent contends that *Oregon Drywall Systems* stands for the proposition that independent contractor status exists when the subcontractor works solely for one employer and that independent contractor status exists when the subcontractor possesses special expertise. 169 Or App at 369. We disagree with both contentions.

Oregon Drywall was a drywall contractor and registered general contractor for residential and commercial buildings. It had its own employees who did drywall work. On occasion, when a drywall project was too large for Oregon Drywall to complete with its own employees, it would contract work to drywall subcontractors. Subcontractor jobs were generally separate from jobs for which Oregon Drywall used its own employees. During the relevant audit period, Oregon Drywall had contracted work to approximately 18 different drywall subcontractors. A premium audit billing assessed Oregon Drywall premiums for its employees and for the 18 subcontractors. Oregon Drywall contested the assessment *only* for the 18 subcontractors. *Oregon Drywall Systems*, 153 Or App at 664-65. We concluded that DCBS erred in holding that the drywall subcontractors who performed services for Oregon Drywall were workers under the workers' compensation system and reversed. *Id.* at 664.

Nowhere does *Oregon Drywall Systems* say or imply that an independent contractor can work for only one employer and that that employer will not be liable for workers' compensation premiums. The closest statement we can find that could lead to that conclusion is "[m]ost subcontractors worked for other contractors as well." *Id.* at 665. If one reads that statement in the negative, one can understand it to imply that some contractors worked for only one contractor--Oregon Drywall. However, when one understands the facts, even that statement is misleading. Each of the 18 drywall subcontractors was an independent drywall contractor. Some, most or nearly all of their work and earnings--the facts are not sufficient to determine which was the case--came from contracts they obtained as drywall *contractors*. Only when they had not obtained their own contracts and had free time did they bid *as subcontractors* on Oregon Drywall jobs that Oregon Drywall could not complete with its own employees. Viewed from that understanding, the *Oregon Drywall Systems* statement at issue is best understood to mean that most of the 18 subcontractors that Oregon Drywall used would also subcontract out their services to other general contractors when the subcontractors were unable to obtain contracts on their own. However, some of the 18 had acted as subcontractors only with Oregon Drywall; otherwise they worked solely as drywall contractors under contracts they had obtained. *Oregon Drywall Systems* does not stand for the proposition that, under the statutes in effect at the time, a subcontractor could perform all of its work for one contractor, under the direct control of that contractor, and that contractor would not be liable for workers' compensation premiums.

The second proposition concerning *Oregon Drywall Systems* made by the dissent that we find troubling is that when a general contractor has a job that requires expertise, that fact suggests that an individual is an independent contractor, rather than a worker. 169 Or App 369. That is an incorrect interpretation of *Oregon Drywall Systems*. A worker's expertise is significant to the analysis of a worker's status only if the right to control test is inconclusive. A worker's expertise becomes relevant only at the first element of the relative nature of the work test--the element that looks at the character of the person's work or business. We expressly did not reach the nature of the work test in *Oregon Drywall Systems*. *Id.* at 669. *Oregon Drywall Systems* expressly follows the method for determining whether an individual is a person entitled to benefits under the workers' compensation system set forth in *S-W Floor Cover Shop*. *Id.* at 666. No other implications should be read into *Oregon Drywall Systems*'s analysis or conclusion.

[5] We note that one factor that distinguishes the facts here from those of *Oregon Drywall Systems* is that there "Oregon Drywall [employer] had no interest or concern in any arrangement subcontractors might make to work with others." 153 Or App at 665. The same cannot be said about the facts here.

and additional facts contained in Roy's and Gary's testimony, we reach the same conclusion here that we did in *HDG Enterprises Inc.*--the right to control factor indicates that an employment relationship existed between Roy and Gary.

169 Or App 363> We agree with the hearings officer that the second factor supports an independent contractor status. The evidence in the record indicates that Gary provided all of his own tools and equipment for laying tile.

The hearings officer concluded that the third factor was neutral because Gary was typically paid on the basis of the amount of materials installed. Although evidence exists in the record in the record that Gary was occasionally paid an hourly rate, those instances were infrequent. We previously have had held that when payment is by quantity, the method of payment factor is generally neutral. *Henn*, 60 Or App at 592. That is our conclusion here as well.

The fourth factor, the right to fire, is difficult to resolve in this instance because Roy and Gary never used written contracts. Thus, there is little evidence in the record concerning this factor. The lack of a written contract could just as readily indicate employee status as it could independent contractor status. Because the evidence is not conclusive, we agree with the hearings officer's conclusion that the fourth factor is neutral.

In summary, our application of the right to control test produces the following results: the right to control factor indicates an employment relationship; the furnishing of tools and equipment factor indicates independent contractor status; and the method of payment factor and the right to fire factor are neutral.

We hold that the result of the right to control factor is dispositive in this instance. *See Cy Investment, Inc.*, 128 Or App at 584. Because of the multiple indicators of an employer-employee relationship revealed by that factor, the only conclusion that can properly be reached after application of the right to control test is that Gary was a Blue Mountain worker during the audit period.

Because Gary was a worker, we must determine whether he was also a subject worker. ORS 656.027 states that all workers are subject workers unless specifically excepted. Subsection (7) excepts sole proprietors who qualify as an independent contractor from subject worker status. Independent contractor status is established if an individual **<169 Or App 363/364>** satisfies all eight standards under ORS 670.600. *See HDG Enterprises Inc.*, 121 Or App at 520. We need look only to the first standard to determine that Gary was not an independent contractor during the audit period. That standard requires that the individual be "free from direction and control over the means and manner of providing the labor or services." ORS 670.600(1). Because in our application of the right to control test we concluded that Gary was not free from direction and control of his services, Gary cannot have been an independent contractor under ORS 670.600.

Petitioner argues that Gary's registration with the CCB is conclusive proof that he was an independent contractor and, consequently, Gary is not a "subject worker." He argues that ORS 656.027(7) specifically excludes sole proprietors. That argument is not well taken. The *present* version of ORS 656.027(7) specifically excludes sole proprietors in subsection (b).[6] That provision creates a conclusive presumption that independent contractors registered with the CCB are not subject workers. However, subsection (b) was added to ORS 656.027(7) in 1995. Or Laws 1995, ch 216, section 3. During the audit period, no conclusive presumption provision existed. In *HDG Enterprises*, we applied the statute in effect at the time of the audit period and held that "registration with the CCB is not conclusive proof that the registrant is an independent contractor." 121 Or App at 522. Without further discussion we reject petitioner's argument concerning registration with the CCB.[7]

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[6] ORS 656.027(7)(b) (1999) provides that "[a]ny sole proprietor registered under * * * ORS 701.035 [the independent contractor license provision] and involved in activities subject thereto is conclusively presumed to be an independent contractor."

[7] The dissent also argues that the hearings officer's conclusion that Roy retained the right to control Gary's work does not rationally follow from the hearings officer's characterizations of Gary as a subcontractor. As we have just shown, within the workers' compensation system, it is entirely possible for a subcontractor to be a worker for purposes of a workers' compensation insurance premium assessment. The hearings officer's use of the terms "subcontractor" and "subcontracting" is not inconsistent with his reasoning.

Petitioner's final argument is that the hearings officer lacked substantial evidence to conclude that Roy had paid Gary any wages for the purpose of calculating workers' compensation premiums. The record contains evidence of how **<169 Or App 364/365>** much money Roy paid Gary during the audit period. SAIF billed Roy for Gary's wages at a rate of 50 percent of that amount. SAIF reasoned that, since Gary supplied his own materials and equipment, some of the money Gary received went towards covering expenses and that only the remainder constituted wages. SAIF used the 50 percent wage rate because that is the rate established by the National Council on Compensation Insurance for workers' compensation premiums for construction contractors. We agree with the hearings officer that the money Roy paid Gary constituted wages.

In summary, substantial evidence exists in the record to support the hearings officer's findings of fact. Based on those findings and applying the right to control test, we hold that, as a matter of law, Roy retained the right to direct or control Gary's day-to-day work and that, therefore, Gary was a worker during the audit period. We further hold that Gary was a subject worker during that period. Finally, we also hold that the record demonstrated that Roy paid Gary wages. Accordingly, although for different reasons, we affirm the DCBS's decision to uphold the proposed order assessing Blue Mountain Pools a workers' compensation premium for the audit period.

Affirmed.

EDMONDS, J., dissenting.

The majority concedes that the hearings officer erred in his application of the law in this case. In arriving at his conclusion that Gary was Roy's worker rather than an independent contractor, the hearings officer concluded that the "right to control" test was inconclusive and applied the "nature of the work" test. The hearings officer's conclusion that the analysis under the "right to control" test was inconclusive was error because he conflated the requirements of the "right to control test" and "the nature of the work test." However, the majority relies on the hearings officer's findings, which it finds are supported by substantial evidence, to conclude that Roy had the right to control Gary's day-to-day activities, contrary to the hearings officer's conclusion. Had the hearings officer and the majority applied the law correctly, they would have determined that Gary was an independent contractor under the "right to control test."

169 Or App 366> According to his opinion, the hearings officer's conclusion is based on the following ultimate findings of fact:

> "Roy Stamp did not direct or control the day-to-day work of Gary Stamp.
>
> "Roy Stamp retained the right to direct or control the day-to-day work of Gary Stamp.
>
> "Gary Stamp provided all of his own tools and equipment for performing the work.
>
> "Gary Stamp was paid on an hourly basis and on the basis of the amount of material installed.
>
> "Gary Stamp has one employee while working on jobs for Roy Stamp but did obtain not [sic] workers' compensation until May 24, 1994."

Initially, it is important to note that the hearings officer's "finding" that Roy retained the right to direct or control the day-to-day work of Gary Stamp is not a "finding of fact" but a legal conclusion. When the facts are generally undisputed as they are in this case, the question of "worker" or "independent contractor" status is a question of law. *Woody v. Waibel*, 276 Or 189, 192 n 3, 554 P2d 492 (1976).[1] The answer to whether Roy had the right to control Gary's day-to-day activities is a legal conclusion that is to be reached by applying the applicable law to all of the pertinent facts.

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[1] Our opinions have also held that the question of "whether a right to control exists under the facts as found is a question of law for the court." *HDG Enterprises v. Natl. Council on Comp. Ins.*, 121 Or App 513, 518, 856 P2d 1037 (1993).

As the court in *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 630, 872 P2d 1 (1994), explained, "[t]he initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test." The application of that test involves several considerations:

> "Factors considered by the courts in determining whether a 'right to control' establishes an employment relationship has included, for example: whether the employer retains the right to control the details for the method of performance; the extent of the employer's control over work schedules; and whether the employer has power to discharge the person without liability for breach of contract. Payment of **<169 Or App 366/367>** wages is also a factor, although it is not considered decisive where it is shown that the employee was actually under the control of another person during the progress of work." *S-W Floor Cover Shop*, 318 Or at 622 (citations and internal quotes omitted).

The hearings officer concluded that the fact that Gary provided his own tools and equipment for performing the work supported a conclusion of independent contractor status. He also ruled that the fact that Gary was paid on the basis of the amount of material installed was a neutral factor. Obviously, the findings that Gary had his own employee while working on jobs for Roy and that Roy did not *actually* direct or control the day-to-day work of Gary also support a conclusion of independent contractor rather than worker status. In addition, the hearings officer found that: (1) Gary "had the right to refuse any particular job"; (2) Gary "needed no oversight from Roy * * * to perform this work"; (3) Gary "did business as a sole proprietor under the assumed business name Style Tile"; (4) "[o]ne of the jobs he routinely subcontracted out during the audit period was the finish tile and brick work which he subcontracted to his brother"; (5) Gary "held himself out to perform ceramic tile wok on jobs that were not related to his brother's swimming pool construction"; (6) Gary "worked on three jobs during the audit period for persons other than his brother"; (7) "[o]nce Roy * * * had a contract to construct a pool, * * * Gary * * * scheduled the work on his calender"; (8) Gary's "charges were based on the amount of tile or other material installed"; and (9) Gary "was paid after the completion of the work" based on a price list that *Gary* established in advance of the job." Finally, there is no evidence of a written contract between Roy and Gary that gives Roy the right to control the day-to-day activities of Gary.

Having made the above findings, the hearings officer was required to apply the proper legal test in order to arrive at a correct conclusion of law. As *S-W Floor Cover Shop* instructs, the hearings officer should have inquired whether the above findings demonstrate that Roy retained the right to go on the job site and could have directed the particulars of how Gary laid the tile and performed the job as any supervisor of a worker would; whether he could have controlled the **<169 Or App 367/368>** hour-by-hour performance of when, where and how Gary worked; and whether he could have discharged Gary in the midst of a job without liability for breach of contract. The right to control the day-to-day activities of a worker is best illustrated by contrasting it with the right to control the end result. The former exists in a "worker" relationship but not in an independent contractor relationship.

As the majority apparently concedes, the hearings officer, looked to facts other than those prescribed by the Supreme Court in *S-W Floor Cover Shop* to arrive at a conclusion that Roy retained the right to control. Those facts included: (1) Roy designating which job Gary was to work on; (2) Roy's expectation that Gary would complete the job in accordance with Roy's general specifications; (3) "90 percent of [Gary's] income during the audit period was from performing ceramic tile installation for swimming pools constructed by his brother"; and (4) "[c]ustomers, either general contractors or homeowners, dealt primarily with [Roy]." The majority deems those factors relevant, and, while I agree that they are relevant, they are not legally sufficient as a matter of law to demonstrate "worker" status. Rather, they are characteristic of *both* "independent contractor" and "worker" relationships, and thus do little to inform the inquiry.

Consequently, the majority's deference to the facts relied on by the hearings officer while at the same time properly recognizing that the hearings officer "misconstrued and misapplied" the law is error. When all of the hearings officer's findings are considered, including those relied on by the majority, there is only one correct legal conclusion that can be reached: the employment relationship between Roy and Gary was an independent contractor relationship. That conclusion necessarily follows because Roy retained no express authority to direct or control the day-to-day work, nor did he ever exercise such

control during the audit period. What is left is to consider is whether Roy had the implicit right to control Gary's day-to-day activities based on the circumstances of their relationship. Those circumstances include the fact that Gary bid on jobs individually and set his own compensation for his work. He was not a salaried employee, but was paid for the work completed. He provided all of his own tools, equipment and materials for the performance of his work. He **<169 Or App 368/369>** could refuse to work or choose to work on a particular job. He determined when he would work. He worked for other people and held himself out as an independent contractor to the public. All of those circumstances are antithetical to "worker" status.

The majority and I also differ regarding the significance of our holding in *Oregon Drywall Systems v. Natl. Council on Comp. Ins.*, 153 Or App 662, 985 P2d 195 (1998). Although it can be said generally that no one case in this area of the law will ever be controlling because of differing circumstances, our precedents can be instructive in what factors to consider in determining whether worker or independent contractor status exists. In *Oregon Drywall*, we held that independent contractor status *existed* as to subcontractors with special expertise and some of whom worked *only* for the employer. 153 Or App at 665, 669. The import of those facts will vary from case to case, but our holding in *Oregon Drywall* is instructive on how to view properly the facts in this case in light of the hearings officer's findings that Roy had other workers who could not do tile work and, thus, he was required to "subcontract" that work out to Gary and the majority's emphasis on the fact that 90 percent of Gary's work during the audit period was done for Roy.[2]

At the heart of the dispute between myself and the majority is a concern about where the majority opinion takes the law in this area when it affirms the hearings officer after he misconstrued and misapplied the appropriate legal tests. I am persuaded, based on the provisions of ORS 656.027(1993); ORS 670.600 (1993) and ORS 656.005(30) and (31) and the Supreme Court's holding in *S-W Floor Cover Shop* that the law requires that a distinction be preserved between "worker" and "independent contractor" status. At stake in the making of that distinction is a policy judgment made by the legislature that the many small businesses who operate as independent subcontractors for general contractors in the building trades all over the state are not subject to the reach **<169 Or App 369/370>** of the workers' compensation law unless the general contractor exercises more than control over the end result. We frustrate that policy through judicial fiat if we permit the division to adjudicate on a basis that is not in accordance with the legislature's intent. In my view, the facts of this case present a classic example of an independent contractor relationship typically found in the construction industry. For these reasons, I dissent from the affirmance of the hearings officer's ruling that Gary was Roy's "worker."

Landau and Linder, JJ., join in this dissent.

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[2] The hearings officer did not have the benefit of our opinion in that case when he decided this case.

Cite as 169 Or App 556 (2000) August 30, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Susan M. Shotthafer, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and BROOKINGS HARBOR HIGH SCHOOL, Petitioners,
v.
SUSAN M. SHOTTHAFER, Respondent.
(98-01697; CA A105289)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 14, 1999.
David O. Wilson, Senior Trial Counsel, argued the cause and filed the brief for petitioners.
Scott M. McNutt, Jr., argued the cause and filed the brief for respondent.
Before De Muniz, Presiding Judge, and Haselton and Wollheim, Judges.
WOLLHEIM, J.
Reversed and remanded for reconsideration.

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169 Or App 558> Liberty Northwest Insurance Corporation (Liberty Northwest) and its insured, Brookings Harbor High School, petition for review of an order of the Workers' Compensation Board that determined that claimant's mental disorder was compensable. We review for errors of law and for substantial evidence. ORS 183.482(8). Because the Board erroneously held that a letter to claimant from her supervisor was not a "disciplinary, corrective or job performance evaluation action," ORS 656.802(3)(b),[1] we reverse and remand for reconsideration.

We summarize the facts from the Board's order and from the record. Claimant began working as a high school teacher in September 1996. Claimant's position was probationary for the first three years, which meant that she was subject to a more rigorous evaluation process, and her contract could be terminated more easily than that of a permanent teacher. Claimant's initial teaching load included two Spanish courses and a film literature course. She was assigned to a "portable" classroom that was not part of the main school building. The principal, Darold Powell, instructed claimant to impose discipline in her classroom because the students generally considered the portable as a place "to party." Claimant attempted to impose a disciplinary approach consistent with the principal's direction.

Claimant's first semester of teaching was uneventful with a few notable exceptions. On one occasion, she was "booed" by students when she was introduced at a school assembly. On other occasions students "egged" the outside of her portable, left a rotten egg inside her classroom, and let the air out of the tires of her car while it was parked in the school lot.

169 Or App 559> In January 1997, Powell wrote a letter to claimant expressing his concern that enrollment in both of her Spanish classes had declined dramatically. In that letter, he noted that Spanish was an elective course and that, if student enrollment continued to decline, the Spanish program and her position may lose funding. The letter asked claimant to give "serious thought" to making the "classes more attractive to students" and encouraged claimant "to consider grades and praise more in line with what [the students] are used to receiving."

In March 1997, claimant received her first performance evaluation. Although it noted some areas that needed improvement, Powell recommended that claimant's employment be continued for the following school year. Shortly thereafter, claimant received a letter from the superintendent, Dr. Paul Prevenas, notifying claimant of the opportunity to renew her probationary teacher contract for the 1997-98 school year. Claimant accepted the contract renewal offer.

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[1] ORS 656.802(3)(b) provides that a mental disorder is not compensable unless:

"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." (Emphasis added.)

In June 1997, claimant gave final exams in her Spanish classes. Many students did not do well and several expressed concerns about their grades. The day after grading the first set of exams, while claimant was giving another exam, the mother of one of claimant's students confronted claimant in her classroom concerning the daughter's exam. Because other students were taking an exam, claimant asked the mother to return at a more convenient time. The mother returned the next day, became very angry with claimant, and wrote a letter to the principal complaining about claimant. On the last day of school, a second parent interrupted claimant's class, expressed anger about grades and threatened claimant. On neither occasion did the parent possess the required pass to enter claimant's classroom. After those two incidents, claimant wrote a lengthy letter to Powell explaining her meetings with the parents and the grades. Claimant ultimately raised several students' final grades for various reasons.

That summer, Powell wrote to claimant telling her that he had received a letter, several phone calls, and personal visits from parents complaining about her Spanish **<169 Or App 559/560>** classes. Among other things, Powell's letter explained (1) his concerns about the strong feelings parents expressed about her teaching abilities; (2) his opinion that it would be very difficult for claimant to overcome the "reputation" she had established in the student body and the community; (3) that he would recommend to Superintendent Prevenas and the Board of Education that her salary step increment for the following year be withheld; and (4) that he would meet with claimant to establish a "plan of assistance." Prevenas subsequently sent claimant a letter providing claimant an opportunity to respond to Powell's recommendation. The day after receiving the superintendent's letter, claimant sought treatment for gastritis and acute situational anxiety. Claimant later responded to Powell's recommendation and to other matters.

In August 1997, several more events occurred. First, the county sheriff responded to a call from claimant's husband concerning suspicious activities by a group of teenagers that had occurred near claimant's house. Second, yet another parent of a Spanish class student wrote to Powell to complain about her daughter's final grade, to complain about an incident involving claimant and the parent that occurred earlier that year, and to request that the principal consider removing claimant from the school system. Powell informed claimant of that letter and claimant responded. Third, Prevenas informed claimant that, because her performance evaluation was not "substandard," the school district could not withhold her salary increment. However, because of "several alleged actions" after that evaluation, the school district had legitimate questions as to the quality of her teaching. Therefore, Prevenas told claimant, he had directed Powell to commence an evaluation process "immediately upon the start of the upcoming 1997-98 school year," and that the school district "reserved" the option to withhold claimant's salary increment for the remaining portion of the school year. Fourth, claimant continued her treatment for anxiety and depression.

After the school year began, a parent of one of claimant's Spanish students wrote to Powell expressing concern about a textbook shortage and potential copyright infringement problems for materials claimant had copied for her students. The parent also complained about claimant's teaching. **<169 Or App 560/561>** In fact, ordering textbooks was not claimant's responsibility, and she had followed administrative instructions to make the copies. Claimant was not given the letter, nor was she given an opportunity to meet with that parent. Rather, claimant was given an opportunity to meet with Powell to "discuss the issues" raised by the parent.

In October 1997, Powell notified claimant that he had met and spoken with several parents of her Spanish class students who had expressed concerns about her teaching. He also informed her that a group of "probably 12 to 15" parents were unhappy about her class and were planning to come in as a group and confront claimant in her class. He instructed claimant to tell the parents to go to the administrative office if they appeared at her classroom. Later, Powell wrote claimant a memorandum explaining that several students had come to him and outlining their complaints. Powell also told claimant that both he and the assistant principal would be formally and informally observing her class. Powell performed a formal observation later that month and prepared a formal evaluation. Claimant responded in writing to the parents' and students' complaints, as well as to the formal evaluation.

In early November 1997, claimant began counseling with Kathleen Kosche, L.C.S.W., who assessed claimant as suffering from depression and anxiety. Kosche also referred claimant to a psychiatrist. Shortly afterwards, claimant received a Notification of Performance Deficiency. By mid-November, claimant began treatment with a psychiatrist, Dr. Martin, who diagnosed claimant as

suffering from anxiety and depression. Claimant also wrote a memo to Powell discussing a conference she had with a parent, quarter grading, and performance problems she was having with some of her students. During that period in mid-November, the assistant principal informally observed claimant's Spanish class on two occasions. In late November, claimant's treating physician, Dr. Manuele, removed claimant from her job in order to treat her physical and mental health. Claimant filed a worker's compensation claim that same day.

In early December 1997, Powell completed claimant's performance evaluation and recommended a plan of **<169 Or App 561/562>** assistance. In addition, the assistant principal completed another Notification of Performance Deficiency. Powell subsequently wrote to claimant explaining that, because a sufficient number of observations had been conducted prior to claimant's departure for medical reasons, it was appropriate for him to complete a formal evaluation. That letter included a copy of the evaluation and invited claimant to meet with him to review it. Several days later, Powell completed a plan of assistance and sent it to claimant.

In February 1998, Prevenas informed claimant that he was considering a recommendation not to renew her contract for the following school year and provided claimant with an opportunity to meet with him and discuss the recommendation. Two weeks later, Prevenas notified claimant of the Board of Education's decision not to renew claimant's contract. Around the same time as the notification, claimant reported to the sheriff that two of her car tires had been slashed while in her driveway.

In April 1998, claimant was examined by Dr. Fried, a psychiatrist, for purposes of an independent medical examination (IME). See ORS 656.325 (allowing an insurer to direct an IME).

Liberty Northwest denied claimant's mental disorder claim. After a hearing, an administrative law judge (ALJ) set aside the denial. The Board reviewed the opinion and order and affirmed.

The Board found that one of the principal causes of claimant's mental condition was the criticism from her students and their parents. The Board cited, as examples, the two confrontations with parents in June 1997, the numerous letters sent to Powell, the information from Powell of oral criticism, and Powell's warning that a group of parents intended to confront claimant in her class. Noting that under ORS 656.802(3)(b), claimant must prove that employment conditions causing a compensable mental disorder are conditions other than those "generally inherent in every working condition," the Board concluded that the extent of criticism experienced by claimant was not "generally inherent." The Board found that those incidents showed that claimant was not just criticized, she was threatened and intimidated.

169 Or App 563> The Board also found that the actions by Powell and the assistant principal in response to complaints and criticism from parents and students were another primary factor in causing claimant's mental condition. Concerning the January 1997 letter from Powell to claimant, the Board reasoned:

> "Because the letter did provide only a suggestion and did not direct claimant to teach in a different manner, we do not consider the letter as 'disciplinary, corrective or job performance evaluation' action. Consequently, whether reasonable or not, we consider it in deciding the compensability of claimant's mental disorder."

The Board also concluded that, although Powell's recommendation to withhold claimant's salary increase constituted a disciplinary action, that recommendation was premature and was therefore unreasonable. Consequently, the Board found that both the January 1997 letter and the recommendation to withhold claimant's salary increase could be considered in determining whether claimant's condition was compensable.

The Board ultimately concluded that parent and student criticism and the actions taken by the school administrators were the major contributing cause of claimant's mental disorder. Thus, because the medical opinions uniformly showed that those employment factors were the major contributing cause of that disorder, claimant established medical causation. The Board also concluded that, because the other requirements for proving the compensability of a mental disorder were not disputed on review, claimant proved compensability of the mental disorder.

Liberty Northwest advances five assignments of error. We address each in order of merit.

Liberty Northwest assigns as error the Board's finding that the principal's January 1997 letter to claimant was not a "disciplinary, corrective or job performance evaluation action." Liberty Northwest argues that the term "reasonable" qualifies the language "disciplinary, corrective or job performance evaluation actions by the employer" and broadens **<169 Or App 563/564>** the application of the statute to include letters and memorandum from supervisors that suggest or recommend that certain actions be taken by employees. Liberty Northwest further argues that the Board's interpretation emphasizes form over substance by focusing more on whether a letter contains a heading that states "performance evaluation" rather than on the content and purpose of that letter. Claimant argues that, because the letter did not contain an order or provide definitive guidance or instructions on how to act, it did not constitute a reasonable order or a corrective action.

We agree with Liberty Northwest. We fail to see how a letter from a supervisor recommending that a corrective action be taken by an employee does not constitute a "corrective or job performance evaluation action." That is particularly so in this instance considering the probationary nature of claimant's employment. The January 1997 letter stated that if certain conditions did not improve, claimant's position could be eliminated. The purpose of the letter was to help claimant improve her "rapport" with her students and make her Spanish classes more attractive to students. The letter noted deficiencies and recommended specific courses of action, some of which claimant adopted. For those reasons, the letter was a corrective action. The Board erred when it held otherwise.

Because the Board did not assign weight to the various causative factors when it determined that compensable work-related factors constituted the major contributing cause of claimant's mental stress, we cannot determine whether the Board's error affected its ultimate conclusion. Therefore, we must reverse the Board's order and remand for the Board to determine the reasonableness of the January 1997 letter and to reweigh the various causative factors to determine the major contributing cause of claimant's mental disorder.

We emphasize that our holding here is only that the January 1997 letter constituted a "disciplinary, corrective or job performance evaluation action." We offer no opinion whether that corrective action was reasonable or unreasonable. The reasonableness or unreasonableness of a corrective **<169 Or App 564/565>** action is a matter for the Board, in the first instance, to determine.

Liberty Northwest's next assignment of error is that the Board erred, as a matter of law, when it stated that "[e]mployment conditions that constitute 'reasonable disciplinary, corrective or job performance evaluation actions by the employer' are not considered in determining compensability of a mental disorder. *See* ORS 656.802(3)(b)." Liberty Northwest argues that the Board's formulation of the law improperly ignores noncompensable employment factors by not considering them at all in the major contributing cause analysis used to determine the compensability of a claim. Liberty Northwest claims that the Board weighed compensable employment factors against only nonemployment factors in its analysis. Claimant responds that the Board's statement is a correct statement of law and that it merely points out that the noncompensable employment factors enumerated in ORS 656.802(3)(b) are not to be weighed as if they were compensable employment factors. Claimant claims that the Board did enumerate and consider reasonable employment disciplinary measures that weighed against compensability of the claim.

Although the Board's statement is not necessarily incorrect, as is demonstrated by claimant's interpretation, we note that the Board's expression of the law is less than clear. Although it appears as if the Board did engage in the proper weighing process in its major contributing cause analysis--despite the unclear statement of law--we describe the proper weighing process here for purposes of clarity.

The first step in that process is for the Board to place each factor causing claimant's mental disorder into one of three different categories. The first category consists of causative work-related factors that are *not excluded* by ORS 656.802(3)(b). The second category consists of causative work-related factors that *are excluded* by ORS 656.802(3)(b). The third category consists of causative factors that are not related to work. The second step requires that the Board weigh the nonexcluded work-related factors against *both* the excluded work-related factors and the non-work-related factors. If the nonexcluded work-related factors outweigh all the other factors, the condition is considered work-related and the claim is *compensable*. However, if the combined weights of the excluded work-related factors and the non-work-related factors outweigh or are of equal weight to the nonexcluded work-related factors, the claim is *not compensable*.

Liberty Northwest also assigns as error the Board's consideration of the incident of claimant's slashed tires and the incident involving several youths near claimant's home to establish that claimant was not just criticized, but rather was threatened and intimidated. Liberty Northwest argues that both incidents failed to meet the ORS 656.802(3)(a) requirement that compensable employment conditions exist in a "real and objective sense" because the relationship of the two incidents to claimant's work was supported solely by claimant's subjective belief that they were related. Claimant points out that the inclusion of an off-premises event as a work-related factor is not excluded by case law or statute so long as the incident flows from a person's work. Claimant argues that making a finding that those incidents were work related is part of the Board's fact finding role. Simply put, claimant argues that claimant testified to the incidents, testified as to the cause of those incidents, the Board chose to believe that testimony, and it reached the same conclusion as claimant. We agree with claimant. The Board did not err as a matter of law in considering those factors. Substantial evidence supports the Board's conclusion that those events were work related.

Liberty Northwest's next assignment of error is that the record does not contain substantial evidence for the Board's finding that claimant was threatened and intimidated. Liberty Northwest argues that if the two events at issue under the previous assignment of error are eliminated from the work-related factors enumerated by the Board, the remaining factors are ones that are "generally inherent in every working situation" and are therefore noncompensable. Even if our resolution of the previous assignment of error--concerning the two off-premises incidents--did not resolve this assignment of error in claimant's favor, substantial evidence exists that would permit a reasonable person to find that claimant was subjected to work-related factors that are **<169 Or App 566/567>** not "generally inherent in every working situation." In addition to the two events cited above, the Board also relied upon evidence of angry confrontations with parents, "booing" at a school assembly, the "egging" incidents, and the unjust blaming of claimant by parents for the lack of books and possible copyright infringement in reaching its conclusion. We agree with the Board that those factors are not "generally inherent in every working situation." *See Whitlock v. Klamath Cty. School District*, 158 Or App 464, 469-75, 974 P2d 705, *rev den* 329 Or 61 (1999) (discussing "generally inherent in every work situation"). The Board did not err when it concluded that claimant was intimidated and threatened at work.

Liberty Northwest's final assignment of error posits that the Board erred when it relied on claimant's own list of stressors, without differentiating between the compensable stressors and noncompensable stressors, in reaching the conclusion that the medical opinions uniformly showed that employment was the major contributing cause of claimant's stress. There was no error. The Board did not merely rely on claimant's list of stressors in reaching its conclusion. Liberty Northwest's argument ignores the fact that claimant's list of stressors was generated during the IME and was generated at the specific request of Liberty Northwest several months after claimant visited Kosche and Martin. The record indicates that Kosche and Martin did not uncritically adopt claimant's list of stressors when they evaluated claimant and reached their separate diagnoses that claimant suffered depression and anxiety from her employment. That fact was further substantiated by Martin's testimony before the ALJ. The Board did not err.

In summary, the Board erred when it found that Powell's January 1997 letter to claimant was not a "disciplinary, corrective or job performance evaluation action." We therefore reverse the Board's order and remand for the Board to determine the reasonableness of the January 1997 letter and to reweigh the various causative factors to determine the major contributing cause of claimant's mental stress.

Reversed and remanded for reconsideration.

Cite as 169 Or App 573 (2000) August 30, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Stacy Frierson, Claimant.

LABOR FORCE OF OREGON, Petitioner,
v.
STACY FRIERSON, Respondent.
(98-03225; CA A105758)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 10, 1999.
Jerald P. Keene argued the cause and filed the brief for petitioner.
Gordon S. Gannicott argued the cause for respondent. With him on the brief was Hollander, Lebenbaum & Gannicott.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded.

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169 Or App 575> Employer petitions for review of a Workers' Compensation Board order awarding claimant permanent partial disability. It argues that the Board incorrectly used findings of impairment that did not meet American Medical Association (AMA) validity criteria in calculating the award. We reverse and remand.

Claimant suffered a compensable lumbar strain while lifting heavy metal tubes. When his claim was closed with no award of permanent partial disability, he requested reconsideration by a medical arbiter. *See* ORS 656.268(7)(a). The medical arbiter, Dr. Bald, performed a series of range-of-motion measurements to determine the extent of claimant's disability. Bald recorded his measurements on a standardized form, which lists five categories of different movements. In each category, the form asks "[a]re measurements within +/- 10 [percent] or five [degrees] (whichever is greater)" and provides a box for the arbiter to check "yes" or "no."[1]

On two of the five categories, Bald checked "no." On three of the five categories, he checked "yes," and he left one subcategory--the "straight leg raising validity check"--blank. As part of his report, Bald also answered specific questions. The fifth question stated: "If any findings are considered invalid, provide rationale and detailed reasoning in accordance with Bulletin 239 and the AMA Guides[.]" Bald responded: "Today's findings are fraught with significant inconsistencies. However, I do feel that they are a reasonable description of the claimant's current level of function." Based on Bald's report, the Department of Consumer and Business Services issued an order on reconsideration that awarded claimant nine percent unscheduled permanent partial disability.

169 Or App 576> Employer requested a hearing before the administrative law judge (ALJ). Relying on OAR 436-035-0007(28), employer argued that Bald's findings were invalid because they did not satisfy the AMA criteria. The ALJ disagreed, reasoning:

> "The employer/insurer's main argument is that Dr. Bald's range of motion findings are invalid pursuant to OAR 436-03[5]-0007(2[8]) and therefore should not be rated. The employer/insurer's argument is set forth in detail at page 4 of its closing argument. Claimant contends on the other hand that Dr. Bald's findings are valid and responds in

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[1] An interpretative bulletin issued by the Workers' Compensation Division describes the relevant validity criterion for those measurements:

> "The AMA's Guides state that 'Reproducibility of abnormal motion is currently the only known criterion for validating optimum effort. The examiner must take at least three consecutive measurements of mobility which must fall within plus or minus ten percent or five degrees (whichever is greater) of each other to be considered consistent.'"

Workers' Compensation Division Bulletin No. 242, at 2 (Feb 1, 1995).

> detail to the employer/insurer's argument at page 3 of his closing argument. After careful consideration of both arguments I must agree with claimant. It is clear that Dr. Bald was aware of significant inconsistencies regarding claimant's range of motion findings as he specifically states at Exhibit 19-3 and 19-4. But Dr. Bald performed three separate measurements for lumbar extension (1.2 percent impairment) and five separate measurements for lumbar flexion (4.0 percent impairment). After performing all of these measurements and after a comprehensive examination of claimant and preparation of a thorough medical arbiter evaluation report, Dr. Bald concluded that his range of motion findings are a reasonable description of claimant's current level of function (permanent impairment). The range of motion findings are therefore valid and support claimant's scheduled PPD award."

The Board adopted the ALJ's opinion and affirmed.

On review, employer argues that the Board incorrectly applied OAR 436-035-0007(28). That rule provides:

> "Validity shall be established for findings of impairment according to the criterion noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990,** unless the validity criterion for a particular finding is not addressed in this reference, is not pertinent to these rules, or is determined by physician opinion to be medically inappropriate for a particular worker. Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physical determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid. When findings are determined to **<169 Or App 576/577>** be invalid, the findings shall receive a value of zero. If the validity criterion are [*sic*] not met but the physician determines the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid." (Boldface in original.)

We held that, under a former version of this rule, findings of impairment that do not meet AMA validity criteria may not be used to rate a claimant's impairment. *Roseburg Forest Products v. Clemons*, 169 Or App 231, 240, __ P3d __ (2000) (interpreting *former* OAR 436-035-0007(27) (1996), renumbered as OAR 436-035-0007(28)(1998).[2]

Under the amended rule, the Board potentially had to resolve two issues in this case. The first issue is whether Bald's findings of impairment satisfy the AMA criteria. If they do not, the second is whether the explanation that Bald gave met the standard stated in OAR 436-035-0007(28); that is, the question becomes whether Bald's statement--"I do feel that [the findings] are a reasonable description of the claimant's current level of function"--constitutes a "written rationale, based on sound medical principles, explaining why the findings are valid."

The ALJ's opinion, which the Board adopted, does not address either issue specifically. Indeed, as we observed in *Roseburg*, the Board had previously held that the former version of OAR 436-035-0007(28) required it to use findings of impairment that did not comply with the AMA criteria unless the physician had issued a written opinion explaining why those findings were invalid. 169 Or App at 237. The Board's opinion in this case does not preclude the possibility that it ruled, as it previously had and as claimant had expressly urged it to do,[3] that Bald's findings should be used **<169 Or App 577/578>** to rate claimant's impairment unless Bald had issued a written opinion explaining why his findings were invalid.

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[2] The Workers' Compensation Division amended the rule in 1997 to add the final sentence quoted above. That amendment is consistent with our reading of the former version of the rule. It also eliminates an incongruity in the former version of the rule. The rule, as amended, permits a physician to explain why findings that do not comply with the AMA guidelines should nonetheless be used, as well as explaining why findings that do comply with the guidelines should nonetheless not be used. *See Roseburg*, 169 Or App at 239 n 7 (noting incongruity).

[3] Claimant advanced that position in this case, first to the ALJ and then to the Board, as a reason why it should use Bald's impairment findings. Claimant made that argument on page three of its closing argument to the ALJ; in his opinion, the ALJ noted that page of claimant's closing argument and agreed with claimant.

Before we can address employer's arguments that the Board failed to apply the rule properly, we must be able to ascertain the basis of the Board's ruling. In other words, for an order to be adequate for judicial review, we must be able to discern what the Board found as fact and why its findings led to its conclusions. *SAIF v. Brown*, 159 Or App 440, 445-46, 978 P2d 407 (1999); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). Because we cannot do so, we reverse and remand for further proceedings consistent with this decision.

Reversed and remanded.

Cite as 169 Or App 625 (2000) September 13, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ed Long, Claimant.

ED LONG, Petitioner,
v.
ARGONAUT INSURANCE CO. and WASATCH ELECTRIC, Respondents.
(98-02853; CA A106544)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 13, 1999.
Gloria D. Schmidt argued the cause and filed the brief for petitioner.
Jerald P. Keene argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Reversed and remanded.

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169 Or App 627> Claimant seeks review of an order of the Workers' Compensation Board (Board) upholding a Workers' Compensation Division (Division) order denying claimant's request for reconsideration on the ground that it was untimely. We reverse and remand.

The facts are not in dispute. Claimant injured his ankle at work on October 1, 1997. Employer accepted the claim. On January 20, 1998, employer closed the claim by notice of closure. It mailed a copy of the notice of closure to claimant on that date, but it neglected to mail a copy to claimant's attorney of record. Claimant's attorney was not aware of the notice of closure until March 24, 1998. On that date, claimant filed a request for reconsideration with the Division. The Division dismissed the request as untimely, because it was not filed within 60 days of the date of the notice of closure.

Claimant requested a hearing, and the administrative law judge (ALJ) reversed, reasoning that the notice of closure did not begin to run the 60-day filing deadline because it had not been mailed to claimant's attorney, as required by rule. The Board reversed the ALJ and upheld the Division's dismissal of the request for reconsideration. According to the Board, the failure to send a copy of the notice of closure to claimant's attorney may provide grounds for a penalty, but it does not mean that the notice was insufficient to begin the running of the 60-day deadline.

On review, claimant argues that, under our decision in *SAIF v. Fuller*, 159 Or App 426, 978 P2d 459 (1999), a notice of closure that has not been mailed to a claimant's attorney does not trigger the 60-day deadline for requesting reconsideration. Employer argues that the Board correctly concluded that the failure to mail a copy of a notice of closure satisfies a condition of imposing a penalty, but it does not affect the validity of the notice itself.

At the outset, we note that, in *Fuller*, we affirmed *without opinion* an order of the Board that concluded that a determination order was invalid because a copy had not been sent to claimant's counsel. The affirmance without opinion **<169 Or App 627/628>** has no precedential value. ORAP 5.20(5) ("Cases affirmed without opinion by the Court of Appeals should not be cited as authority.").

To resolve this dispute, we refer to the wording of the applicable statutes and rules. ORS 656.268(4)(b) (1997) provided that "[t]he 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 Division has promulgated administrative rules to carry out the requirements of the workers' compensation statutes. *See* ORS 656.726(3)(g) (authorizing Division to "[p]rescribe procedural rules" for proceedings not reserved to the Board). Pertinent to this case is OAR 436-030-0015, which provides that an insurer must provide a copy of any notice of closure to the Department and to the parties in accordance with OAR 436-030-0020. That rule, in turn provides:

> "(8) The Notice of Closure shall be effective the date mailed. * * *
>
> "* * * * *
>
> "(9) The original and three color coded copies of the Notice of Closure shall be mailed to:
>
> "(a) The worker (white copy);
>
> "(b) The employer (goldenrod copy);
>
> "(c) The department (yellow copy);
>
> "(d) The worker's attorney, if represented.
>
> "* * * * *
>
> "(11) An insurer who fails to provide the worker's attorney a copy of the Notice of Closure may be assessed a civil penalty * * *."

The notice of closure is thus effective when "mailed." The question in this case is what "mailed" means. The rule expressly provides that mailing requires copies to be sent to the worker, the employer, the department, and the worker's attorney, if the worker is represented. We find it highly unlikely that a notice of closure could be deemed "mailed" within the meaning of the rule merely upon sending a copy to any one of the four listed. For example, if the insurer sent a **<169 Or App 628/629>** copy only to the employer, and not to the worker or the department, the notice of closure has not been "mailed" in any reasonable sense of the term. The rule clearly contemplates sending copies to *all* those listed before a notice of closure may be considered "mailed."

Employer insists that, in establishing a penalty for failure to send a copy of the notice of closure to claimant's attorney, the rules already prescribe all the consequences of that failure. That argument, however, begs the question. It assumes that we are imposing a consequence for the failure to send a copy of the notice to claimant's attorney that the rules do not already impose. As we have observed, the text of OAR 436-030-0020(9) itself provides that a notice of closure is "mailed" only when sent to all the parties listed in the rule. Moreover, it does not necessarily follow that, merely because the rule expresses a consequence of a violation, there may be no others.

Employer also argues that our reading of the Division's rules conflicts with *Freres Lumber Co. v. Jegglie*, 106 Or App 27, 806 P2d 164 (1991). Employer reads that decision as holding that an insurer's failure to mail a copy of a denial to a claimant's attorney does not invalidate the denial, but rather provides good cause for a late filing of a request for hearing. There is no conflict, however. In *Freres*, no party argued and we did not address the question whether failing to mail a copy of a denial to the claimant's attorney affected the timing of a request for hearing. We *assumed* that it did and held that the failure to mail a copy of the denial to the attorney was relevant to a determination of good cause for a late filing of a hearing request. *Id.* at 30-31.

Because employer did not send a copy of the notice of closure to claimant's attorney, the notice never became effective. Accordingly, the Board erred in concluding that claimant's request for reconsideration was untimely.

Reversed and remanded.

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