VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 53

(Pages 935-1366)

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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.

JULY-SEPTEMBER 2001

Van Natta's Workers' Compensation Reporter is published quarterly by the editors, Robert Coe and Merrily McCabe. A one-year subscription costs $300 for the four quarterly volumes; a bi-monthly update service is available for an additional cost of $180. All subscription, billing, editorial and similar correspondence should be addressed to: The Editors, *Van Natta's Workers' Compensation Reporter*, 1007 Parkway Drive NW, Salem, Oregon 97304. Phone (503) 585-5173; fax (503) 540-0114. All requests for permission to make any otherwise infringing use of all or any part of this publication, including photocopying and copying for use with electronic media, should be addressed to the editors.

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CITE AS

53 Van Natta ____ (2001)

In the Matter of the Compensation of
DUANE A. FERREN, Claimant
WCB Case No. 00-06276
ORDER ON REVIEW
Cole, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) found that claimant was entitled to temporary disability benefits for his depression condition beginning December 14, 1999; (2) directed SAIF to reopen and process the claim for new medical conditions pursuant to ORS 656.262 and 656.268; (3) assessed a penalty for SAIF's allegedly unreasonable refusal to pay temporary disability compensation; and (4) awarded a penalty-related attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable refusal to pay and resistance to the payment of compensation. On review, the issues are temporary disability, claim processing, penalties and attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following changes. We change the first stipulation on page 1 to read: "April 9, 1996: Own Motion Order authorized reopening of claim for TTD beginning January 29, 1996."

In the first paragraph of the findings of fact on page 2, we insert the following after the third sentence: "In March 1978, Dr. Woolpert performed a fusion from D12 to L4 with Harrington rods. (Ex. 7)." In the third paragraph of the findings of fact on page 2, we replace the last sentence with the following: "On January 29, 1996, Dr. Kitchel performed a posterolateral fusion at T10 to L3. (Ex. 19)."

In the first full paragraph on page 3, we change the last sentence to read: "An August 12, 1997 Notice of Closure awarded temporary disability compensation on the Own Motion claim from January 29, 1996 through August 5, 1997." In the first full paragraph on page 4, we delete the first sentence.

CONCLUSIONS OF LAW AND OPINION

Claim Processing

The ALJ relied on *John R. Graham*, 51 Van Natta 1740 (1999), and directed SAIF to process claimant's new medical conditions of compression fractures at L1 and L2, pseudoarthrosis at L1-2, and post-traumatic and post-surgical kyphotic deformities of the lumbar spine pursuant to ORS 656.262 and 656.268. We adopt and affirm that portion of the ALJ's order with the following supplementation.

On review, SAIF makes several arguments contending that we should reverse our decision in *Graham*. We rejected those arguments in *Dave A. Humphrey*, 52 Van Natta 2212 (2000), and continue to do so. We decline to revisit our decision in *Graham* and continue to rely on it as controlling precedent. *See, e.g., William L. Adams*, 53 Van Natta 528 (2001); *Michael T. Bergmann*, 52 Van Natta 1931 (2000); *Camilla S. Kosmoski*, 52 Van Natta 1573 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000).

Moreover, in *SAIF v. Ledin*, 174 Or App 61 (2001), the court affirmed our decision in *Larry L. Ledin*, 52 Van Natta 682 (2000), that directed a carrier to reopen the claimant's claim under ORS 656.262(7)(c) for the processing of a "new medical condition," even though the claimant's 5-year "aggravation rights" under the initial injury claim had expired. The carrier contended that ORS 656.262(7)(c) refers only to conditions that existed at the time of the original claim closure, which necessarily excluded a claim for a new medical condition.

The court rejected the carrier's contention. Citing *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579, *rev den* 329 Or 528 (1999), the court repeated that, under ORS 656.262(7)(a), a claim for a new medical condition is subject to the processing requirements of ORS 656.262(4)(a). Noting that subsection (7)(a) of the statute expressly provides that a claimant may bring a new medical condition claim at any time (without regard to any other provision of the Workers' Compensation Law), the court reasoned that it is not relevant to a new medical condition claim that a claimant's aggravation rights have expired or that the Board might exercise its Own Motion jurisdiction.

Finally, the *Ledin* court determined that the carrier's interpretation of ORS 656.262(7)(c) was inconsistent with the *Johansen* holding. When read in light of ORS 656.262(7)(a) as construed in *Johansen*, the court concluded that ORS 656.262(7)(c) requires a carrier to reopen a closed claim to process a claim for a new medical condition. Accordingly, the court affirmed our decision requiring the carrier to reopen the claimant's claim to process the new medical condition rather than treating the new condition as a claim within our Own Motion jurisdiction.

Consistent with the *Ledin* rationale, we affirm the ALJ's decision that SAIF is obligated to process claimant's new medical conditions under ORS 656.262 and 656.268.

Temporary Disability

The ALJ found that claimant had not withdrawn from the work force at the time of his disability from depression. The ALJ concluded that claimant was a "worker" and was entitled to temporary disability benefits for his compensable depression, beginning on December 14, 1999.

SAIF argues that the ALJ erred in finding that claimant was in the work force. Citing *John R. Johanson*, 46 Van Natta 2463 (1994), SAIF contends that the issue of whether a worker is in the workforce is determined at the time of disability. SAIF further contends that claimant was disabled when his low back condition worsened in the autumn of 1999, and subsequently required surgery in October 1999. SAIF argues that, because claimant was not in the workforce at the time of that 1999 disability and there is no evidence that claimant subsequently returned to the workforce at the time of the acceptance of the new medical conditions and Dr. Henderson's December 14, 1999 work release, he was not entitled to temporary disability benefits pursuant to that work release. In other words, SAIF contends that, because claimant was not in the workforce *prior to* the acceptance of the new medical conditions (including depression) and Dr. Henderson's work release, neither SAIF's acceptance of the new medical conditions nor Dr. Henderson's workforce opinion changed claimant's workforce status. Therefore, SAIF argues, claimant is not entitled to temporary disability benefits.

Claimant argues that SAIF's reliance on *Johanson* is misplaced because *Johanson* involved entitlement to temporary disability benefits regarding a claim that was under the Board's Own Motion jurisdiction. Claimant contends that, here, the temporary disability issue pertains to his depression condition, which is a new medical condition that is not under the Board's Own Motion jurisdiction. In other words, claimant asserts that his workforce status prior to the time the new medical condition became disabling is not relevant.

Based on the following reasoning, we find that claimant's workforce status prior to the time the new medical condition became disabling is relevant to his entitlement to temporary disability benefits for the new medical condition. Furthermore, after conducting our review, we conclude that: (1) claimant was in the workforce at the time he became disabled due to the new medical condition; and (2) he is entitled to temporary disability benefits for his compensable depression, beginning on December 14, 1999.

Claimant has the burden of proving the nature and extent of his disability. ORS 656.266. Claimant must be in the work force to be entitled to temporary disability. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989). Work force status is determined at the time of disability. *Id.*; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414, *rev den* 310 Or 71 (1990). A claimant is deemed to be in the work force if he or she is: (1) engaged in regular gainful employment; or (2) although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or (3) the claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. *Dawkins*, 308 Or at 258.

In *Johanson*, the issue was whether the claimant was entitled to temporary disability compensation under the Board's Own Motion jurisdiction. Citing *Kepford*, 100 Or App at 414, we noted that, in order to be entitled to temporary disability compensation, a claimant must be in the workforce *at the time of disability*. We determined that, inasmuch as temporary disability benefits are authorized under the Board's Own Motion jurisdiction only from the time of surgery or hospitalization pursuant to ORS 656.278(1)(a), the "date of disability" for the purpose of determining whether an Own Motion claimant is in the workforce is the date he or she enters the hospital for surgery. 46 Van Natta at 2463-64. Because the claimant had retired before the date of surgery, we found that he was not in the workforce when he underwent surgery and, therefore, he was not entitled to any temporary disability benefits.

Although *Johanson* addressed entitlement to temporary disability benefits for a claim in the Board's Own Motion jurisdiction, the principle stated in *Kepford*[1] that entitlement to temporary disability compensation is based on a claimant's workforce status *at the time of disability* applies equally to claims that are not in the Board's Own Motion jurisdiction. *Gary E. Puckett*, 53 Van Natta 607, *on recon* 53 Van Natta 676 (2001); *Doyce G. Prince*, 52 Van Natta 1883 (2000); *Janie A. Lengele*, 46 Van Natta 950 (1994).

Unlike claims that are in the Board's Own Motion jurisdiction, the "time of disability" for workers whose aggravation rights have not expired is not tied by statute to the date of hospitalization or surgery. In both initial claims and aggravation claims,[2] the critical time for determining whether a claimant has "withdrawn" from the work force is at the time of his or her disability. *Weyerhaeuser Co. v. Kepford*, 100 Or App at 414.

Furthermore, no matter the status of a claim (whether an Own Motion claim, an aggravation claim, or an initial claim), withdrawal from the work force is not irrevocable; *i.e.*, a claimant who has withdrawn from the workforce could be entitled to temporary disability, if he or she reentered the workforce before becoming disabled. *Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990) (a finding that a claimant withdrew from the work force at one time does not irrevocably commit the claimant to retirement for purposes of receiving temporary disability benefits); *Dean L. Watkins*, 48 Van Natta 60 (1996) (a claimant who reentered the workforce during an open aggravation claim was entitled to temporary disability benefits when he was subsequently disabled from working).

For those claimants who are in the workforce at the time of disability, ORS 656.262(4) provides the requirements for provision of temporary disability benefits on an initial or aggravation claim. These provisions include the requirement that the carrier pay the first installment of temporary disability compensation no later than the 14th day after the employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation. ORS 656.262(4)(a). In addition, no temporary disability compensation is due and payable under ORS 656.268 after the attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician.[3] ORS 656.262(4)(g).

The court has held that the provisions of ORS 656.262 and 656.268 apply to new medical condition claims. *See Johansen v. SAIF*, 158 Or App at 680-681. In this regard, the court held that a new medical condition claim is distinct from an initial claim or an aggravation claim and must be processed as any other claim under ORS 656.262 and 656.268. *Id.*; *Labor Ready, Inc. v. Mann*, 158 Or App 666 (1999) (relied on *Johansen* to find that: (1) the duty to pay temporary disability benefits on a new medical condition claim was encompassed in ORS 656.262(4)(a); and (2) the claimant was entitled to interim compensation pending acceptance or denial of a new medical condition claim). Under the reasoning in *Johansen* and *Mann*, we find that new medical condition claims are subject to the same requirements as other claims in determining entitlement to temporary disability benefits, including workforce issues.

Thus, if a claimant has withdrawn from the workforce prior to disability from the new medical condition and has not reentered the workforce before becoming disabled by the new medical condition, the claimant is not in the workforce at the time of disability and, therefore, not entitled to temporary disability benefits. *Dawkins*, 308 Or at 258. In other words, acceptance of a new medical condition does not trigger determination of entitlement to temporary disability in isolation from workforce issues. We proceed to apply these principles to the facts of the present case.

In 1978, claimant sustained a compensable low back injury. As a result of that injury, claimant received vocational training as a dental technician. In 1995, after claimant's aggravation rights expired on his 1978 low back injury claim, he fell while fishing and sustained a worsening of his low back condition that required surgery. Although SAIF initially issued a partial denial of the current low back

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[1] We note that the claim before the court in *Kepford* involved an initial occupational disease claim. 100 Or App at 412.

[2] To receive temporary total disability upon aggravation of a work-related injury, a claimant must be in the work force at the time of the aggravation. *Cutright v. Weyerhaeuser*, 299 Or 290 (1985).

[3] In contrast, pursuant to ORS 656.278(1)(a), temporary disability compensation in an Own Motion claim is conditioned on whether the claimant's condition has worsened requiring surgery or hospitalization, not on an attending physician's time loss authorization. *Janet F. Berhorst*, 51 Van Natta 1008 (1999); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996); *Pamela Vinyard*, 48 Van Natta 1442 (1996).

condition, it subsequently rescinded that denial and stipulated that claimant's current need for treatment and disability was directly related to the compensable back injury. (Ex. 20). SAIF submitted a recommendation to the Board to reopen the claim and authorize payment of temporary disability compensation under the Board's Own Motion jurisdiction. (*Id.*) On April 9, 1996, an Own Motion Order issued that authorized temporary disability benefits as of January 29, 1996, the date of claimant's surgery.

SAIF paid temporary disability benefits on the Own Motion claim from January 29, 1996 to August 5, 1997. On August 12, 1997, SAIF closed the claim by an Own Motion Notice of Closure. By definition, while claimant received temporary disability benefits due to a compensable injury, he remained in the workforce because he was unable to work due to a compensable injury. *Dawkins*, 308 Or at 258; *Darrell A. Pfaff*, 51 Van Natta 889 (1999); *Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Hallbrook*, 46 Van Natta 79 (1994). SAIF does not dispute this; however, it argues that after the Own Motion claim was closed, claimant failed to remain in the workforce.

Claimant began receiving social security disability benefits in 1997. (Ex. 26AA). In December 1998, Dr. Simmons, orthopedist, examined claimant at the request of claimant's treating physician. (Ex. 21). Although Dr. Simmons took a history that claimant had been unable to return to work as a dental technician "since his accident in 1993" [*sic*, "1995"], he also opined that claimant "would have to be prepared to carry out his sitting existence as far as any vocational activity is concerned and use a cane for walking, bending forward." (Ex. 21-1, -3). Dr. Simmons noted that, if that was not satisfactory, then an extension osteotomy would have to be considered to restore normal lumbar lordosis and restore the normal spinal alignment. (Ex. 21-3).

Claimant sought another claim reopening in the Board's Own Motion jurisdiction. On June 6, 1999, claimant's former attorney notified SAIF that, since claimant was receiving social security disability benefits, it appeared that he would not qualify for time loss benefits. (Ex. 21AA). On July 8, 1999, the Board dismissed claimant's request for Own Motion relief, interpreting claimant's former attorney's statements as withdrawing claimant's request for Own Motion relief. (Ex. 21AB). That dismissal order became final by operation of law.

On October 28, 1999, Dr. Simmons reported that claimant wished to proceed with the lumbar extension osteotomy, noting that claimant went back to dentistry after having a similar surgery in 1982 during the initial claim and would like to do that again. (Exs. 21-1, 21B-2). On October 29, 1999, Dr. Simmons performed the proposed lumbar extension osteotomy. (Ex. 22).

On December 27, 1999, SAIF received a December 14, 1999 notice of change of attending physician from Dr. Henderson, psychiatrist, who authorized temporary total disability. (Ex. 22AB). He diagnosed major depression. (Ex. 22AA-2).

On May 24, 2000, claimant made a written request to SAIF for the acceptance of several new medical conditions pursuant to ORS 656.262(7)(a), including several lumbar conditions and depression. (Ex. 23). On July 14, 2000, SAIF issued a Modified Notice of Accepted that accepted the additional lumbar conditions and depression as a result of the March 16, 1978 work injury. (Ex. 24).

On July 26, 2000, Dr. Dunn, M.D., examined claimant for treatment of low back and left leg pain. (Ex. 25A). Dr. Dunn took a history that claimant was currently unable to work because of the unpredictability of his pain. (Ex. 25A-1). He recommended a spinal opiate trial.

On August 23, 2000, Dr. Henderson explained:

> "This is a brief note stating that [claimant] is not able to perform his past regular work as a result of his depression as well as a medical condition involving ankylosing spondylitis, and status post L3-4 and L4-5 resection and extension of osteotomy. Because of the depression of mood, and chronic pain due to severe orthopedic disorders, it is my opinion that he is not able to perform any meaningful gainful employment now or in the future. He has required the recent insertion of a spinal opiate implant on September 8, 2000 by Dr. Joseph Dunn. He is going to require adjustment of the dosages over a significant time period in order to find the optimal medication level." (Ex. 26).

Claimant explained that after his 1978 work injury, he was retrained and worked as a dental technician for approximately 14 years. (Ex. 26AA-1). Claimant stated that, in 1995, he was actively seeking new employment in that field when his back condition significantly worsened and required

surgery, which was performed by Dr. Kitchel. (*Id.*) Claimant had additional back surgery in October 1999. (*Id.*) He asserts that he is still recovering from the extensive surgery and continues to see a psychiatrist for his compensable depression condition. (*Id.*) Claimant explained:

> "I am still unable to work. I have been unable to work on any sort of reliable basis since before the surgery by Dr. Kitchel for which the claim had been earlier reopened. I sincerely believe any attempt to look for work up to the present time would have been and would still now be futile. Hopefully that will change." (Ex. 26AA-1, -2).

The record establishes that claimant did not return to work or seek work following the closure of his Own Motion claim in 1997. Therefore, in order to prove that he was in the workforce at the time of disability, claimant must establish the factors in the third *Dawkins* criteria; *i.e.*, he was willing to work, although not working or making reasonable efforts to obtain employment because a work-related injury made such efforts futile. *Dawkins*, 308 Or at 258.

SAIF argues that claimant failed to remain in the workforce after his Own Motion claim was closed in August 1997. In support of this argument, SAIF relies on Dr. Simmons' December 15, 1998 report that claimant could perform sitting work. (Ex. 21-3). SAIF also argues that claimant's statement is insufficient to establish that the compensable conditions made a reasonable work search futile. On the other hand, SAIF does not dispute claimant's statement that he is willing to work. (Appellants' Brief, page 3).

Even if claimant removed himself from the workforce after the closure of his Own Motion claim by failing to pursue the "sitting work" Dr. Simmons found him capable of performing in December 1998, we find that claimant was in the workforce at the time of his disability in December 1999. As explained above, withdrawal from the workforce is not an irrevocable condition. *Morris*, 103 Or App at 273. Moreover, SAIF concedes that claimant remained willing to work. Therefore, the remaining factor under the third *Dawkins* criteria is futility of a job search. Although claimant's statements do not provide the requisite medical evidence of futility of work or a work search due to the compensable injury, Dr. Simmons' opinion does. *Jeffrey L. Coefield*, 53 Van Natta 614 (2001) (whether it would be futile for a claimant to seek work is an objective standard determined from the record as a whole, especially considering persuasive medical evidence regarding a claimant's ability to work and/or seek work); *Jackson R. Shrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where the record lacked persuasive medical evidence establishing that the claimant was unable to work and/or seek work due to the compensable injury); *Janet F. Berhorst*, 50 Van Natta 1578 (1998) (same; Board cannot infer futility).

Accordingly, based on claimant's statements and Dr. Henderson's reports, we find that claimant was in the workforce when he became disabled by his compensable depression on December 14, 1999.[4] We agree with the ALJ that claimant is entitled to temporary disability benefits for his compensable depression beginning December 14, 1999, as authorized by Dr. Henderson.

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[4] In reaching this conclusion, we acknowledge SAIF's argument that claimant's receipt of social security disability benefits did not establish that he remained in the workforce because the record contains no explanation as to the grounds for those benefits; *i.e.*, whether those benefits were due to the compensable injury. A claimant's eligibility for social security benefits indicates that he or she is disabled from work due to one or a number of medical conditions. However, the provision of social security benefits does not automatically establish that a claimant is disabled from work because of a compensable injury. Therefore, a claimant's entitlement to social security benefits is not determinative evidence regarding whether he is disabled due to the compensable injury, unless the claimant can establish that the entitlement to disability benefits is due to the compensable condition. *See Kenneth C. Felton*, 48 Van Natta 725 (1996). Nevertheless, here, claimant does not rely solely on his receipt of social security benefits to establish that he remained in the workforce. As explained above, claimant established that he was in the workforce at the time of disability by showing that he was willing to work and any work search was made futile by the compensable injury. Therefore, even without considering the social security benefits, claimant has established the requisite workforce issue. *See Felton*, 48 Van Natta at 726 (receipt of social security benefits not determinative to the workforce issue; the claimant established that he was in the workforce by proving willingness to work and futility of a work search due to the compensable injury); *George D. Hilton*, 53 Van Natta 509 (2001) (receipt of social security benefits was not determinative to the workforce issue because the claimant proved he was in the workforce at the time of disability by proving that he was working at that time); *compare Alexander Newton*, 52 Van Natta 1896 (2000) (the claimant failed to establish he was in the workforce by reliance on receipt of social security benefits where he failed to establish that those benefits were based on the compensable injury); *Robert E. Carper*, 48 Van Natta 1160 (1996) (same).

Penalties under ORS 656.262(11) and Penalty-related Attorney Fees under ORS 656.382(1)

The ALJ found that there was no persuasive evidence to support SAIF's position that claimant had withdrawn from the workforce. The ALJ also found that SAIF was not entitled to rely on claimant's receipt of social security disability benefits as automatically providing it with a legitimate doubt about its obligation to pay temporary disability compensation. The ALJ concluded that SAIF's refusal to pay temporary disability was unreasonable and assessed a penalty under ORS 656.262(11)(a)[5] "equal to 25 percent of all temporary disability compensation due for claimant's depression condition." (Opinion and Order, page 8).

The ALJ also awarded a penalty-related attorney fee under ORS 656.382(1)[6] for SAIF's allegedly unreasonable refusal to pay and resistance to the payment of compensation. The ALJ found that SAIF did not have a legitimate doubt about its duty to reopen and process the claim to closure.

Based on the following reasoning, we find that, because SAIF had a legitimate doubt as to its liability for temporary disability benefits due to workforce issues, no penalty under ORS 656.262(11)(a) or penalty-related attorney fee under ORS 656.382(1) is appropriate.

ORS 656.262(11)(a) provides for a penalty of "up to 25 percent of the amounts then due" if a carrier unreasonably delays or unreasonably refuses to pay compensation. The phrase "then due" refers to unpaid compensation. *See Weyerhaeuser Co. v. Knapp*, 100 Or App 615, 619 (1990) (court rejected the claimant's argument that a penalty (under *former* ORS 656.262(10)) should be based on all temporary disability benefits payable until claim closure, because such an interpretation of the statute "fails to give effect to the word 'then'"); *Wacker Siltronic Corporation v. Satcher*, 91 Or App 654, 658 (1988) (to support a penalty, "there must be an unpaid amount 'then due'"); *see also Jeffrey D. Dennis*, 43 Van Natta 857, 858 (1991) (in the context of an untimely denial, "the delay period is the 'then' with regard to the term 'amounts 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. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Here, on December 14, 1999, Dr. Henderson released claimant from work. (Ex. 22AB). In addition, Dr. Henderson's August 23, 2000 letter stated that claimant was unable to perform any meaningful gainful employment due to his compensable depression and orthopedic disorders. (Ex. 26). Furthermore, based on the ALJ's holding, which we have affirmed, claimant is entitled to temporary disability benefits for his compensable depression beginning December 14, 1999. Thus, there are "amounts then due" upon which to base a penalty under ORS 656.262(11)(a), provided that SAIF had no legitimate doubt as to its liability for those amounts.

SAIF contends that it had legitimate doubt as to its liability because claimant was not in the workforce at the time of Dr. Henderson's work release. Relying on Dr. Simmons' December 1998 opinion that claimant could perform "sitting work" and claimant's receipt of social security benefits (without explanation as to the reason for those benefits), SAIF argues that it was not unreasonable for it to decline to pay temporary disability benefits as a result of Dr. Henderson's December 1999 work release. In addition, SAIF relies on claimant's receipt of social security disability benefits, the only explanation for receipt of which was claimant's former attorney's withdrawal of claimant's claim for time loss on the basis that he was apparently not entitled to time loss benefits due to his receipt of social security benefits. Thus, SAIF argues, it had a legitimate doubt about its obligation to pay time loss.

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[5] ORS 656.262(11)(a) provides, in relevant part:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, * * * the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. * * * If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee."

[6] ORS 656.382(1) provides that if a carrier "unreasonably resists the payment of compensation," the carrier shall pay a reasonable attorney fee.

Claimant argues that SAIF is attempting to defend its refusal to pay temporary disability by relying on the Own Motion claim processing before he was treated by Dr. Henderson. Claimant argues that those past processing decisions are irrelevant to SAIF's obligation to pay temporary disability for his *depression* condition. As explained above, we reject that argument and find that if a claimant has withdrawn from the workforce prior to disability from the new medical condition and has not reentered the workforce before becoming disabled by the new medical condition, the claimant is not in the workforce at the time of disability and, therefore, not entitled to temporary disability benefits.

Although we have found that claimant was in the workforce at the time of disability due to his depression condition, we find that SAIF had legitimate doubt as to its liability for temporary disability benefits based on questions about claimant's workforce status at that time. This doubt was raised by both Dr. Simmons' opinion that claimant could do sitting work, claimant's failure to seek such work, and claimant's receipt of social security disability benefits, without explanation as to the reason for those benefits.[7] *See Alexander Newton*, 52 Van Natta 1896 (2000) (the claimant failed to establish he was in the workforce by reliance on receipt of social security benefits where he failed to establish that those benefits were based on the compensable injury); *Robert E. Carper*, 48 Van Natta 1160 (1996) (same). If claimant was not in the workforce at the time of Dr. Henderson's December 1999 work release, he was not entitled to temporary disability benefits. Therefore, we find that SAIF had a legitimate doubt as to its liability for temporary disability benefits.[8] Accordingly, we find that SAIF did not unreasonably delay or resist payment of compensation. Therefore, no penalty or penalty-related attorney fee is appropriate. ORS 656.262(11)(a); 656.382(1). Accordingly, we reverse the ALJ's penalty and penalty-related attorney fee.

Finally, claimant's attorney is entitled to an assessed fee for services on review concerning the temporary disability and claim processing issues. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability and claim processing issues is $1,200, payable by SAIF. 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. Claimant's attorney is not entitled to a fee for services on review related to the penalties and attorney fee issues. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986); *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986).

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[7] In fact, claimant's former attorney's representation that, since claimant was receiving social security benefits, it appeared that he would not qualify for time loss benefits provided a reasonable basis for SAIF to consider that claimant's receipt of social security benefits was not due to the compensable injury and, thus, claimant did not remain in the workforce on that basis.

[8] In contrast, we find that SAIF had no legitimate doubt as to its duty to reopen and process the new medical condition claim for depression pursuant to ORS 656.262 and 656.268. *See William L. Adams*, 53 Van Natta at 528 (penalty assessed under ORS 656.262(11)(a) where, at the time the claimant asked the carrier to pay temporary disability benefits, case law had been decided and required payment of interim compensation and temporary disability benefits on new medical condition claims); *compare Robert A. Rodgers*, 52 Van Natta 1243, *on recon* 52 Van Natta 1356 (2000) (no penalty assessed for the carrier's allegedly unreasonable failure to pay interim compensation where the Board had not previously addressed the issue of entitlement to interim compensation in new medical condition claims preceded by an original claim with expired aggravation rights; in absence of such authority, the carrier had legitimate doubt as to its liability for interim compensation). Here, at the time SAIF accepted claimant's depression condition, our decision in *Rodgers* had issued and required payment of temporary disability benefits on new medical condition claims. By August 28, 2000, SAIF had received Dr. Henderson's August 23, 2000 letter stating that claimant was unable to perform any meaningful gainful employment due to the compensable depression condition. Thus, as of August 28, 2000, SAIF had no legitimate doubt as to its claim processing duties regarding the new medical condition claim for depression.

Nevertheless, the only "amounts then due" are the temporary disability benefits resulting from Dr. Henderson's work release. Because we have found SAIF had legitimate doubt as to its liability for payment of those amounts based on workforce issues, it was not unreasonable for SAIF to fail to pay those amounts. Therefore, no penalties or penalty-related attorney fees are due on those amounts.

ORDER

The ALJ's order dated January 29, 2001 is affirmed in part and reversed in part. The portion of the ALJ's order that awarded a penalty of 25 percent of the temporary compensation due under ORS 656.262(11)(a) is reversed. The portion of the ALJ's order that awarded a $3,500 attorney fee under ORS 656.382(1) is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

In the Matter of the Compensation of
KARL C. MEINK, Claimant
WCB Case No. 00-00763
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) reduced claimant's temporary disability award, as granted by an Order on Reconsideration; and (2) authorized the SAIF Corporation to offset its overpayment of temporary disability from claimant's unscheduled permanent disability award. On review, the issues are temporary disability and offset.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second paragraph on page 2, we change the date in the first sentence to "February 23, 1998." On page 4, we delete the last paragraph.

The issue in this case is whether claimant is entitled to temporary disability compensation from October 8, 1997 through February 22, 1998. Claimant, a truck driver, compensably injured his low back on August 16, 1997. (Ex. 1). Two days later, he was examined by Dr. Bassinger, who diagnosed a lumbosacral strain. (Ex. 2). Dr. Bassinger released claimant to regular work and did not authorize temporary disability. (*Id.*) On the same date, claimant was examined by Mr. McLean, who diagnosed a lumbar muscle strain. (Ex. 3). The record indicates that Mr. McLean was a physician's assistant to Dr. Bassinger. (Ex. 4).

On September 17, 1997, SAIF accepted a nondisabling lumbar strain. (Ex. 3A). SAIF later reclassified the claim as disabling. (Ex. 9B).

On October 8, 1997, McLean recommended light duty and prepared an off-work slip indicating that claimant was unable to work from October 8, 1997 to October 15, 1997. (Exs. 4, 5). On October 15, 1997, McLean released claimant to modified work and claimant accepted an offer of modified work. (Exs. 7, 7A). One week later, McLean reported that claimant was having difficulty with light duty and he excused claimant from work for one week. (Ex. 9). On October 29, 1997, McLean reported that claimant was unable to work until November 6, 1997. (Ex. 12). On November 6, and 14, 1997, McLean recommended light duty. (Exs. 14, 15). McLean last examined claimant on November 17, 1997. (Ex. 16).

Between November 14, 1997 and February 20, 1998, SAIF wrote to claimant and provided explanations of changes in his time loss payments since he had returned to modified work. (Exs. 15A, 16A, 16B, 16E, 17A, 17B, 18A, 19A).

Dr. Bassinger examined claimant on December 8, 1997 and diagnosed "HNP, L4-5/L5-S1, with L5 neuropathy." (Ex. 16D). He referred claimant to Dr. Miller, who recommended surgery. (Ex. 18). Dr. Miller performed an L5-S1 microdiscectomy on February 23, 1998. (Ex. 20).

SAIF issued an updated notice of acceptance at closure, referring to the accepted conditions as a lumbar strain and an L5-S1 disc herniation. (Ex. 22). An October 11, 1999 Notice of Closure awarded, among other things, temporary total disability from February 23, 1998 through February 21, 1999, and temporary partial disability from February 22, 1999 through May 27, 1999. (Ex. 23).

In December 1999, claimant's attorney asked Dr. Bassinger if he agreed with the "work status authorizations" issued by McLean from October 8, 1997 through February 22, 1998. (Ex. 24-1). Dr. Bassinger agreed only with the dates October 8, 1997 through December 8, 1997, noting that he had last seen claimant on December 8, 1997. (*Id.*) In another letter from claimant's attorney, Dr. Bassinger agreed that claimant remained on restricted duty or off work status from October 8, 1997 up to the February 23, 1998 surgery, until he had sufficiently recovered from the surgery. (Ex. 25-2).

Claimant requested reconsideration of the October 11, 1999 Notice of Closure, asserting that he was entitled to time loss benefits from October 8, 1997 through February 22, 1998. (Ex. 26). A January 5, 2000 Order on Reconsideration awarded claimant temporary disability from October 8, 1997 through May 27, 1999, less time worked. (Ex. 27-4). SAIF requested a hearing.

The ALJ found that a physician's assistant was not a medical doctor and, therefore, claimant's time loss of the period in question was not properly authorized. The ALJ concluded that claimant was not entitled to temporary disability compensation from October 8, 1997 through February 22, 1998. There is no dispute concerning the award of temporary disability benefits from February 23, 1998 through May 27, 1999.

We adopt and affirm the ALJ's order and write to address claimant's specific arguments on review. Claimant argues that physician's assistant (PA) McLean acted as an "agent" of Dr. Bassinger and he contends that when the attending physician authorizes temporary disability through an agent, the statutory requirements are met.

ORS 656.262(4)(a) provides that temporary disability compensation shall be paid if authorized by the attending physician. ORS 656.262(4)(g) provides that temporary disability compensation is not due pursuant to ORS 656.268 "for any period of time not authorized by the attending physician." ORS 656.245(2)(b)(B) provides that "[a] medical provider who is not an attending physician cannot authorize the payment of temporary disability compensation."

As claimant acknowledges, Dr. Bassinger did not "directly" authorize any temporary disability benefits for him during the time period in question. Although claimant asserts that Dr. Bassinger was his "attending physician," the temporary disability "authorizations" at issue were signed by PA McLean, not by Dr. Bassinger.

In previous cases, we have held that an attending physician may not delegate "time loss" authority. In *Francisco J. Delacerda*, 46 Van Natta 1021 (1994), we held that that, under *former* ORS 656.268(3), an "attending physician" could not delegate to another physician the authority to release the claimant to modified work. In *Gerald A. Keipinger*, 47 Van Natta 1509 (1995), we found no statutory authority that allowed an "attending physician" to defer authorizations of temporary disability to a partner. In *Delacerda* and *Keipinger*, we reasoned that there was no provision in the statutes that allowed an "attending physician" to delegate temporary disability authorization to another medical provider. *Delacerda*, 46 Van Natta 1022; *Keipinger*, 47 Van Natta 1511.

We reach the same conclusion in this case. We find no statutory authority that allowed Dr. Bassinger to authorize temporary disability benefits through an "agent." To the contrary, ORS 656.262(4)(g) states that temporary disability compensation is *not* due "for any period of time not authorized by the attending physician." Consequently, even if we assume that PA McLean signed temporary disability "authorizations" with Dr. Bassinger's knowledge and consent, we find that such reports did not meet the terms of ORS 656.262(4)(g), ORS 656.262(4)(a) or ORS 656.245(2)(b)(B), because they were not provided by the "attending physician."

Claimant also relies on OAR 436-060-0020(6) (WCD Admin. Order 96-070), to argue that he is entitled to additional temporary disability benefits.[1] OAR 436-060-0020(6) provides:

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[1] For purposes of addressing claimant's argument, we assume, without deciding, that OAR 436-060-0020(6) is valid. *See Kerry Nguyen*, 52 Van Natta 688, 689 n2 (2000).

> "The insurer or self-insured employer shall verify and document temporary disability authorization from the attending physician within five days of the insurer's notice or knowledge of the worker's disability or claim. Authorization from the attending physician may be oral or written. *The insurer, or the Department at time of claim closure or reconsideration, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work.* No compensation is due and payable after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician pursuant to ORS 656.262(4)(f)." (Emphasis supplied).[2]

In previous cases, we have held that OAR 436-060-0020(6) does not require a carrier to obtain verification of a worker's temporary disability status. *See, e.g., Roberta F. Bieber*, 49 Van Natta 1543 (1997). That rule allows the insurer or the Department to "infer authorization" from certain medical records that reasonably reflect an inability to work, or from "a medical report or chart note *generated at the time of*, and indicating, the worker's inability to work." OAR 436-060-0020(6) (emphasis supplied). Here, claimant relies on Dr. Bassinger's "ratification" of the time loss authorization. (Exs. 24, 25). Dr. Bassinger, however, did not "ratify" the time loss authorization until December 1999 and the "ratification" was not "generated at the time of" claimant's inability to work.

The court discussed OAR 436-060-0020(6) in *Reed v. Labor Force of Oregon*, 155 Or App 595, *recon* 157 Or App 665 (1998). In that case, the claimant argued that he was entitled to temporary disability benefits from November 1, 1995 to March 12, 1996. The claimant referred to an April 22, 1996 letter from his physician authorizing time loss from "November 1, 1995 to present, and for another eight weeks[.]" *Id.* at 597. The claimant relied on OAR 436-060-0020(6) to argue that the carrier had an affirmative obligation to contact his physician and verify his entitlement to temporary disability. The court rejected the claimant's argument, reasoning that he was "entitled only to those benefits for which there is contemporaneous evidence of entitlement." *Id.* at 598-99. The court relied on the Board's finding that there was no evidence, apart from the physician's April 22, 1996 letter, to support the claimant's argument that he was disabled in November 1995. The court affirmed the Board's conclusion that the claimant was not entitled to temporary disability benefits for the disputed period. *Id.* at 599-600.

Here, the only "contemporaneous evidence of entitlement" for claimant's temporary disability benefits is from PA McLean's "authorizations." As the court stated in *Reed*, a claimant is "entitled only to those benefits for which there is contemporaneous evidence of entitlement." *Id.* at 599. Because there is no "contemporaneous evidence of entitlement" for temporary disability from an attending physician between October 8, 1997 and February 22, 1998, claimant is not entitled to temporary disability benefits for that period. Claimant's reliance on OAR 436-060-0020(6) is misplaced.

Furthermore, even if claimant may rely on Dr. Bassinger's December 1999 retroactive "authorization" of time loss, ORS 656.262(4)(g) expressly provides that no authorization of temporary disability compensation by the attending physician shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance. That statute applies to limit the award of retroactive time loss to 14 days regardless of whether the claim was open or pending closure. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, 53, *rev dismissed* 329 Or 503 (1999). Thus, even assuming that claimant's time loss has been "ratified" by Dr. Bassinger, his ratification would not provide the necessary authorization for temporary disability from October 8, 1997 through February 22, 1998.

Finally, we address claimant's argument that the doctrine of equitable estoppel precludes SAIF from offsetting the temporary disability it has paid from claimant's permanent disability award.

In *Stovall v. Sally Salmon Seafood*, 306 Or 25, 33 (1978), the Court explained that the "doctrine of estoppel operates to prevent a person from taking a position contrary to that earlier taken; it prevents a person from proving the truth where that is opposed to a false position earlier taken that caused another to rely on the false position and thereby to choose a course of action." The doctrine of estoppel is only intended to protect those who materially change their position in reliance upon another's acts or representations. *Id.* at 34.

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[2] ORS 656.262 has since been renumbered and presumably OAR 436-060-0020(6) now refers to ORS 656.262(4)(g), rather than ORS 656.262(4)(f).

In *Meier & Frank Co. v. Smith-Sanders*, 115 Or App 159, 162-63 (1992), *recon* 118 Or App 261, *rev den* 316 Or 142 (1993), the court applied equitable estoppel in a workers' compensation case. The court found that the employer's act of telling the claimant and her doctor to proceed with surgery caused the claimant to change her position in reliance on the employer's conduct. *Id.* at 163. The court held that the Board did not err in applying equitable estoppel to require the employer to pay the claimant's expenses of surgery. *Id.*

In this case, claimant provides no explanation of how he changed his position in reliance on SAIF's payment of temporary disability. ORS 656.262(10) provides that merely paying or providing compensation shall not be considered an admission of liability. Because we find no evidence that claimant materially changed his position in reliance on SAIF's payment of temporary disability, we are not persuaded by claimant's estoppel argument. *See Frankie Laverdure*, 51 Van Natta 334, 336 (1999); *Gregory J. Knickerbocker*, 48 Van Natta 156 (1996).

In sum, because the record does not include a contemporaneous time loss authorization from an attending physician for the period from October 8, 1997 through February 22, 1998, we agree with the ALJ that claimant is not entitled to temporary disability benefits for that period.[3] Under these circumstances, we have no statutory authority to award claimant temporary disability compensation for that time period.

ORDER

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

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[3] We note that neither party raised an issue as to whether claimant is subject to a managed care contract. *See* ORS 656.005(12)(b); ORS 656.260(13). Claimant did not argue that physician's assistant McLean *himself* qualifies as an attending physician under ORS 656.005(12)(b). To the contrary, as previously discussed, claimant expressly contended that Dr. Bassinger delegated his "attending physician" status to McLean. Rather than engaging in an analysis that runs counter to the parties' stated positions, we have considered only the issues raised by the parties. *See Fister v. South Hills Care*, 149 Or App 214, 218 (1997), *rev den* 326 Or 389 (1998).

Board Member Meyers concurring.

I agree with the majority's ultimate conclusion that the record does not establish that claimant is entitled to the disputed temporary disability benefits. I write separately to express my concerns regarding the processing of this claim.

As discussed in the majority's opinion, in response to numerous time loss authorizations from a physician's assistant, SAIF paid temporary disability benefits. Rather than objecting to the authorizations or seeking clarification as to whether claimant's attending physician was authorizing these benefits, SAIF simply paid time loss. In fact, no objection to these time loss authorizations was lodged until claim closure, at which time the attending physician's retroactive authorization of such benefits was subject to the 14-day statutory limitation of ORS 656.262(4)(g) as required by the *Bundy* rationale.

Although the majority's conclusion is consistent with the statutory scheme, as interpreted by the appellate courts, I am troubled by the decision's implications for the workers' compensation system. In other words, considering that he was receiving temporary disability benefits pursuant to authorizations from the physician's assistant, it was understandable that claimant would not question the validity of such payments. Yet, under the *Bundy* holding and its interpretation of the relevant statutes, claimant's receipt of these benefits is now deemed an "overpayment" because of SAIF's subsequent challenge to its previously undisputed payment of such compensation and the lack of contemporaneous authorization for these now-disputed benefits from an attending physician.

As required under the *Stovall* rationale, a party seeking to rely on the doctrine of equitable estoppel must establish a material change of position in reliance on another party's acts or representations. Yet, because claimant was statutorily obligated to seek medical services for this claim from a managed care organization (MCO) and actually received temporary disability compensation from SAIF for a series of time loss authorizations provided by the MCO personnel who provided such medical services, there was no "change of position" on his part. Lacking this requisite "change of position," the *Stovall* holding prohibits the application of the equitable estoppel doctrine.

Nonetheless, it is understandable that a claimant subject to a MCO should reasonably expect to receive medical treatment from that statutory entity and compensation from the workers' compensation carrier in a manner consistent with the statutory scheme. Likewise, it is equally incumbent on a workers' compensation carrier to ensure that "physician-related" actions from a MCO are conducted in compliance with applicable claim processing regulations. Because neither of these expectations were achieved during the processing of this specific claim, I consider this case to be particularly troubling.

In conclusion, notwithstanding the legal support for today's decision, I submit that the result constitutes a disservice to the workers' compensation system in general and to this claimant in particular. Accordingly, I respectfully submit this concurring opinion.

Board Members Biehl and Phillips Polich dissenting.

We disagree with the majority's conclusion that claimant is not entitled to temporary disability for the period from October 8, 1997 through February 22, 1998.[1] Therefore, for the reasons stated below, we respectfully dissent.

We begin by noting that SAIF challenged the Order on Reconsideration seeking affirmative relief in the form of a reduction in claimant's award of temporary disability. Consequently, SAIF has the burden of establishing error in the reconsideration process. *See Marvin Wood Products v. Callow*, 171 Or App 175 (2000); *Daniel B. Covert*, 52 Van Natta 1635 (2000); *Roberto Rodriguez*, 46 Van Natta 1722, 1724 (1994). In other words, SAIF must persuasively establish, from the reconsideration record, that the Department's award of temporary disability is in error. *See Callow*, 171 Or App at 183.

ORS 656.005(12) provides, in pertinent part:

> "(b) **Except as otherwise provided for workers subject to a managed care contract,** 'attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury and who is:
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> "(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or
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> "(B) For a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States." (Emphasis added.)

The parties do not assert that P-A McLean is a duly licensed medical doctor, doctor of osteopathy, or a maxillofacial surgeon. That, however, does not end the inquiry. ORS 656.260(13) provides: "Notwithstanding ORS 656.005(12) or subsection (4)(b) of this section, a managed care organization contract may designate any medical service provider or category of providers as attending physicians." Consequently, P-A McLean may be an "attending physician," pursuant to ORS 656.005(12)(b), if claimant is subject to a managed care contract, and if that contract designates physician assistants as "attending physicians" or specifically names P-A McLean as an "attending physician." Because the record establishes that claimant is subject to a managed care contract, P-A McLean's status as a "physician assistant" (rather than medical doctor, doctor of osteopathy, or a maxillofacial surgeon) does not automatically exclude him from being an "attending physician" under ORS 656.005(12)(b).[2] (Ex. 3A).

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[1] SAIF does not dispute that claimant was temporarily disabled from October 8, 1997 through February 22, 1998. Rather, SAIF contends that because P-A McLean was not an "attending physician," claimant is not entitled to temporary disability for that time period.

[2] Both the Notice of Acceptance and the MCO enrollment letter are numbered "Exhibit 3A." Because there does not appear to be a dispute regarding the parties' submission of either document, we have considered both exhibits as admitted by the ALJ's order.

We acknowledge that neither claimant nor SAIF have discussed the significance of claimant's being subject to a managed care contract. However, 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). Moreover, our first task is to determine which provisions of the Workers' Compensation Law are applicable. *DiBrito v. SAIF*, 319 Or 244, 248 (1994); *Bobby A. Bradburry*, 52 Van Natta 1560, 1562 (2000). The Board's *de novo* review includes determining which law applies to the facts of a particular case and applying the law as the record/evidence leads it. *See Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard Co. v. Renalds*, 132 Or App 288 (1995)). Because the record establishes that claimant is subject to a managed care contract, and because the "attending physician" status of PA McLean is the issue to be resolved, we conclude that we cannot correctly apply the provisions of the Workers' Compensation Law without examining the MCO issue.[3]

We have previously noted that SAIF must persuasively establish, from the reconsideration record, that the Department's award of temporary disability is in error. Here, the reconsideration record establishes that claimant is subject to a managed care contract. However, the record does not establish which class or classes of medical care providers may be "attending physicians" under the terms of SAIF's managed care contract because the contract itself is not in the record. Consequently, we are unable to exclude P-A McLean, from the class of medical service providers who qualify as "attending physicians" under the terms of ORS 656.005(12)(b) and ORS 656.260(13). Having concluded that P-A McLean cannot be excluded as an "attending physician" for this particular claim, we are not persuaded that the reconsideration record establishes that the Department's award of temporary disability is in error. Consequently, we would reverse the order of the ALJ and reinstate the January 5, 2000 Order on Reconsideration.

We also disagree with the majority's conclusion regarding the viability of claimant's equitable estoppel argument. Thus, we now turn to a discussion of that issue.

Equitable estoppel may be asserted against insurers or employers in workers' compensation cases. *Meier & Frank Co. v. Smith-Sanders*, 115 Or App 159, 163 (1992) (where the employer's act of telling the claimant and her doctor to proceed with surgery caused the claimant to change her position in reliance on employer's conduct, equitable estoppel operated so as to require employer to pay the claimant's expenses of surgery); *Lamarr H. Barber*, 42 Van Natta 292 (1991). "This doctrine of equitable estoppel or estoppel *in pais* is that a person may be precluded by his act or conduct or silence when it was his duty to speak, *from asserting a right* which he otherwise would have had."[4] (Emphasis in original). *Stovall v. Sally Salmon Seafood*, 306 Or 25, 34 (1978) (*quoting, Marshall v. Wilson*, 175 Or 506, 518 (1944)). The doctrine may be applied "when conduct is 'misleading,' even if it is innocent." *Swift & McCormick Metal Processors Association, Inc. v. Durbin*, 117 Or App 605 (1993).

During the time period in question, SAIF sent claimant 8 letters, each of which not only explained the calculation of temporary disability benefits (as authorized by P-A McLean), but also stated that the "attending physician" had verified claimant could not work. (Exs. 15A, 16A, 16B, 16E, 17A, 17B, 18A, 19A). Assuming, *arguendo*, that P-A McLean was not an "attending physician" under SAIF's managed care contract, we conclude (because claimant was not privy to the terms of that contract) that SAIF had a duty to inform claimant that P-A McLean lacked the authority to authorize temporary disability.

Having determined that SAIF had a duty to correctly inform claimant of P-A McLean's authority to authorize temporary disability under the managed care contract, and having further determined that SAIF failed in its duty, we conclude that SAIF is precluded from asserting its alleged overpayment of temporary disability.

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[3] The issue at hearing, as framed by the parties, was "[w]hether a physician's assistant can authorize time loss." (O&O, p. 1).

[4] Here, SAIF asserts an offset from claimant's unscheduled permanent disability award in the sum of $5,177.39 in temporary disability benefits in accordance with P-A McLean's time loss authorizations. (O&O, p. 4).

Accordingly, we would reverse the ALJ and reinstate the January 5, 2000 Order on Reconsideration.

In the Matter of the Compensation of
JAMES V. OXLEY, Claimant
WCB Case Nos. 00-02350 & 99-05414
ORDER ON RECONSIDERATION
Bischoff, Strooband & Ousey, Claimant Attorney
Bostwick, et al., Defense Attorney

Claimant and ESIS have both requested reconsideration of the Board's February 8, 2001 order that set aside ESIS' responsibility denial. ESIS argues that the Board should have addressed compensability of claimant's condition as it applies to ESIS. Claimant notes that the Board's order did not indicate that the portion of the ALJ's order that set aside the compensability portion of ESIS' denial and awarded attorney fees was affirmed.[1] Claimant seeks an order indicating those uncontested portions of the ALJ's order are affirmed.

Prior to the hearing, ESIS denied compensability and responsibility. JCI also contested compensability and responsibility, but did not formally deny the claim. The issues at hearing were compensability and responsibility. The ALJ set aside the portion of ESIS' denial that contested compensability and awarded a $3,500 attorney fee pursuant to ORS 656.386(1), payable by ESIS. The ALJ also set aside JCI's "de facto" denial of responsibility, concluding that JCI was responsible for the claim.[2] In addition, the ALJ awarded a $1,000 attorney fee pursuant to ORS 656.308(2)(d), payable by JCI.

JCI requested review of the ALJ's order and the only issue raised on review was responsibility. The Board order reversed the ALJ's order on the issue of responsibility and found ESIS responsible for the claim. Because compensability was not contested, the Board order did not address that issue and applied only responsibility principles to decide the case. The Board order neglected, however, to indicate that the portion of the ALJ's order that addressed compensability (and was not appealed) and the portion of the order that awarded attorney fees pursuant to ORS 656.386(1) and ORS 656.308(2)(d) were affirmed.

The ALJ had set aside the compensability portion of ESIS' denial, but ESIS did not contest that portion of the ALJ's order on Board review. While it did not contest the ALJ's compensability analysis initially on Board review, the argument ESIS raises for the first time on reconsideration is that the claim is not compensable. Given the procedural posture of this case, we are not inclined to address ESIS' compensability argument at this late date (particularly when ESIS did not initially challenge on review the ALJ's decision to set aside the compensability portion of ESIS' denial).[3]

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[1] JCI has submitted a response to claimant's motion. We have received responses from both claimant and JCI regarding ESIS' motion.

[2] The ALJ believed that JCI was not challenging compensability at the hearing, but JCI argues that it did contest compensability at hearing, although it has conceded compensability on Board review.

[3] ESIS argues that it may escape responsibility for the condition it accepted by denying the claim under ORS 656.262(6)(c) and (7)(b). In other words, ESIS is asserting that claimant's claim is no longer compensable as to it. ESIS further argues that in relying on *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984), the Board order failed to take into account later legislative changes as well as the court's interpretation of the scope of ORS 656.262(6)(c) and (7)(b) in *Barrett Business Services v. Morrow*, 164 Or App 628 (1999). While it is within our discretion by virtue of our "de novo" review authority to address any issue raised in an ALJ's order, under these particular circumstances, we decline to consider ESIS' compensability challenge on reconsideration. In reaching this conclusion, we take particular note that, on Board review, ESIS neither formally nor informally challenged the ALJ's decision to set aside its compensability denial nor did it dispute JCI's description of the issue as responsibility. Under such circumstances, considering that both claims involved accepted conditions, application of the *Kearns* presumption for resolution of the responsibility issue was appropriate.

ESIS has cited *SAIF v. Dobbs*, 172 Or App 446, *on recon*, 173 Or App 143 (2001), as supplemental authority. We find *Dobbs* distinguishable. In *Dobbs*, the ALJ had set aside SAIF/Sherman's compensability and responsibility denials and upheld the responsibility denials of the three other carriers. SAIF/Sherman requested Board review of the ALJ's order, and on review, we upheld SAIF/Sherman's compensability denial and assigned responsibility to an earlier employer, SAIF/J & J. We found that SAIF/Sherman originally accepted a claim for a lumbar strain. In processing the claimant's claim, SAIF/Sherman determined that the compensable strain had combined with the claimant's preexisting degenerative condition that had previously been accepted by SAIF/J & J and then determined that the accepted strain was no longer the major contributing cause of the claimant's "combined condition." SAIF/Sherman therefore denied compensability of the claimant's current condition. On Board review, we upheld SAIF/Sherman's compensability denial, finding that the claimant had failed to show a compensable combination of the SAIF/Sherman strain and the preexisting condition. ESIS apparently cites *Dobbs* in support of its contention that its compensability denial should also be upheld and responsibility assigned to JCI.

We find *Dobbs* to be factually distinguishable. Here, in contrast to *Dobbs*, the ALJ set aside ESIS' compensability denial and, on Board review, ESIS *did not* contest (either formally or informally) that portion of the ALJ's order. Thus, unlike in *Dobbs*, compensability was not before us in this case.

With regard to claimant's arguments on reconsideration, the Board's February 8, 2001 order should have stated that the ALJ's order was affirmed in part and reversed in part. In this regard, we have affirmed that portion of the ALJ's order that set aside ESIS' denial of compensability and awarded a $3,500 attorney fee pursuant to ORS 656.386(1), payable by ESIS, for claimant's counsel's services in setting aside the compensability denial. In addition, because we have found ESIS responsible for the claim, ESIS will pay the $1,000 attorney fee awarded by the ALJ pursuant to ORS 656.308(2)(d) for claimant's counsel's services in prevailing against the responsibility denial.

Accordingly, the Board's February 8, 2001 order is withdrawn. On reconsideration, as modified and supplemented herein, we republish the February 8, 2001 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
JAMES W. JORDAN, Claimant
Own Motion No. 00-0051M
OWN MOTION ORDER OF ABATEMENT
Donald M. Hooton, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 31, 2001 Own Motion Order.

In order to allow sufficient time to consider the motion, we withdraw our order. The SAIF Corporation is granted an opportunity to respond to the motion. To be considered, that response must be filed within 14 days of the date of this order. Claimant's reply, if any, must be filed within 14 days from the date of mailing of SAIF's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNY R. EMERSON, Claimant
WCB Case Nos. 00-07952 & 00-05529
ORDER ON REVIEW
James W. Moller, Claimant Attorney
David L. Jorling, Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) upheld the self-insured employer's denial of a cervical condition; and (2) declined to consider claimant's "post-hearing" argument regarding the employer's alleged prior acceptance of the denied condition. On review, the issues are compensability and the propriety of the ALJ's procedural ruling.

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

Claimant compensably injured his left elbow, left shoulder, and neck in November 1996. Following a March 1997 surgery, by Dr. Ordonez, the claim was closed in November 1997 with an award of 23 percent unscheduled permanent disability and an additional 14 scheduled permanent disability for loss of use or function of the left arm.[1] (Exs. 75, 76).

In early 1999, claimant began to experience an increase in neck and arm pain. By September 1999, the pain had progressively worsened to the point that claimant sought medical care. Eventually, he again came under the care of Dr. Ordonez, who diagnosed cervical radiculopathy at C3-4, C4-5, and C5-6.[2] (Ex. 114-1).

The employer denied the compensability of the cervical conditions (including the radiculopathy) as both a "new" injury/occupational disease and as a consequential condition of the 1996 compensable injury. (Exs. 144, 152). Claimant requested a hearing.

The ALJ determined that the claim for a "new" cervical condition should be analyzed as an occupational disease rather than an injury. Relying on the opinion of Dr. Rosenbaum (an employer-arranged examiner), the ALJ concluded that claimant had failed to establish the compensability of the "new" cervical condition.[3] Alternatively, the ALJ concluded that claimant had failed to establish the compensability of his cervical condition as a consequential condition of the 1996 compensable injury.

During closing argument, claimant asserted that the employer had previously accepted the "current" cervical condition as a part of the 1996 claim, and that consequently its denial was an impermissible "back-up" denial of an accepted condition. The ALJ determined that claimant had not raised that issue prior to closing argument and accordingly, declined to consider it.

Claimant contends that the "back-up" denial issue was specifically identified in his request for hearing, and thus it had been raised prior to closing argument. Consequently, claimant asserts that the ALJ erred in failing to consider the "back-up" denial issue.

We need not address the procedural question because we find that claimant's "current" condition is not the same condition that had been previously accepted by the employer. In arriving at this conclusion, we rely on the opinion of Dr. Ordonez that claimant's current disc condition is "new." (Ex. 114). Because Dr. Ordonez treated claimant for both the 1996 cervical condition as well as the current cervical condition, he is in an advantageous position to offer an opinion regarding the relationship of the two conditions. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986).

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[1] The accepted conditions at closure were: "(1) Left shoulder strain; (2) Bilateral cervical radiculopathy resulting in Minotomy and Decompression at C6-7 and C7-T1; (3) Left elbow ulnar nerve entrapment at the cubital tunnel." (Ex. 74).

[2] Dr. Ordonez also diagnosed right carpal tunnel syndrome, which it not in issue here. (Ex. 114-1).

[3] Neither party challenges the ALJ's decision to analyze the "new" cervical condition claim as an occupational disease rather than an injury. Consequently, on Board review, we treat the "new" condition claim as an occupational disease.

Claimant seeks to establish the compensability of his "current" cervical condition, 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). 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. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). 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).

The record contains two medical opinions regarding causation. One is from Dr. Ordonez. The other is from Dr. Rosenbaum. Dr. Ordonez's opinion supports the compensability of claimant's "current" cervical condition. Dr. Rosenbaum's opinion does not.

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. Ordonez's opinion.

Dr. Ordonez believed that claimant's cervical condition was a "new problem," which was the result of his work tasks and narrow nerve root canals at C3-4, C4-5, and C5-6. (Ex. 114-1; 114-2). Although Dr. Ordonez opined that claimant's work was the major contributing cause of claimant's cervical spine condition, he offered no evaluation of the relative contributions of claimant's work tasks as opposed to claimant's narrow root canals in producing the cervical spine condition. Without such an evaluation, Dr. Ordonez's opinion is merely an unexplained conclusion, and as such, not persuasive. *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). Consequently, we do not rely on Dr. Ordonez's opinion.

Accordingly, based on this record, we conclude that claimant has failed to establish the compensability of his cervical condition as an occupational disease.

ORDER

The ALJ's order dated February 16, 2001 is affirmed.

July 3, 2001 Cite as 53 Van Natta 951 (2001)

In the Matter of the Compensation of
DELORES KINEY, Claimant
WCB Case No. 00-01515
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Sather, et al., Defense Attorney

On May 9, 2001, we abated our April 12, 2001 order to consider the insurer's request for reconsideration. In our April 12, 2001 order, we affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS) and assessed a penalty for an allegedly untimely denial.

The insurer contends that our order is insufficiently explained because it does not address alleged flaws in Dr. Butters' opinion supporting the claim. Specifically, the insurer argues that Dr. Butters' opinion is inadequate because it addresses only the cause of claimant's need for treatment, not the cause of her condition. The insurer also argues that the doctor's opinion is unpersuasive because it fails to analyze claimant's job duties, particularly the amount of time that claimant held a telephone at work with her wrist extended rather than flexed.

Claimant has filed a response to the insurer's argument.

Having fully considered the parties' arguments, we offer the following.

We first note that Dr. Butters did opine that claimant's work caused her CTS condition, not just her need for medical treatment. (*See* Exs. 20, 23).

Second, as we explained in our prior order (that adopted the ALJ's order, with modification), we find Dr. Butters' opinion persuasive because it is thorough, well-explained, and based on an accurate history regarding claimant's hand-intensive clerical work activities. In addition, we find that claimant's work exposure included constant, asymmetric, and repetitive use of her hands and it involved continual (but not continuous) writing with the left hand while on the telephone. In evaluating Dr. Butters' opinion, we note that the doctor described claimant's gripping, pinching and repetitive hand use at work and we continue to find his opinion persuasive on reconsideration -- in part because he relied on a materially accurate history[1] regarding claimant's work activities. (*See* Exs. 21-13, 21-16, 21-30). Under these circumstances, we rely on Dr. Butters' causation opinion and remain persuaded that claimant's CTS is compensable.

Claimant is entitled to an attorney fee for services responding to the insurer's request for reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $375, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case on reconsideration (as represented by claimant's respondent's brief and her counsel's request), the complexity of the issue, and the value of the interest involved.

Accordingly, we republish our April 12, 2001 order as supplemented and modified herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[1] We do not find that the accuracy of Dr. Butters' history or the persuasiveness of his reasoning depends on how often claimant's right wrist was flexed or extended at work. (*See e.g.*, Ex. 21-29-30). Instead, we find that the doctor relied on a materially accurate history that claimant's work activities were hand-intensive and of the type that could and did cause her CTS.

In the Matter of the Compensation of
LESLIE J. LEIDER-KOCH, Claimant
Own Motion No. 01-0159M
OWN MOTION ORDER
Employers Insurance of Wausau, Insurance Carrier

Reviewing Panel: Members Phillips Polich and Haynes.

The insurer submitted claimant's request to "reopen" her 1988 Own Motion claim. Claimant's aggravation rights have expired. The insurer opposed the reopening of claimant's 1988 claim for the provision of temporary disability compensation on the grounds that: (1) claimant's current condition did not require surgery or inpatient hospitalization; (2) claimant's current condition was not causally related to the accepted condition; and (3) the insurer was not responsible for the current condition.

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

In response to the insurer's submission, claimant requested additional time to obtain copies of the insurer's medical file in order to provide further information in support of her request. Claimant also noted that she was seeking "medical coverage" for her back. The insurer responded to claimant's submission, reiterating that claimant's current condition does not require surgery and noting that it had forwarded a copy of its claim file to claimant.

In response to the insurer's submission, claimant contended that: (1) her "accepted diagnosis" is incorrect as reported by the insurer; (2) her current problems are related to her original 1988 injury; (3) her current condition has effected her current ability to work; and (4) she never received a December 13, 1990 Determination Order and, thus, has been deprived of important workers' compensation "rights." Claimant further requested to be seen by "another occupational care doctor" and asserted that she requires further physical therapy "in order to continue working."

Because claimant's aggravation rights have expired in her 1988 compensable injury with the insurer, this claim is within our sole jurisdiction in our Own Motion authority. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Furthermore, the legislature has provided strict limitations on the Board's Own Motion authority.

Pursuant to ORS 656.278(1)(a), where a compensable injury worsens requiring surgery or hospitalization, "the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery[.]" Thus, by statute, a worker is not entitled to temporary disability compensation until his or her compensable condition has worsened requiring surgery or hospitalization and he or she actually undergoes the surgery or hospitalization.

Here, the record does not contain evidence that surgery or hospitalization has been recommended. Therefore, the record does not establish the necessary prerequisite for the reopening of claimant's Own Motion claim for temporary disability benefits; *i.e.*, claimant's compensable condition has not required surgery or hospitalization. For that reason, we are not authorized to reopen claimant's claim for the payment of temporary disability benefits.[1]

Accordingly, claimant's request for temporary disability compensation is denied.[2]

IT IS SO ORDERED.

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[1] Our jurisdiction extends *only* to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. We do not, in our Own Motion authority, have jurisdiction to decide matters such as the compensability of, and the responsibility for, a claimant's disputed condition. Rather, jurisdiction over such disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 or (in the case of some surgery or medical treatment dispute) with the Director under ORS 656.245, 656.260 or 656.327. *See Gary L. Martin*, 48 Van Natta 1802 (1996). Thus, our decision should not be interpreted as a finding regarding the compensability of, or responsibility for, claimant's current condition or the propriety of the proposed medical treatment. Instead, it is merely a determination that claimant's current condition has not required surgery or hospitalization.

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

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97301

In the Matter of the Compensation of
JEFFREY L. COEFIELD, Claimant
Own Motion No. 01-0110M
OWN MOTION ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

On June 4, 2001, we withdrew our May 3, 2001 Own Motion Order that declined to reopen claimant's claim for Own Motion relief on the ground that he was not in the work force when his compensable condition worsened requiring surgery. We took this action in order to consider claimant's submission of additional information regarding the work force issue. Having received the SAIF Corporation's response, we proceed with our reconsideration.

In our prior order, we determined that claimant's current worsening occurred on March 9, 2001, the date Dr. Dale requested authorization for surgery. However, SAIF has submitted an April 9, 2001 Operative Report. Thus, we find that claimant's current condition worsened requiring surgery on April 9, 2001.[1]

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

In order to satisfy the third *Dawkins* criterion, claimant must first establish that he was willing to work. Failing to demonstrate his willingness to work, a claimant would not be considered a member of the work force, and thus, not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 111 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996).

In our prior order, we were persuaded that claimant had demonstrated his willingness to work. We based our conclusion on claimant's affidavit. On reconsideration, and based on the record before us, we continue to find that claimant was and is willing to work.[2]

In order to be found in the work force, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion. Based on a May 31, 2001 response to an inquiry from claimant's attorney, Dr. Dales "authorized" claimant to "be off work and on temporary total disability" commencing April 9, 2001.

As noted above, the date of disability is April 9, 2001, when claimant underwent surgery. Thus, Dr. Dales' response is insufficient to establish that it was futile for claimant to work and/or seek work *prior* to April 9, 2001. There is no other medical opinion that supports claimant's current "futility" contentions. 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 April 9, 2001 (claimant's disability date), he was unable to work and that it would have been *futile* for him to seek work due to his compensable condition.

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[1] The "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). The relevant time period for which claimant must establish he was in the work force is the time prior to his April 9, 2001 hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

[2] Based on claimant's April 4, 2001 affidavit, we found that he was willing to seek employment. Specifically, claimant contended that he was willing to work and would have either sought work or worked within his limitations had it not been for his first surgery and his current need for surgery.

Finally, in our prior order, we found no documentation to support claimant's assertion that he was on "leave of absence" from his employer at the time of his worsening. On reconsideration, claimant submitted a May 30, 2001 letter from his employer, which states that claimant is "employed as a Ramp Agent" and is presently on "medical leave and has been since February 28, 2000."

Notwithstanding this submission, the record lacks *medical* evidence from a physician to support the conclusion that claimant was on "medical leave" prior to his April 9, 2001 disability date. To the contrary, Dr. Rusch found claimant to be medically stationary on January 8, 2001. In addition, Dr. Rusch placed work restrictions on claimant, but did not report that it would be futile for claimant to work due to the compensable injury.

In conclusion, the record does not establish that it would be futile for claimant to seek work prior to his "date of disability" (April 9, 2001). Consequently, because he was not in the work force at that time, he is not entitled to temporary disability benefits.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our May 3, 2001 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
AMMER A. ALEXANDER, Claimant
Own Motion No. 66-0063M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

On July 22, 1999, we issued an Own Motion Order, which authorized the reopening of claimant's December 3, 1954 neck injury claim with the SAIF Corporation for the provision of medical services in the form of modifications to a rental home. Specifically, we authorized the reopening to provide: (1) remodeling of the rental home as necessary; (2) the provision of prosthetic devices such as, but not limited to, a hospital bed and a wheelchair; and (3) live-in care provider to assist claimant.

SAIF has now submitted a request for additional medical benefits relating to claimant's 1954 claim. SAIF recommends reopening of this claim under our Own Motion authority to provide modifications to a home that claimant has now purchased. These modifications would be similar to the ones approved in our prior order.

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

We find that modifications to claimant's home are required to accommodate his wheelchair and assist with his everyday living and care. Hence, we find that the requested medical services are reasonable and necessary and causally related to the compensable injury. Accordingly, claimant's claim is reopened to provide the previously described medical services. *See* OAR 438-012-0037.

This order shall supplement our May 13 and July 22, 1999 orders. 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
LINDA D. LANG, Claimant
WCB Case No. 00-08001
ORDER ON REVIEW
Arthur P. Klosterman, Claimant Attorney
Bruce A. Bornholdt, Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the SAIF Corporation's denial of her occupational disease claim for a right wrist 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 business services system support person for the employer. She began work in this capacity on June 1, 1999. Claimant's work involves repetitive hand and wrist motion associated with keyboarding and a "10-key" machine. (Tr. 6, 7). On August 4, 1999, she sought treatment with Dr. Flaming, who noted right wrist and finger pain. Dr. Flaming's assessment was that claimant's condition was "suspicious of early possible carpal tunnel syndrome." (Ex. 9-2). Also on August 4, 1999, claimant filed a form 801 alleging symptoms of right hand and finger tingling. (Ex. 10). Claimant did not specify a condition or diagnosis for her claim.

On September 21, 1999, claimant was examined by Dr. Williams on behalf of SAIF. (Ex. 13). Dr. Williams' impression was "[t]oday no evidence of carpal tunnel syndrome with history compatible with transient irritation of the right median nerve at the wrist." (Ex. 13-4). On November 2, 1999, Dr. Flaming's diagnosis was "wrist pain" and "repetitive injury syndrome." (Ex. 14).

On November 22, 1999, SAIF issued a denial of the claim, asserting that claimant had "no diagnosable condition." (Ex. 15). Claimant did not request a hearing from that denial.

Claimant continued working for the employer with significant keyboarding and "10-key" responsibilities. On February 3, 2000, claimant returned to Dr. Flaming with complaints of persistent right hand pain (especially at night), and weakness. (Ex. 18). Dr. Flaming diagnosed right carpal tunnel syndrome (CTS). (*Id.*) Nerve conduction studies performed on February 9, 2000 confirmed "moderately severe right carpal tunnel syndrome." (Ex. 21). Claimant filed another claim for her right wrist and fingers. (Ex. 23). On August 25, 2000, SAIF denied the claim on the basis that claimant's claim was for a preexisting disease or condition, and that her work exposure was not the major contributing cause of the combined condition or of a pathological worsening of the disease. (Ex. 27).

Claimant requested a hearing. The ALJ upheld SAIF's denial, finding that as a result of the unappealed denial, claimant now had to prove that her work activity since the denial was the major contributing cause of the combined CTS condition and of a pathological worsening of the disease. The ALJ reasoned that, although the current claim was not barred by principles of claim preclusion, claimant's prior right wrist condition (leading to the November 1999 denial) must be treated as a preexisting, noncompensable condition.

On review, claimant contends that her prior right wrist condition is not the same as her current CTS condition. If claimant's condition addressed by SAIF's November 1999 denial is the same condition for which claimant currently seeks compensation, the current claim is properly characterized as a claim for a worsening of a preexisting noncompensable condition. *Douglass L. Tugg*, 48 Van Natta 1590 (1996); *Mary L. Miller*, 46 Van Natta 369, 370 (1994); *Brian M. Lundquist*, 45 Van Natta 358, 360 (1993). In those circumstances, claimant must prove that her work activities are the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

Like the ALJ, we are not convinced that claimant's current carpal tunnel syndrome is the same exact condition as her prior right wrist condition. Although claimant's treating physician Dr. Flaming diagnosed CTS on the August 4, 1999 Form 827, in his chart note of the same date Dr. Flaming stated that claimant's condition was only "suspicious of early possible carpal tunnel syndrome." (Ex. 9-2). In response to SAIF's November 2, 1999 request for a specific diagnosis, Dr. Flaming stated "wrist pain - repetitive injury syndrome." (Ex. 14). Finally, on September 21, 1999, Dr. Williams found "[t]oday no evidence of carpal tunnel syndrome with history compatible with transient irritation of right median nerve at the wrist." (Ex. 13-4).

Claimant did not have a confirmed diagnosis of CTS until February 3, 2000, when she returned to Dr. Flaming with complaints of persistent right hand pain and weakness. (Ex. 18). Dr. Flaming then diagnosed right carpal tunnel syndrome. (*Id.*) Nerve conduction studies performed on February 9, 2000 revealed "moderately severe right carpal tunnel syndrome." (Ex. 21). On March 7, 2000, Dr. Collada, a consulting neurosurgeon, found a "combination of decrease in sensation and motor strength on the right upper extremity as well as the nerve conduction studies that show slowing in the sensory component of the right median nerve [that] are consistent with carpal tunnel syndrome." (Ex. 21-3). Therefore, although no physician has expressly stated that claimant's current right CTS condition is different from her prior condition, we are not convinced that the two conditions are the same, based on our review of the diagnoses in the contemporaneous medical records.

Nevertheless, even if claimant's condition is not the same as her condition prior to November 1999, we find that her claim is still "based on the worsening of" a preexisting condition. ORS 656.802(2)(b); *SAIF v. Cessnun*, 161 Or App 367 (1999). In *Cessnun*, the court held that a condition is "preexisting" if it precedes either the date the disability becomes manifest or the date of first medical treatment. 161 Or App at 374. *See also Dora A. Redding*, 52 Van Natta 1067, 1068 (2000).

Here, claimant first sought treatment for her carpal tunnel syndrome condition on February 3, 2000, with Dr. Flaming. (Ex. 18). Claimant's right hand and wrist condition that precipitated her August 1999 claim therefore must be considered a "preexisting condition." ORS 656.005(24). Dr. Flaming stated that "[claimant's] original complaint was in August 1999 including right hand numbness and tingling while she was doing a similar job at the same employer. Her persistent and continued work activities caused an aggravation of the carpal tunnel syndrome." (Ex. 30). Based on this comment, we find that claimant's current claim is a continuation of, and "based on the worsening of," her prior right hand and wrist condition. ORS 656.802(2)(b).

Claimant must therefore prove that her work activities are the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). Based on our review of the medical evidence, we are not persuaded that there has been a "pathological worsening" of claimant's right CTS condition. Accordingly, we find that SAIF's denial was properly upheld.

ORDER

The ALJ's order dated February 17, 2001 is affirmed.

Member Phillips Polich dissenting.

The majority finds that what is essentially a premature claim for "no diagnosable condition," has transformed from a (non) condition into a "preexisting condition." I disagree with that analysis and therefore respectfully dissent.

Although the majority finds that claimant's right wrist condition prior to November 22, 1999 represents a "preexisting condition," I find no evidence in the record of a diagnosis of *any* condition prior to that time.

The result reached by the majority is particularly inequitable when viewed in light of the language of SAIF's November 22, 1999 denial, which denied the claim expressly on the basis that there was "no diagnosable condition." (Ex. 15). SAIF's denial was premature. A premature denial is void on issuance. *Deborah S. DeBilt*, 49 Van Natta 732, 733 (1997).

Moreover, even if we consider claimant's right wrist condition prior to November 1999 as a "preexisting condition," I believe that the medical record supports a conclusion that claimant has proved a "pathological worsening" of any such preexisting condition. ORS 656.802(2)(b). On August 4, 1999, Dr. Flaming diagnosed symptoms that were only "*suspicious* of early *possible* carpal tunnel syndrome." (Ex. 9-2) (emphasis added). On September 21, 1999, Dr. Williams found "[t]oday *no* evidence of carpal tunnel syndrome." (Ex. 13-4) (emphasis added). By February 9, 2000, however, nerve conduction studies confirmed "*moderately severe* right carpal tunnel syndrome." (Ex. 21) (emphasis added).

In simple terms, claimant now has CTS, a moderately severe CTS at that, whereas before she did not. Claimant has suffered an objectively-verified worsened right wrist condition since November 22, 1999. In my view, there is no other reasonable interpretation of that medical evidence. Finally, the unrebutted medical opinion from Drs. Flaming and Collada is that claimant's work activity is the major contributing cause of this worsened right wrist CTS condition. (Exs. 30, 31). I would have set aside SAIF's denial. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
JACK B. ROY, Claimant
WCB Case No. 97-00659
ORDER ON REMAND
Schneider, et al., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes.

This matter is before the Board on remand from the Court of Appeals. *Roy v. SAIF*, 171 Or App 526 (2000), *on recon* 172 Or App 663 (2001). The court has reversed our prior order, *Jack B. Roy*, 51 Van Natta 41 (1999), that had affirmed an Administrative Law Judge's (ALJ's) order that had upheld the SAIF Corporation's "pre-closure" denial of claimant's current left knee condition. Reasoning that our failure to fully address claimant's "procedural" argument made our order insufficient for judicial review, the court has remanded for reconsideration.

On remand, we withdraw our prior order and reverse the ALJ's order upholding SAIF's denial, based on the following reasoning.

FINDINGS OF FACT

We summarize the relevant facts and procedural history as follows.

Claimant compensably injured his left knee in August 1996. SAIF accepted "left knee strain/contusion." (Ex. 13). In October 1996, claimant reinjured his left knee in a non-work-related incident. On January 9, 1997, SAIF denied claimant's claim, stating that:

> "We have recently received information that you sustained a new off work injury to your left knee on October 25, 1996. The new injury has been diagnosed as a Grade III retear of the posterior horn of the medial meniscus. Since your accepted claim is not the major cause of this new consequential injury, and since the new injury is the major cause of your current disability and need for medical treatment, the new injury and your current condition on and after October 25, 1996 are not compensable in this claim. Therefore, we must issue this denial of your new consequential injury and current condition. SAIF Corporation will continue to provide benefits related to your accepted left knee strain and contusion." (Ex. 28).

On January 10, 1997, SAIF issued an Amended Notice of Acceptance that accepted a "grade III tear of the posterior horn of the medial meniscus, repaired on October 1, 1996, as a result of the work-related injury of 8/14/96." (Ex. 29). On January 13, 1997, SAIF issued a Notice of Closure awarding five percent scheduled permanent disability for loss of the function of the left knee. (Ex. 30).

The ALJ upheld SAIF's denial of claimant's "new consequential condition" claim and of claimant's "current condition." On review, we affirmed. 51 Van Natta 41. We reasoned that claimant's October 1996 injury resulted in a new meniscal tear that was a "consequential condition" within the meaning of ORS 656.005(7)(a)(A). We further noted Dr. Witczak's unrebutted opinion that claimant's accepted injury was not the major contributing cause of the new meniscal tear or of claimant's subsequent disability or need for treatment. We concluded that it followed that claimant's "current condition" was likewise not compensable, but that SAIF had continued responsibility for any future medical treatment and disability compensably related to the accepted August 1996 injury. *Id.* at 42, 43.

The court reversed. *Roy v. SAIF*, 171 Or App at 526. The court reasoned that SAIF did not elect to close claimant's claim pursuant to *former* ORS 656.268(4)(a) when it issued its denial. Therefore, SAIF was required to refer the claim to the Department of Consumer and Business Services (the Department) "for further examination and a determination of further compensation." *Former* ORS 656.268(2)(a). Although the court agreed with us that claimant's October 1996 injury was a new, consequential injury, the court stated that it was unaware of any statute that would authorize a carrier to deny a consequential condition claim without also closing the underlying accepted claim. 171 Or App at 534, 535. The court therefore remanded to us to determine the effect of SAIF's erroneous failure to close the accepted claim. *Id.*

SAIF and claimant requested reconsideration of the court's decision.[1] 172 Or App 663. On reconsideration, the court noted SAIF's argument that its denial was proper based on *Chaffee v. Nolt*, 94 Or App 83 (1988). However, the court distinguished *Chaffee* in that, there, it had essentially found "harmless error" due to the timing of the carrier's denial in relation to the closure. On reconsideration, the court continued to hold that it was for us in the first instance to make the determination of the effect of SAIF's error. 172 Or App at 666.

CONCLUSIONS OF LAW AND OPINION

On remand, we hold that SAIF impermissibly denied claimant's "consequential condition" claim and "current condition" prior to closing the accepted condition. *Former* ORS 656.268(1)(a). Further, we hold that *Chaffee v. Nolt* is distinguishable and does not permit SAIF's "pre-closure" denial.

Former ORS 656.268(1) (1997) provides, in pertinent part:

> "Claims shall not be closed if the worker's condition has not become medically stationary unless:
>
> "(a) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7) and the worker is not enrolled and actively engaged in training. When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated."

Former ORS 656.268(4)(a) (1997) allowed the carrier to close a claim at the time of a denial based on the accepted injury no longer being the major contributing cause of a combined or consequential condition, if the accepted injury had become medically stationary. *Former* ORS 656.268(2)(a) (1997) otherwise required the carrier to refer the claim to the Department for a determination of further compensation.

Pursuant to the court's analysis, SAIF was required either: (1) to close the accepted claim at the time of its denial, pursuant to *former* ORS 656.268(4)(a); or (2) to refer the claim to the Department for a determination of further compensation pursuant to *former* ORS 656.268(2)(a). Because it did neither, we conclude that SAIF's denial must be set aside and the claim remanded to SAIF for further processing pursuant to law.

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[1] On reconsideration, the court again dismissed claimant's evidentiary arguments.

On remand, SAIF contends that its denial was not truly a "current condition" denial because the language about claimant's "current condition" referred back to claimant's "disability and need for treatment" earlier in the document and purportedly retained responsibility for further treatment for claimant's accepted claim. We disagree. By its express terms, SAIF's June 9, 1997 denial letter denied claimant's "current condition on and after October 25, 1996." (Ex. 28). Therefore, pursuant to the court's analysis, because SAIF did not accept a "combined condition," its "pre-closure" denial of claimant's "consequential condition" claim and of claimant's "current condition" was prohibited. 171 Or App at 534, 535. *Cf.* ORS 656.262(7)(b); *Croman Corp. v. Serrano*, 163 Or App 136 (1999); *Pamela J. Gentry*, 52 Van Natta 918 (2000).

Finally, we address SAIF's "*Chaffee*" argument. In *Chaffee*, the court held that it was proper for the Board to address the compensability of the claimant's new psychological condition, notwithstanding the carrier's failure to close the claimant's underlying claim for a back condition before its denial. 94 Or App at 85, 86. The court concluded that substantial evidence supported the Board's finding that the claimant was medically stationary without permanent impairment at the time the carrier issued its notice of closure. *Id.* at 85. Therefore, despite the fact that the carrier closed the claimant's back claim three days after it denied the psychological claim, the court found that the carrier's conduct was not intended to shortcut the ordinary process of claim closure. *Id.*

Here, in contrast to *Chaffee*, the medical evidence does not establish that claimant's accepted condition was medically stationary at the time of SAIF's January 9, 1997 denial. *See* ORS 656.268(1)(a); *compare Chaffee*, 94 Or App at 85. Dr. Witczak's December 19, 1996 statement that claimant's condition "would be close" to being medically stationary (if he had not reinjured his knee in the October 1996 incident) is speculative in nature and not equivalent to a statement that claimant's accepted condition was medically stationary at the time of closure. (Ex. 23). Accordingly, pursuant to *former* ORS 656.268(1)(a), although SAIF closed claimant's accepted claim on January 13, 1997, four days after its denial, we are not persuaded on this medical record that such action necessarily made SAIF's "pre-closure" denial "harmless error."[2]

Where a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1). We determine the amount of attorney fees by applying the factors 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; the skill of the attorneys; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After considering the factors set 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, on Board review, before the court, and on remand is $12,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as demonstrated by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated.

Accordingly, the ALJ's order dated April 16, 1998 is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for further processing according to law. For services performed before the Hearings Division, Board, and court, claimant's counsel is awarded $12,000, to be paid by SAIF.

IT IS SO ORDERED.

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[2] Moreover, we need not address SAIF's argument that we may take "administrative notice" that claimant withdrew his request for hearing from an Order on Reconsideration regarding its January 13, 1997 Notice of Closure. Taking administrative notice of that fact, and any inferences to be drawn therefrom, would not affect our reasoning because our decision is narrowly guided by the court's analysis of the timing of SAIF's "pre-closure" denial.

In the Matter of the Compensation of
LINDA F. ULBRICHT, Claimant
WCB Case No. 00-06691
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) affirmed an Order on Reconsideration that denied the employer's request for appointment of a medical arbiter panel; and (2) affirmed the Order on Reconsideration's award of 41 percent (131.2 degrees) unscheduled permanent disability for a low back injury and 10 percent (13.5) degrees scheduled permanent disability for loss of use or function of the right foot. On review, the issues are the employer's medical arbiter panel request and extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

On October 18, 1996, claimant compensably injured her low back. On November 1, 1996, claimant underwent an L4-5 discectomy for cauda equina syndrome due to a large disc herniation at L4-5.

On January 24, 1997, the employer accepted a nondisabling L4-5 disc herniation. (Ex. 2). Claimant continued to seek treatment.

On December 1, 1999, Dr. Hacker, claimant's attending physician and surgeon, found claimant medically stationary and recommended no additional treatment. (Ex. 3). He performed a closing examination and recorded claimant's reduced lumbar ranges of motion. He also measured impairment of the right foot consistent with cauda equina syndrome, which included reduced strength of the right foot and hypesthesia in the L5-S1 distribution. Dr. Hacker found that claimant had a fixed neurologic deficit as a result of her condition.

On April 20, 2000, Dr. Rosenbaum, M.D., examined claimant at the employer's request. (Ex. 4). He reported that claimant remained medically stationary and also measured reduced lumbar ranges of motion. Dr. Rosenbaum noted normal strength testing in the iliopsoas, quadriceps, hamstring, gastrocnemius, anterior tibialis, extensor halluces, peronci and posterior tibialis. (Ex. 4-3).

By letter to the employer dated June 11, 2000, Dr. Hacker noted that he reviewed Dr. Rosenbaum's comments. (Ex. 6). Dr. Hacker reiterated that claimant had residual dysfunction related to cauda equina syndrome secondary to a large central disc herniation that he surgically removed in 1996. He noted that claimant continued to have neurologic dysfunction evidenced in objective sensory loss and motor dysfunction that was documented in his last evaluation. Dr. Hacker did not concur with Dr. Rosenbaum's reports.

On June 26, 2000, the employer issued an updated notice of claim acceptance that accepted a disabling L4-5 disc herniation and cauda equina syndrome. (Ex. 8). That same date, the employer issued a Notice of Closure that declared claimant medically stationary as of December 1, 1999, and awarded 23 percent unscheduled permanent disability. (Ex. 7). The impairment findings were based on Dr. Rosenbaum's April 21, 2000 examination. (Ex. 7-2).

On July 25, 2000, claimant requested reconsideration of the Notice of Closure and disagreed with the impairment findings used to rate disability. (Ex. 9). Claimant stated that the employer did not use the findings of her attending physician, Dr. Hacker, in rating her disability. She noted that Dr. Hacker did not agree with Dr. Rosenbaum's report, which the employer used to rate her disability. Claimant argued that the closing evaluation by her attending physician should be used to rate her disability. Claimant expressly did not request the appointment of a medical arbiter and waived the right to such an examination.

On August 2, 2000, the employer wrote to the Appellate Review Unit and requested appointment of a three-member medical arbiter panel. (Ex. 10).

An August 25, 2000 Order on Reconsideration denied the employer's request to appoint a medical arbiter panel. (Ex. 12). Based on Dr. Hacker's December 1, 1999 closing examination, the Order on Reconsideration increased claimant's unscheduled permanent disability award to 41 percent and awarded 10 percent scheduled permanent disability for the right foot. The employer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Relying on *Ramiro Pelayo*, 52 Van Natta 363 (2000), the Appellate Review Unit (ARU) for the Workers' Compensation Division issued an Order on Reconsideration that denied the employer's request to appoint a panel of medical arbiters and proceeded to rate claimant's permanent disability based on the attending physician's closing examination. At hearing and on review, the employer argues that: (1) *Pelayo* is distinguishable on its facts; and (2) certain 1999 amendments to ORS 656.268 entitle a carrier to independently request appointment of a medical arbiter panel if a worker challenges a Notice of Closure based on disagreement with the medical impairment findings used to rate the disability.

The ALJ found that *Pelayo* was applicable despite the factual distinction raised by the employer.[1] Therefore, the ALJ found that it was not error for the ARU to deny the employer's request for a medical arbiter panel and affirmed the Order on Reconsideration. While we agree with the ALJ's ultimate conclusion, we do so based on the following reasoning.

Effective October 23, 1999, the legislature amended various statutory provisions, including sections of ORS 656.268, to phase out claim closure activities by the Department not later than June 30, 2001. 1999 Or Laws chapter 313, sections 1, 16 (Senate Bill 220). The various amendments removed references to claim closures by the Director; *i.e.*, closures via Determination Orders.

On review, the employer agrees that a carrier cannot request reconsideration of its own Notice of Closure under the amended statutes. However, it argues that, once a claimant requests reconsideration and raises an impairment issue, amended ORS 656.268(6)(e), (7)(a), (7)(b), and (7)(c) authorize a carrier to request a medical arbiter panel examination and require the Director to comply with that request.

In response, claimant contends that the current version of ORS 656.268(7) preserves the statutory preference for the attending physician to measure impairment, and only if the appealing party disagrees with the attending physician's rating must a medical arbiter (or panel if requested) be appointed. Claimant reasons that this construction is consistent with the Director's administrative rules providing that impairment at the time of initial closure is established by the attending physician. OAR 436-035-0007(14); 436-010-0280.

Turning to the present case, claimant asserts that the employer failed to rate her impairment using her attending physician's closing examination and, instead, used an insurer-arranged medical examination with which her attending physician did not concur. Claimant contends that the statutory changes and administrative rules do not allow such a result. Based on the following reasoning, we agree with claimant.

In order to determine their meaning, we examine the text of the statutes in context, turning to the legislative history only if we cannot discern the meaning of the statutes from that review. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). Thus, we examine the text of the statute in context to determine its meaning.

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[1] The employer argued that, unlike *Pelayo*, claimant disagreed with the impairment findings and, therefore, the employer was entitled to request a medical arbiter exam because claimant raised the impairment issue. The ALJ rejected the employer's argument, finding that *Pelayo* was not affected by whether or not a claimant disagreed with the impairment findings. Rather, the ALJ found that *Pelayo* was based on statutory limitations on a carrier's remedies when a claim was closed by a Notice of Closure.

Pelayo applied *former* ORS 656.268. Based on the reasoning expressed in this order regarding the construction of *amended* ORS 656.268, it is unnecessary to address the application of the *Pelayo* rationale to this particular case.

The relevant portions of ORS 656.268 provide:

"(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. *The insurer or self-insured employer shall close the worker's claim, as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training according to rules adopted by the director pursuant to ORS 656.340 and 656.726, when:*

"(a) The worker has become medically stationary and there is sufficient information to determine permanent impairment;

"* * * * *

"(5)(a) *Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of the claim shall be pursuant to the standards prescribed by the Director of the Department of Consumer and Business Services.* The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker, to the worker's attorney if the worker is represented, and to the director. * * *

"* * * * *

"(c) If a worker objects to the notice of closure, the worker first must request reconsideration by the director under this section. The request for reconsideration must be made within 60 days of the date of the notice of closure.

"* * * * *

"(6)(a) Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each notice of closure. 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 attending physician at the time of claim closure. If the director determines that a claim was not closed in accordance with subsection (1) of this section, the director may rescind the closure.

"* * * * *

"(e) The period for completing the reconsideration proceeding described in paragraph (d) of this subsection begins upon receipt by the director of a worker's request for reconsideration pursuant to subsection (5)(c) of this section. *The insurer may fully participate in the reconsideration proceeding.*

"(f) Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding.

"(g) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 30 days from the date of the reconsideration order.

"(7)(a) *If the basis for objection to a notice of closure issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director.*

"(b) *If neither party requests a medical arbiter and the director determines that insufficient medical information is available to determine disability, the director may refer the claim to a medical arbiter appointed by the director.*

"(c) *At the request of either of the parties, a panel of three medical arbiters shall be appointed.*

"* * * * *

"(i)(A) *When the basis for objection to a notice of closure issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the closure was not made pursuant to this section, the director is not required to appoint a medical arbiter prior to the completion of the reconsideration proceeding.*"

"* * * * *." (Emphasis added).

Although not contending that it may request or cross-request reconsideration of its own Notice of Closure, the employer contends that it may request appointment of a medical arbiter. Specifically, the employer contends that the "fully participate" language in amended ORS 656.268(6)(e) and the 1999 changes to ORS 656.268(7)(a), (b), and (c)[2] allow a carrier to request a medical arbiter panel when the worker requests reconsideration of a Notice of Closure and challenges the impairment findings in any manner. We need not address this argument because we find that other provisions directly apply to the circumstances of this case.

A carrier is required to close a worker's claim pursuant to Director's rules when the worker has become medically stationary and there is sufficient information to determine permanent impairment. ORS 656.268(1)(a). In closing the claim, the carrier is required to rate the extent of the worker's disability pursuant to the Director's rules. ORS 656.268(5)(a). With the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment. ORS 656.245(2)(b)(B);[3] OAR 436-010-0280;[4] 436-035-0007(14);[5] *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994), *aff'd Liberty NW Insurance Corp. v. Koitzsch*, 155 Or App 494 (1998). However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. *See* OAR 436-035-0007(13);[6] *Roseburg Forest Products v. Owen*, 127 Or App 442 (1994).

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[2] *Former* ORS 656.268(7)(a) provided:

"(7)(a) If the basis for objection to a notice of closure of determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, or if the director determines that sufficient medical information is not available to estimate disability, the director shall refer the claim to a medical arbiter appointed by the director."

As part of the 1999 amendments former ORS 656.268(7)(a) was divided into two parts (amended subsections (7)(a) and (7)(b)) and former ORS 656.268(7)(b) was renumbered as ORS 656.268(7)(c), although the language remained the same as in former ORS 656.268(7)(b).

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

"(2)(b) A medical service provider who is not a member of a managed care organization is subject to the following provisions:

"* * * * *

"(B) * * * Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability."

[4] OAR 436-010-0280 provides the general provisions for determination of impairment by the attending physician. *See* WCD Admin Order No. 00-052, eff. 4/21/00.

[5] OAR 436-035-0007(14) provides:

"(14) Impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0280 except where a preponderance of medical opinion establishes a different level of impairment pursuant to ORS 656.726(3)(f)(B). 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, the impairment is established by the preponderance of evidence." WCD Admin. Order 99-056, eff. 4/26/99.

[6] OAR 436-035-0007(13) provides:

"Impairment findings made by a consulting physician or other medical providers (*e.g.* occupational or physical therapists) at the time of closure may be used to determine impairment if the worker's attending physician concurs with the findings as prescribed in OAR 436-010-0280. If an attending physician's findings or comments are unavailable or incomplete, impairment may be established by the preponderance of medical evidence."

Here, Dr. Hacker, claimant's attending physician, performed a closing examination on December 1, 1999. (Ex. 3). That closing examination provided sufficient information to determine permanent impairment. The employer does not contend otherwise. Specifically, Dr. Hacker declared claimant medically stationary, measured loss of ranges of motion in the low back, and measured loss of strength and sensation in the right foot. Furthermore, he provided sufficient information about the losses in the right foot to identify the affected nerves and muscles, which allows for rating under the Director's rules. Finally, he related these losses to claimant's compensable injury.

With the exception of adopting the medically stationary date, the employer did not use Dr. Hacker's closing examination to close claimant's claim. Instead, the employer closed claimant's claim based on an April 20, 2000 examination performed at its request by Dr. Rosenbaum. (Exs. 4, 7-2). Dr. Hacker did not concur with that report and, instead, disputed several of Dr. Rosenbaum's findings. (Ex. 6). Because Dr. Hacker's closing examination was sufficient to close claimant's claim and he did not concur with Dr. Rosenbaum's report, the employer was not authorized to use Dr. Rosenbaum's report to close claimant's claim. Instead, under the law summarized above, the employer was required to use Dr. Hacker's closing examination.

Under *amended* ORS 656.268(7)(i)(A), when, as here, the basis for objection to the Notice of Closure is disagreement with the impairment used in rating the worker's disability, and the Director determines that the closure was not made pursuant to the provisions of ORS 656.268, the Director "is not required to appoint a medical arbiter prior to the completion of the reconsideration proceeding."

These circumstances fit squarely within the provisions of *amended* ORS 656.268(7)(i)(A). Claimant objected to the Notice of Closure based on a disagreement with the impairment used in rating her disability. Specifically, claimant noted that her disability was not based on her attending physician's closing examination. In addition, by rejecting the employer's request for the appointment of a three-member medical arbiter panel, the Director, in effect, determined that the closure was not made pursuant to the provisions of ORS 656.268. In this regard, the ARU expressly found that Dr. Hacker was claimant's attending physician at claim closure and, in accordance with OAR 436-035-0007(14), his closing exam should be used to determine impairment. Thus, it logically follows that the employer's use of Dr. Rosenbaum's "unconcurred" impairment findings was contrary to Director rules.

Therefore, the employer failed to properly close the claim because it rated impairment based on an examination that was not concurred with by the attending physician and failed to rely on the attending physician's closing exam that provided sufficient information to determine permanent impairment. *See* ORS 656.268(1)(a); 656.268(2)(b)(B); 656.268(5)(a); OAR 436-010-0280; 436-035-0007(13) and (14). Because the employer failed to properly close the claim under the Director's rules as provided under ORS 656.268, the Director was *not* required to appoint a medical arbiter. ORS 656.268(7)(i)(A). Accordingly, we find that the Director did not err in failing to grant the employer's request to appoint a medical arbiter panel.

Finally, although raising issues of extent of scheduled and unscheduled permanent disability, the employer makes no argument regarding those issues other than the above argument regarding appointment of a medical arbiter panel, which we have rejected. As explained above, on this record, only the attending physician's findings may be used to rate impairment. We find that the Order on Reconsideration properly determined claimant's scheduled and 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 (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 28, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the employer.

In the Matter of the Compensation of
PAULINE YOUNG, Claimant
Own Motion No. 00-0221M
OWN MOTION ORDER ON RECONSIDERATION
Liberty Northwest Ins. Corp., Insurance Carrier

Reviewing Panel: Members Biehl and Haynes.

On July 7, 2000, we issued an Own Motion Order that authorized the reopening of claimant's 1989 injury claim to provide temporary disability compensation beginning the date claimant was hospitalized for a proposed surgery. The insurer has requested that we withdraw our Own Motion order because the claim "has now been accepted as a new condition reopening." We treat the insurer's request as a request for reconsideration of our unappealed July 7, 2000 order.

A request for reconsideration of an Own Motion order must be filed within 30 days after the date the order was mailed, or within 60 days after the mailing date if the requesting party establishes good cause for failing to file the request within 30 days after the mailing date. OAR 438-012-0065(2). In extraordinary circumstances, however, we may, on our Own Motion, reconsider a prior order. *Id.*

Under the particular facts of this case, we find that extraordinary circumstances exist that justify reconsideration of our prior order. In this regard, the insurer has accepted the condition on which the Own Motion Order was based as a "new condition." Furthermore, the insurer expressly seeks "rescission" of our prior order. Under these extraordinary circumstances, we withdraw our prior order and issue the following order in its place.

Based on the insurer's announcement, we are persuaded that the insurer has reopened the claim for acceptance and processing of a "post-closure" new condition. Under such circumstances, the claim is subject to closure under ORS 656.268. *See SAIF v. Ledin*, 174 Or App 61 (2001); *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999). In light of such circumstances, an Own Motion Order is not warranted.[1]

Accordingly, on reconsideration, we deny the request for Own Motion relief. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Nonetheless, in the event that any temporary disability benefits were previously paid pursuant to our July 7, 2000 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).

In the Matter of the Compensation of
MARK HOPKINS, Claimant
WCB Case No. 00-01117
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

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

FINDINGS OF FACT

We adopt the "Stipulated Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The parties agreed to waive the scheduled hearing and submit the matter on the record, with stipulated facts and written argument. We begin with a summary of the most significant stipulated facts.

Victory Outreach Ministries (Victory) is a charitable organization that provides lodging and assistance to disadvantaged individuals. Claimant resided at a Victory facility on December 29, 1999, the date of his injury.

Kobos Company (Kobos) and Victory had an arrangement whereby Victory assigned residents to perform services for Kobos and Kobos donated cash to Victory. The amount of money donated under the arrangement depended solely on Kobos' willingness to donate. In this case, Kobos paid Victory $750 for the project that claimant worked on in December 1999. Claimant received no remuneration from Kobos, nor did he expect to be paid for his services. None of the "charitable donation" made by Kobos to Victory went directly to claimant in any manner, for room, board or otherwise.

On December 29, 1999, claimant injured his back while performing services for Kobos. The insurer, who provided workers' compensation coverage to Kobos, denied claimant's injury claim on the ground that claimant was not an employee of Kobos and that, under ORS 656.027(2), volunteers performing services for a charitable organization are not considered subject workers. The parties stipulated that the sole dispute was whether claimant was a subject employee of Kobos.

The ALJ found that claimant was a "worker" under ORS 656.005(30), because he furnished services for Kobos for the remuneration ($750) that was paid to Victory. Reasoning that claimant was not excluded from being a "subject worker" by ORS 656.027(11)[1] or 656.027(20),[2] the ALJ concluded that claimant was a subject worker and set aside the insurer's denial.

On review, citing the parties' stipulation that claimant received no remuneration and did not expect to be paid by Kobos for his services on the date of injury, the insurer challenges the ALJ's determination that he was a "worker" under ORS 656.005(30). Moreover, the insurer asserts that claimant is not a "subject worker" under the statutory exclusions in ORS 656.027(11) and 656.027(20). For the following reasons, we conclude that claimant was not a "worker" under ORS 656.005(30) and, therefore, reverse.[3]

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[1] ORS 656.027(11) excludes "[a] person performing services primarily for board and lodging received from any religious, charitable or relief organization" from among workers subject to ORS Chapter 656.

[2] ORS 656.027(20) excludes "[a] person performing services on a volunteer basis for a nonprofit, religious, charitable or relief organization, whether or not such person receives meals or lodging or nominal reimbursements or vouchers for meals, lodging or expenses" from among workers subject to ORS Chapter 656.

[3] Given our disposition of this case, we need not address the applicability of ORS 656.027(11) and ORS 656.027(20).

The dispositive issue is whether claimant was a "worker" when he was injured. ORS 656.005(30) defines a worker as "any person * * * who engages to furnish services for remuneration, subject to the direction and control of an employer." *See Liberty Northwest Ins. Corp. v. Church*, 106 Or App 477, 481, *rev den* 312 Or 16 (1991). Claimant bears the burden of proving the existence of the employment relationship. *See Hix v. State Acc. Ins. Fund*, 34 Or App 819, 825 (1978); *see also Rogers v. State Acc. Ins. Fund*, 289 Or 633, 641-642 (1980) (stating that the "essence of the Workers' Compensation Act is that financial consequences flow from the existence of the employment relationship itself" and "[l]iability and compensability are predicated on employment").

Here, the parties stipulated that claimant received no remuneration for the services he provided Kobos and there is no evidence of an agreement (between claimant and Kobos or Victory) involving an exchange of services for remuneration. Under these circumstances, we are not persuaded that claimant was a "worker" under ORS 656.005(30) when he was injured. *See e.g., Audencia Montez*, 52 Van Natta 805 (2000). Consequently, claimant was not a "subject worker" under ORS Chapter 656 and he is not entitled to workers' compensation benefits.[4] *See S-W Floor Covering Shop v. National Council on Compensation Insurance*, 318 Or 614, 630 (1994) (one who is not a "worker" is not subject to workers' compensation coverage).

ORDER

The ALJ's order dated January 13, 2001 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

[4] Although our decision reinstates the insurer's denial, we acknowledge that the Kobos/Victory charitable arrangement creates a loophole in the workers' compensation system. Victory provides lodging and assistance to disadvantaged people and then uses these same individuals to perform work for Kobos. In exchange for a "donation," Kobos receives labor. Victory profits because it receives money for its programs using people who expect no remuneration and Kobos profits because it receives labor without having to use its own employees. Individuals such as claimant, however, who become injured when performing work are the losers from this arrangement. Based on this decision, claimant's medical treatment or disability will not be covered by workers' compensation.

In the Matter of the Compensation of
CHRISTOPHER W. WACEK, Claimant
WCB Case No. 00-06127
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

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

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

On October 14, 1999, claimant was compensably injured when he was struck on the head and back by three to four falling seed bag bundles.[1] (Tr. 7; Ex. 2). The claim was initially accepted for cervical and lumbar strains. (Ex. 5).

In January 2000, an MRI revealed a "central and right paramedian disc herniation at C5-6." (Ex. 9). In May 2000, claimant requested that the employer modify its acceptance to include the herniated disc condition. (Ex. 18-1).

[1] Each bundle contained about 500 bags and weighed approximately 50 pounds. (Tr. 7).

In August 2000, the employer denied the disc condition. (*Id.*) Claimant requested a hearing.

The ALJ relied on Dr. Throop's opinion (consulting neurologist), and concluded that claimant had established the compensability of his cervical disc condition.[2]

Here, the ultimate question to be resolved is the cause of claimant's cervical disc condition. Because of the possible alternative causes for claimant's cervical disc 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).

According to Dr. Throop, the weight of the bag bundles that struck claimant thrust his head forward, squeezed two vertebrae together (C5 and C6), and thus squeezed the disc out such that it ruptured.[3] (Ex. 22-14; 22-29). Taking into account the above described mechanism of injury, along with his personal review of the chart notes of chiropractor Burdell, and Dr. Dorchuck, along with the MRI report of Dr. Clautice (reporting no abnormalities other than the C5-6 herniated disc, and claimant's lack of prior cervical problems)[4], Dr. Throop opined that the major contributing cause of claimant's C5-6 disc condition was the October 1999 work injury.[5] (Exs. 9; 20; 22-22; 22-23; 22-25; 22-28; 22-31). Based on Dr. Throop's explanation of the mechanism of injury, as well as his overall thoroughness, we find Dr. Throop's opinion persuasive.

The employer contends that Dr. Throop's opinion is not persuasive because claimant did not tell him about a "pop" in his neck that occurred around the first week of November 1999 (after the work incident).[6] For the following reasons, we reject the employer's argument.

First, although claimant did not personally tell Dr. Throop about the neck "pop," Dr. Throop was aware of that particular history from reviewing Dr. Dorchuck's chart notes. (Ex. 22-17 to 18). Moreover, Dr. Throop explained that considering that claimant experienced the onset of neck pain at the time of the October 1999 work incident, and further considering the absence of neck pain prior to the work incident, that "the most likely thing, the medical probability is that the initial injury either caused the initial rupture of the disc or caused weakening to the point where it took very little to make it rupture further out." (Ex. 22-19).

In contrast to Dr. Throop's opinion is the opinion of Dr. Fuller. Dr. Fuller reported that the MRI revealed a "slight disc space narrowing at C5-6" and reasoned that because "[t]his type of narrowing takes up to a year to accomplish," the "right-sided paramedian disc at C5-6 is a pre-existing condition." (Ex. 16-4). Later in the same report, Dr. Fuller indicated (in reference to the "pop" claimant felt in

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[2] The ALJ determined that claimant had established compensability under the "major contributing cause" standard. Because neither party challenges the applicability of the "major contributing cause" standard, we use the "major contributing cause" standard on Board review. Moreover, because we find that claimant has established the compensability of his herniated disc condition under the "major contributing cause" standard, we necessarily find that he has also established compensability under the "material contributing cause" standard.

[3] Dr. Throop's understanding of how claimant was struck and pushed forward was based on claimant's description. (Ex. 22-14). The ALJ determined that claimant was credible. (O&O. 5). The employer does not challenge claimant's credibility.

[4] The employer contends that Dr. Throop is not in as advantageous position as Dr. Fuller to render an opinion because Dr. Throop did not personally review the MRI film. We note, however, that the report on which Dr. Throop relied, concluded that the only defect in claimant's cervical spine was at C5-6. That is the same conclusion made by Dr. Fuller. Consequently, we reject the employer's assertion.

[5] Chiropractor Burdell was the initial attending physician. Dr. Dorchuck is claimant's current attending physician. Dr. Dorchuck concurred with Dr. Throop's opinion regarding causation. (Ex. 21).

[6] We acknowledge that Dr. Throop indicated that he would have liked to have known about the "pop" and that knowing about it would make a diagnosis easier. (Ex. 22-33; 22-35). Nonetheless, given the explanation for his overall opinion, we are not persuaded that his not knowing about the "pop" at the time of its occurrence renders his opinion unpersuasive.

November 1999) that "there would appear to be a spontaneous herniation of the disc occurring around the first week in November." (Ex. 16-5). Without further explanation, Dr. Fuller's opinion is internally inconsistent.[7] Consequently, we do not consider it well reasoned, and as such, it is unpersuasive. *Somers*, 77 Or App at 263.

In conclusion, we find that Dr. Throop's opinion, as supported by Dr. Dorchuck, persuasively established the compensability of claimant's cervical disc condition. Consequently, we agree with the ALJ's compensability determination.

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

ORDER

The ALJ's order dated February 21, 2001 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

[7] The employer suggests that when Dr. Fuller wrote "the discopathy noted at C5-6 likely pre-exists," he was referring to the disc space narrowing and not the herniated disc itself. (Ex. 16-4). We note however, the entire sentence reads: "The discopathy noted at C5-6 likely pre-exists, noting disc space narrowing on careful review." (*Id.*) Thus substituting "disc space narrowing" for "discopathy," renders the phrase "noting disc space narrowing on careful review," redundant. Moreover, in a following paragraph, Dr. Fuller clearly states his belief that the "right-sided paramedian disc at C5-6 is a pre-existing condition." (*Id.*) Consequently, we reject the employer's argument.

In the Matter of the Compensation of
CHRISTINE A. PFISTER, Claimant
WCB Case Nos. 00-01685, 00-00938, 99-06470 & 99-00860
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Scheminske, et al., Defense Attorney
Employers Defense Counsel, Defense Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld Liberty Northwest Insurance Corporation/Select Care's compensability and responsibility denial of claimant's occupational disease claim for right ulnar neuropathy; (2) upheld the SAIF Corporation's compensability and responsibility denial of the same condition; (3) upheld Liberty Northwest Insurance Corporation/Peace Health's compensability and responsibility denial for the same condition; and (4) upheld Constitution State Service Company's compensability and responsibility denial of the same condition. On review, the issues are compensability and responsibility.

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

Claimant argues that Liberty Northwest/Select Care accepted her right ulnar neuropathy in February 1997 when it accepted claimant's claim as nondisabling right wrist tendinitis. Claimant asserts that her condition had been misdiagnosed and that Liberty Northwest/Select Care actually accepted her right ulnar neuropathy. Claim acceptance encompasses only those conditions specifically and officially accepted in writing. *Johnson v. Spectra Physics*, 303 Or 49, 56 (1987). Here, Liberty Northwest/Select Care specifically accepted the condition of right wrist tendinitis, nothing more. There is no evidence that tendinitis is a symptom of ulnar neuropathy. Under such circumstances, we conclude that Liberty Northwest/Select Care accepted only the specific condition of right wrist tendinitis and did not accept right ulnar neuropathy in February 1997.

ORDER

The ALJ's order dated February 28, 2001 is affirmed.

In the Matter of the Compensation of
STEPHEN L. DARGIS, Claimant
WCB Case No. 00-08599
ORDER ON REVIEW
Thaddeus J. Hettle, Defense Attorney

Reviewing Panel: Members Phillips Polich and Meyers.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Johnson's order that dismissed his request for hearing. On review, the issue is propriety of the dismissal. We affirm.

FINDINGS OF FACT

On November 15, 2000, claimant's attorney requested a hearing on claimant's behalf regarding the self-insured employer's November 7, 2000 compensability denial. Claimant's attorney submitted a retainer agreement that provided, in part: "My attorney is authorized to sign my name and in all other respects to act for me in connection with my claim." A hearing was scheduled for February 5, 2001.

On February 2, 2001, claimant's attorney wrote to the Hearings Division and withdrew the request for hearing. The ALJ issued an Order of Dismissal, indicating that the request for hearing had been withdrawn, and dismissing the matter without prejudice.

CONCLUSIONS OF LAW AND OPINION

Claimant requests review of the ALJ's order of dismissal, asserting that he did not agree to a withdrawal of his request for hearing and did not authorize it. Claimant requests an opportunity to present evidence before the ALJ.

The issue on review is whether claimant's hearing request should have been dismissed. Claimant has the burden of proving that the dismissal order was not appropriate. *E.g., Richard H. Calkins*, 52 Van Natta 1641 (2000). When 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., Jeffrey R. Getch*, 53 Van Natta 663 (2001).

The employer argues that claimant does not assert that his attorney lacked "legal authority" to withdraw the request for hearing. The employer contends that claimant's allegations that he did not authorize the withdrawal of the request for hearing have no bearing on whether the Order of Dismissal is appropriate.

In his reply brief, claimant asserts that he does not recall signing a retainer agreement allowing his attorney to sign his name and to act on his behalf in connection with his workers' compensation claim. Claimant contends that his attorney should have first advised him of his decision to withdraw the hearing request.

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[1] We note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. Claimant 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
Department of Business and Consumer Services
350 Winter Street NE, Room 160
Salem, OR 97301-3878

In previous cases, we have held that the dispositive issue is not a claimant's state of mind at the time a hearing request is withdrawn, but whether the claimant's attorney represented the claimant and whether the attorney withdrew the hearing request. *See, e.g., Gilberto Garcia-Ortega*, 48 Van Natta 2201 (1996); *Jerry R. Testerman*, 46 Van Natta 1114 (1994).

In *Rachelle M. Rock*, 50 Van Natta 1168 (1998), the claimant requested review of a dismissal order, arguing that her former attorney had withdrawn her request for hearing without her full understanding of the transaction and the effect the withdrawal would have on her claim. We reasoned that the claimant had signed a retainer agreement employing her former attorney and granting him authority to act on her behalf regarding her claim. The claimant's then-attorney of record withdrew the hearing request and the claimant did not dispute her former attorney's authority to act on her behalf, nor did she dispute the fact that the ALJ had dismissed her request for hearing in response to her former attorney's withdrawal of the hearing request. Under those circumstances, we affirmed the dismissal order.

We reach the same conclusion in this case. Claimant signed a retainer agreement that granted his attorney the authority act on his behalf regarding the workers' compensation claim. On February 2, 2001, claimant's then-attorney of record wrote to the Hearings Division and withdrew the request for hearing. Although claimant asserts that his attorney did not inform him of the decision to withdraw the hearing request, claimant does not contend that his then-attorney did not have the authority to act on his behalf at that time. *See Karen L. Johnson*, 52 Van Natta 1430 (2000) (although the claimant asserted that she was "intimidated" into withdrawing her hearing request, she did not assert that her attorney lacked authority to withdraw her hearing request). Consequently, we find that the ALJ properly dismissed claimant's request for hearing.

With his request for review, claimant includes photographs of his shoulder surgery, and he includes a newspaper article with his appellant's brief. We treat claimant's submissions as a request to remand for admission of additional evidence. Because we find the ALJ's dismissal order proper, however, claimant's request for remand to develop the record on the merits of his claim is rendered moot. *See Rachelle M. Rock*, 50 Van Natta at 1168.

ORDER

The ALJ's order dated March 15, 2001 is affirmed.

In the Matter of the Compensation of
LAWRENCE G. VANDAMME, Claimant
Own Motion No. 01-0067M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Reviewing panel: Members Haynes and Bock.

The SAIF Corporation requests reconsideration of our June 26, 2001 Own Motion Order on Reconsideration in which we authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant is hospitalized for surgery. Specifically, SAIF argues that claimant has not provided any evidence demonstrating his willingness to work. Accordingly, SAIF contends that claimant was not in the work force at the time of the current disability.

In both our June 26 and May 10, 2001 orders, we were persuaded that claimant had demonstrated his willingness to work.[1] After further considering the current record (including SAIF's June 26, 2001 letter), we continue to reach our previous conclusion. In other words, we have nothing further to add to the findings and reasoning set for in our prior orders regarding claimant's "willingness" to work and/or seek work. Consequently, we adhere to our previous determination that claimant was in the "work force," and, as such, is entitled to temporary disability.

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[1] We reiterate, that based claimant's February 15, 2001 statement, we find that he was willing to seek employment. As noted in our prior orders, claimant specifically stated that "I have always been willing to work and always will be. * * * I am not working but willing to work, and am not seeking work because of this work related injury has made such efforts futile."

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our June 26, 2001 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

July 12, 2001 Cite as 53 Van Natta 973 (2001)

In the Matter of the Compensation of
DUSTIN M. RUTLEDGE, Claimant
WCB Case No. 99-05380
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) found his claim was not prematurely closed; and (2) affirmed an Order on Reconsideration that did not award any permanent disability. On review, the issues are premature closure and extent of unscheduled permanent disability.

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

We write to address claimant's argument that the ALJ erred by finding that the medical arbiter's report was not persuasive because he found no objective abnormalities or evidence of disability. According to claimant, the arbiter found that only the sensory findings were not objective findings.

On June 3, 1999, Dr. Wynn performed a medical arbiter examination. He explained:

> "Currently I do not think any of the findings are considered invalid, although, in my view, the sensory exam findings are completely subjective and are not objective findings. In my view also, the range of motion findings are of limited usefulness." (Ex. 42-2).

Dr. Wynn concluded that claimant had sustained a cervical thoracic myofascial strain without clear neurologic involvement. He explained:

> "[Claimant's] exam is abnormal based upon subjective symptoms. I do not find any objective neurological abnormalities on exam, or any neurological evidence of disability on today's exam." (Ex. 42-2, -3).

ORS 656.283(7) requires that "[a]ny finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings." *See also* ORS 656.726(3)(f)(B) (impairment is established by a preponderance of medical evidence based upon objective findings); OAR 436-035-0010 (all disability ratings shall be established on the basis of medical evidence that is supported by objective findings). ORS 656.005(19) defines objective findings as "verifiable indications of injury or disease."

Here, Dr. Wynn expressly rejected claimant's sensory findings as completely subjective and he said the range of motion findings were of "limited usefulness." (Ex. 42-2). Furthermore, he found that claimant's exam was abnormal based on *subjective* symptoms, and he did not find any objective neurological abnormalities on exam, or any neurological evidence of disability. (Ex. 42-2, -3). In light of Dr. Wynn's conclusion that claimant's exam was abnormal based upon subjective symptoms, we agree with the ALJ that Dr. Wynn's opinion is not sufficient to establish permanent impairment.

Dr. Gabr, claimant's attending physician, performed a closing examination and concluded that claimant had no residual permanent damage from the work injury. (Ex. 30). We agree with the ALJ that there is no persuasive evidence in this record that claimant has any permanent impairment due to the December 1998 compensable injury.

ORDER

The ALJ's order dated March 7, 2001 is affirmed.

In the Matter of the Compensation of
DARWIN B. LEDERER, Claimant
WCB Case No. 00-09047
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Breathouwer & Gilman, Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Fitzwater's order that set aside its denial of claimant's "bilateral pars defects" and "spondylolisthesis." On review, the issue is compensability.

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

Applying ORS 656.005(7)(a)(B), the ALJ set aside the employer's denial, concluding that claimant had proved that his compensable work injury was the major contributing cause of the need for treatment or disability for the "combined condition," consisting of the compensable injury and preexisting bilateral pars defects and spondylolisthesis. On review, the employer contends claimant has not carried his burden of proving a pathological worsening of his preexisting bilateral pars defect and spondylolisthesis pursuant to ORS 656.225(1).

The employer's contention notwithstanding, application of ORS 656.225 is limited by its terms to "disability caused by or medical services *solely directed to a worker's preexisting condition.*" (Emphasis added). *E.g., Anne M. Walker*, 49 Van Natta 600 (1997); *Linda F. Hansen*, 48 Van Natta 2560 (1996). Therefore, where a worker's disability or need for medical services was caused by a "combined condition," *i.e.*, the combination of a preexisting condition and the compensable injury, we have held that the provisions of ORS 656.225(1) are not germane to the compensability issue. *E.g., Mitchell J. Thompson*, 50 Van Natta 289, 291 n. 3 (1998); *Anne M. Walker*, 49 Van Natta at 600; *Paul E. Hargreaves*, 48 Van Natta 1676, 1677 (1996).

Here, the medical evidence establishes that the compensable work injury combined with claimant's preexisting spondylolisthesis and pars defect. (Exs. 40, 43-6). Consequently, we conclude that ORS 656.225(1) is not applicable[1] and that the ALJ correctly applied the provisions of ORS 656.005(7)(a)(B).[2]

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[1] Asserting that the claim that claimant made was for bilateral pars defects and spondylolisthesis as aggravated by the compensable injury, the employer contends that the issue is whether those specific conditions are separately compensable apart from any "combined condition" or the accepted lumbar strain. Thus, the employer contends that, to determine whether these conditions are compensable, we must necessarily focus on the two preexisting conditions and the disability produced and the treatment required by them. Because the focus, according to the employer, should be on the disability and/or treatment caused by the disputed conditions, it argues that ORS 656.225(1) represents the applicable legal standard. We disagree.

It is true that claimant did not characterize his claim for the bilateral pars defects and spondylolisthesis in terms of "combined condition." However, ORS 656.225 applies only if disability is solely caused by or medical services are solely directed to the worker's preexisting conditions. As previously noted, the medical evidence does not indicate this is so, but rather establishes that the disability or medical treatment were the result of a combination of both the compensable injury *and* the preexisting conditions. Thus, we reject the employer's contention that ORS 656.225 is applicable.

[2] Citing *Dillon v. Whirlpool Corp.*, 172 Or App 484 (2001), the employer faults the ALJ's deference to the attending physician's opinion in concluding that claimant had sustained his burden of proving the compensability of the "combined condition." We agree with the employer that *Dillon* holds that there is no requirement that a fact finder defer to the opinion of an attending physician. *Id.* at 489. However, automatic deference to the opinions of attending physicians has never been the practice of the Board. On numerous occasions, we have found persuasive reasons not to defer to the opinion of an attending physician, both before and after *Dillon*. *E.g., Carlos Nuno*, 53 Van Natta 694 (2001); *Robert A. Ash*, 52 Van Natta 2248 (2000). Accordingly, we perceive nothing in Dillon that should alter our customary practice under de novo review of giving greater weight to the attending physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). In this case, we agree with the ALJ's reasoning that there are no persuasive reasons not to give greater weight to the attending physician's opinion. Finally, contrary to the employer's assertion that this case involves expert medical analysis, rather than expert observation, *see Hammons v. Perini Corp.*, 43 Or App 299 (1979), we agree with the ALJ that this was an appropriate case in which to apply the general principle of giving the attending physician's opinion greater weight.

Claimant's attorney is entitled to an assessed attorney fee for services related to the compensability issue on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and apply 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 and counsel's representation of time spent preparing the brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 22, 2001is affirmed. For services on review, claimant's counsel is awarded $1,500, as a reasonable assessed attorney fee, payable by the employer.

July 17, 2001 Cite as 53 Van Natta 975 (2001)

In the Matter of the Compensation of
KARRY L. JESCHKE, Claimant
WCB Case No. 00-09147
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorney
Bottini, Bottini & Oswald, Defense Attorney

Reviewing Panel: Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of her low back injury claim on the ground that she failed to cooperate with the investigation of her claim. On review, the issue is the propriety of the employer's denial.

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

The ALJ upheld the employer's "non-cooperation" denial that resulted from claimant's failure to attend an employer-arranged medical examination. *See* ORS 656.262(15). Among claimant's contentions on review is that the employer's notice of the medical examination was inadequate.

Claimant, however, did not challenge the adequacy of the notice at hearing. (Tr. 3). Moreover, claimant does not specifically allege on review that the notice did not comply with applicable administrative rules or statutes. Instead, claimant argues that the notice did not adequately warn her of the consequences of failing to attend the examination. We disagree.

The employer's letter advised claimant in bold print that failure to attend the examination or failure to cooperate may result result in suspension of benefits and claim denial. (Ex. 6-1). We, therefore, find that the employer's letter sufficiently apprised claimant of the importance of the examination appointment and the seriousness of the consequences of not attending the examination. Thus, we conclude that the consequences of failing to attend the examination were made sufficiently clear to claimant.

ORDER

The ALJ's order dated January 9, 2001 is affirmed.

In the Matter of the Compensation of
DEBRA L. McADOO, Claimant
WCB Case No. 00-07196
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration that awarded 17 percent (54.4 degrees) unscheduled permanent disability for a low back injury, whereas a Notice of Closure awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. [1]

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

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). This preponderance of medical opinion must come from findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).

On review, the employer argues that claimant has no impairment due to her lumbosacral strain condition. In support of its argument, the employer relies on the opinions of Drs. Farris, neurologist, and Gripekoven, orthopedist, who examined claimant on behalf of the employer. (Exs. 17, 22). However, there is no indication that Dr. Goslin, claimant's attending physician, concurred with the opinions of Drs. Farris and Gripekoven. Therefore, those opinions may not be used to determine impairment.

In addition, as the ALJ noted, the employer did not just accept a lumbosacral strain. Instead, it accepted a combined condition. Specifically, the employer accepted "lumbosacral strain combined with pre-existing chronic low back pain & disc herniation at L-5 S-1 with left lateralization and bilateral leg radiation." (Exs. 19, 24). Thus, the accepted condition encompasses the current low back combined condition. On that basis, the ALJ found that the medical arbiter panel properly determined that the accepted condition resulted in valid impairment. Applying OAR 436-035-0007(4)(c),[2] the ALJ found that the Order on Reconsideration properly rated that impairment. We agree.

On review, the employer argues that ORS 656.214(5)[3] requires a finding of no permanent disability due to the compensable injury. In making this argument, the employer relies on the opinions of Drs. Farris and Gripekoven. As discussed above, because the attending physician did not concur with those opinions, we may not rely on them to determine whether claimant is entitled to permanent disability.

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[1] Although claimant cross-requests review of the ALJ's order, she makes no argument on review regarding that cross-request. Instead, claimant requests that we affirm the ALJ's order. (Respondent/Cross Appellant's Brief, page 4). Under these circumstances, we find that the only issue on review is extent of permanent disability, the issue raised by the employer.

[2] 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."

[3] 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."

Moreover, to the extent that the employer argues that OAR 436-035-0007(4)(c) is inconsistent with ORS 656.214(5), we rejected that argument in *Dewey C. Harvey*, 52 Van Natta 1556 (2000). In *Harvey*, the carrier 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. Thus, the "combined condition" accepted by the carrier included both the injury and the preexisting disease. The carrier did not issue a written denial of the combined condition under ORS 656.262(7)(b). Therefore, the entire combined condition remained the accepted condition and, thus, in the absence of a pre-closure denial, the entire "combined condition" was ratable. *See SAIF v. Belden*, 155 Or App 568, 576-75 (1998), *rev den* 328 Or 330 (1999) (where the carrier accepted a combined condition but did not issue a denial of the combined condition, entire combined condition properly rated); *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). Consequently, because the entire accepted combined condition was due to the compensable injury, we found that the rule was consistent with the statute.

The same reasoning applies here. Because the entire accepted combined condition is due to the compensable injury, and the medical arbiter panel measured valid impairment due to the accepted combined condition, that impairment is due 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 the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 2, 2001 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,200, payable by the employer.

July 17, 2001 Cite as 53 Van Natta 977 (2001)

In the Matter of the Compensation of
ROGER S. PASKVAN, Claimant
Own Motion No. 00-0282M
OWN MOTION ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Reviewing panel: Members Phillips Polich and Haynes.

Claimant requested reconsideration of our May 18, 2001 Own Motion Order that affirmed the insurer's January 26, 2001 Notice of Closure. On June 18, 2001, we withdrew our May 18, 2001 order and established a briefing schedule to allow the parties to submit their written positions regarding claimant's request for reconsideration.

On July 6, 2001, claimant announced that he was withdrawing his request for reconsideration.

In light of such circumstances, we conclude that claimant has withdrawn his request for reconsideration of our May 18, 2001 Own Motion Order Reviewing Carrier Closure. Accordingly, on reconsideration, we adhere to and republish our May 18, 2001 order in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JENNIFER D. REYNOLDS, Claimant
WCB Case Nos. 00-05932, 00-01240 & 99-09615
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewing Panel: Members Phillips Polich, Bock, and Haynes. Member Haynes chose not to sign the order.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's L4-5 annular fissure. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the fifth paragraph on page 2, we change the last sentence to read: "Although claimant developed some back discomfort after the accident, her back symptoms resolved." In the second paragraph on page 3, we change the second sentence to read: "Claimant complained of ongoing low back pain, and a lumbar MRI was performed." In the first full paragraph on page 5, we replace the last sentence with the following: "The employer contends that claimant sustained a new off-the-job injury that caused her current low back condition."

We write only to address the employer's argument that the opinion of Dr. Denekas establishes that claimant sustained a new off-the-job back injury in 1999. Dr. Denekas explained:

> "It is important to note that, as stated above, this individual had an MRI of her back ordered in 1999, soon after an episode of pain in her back from yard work. Therefore, again, in my opinion, it would appear that this episode appears to have precipitated investigation of her back condition, rather then [sic] a remote episode from 1994.
>
> "It is also noted at the time of her [1999] MRI, there was an annular tear identified in the disk. It would not be reasonable to expect that this particular finding would present as relates to injuries from 1994, as I understand the nature of this particular finding. This appears to be an area of inflammation in the annular wall of the disk that would be secondary to acute or subacute injury to the disk. This, therefore, would be more suggestive of an acute injury related to the episode on June 30, 1999, rather than the work-related episodes." (Ex. 76-3, -4).

Dr. Denekas relied on a June 30, 1999 chart note from a chiropractor that said claimant had "LBP following yard work - hurts across whole LB[.]" (Exs. 46, 76-2). He assumed, based on the time sequence, that the MRI was based on an injury from the June 30, 1999 episode. (Ex. 76-2). In a deposition, Dr. Denekas explained that he had no information about the June 1999 incident other than the chart note. (Ex. 73A-29). However, he relied on the fact that claimant's doctor later recommended a lumbar MRI. (*Id.*)

We find that the record is insufficient to establish that claimant sustained a new off-the-job injury in June 1999. Dr. Denekas' "assumption" that the MRI was necessary because of an injury from the June 30, 1999 yard work incident is not persuasive. (Ex. 76-2). *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (the doctors' use of the words "could," "can," "it is reasonable to assume" and "we would like to assume" militated against a finding of medical causation in terms of probability). Moreover, we are not persuaded by his statement that this "appears" to be an area of inflammation in the annular wall of the disk that was "more suggestive" of an acute injury on June 30, 1999.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by 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 21, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by self-insured employer.

July 17, 2001 Cite as 53 Van Natta 979 (2001)

In the Matter of the Compensation of
TIMOTHY A. VINTON, Claimant
WCB Case Nos. 00-07642 & 00-06135
ORDER ON REVIEW
Max Rae, Claimant Attorney
Thaddeus J. Hettle & Associates, Defense Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich dissents.

The SAIF Corporation, on behalf of Diamond B. Lumber Co., requests review of that portion of Administrative Law Judge (ALJ) Black's order that set aside its compensability and responsibility denial of claimant's current low back condition. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld Johnston & Culberson, Inc.'s, (JCI's) compensability and responsibility denial, on behalf of Oberto/Smokecraft, of his current low back condition; and (2) declined to assess penalties against SAIF or JCI for allegedly unreasonable compensability denials. On review, the issues are compensability, responsibility and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

In December 1986, claimant injured his back while working as a chain puller for SAIF's insured. (Ex. 5). He was diagnosed with a lumbar strain. (Ex. 2). A December 1986 x-ray showed evidence of "at least partial spondylolysis involving L-4 bilaterally with only a suggestion of minimal anterior spondylolisthesis at L-4." (Ex. 3). SAIF accepted a disabling lumbar strain. (Ex. 6). A March 10, 1987 Notice of Closure awarded only temporary disability. (Ex. 7). The Notice of Closure was affirmed in February 1988. (Ex. 35).

On June 15, 1987, claimant injured his back while pulling lumber. (Exs. 8, 11). He was initially diagnosed with an acute lumbar sprain. (Ex. 9). A bone scan in July 1987 showed longstanding bilateral pars interarticularis defects at L4. (Exs. 15, 16). Dr. Westfall diagnosed an L4 pars interarticular defect and recurrent musculoskeletal pain syndrome. (Ex. 17). In September 1987, Dr. Pollard diagnosed spondylolisthesis, mild slip at L4. (Ex. 20). He felt the defect at L4 was probably developmental from childhood. (Exs. 16, 20).

In October 1987, claimant was referred to Dr. Tiley, who diagnosed minimally unstable spondylolisthesis and spondylolysis at L4-5 with disc degeneration. (Ex. 25). He interpreted an MRI as showing disc degeneration at L4-5 and L5-S1. (Ex. 26). In December 1987, Dr. Tiley found that claimant had significant instability from spondylolisthesis at L4-5. (Exs. 26, 30). He recommended surgery, specifically an "osteosynthesis with screw fixation for the spondylolysis and spondylolisthesis at L4-5 and an L4 to sacrum fusion for his degenerative disc disease at those levels." (Ex. 31). SAIF authorized surgery, referring to the date of injury as "December 9, 1986." (Ex. 31A). In January 1988, Dr. Tiley performed surgery and his diagnosis was "[s]pondylolysis L4." (Ex. 33).

Claimant's back pain continued. (Exs. 37, 38, 39). In September 1988, Dr. Tiley reported that a CT scan showed that one of the screws was loose and he recommended surgery. (Ex. 42). In October 1988, SAIF authorized surgery, again referring to the date of injury as "December 9, 1986." (Ex. 42A). On December 7, 1988, Dr. Tiley performed surgery, described as a "redo" of pars repair at L4. (Ex. 43-3). Dr. Tiley's diagnosis was "[f]ailed attempt at repair of pars defect, with spondylolisthesis at L4." (*Id.*) An August 1, 1989 Determination Order awarded 18 percent unscheduled permanent disability for claimant's low back. (Ex. 51). A February 27, 1990 Opinion and Order increased the award to 76 percent. (Ex. 52).

Claimant continued to have back pain and he sought treatment in March 1990 from Dr. Gilberts. (Ex. 53). He was also treated by Drs. White, Chester and Hiebert with physical therapy and epidural injections. (Exs. 53, 54, 58, 59, 64, 69). A June 14, 1990 imaging report said the findings raised the possibility of an incomplete fusion. (Ex. 57).

On June 29, 1990, SAIF denied an aggravation claim on the basis that claimant's condition had not worsened since the last award of compensation. (Ex. 60). SAIF explained that it had accepted a lumbar strain. (*Id.*) In May 1991, a claim disposition agreement (CDA) with SAIF was approved. (Ex. 73). The CDA also referred to the accepted condition as a lumbar strain. (Ex. 73-1).

Claimant testified that, between January 1992 and September 1997, he did not have any treatment or miss any work because of his back. (Tr. 16-18, 29). In November 1992, claimant began working for Oberto/Smokecraft as a sanitation worker. (Ex. 74). On September 22, 1997, he injured his low back while pulling and lifting a 55 pound barrel. (Exs. 74, 75). He sought treatment from Dr. Tiley, who diagnosed a lumbosacral strain superimposed on the previous surgery for spondylosis. (Exs. 75, 76, 77). JCI, on behalf of Oberto/Smokecraft, accepted a lumbosacral strain. (Ex. 78).

On January 31, 2000, Dr. Tiley reported that claimant's x-rays showed a failure of union of the pars fracture and he felt claimant had some instability at L4-5. (Ex. 76). On February 7, 2000, Dr. Tiley signed an aggravation form regarding the SAIF claim. (Ex. 79). He reported that claimant had a failed back procedure and he recommended additional surgery; *i.e.*, a formal instrumented arthrodesis. (Ex. 80-2).

In July 2000, Dr. White performed a records review on behalf of SAIF. (Ex. 83).

On August 3, 2000, SAIF denied claimant's current low back condition on the basis that his medical treatment and disability were not compensably related to the original accepted claim. (Ex. 87).

Dr. Farris examined claimant in August 2000 on behalf of JCI. (Ex. 88).

On October 4, 2000, JCI wrote to claimant's attorney, asserting that claimant's current medical treatment and requested surgery were unrelated to his accepted lumbosacral strain claim. (Ex. 90).

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing regarding the denials from SAIF and JCI. At hearing, JCI's attorney clarified that JCI was denying compensability and responsibility of claimant's current low back condition. (Tr. 2-4). Claimant also agreed to allow SAIF to amend its denial to include a denial of responsibility. (Tr. 4).

The ALJ found that ORS 656.308(1) did not apply to claimant's accepted 1997 injury with JCI. The ALJ relied on Dr. Tiley's opinion to conclude that the 1986 injury with SAIF was the major contributing cause of claimant's "consequential" low back condition. The ALJ therefore set aside SAIF's denial of claimant's current low back condition.

SAIF argues that the only condition it accepted was a lumbar strain and it did not accept any of claimant's preexisting back conditions. Relying on ORS 656.262(10), SAIF contends that its previous payment of claimant's back surgeries and permanent disability award does not constitute an acceptance of the preexisting conditions. Further, SAIF argues that, if claimant's current low back condition is a "consequential condition," there is no medical evidence that establishes that claimant's 1986 lumbar strain is the major contributing cause of the consequential condition.

On review, claimant argues that SAIF's denial was properly set aside. According to claimant, SAIF's preauthorizations of his 1988 surgeries are acceptances of the compensability of the surgeries as treatment for the accepted lumbar strain condition. Claimant contends that the failure of the 1988 surgeries is now a compensable consequence as to SAIF. Claimant also cross-requests review, arguing that ORS 656.308(1) applies to the 1997 injury with JCI.

On the other hand, JCI contends that this case does not involve a responsibility dispute. Rather, JCI argues that the persuasive medical evidence establishes that claimant currently suffers from preexisting L4 spondylolysis and spondylolisthesis at L4-5, neither of which was accepted by SAIF or JCI. According to JCI, claimant must first establish compensability of his spondylolysis and spondylolisthesis at L4-5 and it contends that the medical evidence is insufficient to establish compensability of those conditions.

We begin by addressing the scope of each acceptance, which is a question of fact. *See SAIF v. Dobbs*, 172 Or App 446 (2001); *SAIF v. Tull*, 113 Or App 449 (1992).

SAIF specifically and unambiguously accepted a lumbar strain resulting from the December 1986 injury. (Ex. 6). Despite the fact that SAIF authorized two surgeries in 1988 and indicated they were related to the December 9, 1986 injury (Exs. 31A, 42A), SAIF did not accept any additional conditions. Furthermore, the CDA approved in May 1991 referred to the accepted condition as a "lumbar strain."[1] (Ex. 73-1).

Nevertheless, claimant argues that SAIF's preauthorizations of his 1988 surgeries constitute acceptances of the compensability of the surgeries as treatment for the accepted lumbar strain condition. The fact that SAIF paid for claimant's medical treatment or a permanent disability award does not establish that it accepted any additional conditions. To the contrary, SAIF relies on ORS 656.262(10), which provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review of such an order or notice of closure, shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

In *Johnson v. Spectra Physics*, 303 Or 49, 58 (1987), the Court held that an insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). Here, SAIF accepted only a lumbar strain resulting from the December 1986 injury. (Ex. 6). Although claimant had been diagnosed with spondylolysis and spondylolisthesis at L4-5 and degenerative disc disease, SAIF did not accept any of those conditions.

Thus, despite the fact that SAIF paid for claimant's prior surgeries in 1988 and preauthorized those procedures, and also paid a permanent disability award, the current statutory scheme is inconsistent with claimant's argument that SAIF thereby accepted claimant's spondylolysis or spondylolisthesis. *Compare Deluxe Cabinet Works v. Messmer*, 140 Or App 548 (under *former* ORS 656.262(10), a carrier's failure to challenge a determination order precluded the carrier from subsequently contesting the compensability of a condition rated therein), *rev den* 324 Or 305 (1996).

Claimant also argues that SAIF's acceptances of the "ORS 656.245" claims for the compensability of the 1988 surgeries is now final and preclusive. However, the issue here is whether claimant's *current* proposed treatment for his current condition is compensable; SAIF is not disputing the payment for the 1988 surgeries. We conclude that the only condition accepted by SAIF was a lumbar strain. *See Kim D. Wood*, 48 Van Natta 482, 484, *aff'd mem* 144 Or App 496 (1996) (because there was a specific acceptance of a "left knee strain," it was not necessary to examine the contemporaneous medical evidence to determine what condition was accepted, even though no physician had diagnosed a knee strain at the time of acceptance).

The dissent relies on *Kevin J. Nettles*, 53 Van Natta at 224, to support its contention that we are not precluded from examining the contemporaneous medical record in all cases involving an expressly accepted condition. The dissent explains that, in *Nettles*, we found that the contemporaneous medical record did not support the fact that the carrier had accepted a low back herniated disc condition, despite the explicit acceptance of "low back sciatica symptoms."

For the following reasons, we find that *Nettles* is distinguishable. In *Nettles*, the carrier accepted a right thigh strain and low back strain. The claimant requested acceptance of right lower extremity sciatica and disc herniation at L4-5 and L5-S1. An ALJ approved a stipulated order of dismissal in which the carrier agreed to accept "right lower extremity sciatica due to low back strain." The carrier then issued an updated notice of acceptance at claim closure and accepted "low back sciatica symptoms."

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[1] We note that the function of a CDA is not to accomplish claim processing functions under ORS 656.262 or otherwise resolve compensability issues. *See, e.g., Kevin J. Nettles*, 53 Van Natta 224 (2001). In other words, a CDA cannot be used to accept a condition or modify a prior acceptance. Here, however, the CDA refers to the same condition in SAIF's notice of acceptance.

After claim closure, the claimant requested reconsideration, and the carrier later requested a hearing regarding the order on reconsideration. The parties subsequently entered into a claim disposition agreement (CDA) that listed the accepted condition as "right thigh strain, low back strain and right lower extremity sciatica due to low back strain." After the CDA was approved, the carrier's request for hearing regarding the Order on Reconsideration was dismissed.

An aggravation claim was filed, which attributed the claimant's pain to a herniated disc at L4-5. The carrier issued a responsibility denial for the claimant's current need for medical treatment, based on the prior CDA. At hearing, the parties stipulated that the carrier's denial was amended to deny L4-5 disc herniation. The claimant argued that the carrier's updated notice of acceptance at claim closure that referred to "low back sciatica symptoms" amounted to an acceptance of the condition causing the symptoms. The claimant relied on *Georgia Pacific Corp. v. Piwowar*, 305 Or 494 (1988), to contend that, by accepting sciatica symptoms, the carrier had accepted the L4-5 disc herniation. The claimant raised the same arguments on review. On the other hand, the carrier argued that the language of the stipulation and the CDA limited the acceptance to the conditions set forth in those agreements.

Based on the parties' stipulation (accepting right lower extremity sciatica due to low back strain) we found that that was the condition that the parties intended to have accepted. Although the updated notice of acceptance, which issued soon after the stipulation, listed only sciatica symptoms, we were persuaded, based on the stipulation that preceded the notice of acceptance, that the carrier agreed to accept sciatica due to the accepted strain and did not agree to accept a disc herniation or sciatica in general. Our conclusion was supported by contemporaneous medical evidence, which did not support the existence at that time of a disc herniation at L4-5 or a herniated disc-related sciatica.

Here, in contrast, this case involves only an acceptance, and does not include a stipulation or an updated notice of acceptance. In previous cases, we have held that when a carrier accepts a specific condition, rather than symptoms, it is not necessary to resort to medical records to determine what was accepted. In that situation, the reasoning in *Piwowar* does not apply to determine the scope of acceptance. *See, e.g., Quinna J. Nolan*, 53 Van Natta 226 (2001); *David A. Robbins*, 52 Van Natta 1323 (2000); *Filbert M. Fimbres*, 52 Van Natta 772 (2000), *aff'd mem Fimbres v. SAIF*, 173 Or App 446 (2001). Instead, the acceptance is limited to the condition specifically accepted in writing; *i.e.*, SAIF's acceptance is limited to a lumbar strain.

We turn to the scope of JCI's acceptance. As a result of claimant's September 1997 injury, JCI accepted a lumbosacral strain. (Ex. 78). Relying on ORS 656.308(1), claimant argues that the question of whether JCI assumed responsibility for his prior accepted lumbar strain and "everything associated with it" when it accepted the 1997 lumbosacral strain turns on whether the prior condition was involved in the new injury. According to claimant, JCI's acceptance clearly involved the preexisting conditions, which was sufficient to bring the preexisting problems within the scope of the 1997 acceptance.

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."

The court has construed ORS 656.308(1) to require a shift of responsibility only when the claimant's new compensable injury is for or includes the "same condition" previously accepted. *See, e.g., Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 182 (1996); *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371-72 (1993). In *Multifoods Specialty Dist. v. McAtee*, 164 Or App 654, 662 (1999), the court held that, for the purpose of ORS 656.308(1), a new compensable injury "involves the same condition" when the new injury encompasses, or has as part of itself, the prior compensable injury. *See also Barrett Business Services v. Morrow*, 164 Or App 628, 631 (1999).

Here, as we discussed above, the compensable injury accepted by SAIF was limited to a lumbar strain. Claimant testified that he did not have any treatment for his back between January 1992 and September 1997 and did not miss any time from work because of his back. (Tr. 16-18, 29). On September 22, 1997, he injured his low back while working for Oberto/Smokecraft and JCI accepted a lumbosacral strain. (Ex. 78).

We find no medical evidence that establishes that claimant's 1997 injury involved the same condition as the prior *compensable* injury; *i.e.*, the 1986 lumbar strain accepted by SAIF. In September 1997, Dr. Tiley diagnosed a lumbosacral strain superimposed on the previous surgery for spondylosis. (Exs. 75, 76, 77). His reports, however, do not indicate that claimant's September 1997 strain was related to the 1986 lumbar strain accepted by SAIF. Dr. Tiley's January 31, 2000 chart note indicated that claimant had continued symptoms after 1997, but he reviewed x-rays and found that claimant had a failed surgery for the prior claim and needed additional surgery. (Ex. 76-1). In a later report, Dr. Tiley said he did not believe that claimant's 1986 lumbar strain played any role in claimant's current condition. (Ex. 86-2). Likewise, Dr. White reported that claimant's 1986 strain had been medically stationary for many years and claimant had no permanent injury or impairment from that strain. (Ex. 83-5).

ORS 656.308(1) provides that 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. We find no medical evidence that shows claimant's September 1997 injury "encompassed, or had as part of itself," the prior *compensable* lumbar strain accepted by SAIF. Because there is no persuasive evidence that the September 1997 injury involved the "same condition," ORS 656.308(1) does not apply.[2] *See McAtee*, 164 Or App at 663 (the claimant's new lumbar strain did not involve the same condition previously accepted); *see also 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"). As discussed earlier, we have rejected claimant's assertion that SAIF's acceptance of the 1986 compensable injury included his preexisting spondylolysis and spondylolisthesis at L4-5. We conclude that JCI's acceptance was limited to a lumbosacral strain and did not include any preexisting conditions.

We agree with JCI that claimant must first establish compensability of his current low back condition. We find no medical opinions diagnosing claimant's current condition as a lumbar or lumbosacral strain. Instead, the following medical reports show that claimant's current disability and need for treatment is related to the failure of the 1988 surgeries.

Dr. Tiley explained that the radiographic studies showed a failure of union of the pars interarticularis and posterior lateral arthrodesis previously done at L4-5. (Ex. 86-2). He said that claimant's 1988 surgeries were unsuccessful in stabilizing the L4-5 level and he recommended additional surgery to stabilize that level. (Exs. 76, 80-2, 82, 86-2). Dr. Tiley explained that claimant had a "failed back procedure and he needs to have that taken apart and have a formal instrumented arthrodesis." (Ex. 80-2). In a later report, he agreed that claimant's back condition and the failure of his arthrodesis (fusion) was the current reason for his need for treatment. (Ex. 89-1).

Similarly, Dr. Farris diagnosed "[f]ailed attempt at arthrodesis of the pars interarticularis defects x 2." (Ex. 88-17). He explained that claimant's current disability and need for treatment was due to the preexisting spondylolisthesis and the two failed lumbar spine surgeries in 1988. (Ex. 88-19). Dr. White also found that claimant's current need for treatment was related to his preexisting spondylolisthesis. (Ex. 83-5).

Based on these medical reports, we find that claimant's current disability and need for treatment is for the failure of his arthrodesis (fusion) at L4-5 previously done in 1988. The medical records show that claimant's 1988 surgeries were related to his spondylolysis and spondylolisthesis at L4-5, as well as degenerative disc disease. Dr. Tiley recommended the first surgery in 1988, specifically an "osteosynthesis with screw fixation *for the spondylolysis and spondylolisthesis at L4-5* and an L4 to sacrum fusion *for his degenerative disc disease at those levels.*" (Ex. 31; emphasis supplied). On December 7, 1988, Dr. Tiley performed additional surgery because one of the screws had loosened and the bone graft was not sufficient to stabilize claimant. (Exs. 42, 43-1). He diagnosed "L4-5 spondylolysis with spondylolisthesis." (Ex. 43-1).

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[2] Furthermore, ORS 656.308(1) does not apply to the SAIF claim. ORS 656.308(1) provides that a carrier "shall remain responsible for future compensable medical services and disability relating to the compensable condition[.]" Here, we find no evidence that claimant's current disability and need for treatment is related to the lumbar strain accepted by SAIF.

Claimant's spondylolysis and spondylolisthesis at L4-5 are not accepted conditions and, therefore, he must first establish compensability of those conditions. Claimant relies on *Barrett Business Services v. Hames*, 130 Or App 190, *rev den* 320 Or 492 (1994), arguing that conditions caused by compensable medical services are compensable as consequential conditions. He contends that the failure of the 1988 surgeries is now a compensable consequence as to SAIF.

SAIF responds that *Hames* is distinguishable because claimant's 1988 back surgeries, which ultimately failed, were not directed at his compensable lumbar strain. SAIF contends that claimant does not have a compensable consequential condition under ORS 656.005(7)(a)(A) because the 1986 lumbar strain is not the major contributing cause of the spondylolysis and spondylolisthesis at L4-5.

ORS 656.005(7)(a)(A) provides that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." In *Roy v. McCormack Pacific Co.*, 171 Or App 526 (2000), *adhered to on recon*, 172 Or App 663 (2001), the court explained a "consequential condition":

> "We have defined a "consequential" injury or condition in past cases, by comparing a consequential injury with an initial compensable injury. In *Albany General Hospital v. Gasperino*, 113 Or. App. 411, 415, 833 P2d 1292 (1992), we said,
>
> 'The distinction is between a condition or need for treatment that is caused by the *industrial accident*, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the *compensable injury*. It is the latter that must meet the major contributing cause test.'" 171 Or App at 528 n.1 (emphasis in original).

In *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 536 (1997), the court said that a "consequential condition" under ORS 656.005(7)(a)(A) is "a separate condition that arises from the compensable injury, for example, when a worker suffers a compensable foot injury that results in an altered gait that, in turn, results in back strain."

In this case, claimant makes no argument that the failure of his arthrodesis at L4-5 or his spondylolysis and spondylolisthesis at L4-5 were caused directly by either work injury or that those were new conditions that arose out of and in the course of his employment. *Compare Robinson v. Nabisco Inc.*, 331 Or 178 (2000) (the claimant argued that an injury that occurred during a compelled medical examination was a new compensable injury that arose out of and within the course of employment); *Gasperino*, 113 Or App at 414 (condition that arose directly, but belatedly, from the original injury was subject to material contributing cause standard, not major contributing cause standard).

Rather, claimant relies on *Hames*, 130 Or App at 196, where the court held that when reasonable and necessary treatment for a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). *See Dennis M. Getz*, 53 Van Natta 375 (2001) (applying ORS 656.005(7)(a)(A) to an injury that occurred during a physical capacities evaluation).

Claimant has a compensable lumbar strain with SAIF and a compensable lumbosacral strain with JCI. There is no medical evidence that supports the conclusion that medical treatment for either claimant's lumbar strain or lumbosacral strain was the major contributing cause of a new compensable injury. Indeed, there has been no "new injury." Rather, claimant's current need for medical treatment is for the failure of his arthrodesis (fusion) at L4-5 previously done in 1988.

Furthermore, there is no medical evidence that establishes that claimant's compensable lumbar strain with SAIF is the major contributing cause of the current consequential condition. To the contrary, the medical opinions indicate that claimant's 1986 lumbar strain did not play a role in his current condition. In an April 18, 2000 report, Dr. Tiley indicated that claimant's condition was "related to the original claim of 1986." (Ex. 82). Nevertheless, Dr. Tiley apparently assumed that the "1986 claim" included the previous surgeries. (*See* Ex. 86-1). In a later concurrence letter from JCI's attorney, Dr. Tiley agreed that the *surgeries* authorized by SAIF under the 1986 claim were the major contributing cause of claimant's disability and need for treatment for his failed arthrodesis. (Ex. 89-2). Dr. Tiley did

not "think that the 1986 lumbar strain now plays any role in this man's current condition[.]" (Ex. 86-2). Similarly, Dr. White concluded that claimant's current treatment was related to preexisting spondylolisthesis, not the December 1986 lumbar strain. (Ex. 83-5). He said that the December 1986 strain played no part in the need for surgery and there was no permanent injury or impairment from that strain. (Ex. 83-5). Dr. Farris explained that the 1986 lumbar strain caused only a symptomatic worsening of claimant's preexisting spondylolysis and the spondylolisthesis. (Ex. 88-18). He concluded that the major contributing cause of claimant's current low back condition, disability and need for treatment was the spondylosis and spondylolisthesis that preexisted the 1986 claim. (Ex. 88-18).

In addition, there is no persuasive medical evidence that establishes that claimant's compensable lumbosacral strain with JCI is the major contributing cause of claimant's current consequential condition. In a July 2000 report, Dr. Tiley said that the September 1997 incident was the major contributing cause of claimant's current "combined condition." (Ex. 86-2). In that report, however, Dr. Tiley explained that the spondylolysis and spondylolisthesis and the two prior surgeries had "combined" with the 1997 incident. (*Id.*) Thus, Dr. Tiley's reference to a combined condition included claimant's preexisting spondylolysis and spondylolisthesis, as well as the two prior surgeries. In a later concurrence letter from JCI's attorney, Dr. Tiley agreed that the contribution from claimant's September 1997 injury was minor, whereas the surgeries authorized by SAIF under the 1986 claim were the major contributing cause of claimant's disability and need for treatment for his failed arthrodesis. (Ex. 89-2). We find that Dr. Tiley's reports do not support the conclusion that the 1997 lumbosacral strain is the major contributing cause of claimant's consequential condition.

Likewise, Dr. Farris said that the September 1997 injury caused no more than a symptomatic worsening of claimant's significant preexisting lumbar spine condition. (Ex. 88-18). He explained that the 1997 incident did not cause a failure of the arthrodesis because that failure had been documented several years earlier. (*Id.*) Dr. Farris concluded that claimant's preexisting spondylolysis and spondylolisthesis, not the 1997 incident, were the major contributing cause of his current disability and need for treatment. (*Id.*)

In sum, we find no medical persuasive evidence that establishes that claimant's treatment for either the compensable lumbar strain or the compensable lumbosacral strain was the major contributing cause of a new injury. Consequently, claimant has not established compensability of a consequential condition under ORS 656.005(7)(a)(A). As we discussed above, ORS 656.308(1) does not apply to claimant's current condition. We conclude that claimant has failed to establish compensability of the failure of his arthrodesis at L4-5 or his spondylolysis and spondylolisthesis at L4-5. In light of our conclusion, it is unnecessary to address the issue of responsibility.

Penalties

Claimant argues that he is entitled to penalties against SAIF and JCI for the allegedly unreasonable compensability denials. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). We conclude that claimant is not entitled to a penalty.

ORDER

The ALJ's order dated December 13, 2000 is reversed in part and affirmed in part. The portion of the ALJ's order that set aside SAIF's denial is reversed. SAIF's compensability and responsibility denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Member Phillips Polich dissenting.

Because I believe that the medical record viewed as a whole supports the ALJ's conclusion to set aside SAIF's denial, I respectfully dissent.

To begin, I emphasize that I am not contending that SAIF is still "on the hook" for claimant's current low back condition merely because it a) paid for the prior low back surgeries, or b) paid a permanent disability award related to claimant's 1986 compensable injury. *See* ORS 656.262(10). However, I do note that Dr. White's opinion that claimant's 1986 lumbar strain condition did *not* result

in permanent injury or impairment is contrary to the law of the case; *i.e.*, that claimant was eventually awarded 76 percent unscheduled permanent disability for his 1986 "lumbar strain." (Exs. 52, 83-5). *See Kuhn v. SAIF*, 73 Or App 768 (1985).

Rather, I believe that the contemporaneous medical record provides overwhelming evidence that the condition processed by SAIF was not merely a lumbar strain, but instead necessarily included an L4 spondylolysis and/or L4-5 spondylolisthesis condition, for which claimant underwent two surgeries with Dr. Tiley. (Exs. 33, 43-3). This more serious and complex medical condition is also reflected in the large permanent disability award described above.

After claimant's December 1986 injury, SAIF continued to process claimant's claim, including providing medical benefits for the two surgeries with Dr. Tiley. In February 2000, Dr. Tiley reported that claimant had a failed back procedure and recommended an additional surgery, a formal instrumented arthrodesis. (Ex. 80-2). The "failed back procedures" were compensable medical services processed under the December 1986 claim with SAIF. Dr. Tiley agreed that the "major contributing cause to claimant's disability and need for treatment, his failed arthrodesis * * * was the surgeries authorized by SAIF" under the 1986 claim. (Ex. 89-2).

I acknowledge our decision in *Kim D. Wood*, 48 Van Natta 482, *aff'd mem* 144 Or App 496 (1996), cited by the majority. In other words, SAIF expressly accepted only a "lumbar strain" condition, and we will therefore generally not "go behind" the language of that acceptance to explore the medical record to determine the accepted condition. 48 Van Natta at 484.

However, in *Kevin J. Nettles*, 53 Van Natta 224 (2001), we examined the contemporaneous medical record to determine what condition had been accepted, despite the existence of an "Updated Notice of Acceptance" specifying acceptance of, *inter alia*, "low back sciatica symptoms." In *Nettles*, we found that the contemporaneous medical record did not support the fact that the carrier had accepted a low back herniated disc condition despite the explicit acceptance of "low back sciatica symptoms." 53 Van Natta at 226, 227. *Cf. Georgia Pacific v. Piwowar*, 305 Or 494 (1988) (acceptance of the symptoms of a condition encompasses the causes of the symptoms). Thus, I do not believe that in all cases involving an expressly accepted condition we are precluded from examining the contemporaneous medical record.

In the Matter of the Compensation of
GLENDA G. BRADEN, Claimant
WCB Case No. 00-07986
ORDER ON REVIEW
Schneider, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant sustained a low back injury when she lifted a garbage bag on August 21, 2000, while working. In coming to this conclusion, the ALJ relied on the opinion of claimant's treating physician, Dr. Meigs. SAIF contends that Dr. Meigs' opinion is not sufficient to carry claimant's burden of proof.

The record contains two opinions. Examining surgeon, Dr. Yarusso, diagnosed a "somatic pain disorder." (Ex. 21-5). Although finding that the August 21, 2000 incident "could have produced a mild strain to her low back," Dr. Yarusso thought that claimant's "progression of symptoms and current symptoms * * * are marked with inconsistencies and do not blend together to form a concrete picture for a pure underlying medical condition such as a low back strain." (*Id.*)

Dr. Yarusso also considered claimant as having preexisting conditions, including "personality characteristics and psychosocial issues," that he thought played "a significant role in the onset, severity, exacerbations, and maintenance of her current complaints." (*Id.* at 7). In particular, Dr. Yarusso pointed to claimant filing for bankruptcy one week after the accident and the "inconsistencies and symptom magnification displayed on today's exam[.]" (*Id.*)

Dr. Meigs concurred with Dr. Yarusso's report. (Ex. 23).

Dr. Yarusso then provided a supplemental report reiterating that the August 2000 accident did not likely cause "any strain or organic condition in claimant's back" because the mechanism of injury was "minimal," claimant's condition had not improved since the incident, and his examination showed "numerous inconsistencies." (Ex. 25-1). Dr. Yarusso reiterated that claimant had a somatic pain disorder rather than an organic injury. (*Id.* at 2).

During a deposition, Dr. Meigs explained that, when he first saw claimant in August 2000, he diagnosed "an acute lumbosacral strain and somatic dysfunction." (Ex. 26-5). Dr. Meigs also thought that claimant sustained a mild strain as a result of the August 21, 2000 accident. (*Id.* at 7).

Dr. Meigs further explained, however, that he saw no "signs of a strain" when he examined claimant immediately before Dr. Yarusso's examination in October 2000. (*Id.* at 9). According to Dr. Meigs, the August 2000 injury ceased to be a factor in causing claimant's symptoms between his examinations on September 7, 2000, and September 21, 2000. (*Id.* at 24). Dr. Meigs continued to find that claimant initially sustained a back strain. (*Id.* at 23).

We agree with the ALJ that Dr. Meigs provided the more persuasive opinion. As the treating physicians, Dr. Meigs' opinion is entitled to deference. *See Weiland v. SAIF*, 64 Or App 810 (1983). In particular, because Dr. Meigs saw claimant shortly after the August 21, 2000 accident, continued treating her, and based his opinion on an accurate history, we find no persuasive reasons not to defer to his opinion. *Id.*

Based on Dr. Meigs' opinion, we find that claimant proved that, at least initially, she sustained a compensable injury. According to Dr. Meigs, however, claimant's injury was no longer a factor when he saw her on September 21, 2000. Thus, we conclude that claimant proved compensability only through September 20, 2000. After that date, the medical evidence shows that her compensable injury was not the major contributing cause of her need for treatment and disability.[1] Consequently, we reinstate SAIF's denial for the period after September 20, 2000.

Because we have partially reinstated SAIF's denial, it is necessary to modify the ALJ's attorney fee award. Claimant's attorney is entitled to an assessed fee for services at hearing and on review for partially prevailing over SAIF's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $2,750, 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 respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 9, 2001 is affirmed in part, reversed in part, and modified in part. We reverse that portion of the order that set aside SAIF's denial in its entirety. SAIF's denial is set aside to the extent that it denied claimant's low back injury before September 21, 2000. The denial is reinstated and upheld to the extent it denied compensability as of September 21, 2000. For services at hearing and on review, claimant's attorney is awarded a fee of $2,750, to be paid by SAIF.

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[1] Because Dr. Meigs stated that the accident was not a factor in claimant's condition as of September 21, 2000, we come to this conclusion whether we apply ORS 656.005(7)(a) or 656.005(7)(a)(B).

In the Matter of the Compensation of
SERAFIN P. GUZMAN, Claimant
WCB Case No. 00-07980
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
David L. Bussman, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that awarded claimant 16 percent (30.72 degrees) scheduled permanent disability for the loss of use or function of his right arm, in addition to an Order on Reconsideration that had awarded 12 percent (18 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 adopt and affirm the ALJ's order with the following supplementation.

In May 1999, claimant compensably fractured both the radius and ulna of his right arm.[1] (Exs. 1; 2). In May 2000, a Notice of Closure awarded 12 percent (18 degrees) scheduled permanent disability for loss of use or function of claimant's right wrist.[2] (Ex. 13). Claimant requested reconsideration.

Drs. Reimer, Geist, and McKillop performed a medical arbiter evaluation. (Ex. 18). Relying on that evaluation, the Appellate Review Unit issued an Order on Reconsideration that affirmed the Notice of Closure. (Ex. 19). Claimant requested a hearing.

The ALJ determined that the medical arbiter evaluation established that claimant had: (1) reduced range of right elbow motion; and (2) loss of pronation and supination of the right wrist. The ALJ further determined that: (1) those findings were the result of the compensable injury; and (2) claimant had not received an award for those findings. Consequently, the ALJ awarded 16 percent scheduled permanent disability for loss of use or function of claimant's right arm, in addition to claimant's 12 percent "right wrist" award.

On review, the insurer contends that: (1) claimant's range of motion measurements for loss of pronation and supination are unreliable and thus not valid for rating purposes; and (2) claimant is not entitled to disability for loss of elbow range of motion for a "wrist" injury. For the reasons stated below, we disagree.

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). 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). Where a preponderance of the evidence establishes a different level of impairment, the impairment is established by the preponderance of evidence.[3] (*Id.*)

Here, the medical arbiters reported claimant's right arm pronation to be 40 degrees, and supination to be 10 degrees.[4] (Ex. 18-4). The medical arbiters also reported that the measurements were "somewhat variable," but they found that "regardless of the variability" the loss in both pronation and supination was the result of the compensable fractures. (Ex. 18-4; 18-6).

OAR 436-035-0007(28) provides:

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[1] The fracture was displaced, comminuted, and angulated. (Ex. 18-2).

[2] The Notice of Closure also awarded temporary disability and unscheduled permanent disability for injury to claimant's back. (Ex. 13). Those awards are not at issue here.

[3] The preponderance of medical evidence must come from findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins Corp.*, 125 Or App 666, 670 (1994).

[4] The corresponding measurements for the uninjured left arm were 88 degrees pronation and 84 degrees supination. (Ex. 18-4).

> "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 physician 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 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."

Although the AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990, prescribe the means for measuring pronation and supination (by goniometer readings rounded to the nearest 10 degrees), the Guides do not provide any validity criteria for those measurements. (AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990, p. 33). Because the validity criterion for pronation and supination findings are not addressed in this reference, AMA Guides are not pertinent. *See* OAR 436-035-0007(28). Consequently, in determining the validity of these impairment findings, we turn to the medical arbiters' report.

When specifically asked if any of their findings were "invalid," the medical arbiters did not expressly state the findings were either "valid" or "invalid," but rather acknowledged "some discrepancy" in the range of motion and opined that "it becomes extremely difficult to evaluate as a result of his symptoms of pain." (Ex. 18-6). Because the medical arbiters were specifically asked "if any findings were invalid" and because they expressly stated the range of motion was "difficult to evaluate" rather than "invalid," we conclude that the medical arbiters considered claimant's "somewhat variable" pronation and supination measurements to be valid.[5]

ORS 656.268(14) provides that direct medical sequelae to the original accepted condition (unless specifically denied) shall be included in rating permanent disability. Here, both the medical arbiters, as well as Drs. Arbeene and Bell, reported that claimant had a reduced range of motion of the right elbow as a residual of his wrist fractures. (Exs. 8-5; 18-6). Consequently, we conclude that claimant's loss of right elbow motion should be rated as "direct medical sequelae" of the accepted condition. *See Quinna J. Nolan*, 53 Van Natta 226, 227 (2001) (extent of permanent disability benefits is limited to permanent impairment caused by accepted conditions or the direct medical sequelae of accepted conditions).

Because we have concluded that the medical arbiters found claimant's pronation and supination measurements to be valid, we further conclude that their measurements should be used to rate claimant's impairment.[6] OAR 436-035-0007(14) (WCD Admin Order No. 98-055). We also use the arbiters' impairment findings in rating claimant's lost range of elbow motion. Based on each of those impairment findings, we affirm the ALJ's scheduled permanent disability award.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, 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.

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[5] When asked the same question regarding findings in claimant's low back, the medical arbiters expressly stated they questioned his low back complaints. (Ex. 18-7). In contrast, the medical arbiters did not expressly question claimant's arm complaints. In light of such circumstances, we conclude that the medical arbiters believed claimant's arm impairment findings were valid.

[6] Under *Koitzsch*, only one other evaluation in this record can be used to rate claimant's impairment, *i.e.*, the report of Drs. Arbeene and Bell (insurer-arranged examiners), which was ratified by the attending physician. (Exs. 8; 9). Because their evaluation was prepared approximately 10 months prior to the Order on Reconsideration (as opposed to the medical arbiters evaluation which was performed one month prior to the Order on Reconsideration) we find the medical arbiters' evaluation more persuasive. *See Kelly J. Zanni*, 50 Van Natta 1188 (1998) (medical evaluation closer in time to Order on Reconsideration found more persuasive).

ORDER

The ALJ's order dated March 9, 2001 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

In the Matter of the Compensation of
ROBERT L. HAGEBUSH, Claimant
WCB Case Nos. 00-02369 & 99-09857
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Employers Defense Counsel, Defense Attorney
John M. Pitcher, Defense Attorney

Reviewing Panel: Members Phillips Polich, Bock, and Meyers. Member Meyers dissents.

Weyerhaeuser Co., a self-insured employer, requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for a bilateral wrist condition; and (2) upheld Liberty Northwest Insurance Corporation's responsibility denial of the same condition. On review, the issue is responsibility.

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

At hearing, the parties stipulated that claimant worked for Weyerhaeuser from June 26, 1973 through March 31, 1999, and that claimant worked for Liberty's insured from April 1, 1999 through the present.

The ALJ found that Weyerhaeuser was initially responsible pursuant to the last injurious exposure rule because the medical record reflected that claimant first sought treatment for his bilateral carpal tunnel syndrome (CTS) symptoms in 1992. *See Agricomp Insurance v. Tapp*, 169 Or App 208, 212 (2000); *Timm v. Maley*, 125 Or App 396, 401 (1993). On review, Weyerhaeuser first contends that claimant's "prescription" for wrist splints by its company nurse in 1992 does not constitute medical treatment sufficient to constitute the triggering event for initial responsibility.

We need not resolve that issue, however, because we agree with the ALJ that claimant sought treatment for bilateral CTS symptoms in 1992 with Dr. Marie. (Ex. 2). Claimant testified that he had symptoms in both hands as early as 1987 or 1988, and continued to have those symptoms in 1992, although his right hand was not bothering him "as much" when he saw Dr. Marie. (Ex. 19-22 (Depo. of claimant); Tr. 19, 23). During her examination on April 2, 1992, Dr. Marie noted left hand symptoms of pain and numbness, as well as testing for right hand numbness. (Ex. 2-2). Dr. Marie continued claimant's prescription for "cock-up splints" (originally provided by Weyerhaeuser) for both wrists. (Ex. 2-2; Tr. 17).

Considered with the persuasive medical evidence discussed below, the foregoing evidence establishes that claimant sought treatment for bilateral CTS in 1992.

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, absent persuasive reasons not to do so, we defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 63 Or App 810 (1983). Here, we find no persuasive reasons not to defer to claimant's treating physician, Dr. Knowlton.

Dr. Knowlton concluded, after reviewing Dr. Marie's chart notes, that the chart notes provided evidence of treatment for bilateral CTS.[1] (Ex. 22-33). Although Dr. Jewell, a consulting physician, felt

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[1] We acknowledge Weyerhaeuser's argument that Dr. Knowlton misunderstood the manner in which claimant was using his wrist splints, and that claimant used the splints only at night. However, even if that were true, that misunderstanding does not affect Dr. Knowlton's more general interpretation of Dr. Marie's chart notes; *i.e.*, that claimant sought treatment for bilateral CTS in 1992.

that Dr. Marie's reports were "not very diagnostic" for CTS, the triggering event for first assignment of responsibility is the date that claimant first sought treatment for CTS symptoms, "even if not correctly diagnosed until later." (Ex. 20-10); *SAIF v. Kelly*, 130 Or App 185, 188 (1994); *Donna R. Goodrich*, 52 Van Natta 2089, 2091 (2000). Dr. Jewell did not specifically contest the fact that claimant sought treatment for the above-referenced bilateral hand and wrist symptoms in 1992. Based on Dr. Knowlton's persuasive opinion, we find that the symptoms for which claimant sought treatment in 1992 were subsequently confirmed to be CTS. *See Donna R. Goodrich*, 52 Van Natta at 2091.

Weyerhaeuser next contends that the ALJ failed to properly distinguish between claimant's left and right wrists. It argues that claimant did not seek treatment for *right* CTS while under its employ. We disagree.

As stated above, Dr. Knowlton interpreted Dr. Marie's reports as providing treatment for *bilateral* CTS. (Ex. 22-33). Claimant testified that he had symptoms in both hands dating to 1987 or 1988, as well as when he treated with Dr. Marie in 1992. (Ex. 19-22; Tr. 19, 23). He testified that he wore "cock-up" splints on both hands in 1992 to relieve his symptoms of night-time numbness. (Tr. 17). In sum, we agree with the ALJ that the preponderance of evidence establishes that claimant sought treatment for both hands while working for Weyerhaeuser. Initial responsibility was properly assigned to Weyerhaeuser.

Finally, Weyerhaeuser does not specifically contest the ALJ's determination that there is no persuasive evidence that claimant's work exposure at Liberty's insured actually contributed to a worsening of claimant's bilateral CTS condition. *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992). Accordingly, responsibility remains with Weyerhaeuser.

ORDER

The ALJ's order dated February 28, 2001 is affirmed.

Board Member Meyers dissenting.

I agree with Weyerhaeuser that claimant did not seek treatment for carpal tunnel syndrome during his tenure with the company. I believe that responsibility for claimant's bilateral CTS condition should have been assigned to Liberty. At the least, Weyerhaeuser should not be responsible for claimant's right wrist CTS. I therefore respectfully dissent.

The contemporaneous medical record reveals that claimant sought treatment for his left hand and right elbow only in 1992. Claimant confirmed, in his testimony at hearing, that he did not remember having a "specific complaint" regarding anything in his right arm. (Tr. 12). In March of 1992, Dr. Marie diagnosed a "R epicondylitis" (an elbow condition) and "neuropathy of the L UE." (Ex. 2-2). There was no diagnosis of CTS at that time. As to the right wrist, there was no diagnosis at all.

Although the majority correctly notes that Dr. Marie tested for right hand numbness on April 2, 1992, no right hand symptoms of any kind were actually recorded on that date. (Ex. 2-2). What Dr. Marie actually stated was "There is no numbness to pinprick in the right hand. There is no tenderness about the right elbow. Negative Phalen's and Tinel's." (*Id.*)

The evidence for a left wrist CTS while claimant worked for Weyerhaeuser is similarly unpersuasive. Again, Dr. Marie diagnosed only a "neuropathy of the L UE" in 1992. (Ex. 2-2). Also in 1992, Dr. Marie recorded claimant's description of an event when, "while at a playground, he grabbed the monkey bar and pain shot down his L arm and into the L hand." (Ex. 2-1). Dr. Knowlton, on whose opinion the majority relies, agreed that the acute pain accompanying such a reaching maneuver would not be a symptom associated with CTS. (Ex. 22-21). Dr. Jewell explained that claimant's 1992 complaints, even assuming his symptoms were bilateral, were too vague to be diagnostic of CTS. (Ex. 20-10). Therefore, I believe a diagnosis of left wrist CTS in 1992 is also not supported by the record.

I believe the majority has erroneously concluded that claimant first sought treatment for bilateral CTS in 1992. Responsibility should lie with Liberty.

For the above reasons, I respectfully dissent.

In the Matter of the Compensation of
ESTHER A. HANDSAKER, Claimant
WCB Case No. 00-05762
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
VavRosky, MacColl, Olson, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Fulsher's order that: (1) upheld the self-insured employer's "de facto" denial of claimant's omitted condition claim for right arm conditions; (2) declined to award an assessed fee pursuant to ORS 656.386(1); and (3) declined to award penalties and attorney fees for the employer's allegedly unreasonable claim processing. On review, the issues are scope of acceptance, penalties and attorney fees.

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

The employer accepted claimant's injury claim as disabling right lateral epicondylitis. Claimant's attorney wrote the employer, requesting that it amend its acceptance to include ulnar nerve irritation and medial collateral ligament sprain. The employer did not respond to claimant's request. Claimant requested a hearing.

At hearing, claimant sought to have the employer's acceptance amended to include the above conditions pursuant to ORS 656.262(6)(d).[1] The ALJ determined that claimant had not established that the acceptance should be expanded to include the medial collateral sprain and ulnar nerve irritation.

On review, claimant contends that ORS 656.262(6)(d) applies to her "omitted" medical conditions claim and that she has proven that the disputed conditions are compensable, thus entitling to her to expansion of the acceptance notice. Moreover, claimant asserts that she is entitled to an assessed fee under ORS 656.386(1)(b)(B), given the employer's lack of response to her omitted conditions claim.

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. *Patrick C. McGeehan*, 52 Van Natta 1342 (2000). We agree with the ALJ that the medical evidence does not establish that the claimed medial collateral ligament conditions are a separate diagnosis from that of the "right lateral epicondylitis" condition already accepted by the employer. On the contrary, the medical evidence (from Drs. Davis and Woodward) establishes that claimant's additional claimed conditions are encompassed in the accepted condition of right lateral epicondylitis. (Exs. 17, 30). Moreover, we agree with the ALJ's reasoning that claimant does not have right ulnar neuropathy. Under these circumstances, we agree with the ALJ's decision not to expand the employer's notice of acceptance.

Finally, claimant is correct that the employer's failure to respond to her request for acceptance of additional conditions created a "denied claim" for purposes of ORS 656.386(1)(b)(B).[2] However, in order to qualify for an assessed fee under ORS 656.386(1), claimant must have finally prevailed in the hearing before the ALJ. Because we have affirmed the ALJ's decision upholding the employer's "de facto" denial, claimant has not done so and is, thus, not entitled to an assessed fee. *Donna R. Roberts*, 51 Van Natta 103, 109 (1999).

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[1] ORS 656.262(6)(d) states that:

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

[2] ORS 656.386(1)(b)(B) defines a "denied claim" as a claim for compensation for a condition omitted from a notice of acceptance "which the insurer or self-insured employer does not respond to within 30 days."

ORDER

The ALJ's order dated March 27, 2001 is affirmed.

In the Matter of the Compensation of
RAMON KETRING, Claimant
WCB Case No. 00-08519
ORDER ON REVIEW (REMANDING)
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Fitzwater's order that: (1) denied his request for additional temporary disability benefits; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to pay temporary disability. In his brief, claimant raises an issue regarding the scope of acceptance. On review, the issues are temporary disability, penalties and scope of acceptance. We vacate the ALJ's order and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In his brief, claimant raises an issue concerning the scope of acceptance. The insurer responds that the Board should not address any issues that were not before the ALJ. For the following reasons, we find that the scope of acceptance issue was properly raised at hearing.

On January 2, 1999, claimant compensably injured his back. The insurer accepted an L4-5 disc herniation on March 18, 1999. (Ex. 14). On April 23, 1999, claimant wrote to the insurer, asserting, among other things, that the acceptance was incomplete and his condition was "[h]erniated disc L4-5 with Myelop[a]thy, Foot Drop right foot." (Ex. 15C). There is no evidence in this record that the insurer responded to that portion of claimant's April 23, 1999 letter.

On March 3, 2000, Dr. Fogg indicated that claimant was "at maximum medical improvement[.]" (Ex. 29). After examining claimant on June 8, 2000, Dr. Wurgler reported that he considered claimant to be medically stationary. (Ex. 39).

The insurer issued an updated notice of acceptance at closure, referring to the accepted condition as an L4-5 disc herniation. (Ex. 42). An August 1, 2000 Notice of Closure awarded temporary total and temporary partial disability and 25 percent unscheduled permanent disability for reduced lumbar range of motion. (Ex. 43). The Notice of Closure indicated that claimant was medically stationary as of June 8, 2000. (*Id.*) Claimant requested reconsideration, raising issues of premature closure, medically stationary date and temporary disability. (Ex. 44-2).

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[1] We note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. Claimant 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
Department of Business and Consumer Services
350 Winter Street NE, Room 160
Salem, OR 97301-3878

On August 11, 2000, claimant wrote to the Workers' Compensation Division (WCD), objecting to the insurer's omission of certain accepted conditions.[2] (Ex. 43A). He asserted, among other things, that the updated notice of acceptance at closure was incomplete and should include lumbar disc herniations with myelopathy, and impingement of the L5 nerve root. (Ex. 43A). On September 13, 2000, the insurer responded to claimant regarding his August 11, 2000 letter, stating that the accepted condition of L4-5 disc herniation reasonably apprises the nature of the compensable condition, and noting that a corrected notice would not be issued. (Ex. 44C). On September 21, 2000, claimant wrote to WCD regarding the insurer's September 13, 2000 letter, again asserting that the insurer had omitted lumbar disc herniations with myelopathy, and impingement L5 nerve root. (Ex. 44B).

An October 17, 2000 Order on Reconsideration modified the temporary disability award, but otherwise affirmed the Notice of Closure, including the June 8, 2000 medically stationary date. (Ex. 45).

Claimant requested a hearing regarding the October 17, 2000 Order on Reconsideration. At hearing, claimant raised an issue about the scope of acceptance and the insurer's attorney responded that he was not prepared to address that issue. (Tr. 3-4, 6). The ALJ determined that, because claimant had requested a hearing on the Order on Reconsideration, but not the scope of acceptance, she did not have authority to address that issue. (Tr. 10-13). The ALJ's order addressed only the issues of temporary disability and penalties.

The Board's rules provide that amendments to the issues raised and relief requested at hearing "shall be freely allowed." OAR 438-006-0031, OAR 438-006-0036; *see SAIF v. Ledin*, 149 Or App 94 (1997) (a carrier may amend its denial at hearing), *on remand Larry L. Ledin*, 50 Van Natta 115 (1998). Where such an amendment is permitted, to afford due process, the responding party must be given an opportunity to respond to the new issues raised. *See* OAR 436-006-0091(3); *Sandra L. Shumaker*, 51 Van Natta 1981 (1999), *on recon* 52 Van Natta 33 (2000). In other words, a party's remedy for surprise and prejudice created by a late-raised issue is a motion of continuance. *See* OAR 438-006-0031, OAR 438-006-0036.

Here, claimant requested a hearing concerning the October 17, 2000 Order on Reconsideration. At hearing, he raised an issue about the scope of the insurer's acceptance. (Tr. 3-4, 7-13). Thus, claimant attempted to amend his request for hearing to add the scope of acceptance issue. The insurer's attorney objected, stating that he was not prepared to address that issue. (Tr. 6).

Based on *Ledin* and pursuant to OAR 438-006-0031 and 438-006-0036, we find that claimant should be allowed to amend his request for hearing to include the scope of acceptance issue. We construe the insurer's comments at hearing to mean that, if claimant is allowed to amend his request for hearing, the hearing should be continued and the record reopened to permit the insurer to respond to the newly raised issue. Because the authority to consider motions for continuance of hearings rests with the ALJ, we find it appropriate to remand this case to the ALJ for consideration of the insurer's motion to continue the hearing in light of claimant's amended request for hearing.[3]

Accordingly, we vacate the ALJ's order dated March 8, 2001 and remand this case to ALJ Fitzwater to allow claimant an opportunity to amend the request for hearing and for consideration of the insurer's motion to continue the hearing. These further proceedings may be conducted in any manner that the ALJ finds will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.

IT IS SO ORDERED.

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[2] The letter was addressed to WCD, as well as the insurer.

[3] In reaching this conclusion, we make no comments as to the merits of claimant's scope of acceptance argument. Furthermore, because we are remanding the case to the ALJ, we do not address the remaining issues. The parties may direct their arguments regarding those issues to the ALJ on remand.

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UPDATE PAGES

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In the Matter of the Compensation of
ANDREW F. CURTRIGHT, Claimant
WCB Case No. 00-07788
ORDER ON REVIEW
David C. Force, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated February 23, 2001 is affirmed.

Board Member Phillips Polich dissenting.

At hearing, SAIF conceded all elements regarding compensability of claimant's occupational disease claim for a mental disorder with one exception, *i.e.*, whether the "employment conditions producing [claimant's] mental disorder are conditions other than those generally inherent in every working situation." ORS 656.802(3)(b). Based on the following reasoning, I find that claimant has proved this remaining element and has established compensability of his mental disorder claim. Because the majority finds otherwise, I respectfully dissent.

In 13 years of employment as a school custodian, claimant's job duties had never changed and he was able to complete those duties during his regular eight-hour workday. In June 2000, due to budget constraints, there was a reduction in the custodial staff from four full time custodians to just two. Claimant's job duties and hours remained the same. The summer maintenance schedule also included cleaning, waxing, and buffing all of the floors in the high school and elementary school. Claimant was concerned about completing the floors before the start of school in the fall and had to let his other duties go. Claimant repeatedly approached his supervisors about his concerns regarding completing his job duties and was merely told to do what he could. In essence, what changed was the employer's expectations regarding what claimant would accomplish, the assigned workload never changed.

An employer has the responsibility to ensure that the assigned workload has a reasonable expectation of being accomplished in the time allotted and/or with the resources allocated. No one believed or expected that claimant would be able to complete his assigned job duties, yet those assigned responsibilities were never changed, even after the staff was reduced by half. Although the employer in this case did not pressure claimant to complete all of his assigned duties, certainly the atmosphere was such that claimant felt obligated to push on and get more than just the floors completed. As long as the volume of assigned duties remained unreasonable, the employment conditions that produced claimant's mental disorder were conditions other than those generally inherent in every working situation. Accordingly, I would find claimant's mental disorder compensable.

In the Matter of the Compensation of
FRANK A. GREEK, SR., Claimant
WCB Case Nos. 00-08408 & 00-03694
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
John M. Pitcher, Defense Attorney
Bottini, Bottini & Oswald, Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

Fremont Indemnity (Fremont), on behalf of Collins Products, requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its responsibility denial of claimant's "new injury" claim for a left knee condition; (2) upheld Weyerhaeuser Company's responsibility denial of claimant's aggravation claim for a left knee condition; and (3) awarded claimant an $1,800 attorney fee pursuant to ORS 656.386(1) for his attorney's efforts in obtaining an "at hearing" rescission of Fremont's compensability denial. On review, the issues are responsibility and attorney fees.

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

In the fourth paragraph of the ALJ's statement of the issues, we replace "at least by August 1, 2000" with "at least by May 1, 2000."

Claimant suffered a compensable left knee injury on November 7, 1995 while working for Weyerhaeuser. Weyerhaeuser accepted his claim for left knee contusion and left knee quadriceps atrophy with secondary chondromalacia patella.

On January 14, 2000, claimant reinjured his left knee while working for Fremont's insured. Fremont denied compensability and responsibility for claimant's left knee injury. (Exs. 14, 18A). Weyerhaeuser issued a partial denial of compensability of claimant's left knee chondral fracture and malalignment conditions. (Ex. 24). Claimant requested a hearing from all denials.

At hearing, Weyerhaeuser accepted responsibility for claimant's left knee condition after May 1, 2000. However, Weyerhaeuser continued to deny responsibility for a discrete period of time from January 14, 2000 to May 1, 2000. (Tr. 7, 12). After confirming that claimant was not specifically claiming the chondral fracture and malalignment conditions against it, Fremont withdrew its compensability denial. (Tr. 12).

As to the responsibility issue, the ALJ held that ORS 656.308(1) did not apply because claimant's later injury did not involve the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 181 (1996); *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371-372 (1993). The ALJ then concluded that responsibility for claimant's left knee condition for the disputed time period rested with Fremont, as the medical evidence established an "independent contribution" from the January 2000 injury.

On review, the parties agree that ORS 656.308(1) does not apply. Nevertheless, Fremont contends that the ALJ erred in failing to apply ORS 656.005(7)(a)(A)[1] (the "consequential condition" statute), citing *Albert H. Olson*, 51 Van Natta 685 (1999).[2] Even under that standard, however, we find that the medical evidence proves that the January 14, 2000 injury is the major contributing cause of claimant's left knee condition during the disputed time period.

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[1] ORS 656.005(7)(a)(A) provides: "No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

[2] ORS 656.005(7)(a)(A) does not apply here in the absence of more than one prior accepted claim. *See Conner v. B&S Logging*, 153 Or App 354 (1997); *Albert H. Olson*, 51 Van Natta 685 (1999); *Donald L. Webb*, 52 Van Natta 1005 (2000); *Douglas R. Barnes*, 52 Van Natta 2097 (2000). Although Weyerhaeuser originally accepted claimant's 1995 left knee injury for left knee contusion and quadriceps atrophy with secondary chondromalacia patella, Fremont never accepted any left knee claims or conditions.

Weyerhaeuser Co. v. Pitzer, 123 Or App 1, 3 n1 (1993), cited by Fremont, is distinguishable. There, responsibility was not at issue because the claimant, on review to the court, did not challenge a denial of a carrier's new injury claim.

Where the medical evidence is divided, we rely on medical opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). Absent persuasive reasons to the contrary, we defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 63 Or App 810 (1983).

Here, we find no persuasive reasons not to defer to claimant's treating physician, Dr. Wenner. Dr. Wenner concluded that "the Collins injury" was the major contributing cause of claimant's need for acute medical care (after January 14, 2000). (Ex. 25-1). Dr. Bald, who examined claimant on May 1, 2000 at the request of Weyerhaeuser, essentially shared Dr. Wenner's opinion. Dr. Bald concluded that the "major contributing cause of claimant's acute need for treatment beginning in January 2000, was the work injury of January 14, 2000." (Ex. 21-6). Dr. Bald also found that the January 2000 injury had resolved "at this point in time," *i.e.* May 1, 2000. (*Id.*) However, again, the responsibility dispute is limited to the time period ending on May 1, 2000.

Dr. Marble examined claimant at the request of Fremont. On July 11, 2000, Dr. Marble agreed with the statement that "the January 2000 injury was the major (*i.e.* more that 50%) contributing cause of the acute care [claimant] received, but no longer is the cause of the need for treatment." (Ex. 18-1). Dr. Marble later clarified his opinion to indicate that, although the "new" injury was the major cause of claimant's need for treatment "at that time," the major contributing cause of this new injury were the "preexisting factors" stemming from the 1995 injury. (Ex. 22-1). We are not satisfied, however, that Dr. Marble adequately explained this change in opinion. As such, his opinion is unpersuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987). Therefore, even if ORS 656.005(7)(a)(A) applies, we would find that responsibility was properly assigned to Fremont.

Finally, Fremont contends that the ALJ erred in awarding claimant an attorney fee pursuant to ORS 656.386(1)[3] because claimant "withdrew" any claim against it for certain left knee conditions before it rescinded its compensability denial. (*See* Tr. 12). We disagree.

Evaluating the exhibits in the record, as well as the colloquy at hearing, we conclude that claimant's claim for a new injury on January 14, 2000 represented a claim for a left knee injury in general. (Exs. 8, 14; Tr. 11, 12). As opposed to his specific claims with Weyerhaeuser, claimant never made claim for any specific conditions against Fremont. Likewise, Fremont simply denied claimant's "injury to your left knee" and claimant's "left knee condition." (Exs. 14, 18A).

Nevertheless, even assuming claimant did "withdraw" those specific claims, claimant's withdrawal of claims for a chondral fracture or malalignment conditions did not represent a withdrawal of his entire claim for a "left knee injury" in relation to Fremont. (Tr. 11, 12). In other words, by rescinding its denial, Fremont agreed not to challenge the compensability of a left knee injury claim on January 14, 2000, which encompassed potentially more than just the two specific conditions "withdrawn" by claimant at hearing.

Lastly, we affirm the amount of the ALJ's attorney fee awarded in relation to Fremont's compensability denial. ORS 656.386(1) allows an attorney fee "in such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by an Administrative Law Judge." As a result of Fremont's denials, claimant's counsel was required to request a hearing and prepare for hearing on the issues of both responsibility and compensability. Accordingly, we agree with the ALJ that $1,800 is a reasonable assessed fee for claimant's counsel's efforts in obtaining a rescission of Fremont's compensability denial at hearing.

ORDER

The ALJ's order dated March 30, 2001 is affirmed.[4]

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[3] We consider the ALJ's reference to "ORS 656.382" to be a typographical error.

[4] Inasmuch as the only issues on review are responsibility and attorney fees, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2). ORS 656.308(2)(d); *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986).

In the Matter of the Compensation of
LEOPOLDO OLVERA, Claimant
WCB Case No. 00-06497
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's request for acceptance of "combined" low back conditions; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to timely process claimant's claim. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last sentence of the last paragraph on page 2.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ set aside SAIF's denial of claimant's low back "right lateral recess stenosis at L4-5, developmentally small canal at L3-4 and L4-5, lumbar disc disease and deconditioning," concluding that the claimed conditions were compensable as combined conditions under ORS 656.005(7)(a)(B).[1] On review, SAIF contends that the ALJ erred, because claimant's request for acceptance of the preexisting conditions did not specify that they be accepted as "combined conditions." SAIF also argues that it should not be ordered to accept the preexisting conditions because they did not arise out of claimant's employment and were not worsened by claimant's employment. We conclude that the issue of the compensability of claimant's preexisting conditions as "combined conditions" was properly before the ALJ, but agree that SAIF should not be ordered to accept the preexisting conditions as independently compensable. We reason as follows.

We begin by briefly recounting the relevant facts. Claimant injured his low back on November 29, 1998, as a result of which SAIF accepted a low back strain. A May 25, 1999 MRI revealed a herniated disc at L4-5 on the right, degenerative disc disease at L4-5 and L5-S1, and a developmentally small canal at L3-4 and L4-5. (Exs. 5, 6). On November 1, 1999, Dr. Donovan concluded that claimant was deconditioned, for which claimant underwent a two-week work conditioning program. (Exs. 13, 14).

On February 16, 2000, SAIF modified its acceptance to include a "right L4-5 herniated disc," and, on February 24, 2000, closed the claim by Notice of Closure that awarded 6 percent unscheduled disability. (Exs. 19, 20, 21).

On May 8, 2000, claimant returned to Dr. Stevens complaining of ongoing low back and right leg pain. Dr. Stevens diagnosed an L4-5 disc with chronic, intermittent right leg sciatica and weakness and ordered a repeat MRI. (Exs. 24, 25).

On June 19, 2000, claimant's counsel requested that SAIF's Notice of Acceptance be amended to include right lateral recess stenosis at L4-5, developmentally small canal at L3-4 and L4-5, lumbar disc disease and deconditioning, stating that a response was due within 30 days, pursuant to ORS 656.262(6)(a). (Ex. 26). On July 13, 2000, SAIF responded to claimant's counsel's request, stating that it had 90 days to determine compensability of those conditions, as the MRI listing the requested conditions did not occur until after its December 4, 1998 acceptance. (Ex. 27).

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[1] ORS 656.005(7)(a)(B) provides:

"If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

On August 30, 2000, SAIF denied the new medical condition claim/objection to notice of acceptance, on the ground that the claimed conditions were not compensably related to the accepted injury and that those conditions preexisted the injury and were not caused or pathologically worsened by the injury. (Ex. 30). Claimant requested a hearing.

At the hearing, claimant agreed that he was appealing the August 30, 2000 denial and asserted that the claimed conditions were compensable as combined conditions. (Tr. 2, 3). Although SAIF initially objected to addressing the compensability of the requested conditions as "combined conditions" because claimant's written request for the claimed conditions had not specified that he was seeking acceptance of "combined conditions," at the conclusion of the discussion regarding the compensability issue, the ALJ asked SAIF's attorney if she had any argument with the issue of compensability as previously discussed. SAIF's attorney responded, "No." When the ALJ asked if she had a request for continuance or a motion for surprise, she responded, "No." (Tr. 8). The parties proceeded to hearing on the compensability issue as summarized by claimant.[2]

On this record, we find that the parties expressly agreed to try the issue of compensability of the combined low back condition outside the express terms of the denial. Thus, SAIF waived any procedural challenge based on the language of its denial. *See Thomas v. SAIF*, 64 Or App 193 (1983); *see also Weyerhaeuser 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). Accordingly, the issues litigated at hearing included the August 30, 2000 denial, which was modified to include compensability of claimant's "combined condition" claim.

The ALJ concluded that, on the merits, claimant had established a compensable combined condition under ORS 656.005(7)(a)(B).[3] The ALJ set aside SAIF's denial and directed SAIF to accept claimant's claim for all of his omitted conditions.

In response to SAIF's arguments concerning the merits of compensation, we emphasize that, because claimant requested acceptance of the disputed conditions as part of a combined condition, SAIF should accept those conditions only as part of the combined condition, consisting of the compensable injury and the preexisting low back and deconditioning conditions. Our affirmance of the ALJ's opinion should not be construed as a finding that the disputed conditions are independently compensable, in and of themselves. There is no medical evidence that claimant's preexisting low back conditions have changed, worsened or been accelerated by the compensable 1998 injury. (Exs. 29, 31B, 32, 33). Thus, SAIF is not responsible for the disputed conditions except as a part of the "combined condition." *See Karen S. Carman*, 49 Van Natta 637 (1997) (carrier's acceptance of a preexisting condition as a part of a "combined condition" could coexist with prior denial of the preexisting condition as independently compensable).

Penalties

The ALJ concluded that SAIF's response to claimant's request for omitted conditions under ORS 656.262(6)(d) incorrectly contended that claimant was making a claim for "new medical conditions" under ORS 656.262(7)(a), which allows a 90-day processing period. On review, SAIF concedes that, under *Kimberly R. Rice*, 52 Van Natta 138, n.1 (2000), its response stating that it had 90 days to process the claim was in error. Nevertheless, SAIF argues that no penalty should be assessed because there were no amounts then due. We agree.

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[2] We are cognizant that SAIF requested reconsideration of the ALJ's order. The ALJ agreed that SAIF initially objected to proceeding on the "combined condition" issue. The ALJ concluded that claimant's use of the combined condition statute was not a new issue, but only a new legal theory, and also noted that SAIF agreed that the issue was compensability of the conditions set forth in the denial and declined to move for a continuance or to assert any surprise. Assuming without deciding that the ALJ's reasoning was correct, as discussed above, SAIF's actions were sufficient to place the compensability of the preexisting conditions as framed by claimant as "combined conditions" before the ALJ.

[3] On review, SAIF has not challenged the compensability of the combined conditions on the merits.

The record does not establish that there was compensation due in the form of unpaid medical bills or temporary disability at the time of the delay period. *See Melody L. Rivers*, 48 Van Natta 2089 (1996) (a penalty may be assessed under ORS 656.262(11)(a) if there are amounts then due between the date when the acceptance or denial should have issued and the date of the denial). Thus, we decline to assess 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 the compensability issue, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.[4]

ORDER

The ALJ's order dated March 21, 2001, as reconsidered April 9, 2001, is affirmed in part and reversed in part. That portion of the order that assessed a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000.

[4] Claimant is not entitled to an attorney fee for his counsel's services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

In the Matter of the Compensation of
JENINE F. VILLARREAL, Claimant
WCB Case Nos. 00-05603 & 00-01286
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorney

Reviewing Panel: Members Phillips Polich and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of claimant's right knee injury claim. The employer cross-requests review of that portion of the ALJ's order that set aside its partial denial of claimant's claim for a left knee meniscus tear condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Ordinarily, claimant's attorney would be entitled to an assessed fee for services on review regarding the employer's request for review of the ALJ's compensability decision regarding the left knee meniscus tear condition. ORS 656.382(2). However, claimant's attorney did not submit a cross respondent's brief or reply brief addressing the employer's request for review. *See Shirley M. Brown*, 40 Van Natta 879 (1988) (because the claimant did not submit a brief, she was not entitled to an assessed attorney fee for Board review). In addition, claimant's attorney was unsuccessful in challenging the ALJ's compensability decision regarding the right knee injury claim. Therefore, claimant's attorney is not entitled to an assessed fee for services on review.

ORDER

The ALJ's order dated January 11, 2001, as amended January 16, 2001, is affirmed.

In the Matter of the Compensation of
KEVIN W. WILSON, Claimant
WCB Case No. 00-04626
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) ordered it to pay temporary total disability compensation for the period from April 25, 2000 through April 27, 2000; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to pay that compensation. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury when he fell from a ladder on April 25, 2000. He sought emergency room treatment that day. Dr. Abraham took claimant off work for the rest of the day and released to him to "office-type work only the rest of this week." (Ex. 1-2). The same day, Dr. Abraham filled out a form indicating "No work for 2 days." (Ex. 2).

On April 27, 2000, Dr. Carter put claimant's right arm in a cast and released him to "one-handed duty next Monday." (May 1, 2000).

SAIF paid temporary disability for the period from April 28, 2000 until May 16, 2000, but denied claimant's request for temporary disability for the period from April 25, 2000 through April 27, 2000. Claimant requested a hearing.

The ALJ found claimant was entitled to temporary total disability benefits for the period in question, reasoning that claimant was totally disabled at the time and SAIF paid temporary total disability benefits for a period exceeding 14 days. The ALJ also found SAIF's failure to pay those benefits unreasonable under ORS 656.210(3). We disagree and reverse.

ORS 656.210(3) provides:

> "No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period."

Under the statute, temporary total disability benefits are not recoverable for the first three days following an injury, unless the total disability continues for at least 14 days. *Tennant v. Slack*, 102 Or App 470, 472, *rev den* 310 Or 547 (1990).[1] *See* OAR 436-060-0020(2)(c); OAR 436-060-0030(1).

The Supreme Court has construed the phrase "the total disability" in ORS 656.210(1)

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[1] In *Bostick v. Ron Rust Drywall*, 138 Or App 552, 555 (1996), the claimant did not argue that he was entitled to be compensated for the first three days of disability. However, the court commented that, had the claimant "been injured on a Monday or Friday instead of a Wednesday, he would have been eligible for *two days* of disability benefits if he had remained disabled for five days." 138 Or App at 558 (emphasis added).

> "to mean the loss, including preexisting disability, of use or function of any scheduled or unscheduled body part which *incapacitates* the worker from regularly performing work at a gainful and suitable occupation. Total disability describes the extent of disability that a worker may suffer. 'Permanent' or 'temporary' describes duration, not the extent, of disability. If the total disability is permanent, payment of compensation is made according to ORS 656.206; if the disability is temporary, payment is made according to ORS 656.210. In either case, benefits for total disability are only available where the requisite *incapacity* to work exists." *Cutright v. Weyerhaeuser Company*, 299 Or 290, 295 (1985) (emphasis added).

Thus, temporary total disability is defined as incapacitation, not just partial disability.[2]

Here, Dr. Carter released claimant to modified work effective May 1, 2000, within 14 days of the work injury.[3] Accordingly, because claimant was not totally disabled for at least 14 days after the injury, he is not entitled to temporary total disability benefits for the period from April 25, 2000 through April 27, 2000. *See id.* Because claimant was not entitled to the benefits in question, SAIF's failure to pay them was not unreasonable. Consequently, the ALJ's order is reversed.

ORDER

The ALJ's order dated October 16, 2000 is reversed.

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[2] Use of the terms "partial" and "total" in the same statute evinces the legislature's recognition that the different terms have different meanings. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 611 (1993) (stating general principle). Moreover, we are not free to assume that the terms partial and total have the same meaning, when that reading would render the statute essentially meaningless. *See id.* (statute properly construed to give effect to all provisions).

[3] We need not resolve the apparent inconsistency between Exhibits 1 and 2 regarding claimant's disability status from April 25, 2000 through April 27, 2000, because we find that temporary disability benefits are not recoverable for that time in any event.

Board Member Biehl dissenting.

Because I believe that the statute and its context mandate that claimant be paid temporary disability for the first three days of missed work under these facts, I respectfully dissent.

I begin by providing a short description of claimant's injury. Claimant is an electrician who fell 12 feet off a ladder at work on April 25, 2000. He fractured the radial head of his right elbow in the fall. (Ex. 1-1). At the occupational medicine clinic that day, claimant was instructed by the doctor to remain off work for the rest of the day and restricted to only "office-type" work for the rest of the week. (Ex. 1-2). That same day, however, claimant was also restricted to "no work for 2 days." (Ex. 2).

Within two days, on April 27, 2000, claimant was placed in a "long arm cast," to immobilize his arm for 10 to 14 days. (Ex. 4). It is uncontested that claimant, in fact, was off work for more than 14 days. In addition, the parties stipulated at hearing that claimant called in to work on both April 26, 2000 and April 27, 2000, but no modified work was available. (Tr. 2). Claimant was released to modified work ("one-handed duty") as of May 1, 2000. (Ex. 4). Again, no such work was available from the employer.

In reversing the ALJ, I believe the majority misconstrues ORS 656.210(3) and *Cutright v. Weyerhaeuser*, 299 Or 290 (1985). In emphasizing the term "incapacity," (to work) from *Cutright*, the majority fails to note that incapacity means simply the inability to work, which need not necessarily be a purely physical concept. As a result of the employer's failure to offer modified work, claimant was *unable* to work after May 1, 2000. As the Court noted in *Cutright*, "The entire scheme of Workers' Compensation Law is to compensate *workers*, who are active in the labor market, for wages lost because of inability (or reduced capacity) to work as a result of a compensable injury * * *" (emphasis in original). 299 Or at 296. Undeniably, claimant was "active in the labor market" when he called in to his employer seeking modified work.

In this same vein, I note the Court's comment in *Cutright* that "TTD benefits are wage replacement for those persons working *or seeking work* * * *" (emphasis added) 299 Or at 301.

The majority also fails to note that *Cutright* recognizes that an injured worker's disability status must be determined in relation to "gainful and suitable" work, not "all jobs." *See* ORS 656.206(1)(a) (definition of "permanent total disability," which the court referenced in interpreting ORS 656.210). 299 Or at 294, 295. "Suitable" work for an injured worker such as claimant means work within his injury-related medical restrictions. Because the employer provided no such "suitable" job for claimant, claimant was "totally disabled" from his work for more than 14 days following his injury. ORS 656.210(3).

The ALJ was correct to read ORS 656.210(3) in context with ORS 656.268(4)(a) through (c). Under the latter statute, a carrier can unilaterally *terminate* a claimant's temporary disability benefits when, among other reasons, it *has* made a written offer of modified work when claimant has been released to light duty. ORS 656.268(4)(c). Otherwise, when, as here, the employer fails to offer modified work, temporary total disability benefits remain payable.

In my view, the ALJ was correct to award claimant temporary total disability for the first three days of his disability from work. I would affirm the ALJ's order. I therefore respectfully dissent.

In the Matter of the Compensation of
JANICE K. CONNELL, Claimant
Own Motion No. 01-0218M
ORDER POSTPONING ACTION ON REVIEW OF CARRIER CLOSURE
Hollander & Lebenbaum, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant has requested Board review of the SAIF Corporation's June 28, 2001 Notice of Closure, which closed her claim with an award of temporary disability compensation from June 1, 1998 through June 13, 2001. SAIF declared claimant medically stationary as of June 13, 2001. Claimant contends she is entitled to additional benefits as she was not medically stationary at the time her claim was closed.

Claimant contends she was not medically stationary at the time her claim was closed because she needs further treatment in the form of a posterior osteotomy from T10 to L5, with fusion and instrumentation, which would materially improve her functional status. The reasonableness and necessity of the medication pump is presently being disputed by SAIF. Pursuant to ORS 656.327, this medical services issue is within the Director's jurisdiction. By order dated June 6, 2001, the Director found that the proposed treatment isn't appropriate for claimant's compensable conditions. Claimant appealed the Director's order. A contested case hearing is currently scheduled for August 22, 2001 (Case No. 2001-0064). Should the Administrative Law Judge (ALJ) find that the posterior osteotomy is both reasonable and necessary to materially improve claimant's current back condition, the 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. Thus, we conclude that it would be in the best interest of the parties to defer action on the request for review of the carrier's June 13, 2001 closure. We defer action on this request for own motion relief and request that the ALJ 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
ALEX N. MONTERROSO, Claimant
WCB Case No. 99-09679
ORDER ON REVIEW
Willner, et al., Claimant Attorney
Hoffman, et al., Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes. Member Haynes chose not to sign the order.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the insurer'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 changes. On page 2, we change the fifth paragraph to read: "The SAIF Corporation, on behalf of Jugs Company, accepted a lumbar strain resulting from claimant's March 17, 1999 injury. (Ex. 5)." In the seventh paragraph on page 2, we replace the first two sentences with the following: "While working for Onsite Commercial Staffing on September 14, 1999, claimant squatted to pick up sponge-type computer objects and experienced back pain." In the first paragraph on page 3, we replace the first sentence with the following:

> "SAIF, on behalf of Jugs Company, issued an updated notice of acceptance at closure regarding the March 17, 1999 injury, which referred to the accepted condition as a lumbar strain. (Ex. 17). SAIF issued a Notice of Closure on September 30, 1999. (Ex. 18)."

On page 3, we replace the fourth paragraph with the following:

> "On April 26, 2000, Drs. Laycoe and Watson examined claimant on behalf of the insurer. They diagnosed "[b]ack and leg pain following industrial event of injury, reported September 14, 1999[,]" a prior history of similar events in March 1999, "presumably resolved[,]" and "[s]trong suggestion of psychological or social/cultural features influencing evaluation and potential recovery. (DSM 4:316)." (Ex. 29-5). They reported that claimant's ongoing complaints and failure to improve was due to the diagnosis of psychological or social/cultural features. (Ex. 29-6). Dr. Brett and Dr. Gudmundsen did not agree with the report from Drs. Laycoe and Watson. (Exs. 31, 34)."

We do not adopt the findings of ultimate facts.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's industrial incident on September 14, 1999 was not a material contributing cause of his low back pain thereafter, and, therefore, claimant did not experience a compensable injury. On review, claimant argues that the September 14, 1999 work incident is compensable and there is no persuasive evidence of a preexisting or combined condition.

We first address the insurer's argument that claimant's condition has already been accepted by SAIF on a prior claim. The insurer contends:

> "On September 30, 1999, Jugs [SAIF] filed an updated notice of acceptance at closure for claimant's lumbar strain due to the March 17, 1999 injury (Ex. 17). Thus, after the September 14, 1999 injury Jugs [SAIF] accepted the lumbar strain. Why then is claimant proceeding against On-Site [the insurer]? What claimant is essentially doing is trying to have the lumbar strain processed by two carriers. However, Jugs [SAIF] has accepted the claim for lumbar strain rather than denying it, so claimant cannot get benefits whether temporary or permanent from both employers." (Respondent's br. at 4-5).

For the following reasons, we do not agree that claimant's September 14, 1999 injury has already been accepted by SAIF on a prior claim. On April 12, 1999, SAIF, on behalf of Jugs Company, accepted a lumbar strain resulting from claimant's March 17, 1999 injury. (Ex. 5). It is unclear when claimant

began working for Onsite Commercial Staffing, but he was working there by September 14, 1999, when he filed a claim against Onsite for a low back injury. (Exs. 7, 8).

There is no evidence that claimant filed a claim against SAIF for a September 14, 1999 injury. On September 30, 1999, SAIF, on behalf of Jugs Company, issued an updated notice of acceptance at closure regarding the March 17, 1999 injury, which referred to the accepted condition as a lumbar strain. (Ex. 17). SAIF issued a Notice of Closure on September 30, 1999, awarding temporary disability. (Ex. 18).

At hearing, the insurer argued that, because SAIF issued an acceptance after the September 14, 1999 injury, and there was no evidence that SAIF denied any benefits, claimant is barred from proceeding against the insurer. (Tr. 6). The insurer raises the same issue on review.

ORS 656.262(7)(c) provides that when a carrier determines that the claim qualifies for claim closure, the carrier shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. SAIF complied with ORS 656.262(7)(c) by issuing an updated notice of acceptance at closure on September 30, 1999. SAIF's updated notice of acceptance at closure referred to claimant's March 17, 1999 injury, as did the Notice of Closure. (Exs. 17, 18).

Because there is no evidence that claimant filed a claim against SAIF for a September 14, 1999 injury, we are not persuaded by the insurer's argument that claimant is barred from proceeding against the insurer. We do not understand how SAIF could be deemed to have accepted a condition for which there was no claim. SAIF's updated notice of acceptance at closure referred specifically to the March 17, 1999 injury and made no reference to the September 14, 1999 injury. Furthermore, SAIF's September 30, 1999 Notice of Closure expressly provided that "[a]ll disability awarded herein on this claim is caused solely by the conditions accepted by SAIF in writing." (Ex. 18).

Moreover, we find no evidence to support the conclusion that claimant's March 17, 1999 lumbar strain is the same as his September 14, 1999 low back condition. To the contrary, claimant testified that, after June 29, 1999, he did not see any physicians regarding the March 1999 injury because he was feeling better. (Tr. 13). Dr. Blanchard examined claimant on June 29, 1999 and reported that he could return to modified work on July 6, 1999 and, if that was tolerated, he could return to regular work. (Ex. 6). Drs. Laycoe and Watson indicated that claimant's March 1999 injury had "presumably resolved." (Ex. 29-5).

We turn to the merits and begin by addressing the appropriate standard of proof. Claimant argues that the September 14, 1999 work incident was a material cause of his disability or need for a treatment for a low back condition. Claimant contends there is no persuasive evidence of a combined condition. On the other hand, the insurer argues that the major contributing cause standard applies because claimant's low back condition combined with his preexisting personality traits.

The insurer relies on the opinion of Drs. Watson and Laycoe to contend that claimant has preexisting personality traits. Dr. Watson, neurologist, and Dr. Laycoe, orthopedic surgeon, examined claimant on one occasion and diagnosed, among other things, "[s]trong *suggestion* of psychological or social/cultural features influencing evaluation and potential recovery. (DSM 4:316)." (Ex. 29-5; emphasis supplied). They said that diagnosis was a preexisting personality trait, and was the major cause of the combined condition. (Ex. 29-6). They found that claimant's prognosis was guarded in view of the marked "overlay" present. (*Id.*)

Claimant's treating physicians, Drs. Brett and Gudmundsen, disagreed with Drs. Watson and Laycoe. Dr. Gudmundsen had examined claimant on several occasions and explained that she found no evidence of functional overlay. (Ex. 34). Similarly, Dr. Brett did not believe there was any significant functional overlay. (Ex. 31).

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, we are more persuaded by the opinions of Drs. Brett and Gudmundsen, who examined claimant on several occasions, than the opinion of Drs. Watson and Laycoe, who examined him once. We find no evidence that Drs. Watson or Laycoe had any particular expertise in diagnosing psychological conditions. More importantly, their diagnosis of a "[s]trong

suggestion" of psychological or social/cultural features is not persuasive because it is couched in terms of possibilities, not in terms of reasonable medical probability. *See Gormley v. SAIF*, 52 Or App 1055 (1981). Under these circumstances, we are not persuaded that claimant had a preexisting psychological condition or any other preexisting condition that combined with the September 14, 1999 incident to cause his disability or need for treatment. Consequently, we find that a material contributing cause standard applies.

The insurer denied the claim on the basis that the September 14, 1999 injury did not arise out of or in the course of claimant's employment. (Ex. 30). The insurer makes the same argument on review. Further, the insurer contends that claimant is not credible and neither are his treating physicians. The insurer also raises an argument about the lack of any "verifiable" findings.

The ALJ did not make any express credibility findings. Nevertheless, although the ALJ found that claimant had not experienced a compensable injury, he specifically found that claimant experienced pain after picking up sponges at work on September 14, 1999. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). On *de novo* review, we find that claimant is a credible witness.

For an injury to be compensable, it must "aris[e] out of" and occur "in the course of employment[.]" ORS 656.005(7)(a). The "arise out of" prong of the compensability test requires a causal link between the worker's injury and his or her employment. *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997). The requirement that the injury occur "in the course of" the employment concerns the time, place, and circumstances of the injury. *Id.*

Claimant testified that he squatted to pick up sponge-like computer objects at work on September 14, 1999. (Tr. 14-15). When he attempted to stand up, he experienced the severe onset of low back and leg pain. (Tr. 15; Ex. 14). Because the record establishes that claimant was injured during the hours of his normal work day at the employer's premises, we find that the injury occurred in the course of employment. In addition, based on claimant's testimony, we find that he was engaged in an activity within the boundaries of his work when he was injured. Under these circumstances, we are satisfied that a sufficient causal link exists between claimant's injury and a risk connected with employment, and we conclude that the injury arose out of and in the course of his employment.

Next, we turn to the insurer's argument that claimant did not sustain an injury on September 14, 1999. The insurer contends that it was a minor injury, if it occurred at all.

Claimant acknowledges that the event that led to his disability and need for treatment appears to be a minimal industrial incident. Nevertheless, he asserts that the September 14, 1999 injury is compensable.

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[.]" ORS 656.005(7)(a).

After the September 14, 1999 work incident, claimant experienced the immediate onset of pain when he tried to stand up. (Tr. 15). He was transported by ambulance to a hospital. (Ex. 9). A lumbar MRI showed early degenerative changes at L5-S1 and a disc bulge at that level. (Ex. 11). Dr. Smood diagnosed "[b]ack pain with radiculopathy" and MRI evidence of a small L5-S1 herniation. (Ex. 14). The discharge report from Dr. Warden said that claimant was in significant pain and was hesitant to move his lower extremities secondary to the pain, but after he was assured that he had purely musculoskeletal pain, he was able to ambulate. (Ex. 15-1). Dr. Warden diagnosed "[l]ow back pain. (*Id.*) Similarly, Dr. Bohling diagnosed low back pain, and he authorized time loss and recommended physical therapy. (Ex. 16). Claimant had physical therapy and in October 1999, he began treating with Dr. Gudmundsen, DC. (Ex. 21). A later lumbar myelogram was reported to be normal. (Ex. 24C).

Based on claimant's testimony and the medical records, we find that the preponderance of evidence supports a conclusion that claimant sustained a low back injury at work on September 14, 1999. A claimant need not prove a specific diagnosis if he or she proves that the condition is work-related. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992). In reaching our conclusion, we rely on

the opinions of Drs. Brett and Gudmundsen to establish causation. Dr. Gudmundsen concluded that claimant's September 14, 1999 work incident was the major contributing cause of his injuries.[1] (Ex. 34). Dr. Brett said that claimant's condition was mainly a result of the September 14, 1999 injury.[2] (Ex. 24A). In addition, Drs. Laycoe and Watson diagnosed "[b]ack and leg pain following industrial event of injury, reported September 14, 1999." (Ex. 29-5).

Finally, we address the insurer's contention concerning the lack of any "verifiable" findings. Citing ORS 656.005(19), which pertains to "objective findings," the insurer argues that there is no causal connection between any verifiable findings and a September 1999 injury.

Because the insurer raises an argument concerning the lack of objective findings for the first time on review, we are not inclined to address it. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). In any event, we agree with claimant that his symptoms were supported by objective findings.

"Objective findings" are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. ORS 656.005(19). "Objective findings" do not include "physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." *Id.*

On September 14, 1999, Dr. Smood reported that claimant had low back pain with decreased sensation and movement in the lower extremities, along with tenderness in his back. (Ex. 8). Claimant's lumbar MRI showed early degenerative changes at L5-S1 and a disc bulge at that level. (Ex. 11). On September 15, 1999, Dr. Warden described a loss of strength in the lower extremities, secondary to pain. (Ex. 15-2). On September 16, 1999, Dr. Bohling reported that claimant's range of motion was zero percent and he was tender over the low back paraspinal muscles. (Ex. 16). Physical therapists referred to claimant's reduced lumbar range of motion and tenderness. (Ex. 16A, 16C). By September 30, 1999, Dr. Bohling said claimant was improving, but he still had reduced range of motion and tenderness in the low back paraspinal muscles. (Ex. 19). Dr. Gudmundsen referred to tenderness to palpation and diminished range of motion. (Exs. 23A, 23E). Dr. Brett described moderately severe paralumbar muscle spasms. (Ex. 24). Based on these medical reports, we find that claimant has established objective findings of an injury. In sum, we conclude that claimant has established that he sustained a compensable low back injury on September 14, 1999.

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

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[1] The insurer argues that Dr. Gudmunsen's opinion is not persuasive because she did not evaluate all the relative contributions to claimant's condition, as required in *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). Because a material contributing cause standard applies in this case, the *Dietz* analysis does not apply; it is therefore not necessary for a medical expert to "weigh relative causes." *See Richey v. Barrett Business Services*, 173 Or App 29 (2001).

The insurer also contends that Dr. Gudmundsen is not "credible" because she thought claimant had an L5-S1 disc herniation. According to the insurer, no other physician diagnosed an L5-S1 disc herniation. To the contrary, Dr. Smood explained that there was MRI evidence of a small L5-S1 herniation. (Ex. 14-2). Claimant's September 14, 1999 MRI showed a disc bulge at L5-S1. (Ex. 11). Although Dr. Gudmundsen referred to an L5-S1 disc "herniation" in one report, she subsequently indicated that claimant had a disc bulge at L5-S1, with a lumbar sprain/strain. (Exs. 28, 34). We find that Dr. Gudmunsen's opinion is sufficient to establish that claimant's September 14, 1999 work incident was a material cause of his low back condition.

[2] The insurer argues that Dr. Brett's opinion is not entitled to any weight because he did not have an accurate history that claimant was injured in March 1999. As we discussed earlier, we find no evidence that claimant's March 17, 1999 injury is related to his September 14, 1999 injury, and no evidence of a preexisting condition that combined with the September 14, 1999 incident to cause claimant's disability or need for treatment. Under these circumstances, we do not believe that the fact that Dr. Brett was apparently not aware of claimant's March 1999 back injury detracts from his opinion on causation. *See Johnny R. Richey*, 53 Van Natta 743 (2001).

ORDER

The ALJ's order dated February 26, 2001 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the insurer denial is reversed. The claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $4,500, payable by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
SHAWN J. SEVERNS, Claimant
WCB Case No. 00-05354
ORDER ON RECONSIDERATION
Mustafa T. Kasubhai, P.C., Claimant Attorney
Hornecker, Cowling, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Bock.

The insurer requests reconsideration of that portion of our June 26, 2001 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's occupational disease claim for a low back condition.

On reconsideration, the insurer contends that claimant has not met his burden of proving a "pathological worsening" of a preexisting low back condition pursuant to ORS 656.802(2)(b). We disagree.

ORS 656.802(2)(b) applies where an occupational disease claim is "based on the worsening" of a preexisting condition. If so, the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. *See William A. Strode*, 53 Van Natta 212 (2001). Here, we find that ORS 656.802(2)(b) does not apply.

For the same reasons that we deferred to Dr. Amstutz on the low back compensability issue, we defer to Dr. Amstutz' opinion as to whether claimant's low back claim is "based on the worsening" of a preexisting condition.

On December 14, 2000, Dr. Amstutz agreed with an opinion summary letter that stated that claimant's "problems in his low back were more probably than not unrelated to any idiopathic degenerative process." (Ex. 17-2). Dr. Amstutz explained that claimant's spina bifida occulta condition, for instance, occurred at a lower level than his L5-S1 disk condition. (*Id.*) Although earlier Dr. Amstutz had stated that there was a "minor contribution, probably 25%," to claimant's low back condition attributable to a transitional spine and a spina bifida occulta, this comment still does not equate to a statement that the low back condition was "based on the worsening" of either the transitional spine or spina biffida occulta conditions. (Ex. 16-4).

Although Drs. Denekas and Strum diagnosed lumbar degenerative disk disease, they stated that "there is no medical evidence to support that [claimant's] work activities change[d] the progression of his degenerative disk disease and therefore it is not felt that his employment is the major cause of his degenerative disk disease or his need for treatment in regard to his low back." (Ex. 12-6). Drs. Denekas and Strum thus do not support compensability on a "major contributing cause" basis. However, these physicians did not state that claimant's degenerative disk disease condition "combined" with claimant's work activity or with any other condition, nor do their opinions support that claimant's condition was "based on the worsening" of the preexisting condition.

Therefore, based on the above medical opinions, we find that claimant's low back claim was not "based on the worsening of" a preexisting condition. ORS 656.802(2)(b); *see Vergil E. Meier*, 53 Van Natta 378 (2001) (although the claimant had a preexisting degenerative cervical condition, his claim was not "based on the worsening" of any such condition).

Accordingly, we withdraw our June 26, 2001 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
ALVINO H. GUARDIOLA, Claimant
WCB Case No. 00-08790
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that: (1) directed it to accept and process claimant's right shoulder bursitis, rotator cuff impingement, and tendinitis as new medical conditions; and (2) awarded claimant's counsel an attorney fee. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize as follows. Claimant, a nurseryman, compensably injured his right shoulder in January 1995 when carrying heavy bundles of trees. On April 4, 1995, SAIF accepted a nondisabling right trapezius muscle strain. (Ex. 6).

On September 30, 1996, claimant sought treatment from Dr. Martin for ongoing right shoulder symptoms. Dr. Martin differentially diagnosed right shoulder tendonitis, rule out rotator cuff tear. (Ex. 9). On December 12, 1996, Dr. Hubbard, neurologist, evaluated claimant. Dr. Hubbard diagnosed right rotator cuff impingement and a right trapezius muscle strain and referred claimant for further evaluation. (Ex. 13).

On February 3, 1997, Dr. Blake, orthopedic surgeon, concluded that claimant had either a chronic rotator cuff bursitis with impingement or a small rotator cuff tear. (Ex. 14). Ultrasound performed in March 2000 showed tendinopathy of the right distal supraspinatus tendon without a tear. Dr. Blake diagnosed chronic tendinopathy with impingement syndrome, and, on April 25, 2000, he formally requested approval of a right shoulder decompression procedure. (Exs. 17, 18).

On July 25, 2000, SAIF submitted an Own Motion recommendation to the Board. In that recommendation, SAIF stated that the accepted conditions were "muscle strain, right trapezius and right shoulder bursitis." (Ex. 26A-3). On August 9, 2000, the Board, under its Own Motion authority, issued an order authorizing the payment of temporary disability compensation. (Ex. 29).

On August 16, 2000, claimant formally requested acceptance of "chronic impingement syndrome right shoulder, rotator cuff tendinitis right shoulder, shoulder bursitis and tendinopathy involving the right distal supraspinatus," pursuant to ORS 656.262(7)(a). (Ex. 31). In a letter dated November 22, 2000, SAIF stated that the claimed conditions were already encompassed within the scope of a prior acceptance issued April 4, 1995 and July 25, 2000. SAIF declined to formally accept the requested conditions, but stated that it would not deny the conditions and would continue to pay for treatment and disability pursuant to the previously issued acceptance. (Ex. 36). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that SAIF must accept and process claimant's right shoulder bursitis, rotator cuff impingement and tendinitis as new medical conditions, and awarded claimant's counsel an attorney fee for prevailing against SAIF's denial of those conditions. On review, SAIF contends that claimant is not entitled to an attorney fee under ORS 656.386(1) for obtaining the acceptance of a "new medical

condition" claim because SAIF had already accepted the requested conditions in its July 25, 2000 Own Motion recommendation to the Board. SAIF also argues that the principle enunciated in *SAIF v. Tull*, 113 Or App 449 (1992), whether an acceptance occurs or not is an issue of fact, relieves it of the necessity of complying with the statutory requirements of ORS 656.262, as it has acknowledged responsibility for the claim and has obligated itself to provide the benefits due under the law by means of the Own Motion recommendation. We disagree with SAIF's arguments, reasoning as follows.

Underlying SAIF's argument that it has already accepted claimant's "new medical conditions" claim by means of an Own Motion recommendation, are the same jurisdictional arguments we previously rejected in *Larry L. Ledin*, 52 Van Natta 680 (2000), *aff'd SAIF v. Ledin*, 174 Or App 61 (2001), and *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999). In other words, assuming for the sake of argument that SAIF's Own Motion processing of the conditions constituted an acceptance, SAIF is still required to process claimant's right shoulder bursitis, rotator cuff impingement and tendinitis conditions as "new medical conditions" pursuant to ORS 656.262(7)(c) and 656.268.

In *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579, *rev den* 329 Or 527 (1999), the court held that under ORS 656.262(7)(a) a claim for a new medical condition is subject to the processing requirements of ORS 656.262(4)(a). ORS 656.262(7)(a) expressly provides that a claimant may bring such a new medical condition claim at any time, without regard to any other provision of the Workers' Compensation Law. As the court explained in *SAIF v. Ledin*, 174 Or App at 61, it is not relevant to a new medical condition claim that the claimant's aggravation rights have expired or that the Board might exercise its Own Motion jurisdiction.

In this case, SAIF has never formally accepted claimant's requested right shoulder conditions.[1] SAIF's Own Motion recommendation to the Board is just that: a recommendation provided to the Board under its Own Motion authority. As we discussed in our Own Motion order in *Ledin*, 52 Van Natta at 682 n.1, an Own Motion order does not preclude a reopening under ORS 656.262(7)(c), although it might affect temporary disability benefits for the same condition for the same time period (*i.e.*, there may be a possibility of an offset). *See, e.g., Steven R. Azorr*, 52 Van Natta 2148, 2150 n. 10 (2000).

ORS 656.262(6)(a) provides that written notice of acceptance or denial of a claim shall be furnished to the claimant. ORS 656.262(6)(b) specifies the information that must be included in the Notice of Acceptance.[2]

Here, claimant formally requested acceptance of new medical conditions under ORS 656.262(7)(a). As the court discussed in *Johanson* and *Ledin*, a claim for new medical conditions under that statute is subject to specific statutory processing requirements. SAIF's incidental notation on an Own Motion form is not adequate compliance with the statute. Consequently, even under the *Tull* analysis, we continue to conclude that the record does not establish that SAIF accepted claimant's new

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[1] On April 4, 1995, SAIF accepted a nondisabling "muscle strain, right trapezius." (Ex. 6).

[2] ORS 656.262(6)(b) provides that the Notice of Acceptance shall:

"(A) Specify what conditions are compensable.

"(B) Advise the claimant whether the claim is considered disabling or nondisabling.

"(C) Inform the claimant of the Expedited Claim Service and of the hearing and aggravation rights concerning nondisabling injuries, including the right to object to a decision that the injury of the claimant is nondisabling by requesting reclassification pursuant to ORS 656.277.

"(D) Inform the claimant of employment reinstatement rights and responsibilities under ORS chapter 659.

"(E) Inform the claimant of assistance available to employers from the Reemployment Assistance Program under ORS 656.622."

In its brief, SAIF concedes that its Own Motion recommendation does not comply with all the requirements of a formal notice of acceptance.

medical conditions prior to the issuance of its November 22, 2000 letter declining to accept the requested conditions. Moreover, because SAIF's Own Motion recommendation does not qualify as a formal acceptance of claimant's right shoulder bursitis, it follows that it could not function as a prior acceptance that encompassed right shoulder chronic impingement syndrome, rotator cuff tendonitis and tendinopathy involving the right distal supraspinatus.[3]

Thus, because claimant's "new medical conditions" claim for right shoulder bursitis, right shoulder chronic impingement syndrome, rotator cuff tendonitis and tendinopathy involving the right distal supraspinatus have been found compensable after claim closure,[4] the claim must be reopened under ORS 656.262(7)(c) for the payment of benefits for the "new condition" (including claim closure under ORS 656.268).[5]

Finally, claimant's request for acceptance of new medical conditions pursuant to ORS 656.262(7)(a) was made on August 16, 2000. SAIF did not respond to claimant's request until November 22, 2000, more than 90 days later. SAIF explained that it was unable to accept the additional conditions because they were already encompassed within the scope of the prior acceptance. (Ex. 36). Had SAIF responded in the manner that it did within 90 days, there would be no denied claim. *See, e.g., Michal A. Fleming*, 52 Van Natta 383 (2000). However, because SAIF did not timely respond to claimant's request, its inaction resulted in a "de facto" denied claim under ORS 656.386(1)(b)(C). *See, e.g., Gilbert M. Sanchez*, 51 Van Natta 248 (1999). Consequently, we affirm the ALJ's attorney fee award for prevailing against SAIF's claim denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to the compensability issue, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.[6]

ORDER

The ALJ's order dated March 16, 2001 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, to be paid by the SAIF Corporation.

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[3] SAIF does not contend that the claimed conditions were encompassed in its 1995 acceptance of claimant's "right trapezius muscle strain."

[4] We note that SAIF submitted "Supplemental Exhibits" numbered from 38 through 40 with its brief that were not included as exhibits by the ALJ. Exhibit 38 is a chart note dated January 22, 2001 regarding a fall claimant experienced at work on January 15, 2001. Exhibit 39 is a report of an imaging study that took place on January 22, 2001. Exhibit 40 is a February 1, 2001 file review report from Dr. Jones. Neither the transcript nor the ALJ's order mentions those exhibits. Therefore, the record does not support a conclusion that they were admitted at hearing and we do not consider them on review. In any event, even if those exhibits were considered, they are not likely to affect the outcome of this case. Thus, remand is not warranted. *See* ORS 656.295(5); *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

[5] SAIF also argues that the Board lacks jurisdiction under its Own Motion authority to direct processing under ORS 656.262(7)(c). *E.g., Craig J. Prince*, 52 Van Natta 108, 111 (2000). We agree. This case, however, did not arise under the Board's Own Motion authority. Rather, it arose as a compensability dispute within the Hearings Division's jurisdiction. Thus, we have the authority to direct SAIF to process the claim under ORS 656.262(7)(c). *See Larry L. Ledin*, 52 Van Natta at 684, *aff'd SAIF v. Ledin*, 174 Or App 61 (2001).

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

In the Matter of the Compensation of
TED A. DIGGS, Claimant
WCB Case No. 00-07328
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's combined "lumbar, thoracic, strain, right shoulder contusion and strain" conditions. On review, the issues are the procedural propriety of the denial and compensability. We reverse.

FINDINGS OF FACT

On November 11, 1999, claimant tripped at work, injuring his back and right shoulder. Claimant initially sought chiropractic treatment, but began treating with Dr. Verzosa, M. D., in late December 1999. Dr. Verzosa diagnosed a lumbar strain, thoracic sprain, and right shoulder contusion and sprain.

By letter dated January 24, 2000, the insurer accepted claimant's claim as disabling lumbar thoracic strains, and right shoulder contusion strains. Claimant continued to treat with Dr. Verzosa.

On May 19, 2000, claimant was examined by Dr. Williams, neurologist, and Dr. Woodward, orthopedist, at the request of the insurer. On July 28, 2000, claimant was examined by Dr. Arbeene, orthopedist, at the request of the insurer.

On August 9, 2000, the insurer issued an "Initial Notice of Acceptance" indicating that claimant's accepted conditions were lumbar, thoracic strains, right shoulder contusion and strain that combined with preexisting noncompensable degenerative disc disease. Also on August 9, 2000, the insurer issued a denial of claimant's current need for medical treatment and disability on the basis that the accepted condition "is no longer the major contributing cause of [claimant's] combined condition."

Claimant's claim was closed by an August 17, 2000 Notice of Closure that awarded temporary disability benefits.

On October 17, 2001, claimant was examined by Dr. Donovan, medical arbiter, at the request of the Appellate Unit of the Workers' Compensation Division.

On December 27, 2001, the insurer issued an amended denial which indicated that claimant's accepted lumbar and thoracic strain had combined with preexisting thoracolumbar degenerative disc disease and spinal stenosis. The amended denial denied claimant's current back condition on the basis that the accepted conditions were no longer the major cause of the combined condition.

Claimant has degenerative disc and degenerative joint disease in his lumbar spine that preexisted the November 22, 1999 industrial injury.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the insurer's denial, issued on the same day as its acceptance of a combined condition, was an invalid "pre-closure" denial of a combined condition under ORS 656.262(6)(c). Consequently the ALJ set the denial aside as procedurally improper. We disagree.

Subsequent to the ALJ's order, we issued our decision in *Jeff E. White*, 53 Van Natta 220 (2001). In *White*, the carrier simultaneously accepted and denied a "combined condition" in one document. We concluded that ORS 656.262(6)(c) was sufficiently broad to include both the issuance of separate documents evidencing the acceptance and denial of a "combined condition," as well as the acceptance and "later" denial of a "combined condition in the same document so long as the time period for the acceptance of the combined condition was identified. Accordingly, we found that the carrier's denial was procedurally proper. *See also John J. Shults*, 53 Van Natta 383 (2001) (acceptance of a combined condition and a denial of a combined condition, issued on the same day, but in separate documents, was permissible under ORS 656.262(6)(c)).

Here, pursuant to its August 9, 2000 "Initial Notice of Acceptance," the insurer accepted a combined condition with an injury date of November 22, 1999. (Ex. 149). The acceptance did not specify a date different from the date of its prior January 2000 acceptance. Under such circumstances, the most reasonable interpretation is that the insurer's August 9, 2000 "Initial Notice of Acceptance" replaced or superceded the January 24, 2000 acceptance. *Shults*, 53 Van Natta at 385, n. 2. Thus, the insurer accepted a "combined condition" from the onset of the claim; *i.e.*, November 22, 1999.

We turn to an analysis of the insurer's "combined condition" denial which issued on the same day of its acceptance of the "combined condition," *i.e.*, August 9, 2000. The denial denied claimant's *current* need for treatment and disability and referenced a "combined" condition. Such circumstances support a conclusion that the insurer was denying an accepted combined condition effective the date of its August 9, 2000 denial. (Ex. 148). Because the time period for the acceptance of the "combined condition" is identified (November 22, 1999 to August 9, 2000) and because the insurer's denial was subsequent to its acceptance of a combined condition, it is procedurally valid. *Shults*, 53 Van Natta at 386. We now turn to the merits.

In light of claimant's preexisting degenerative disease, and given the multiple strain conditions that claimant suffered, the issue of whether the accepted injuries remain the major contributing cause of claimant's combined condition presents a complex medical question.[1] Thus, although claimant's testimony is probative, this issue must be resolved by expert medical opinion. *See Barnett v. SAIF*, 122 Or App 279, 283 (1993).

The only medical evidence that arguably supports compensability comes from Dr. Verzosa, claimant's treating physician. Although Dr. Verzosa agreed that it was medically probable that claimant was still suffering from symptoms of the combined condition in July 2000, he did not address the question of whether the accepted conditions remained the major cause of claimant's disability or need for treatment. (Ex. 157). Consequently, Dr. Verzosa's opinion is not sufficient to establish the compensability of claimant's current combined condition.

Because Dr. Verzosa's opinion is not sufficient to carry claimant's burden of proof, and in light of the contrary opinions from Drs. Arbeene and Donovan, we conclude that claimant has not established that his compensable injury remains the major contributing cause of his disability or need for treatment for the combined condition.[2] Accordingly, the insurer's denial must be upheld.

ORDER

The ALJ's order dated January 10, 2001 is reversed. The insurer's denial, as amended, is reinstated and upheld. The ALJ's award of an assessed attorney fee is reversed.

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[1] The insurer's August 9, 2000 denial indicated that claimant's right shoulder condition had also combined with the preexisting degenerative condition. However, its December 27, 2000 amended denial indicates that the accepted lumbar and thoracic strain were the conditions that had combined with the preexisting degenerative disc disease and spinal stenosis. Consequently, the "combined condition" at issue is the "combined lumbar and thoracic condition" identified in the insurer's December 27, 2000 amended denial.

[2] In the event that we found the insurer's denials procedurally proper, claimant requested that the matter be remanded in order for the ALJ to make a credibility finding. Even assuming that this is a proper basis for remand, it is not necessary in light of our conclusion that the record does not contain sufficient medical evidence to establish compensability.

Member Phillips Polich dissenting.

For the same reasons that I joined with Board Member Biehl to dissent in *Jeff E. White*, 53 Van Natta 220 (2001), I respectfully dissent. *See also John J. Shults*, 53 Van Natta 383 (2001) (Member Phillips Polich, specially concurring).

Here, I find no support for the majority's interpretation of the insurer's simultaneous (same day) acceptance and denial of a "combined condition." In my view, the statute focuses on a sequence of accepting and denying as opposed to allowing a retroactive acceptance as of a particular date. ORS 656.262(6)(c). I also continue to believe that the Court of Appeals' decision in *Blamires v. CleanPak Systems, Inc.*, 171 Or App 163 (2000) requires an acceptance of a combined condition before a denial of a combined condition. 171 Or App at 167. *See also Croman Corp. v. Serrano*, 163 Or App 136 (1999).

The statute premises a "later" denial on the contingency that the otherwise compensable injury "ceases to be" the major contributing cause of the combined or consequential condition. A carrier may later deny the condition only when there is a change in the condition; *i.e.*, medical evidence indicates that the compensable injury "ceases to be" the major contributing cause of the previously accepted combined or consequential condition. ORS 656.262(6)(c).

Here, although the insurer's August 9, 2000 acceptance of a combined condition did not specify an "effective" date, the majority interprets this acceptance to "relate back" to the initial, January 24, 2000 acceptance, citing *John J. Shults*. Therefore, the August 9, 2000 denial, which denies claimant's current disability and need for treatment, is later in time (than the acceptance) under the majority's analysis and procedurally valid. I do not believe this leap of faith is supported by the statutory language, as explained above.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
TIMOTHY J. ALDERMAN, Claimant
WCB Case No. 01-00046
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes. Member Haynes chose not to sign the order.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) found that claimant's occupational disease claim was timely filed; and (2) set aside its denial of claimant's occupational disease claim for his cervical and lumbar strains. On review, the issues are timeliness and compensability.

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

On review, the insurer contends that claimant's testimony establishes that he was aware that he had an occupational disease as early as 1997. The insurer argues that, as set forth in *Louis Szabo*, 51 Van Natta 121, 122 (1999), in order for a physician to inform a claimant that he is suffering from an occupational disease under the statute, the physician must have told the claimant "simply and directly" that his disease arose out of his employment. *See Liberty Northwest Ins. Corp. v. Meeker*, 106 Or App 411 (1991).

After reviewing claimant's testimony regarding his discussions with Dr. Orth and the medical reports in the record, we agree with the ALJ that claimant was not told by his physician that he had an occupational disease until after November 9, 1999. In other words, the record does not establish that claimant was "simply and directly" told that his disease arose out of his employment until May 24, 2000. (Ex. 20, 38-4). Accordingly, we agree with the ALJ that the occupational disease claim was timely filed. ORS 656.807(1)(a).

Claimant is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the 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 12, 2001 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
WALTER D. HILL, Claimant
WCB Case No. 00-08143
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Meyers and Bock. Member Biehl chose not to sign the order.

Claimant requests review of Administrative Law Judge (ALJ) Fitzwater's order that: (1) declined to dismiss claimant's request for hearing without prejudice; (2) found that the SAIF Corporation was not required to amend its acceptance to include additional conditions; and (3) declined to assess a penalty for SAIF's allegedly unreasonable claims processing. On review, the issues are motion to dismiss, scope of acceptance and penalties.

We adopt and affirm the ALJ's order with the following change and supplementation. In the first sentence on page 3, we change "denial" to "acceptance."

Motion to Dismiss

Claimant argues that the ALJ abused her discretion in denying his motion to dismiss his hearing request without prejudice. According to claimant, the ALJ failed to provide any reasoning for denying the motion.

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. *Julie Mayfield*, 42 Van Natta 871 (1990). In *Ronald D. Robinson*, 44 Van Natta 2500, 2501-02 (1992), we explained that a party requesting a hearing cannot circumvent the Board's postponement or continuance rules by obtaining a dismissal without prejudice and then subsequently filing a new hearing request on the same issues. We concluded that the moving party must provide an explanation for withdrawing the hearing request and having the hearing request dismissed without prejudice. *Id.* at 2502. The party filing the hearing request initiates the hearing process and must therefore be prepared to present its case at the scheduled hearing. We reasoned that, to hold otherwise, would delay litigation, encourage lack of preparation, and prejudice the opposing party that has prepared for hearing. *Id.* On review, we will not disturb the terms and conditions imposed by the ALJ except under a showing of an abuse of discretion. *Cathy A. Inman*, 47 Van Natta 1316, 1319 (1995), *aff'd mem Inman v. Beverly Enterprises*, 144 Or App 192 (1996).

Here, the ALJ explained that claimant's counsel had requested a dismissal because he was "tired" of addressing the particular issue in dispute and wanted to protect claimant from any future claim preclusion by having the case dismissed without prejudice. The ALJ noted that SAIF was prepared to litigate and opposed claimant's motion. Further, SAIF could be prejudiced if claimant later filed another request for hearing on the same issues. The ALJ concluded that claimant had not provided a sufficient explanation for dismissing the hearing request without prejudice. After reviewing the record and the parties' arguments, we find no abuse of discretion. We are not persuaded that the ALJ erred in denying claimant's motion to dismiss without prejudice.

Penalties

Claimant argues on review that he is entitled to a penalty and a penalty-related attorney fee for SAIF's allegedly unreasonable claims processing. Although claimant referred to a penalty issue in his request for hearing, we find no evidence that he raised that issue at hearing or in his hearing memorandum. The ALJ's order referred to only two issues at hearing: dismissal and scope of acceptance. Because claimant apparently did not pursue a penalty issue at hearing, we are not inclined to address that issue. In any event, even if we assume that claimant properly raised this issue, we find that SAIF's claims processing was reasonable. Furthermore, in light of our disposition on the merits, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Claimant is not entitled to a penalty or a penalty-related fee.

ORDER

The ALJ's order dated February 21, 2001 is affirmed.

In the Matter of the Compensation of
DUANE A. FERREN, Claimant
WCB Case No. 00-06276
ORDER ON RECONSIDERATION
Cole, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests reconsideration of our July 2, 2001 order that affirmed in part and reversed in part an Administrative Law Judge's (ALJ's) order. Specifically, we affirmed that part of the ALJ's order that: (1) found that the SAIF Corporation was obligated to process claimant's new medical conditions under ORS 656.262 and 656.268; (2) found that claimant was a "worker" and was entitled to temporary disability benefits for his compensable depression condition beginning on December 14, 1999 and continuing until termination was permitted under law; and (3) ordered SAIF to pay an out-of-compensation attorney fee equal to 25 percent of the additional temporary disability benefits awarded by the ALJ's order, not to exceed $1,500. We reversed that portion of the ALJ's order that awarded penalties under ORS 656.262(11) and penalty-related attorney fees under ORS 656.382(1). Finally, we awarded claimant's attorney an assessed fee of $1,200 under ORS 656.382(2) for services on review concerning the temporary disability and claim processing issues. In his request for reconsideration, claimant requests that we award his attorney an out-of-compensation fee of 25 percent of the increased temporary disability compensation awarded by our order.

We acknowledge that, on July 13, 2001, SAIF filed a petition for judicial review of the Board's July 2, 2001 order. Nevertheless, because that order remains within 30 days of its issuance, the Board retains jurisdiction under ORS 656.295(8) to issue an Order on Reconsideration further considering this case. *See Haskell Corporation v. Filippi*, 152 Or App 117 (1998); *SAIF v. Fisher*, 100 Or App 288 (1990); *Marietta Z. Smith*, 51 Van Natta 731 fn 1 (1999).

If claimant had requested Board review and if we had increased claimant's temporary disability compensation on review, claimant's attorney would have been entitled to a fee paid from that increase. ORS 656.386(2); OAR 438-015-0055(1). However, here, claimant did not request Board review, SAIF did. Moreover, we did not increase claimant's temporary disability compensation on review. Instead, we affirmed the temporary disability compensation awarded by the ALJ. Therefore, there is no increased temporary disability compensation upon which to base an out-of-compensation attorney fee on review under ORS 656.386(2) and OAR 438-015-0055(1).

Finally, we affirmed the ALJ's award of an out-of-compensation attorney fee based on the temporary disability compensation awarded by the ALJ's order. ORS 656.386(2); OAR 438-015-0045. Pursuant to ORS 656.382(2), we awarded a $1,200 assessed attorney fee for claimant's counsel's services on review regarding the claims processing *and* temporary disability compensation issues. Therefore, claimant's attorney was compensated for his successful efforts at hearing and on review regarding the temporary disability compensation issue. Nevertheless, because claimant did not request Board review and because there was no increased temporary disability compensation awarded on review, claimant's attorney is not entitled to an additional out-of-compensation attorney fee on review regarding the temporary disability compensation issue.

Accordingly, we withdraw our July 2, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our July 2, 2001 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
PATRICIA J. HURD, Claimant
WCB Case No. 00-09221
ORDER ON REVIEW (REMANDING)
Schneider, et al., Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's current low back condition; (2) awarded a 10 percent penalty for an allegedly unreasonable denial; and (3) awarded an assessed fee "in accordance with ORS 656.262(11)(a)." On review, the issues are the procedural validity of the denial, compensability, penalties and attorney fees. We vacate the ALJ's order and remand.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following additional findings. On February 15, 2001, the employer's attorney wrote a letter to claimant's counsel regarding a recent discussion of the issues. The employer's counsel stated that the employer continued to deny the current back condition on the grounds that "the compensable injury of August 30, 1999, is not the major or at least material contributing cause to the condition and treatment in October 2000." (Ex. 27).

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's November 29, 2000 denial of claimant's current low back condition on the ground that the denial stated the incorrect legal test.[1] Specifically, the ALJ observed that, according to the employer's denial, the medical evidence had established that the accepted injury of August 30, 1999 was not the "major contributing cause" of claimant's need for treatment beginning October 4, 2000. Noting that the employer had not accepted or contended that there was a "combined condition," the ALJ determined that ORS 656.005(7)(a)(B) did not apply. Therefore, the ALJ reasoned that, because a material rather than the major contributing cause standard was applicable, the denial had misstated the correct legal test and should be set aside. Moreover, the ALJ determined that the employer's denial was unreasonable and that a 10 percent penalty was appropriate. Finally, the ALJ awarded an assessed fee in "accordance with ORS 656.262(11)(a)."

On review, the employer contends that the ALJ incorrectly set aside its denial on the ground that it incorrectly stated the appropriate legal standard. The employer notes its counsel's February 15, 2001 letter, in which it asserted that the original injury was not a material contributing cause of the current condition, and argues that the letter amended its original denial to include the material contributing cause test. Thus, the employer asserts that the ALJ should have evaluated the medical evidence and made a decision on the merits of the denial. Finally, the employer contends that the ALJ should not have assessed a penalty or awarded an assessed fee.

Claimant argues that the issues were framed by the employer's written denial and that the employer did not properly amend its denial to raise a material contributing cause defense. Therefore, claimant contends that the ALJ correctly decided the case based on the procedural invalidity of the employer's November 29, 2000 denial.

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), *on remand Larry L. Ledin*, 50 Van Natta 115 (1998).

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[1] The parties waived personal appearance and agreed to submit the matter based on the medical records and telephonic closing arguments.

Where such an amendment is permitted, to afford due process, the responding party must be given an opportunity to respond to the new issues raised. OAR 436-006-0091(3); *John E. Noyer*, 46 Van Natta 395 (1994); *Patricia N. Hall*, 40 Van Natta 1873, 1874 (1988) ("because claimant has the burden of proving compensability, it is not fair to require claimant to prove a proposition she had no notice of until the hearing convened"). In other words, a party's remedy for surprise and prejudice created by a late-raised issue is a motion of continuance. *Id.*; OAR 438-006-0031, OAR 438-006-0036.

In this case, even assuming that its written denial was based solely on major contributing cause grounds, the employer was entitled to amend its denial or raise additional issues under the above authority. In its February 15, 2001 letter, the employer asserted that it was denying claimant's current condition on both major and material contributing cause grounds. By interpreting the employer's denial as having raised only the major contributing cause issue, the ALJ effectively concluded that the denial could not be amended. Based on *Ledin* and its progeny, the employer should have been allowed to amend its denial at hearing to include the material contributing cause defense.

This conclusion raises the question of whether claimant would be entitled to a continuance of the hearing in order to respond to the new issue raised by the employer's counsel's letter. Because the original authority to consider motions for continuance of hearings rests with the ALJ, and because claimant may have been surprised by the employer's new defense at hearing, we conclude that the case should be remanded to the ALJ to allow claimant the opportunity to respond to the material causation issue and, if claimant makes such a motion, for the ALJ to decide whether a continuance is appropriate. *See Sandra L. Shumaker*, 51 Van Natta 1981, 1982 (1999), *on recon* 52 Van Natta 33 (2000).

Accordingly, we vacate the ALJ's order dated March 14, 2001 and remand this case to ALJ Peterson for further proceedings. These further proceedings may be conducted in any manner that the ALJ finds will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.

IT IS SO ORDERED.

July 26, 2001 Cite as 53 Van Natta 1018 (2001)

In the Matter of the Compensation of
LEORA MITCHELL, Claimant
WCB Case No. 00-09313
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Miller, Nash, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that reduced her scheduled permanent disability for loss of use or function of the right leg (knee) from 20 percent (30 degrees), as awarded by an Order on Reconsideration, to 8 percent (12 degrees). On review, the issue is extent of scheduled permanent disability.

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

At hearing and on review, the sole issue is whether claimant is entitled to a rating of scheduled permanent disability for loss of strength due to her accepted right knee strain and medial meniscus tear conditions.

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). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *Koitzsch v. Liberty Northwest*, 125 Or App at 670.

Claimant's attending physician, Dr. Kaesche, M.D., concurred with the impairment findings of Dr. McNeill, examining orthopedist, who measured claimant's muscle strength in her lower extremities as 5/5. (Exs. 3-5, 4). Thus, the attending physician's opinion does not support any impairment rating for loss of strength. OAR 436-035-0007(19)(a) (grade 5/5 results in zero percent impairment). Based on the findings of Dr. McNeill, as concurred with by Dr. Kaesche, an August 29, 2000 Notice of Closure awarded 8 percent scheduled permanent disability (3 percent for loss of range of motion combined with 5 percent for the partial medial meniscectomy surgery). (Ex. 6).

Following claimant's request for reconsideration, a medical arbiter's examination took place on October 24, 2000. In response to questions from the Appellate Review Unit (ARU) regarding muscle strength loss due to the accepted condition, the arbiter, Dr. Anderson, M.D., listed claimant's muscle strength loss as: "Right/Left: Flexors: 4/5. Extensors: 4/5."[1] (Ex. 8-3). Based on Dr. Anderson's statement, the ARU stated that "Gray's Anatomy, 1995, indicates [that] the sciatic (hamstring only) and femoral nerves are involved" and rated loss of strength impairment as 14 percent based on impairment to the "sciatic [nerve] (hamstring only)" and the "femoral [nerve] (quadriceps)." (Ex. 9-2). Combining this 14 percent impairment with 3 percent impairment for loss of range of motion measured by the medical arbiter and 5 percent impairment for claimant's surgery, the ARU awarded 20 percent scheduled permanent disability. (Ex. 9-3).

The insurer requested a hearing, contending that the medical arbiter's report was insufficient to rate muscle strength impairment because it did not identify the muscles involved. The ALJ agreed with the insurer, relying on *Anthony W. Abshire*, 52 Van Natta 635 (2000) (the claimant was not entitled to impairment for loss of strength where the medical 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), and *Melody R. Ward*, 52 Van Natta 241 (2000) (no award for loss of strength where medical arbiter measured loss of flexion strength in knee but failed to explain whether that loss was due to loss of muscle, nerve damage, disruption of musculotendinous unit, range of motion loss, or some other reason). The ALJ reasoned that, although under OAR 436-035-0007(19)(a) and (b)[2] it is appropriate to use current anatomy texts to determine which *nerve* innervates a particular muscle in order to rate muscle strength weakness, there is no similar rule that allows the fact finder to use an anatomy text or other source to determine which *muscle* is the source of strength loss. Instead, the ALJ found that medical evidence in the record must identify the weakened muscle. We agree with the ALJ's reasoning and offer the following supplementation.

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[1] Specifically, the ARU asked Dr. Anderson to respond to the following questions:

"Describe any MUSCLE STRENGTH loss, DUE TO THE ACCEPTED CONDITION(S), in the **0 - 5/5 method** (see table). Identify the specific body part and applicable peripheral nerve, nerve root, or muscle. Include a comment on whether the loss of strength is **due to** loss of muscle, nerve damage, disruption of the musculotendinous unit, range of motion loss, or other. If other, explain the etiology in detail." (Ex. 9-5 (emphasis in original)).

[2] OAR 436-035-0007(19) provides, in relevant part:

"To determine impairment due to loss of strength, the 0 to 5 international grading system and 0 to 5 method as noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. Revised, 1990** shall be used. The grade of strength shall be reported by the physician and assigned a percentage value from the table in subsection (a) of this section.

"(a) The grading shall be valued as follows:

"Grade	Description	Percent
"5/5:	The worker retains range of motion against gravity with full resistance applied.	0%
"* * * * *		
"4/5	The worker retains range of motion against gravity with some resistance applied.	20%

"* * * * *

"(b) The peripheral nerve or spinal nerve root which supplies (innervates) certain muscles may be identified by referencing current anatomy texts or the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. (Revised), 1990 or 4th Ed., 1993.**" (Bold in original).

On review, claimant argues that *Abshire* and *Ward* are distinguishable because the medical evidence in those cases did not refer to the specific muscles responsible for the alleged muscle weakness. In contrast, claimant argues that Dr. Anderson specifically identified the involved muscles here as "flexors and extensors" and linked the loss of strength to claimant's "torn medial meniscus and recovery period after surgery." (Exs. 8-3, -4). Claimant argues that Dr. Anderson's use of the terms "flexors and extensors" instead of "hamstrings and quadriceps" to identify the muscles involved is merely a question of "semantics" and, as such, does not render the medical arbiter's report inadequate to measure loss of strength. We disagree.

In *SAIF v. Alton*, 171 Or App 491 (2000), the court explained the burden of proof in the context of establishing entitlement to permanent disability benefits. The court noted that the burden of proving that an injury or occupational disease is compensable, and of proving the nature and extent of any disability resulting therefrom, is on the claimant. ORS 656.266. The court also noted that the claimant must meet his or her burden by a preponderance of the medical evidence. 171 Or App at 497. In explaining this standard, the court relied on OAR 436-035-0005(10) and ORS 656.005(19) and concluded that "[t]hose provisions indicate that, in order for a workers' compensation claimant to meet the applicable burden of proof, the evidence put forth by the claimant ordinarily must be composed of express findings, opinions, and reasoning of the treating physicians or medical arbiters." *Id.* at 498 (citations omitted).

The *Alton* court agreed with the general proposition that "experts generally need not express themselves with particular word choices," *i.e.*, experts need not use "magic words." *Id.* at 502 fn 6 (citation omitted). However, the court explained:

> "That does not mean, however, that the Board's factfinding role extends to supplying a medical opinion when the substance of the opinion is significantly in doubt because of the expert's failure to articulate it. *See SAIF v. Calder*, 157 Or App 224, 228 * * * (1998) ('The Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge.'); *Rolfe v. Psychiatric Security Review Board*, 53 Or App 941, 951 * * *, *rev den* 292 Or 334 * * * (1981) ('It is one thing, however, to say that an agency may employ its experience and expertise to evaluate and understand evidence and quite another to allow it to use its special knowledge as a substitute for evidence presented at a hearing.'). The fact remains that, in the workers' compensation area, the legislature expressly requires compensability and extent determinations to be made based on *preponderant medical* evidence. To meet that standard, a medical opinion must be expressed by the medical expert, even if less-than-artfully, rather than divined by the factfinder. *See generally Uris v. State Compensation Department*, 247 Or 420, 424 * * * (1967) (endorsing the 'settled rule' that where a worker's injuries are of such character as to require skilled and professional persons to determine the cause and extent thereof, the question is one of science and must necessarily be determined by testimony of skilled, professional persons). We endorse no more liberal standard of proof or liberal view of the Board's factfinding role in these cases." *Id.* (emphasis in original).

We proceed to apply the burden of proof as explained in *Alton* to the facts of this case. For purposes of determining injury-related permanent partial disability, 656.268(5)(a), ORS 656.283(7), and 656.295(5), require application of the "standards" for the evaluation of disabilities adopted by the Director. We have previously held that the standards may not be applied "loosely or by analogy," because they are specific and precise. *Terry W. Prater*, 43 Van Natta 1288, 1291 (1991); *see Kelly D. Mustoe*, 46 Van Natta 285, *aff'd mem Mustoe v. Career Management Consultants*, 130 Or App 679 (1994); *Ralph A. Neeley*, 42 Van Natta 1638, 1639 (1990).

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 at 244-45 (no statutory authority for an ALJ to remand to the Director for clarifying report from the medical arbiter regarding loss of flexion strength in knee where the medical arbiter failed to explain whether that loss was due to loss of muscle, nerve damage, disruption of musculotendinous unit, range of motion loss, or some other reason).

Finally, as noted in *Alton*, the court has determined that the Board is *not* an agency with specialized medical expertise entitled to take official notice of technical facts within specialized knowledge. *Calder*, 157 Or App at 228. Consequently, our findings must be based on a preponderance of medical evidence in the record. *Alton*, 171 Or App at 497; *Calder*, 157 Or App at 228; *Glen D. Oetken*, 52 Van Natta 1528 (2000). However, we may take administrative notice of facts "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *Calder*, 157 Or App at 227; *Jesse R. Walker*, 45 Van Natta 974 (1993); *Rodney J. Thurman*, 44 Van Natta 1572, (1992); *Susan Teeters*, 40 Van Natta 1115 (1988). A medical dictionary, when used to define medical terms, is such a source. *Calder*, 157 Or App at 227. On the other hand, we may not go beyond a dictionary definition to reach inferences that cannot be reasonably drawn from the medical evidence itself. *Id.* (Board went beyond the dictionary definition and beyond reasonable inferences that could be drawn from the medical evidence when it determined by use of a medical dictionary that the coracobrachial ligament was a ligament in the arm involved in flexion and, from that dictionary definition and the mention of the coracobrachial ligament in an operative report, determined that the claimant had suffered loss of arm strength).

Here, claimant's disability is addressed by the current standards. Specifically, OAR 436-035-0007(19)(a) and (b), as summarized above, and OAR 436-035-0230(9)[3] and (10)[4] apply to rate claimant's loss of strength. In order to apply these rules, however, we need to know the peripheral nerve(s) or the spinal nerve root(s) and the weakened muscle(s) involved. Thus, in addition to persuasive medical evidence that loss of strength is caused by the compensable injury and the measurement of that loss on a 0 to 5 scale, the rules also require the identification of the affected nerve(s) and the weakened muscle(s) to rate that loss.

Here, the affected nerve(s) are not explicitly identified in the medical record. Nevertheless, as the ALJ explained, OAR 436-035-0007(19)(b) allows us to use current anatomy texts or the *AMA Guides* to identify the peripheral nerve or spinal nerve root that supplies certain muscles. Therefore, our initial task is to determine whether the medical record sufficiently identifies the weakened muscle(s). In approaching this task, we emphasize, as has the court on multiple occasions, that we do not have the medical expertise to take official notice of technical facts; *e.g.*, to identify specific muscles by reference to their function. Therefore, evidence of specific weakened muscles must come from the medical record itself; *i.e.*, either from the attending physician or the medical arbiter.

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[3] OAR 436-035-0230(9) provides, in relevant part:

"Loss of strength in the leg or foot due to peripheral nerve injury is determined according to the specific peripheral nerve supplying (innervating) the weakened muscle(s) as described in the following table and as modified pursuant to OAR 436-035-0007(19).

"* * * * *

"Peripheral Nerve	Leg Impairment
"Femoral (Below the iliacus nerve)	30%
"Nerves to obturator Internus & Piriformis	10%
"Nerves to quadratus femoris "muscle/nerve to superior "gemellus muscle/obturator	10%
"Superior Gluteal	20%
"Inferior Gluteal	25%
"Sciatic (above hamstring innervation)	75%
"Sciatic (hamstring loss only)	40%
"Tibial Nerve (medial popliteal or "internal popliteal above knee)"	35%

[4] OAR 436-035-0230(10) provides, in relevant part:

"Valid loss of strength in the leg or foot, substantiated by clinical findings, shall be valued pursuant to section (9) of this rule as if the nerve supplying (innervating) the weakened muscle(s) was impaired. * * *"

Here, the only evidence of weakened muscles comes from Dr. Anderson, who identified the weakened muscles as "extensors" and "flexors." "Extensor" is defined as "a general term for any muscle that extends a joint." *Dorland's Illustrated Medical Dictionary* 594 (28th ed. 1994). "Flexor" is defined as "any muscle that flexes a joint." *Id.* at 639. Thus, Dr. Anderson's use of the terms "extensors" and "flexors" simply identifies the generic function of the referenced muscles, it does not identify the specific muscles themselves.

Moreover, although claimant argues that the terms "flexors and extensors" mean "hamstrings and quadriceps," he cites no source that we may use to define those terms in support of his argument. As noted above, a medical dictionary does not provide such a definition. Instead, claimant appears to rely on the ARU's statement that "Gray's Anatomy, 1995, indicates the sciatic (hamstring only) and femoral nerves are involved." (Ex. 9-2 (emphasis added)). However, as addressed above, the initial question that must be answered is whether the medical arbiter adequately identified the *weakened muscles*. Assuming, without deciding, that we may use an anatomy textbook such as *Gray's Anatomy* to identify specific leg muscles involved from the functional terms "flexors" and "extensors," our examination of *Gray's Anatomy* failed to produce any such specific identification. In addition, our examination of the chart of muscles in *Dorland's* also failed to produce identification of specific weakened leg muscles from the term "flexors" and "extensors." *Dorland's*, pages 1890-1903. To the contrary, the specific muscles in that chart beginning with the term "flexor" or "extensor" refer to the hands or feet, not the legs. *Dorland's*, pages 1892-93. Thus, definitional sources do not directly provide the information needed to identify the specific weakened leg muscles involved.

Our search for a source of information that we may take administrative notice of to define the "weakened muscles" involved in this case leads us to the conclusion that trying to identify specific weakened leg muscles from the functional terms "flexors" and "extensors" goes beyond simply seeking definitions of medical terms and drawing reasonable inferences from the medical evidence, and enters the realm of reaching medical conclusions on our own, a practice strictly forbidden by the court. *Calder*, 157 Or App at 228; *Alton*, 171 Or App at 497.

On this record, we find that the medical arbiter failed to adequately identify the weakened muscles and, therefore, did not report claimant's impairment in the manner required by the standards.[5] Thus, we rely, instead, on Dr. McNeill's impairment findings, which were ratified by claimant's attending physician, and show full strength of 5/5 in the lower extremities. (Exs. 3, 4). OAR 436-035-0007(14); *Rosemary Peterson*, 52 Van Natta 1552 (2000). Accordingly, claimant is not entitled to an impairment rating for loss of strength.

ORDER

The ALJ's order dated April 1, 2001 is affirmed.

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[5] Claimant also argues that *Darlene Corthell*, 52 Van Natta 126 (2000), supports a finding that she is entitled to impairment rating for loss of strength in her right knee even if she did not establish damage to a particular nerve or muscle. In *Corthell*, the question was whether the record was adequate to establish entitlement for loss of strength in the forearm where the medical arbiter found that the strength limitation was due to altered tendon dynamics within the carpal tunnel following a carpal tunnel release rather than any nerve or muscle injury. We found that, under OAR 436-035-0110(8)(a), which provided that "[v]alid loss of strength in the arm, forearm or hand, substantiated by clinical findings, shall be valued as if the peripheral nerve supplying (innervating) the weakened muscle(s) was impaired, pursuant to this section[,]" the claimant had proved a valid loss of strength meeting the standards for rating permanent impairment.

We find *Corthell* distinguishable. In *Corthell*, there is no indication that the medical record failed to adequately identify the "weakened muscle(s)" so that there was insufficient information to apply the standards. In other words, there, the medical arbiter apparently reported the claimant's impairment in the manner required by the standards and sufficiently identified the "weakened muscles."

In the Matter of the Compensation of
MARK BLANCHARD, Claimant
WCB Case No. 00-08739
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
Sheridan, Bronstein, et al., Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's injury claim for head, neck, back and left wrist conditions. On review, the issue is compensability.

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

Claimant was involved in a motor vehicle accident within the course and scope of his employment on July 24, 2000. (Ex. A1). As a result of that incident, claimant filed a claim for injuries to his head, neck, back, and left wrist. (Exs. 2; 10). On November 30, 2000, the insurer denied the claim. (Ex. 54). Claimant requested a hearing.

The ALJ determined that the July 24, 2000 motor vehicle accident resulted in injury to claimant that required medical services. Consequently, the ALJ set aside the insurer's denial.

The insurer does not dispute that claimant was involved in the July 24, 2000 motor vehicle accident (MVA). Nor does the insurer dispute that claimant was within the course and scope of his employment at the time of the accident. Rather, the insurer contends that claimant's post-accident medical services were not "required." Consequently, the insurer argues that the MVA did not result in a compensable injury. We disagree with the insurer's contention.

Both police and emergency medical personnel (EMT) were summoned to the accident scene. (Exs. A1; 1). At the scene, claimant reported moderate pain in his low and mid back, as well as left wrist pain. (Ex. 1). The EMTs noted tenderness and spasm along claimant's lumbar/thoracic spine, applied a cervical collar, and transported claimant to the emergency room. (*Id.*)

The following day, claimant was seen by Dr. Blessley (chiropractic physician). (Ex. 2). Dr. Blessley reported swelling on the left side of claimant's face and neck, as well as spasm in the muscles of his upper and mid back. (Ex. 4-2). Additionally, Dr. Blessley noted abrasion and contusion on claimant's left wrist. (*Id.*) Dr. Blessley assessed claimant's condition as: (1) "cervicothoracic sprain/strain/subluxation with associated myospasm;" (2) "lumbosacral sprain/strain/subluxation with associated myospasm;" and (3) "wrist strain/sprain." (Ex. 6). As a result of his assessment, Dr. Blessley recommended a treatment plan consisting of manipulation and home exercise. (*Id.*)

"Under ORS 656.005(7)(a), the harm, damage or hurt that is sufficient to amount to an 'injury' is one 'requiring medical services or resulting in disability or death.'" *K-Mart v. Evenson*, 167 Or App 46, 50 (2000). "The medical services need not be directed toward the cure of any existing, identifiable disease; diagnostic or other medical services will suffice." *Id.* (citing *Finch v. Stayton Canning Co.*, 93 Or App 168, 173 (1988)).

Here, claimant suffered sufficient harm from the MVA to warrant EMT transportation to the emergency room, as well as the commencement of medical treatment from Dr. Blessley. Consequently, we conclude that claimant "required" medical services as a result of the July 24, 2000 MVA. In other words, we conclude that the MVA caused a compensable injury.

We acknowledge that Dr. Schilperoort, an insurer-arranged medical examiner, opined that claimant incurred little, if any, injury as a result of the MVA.[1] (Ex. 53-8). Dr. Schilperoort based his opinion largely on his belief that: (1) claimant's pain levels were disproportionate; and (2) claimant had

[1] Dr. Schilperoort's examination was performed on November 8, 2000, over three months after the date of the MVA. (Ex. 53).

psychological problems. (*Id.*) However, in rendering his opinion, Dr. Schilperoort did not expressly question either the observations or medical judgment of the EMTs in transporting claimant to the emergency room. Nor did Dr. Schilperoort expressly question the observations or medical judgment of Dr. Blessley in beginning claimant on a course of conservative care. Consequently, even if we assume that claimant has psychological problems and exaggerated his levels of pain, we are unable to conclude, in light of the observations of the EMTs and Dr. Blessley, that claimant's post-MVA medical services were not "required."

Based on this record, we agree with the ALJ that the July 24, 2000 MVA resulted in injury to claimant that required medical services. Accordingly, the claim is compensable. 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 $1,000, 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.

ORDER

The ALJ's order dated March 19, 2001 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

In the Matter of the Compensation of
STEVEN C. BOLING, Claimant
WCB Case Nos. 01-00030 & 00-06146
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Gene L. Platt, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) modified the July 21, 2000 Order on Reconsideration to set aside the insurer's April 27, 2000 Notice of Closure as premature; and (2) modified the December 7, 2000 Order on Reconsideration to set aside the insurer's September 6, 2000 Notice of Closure as premature. The insurer also objects to the admission of Exhibit 58a. On review, the issues are evidence, premature closure, and, potentially, temporary disability and extent of scheduled permanent disability.

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

The insurer objects to Exhibit 58a, an August 29, 2000 Opinion and Order by a prior ALJ, on the grounds that it was not included in the exhibit lists. In the alternative, the insurer objects to the inclusion of Ex. 58a in WCB Case No. 01-00030 because it was not included in the reconsideration record. *See* ORS 656.283(7). We disagree.

Exhibit 58a was admitted at hearing without objection. (O&O at 1). In those circumstances, we will not address an evidentiary argument on review. *See Fister v. South Hills Health Care*, 149 Or App 214, 218-219 (1997), *rev den* 326 Or 389 (1998) (because the carrier did not object to the claimant's testimony at hearing, the Board should not have addressed its argument on review that the testimony was inadmissible pursuant to ORS 656.283(7)) .

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 438-010-015(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 16, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
KAREN K. DAGIT, Claimant
WCB Case No. 99-09129
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Martha Brown's order that upheld the SAIF Corporation's "de facto" denial of claimant's occupational disease claim for an L5-S1 condition. On review, the issue is compensability.

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

The ALJ upheld SAIF's denial of claimant's occupational disease claim for an L5-S1 condition. On review, claimant does not contest the ALJ's decision that she failed to establish a compensable occupational disease claim on the merits. Rather, claimant contends that the ALJ did not have "subject matter jurisdiction" to determine the compensability of SAIF's "de facto" denial of the occupational disease claim because she did not raise her occupational disease claim until closing argument. We disagree, for the following reasons.

We begin with a summary of the procedural posture of this case. On November 18, 1999, claimant's former counsel filed a hearing request contesting SAIF's November 17, 1999 current condition denial. (Ex. 37). A WCB Case number was assigned to the request and a hearing was scheduled for May 25, 2000. (*Id.*)

On April 6, 2000, prior to the scheduled hearing, claimant's former counsel filed an occupational disease claim with SAIF for L4-5 and L5-S1 disc herniations, referencing the assigned hearing and WCB Case number on the cover letter. (Ex. 39). The May 25, 2000 hearing was postponed at claimant's former counsel's request because the 90 day period for SAIF's response to the April 6, 2000 occupational disease claim had not yet expired. (Hearing file).

SAIF did not accept or deny the claim. On July 31, 2000, after the statutory period for SAIF to respond to the occupational disease claim had passed, the hearing was rescheduled for October 5, 2000. (*Id.*)

Instead of proceeding to hearing on that date, the parties requested that the matter be decided on the written record with written closing arguments. (*Id.*) In the October 18, 2000 written closing argument submitted by claimant's former counsel, he identified the issues as follows: "Claimant appealed SAIF's 11/17/99 denial of aggravation of her 9/30/96 injury claim. She also has alleged de facto denial of an occupational disease claim for her L5-S1 condition. Claimant withdraws her appeal of the 11/17/99 denial, and proceeds on the sole remaining issue: the compensability of her occupational disease claim * * *." (*Id.*) SAIF did not submit a responsive written argument.

Prior to the record closing, claimant's former counsel withdrew. On January 5, 2001, claimant retained new counsel to represent her in this matter. (*Id.*)

The record closed as of February 2, 2001, upon the ALJ's receipt of a letter from claimant's present counsel indicating that SAIF had not filed its written closing argument. (*Id.*) Based on the written record, the ALJ found claimant's occupational disease claim not compensable.

We note initially that claimant did not raise this "jurisdictional" issue until review. We generally do not consider issues that are raised for the first time on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing).

An exception to this general rule is made for matters involving subject matter jurisdiction. *See Schlect v. SAIF*, 60 Or App 449 (1982) (subject matter jurisdiction may be raised at any time during the course of litigation). Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry. It exists when a statute authorizes that body to do something about the dispute; an ALJ's erroneous exercise of that authority does not deprive him or her of subject matter jurisdiction. *SAIF v. Roles*, 111 Or App 597 (1992). Where a denial is based on the ground that a condition is not compensable, *i.e.*, causation is at issue, the Board has jurisdiction. Thus, we conclude that the ALJ had subject matter jurisdiction over compensability of claimant's occupational disease claim.

Claimant, however, challenges the ALJ's decision to address the compensability issue because it was not timely raised. We have consistently held that an issue raised for the first time during closing argument should not be addressed by the ALJ. *See Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995); *see also Mark A. Klouda*, 51 Van Natta 265 (1999) (where the parties elect to present their case based on the documentary record, we interpret the presentation of that record as the "hearing," and we will not consider an issue raised for the first time in closing argument); *Cindy M. Penturf*, 50 Van Natta 1718 (1998) (same).

Although the occupational disease claim was not raised in claimant's original request for hearing, by means of the subsequent occupational disease claim and postponement of the hearing to allow the 90-day period to process the occupational disease claim to run, the compensability of claimant's occupational disease claim became an issue "consolidated" with the prior hearing request's "current condition" denial issue. In effect, claimant filed a supplemental hearing request and there was a consolidated hearing. As a consequence, the occupational disease claim was ripe for adjudication and was properly before the ALJ for hearing on October 5, 2000.

Moreover, when the parties agreed to submit the case on the written record, neither party attempted to limit the issues. To the contrary, claimant's written closing argument indicates that all issues were litigated and that claimant was withdrawing one of the issues. Consequently, unlike the new issues raised in *Millsap*, *Klouda*, and *Penturf*, the issue of claimant's occupational disease claim in the present case was not a "new" issue, but was an issue that had already been placed before the ALJ by virtue of claimant's letter to SAIF and her hearing postponement. *See Pacific Motor Trucking v. Yeager*, 64 Or App 28 (1983). Under such circumstances, the facts of *Millsap* and its progeny are distinguishable from those in the present case.

Finally, because the parties proceeded to litigate the compensability of the occupational disease issue, claimant waived any timeliness challenge to the claim. It would be improper for the Board to decide the issue now. *See Weyerhaeuser v. Bryant*, 102 Or App 432, 435 (1990); *Thomas v. SAIF*, 64 Or App 193 (1983). In other words, even if this particular issue is characterized as "jurisdictional," we still decline to address the issue, based on claimant's failure to raise a challenge to the occupational disease claim at hearing.

ORDER

The ALJ's order dated March 30, 2001 is affirmed.

In the Matter of the Compensation of
JANET F. TILLITT, Claimant
WCB Case No. 99-08887
ORDER DENYING RECONSIDERATION
Sheridan, Bronstein, et al., Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

Claimant, *pro se*, requests reconsideration of our June 19, 2001 order affirming the Administrative Law Judge's (ALJ's) order that upheld the insurer's *de facto* denial of her injury claim for a L4-5 disc condition. Because we find that our prior order has become final, we lack authority to reconsider our June 19, 2001 order.

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).

Here, the 30th day following our June 19, 2001 Order on Review was July 19, 2001. Claimant did not clarify that she was requesting reconsideration of this order until July 20, 2001.[1] By that time, the 30-day period in which the Board could reconsider its June 19, 2001 order had expired.

Because our June 19, 2001 order has not been stayed, withdrawn, modified or appealed within 30 days of its mailing to the parties, we are without authority to alter our prior decision. *See* ORS 656.295(8); *International Paper Co. v. Wright*, 80 Or App at 447; *Fischer v. SAIF*, 76 Or App at 659; *Darlene E. Parks*, 48 Van Natta 190 (1996); *see also Barbara J. Cuniff*, 48 Van Natta 1032 (1996) (although motion was hand-delivered to the Board's Portland office on the 30th day, the statutory period had expired by the time the motion was brought to the Board's attention). Consequently, claimant's motion for reconsideration is denied.

IT IS SO ORDERED.

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[1] In a July 8, 2001 letter, claimant requested that we "review all exhibits again." However, claimant's letter expressly referred to WCB Case No. 00-09581, which coincided with an ALJ's June 20, 2001 order. In light of such circumstances, claimant's letter was processed as a request for Board review of the ALJ's June 20, 2001 order in WCB Case No. 00-09581. It was not until July 20, 2001 that claimant clarified that it was this case (WCB Case No. 99-08887) in which she was requesting further review. By that time, our authority to further consider our June 19, 2001 order had expired.

Finally, even if claimant's July 8, 2001 letter had been initially interpreted as a motion for reconsideration, today's decision would be unchanged. Our statutory authority to reconsider a prior decision is not premised on when a motion for reconsideration is filed. Instead, our authority is contingent on our issuance of another order (be that an abatement, reconsideration, amended, or any other order) prior to the expiration of the 30-day statutory period. Thus, regardless of when a motion for reconsideration is filed, the 30-day statutory period continues to run unless a Board order is withdrawn, abated, or reconsidered. *See Cynthia J. Thiesfeld*, 51 Van Natta 1420 (1999); *Darlene E. Parks*, 48 Van Natta 190 (1996). Here, because our June 19, 2001 order was not withdrawn, abated, modified, or reconsidered by July 19, 2001, our statutory authority to reconsider the June 19, 2001 order has expired. Moreover, even if we had statutory authority to reconsider, further review of the record does not cause us to alter our prior order. In other words, further review of the exhibits does not change our determination that the ALJ correctly upheld the insurer's *de facto* denial of claimant's injury claim for a L4-5 disc condition.

In the Matter of the Compensation of
JOY M. WALKER, Claimant
WCB Case No. 00-07085
ORDER ON REIVEW
Fontana & Takaro, Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) dismissed her request for hearing as untimely; (2) upheld the self-insured employer's denial of her L5-S1 disc herniation; and (3) declined to award penalties for the employer's allegedly unreasonable denial. In her brief, claimant requests remand to address compensability of her claim as an occupational disease. On review, the issues are the propriety of the dismissal, remand, compensability and penalties. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Dismissal

We adopt and affirm that portion of the ALJ's order that granted the employer's motion to dismiss, with the following change and supplementation. In the fourth full paragraph on page 3, we delete the second sentence.

The ALJ concluded that claimant's injury claim was not timely filed pursuant to ORS 656.265, and the employer did not have sufficient knowledge of an injury that would have led it to conclude that workers' compensation liability was a possibility.

Claimant argues that the employer had sufficient knowledge of the November 22, 1999 injury to satisfy the requirements of ORS 656.265. She contends that her testimony establishes that she timely notified her supervisor of the back and leg pain she suffered as a result of lifting a patient on November 22, 1999.

Although the ALJ did not make any demeanor-based credibility findings regarding claimant's testimony, he found that her testimony was inconsistent and he did not rely on it. In concluding that claimant did not tell her employer that she hurt her back lifting a patient within 90 days of the incident, the ALJ found that claimant was not a reliable witness. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). On *de novo* review, we agree with the ALJ that claimant did not notify her employer that she injured her back lifting a patient within 90 days of the November 22, 1999 incident.

Claimant contends that ORS 656.265(4) requires only that an injury claim be filed within one year of the date of injury. According to claimant, the ALJ erred in holding that the employer must have knowledge of the injury within 90 days of the accident.

ORS 656.265 provides, in part:

> "(1) Notice of an accident resulting in injury or death shall be given immediately by the worker or dependent of the worker to the employer, but not later than 90 days after the accident. * * *
>
> "* * * * *
>
> "(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:

"(a) The employer had knowledge of the injury or death[.]"

The ALJ found, and we agree, that claimant did not inform her employer that she injured her back lifting a patient at work within 90 days of the November 22, 1999 incident. In *Keller v. SAIF*, 175 Or App 78 (2001), a case decided after the ALJ's order was issued, the court interpreted ORS 656.265(4)(a) and held that an employer must have knowledge of the injury within the 90-day period for filing notice of the claim. The court rejected the claimant's argument that the knowledge requirement could be satisfied if the employer learns of the injury any time within one year after the date of the accident. *See also Jeffrey E. Henderson*, 50 Van Natta 2340 (1998) (ORS 656.265(1) and (4)(a) bar a claim unless "notice" of the claim is given within one year of the accident and the employer had "knowledge" of the injury or condition within 90 days). Claimant's argument regarding the interpretation of ORS 656.265(4) is not persuasive.

Remand / Occupational Disease Claim

Claimant asserts that the ALJ failed to address compensability of her herniated disc as an occupational disease. She contends that the timeliness requirements of ORS 656.265 do not apply to occupational disease claims and she requests remand for the ALJ to address compensability as an occupational disease.

The ALJ framed the issues at hearing as a claim for a herniated disc as a result of a November 22, 1999 injury, or alternatively, as an occupational disease resulting from claimant's work activities lifting patients. Although the ALJ found that claimant's injury claim was not timely filed, he did not address the occupational disease claim.

The parties presented evidence regarding both theories of injury and occupational disease. Furthermore, the ALJ addressed credibility in that he found that claimant's testimony was inconsistent and he did not rely on it. Under these circumstances, the case has not been "improperly, incompletely or otherwise insufficiently developed" pursuant to ORS 656.295(5), and we find no compelling reason to remand to the ALJ. Consequently, we deny claimant's request for remand.

There is no argument that claimant's occupational disease claim was untimely. *See* ORS 656.807. To establish compensability as an occupational disease, claimant must establish that her employment conditions were the major contributing cause of her L5-S1 disc herniation. ORS 656.802(2)(a). Claimant relies on the opinion of her treating surgeon, Dr. Kuether.

Dr. Kuether examined claimant on one occasion before he performed surgery. On August 3, 2000, he reported the following history:

> "[Claimant] is a 30-year-old female employed as a certified nursing assistant who injured her back last November. At that time, she developed radiating pain in her right lower extremity and back pain. She was seen at that time for this and was treated conservatively with anti-inflammatory medications. The discomfort improved somewhat and she continued to work. However now in the recent past, the pain has gotten significantly worse with associated numbness and near constant discomfort in the right lower extremity." (Ex. 8-1).

Dr. Kuether diagnosed a right L5-S1 disc herniation and performed surgery on August 23, 2000. (Exs. 8, 9).

In a November 28, 2000 letter, Dr. Kuether responded to questions from claimant's attorney. (Exs. 13, 14). He referred to his history of claimant's back injury and found that claimant's November 22, 1999 work incident was a "contributing cause" of her L5-S1 disc herniation and need for surgery. (Ex. 14-2). He responded to claimant's attorney's question about an occupational disease theory, explaining:

> "With regard to the question of whether [claimant's] working conditions or a series of traumatic events or occurrences at work [were] the major contributing cause, either of the L5-S1 disc herniation or of a material worsening of the L5-S1 disc herniation for which [claimant] required surgery, once again the answer to this question would be yes. This type of activity would make any person prone to these sort of injuries. Once a disc herniation has occurred resulting in a radiculopathy, many times these symptoms will improve with conservative therapy as happened with [claimant]. However, a return to

> these activities with resulting symptoms can easily occur. Due to the size of her disc herniation I am amazed that she did clinically improve following the initial event. It would be easy to concede that any additional activity could easily reexacerbate the painful radiculopathy that she had. Some patients can avoid surgery following disc herniations if they clinicially resolve; however, if these symptoms recur after an increase in the activity level, many require surgery for removal of the disc herniation." (*Id.*)

For the following reasons, we find that Dr. Kuether's opinion is not sufficient to establish compensability of claimant's disc herniation as an occupational disease. First, we are not persuaded that Dr. Kuether had an accurate understanding of claimant's medical treatment for her back after the November 22, 1999 work incident. Claimant sought treatment from the emergency room on November 28, 1999. The report referred generally to claimant's occupation as a CNA, which involved lifting patients (Ex. 3A-1), but there is no mention of a specific lifting incident at work. (Exs. 3A, 3B). Dr. Wiebe examined claimant on December 10, 1999, and reported that she had left leg symptoms and she was "not sure when this happened." (Ex. 4-1, -2). He reported that claimant had no foot drop and her SLR was normal. (Ex. 4-1). Dr. Wiebe diagnosed an acute lumbar strain and specifically noted that he "[did] not think she has a disc." (*Id.*)

We find no evidence that Dr. Kuether had the opportunity to review Dr. Wiebe's December 10, 1999 chart note. Dr. Kuether believed that claimant initially developed radiating pain in her *right* lower extremity after a specific incident on November 22, 1999 (Exs. 8, 14), which is inconsistent with Dr. Wiebe's December 10, 1999 chart note. Moreover, Dr. Kuether's conclusion that claimant sustained a disc herniation on November 22, 1999 is inconsistent with Dr. Wiebe's December 10, 1999 comments that claimant had a strain without any disc involvement.

In addition, there is no evidence that Dr. Kuether reviewed claimant's July 2000 medical reports. Claimant reported on July 21, 2000 that she developed low back and right leg pain after a coughing spell. (Ex. 4D). Part of a July 24, 2000 chart note referred to "[right] hip pain since Dec. 1999[,]" but another part of that chart note referred to right leg pain for 3 months. (Ex. 5). Dr. Wiebe first mentioned concern about a disc problem when he examined claimant on July 29, 2000. (Ex. 6).

Dr. Kuether did not discuss the inconsistencies with his history of claimant's symptoms and the aforementioned chart notes. We find that Dr. Kuether did not have an accurate understanding of claimant's previous medical reports and treatment and, therefore, his causation opinion 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).

Furthermore, we find that Dr. Kuether's comments about claimant's occupational disease claim are confusing and inadequately explained. Without describing the nature of claimant's job duties, he simply reported that "[t]his type of activity would make any person prone to these sort of injuries." (Ex. 14-2). Although he believed that claimant's disc herniation occurred on November 22, 1999, he said "[d]ue to the size of her disc herniation I am amazed that she did clinically improve following the initial event." (*Id.*) Dr. Kuether's opinion is not well-reasoned and lacks adequate explanation. In addition, we are not persuaded by Dr. Kuether's opinion on causation because it was not based on an accurate history.

The only other opinion on causation is from Dr. Dietrich, who performed a records review on behalf of the employer. Dr. Dietrich reported that claimant's disc extrusion most likely occurred with the July 21, 2000 coughing episode. (Ex. 17-4). His opinion does not support compensability under an occupational disease theory. We conclude that the medical evidence is insufficient to establish that claimant's work activities were the major contributing cause of her L5-S1 disc herniation.

Penalties

Claimant contends that she is entitled to penalties for the employer's allegedly unreasonable denial. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Therefore, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated March 5, 2001 is affirmed.

In the Matter of the Compensation of
VITALIY A. DIKOV, Claimant
WCB Case No. 00-08904
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Meyers. Member Meyers chose not to sign the order.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the insurer's denial of claimant's thoracic condition; (2) declined to assess a penalty for an allegedly unreasonable denial; (3) declined to assess a penalty for an allegedly untimely denial; and (4) declined to award temporary disability. On review, the issues are compensability, penalties, and temporary disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant compensably injured his mid-back on June 16, 1999, when he was pushing upward on a 4-foot crowbar while performing his job as a welder. On August 6, 1999, the insurer accepted a thoracic sprain. (Ex. 3).

Dr. Carvalho treated conservatively and claimant received ongoing chiropractic treatments from Dr. Baker. Claimant continued to perform his regular job. However, his condition did not improve. On February 4, 2000, claimant felt a crack in his back while sleeping that resulted in increased pain. He apparently reported to work that day, but was unable to continue and sought emergency medical care. (Ex. 6). He has not returned to work since that day.

X-rays of his thoracic spine taken on February 23, 2000 showed no abnormalities, including no significant degenerative disease. (Ex. 6A).

On March 10, 2000, claimant was examined for the insurer by Dr. Duncan, chiropractor, and Dr. Neumann, a physician. They diagnosed a thoracic strain with persistent symptoms and recommended ruling out a disc or a compression fracture. (Ex. 7).

On March 22, 2000, Dr. Carvalho released claimant to modified work. (Ex. 7A).

On March 29, 2000, claimant underwent an MRI of his thoracic spine. (Ex. 8).

Dr. Hill, neurosurgeon, examined claimant on April 10, 1999. (Ex. 10).

On April 14, 2000, Dr. Long, a physician, examined claimant on referral from Dr. Hill. Dr. Long diagnosed a T8-9 thoracic disc injury. (Ex. 11). On June 28, 2000, Dr. Long took claimant off work. (Exs. 12, 12A).

On August 21, 2000, claimant requested acceptance of a central T8-9 disc herniation as an "omitted medical condition." (Ex. 13). The insurer received this letter the next day.

Claimant continued to treat with Dr. Long, but his condition did not improve. Dr. Long referred claimant to Dr. Slack for a thoracic discography. (Ex. 14). The discography was performed on December 5, 2000. (Ex. 18).

On January 31, 2001, Dr. Young reported on his review of four imaging studies performed on claimant. (Ex. 16).

On February 12, 2001, the insurer denied claimant's T8-9 herniated disc claim. (Ex. 17). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

Upon finding that claimant did not have a disc herniation at the T8-9 level, but only had a disc bulge/protrusion that was clinically insignificant and without nerve root compression, the ALJ concluded that claimant had failed to prove compensability. Claimant asserts that Dr. Long diagnosed a disc lesion at T8-9 and that his opinion is sufficient to prove compensability. The insurer contends that claimant's mild T8-9 disc bulge was neither work-related nor the source of claimant's symptoms. We disagree with the insurer's contention.

Claimant had an accepted claim for a thoracic sprain due to an injury on June 16, 1999. His mid-back condition failed to improve, and, on March 10, 2000, Dr. Duncan and Dr. Neumann, who examined claimant for the insurer, diagnosed his condition as a thoracic strain by history, but recommended a thoracic CT scan to rule out the possibility of an underlying compression fracture and/or disc pathology. (Ex. 7-6). Apparently, this CT scan was not performed.

On March 29, 2000, claimant underwent an MRI of his thoracic spine area, which was interpreted by Dr. Morgan as normal with only a mild disc bulge without nerve root compression. (Ex. 8). On April 10, 2000, Dr. Hill evaluated claimant, but was at a loss to explain his symptoms. (Ex. 10). Dr. Hill referred claimant to Dr. Long for evaluation of the mid-back pain that dated from the June 16, 1999 work injury. Dr. Long interpreted the MRI sagittal images as showing a posterior disc lesion at T8-9, with some migration of herniated nuclear material behind the superior posterior aspect of T9, the axial sections demonstrating a small central disc herniation producing a little thecal impression but no cord impression, and the axial sections indicating a central area of high intensity. (Ex. 11-3). On December 5, 2000, Dr. Slack performed a thoracic discography that confirmed a T8-9 disc injury. (Ex. 15B-1). Thus, the medical record indicates that claimant has been diagnosed with a T8-9 disc lesion by two physicians.[1]

Accordingly, the causation issue (as opposed to the question of diagnosis) must be resolved. *Stewart E. Myers*, 41 Van Natta 1985 (1989). Because of multiple potential causal factors, this issue is of sufficient medical complexity to require expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). It is claimant's burden to prove that his T8-9 herniated disc is compensable.

Medical opinions regarding causation are provided by Dr. Duncan, chiropractor, Dr. Young, radiologist, and Dr. Long, claimant's current treating physician. When there is a dispute between medical experts, more weight is given to those medical opinions that are well-reasoned and based on complete medical information. *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).

Dr. Duncan reviewed the March 29, 2000 MRI scan. He agreed with the radiologist that claimant had only a mild disc protrusion that was probably degenerative and unrelated to "any motor vehicle accident." (Ex. 15). Dr. Duncan's report is confusing[2] and conclusory and is, therefore, not persuasive.

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[1] We note that the lack of a definitive diagnosis does not per se defeat the claim, *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1998), nor is it a necessary predicate to compensability that the medical experts know the exact mechanism of the disease. *Robinson v. SAIF*, 78 Or App 581 (1986); *Candace M. Griffin*, 42 Van Natta 624 (1990).

[2] Dr. Duncan identified the radiologist as "Dr. Hill." The radiologist who interpreted the March 29, 2001 MRI was Dr. Morgan. (Ex. 8). Claimant's injury of June 16, 1999 resulted from his manipulation of a crowbar at work, not from a motor vehicle accident.

Dr. Young reviewed three imaging studies of the thoracic spine[3] and concluded that claimant had a small T8-9 disc bulge that showed moderate degenerative disc desiccation. He emphasized that the bulge was not sufficient to be a disc herniation and did not compress the spinal cord or adjacent neural structures. He explained that it took 18 months to two years to see the earliest possible changes of degenerative disc desiccation. Thus, based on the MRI, he opined that the degenerative disc bulge at T8-9 predated the June 16, 1999 injury and was not causally related to that injury. Dr. Young also opined that the degeneration at T8-9 probably combined with the June 16, 1999 injury to cause claimant's need for treatment, but that the major contributing cause of the combined condition, disability and need for treatment was the preexisting degenerative disease at T8-9 and not the injury. (Ex. 16-3).

In contrast to Dr. Young, Dr. Long opined that the major contributing cause of claimant's T8-9 disc injury was the work incident of June 16, 1999. Dr. Long explained that the mechanism of injury produced sustained loading of the thoracic and lumbar spines, maximal at the apex of the thoracic curve. Dr. Long reasoned that claimant's acute mid-dorsal symptoms must have been the result of a central posterior T8-9 disc injury on June 16, 1999, as there was no history of prior symptoms and no demonstrated chronic bone changes at T8-9 or any other thoracic level prior to that time. Dr. Long opined that it was highly probable that claimant did not have preexisting changes in the mid-thoracic spine prior to the work incident on June 16, 1999. (Ex. 18-2).

After reviewing Dr. Young's report, Dr. Long deferred to Dr. Young's opinion about how rapidly dessication can develop in an intervertebral disc. Nevertheless, Dr. Long disagreed with Dr. Young's opinion that the major contributing cause of claimant's condition was the mild dessication of the T8-9 disc, as he reasoned that that view was inconsistent with Dr. Young's opinion that the T8-9 disc was not the cause of claimant's current symptoms. Dr. Long continued to opine that, even if claimant had mild dessication of the T8-9 disc prior to the June 16, 1999 incident, the major contributing cause of claimant's current symptoms, disability and need for treatment was the traumatic injury to the disc in that incident. (Ex. 20-2). Because Dr. Long's opinion is better reasoned and is based on a more complete factual basis, we find it more persuasive than that of Dr. Young. *See Somers*, 77 Or App at 263. Consequently, we conclude that claimant has established that his T8-9 disc herniation is compensable. We reverse that portion of the ALJ's order that upheld the insurer's denial.

Temporary Disability Compensation

Commencing December 2, 1999

The ALJ concluded that claimant was not entitled to temporary disability compensation as of December 2, 1999 because the authorization was provided by claimant's chiropractor, who was at that time no longer serving as an attending physician. Although claimant raised this issue on review, he concedes in his brief that the ALJ correctly decided this matter.

Commencing February 4, 2000

The ALJ also concluded that claimant was not entitled to temporary disability compensation based on the February 23, 2000 report by claimant's former attending physician, Dr. Carvalho, because nothing in that report indicated that she was taking claimant off work and authorizing temporary disability. On review, claimant contends that Dr. Carvalho's report is sufficient to authorize time loss compensation. We agree.

Temporary disability is not due and payable "for any period of time not authorized by the attending physician." ORS 656.262(4)(g). Here, we find that, although Dr. Caravalho stated that claimant "continues to be off work and says he is not able to work even a few hours a day because of pain," the attending physician did not authorize temporary disability. Dr Caravalho did not state that claimant's ability to work was limited in any way. Rather, she ordered a PCE to determine the level of his ability to work. (Ex. 6). At claimant's follow-up visit on March 22, 2000, Dr. Caravalho released claimant to medium work, based on the PCE. (Ex. 7A).

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[3] These imaging studies consisted of x-rays of the thoracic spine taken on July 6, 1999 and February 24, 2000; and an MRI taken on March 29, 2000. (Ex. 16).

Under these circumstances, we do not interpret Dr. Caravalho's February 23, 2000 report as authorizing temporary disability. *Kerry Nguyen*, 52 Van Natta 688 (2000) (the claimant was not entitled to temporary disability benefits for period not authorized by attending physician; Board declined to "infer" entitlement from medical record); *Marilyn D. Monroe*, 52 Van Natta 432 (2000) (Board rejected ALJ's reasoning that attending physician "impliedly" authorized temporary disability; instead, Board found the claimant entitled to temporary disability only for the single day actually authorized by the attending physician). Thus, we affirm that portion of the ALJ's order that did not award temporary disability based on Dr. Caravalho's February 23, 2000 report.

Penalties

Unreasonable Denial

The ALJ declined to assess a penalty for the insurer's denial of claimant's T8-9 herniated disc claim, reasoning that, because claimant had not established compensability, the insurer had a legitimate doubt about the compensability of the condition. Although we have concluded that claimant's T8-9 disc condition is compensable, we nevertheless decline to assess a penalty for an allegedly unreasonable denial.

In determining whether a delay or refusal to pay compensation is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Co.*, 93 Or App 588, 591 (1988); *Errol L. Schrock*, 52 Van Natta 1888 (2000). Here, at the time of the insurer's February 12, 2001 denial of claimant's T8-9 disc claim, the insurer had obtained the November 15, 2000 report of Dr. Duncan, who diagnosed a mild disc protrusion at T8-9 that was probably degenerative and unrelated to the work incident, and the January 31, 2001 report of Dr. Young, who stated that the major contributing cause of claimant's need for treatment and disability of his combined condition was not the June 16, 1999 work injury. Based on those circumstances, we find that the employer had a legitimate doubt as to the compensability of claimant's T8-9 herniated disc as an injury or "combined condition" claim at the time of its denial.

Delay in Accepting or Denying Within 90-Day Period

The ALJ concluded that the insurer's delay was unreasonable and that a 25 percent penalty was warranted. However, the ALJ did not assess a penalty, determining that no amounts were then due on which to assess a penalty. The ALJ's decision was premised on the upholding of the insurer's denial. Because we have reversed the ALJ's compensability decision, we likewise reverse this portion of the ALJ's penalty decision.

Because the insurer offered no excuse or justification for its delay in processing claimant's "new medical condition" claim for almost six months, we assess a 25 percent penalty. This penalty shall be assessed on the compensation "then due" as of the date of hearing (February 26, 2000) as a result of our conpensability decision.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 28, 2001 is reversed in part and affirmed in part. That portion of the order upholding the insurer's denial of claimant's T8-9 disc condition is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for the payment of benefits according to law. That portion of the ALJ's order that declined to assess a penalty for an untimely denial is reversed. The insurer is assessed a penalty equal to 25 percent of the compensation due as of February 26, 2000 as a result of our order, to be paid in equal shares to claimant and his counsel. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, payable by the insurer.

In the Matter of the Compensation of
CYNTHIA L. MOLINA
WCB Case No. CV-01001
ORDER ON REVIEW (CRIME VICTIMS' ACT)

Applicant has requested review by the Workers' Compensation Board of a Determination Order dated December 19, 2000, as reconsidered on February 2, 2001, issued by the Department of Justice Crime Victims' Assistance Section (Department). By these orders, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on its finding that applicant was not the victim of a compensable crime.

In her request for review, applicant argued that her claim should be covered under the Compensation of Crime Victims Act (Act). Following our receipt of the request for review, applicant was advised that she was entitled to a fact finding hearing before a Special Hearings Officer. To exercise her right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed her copy of its record. In addition, if applicant chose not to request a hearing, she was provided the opportunity to submit written argument within 30 days from the date the Department mailed her copy of its record. The Department was also provided the opportunity to submit written argument. The Department mailed a copy of its record to applicant on May 11, 2001. Having received no hearing request or further written argument from applicant or the Department, we have conducted our review based solely on the written record. See OAR 438-82-030(2).

The standard for our review under the Act is *de novo*, based on the entire record. ORS 147.155(5); *Jill M. Gabriel*, 35 Van Natta 1224, 1226 (1983). Based on our *de novo* review of the record, we make the following findings.

FINDINGS OF FACT

On August 6, 1999, at about 9:30 p.m., applicant was stopped at a traffic signal at an intersection in Lake Oswego when her car was struck from behind by another car. (Ex. B1-6-7). Applicant may have started to move forward when the collision occurred. (Ex. B1-6). It was raining at the time and the road was wet. (Ex. B1-2). Applicant did not see the car coming but heard the sound of it attempting to stop. (Ex. B1-6). The impact pushed applicant's car into the intersection. Due to the volume of traffic at the intersection, applicant drove to the next traffic light and turned left onto an intersecting roadway. She did this to get the other driver's information. (*Id.*)

Applicant saw the car that struck her proceed east on the road from which she had turned off. This car had front-end damage, broken headlights, and the engine was smoking. Applicant turned back onto the road and caught up to the car, which was stopped at a red light. Applicant got behind the car and began to flash her high beams and honk her horn. Applicant turned on her right turn signal to signal the other driver to pull over. Applicant continued to follow the car attempting to get the driver to pull over. Applicant reported witnessing several traffic violations by the driver while she followed the car. Applicant found it too dangerous to continue following the car and discovered that she had severe pain when turning her head. (Ex. B1-6-7). Applicant stopped at a store, telephoned 911, and was taken to OHSU by ambulance.

A witness (Mr. Richmond) also reported the collision. (Ex. B1-3, -5). Mr. Richmond reported that the car that struck applicant had earlier almost struck him and a guardrail. He reported that both cars paused for a minute after the collision, then drove through the intersection and down the road. He did not see where applicant's car went, but saw the car that almost struck his car continue driving east. He reported that the car went over the curb on the right side of the road and drove with its right tires on or near the grass. He gave the police officer the license plate number of the car and described the driver and the damage to the car. (Ex. B1-5). The police were unable to locate the car that night.

On August 7, 1999, at about 7:30 p.m., Ms. Diana Atkins went to the Lake Oswego Police Department and reported her involvement in the collision. (Ex. B1-4-6). She reported that she hit another car from behind the night before. She reported that it was raining and wet and she could not stop and slid into the back of a car that was stopped at a light. (Ex. B1-5). She reported that she did not know where the collision occurred. She could not remember her speed, nor could she estimate it.

She reported that both cars sat for a minute, then the other car drove off and she could not keep up with it. She reported that the other car did not pull over or stop. She reported that she was not aware that applicant had got behind her.

Ms. Atkins did not have insurance at the time of the accident. She could not explain why she went to the Lake Oswego Police Department when she did not know where the collision occurred. She reported that she had no reason for failing to contact the police the night before. Although Ms. Atkins' driving record indicated that her license was suspended in 1992 for failure to report a vehicle accident, she denied ever being in an accident before and not reporting it. (Ex. B1-6). She said that she did not know she had to report an accident to the police if the other car left the scene. Finally, she reported that she had not been drinking or using any drugs the night of the accident.

On August 12, 1999, police collected evidence from Ms. Atkins' car and interviewed her mother, Betty Atkins. Betty Atkins reported that her daughter called her at work between 11:00 p.m. and 12:00 a.m. the night of the accident and told her that she had been in a motor vehicle accident that evening. (Ex. B1-10). Betty Atkins reported that her daughter told her that she had rear-ended a car driven by a woman, which had been at a green light. (Ex. B1-11). Her daughter told her that it had been raining and she was unable to stop and slid into the car. Her daughter told her that the woman drove off and she followed her for "aways" and could not imagine why the woman did not stop. Betty Atkins reported that her daughter had a drinking problem in the past, but had gone through "the programs" and did not drink anymore. (*Id.*)

On April 14, 2000, Ms. Atkins was indicted on two counts of failure to perform the duties of a driver to injured persons, a Class C felony. (Ex. C2-1).

Since the accident, applicant has received ongoing medical treatment for cervical and low back pain. (Exs. D1, D3, D5, D7, D9). Medical benefits were paid by applicant's auto insurance until the medical benefits on that policy were exhausted. (Ex. D9-3). There are medical bills that remain unpaid.

On September 30, 2000, applicant applied for compensation under the Crime Victims Act. (Ex. B2). On December 19, 2000, the Department issued a Determination Order that denied applicant's request for compensation, finding that applicant was not the victim of a "compensable crime."

Applicant requested reconsideration. On February 2, 2001, the Department issued an Order on Reconsideration affirming its prior order.

CONCLUSIONS OF LAW

Pursuant to ORS 147.015, applicant is entitled to an award under the Act, if, among other requirements, she "is a victim * * * of a compensable crime that has resulted in or may result in a compensable loss." ORS 147.015(1). A "compensable crime" means "an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4). A "crime" is an offense for which a sentence of imprisonment is authorized and may be either a felony or a misdemeanor. ORS 161.515.

ORS 161.085(7) defines "intentional" as an act with a conscious objective to cause the result or to engage in the conduct described. "Knowing" means that a person acts with an awareness that his/her conduct is of a nature so described or that a circumstance so described exists. ORS 161.085(8). "Reckless" is defined as an act where the person is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or that the circumstance exists. ORS 161.085(9). The risk must be of such nature and degree that the disregard thereof constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation. *Id.*

Following our *de novo* review of the documentary evidence, we are persuaded that applicant was not the victim of a compensable crime. Accordingly, based on the following reasoning, we conclude that the Department's orders denying the claim should be affirmed.

Applicant argues that Ms. Atkins knowingly and recklessly caused her bodily injury in the motor vehicle accident of August 6, 1999. She also notes that a witness, Mr. Richmond, reported to the police that Ms. Atkins almost struck his car and a guardrail before striking applicant's car and leaving the area. Applicant argues that Ms. Atkins' report to the police that applicant would not pull over was not correct, since applicant had got behind Ms. Atkins and was trying to get her to pull over. Applicant also argues that Ms. Atkins' mother's report to the police that her daughter called her the night of the accident and told her that she (Ms. Atkins) had rear-ended a woman proves that Ms. Atkins knowingly hit her, injured her, and left the scene, without reporting the accident to the police on August 6, 1999.

Ms. Atkins was indicted for two counts of failure to perform the duties of a driver to injured persons pursuant to ORS 811.705. (Ex. C2). Specifically, the indictment stated that Ms. Atkins was the driver of a vehicle that was involved in an accident the resulted in physical injury to applicant and that Ms. Atkins: (1) "unlawfully and knowingly fail[ed] to immediately stop the vehicle at the scene of the accident or as close thereto as possible and remain at the scene;" and (2) "unlawfully and knowingly fail[ed] to remain at the scene of the accident until defendant [Ms. Atkins] had given the other driver * * * the name and address of the defendant [Ms. Atkins] and the registration number of the vehicle that the defendant [Ms. Atkins] was driving." (*Id.*) Failure to perform the duties of a driver to injured persons is a Class C felony. ORS 811.705(2).

The preponderance of the evidence establishes that Ms. Atkins did not remain at the scene of the accident; instead, she left the scene of the accident without providing the information required by law. Ms. Atkins' act of leaving the scene of the accident is an intentional, knowing, or reckless act. In addition, such an act would be punishable as a crime and Ms. Atkins has been indicted for two Class C felonies in this regard.

Nevertheless, the act of leaving the scene of the accident did not *result in* applicant's injury, as required by the Act. ORS 147.005(4); 147.015(1); *see Edgar Jason Knapp*, 40 Van Natta 433 (1988) (the applicant was not the victim of a "compensable crime" where the driver's decision to drive while his license was suspended was not the offense that resulted in injury; instead, the offense that resulted in injury was the driver's "careless driving," which is not "an intentional, knowing or reckless act" that would be "punishable as a crime in this state"); *Joy S. Lucas*, 39 Van Natta 659, *on recon* 39 Van Natta 662 (1987) (the applicant was not the victim of a "compensable crime" where the driver's action in leaving the scene of the accident was not the offense that resulted in injury; instead, the collision caused the applicant's injury and the record failed to establish that the collision was an intentional, knowing, or reckless act punishable as a crime).

Here, applicant's injuries were solely attributable to the collision. However, the record does not establish that this collision was an intentional, knowing, or reckless act that would be punishable as a crime in Oregon. The police report shows that it was raining and the pavement was wet at the time of the accident. (Ex. B1-2). Ms. Atkins reported that it was raining, dark, and wet and that she could not stop and slid into the back of the car in front of her. (Ex. B1-5). Applicant's report supports that of Ms. Atkins in that applicant stated that she did not see the car coming but she heard it attempting to stop. (Ex. B1-6). Under these circumstances, the evidence does not establish that the collision was an intentional or knowing act.

Applicant argues that Ms. Atkins' actions in colliding with her vehicle were reckless. In support of her argument, she points to Mr. Richmond's report that Ms. Atkins' car almost struck his car and a guardrail before striking applicant's car and her own observations of Ms. Atkins' driving as she followed Ms. Atkins after the accident.

The Act requires that the reckless act be punishable as a crime in Oregon. ORS 147.005(4). Under the Oregon Penal Code, "recklessly" means that "a person is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur." ORS 161.085(9). Thus, criminal recklessness has a specific meaning; it does not include an accidental or, even, negligent act. *Compare* ORS 161.085(9) and (10); *Kathleen K. Hyde*, 44 Van Natta 2375 (1992) (application for compensation denied where there was insufficient evidence to determine whether or not a fatal shooting was a reckless act that would be punishable as a crime in Oregon).

Here, although Ms. Atkins' driving may have been careless or negligent, the evidence does not establish that it reached the level of "reckless." Although the police investigated the traffic accident, Ms. Atkins was not charged with "reckless driving" or any other crime relating to the cause of the collision.[1]

Thus, under the circumstances of this case, it has not been established that applicant was the victim of a "compensable crime" as statutorily defined. *See Dianna Lawton*, 38 Van Natta 1543 (1986) (the applicant's claim for benefits properly denied by Department because applicant's injury, which occurred when struck by a vehicle in a crosswalk, was not proven to be the result of an intentional, knowing, or reckless act that would be punishable as a crime). Consequently, the Board is without authority to grant applicant's request for benefits.

Throughout this process applicant has strongly advocated her entitlement to benefits. We fully recognize her arguments and appreciate her frustrations. Yet, the Act provides for benefits to injured victims, subject to very specific requirements. Applicant has unquestionably suffered a serious injury that required considerable medical treatment. However, her damages resulting from this injury are not the responsibility of the Crime Victims Fund because she is not a victim of a "compensable crime" as defined under the Act.

ORDER

The Department's December 19, 2000 order, as reconsidered on February 2, 2001, is affirmed.

IT IS SO ORDERED.

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[1] We do not intend to imply that a charge of a crime is required in order to prevail under the Act. There may be circumstances where a crime has obviously occurred that has caused the victim bodily injury but no criminal charges were made; *e.g.*, the alleged perpetrator was not identified or was deceased. However, that is not the case here. Ms. Atkins was specifically identified as the driver of the car that struck applicant and charged with a crime relating to leaving the scene of the accident. Nevertheless, she was not charged with "reckless driving" or any other crime relating to the cause of the collision, which is the event that caused applicant's injuries. Instead, Ms. Atkins was solely charged with failure to perform the duties of a driver to injured persons, which, as explained above, did not result in injury to applicant. The reviewable record does not support a conclusion contrary to that reached by the district attorney who filed the charges against Ms. Atkins.

In the Matter of the Compensation of
JACK B. ROY, Claimant
WCB Case No. 97-00659
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

On July 6, 2001, we reversed an Administrative Law Judge's (ALJ's) order that had upheld the SAIF Corporation's "pre-closure" denial of claimant's current left knee condition. Contending that the medical evidence established that claimant's accepted condition was medically stationary at the time of its denial, SAIF seeks reconsideration of our decision.

In order to further consider this matter, we withdraw our July 6, 2001 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
GERARDO ZUNIGA, Claimant
WCB Case No. 00-06085
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Randy Rice, Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich chose not to sign the order.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that reduced claimant's unscheduled permanent disability award from 7 percent (22.4 degrees) for his low back condition, as awarded by an Order on Reconsideration, to 3 percent (9.6 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the first paragraph on page 2, we change the last sentence to read: "The insurer accepted a disabling lumbosacral strain."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on October 21, 1999, and the insurer accepted a lumbosacral strain. (Exs. 39, 55). An April 6, 2000 Notice of Closure awarded only temporary disability. (Ex. 54). Claimant requested reconsideration and was examined by a medical arbiter panel. (Exs. 60, 68). A July 21, 2000 Order on Reconsideration awarded 7 percent for claimant's low back condition, which included a value of 2 percent for reduced lumbar extension and .6 percent for reduced right lateral flexion. (Ex. 70). The insurer requested a hearing.

The ALJ relied on the findings of the medical arbiter panel and found that claimant was entitled to an unscheduled permanent disability award of 3 percent. The ALJ noted that the measurements on the lumbar range of motion form recorded by the arbiter panel exceeded 5 degrees of variation, thereby rendering the measurement invalid. Nevertheless, the ALJ reasoned that the arbiter panel understood the form and formula set forth and still believed the measurements were valid.

On review, the insurer argues that the preponderance of evidence establishes that claimant is not entitled to any permanent disability. The insurer contends that the medical arbiter panel's range of motion findings were not valid or reliable.

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).

For the following reasons, we find that Dr. Kadwell has provided the most well-reasoned and persuasive evidence of claimant's injury-related impairment.

Claimant's attending physician at closure was Dr. Kadwell. Claimant's December 1999 lumbar MRI was normal. (Exs. 29, 30). On January 21, 2000, Dr. Kadwell noted that "it's very difficult to determine why this patient is not improving." (Ex. 34). Claimant had physical therapy, as well as chiropractic treatments.

On March 9, 2000, Dr. Baker examined claimant on behalf of the insurer. (Ex. 48). He reported that claimant's lumbar range of motion was completely normal and he commented that claimant "appears to be quite comfortable and does not seem to experience discomfort in any way." (Ex. 48-5). Dr. Baker said that claimant's persisting subjective complaints were not supported in any way by objective evidence of impairment. (Ex. 48-6, -7, -8). He noted that claimant's sensory pattern was nonphysiologic and nonanatomic. (Ex. 48-6). Dr. Baker explained that claimant's muscle strain should have long since healed and he found no objective, measureable, valid explanation for the persistence of symptoms. (Ex. 48-7).

Dr. Kadwell concurred with Dr. Baker's report. (Ex. 50). On April 3, 2000, Dr. Kadwell reported that claimant's lumbosacral strain had resolved. (Ex. 51). He explained:

> "[Claimant] really hasn't improved for the last 5-6 months despite having seen 4-5 physicians - all who could not find objective findings. An MRI was totally normal. Dr. Baker, an orthopedic surgeon did an independent exam on March 29, and this has been read. I concur with the report that he is now medically stationary and should return to regular duties. There is [*sic*] no objective findings to substantiate his complaints of pain." (*Id.*)

Although claimant relies on the medical arbiter panel's report to establish impairment, we are not persuaded by their report for the following reasons. The medical arbiter panel, which included Drs. Grossenbacher, Gripekoven and Reimer, examined claimant on July 12, 2000. They found that claimant's sensory examination was invalid in that it did not follow any true anatomical nerve root or dermatological distribution. (Ex. 68-4, -5). The panel found no objective measurable impairment to significantly limit claimant's ability to repetitively use his lumbar spine. (Ex. 68-5). In addition, they explained:

> "The panel finds no permanent restrictions in reference to residual functional capacity based on any objective measurable impairment. Based on normal examination and no objective measurable impairment, the patient has no restriction in reference to lifting/carrying capacity, number of consecutive hours, permanent preclusion from any stooping, crawling, climbing, reaching, etc., and there are no permanent restrictions by objective examination in reference to number of hours." (Ex. 68-5, -6).

ORS 656.283(7) requires that "[a]ny finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings." *See also* ORS 656.726(3)(f)(B) (impairment is established by a preponderance of medical evidence based upon objective findings); OAR 436-035-0270(2) (if there is no measurable impairment, no award of unscheduled permanent disability shall be allowed). ORS 656.005(19) defines objective findings as "verifiable indications of injury or disease."

Here, despite the fact that the medical arbiter panel reported that claimant had reduced lumbar range of motion, they found that he had no objective measurable impairment. (Ex. 68-5, -6). Based on that finding, we conclude that their report is insufficient to establish that claimant has any permanent impairment related to the compensable injury. In addition, the medical arbiter panel's report is not persuasive because it is internally inconsistent.

Moreover, although the Order on Reconsideration indicated that claimant was entitled to 2 percent impairment for reduced lumbar extension, we agree with the insurer that the "range of motion" form provided by the medical arbiter panel shows that the findings for lumbar extension were invalid.

Findings of impairment that do not meet America Medical Association (AMA) validity criteria may not be used to rate a claimant's impairment. *Labor Force of Oregon v. Frierson*, 169 Or App 573, 577 (2000); *see Roseburg Forest Products v. Clemons*, 169 Or App 231, 240 (2000) (interpreting *former* OAR 436-035-0007(27) (1996)). In *Frierson*, 169 Or App at 577, the court interpreted OAR 436-035-0007(28) and found that the Board potentially had to resolve two issues. The first issue was whether the physician's findings of impairment satisfied the AMA criteria. If they did not, the second issue was whether the explanation given by a physician met the standard stated in OAR 436-035-0007(28); *i.e.*, whether it constituted a "written rationale, based on sound medical principles, explaining why the findings are valid." *Id.*

The Workers' Compensation Division (WCD) describes the relevant validity criteria for measuring range of motion:

> "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. 239, at 31 (July 15, 1998).

In this case, we find that the lumbar extension measurements from the medical arbiter panel did not satisfy AMA validity criteria. The panel reported that claimant's three lumbar extension measurements were 20, 16 and 12.[1] (Ex. 69). The medical arbiter panel did not respond to the question concerning lumbar extension that said "Are measurements within +/- 10% or 5 [degrees] (whichever is greater)?" (*Id.*) Based on WCD Bulletin No. 239, the findings are considered invalid if they vary more than 5 degrees or 10 percent. The medical arbiter panel recorded lumbar extension measurements that varied by 6 degrees, which indicates that the findings were invalid.

Under these circumstances, we conclude that claimant's lumbar extension measurements did not satisfy AMA validity criteria. Based on *Frierson*, we must determine whether the explanation given by a physician met the standard stated in OAR 436-035-0007(28) (WCD Admin. Order No. 98-055), which 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 physician 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 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, xplaining why the findings are valid." (Bold in original).

Claimant argues that, because the medical arbiter panel responded that only the sensory exam was invalid, the rest of the exam, including range of motion findings was valid. We disagree.

As discussed above, on the lumbar spine range of motion form, the medical arbiter panel did not respond to the lumbar extension question that said "Are measurements within +/- 10% or 5 [degrees] (whichever is greater)?" (Ex. 69). In their report, the panel was asked "If any findings are considered invalid, provide rationale and detailed reasoning in accordance with Bulletin 239 and the AMA Guides; include anatomic findings if applicable." (Ex. 68-5). The panel responded only by stating that claimant's sensory examination was invalid. (*Id.*) Based on the fact that the medical arbiter panel did not respond to the specific question on the range of motion form as to whether claimant's lumbar extension measurements met the validity criteria, we are not willing to infer, as claimant urges, that the panel believed those findings were valid. In any event, the panel did not provide any written rationale explaining why the findings are valid, as required by OAR 436-035-0007(28). *See Stacy Frierson*, 53 Van Natta 124 (2001) (on remand) (physician did not provide written rationale explaining why the claimant's lumbar flexion findings were valid). Furthermore, as discussed earlier, based on the medical arbiter panel's conclusion that claimant had no objective measurable impairment, we find that their report is insufficient to establish that claimant is entitled to an impairment value for reduced range of motion.

In sum, we conclude that claimant is not entitled to an award of unscheduled permanent disability. Consequently, we reverse the ALJ's order and reinstate the April 6, 2000 Notice of Closure, which did not award any permanent disability.

ORDER

The ALJ's order dated April 9, 2001 is reversed. In lieu of the ALJ's and Order on Reconsideration's unscheduled permanent disability award, the April 6, 2000 Notice of Closure is reinstated and affirmed.

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[1] We note that there is a mathematical error with regard to the finding of "16"; *i.e.*, 24 less 10 is 14, not 16. (Ex. 69).

In the Matter of the Compensation of
VAN G. JOHNSTON, Claimant
WCB Case Nos. 00-03453 & 00-03452
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich chose not to sign the order.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, correction, supplementation, and summary. We do not adopt the ALJ's finding that claimant began working for the employer in 1988. Instead, we find that claimant began working for the employer on May 1, 1991.[1] We also do not adopt the ALJ's second finding of ultimate fact.

Claimant was 54 years old at the time of the hearing. His job with the employer involved driving a truck to haul rock, sand, dirt, gravel, and asphalt from the employer's plants in Reedsport and North Bend to building construction or road construction sites. (Tr. 5, 15-17). Claimant usually worked eight hours a day, five days a week, although occasionally he had to work 10-12 hours a day. (Ex. 15-2). Although more than 50 percent of actual time and miles traveled were on paved roads, claimant also drove off of paved roads to make deliveries. (Tr. 23). When driving off-road, claimant would be bounced around and he loosened his seat belt to keep from being "cut in half." (Tr. 9). On some jobs, if he was driving off-road in the brush, claimant did not use his seat belt due to the bouncing caused by the terrain. (*Id.*) Claimant estimated that he hit his head on the top of the cab interior two to three times a month from the physical impact of being jarred. (Tr. 10).

In 1997, claimant had an insidious onset of low back and left-sided radiating pain down the posterior thigh. (Ex. 1). At that time, x-rays showed moderate degenerative disc disease between L5 and S1. (*Id.*) On October 9, 1997, claimant was initially treated for this problem by his family physician, Dr. Bartley, who referred him to Dr. Sandell, an orthopedic surgeon. (Ex. 15-2).

A November 13, 1997 MRI ordered by Dr. Sandell showed disease at L3-4, L4-5, L5-transitional sixth vertebral body, with a protruding disc at L4-5 that effaced the left L4 nerve root. (Ex. 2). Dr. Sandell treated claimant conservatively, including three steroid injections to the L4, L5 interspace, the last injection occurred in August 1999. This conservative treatment improved the left-sided radicular pain. (Exs. 6, 15-2, 24).

In late 1999, claimant developed right-sided low back pain with radiation into the right leg and numbness into the right foot. (Ex. 6). On March 15, 2000, claimant returned to Dr. Bartley, who referred him to Dr. Keiper, neurosurgeon. (*Id.*) An MRI began on March 25, 2000 and completed on April 8, 2000 showed severe degenerative disc changes at L4-5, with a large herniated disc at L4-5 causing moderate bilateral foraminal narrowing, and broad disc bulges at L3-4 and L2-3. (Exs. 9, 12).

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[1] Claimant testified that he began working for the employer in 1988. (Tr. 5). Claimant also reported to Dr. Fuller, examining orthopedist, that he had worked since 1988 for the employer as a truck driver, having been employed before that for 20 years at a sawmill, until that mill closed in 1987. (Ex. 25-2). On the other hand, claimant reported to Dr. Tsai, examining neurologist, that he "worked from 1988 to 1991 for the Bohemia Division and from 1991 to the present" for the employer as a truck driver. (Ex. 15-2). In his request for an opinion from Dr. Keiper, claimant's treating neurosurgeon, claimant's attorney provided a history of claimant driving large trucks for the employer since May 1991, having previously driven trucks for another company for three years and, prior to that, performing physical labor jobs in sawmills for 20 years. (Ex. 21-1-2). Finally, the 801 form stated that claimant's date of hire with the employer was May 1, 1991. (Ex. 4). We find that claimant's more detailed report of working for several years for another company as a truck driver before beginning to work for the employer in 1991 more persuasive. In addition, the date of hire on the 801 form supports that finding. Therefore, we find that claimant began to work for the employer on May 1, 1991.

On April 7, 2000, Dr. Keiper examined claimant and recorded a long history of back problems "dating over a year." (Ex. 11-1). Dr. Keiper reviewed the incomplete March 25, 2000 MRI and diagnosed L4-5 disc herniation on the right with neurologic deficit, unresponsive to conservative treatment. (Ex. 11-3). Dr. Keiper recommended surgery pending completion of the MRI. (Ex. 11-3-4).

On April 13, 2000, Dr. Tsai, neurosurgeon, examined claimant on behalf of SAIF. (Ex. 15). Dr. Tsai found that claimant had degenerative disc disease, most marked at L4-5, with right L5 radiculopathy. He related claimant's low back condition to his preexisting degenerative disc disease.

By letter dated April 17, 2000, SAIF sent Dr. Keiper a copy of Dr. Tsai's April 13, 2000 report. Dr. Keiper marked a box indicating that he concurred "with the diagnosis(es), findings and opinions and discussion as expressed in the report from Chen Tsai, M.D." (Ex. 16). That same date, SAIF sent Dr. Bartley a copy of Dr. Tsai's report. (Ex. 18). Dr. Bartley marked a box indicating that she did not concur with Dr. Tsai's report; she provided no discussion regarding the lumbar condition. (*Id.*)

On April 17, 2000, Dr. Keiper performed a right L4-5 hemilaminotomy and discectomy. (Ex. 17).

On April 24, 2000, SAIF denied claimant's claim for an occupational disease to his low back. (Ex. 19).

On June 1, 2000, Dr. Keiper retracted his concurrence with Dr. Tsai's report, stating that he did not recall agreeing to that report and, if he did, it was because he missed the part that stated that the back condition was due to a preexisting degenerative disc disease. (Ex. 22-1). Dr. Keiper stated that claimant's work exposure was the major contributing cause of the pathologic worsening of the degenerative disc disease in his lumbar spine. (*Id.*) Dr. Bartley concurred with Dr. Keiper's opinions. (Ex. 23-2).

On July 12, 2000, Dr. Fuller, orthopedist, and Dr. Radecki, physiatrist, examined claimant on behalf of SAIF. (Ex. 25). The record was held open to allow Dr. Keiper the opportunity to respond to the report from Drs. Fuller and Radecki. (Exs. 25A, 26).

CONCLUSIONS OF LAW AND OPINION

Relying on the medical opinions of Dr. Keiper, claimant's treating neurosurgeon, the ALJ concluded that claimant had established compensability of his occupational disease claim for lumbar degenerative disc disease and a L4-5 disc herniation. Specifically, the ALJ found that Dr. Keiper's opinion proved that claimant's work activities with the employer were the major contributing cause of a pathological worsening of his low back condition. On review, SAIF argues that Dr. Keiper's opinion is insufficient to meet claimant's burden of proving a compensable occupational disease claim. Based on the following reasoning, we agree with SAIF.

To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). It is not sufficient to establish that work activities are the major contributing cause of the current need for treatment. *See Jeffery L. Dennis*, 52 Van Natta 344 (2000) (finding that the court's decision in *SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998), did not eliminate the explicit requirement in ORS 656.802(2)(b) that a claimant prove that employment conditions are the major contributing cause of the combined condition). In occupational disease claims, a disease or condition is "preexisting" if it contributes or predisposes the claimant to disability or a need for treatment and precedes either the date of disability or the date when medical treatment is first sought, whichever occurs first. *SAIF v. Cessnun*, 161 Or App 367, 371 (1999).

Determining the "major contributing cause" of claimant's low back condition involves evaluating the relative contribution of different causes of the condition and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *review dismissed* 321 Or 416 (1995). The fact that work activities may have precipitated the worker's disability or need for treatment does not necessarily mean that the work activities are the major cause. *Id.* Indeed, "major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *McGarrah v. SAIF*, 296 Or 145, 166 (1983). Because of the multiple potential causal factors, this issue is of sufficient medical complexity to require expert medical opinion for its resolution. *See Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Uris v. Compensation Department*, 247 Or 420, 424-26 (1967).

On April 13, 2000, Dr. Tsai, examining neurosurgeon, examined claimant, took a detailed history, reviewed the MRI reports from 1997 and 2000, and reviewed x-ray films taken at his request on April 13, 2000. (Ex. 15). He found that the degenerative disc disease at L4-5 and L3-4 was already present in the 1997 MRI reports and the 2000 MRI report showed progression of that condition. (Ex. 15-14). He also noted that the April 2000 x-rays revealed several features indicating a rather advanced stage of degeneration at L4-5, including traction spurs indicative of longstanding instability at L4-5, associated with advanced degenerative disc disease, especially at L4-5, less marked at L5-S1, and mild at L1-2 and L2-3. (Ex. 15-12). He noted that claimant had severe, preexisting degenerative disc disease of the lumbar spine, with chronic segmental instability at the L4-5 level. (Ex. 15-14). He diagnosed degenerative disc disease, most marked at L4-5, with right L5 radiculopathy and opined that "[t]he contributing cause of [that diagnosis] was due to pre-existing degenerative disk disease, as evidenced by overwhelming radiological findings, as described." (Ex. 15-14).

SAIF asked Dr. Keiper to review Dr. Tsai's report. (Ex. 16). Dr. Keiper responded by marking a box indicating that he concurred "with the diagnosis(es), findings and opinions and discussion as expressed in the report." (*Id.*). Dr. Keiper did not qualify his concurrence in any manner.

Subsequently, claimant's attorney asked Dr. Keiper to reconsider Dr. Tsai's report. (Ex. 21). He also asked Dr. Keiper to consider claimant's work history and whether the work conditions were the major contributing cause of a pathological worsening of a preexisting disease process and the major contributing cause of the combined condition formed by the preexisting process and the work environment. (Ex. 21-2).

Dr. Keiper responded by stating that he did not remember concurring with Dr. Tsai's report and, if he did, it was because he "missed the part which stated that the back condition was due to a pre-existing degenerative disc disease." (Ex. 22-1). Although earlier agreeing with Dr. Tsai's report that explained in detail the basis for his conclusion that claimant had longstanding lumbar degenerative disc disease, Dr. Keiper stated that he was unable to say whether claimant had any degree of degenerative disc disease in the lumbar spine prior to beginning to work for the employer in 1991 because he had no radiographic documentation of degenerative disc disease at that time. (*Id.*) However, Dr. Keiper also stated that it was likely that claimant may have had normal changes of aging in his spine at that time. He stated that there was "no doubt" that the major contributing cause of claimant's current need for treatment in his low back was work exposure and that the degeneration in claimant's back was due to the accumulative effects of his occupational exposure. He also stated that "undoubtedly" claimant's work exposure was the major contributing cause to the pathologic worsening of the degenerative disc disease in claimant's lumbar spine and that the cumulative work exposure over thirty years was the major contributing cause of claimant's current low back condition. (*Id.*).

Dr. Bartley, claimant's treating family physician, checked a box indicating that she concurred with Dr. Keiper's opinion. (Ex. 23-2). She provided no discussion regarding causation of claimant's low back condition.

Dr. Tsai provided another opinion explaining the physical process of degenerative lumbar disease in relation to the findings in claimant's x-rays. (Ex. 20A-2). He found that this process eventually caused claimant's disc herniation. He also stated that he was not aware of any research indicating that driving a truck or vehicle that vibrates caused lumbar degenerative disease. (*Id.*) However, he stated that it was possible it caused exacerbation of symptoms. (*Id.*)

On July 12, 2000, Dr. Fuller, examining orthopedist, and Dr. Radecki, examining physiatrist, examined claimant on behalf of SAIF. They took a history of claimant's work activity as driving a truck hauling rock and including a lot of off-road work, with claimant reporting that "sometimes the ground is so uneven that it 'puts my ass through my shoulders.'" (Ex. 25-2, -10). They discussed the mechanics of degenerative disc disease and opined that claimant's x-ray findings revealed endstage degenerative narrowing with anterior and posterior bone spurs. (Ex. 25-11). They opined that the maturity of these findings suggest that the condition was present in excess of ten years. (Ex. 25-13).

Drs. Fuller and Radecki also discussed whether driving vehicles that are rough riding or vibrate caused degenerative disc disease or disc herniations. (Ex. 25-11). They stated that rough riding is alleged by some to cause axial loading of the spine, although they noted that this is only a theory. Drs.

Fuller and Radecki stated that proponents of this theory claim that this type of axial loading causes compression of the disc. However, they also noted that these proponents fail to state that the amount of axial loading has to be phenomenal. In addition, they noted that the facet joints take a fair amount of the compression on the disc space. They noted that traumatic disc herniations occur when people fall from a scaffolding, out of the back of a truck, from the top of a load, or something similar, when the amount of force is very significant. (*Id.*) They found that this did not pertain to claimant's case because his axial loading forces as a truck driver were negligible. They also opined that vibration had never been shown to cause discopathy. Instead, they opined that the major contributing cause of claimant's low back condition was his degenerative disc disease.

Claimant's attorney asked Dr. Keiper to respond to Drs. Fuller's and Radecki's report. (Ex. 25A). Claimant's attorney summarized claimant's testimony at hearing regarding his work activities (including his testimony the bouncing was so extreme that two to three times a month he hit his head on the ceiling of the cab) and asked Dr. Keiper whether it was medically probable that the major cause of claimant's herniated disc was his truck driving activities. (Ex. 25A-2). In addition, claimant's attorney provided Dr. Keiper with a copy of a medical article, focused Dr. Keiper's attention to a particular section of that article,[2] and asked whether he agreed with that study. (Ex. 25A-3).

Dr. Keiper responded that claimant never indicated to him any one particular time in his history where he had the acute onset of back pain and right leg pain. (Ex. 26). He stated that he "cannot say for sure whether [claimant's] work activities were responsible for his disc herniation. [Claimant] never mentioned that in his history." (*Id.*) He also stated that there was "no doubt that extreme bouncing in a truck could be a causative factor in the degeneration of lumbar disc disease." (*Id.*). Finally, he stated that he agreed "with the study that [claimant's attorney] included on the analysis of surgery for low back pain." (*Id.*).

Read as a whole, Dr. Keiper's medical opinions both attribute claimant's degenerative disc disease and the L4-5 disc herniation to his work activities in major part and find that the work activities were the major contributing cause of the combined condition and pathological worsening of the degenerative disc disease. However, after our *de novo* review, we find that Dr. Keiper's opinions do not meet claimant's burden of proof under either ORS 656.802(2)(a) or (b).

The examining physicians persuasively explained that claimant had longstanding degenerative disc disease at the time he sought medical treatment in 1997.[3] Dr. Keiper initially concurred with Dr.

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[2] This medical article, entitled "Small Area Analysis of Surgery for Low-Back Pain" and accepted for publication January 7, 1991, attempted to ascertain why the rates of spine surgery (discectomy, laminectomy, fusion) for low back pain vary several-fold among "small areas" such as counties or hospital market areas. (Ex. 25A-6-10). The article explained the method used in attempting to explain this variation, including limiting the study to counties in the State of Washington and postulating six classes of nonmedical variables that might affect surgery rates, one of which was the percentage of the labor force in heavy labor and transportation occupations. The article stated that, in all, the effect of 28 explanatory variables was tested, which accounted for only a minor part of the varying rates of surgery. The article concluded that the question of what accounts for the major part of the variability remained unanswered and postulated that the remaining task was to quantify the "practice style factor" in order to better understand the effects of that factor. (Ex. 25A-9).

Claimant's attorney directed Dr. Keiper's attention to the section of the article that discussed the class of nonmedical variables involving occupation. (Exs. 25A-3, -7). That section stated, in part, that the authors particularly considered heavy lifting and transportation occupations "because workers in these occupations both report back pain and file industrial insurance claims for back sprain more frequently than workers in other occupations; in addition, heavy lifting occupations increase the risk of lumbar disc degeneration, and transportation occupations increase the risk of lumbar disc herniation." (Ex. 25A-7 (footnotes omitted)).

[3] The examining physicians also noted that 1997 chart notes from claimant's treating physician at that time, Dr. Sandell, indicate that claimant reported being told about 20 years earlier that he had a herniated disc at L5 and had been taken off work for six to eight weeks before recovering sufficiently to return to work. (Exs. 24, 25). Claimant and his wife reported that they had no memory of any such problem in the 1970s. (Ex. 25-1, -3, -8, Tr. 14, 31). On this record, we need not determine whether claimant had a L5 disc herniation in the 1970s. As noted above, 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 at 371. Even if claimant did not have a L5 disc problem in the 1970s, the persuasive medical evidence establishes that claimant's degenerative disc disease contributed to his need for treatment and preceded the date he sought medical treatment in 1997.

Tsai's opinion that claimant's low back condition was caused by the preexisting degenerative disc disease, without relating it to the work activities. Dr. Keiper did not explain his later change of opinion, other than to say that he "missed the part" of Dr. Tsai's opinion that stated that claimant's back condition was due to the preexisting degenerative disc disease. We do not find Dr. Keiper's unexplained change of opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive). Moreover, even if we disregard Dr. Keiper's concurrence with Dr. Tsai's opinion, we do not find Dr. Keiper's remaining opinions persuasive.

We do not find Dr. Keiper's conclusion that the work activities caused the degenerative disc disease and caused the combined condition and pathological worsening of the degenerative disc disease persuasive because it is entirely unexplained. *See Blakely v. SAIF*, 89 Or App 653, 656, *rev den* 305 Or 972 (1988) (physician's opinion lacked persuasive force because it was unexplained); *Somers v. SAIF*, 77 Or App 259 (1986). Dr. Keiper did not evaluate the relative contribution of the different causes of claimant's low back condition and decide which was the primary cause. *See Dietz v. Ramuda*, 130 Or App at 401. In other words, he did not evaluate the relative contribution of the preexisting degenerative disc disease and the work activities. Instead, he simply stated, without explanation, that the work activities were the major contributing cause. (Ex. 22). That is not sufficient to meet the requirements to prove major contributing cause.

In addition, Dr. Keiper's final opinion does not cure these problems. (Ex. 26). It also fails to offer any evaluation of the relative contribution of the degenerative disc disease. Furthermore, after reviewing the report from Drs. Fuller and Radecki that found that claimant's truck driving activities were not sufficient to cause claimant's low back condition, Dr. Keiper only stated that extreme bouncing in a truck "could be" a causative factor in the degenerative disc disease. *See Gormley v. SAIF*, 52 Or App 1055 (1981); *Ted L. Golden*, 51 Van Natta 55, 56 (1999) ("could have" and "may have" indicate only possibility, not medical probability). Finally, Dr. Keiper's statement that he agrees with the study provided by claimant's attorney does not increase the persuasiveness of his opinion. That study attempts to explain regional variation in the number of surgical procedures for low back pain, an inquiry that is not relevant to the causation issue before us. To the extent that the study cited other studies, Dr. Keiper did not discuss them or apply them to claimant's condition.

Finally, although Dr. Bartley concurred with one of Dr. Keiper's opinions, that opinion was unexplained and Dr. Bartley added no causation explanation of her own regarding the lumbar condition. Therefore, Dr. Bartley's concurrence does not help claimant's position. The remaining medical opinions are from the examining physicians and do not support compensability. Accordingly, in the absence of persuasive medical evidence supporting compensability, we conclude that the claim must fail.

The ALJ awarded claimant's attorney $6,000 for services at hearing regarding compensability of claimant's bilateral carpal tunnel syndrome and low back conditions. On review, we have reversed the ALJ's decision regarding compensability of the low back condition. Therefore, we reduce the ALJ's assessed attorney fee accordingly. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding compensability of the bilateral carpal tunnel syndrome condition $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to this issue at hearing, the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 13, 2001 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside SAIF's denial of claimant's low back condition is reversed. SAIF's denial of claimant's low back condition is reinstated and upheld. The ALJ's assessed fee for services at hearing is modified to $3,000. The remainder of the order is affirmed.

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 1047-1094 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH AUGUST 20, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, JULY-SEPTEMBER 2001.

In the Matter of the Compensation of
HILLARY A. BREWER, Claimant
WCB Case No. 00-08234
ORDER ON REVIEW
Baxter & Baxter, Claimant Attorney
Sheridan, et al., Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Meyers. Member Meyers chose not to sign the order.

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 thumb condition. With its brief, the insurer submits affidavits from claimant's co-worker (who did not testify at the hearing) and the insurer's counsel's legal assistant in support of the insurer's motion that the case be remanded to the Hearings Division for further evidence taking. *See* ORS 656.295(5). On review, the issues are remand and compensability.

We deny the motion for remand and adopt and affirm the ALJ's order with the following supplementation.

Remand

The ALJ set aside the insurer's denial based on claimant's credible testimony and the unrebutted medical opinion of Dr. Seymour. In finding claimant credible based on her demeanor, the ALJ discounted testimony from claimant's supervisor that claimant had described a non-work related injury to her right thumb during an altercation with her boyfriend. The insurer did not offer testimony from a co-worker, Hokinson, nor did the insurer request a postponement or continuance to take his testimony.

On review, the insurer submits affidavits from the co-worker and from the insurer's counsel's legal assistant, and moves to remand to the ALJ for the taking of additional testimony from the co-worker on the issue of claimant's alleged off-work thumb injury. For the following reasons, we deny remand.

Our review is limited to the record developed at hearing. ORS 656.295(5). We may remand only if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). A compelling reason for remand exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, we find no compelling reason to remand. Initially, we note that the insurer seeks to admit testimony of a witness never offered at hearing, as opposed to offering a correction or retraction of testimony already in the record. *Cf. Robert D. Blanchfield, Jr.*, 44 Van Natta 2276 (1992) (second order remanding) (Board remanded to the ALJ for admission of additional evidence after a witness submitted a statement purporting to "retract" his testimony at hearing, where that witnesses' testimony was "central" to the ALJ's decision).

Here, in seeking to admit testimony from a co-worker, the insurer submits an affidavit on review detailing its "pre-hearing" efforts to locate the co-worker. The insurer contends that the co-worker was out of state and therefore unavailable at the time of the hearing. However, this information was not presented to the ALJ. Moreover, although the insurer attempted to introduce statements by the co-worker through the testimony of another witness, when claimant's objection to those statements was sustained on hearsay grounds, the insurer did not move for a postponement or continuance to take the co-worker's "live" testimony. (Tr. 21, 22); *see Sonja M. Dairy*, 46 Van Natta 534 (1994); *Phillip G. Michael*, 46 Van Natta 519 (1994) (Board declined to remand for testimony from the claimant's uncle when, among other reasons, the claimant did not object to the closure of the record or request a continuance to obtain the testimony).

Therefore, even assuming that the co-worker's testimony would be reasonably likely to affect the outcome, we find no compelling reason for remand. We conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). Accordingly, we deny the insurer's motion for remand.

Compensability

The ALJ found claimant's testimony relating to her right thumb condition credible based on his "close and careful" observation of her demeanor at hearing. (O&O at 3). On review, the insurer contends that claimant is not credible. The insurer argues that claimant never convincingly denied a conversation between herself and her supervisor about her alleged off-work injury during a fight with her boyfriend.

We generally defer to the ALJ's demeanor-based credibility findings. *Erck v. Brown Oldsmobile*, 311 Or 519, 528 (1991); *James E. Board*, 52 Van Natta 442, 443 (2000). Here, we find no reasons not to defer to the ALJ's demeanor-based credibility finding in favor of claimant.

First, although claimant admitted that it was "possible" that she had had a conversation about her boyfriend with the supervisor, she stated that it was not possible that she had said her boyfriend had hurt her. (Tr. 36-38). Next, the medical record contains no mention of an off-work thumb injury. Instead, the medical reports uniformly attribute claimant's right thumb condition to her work activity for the employer.[1] (*See* Exs. 2a, 3, 11).

Finally, the insurer submits a copy of the audio tape of the hearing, for our independent evaluation of the supervisor's testimony and English-speaking abilities. We need not decide whether we can consider this tape, however, as our result would be the same even if we assume that the supervisor has no problems understanding English. Based on the above reasoning, we find no persuasive reasons to reject the ALJ's demeanor-based credibility finding in favor of claimant.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 30, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

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[1] We acknowledge the insurer's argument that the medical opinion rests on claimant's history. However, we have affirmed the ALJ's credibility finding in favor of claimant.

In the Matter of the Compensation of
LLOYD CARLTON, Claimant
WCB Case No. 00-06066
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Schwabe, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that awarded a $4,000 attorney fee for the insurer's allegedly unreasonable discovery violation. Claimant cross-requests review, challenging the dismissal of his request for hearing seeking claim reclassification and alleging entitlement to temporary disability. On review, the issues are jurisdiction, potentially, claim reclassification and temporary disability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In April 1999, the insurer accepted a nondisabling claim for "bi-lateral arm/hand strain." (Exs. 1, 3). In March 2000, claimant requested claim reclassification from both the insurer and the Director. (Exs. 38, 41). When the insurer failed to respond within 14 days to his request, claimant again requested reclassification from the Director. (Ex. 45). A June 14, 2000 Determination Order ordered the claim to "remain classified as non-disabling." (Ex. 60). The Determination Order advised: "Any party to the claim has the right to request a reconsideration for a period of 60 days from the mailing date of the determination order." (*Id.*)

On August 11, 2000 (more than 30 days after the Determination Order), claimant requested a hearing seeking claim reclassification, procedural temporary disability, penalties for allegedly unreasonable claims processing and failure to provide discovery, reimbursement for prescriptions and mileage, and attorney fees. The ALJ determined that claimant's request for hearing was not filed within 30 days of the June 14, 2000 Determination Order. Consequently, relying on ORS 656.277(1), the ALJ dismissed claimant's hearing request for reclassification as untimely. In light of this dismissal, the ALJ reasoned that, because the claim remained "nondisabling," the Hearings Division lacked authority to award procedural temporary disability. *See Carmen Mendoza*, 51 Van Natta 1986 (1999) (Board has no authority to create an overpayment by awarding procedural temporary disability beyond which a claimant is substantively entitled).

Finally, the ALJ determined that the insurer had unreasonably failed to provide claimant with discovery as required by OAR 438-007-0015. Reasoning that a penalty had already been assessed (by means of the parties' "pre-hearing" stipulation), the ALJ awarded an assessed attorney fee of $4,000 under ORS 656.382(1).

Claimant first challenges the ALJ's decision that, because he did not request a hearing within 30 days of the issuance of the Determination Order, his request for hearing should be dismissed. Claimant contends that the June 14, 2000 Determination Order was defective in that it contained an erroneous appeal notice. We agree.

An ALJ's order issued on behalf of the Director does not become final when the order contains an incorrect statement of the parties' appeal rights. *See Oldham v. Plumlee*, 151 Or App 402 (1997); *Lankford v. Copeland*, 141 Or App 138, 143 (1996); *Delbert Shay*, 52 Van Natta 2020 (2000).

Here, the Determination Order is a Director's order issued under ORS 656.277(1) regarding the classification of a claim. That order contains an incorrect statement of the parties' appeal rights in that it instructed the parties to seek reconsideration within 60 days of the order. Contrary to this notice, a dissatisfied party must request a hearing with the Board within 30 days of the Determination Order. *See* ORS 656.277(1).

Consistent with the *Lankford* rationale, we conclude that the June 14, 2000 Determination Order is not final. Accordingly, we conclude that we lack jurisdiction to consider the Determination Order and claimant's request for hearing is dismissed with regard to this issue.

As a result of our decision, jurisdiction over the June 14, 2000 Determination Order remains with the Workers' Compensation Division to issue a corrected order containing a proper notice of the parties' "appeal rights." Therefore, the parties should contact the Workers' Compensation Division for the issuance of such an order. Thereafter, should either party timely seek a hearing from the corrected order, an ALJ may consider the merits of the classification issue.

We turn to the insurer's argument that the ALJ lacked jurisdiction to address the penalty issue because, after dismissing claimant's request for hearing concerning the reclassification issue and finding a lack of authority to address the temporary disability matter, the only issue pending at hearing was a penalty for alleged discovery violations. *See* ORS 656.262(11)(a). Alternatively, the insurer asserts that (assuming there was a discovery violation) the amount of the fee awarded was excessive.

As noted above, claimant's request for hearing identified the issues of claim reclassification, temporary disability, penalties for allegedly unreasonable claims processing and failure to provide discovery, reimbursement for prescriptions and mileage, and attorney fees. Before the hearing, the

insurer agreed to pay the reimbursements for prescriptions and mileage, as well as a penalty of 25 percent of the amount of the medical reimbursements. As we decided above, jurisdiction of the reclassification issue remains with the Director. Thus, determining whether the penalty matter is the "sole issue" depends on whether entitlement to temporary disability remains an issue before the Board.[1]

In *Joseph E. Bridwell*, 49 Van Natta 1061 (1997), we reversed the ALJ's order dismissing the claimant's request for hearing alleging entitlement to interim compensation and penalties. Based on a previous decision finding that the Hearings Division has jurisdiction to consider entitlement to interim compensation, we reinstated the claimant's hearing request and considered the merits. *Accord Gary L. Day*, 50 Van Natta 2405, 2408 (1998) (Board had jurisdiction to address interim compensation and penalties for accepted nondisabling claim).

Bridwell was distinguished, however, in the subsequent cases of *Roberta F. Bieber*, 49 Van Natta 1541 (1997), and *Carmen Mendoza*, 51 Van Natta 1986 (1999). In *Bieber*, the claimant requested a hearing, alleging entitlement to temporary disability. The ALJ dismissed the claimant's request for hearing on the basis that she first needed to seek reclassification of her nondisabling claim. Relying on *Alfredo Martinez*, 49 Van Natta 67 (1997), where we found that we had jurisdiction to consider a temporary disability matter but lacked authority to award such benefits if such action created an overpayment, we reinstated the claimant's request for hearing on the basis that we had jurisdiction over the temporary disability matter. Because the proceeding, however, did not involve the claimant's appeal of her nondisabling claim status and she was seeking temporary disability for a nondisabling claim, we concluded that we lacked authority to award such benefits. 49 Van Natta at 1543.

Similarly, the claimant in *Mendoza* sought temporary disability benefits while challenging the nondisabling status of her claim in a proceeding before the Director. Because the claimant's entitlement to temporary disability was dependent on her appeal of the classification issue, we found that we lacked "authority to create an overpayment by awarding procedural temporary disability beyond that to which [the] claimant is substantively entitled." 51 Van Natta at 1987.

Here, unlike the claimants in *Bridwell* and *Day*, claimant is seeking more than interim compensation because he alleges entitlement to temporary disability after the insurer issued its acceptance. Thus, consistent with our decisions in *Bieber* and *Mendoza*, we conclude that, although we have jurisdiction over the temporary disability issue, we lack authority to award such benefits since the claim is nondisabling and jurisdiction of the reclassification matter is with the Director.

Under ORS 656.262(11)(a), the Director "shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the" penalty. We have applied this statute in cases where, although initially involving more than the penalty issue, the additional matters subsequently are removed from the ALJ's consideration, such as rescission of a denial or withdrawal of the matter by a party. *E.g., Lushona K. Icenhower*, 52 Van Natta 886 (2000), *Francisco J. Martinez*, 52 Van Natta 666 (2000). We find a distinction between those cases and the circumstances presented in this case.

Here, the Hearings Division and Board have jurisdiction over the temporary disability issue and the matter continues to be part of claimant's request for hearing, even though both forums lack authority to address the issue. This is different from an issue that has been removed entirely from the ALJ's consideration, either because it was resolved, withdrawn by a party or dismissed by the ALJ.

Thus, we conclude that, because we retain jurisdiction of the temporary disability issue, the penalty matter is not the "sole issue" and ORS 656.262(11)(a) does not apply to provide sole jurisdiction to the Director. We turn to the merits of the alleged discovery violation.

Claimant filed his request for hearing on August 11, 2000. The hearing request contained a notice to the insurer demanding copies of "all medical reports, records, and all claim documents." On August 25, 2000, the insurer sent claimant a copy of the 801 and the notice of acceptance.[2] (Ex. 66).

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[1] Because entitlement to an attorney fee was based on the same grounds as the penalty, it does not qualify as a separate matter on which to assess a penalty. *See Corona v. Pacific Resource Recycling*, 125 Or App 47 (1993).

[2] This material was not sent to claimant as a direct response to his request for discovery. Rather, it was a copy of the insurer's response to DCBS's letter to the insurer of April 27, 2000. (Ex. 66).

OAR 438-007-0015(3) requires a carrier to provide claimant with copies of all medical and vocational reports and other documents pertaining to the claim within 15 days of the mailing of a request for hearing. Although the insurer stipulated that it had timely received medical records directly from the medical providers, the record does not indicate that the insurer provided claimant with any discovery, other than Exhibit 66, within 15 days of the mailing of the request for hearing.[3] The insurer provided no explanation for its failure to timely provide discovery. Consequently, we conclude that the insurer acted unreasonably when it did not comply with the Board's discovery rules.

ORS 656.382(1) authorizes the award of a carrier-paid attorney fee if a carrier "unreasonably resists the payment of compensation," provided that there are no amounts of compensation then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(11). *Corona v. Pacific Resource Recycling*, 125 Or App 47 (1993); *Oliver v. Norstar, Inc.*, 116 Or App 333 (1993); *Martinez v. Dallas Nursing Home*, 114 Or App 453, *rev den* 315 Or 271 (1992); *Mark A. Klouda*, 51 Van Natta 823, 824 (1999).

On the other hand, there is no "unreasonable resistance to payment of compensation" if all compensation was paid, even if the carrier acted unreasonably. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993) (where carrier did not timely accept the claim, but paid all compensation due, there was no unreasonable resistance to payment of compensation and, thus, liability for attorney fees under ORS 656.382(1)); *Klouda*, 51 Van Natta at 824.

Here, the insurer was required to provide claimant with discovery within 15 days of his request for hearing; *i.e.*, August 26, 1999. The insurer failed to provide discovery until November 13, 2000, when it submitted exhibits for the hearing scheduled for November 15, 2000. Because of the parties' "pre-hearing" stipulation regarding the unpaid medical benefits, there were amounts of compensation due during the period the insurer failed to provide discovery. *See Kenneth A. Meyer*, 50 Van Natta 2301 (1998) (the claimant entitled to penalty for carrier's discovery violation if there were "amounts then due" during the delay period). Consequently, we conclude that the insurer unreasonably resisted the payment of compensation.

Because the insurer has already been assessed the maximum penalty for its nonpayment of medical benefits, and because the discovery violation is not the same conduct for which the insurer was assessed a penalty under ORS 656.262(11), the ALJ appropriately assessed a carrier paid attorney fee pursuant to ORS 656.382(1).

After considering the factors set forth in OAR 438-015-0010(4), we award an assessed fee of $4,000 for the insurer's unreasonable discovery violations. In arriving at this amount, we have particularly considered the time devoted as a result of the insurer's unreasonable conduct (as represented by the record, including the time required by claimant's counsel to attend a hearing 200 miles from his office), the value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might be uncompensated. *See Carmen O. Macias*, 53 Van Natta 698 (2001) (travel time is appropriately considered in determining a reasonable attorney fee); *Laura R. Franke*, 52 Van Natta 1271 (2000).

Claimant's attorney is not entitled to an attorney fee for efforts in defending the ALJ's attorney fee award on review. *Dotson v. Bohemia*, 80 Or App 233 (1986), or for services devoted to the reclassification and temporary disability issues.

ORDER

The ALJ's order dated December 18, 2000 is affirmed.

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[3] The record contains 65 exhibits that predate claimant's request for hearing.

In the Matter of the Compensation of
ELIZABETH JULE, Claimant
WCB Case No. 00-06185
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Reinisch, MacKenzie, Healey, et al., Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's injury claim for a cervical and/or thoracic condition; and (2) awarded a $5,650 attorney fee pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's claim for a cervical or interscapular strain based on the opinion of claimant's treating physician, Dr. Ampel. On review, the employer contends that the ALJ should have applied the "major contributing cause" standard to this "combined condition" case. We agree.[1]

Claimant has the burden of proving a compensable injury, established by medical evidence supported by objective findings. ORS 656.005(7)(a); ORS 656.266.[2] Moreover, "if an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition." ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon*, 149 Or App 309 (1997), *rev den* 326 Or 389 (1998).

There must be medical opinion establishing that claimant's April 19, 2000 work injury has "combined with" a preexisting condition. *See Dorothy Green*, 53 Van Natta 826 (2001). We rely on those opinions that are well-reasoned and based on complete and accurate information. *Miller v. Granite Construction*, 28 Or App 473, 476 (1977). Absent persuasive reasons to do otherwise, we rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 63 Or App 810 (1983).

Dr. Ampel, claimant's treating physician, characterized claimant's condition as "History of pain in the posterior neck and into the arms with associated paresthesias consistent with cervical strain and possibly cervical radiculopathy, with degenerative joint disease of the cervical spine." (Ex. 53).

Dr. Woodward, who examined claimant at the request of the employer, concluded that, if claimant indeed suffered an on-the-job injury to her neck or upper back, the injury combined with her preexisting cervical degenerative changes. (Ex. 50-8). Thus, Dr. Woodward's opinion likewise supports a "combining."

Drs. Farris and Schilperoort also examined claimant at the request of the employer. (Ex. 60). However, by the time of their examination on November 10, 2000, claimant had no current symptoms. Drs. Farris and Schilperoort diagnosed a symptomatic exacerbation of preexisting cervical and thoracic spine multilevel degenerative changes associated with the work injury. (Ex. 60-6). Although it is one plausible interpretation of their opinion, Drs. Farris and Schilperoort did not expressly describe claimant's condition as a "combined condition."

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[1] In light of our disposition of the ALJ's order on this basis, we need not address the employer's "credibility" arguments.

[2] Due to the presence of a potentially-contributory degenerative condition in claimant's cervical and thoracic spine, this case presents a complex medical issue, resolution of which requires expert medical opinion. *Barnett v. SAIF*, 122 Or App 279 (1993).

Given the timing of their examination, we rely on Drs. Ampel and Woodward on the issue of whether claimant has a "combined condition." In other words, we find that claimant's cervical strain condition "merged" or "existed harmoniously" with her cervical degenerative joint disease. *See Luckhurst v. Bank of America*, 167 Or App 11, 16-17 (2000).

Accordingly, based on the opinions of Drs. Ampel and Dr. Woodward, we find that claimant suffered from a "combined condition" after her April 19, 2000 work injury. She must therefore prove that her injury was the major contributing cause of her disability or need for treatment. ORS 656.005(7)(a)(B). We agree with the employer that there is no such proof in the record. Dr. Ampel supports claimant's claim only arguably on a "material contributing cause" standard. Drs. Woodward, Farris and Schilperoort do not support compensability on even a material contributing cause basis.

Thus, we conclude that claimant did not carry her burden of proof under ORS 656.005(7)(a)(B). We therefore reverse the ALJ's order setting aside the employer's denial. Consequently, we also reverse the ALJ's assessed attorney fee award.

ORDER

The ALJ's order dated May 1, 2001 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's assessed attorney fee is also reversed.

In the Matter of the Compensation of
MARK T. SHUMP, Claimant
WCB Case No. 00-09384
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl. Member Biehl chose not to sign the order.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that increased claimant's unscheduled permanent disability award for a shoulder condition from 18 percent (57.6 degrees), as awarded by an Order on Reconsideration, to 32 percent (102.4 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

We adopt the portion of the ALJ's "Ultimate Findings of Fact" that Dr. Marble's medical arbiter report represents the appropriate measurement of claimant's impairment.[1] We do not adopt the remainder of the ALJ's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant had a 1999 work injury that resulted in an accepted disabling claim for left shoulder dislocation. (Exs. 1; 9). The claim was closed in July 2000 by a Notice of Closure that awarded 8 percent unscheduled permanent disability. (Ex. 8). Claimant requested reconsideration.

Following an October 26, 2000 medical arbiter evaluation by Dr. Marble, an Order on Reconsideration increased the award to 18 percent unscheduled permanent disability. (Ex. 17-5). Claimant requested a hearing.

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[1] The parties do not challenge the ALJ's determination that Dr. Marble's medical arbiter evaluation should be used to rate claimant's permanent impairment.

The ALJ relied on Dr. Marble's medical arbiter evaluation and determined that claimant was entitled to an additional impairment award for "chronic dislocations" pursuant to OAR 436-035-0330(14). Consequently, the ALJ increased claimant's unscheduled permanent disability award from 18 percent (57.6 degrees) to 32 percent (102.4 degrees).

OAR 436-035-0330(14) provides:

> "Chronic dislocations of the shoulder joint, are valued at 15% unscheduled impairment when a preponderance of medical opinion places permanent new restrictions on the worker which necessitate a reduction in the strength lifting category pursuant to OAR 436-035-0270 and 436-035-0310."

When specifically asked to "describe any chronic shoulder dislocations," Dr. Marble responded:

> "I do not understand this question. This young man had a dislocation. He now has chronic instability and it will limit his ability to work, as noted above. He does not have a chronic dislocation. What he does have is intermittent, recurring subluxation." (Ex. 13-5).

The employer contends, based on Dr. Marble's opinion, that claimant's "intermittent, recurring subluxation" is not a "chronic dislocation" as described by OAR 436-035-0330(14). We agree with the employer.

Dr. Marble's opinion is the only medical opinion in the record discussing claimant's condition in terms of "chronic dislocations." Because Dr. Marble expressly differentiated claimant's "intermittent, recurring subluxation" condition from "chronic dislocations," and because Dr. Marble expressly opined that claimant does not have a "chronic dislocation," we conclude that claimant is not entitled to an impairment value under OAR 436-035-0330(14).

Claimant asserts that a "subluxation" is synonymous with "dislocation." Consequently, claimant argues that his "chronic subluxation" entitles him to an impairment value under OAR 436-035-0330(14). We disagree.

Stedman's Electronic Medical Dictionary v. 4.0 (1998) defines "subluxation" as an incomplete "dislocation." Because Dr. Marble and the medical dictionary differentiate between "subluxation" and "dislocation," we conclude that the record does not support a conclusion that the two terms are synonymous.[2] Accordingly, we reject claimant's argument.

In conclusion, we conclude that claimant has not established entitlement to an impairment value for "chronic dislocations" under OAR 436-030-0330(14). We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated April 16, 2001 is reversed. The Order on Reconsideration award of a total of 18 percent (57.6 degrees) unscheduled permanent disability is affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

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[2] In reaching this conclusion, we consider *Daralynn Nevett*, 52 Van Natta 1856 (2000) to be useful. There, we held that "some" limitation did not equal "significant" limitation for the purpose of establishing entitlement to an impairment award for a "chronic condition" under OAR 436-035-0010(5).

In the Matter of the Compensation of
CAROLYN S. WECHTER, Claimant
WCB Case No. 00-05178
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Fulsher's order that affirmed an Order on Reconsideration finding that claimant's cervical injury claim was not prematurely closed. On review, the issue is premature closure.

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

Claimant compensably injured her right shoulder and back in November 1996. (Ex. 1). The claim was accepted and processed to closure in December 1997.[1] (Ex. 4).

In August 1999, the claim was reopened for acceptance of a "combined condition of cervical strain C5-6 disc protrusion with forminal [sic] narrowing." (Ex. 12). On January 4, 2000, Dr. Kitchel, the attending physician, released claimant for full duty work. (Ex. 13). On February 26, 2000, Dr. Coletti, a SAIF-arranged examiner, opined that claimant's cervical condition was medically stationary. (Ex. 14-6). On March 28, 2000, Dr. Kitchel concurred with Dr. Coletti's opinion. (Ex. 15). SAIF closed the claim on April 11, 2000.[2] (Ex. 17).

On May 18, 2000, claimant began treating with Dr. Gallo. (Ex. 19). Dr. Gallo opined that: (1) claimant was suffering from C6 radiculitis secondary to her C5-6 disc bulge; (2) claimant would benefit from cervical foraminotomy; (3) the major cause of claimant's current condition was the 1996 work injury; and (4) claimant was not able to work. (Ex. 20-4). Dr. Gallo also authorized time loss benefits. (*Id.*) On May 23, 2000, Dr. Kitchel agreed that claimant would benefit from cervical foraminotomy.[3] (Ex. 21; 25). On May 31, 2000, Dr. Gallo indicated that claimant's neck condition was not stationary, and had worsened over the last few months.[4] (Ex. 23).

Claimant requested reconsideration of the Notice of Closure, contending her cervical condition was not stationary at the time of closure. (Ex. 24). The July 6, 2000 Order on Reconsideration affirmed the April 11, 2000 Notice of Closure. (Ex. 27). Claimant requested a hearing.

The ALJ determined that claimant's cervical condition was stationary at the time of claim closure. Consequently, the ALJ affirmed the Order on Reconsideration.[5]

Claimant contends that her condition was not medically stationary at the time of the April 2000 Notice of Closure. Consequently, claimant asserts that her claim was prematurely closed. We disagree.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 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).

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[1] The Notice of Closure awarded 8 percent unscheduled permanent disability. (Ex. 4).

[2] The April 11, 2000 Notice of Closure awarded 10 percent unscheduled permanent disability. (Ex. 17).

[3] However, Dr. Kitchel did not agree that the major cause of claimant's current condition was the 1996 work injury. Nor did Dr. Kitchel disagree with his previous opinion that claimant's condition was stationary in February 2000. (Ex. 21).

[4] Dr. Gallo noted that "neurologically," claimant was not much worse. (*Id.*)

[5] SAIF denied claimant's "current" condition on June 16, 2000. (Ex. 26). The ALJ concluded that the "current condition" denial should be upheld. Claimant does not challenge that portion of the ALJ's order.

Here, the record establishes that, on March 28, 2000, Dr. Kitchel concurred with Dr. Coletti's assessment that claimant's condition was stationary as of February 26, 2000. (Ex. 15). As of May 31, 2000, both Dr. Gallo and Dr. Kitchel opined that claimant's condition was no longer stationary, and that she needed additional treatment and was restricted from work. Nevertheless, neither doctor have expressly disagreed with Dr. Coletti's previous finding (as concurred by Dr. Kitchel) that claimant's condition was stationary as of February 26, 2000. In the absence of further clarification by Dr. Gallo, and in light of the unequivocal nature of Drs. Kitchel and Coletti's opinion regarding the stationary status of claimant's neck condition, the record does not support a conclusion that the April, 2000 Notice of Closure was premature. *See Stephanie A. Dys-Dodson*, 53 Van Natta 207, 208 (2001).

ORDER

The ALJ's order dated April 10, 2001 is affirmed.

August 6, 2001 Cite as 53 Van Natta 1056 (2001)

In the Matter of the Compensation of
WARREN L. BENFIELD, Claimant
WCB Case No. 00-09406
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that directed SAIF to accept and reopen claimant's left knee injury claim for additional conditions. On review, the issues are jurisdiction and claim processing.

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

Claimant compensably injured his left knee in October 1970. (Ex. 1). SAIF accepted the claim for "left knee strain" and originally closed the claim on September 23, 1971. (Ex. 2-2). Claimant's condition worsened, requiring knee-replacement surgery on October 13, 1999. (Ex. 6). Claimant brought a new medical condition claim for "post-traumatic arthritis left knee - total replacement (new)." (Ex. 14). By letter of October 17, 2000, SAIF refused to expand its acceptance, contending that the original acceptance "reasonably apprised" claimant of the accepted conditions. (Ex. 17). Claimant requested a hearing.

The ALJ directed SAIF to reopen and process claimant's new medical condition claim for the additional condition of left knee post-traumatic arthritis, pursuant to *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579, *rev den* 329 Or 527 (1999). *See also Ronald A. Carnagey*, 53 Van Natta 372 (2001); *John L. Graham*, 51 Van Natta 1740 (1999).

On review, SAIF makes several arguments that *Johansen* and *Graham* were wrongly decided. As to the former, we are bound to follow the court's decision. *See Robert E. Lance*, 52 Van Natta 1432 (2000). Moreover, the court has recently reaffirmed its holding and rationale in *Johansen* in *SAIF v. Ledin*, 174 Or App 61 (2001). *See Duane A. Ferren*, 53 Van Natta 935 (2001). As to the latter, after considering SAIF's arguments, we again adhere to our decision in Graham and continue to rely on it. *See Duane A. Ferren*, 53 Van Natta at 936; *Ronald A. Carnagey*, 53 Van Natta at 373; *Dave A. Humphrey*, 52 Van Natta 2212, 2214 (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 $800, 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 16, 2001 is affirmed. For services on review, claimant's attorney is awarded $800, payable by SAIF.

In the Matter of the Compensation of
LETA M. GRIEVES, Claimant
Own Motion No. 01-0144M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of the SAIF Corporation's April 6, 2001 Notice of Closure, which closed her claim with an award of temporary disability compensation from January 17, 2000 through March 15, 2001. SAIF declared claimant medically stationary as of March 15, 2001. Claimant contends that she was 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 the date of closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant's condition was medically stationary at the time of the April 6, 2001 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: (1) although she completed the prescribed series of three SynVisc injections to her right knee, SAIF closed her claim before the period within which she would have achieved maximum pain relief according to SynVisc literature; (2) she feels chronic knee pain even when sedentary; (3) based on information provided by the Arthritis Foundation, she requires further physical therapy that SAIF will not approve; (4) she has gained weight as a result of her right knee condition and the January 2000 surgery, which causes her knee condition to worsen; (5) her knee condition has caused her to have an abnormal gait which has caused her to have hip problems that are currently not being treated because SAIF has not given her physician authorization to treat it; (6) she requires supplements to maintain her comfort level; (7) if nothing is done for her knee it will continue to deteriorate and, "since [her] knee is getting worse[,] how can [she] be considered medically stationary?;" and (8) a knee replacement "is the only logical next step." Claimant relies on these contentions to support her position that she was not medically stationary at the time of claim closure.

Even if we were to consider claimant's assertion that she may require further treatment in the form of additional therapy and medications, 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. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Furthermore, in contending that she is not medically stationary because her right knee condition is worsening or will worsen in the future, claimant is not applying the workers' compensation definition of "medically stationary." The essential question is whether or not claimant's condition will improve rather than whether or not it will "deteriorate" or worsen in the future. ORS 676.005(17). Such worsening is contemplated under the Act. *See* ORS 656.278(1)(a). In this regard, 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 compensation. However, expected worsening does not mean that a worker is not medically stationary at closure. *Tommy L. Brown*, 42 Van Natta 558 (1990) (possible future worsening is irrelevant to determination of medically stationary date).

Additionally, other than a general article regarding osteoarthritis from the Arthritis Foundation, claimant offers no medical documentation to support her contentions that she is not medically stationary and requires further surgery. As noted above, whether claimant's right knee condition was medically stationary at claim closure presents a medical question that must be resolved based on competent medical evidence. The general information claimant has obtained from the Arthritis Foundation is not specific to claimant's right knee condition, nor is there any medical evidence in the record that relates this general information to claimant's specific right knee condition. Indeed, as part of its response to claimant's request for information, the Arthritis Foundation advised claimant to contact her physician, explaining that the Foundation had given claimant their "most up-to-date general information" but "[o]nly your physician with your full medical history can determine what is advisable for you."

The only medical evidence regarding whether claimant is medically stationary is from Dr. Jacobson, claimant's attending physician. Dr. Jacobson apparently performed the January 2000 right knee surgery for which claimant's Own Motion claim was reopened. In addition, he followed her treatment after that surgery.

In a March 15, 2001 medical report, Dr. Jacobson concluded that claimant was medically stationary as of the date of the report. Although he noted that "down the road, the arthritis has the potential of getting worse," the potential of future worsening does not negate the finding of medically stationary status, as explained above. He further stated that claimant was "as good as she is going to be." Although indicating that he could continue to "fine tune" things and treat claimant as necessary, Dr. Jacobson does not indicate that this ongoing medical care will materially improve claimant's compensable condition. Dr. Jacobson's medical opinion is unrebutted. Moreover, as claimant's long time treating physician Dr. Jacobson was in the best position to express an opinion regarding claimant's medically stationary date.

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

Accordingly, we affirm SAIF's April 6, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

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

In the Matter of the Compensation of
JEFFREY COEFIELD, Claimant
Own Motion No. 01-0110M
OWN MOTION ORDER OF ABATEMENT
Martin L. Alvey, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests reconsideration of our July 6, 2001 Own Motion Order on Reconsideration, that declined to reopen his claim for the payment of temporary disability compensation.

In order to allow sufficient time to consider the motion, we abate our order. The SAIF Corporation is granted an opportunity to respond to the motion. To be considered, that response must be filed within 14 days of the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL E. DAVIS, Claimant
WCB Case No. 01-00238
ORDER ON REVIEW
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hoguet's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal order. We vacate and remand.

FINDINGS OF FACT

Pursuant to claimant's request for hearing, a hearing was scheduled for April 4, 2001. Claimant failed to appear for the hearing either by himself or through counsel. The insurer moved to dismiss claimant's request for hearing.

On April 6, 2001, the ALJ issued an Order of Dismissal dismissing claimant's request for hearing. The order also contained a "Show Cause" order that allowed claimant "15 days after the mailing date of this Order to request in writing that this Order be reconsidered and set aside by showing good cause through written explanation why he failed to appear at the hearing."

On April 19, 2001, claimant filed a "Petition of Appeal of Order of Dismissal." His petition stated that he was living out of state, and that he did not have funds to travel to Oregon for the hearing. Claimant also alleged that he was not contacted on the day of the hearing. Finally, claimant explained that he intended to return to Portland by the end of April 2001 and would like a rescheduled hearing.

CONCLUSIONS OF LAW AND OPINION

Initially, we note that the only issue on review is the propriety of the ALJ's dismissal order. Thus, claimant's substantive arguments regarding the merits of his claim are not before us at this time. *See Marty C. Hayter*, 53 Van Natta 37, 38 (2001).

An ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. *See Olga G. Semeniuk*, 46 Van Natta 152 (1994); *Harold Harris*, 44 Van Natta 468 (1992). We have interpreted a claimant's "post-dismissal order" correspondence after a hearing request has been dismissed for failure to appear as a motion for postponement of the scheduled hearing. *See Marty C. Hayter*, 53 Van Natta at 38 n1. In those cases, where the ALJ did not have an opportunity to rule on the motion, and the motion is filed within the time parameters set forth in the "show cause" portion of the dismissal order, we have remanded to the ALJ for consideration of the motion. *See Teresa Marion*, 50 Van Natta 1165 (1998); *Brent Harper*, 50 Van Natta 499 (1998).

Here, the ALJ issued a combined Dismissal Order and Show Cause order, as described above, on April 6, 2001. Such a "combined" order was proper, because claimant did not appear at the scheduled hearing and no communication regarding the non-appearance was received. *See Marcelino Ruiz*, 52 Van Natta 946, 948 n1 (2000).

On April 19, 2001, claimant filed a "Petition of Appeal of Order of Dismissal," within the 15-day parameter of the ALJ's Show Cause Order.[1] Because claimant's submission provided reasons for his failure to appear at the hearing, we interpret claimant's "petition" as a motion to postpone the April 4, 2001 hearing. *See Brent Harper*, 50 Van Natta at 500; *Randy L. Nott*, 48 Van Natta at 1.

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[1] The insurer contends that we should consider claimant's "motion to postpone" untimely because it was not properly served on either the insurer or its counsel, citing OAR 438-005-0046(2). We disagree. Because the insurer has had an opportunity to fully respond to claimant's motion, the insurer was not prejudiced by claimant's failure to properly serve the motion. In those circumstances, we will consider claimant's motion. *See Lisa A. Hiner*, 52 Van Natta 2203 n1 (2000); *Charles J. Williams*, 49 Van Natta 601 (1997).

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely, or otherwise insufficiently developed. *See Bailey v. SAIF*, 296 Or 41, 45 n3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. *Brent Harper*, 50 Van Natta at 500.

Based on claimant's "post-Show Cause/Dismissal order" submission, and the insurer's challenge to the submission, we find a compelling reason to remand this case for further development of the incomplete record regarding claimant's postponement request. *See* ORS 656.295(5); *Brent Harper*, 50 Van Natta at 500.

Accordingly, following further development of claimant's explanations for failing to appear at the scheduled hearing, the ALJ shall determine whether claimant's non-appearance was justified and constituted extraordinary circumstances beyond his control. The development of the record may be made in any manner that the ALJ deems appropriate. If the ALJ finds that claimant's explanation satisfies the "extraordinary circumstances" standard, a hearing will then be scheduled for the parties to present evidence on the issues raised by claimant's hearing request. If the ALJ finds that "extraordinary circumstances" have not been presented, the ALJ shall issue a dismissal order.

The ALJ's order dated April 6, 2001 is, therefore, vacated. This matter is remanded to ALJ Hoguet for further proceedings consistent with this order. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice, and that will insure a complete record of all exhibits and testimony.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAUL T. MILLIGAN, Claimant
WCB Case No. 00-09115
ORDER ON REVIEW
David L. Bussman, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Fulsher's order that dismissed his Request for Hearing. Claimant has also submitted medical records not admitted into evidence at the hearing. We treat such a submission as a motion for remand to the ALJ for further proceedings. *Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are motion for remand and the propriety of the ALJ's dismissal order.

We deny claimant's motion and adopt and affirm the ALJ's order with the following supplementation regarding the motion for remand.

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 as 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 and that it is likely to affect the outcome of the hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Because the submitted documents do not concern the issue of whether the ALJ properly dismissed the hearing request (the only issue on review), there is no compelling reason to remand this matter to the ALJ for further proceedings because the submitted evidence is not likely to affect the outcome of the hearing, even assuming the documents submitted were not obtainable with due diligence prior to the hearing. *Compton v. Weyerhaeuser*, 301 Or at 646; *Juana M. Lopez*, 52 Van Natta 1654 (2001). Consequently, we deny claimant's motion to remand.

ORDER

The ALJ's order dated March 7, 2001, as reconsidered on April 11, 2001, is affirmed.[1]

[1] We note that claimant is 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 1-800-0927-1271 (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
MICHELE A. JACHALKE, Claimant
WCB Case Nos. 00-03807 & 00-01579
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Meyers.

Liberty Northwest Insurance Corporation (Liberty) requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of responsibility for chondromalacia of the right patella and right lateral tibial plateau; and (2) upheld the SAIF Corporation's denial of responsibility for the same conditions. On review, the issue is responsibility.

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

We do not adopt the discussion of the "forms" of the "last injurious exposure rule" on page 9 of the order.

The ALJ assigned responsibility for claimant's compensable chondromalacia of the right lateral tibial plateau and the right patella to Liberty. Liberty contends that SAIF's injury contributed to claimant's chondromalacia condition. Based on this reasoning, Liberty asserts that responsibility shifts to SAIF. For the following reasons, we disagree.

The issue in this case is responsibility for the disputed right knee chondromalacia conditions in the context of successive accepted right knee injuries to the same body part. In deciding responsibility, we first determine whether the current condition has been previously accepted. If so, then responsibility is decided under ORS 656.308(1). If not, then responsibility is resolved under the rebuttable presumption of *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984) or ORS 656.005(7)(a)(A), depending on whether the medical evidence establishes that a prior accepted injury is the major contributing cause of a consequential condition. *See Conner v. B&S Logging*, 153 Or App 354 (1998); *Terry L. Davis*, 52 Van Natta 2185 (2000); *Douglas R. Barnes*, 52 Van Natta 2097 (2000); *Thomas L. Hinson*, 51 Van Natta 1942, 1944 (1999).

Here, because the chondromalacia conditions have not been previously accepted, ORS 656.308(1) does not apply to this case. The ALJ concluded, based on Dr. Laubengayer's persuasive opinion, that the 1994 injury was the major contributing cause of consequential right knee chondromalacia conditions. Based on the persuasive medical evidence from Dr. Laubengayer, we agree with the ALJ that the medical evidence establishes that the 1994 Liberty injury is the major contributing cause of claimant's

consequential right knee conditions.[1] We agree with the ALJ, therefore, that Liberty is responsible for the right knee chondromalacia conditions under ORS 656.005(7)(a)(A). *See Albert H. Olson*, 51 Van Natta 685, 687 (1999).

Because the ALJ's order addressed the compensability of claimant's condition, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue which was potentially at risk by virtue of our *de novo* review of the ALJ's order. After considering the factors set 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 $700, payable by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the one page argument in the respondent's brief submitted by claimant). *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 29, 2001 is affirmed. For services on Board review, claimant's attorney is awarded $700, payable by Liberty Northwest.

[1] Liberty argues that Dr. Laubengayer did not attribute claimant's chondromalacia in the right patella to the 1994 injury. We disagree. Dr. Laubengayer attributed the majority of claimant's problems seen at the second arthroscopy surgery to the first (1994) injury. (Ex. 101A-12). In addition, Dr. Laubengayer also specifically stated that "the majority of the problem with the patella was from the first injury." (Ex. 101A-17). Thus, we find no merit in Liberty's contention and conclude that Dr. Laubengayer attributed both the chondromalacia of the right tibial plateau and the chondromalacia of the patella in major part to the 1994 compensable injury with Liberty's insured.

In the Matter of the Compensation of
PATRICIA J. LATAL, Claimant
WCB Case No. 00-04009
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) upheld the self-insured employer's denial of claimant's "consequential condition" claim for a low back condition; and (2) declined to asses a penalty for allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

Claimant compensably injured her left shoulder on September 21, 1998.[1] (Ex. 15). Claimant's left shoulder was surgically repaired in February 1999. (Ex. 25).

In March 1999, claimant filed a claim a low back strain, allegedly due to her inability to use her left arm following surgery.[2] (Ex. 27). The back condition was denied on May 19, 2000. (Ex. 52). Claimant filed a request for hearing seeking: (1) to establish the compensability of her low back condition; and (2) penalties for allegedly unreasonable claim processing.

[1] The claim was initially accepted in October 1998, as a left shoulder contusion. (Ex. 20). Later, in August 1999, the acceptance was amended to include both a left shoulder contusion and a left subacromial impingement. (Ex. 38).

[2] The employer does not dispute that Exhibit 27 (an 827 form signed by claimant and her then attending physician, Dr. Spady) constitutes a "claim." (Closing argument, 12).

The ALJ determined that the medical evidence did not support a conclusion that the major contributing cause of claimant's low back condition was her compensable shoulder condition. Consequently, the ALJ concluded that claimant had failed to establish the compensability of her low back condition as a "consequential" condition. The ALJ also concluded that because the denial was upheld, it was not necessary to address the merits of the claim for penalties.

In order to establish her low back condition as a "consequential" condition of her compensable injury, claimant must prove that the compensable injury is the major contributing cause of the low back condition.[3] ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411, 415 (1992). To satisfy the "major contributing cause" standard, claimant must establish that her work 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 low back condition and deciding which is the primary cause. *See 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. *Dietz*, 30 Or App at 401; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997); *Elaine M. Baxter*, 51 Van Natta 1898 (1999). Because of the possible alternative causes for her low back 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).

Claimant contends that the opinions of Dr. Spady (attending physician) and Dr. Smith (attending surgeon for the February 1999 shoulder surgery) establish the compensability of her low back condition. For the reasons stated below, we disagree.

With regard to the cause of claimant's low back condition, Dr. Spady opined: "The degenerative process may be a preexisting condition but without the forceful injury while at work the radiculopathy and back pain may very well have never occurred." (Ex. 44A). We interpret Dr. Spady's opinion as supporting a conclusion that claimant's compensable injury is the precipitating cause, but not necessarily the major contributing cause, of claimant's low back condition. Without further explanation, such an opinion is insufficient to establish the compensability of claimant's low back problem as a "consequential condition." *Gasperino*, 113 Or App at 415.

Dr. Smith initially concurred with the opinion of Drs. Gripekoven and Reimer (employer-arranged examiners) that claimant's low back condition was "related to a preexisting degenerative condition in [claimant's] lumbar spine and is not related in any way to her left shoulder injury." (Exs. 39-7; 42). Later, Dr. Smith opined that claimant's low back condition was a "combined condition" consisting of a mechanical strain and degenerative lumbar disc disease and that claimant's work injury "precipitated" her low back symptoms. (Ex. 57-2; 58-1). Without additional explanation, Dr. Smith then concluded that the work injury was the major contributing cause of claimant's low back symptoms. (Ex. 58-2). From those remarks we conclude that Dr. Smith equates "precipitating cause" with "major contributing cause." Consequently, without further discussion concerning the relative contributions of the preexisting degenerative disc disease and the work injury in producing claimant's low back problem, we are unable to conclude that Dr. Smith's opinion establishes the compensability of claimant's low back condition.

Based on this record, we agree with the ALJ that claimant failed to establish the compensability of her low back condition.

Claimant asserts she is entitled to a penalty pursuant to ORS 656.262(11) for the employer's unreasonable delay (191 days beyond the time required by ORS 656.262(6)(a)) in the denial of her low back condition. Because we have upheld the 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). Consequently, no penalty can be awarded.

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[3] In her appellate brief, claimant suggests that because of the Supreme Court's recent decision in *Smothers v. Gresham Transfer, Inc.*, 332 Or 83 (2001), the material contributing cause standard rather than the major contributing cause standard applies. The *Smothers* holding does not alter the relevant statutory standards that are applicable in this case.

ORDER

The ALJ's order dated March 7, 2001 is affirmed.

In the Matter of the Compensation of
DOUG MADRID, Claimant
WCB Case No. 00-07679
ORDER ON REVIEW
Coughlin, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Biehl. Member Bock concurs. Member Biehl dissents.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) declined to find that the SAIF Corporation had *de facto* denied claimant's claim for DeQuervain's tenosynovitis in his left thumb; (2) declined to award an assessed attorney fee for prevailing over the alleged *de facto* denial; and (3) declined to assess penalties or a penalty-related attorney fee for SAIF's allegedly unreasonable and untimely claim processing. On review, the issues are claim processing, penalties, and attorney fees.

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

On review, claimant contends that the ALJ erred in determining that his claim for left thumb DeQuervain's tenosynovitis was a new medical condition claim that SAIF properly and timely processed pursuant to ORS 656.262(7)(a). Specifically, claimant contends that the ALJ failed to apply *Johansen v. SAIF*, 158 Or App 672, 679, on recon 160 Or App 579, *rev den* 329 Or 527 (1999). In *Johansen*, the court explained that "[a] new medical condition (1) arises after acceptance of an initial claim, (2) is related to an initial claim, and (3) *involves a condition other than the condition initially accepted.*" (Emphasis added).

Claimant does not dispute that the first two criteria in *Johansen* are met under the facts of this case. However, claimant contends that the third *Johansen* criteria was not met because the left thumb DeQuervain's tenosynovitis condition did not involve a condition other than the condition initially accepted. Therefore, claimant argues, his claim for left thumb DeQuervain's tenosynovitis was not a "new medical condition" claim under ORS 656.262(7)(a), which provides the carrier 90 days to process the claim. Instead, claimant argues, his claim was an "omitted condition" claim under ORS 656.262(6)(d), which provides the carrier 30 days to process the claim. We disagree.

Here, following the work injury, claimant was diagnosed with left thumb sprain and left thumb tendonitis conditions. SAIF initially accepted "left thumb sprain and left thumb tendonitis." (Ex. 10). Subsequently, claimant began treating with Dr. Hales, orthopedist, who diagnosed left thumb DeQuervain's stenosing tenosynovitis. (Ex. 15-1). On May 9, 2000, claimant made a claim for left thumb DeQuervain's tenosynovitis. In response to SAIF's inquiry, Dr. Hales explained that "the accepted left thumb tendonitis certainly encompasses the diagnosis of DeQuervain's tenosynovitis because DeQuervain's tenosynovitis is a form of thumb tendonitis." (Ex. 23).

On July 19, 2000, SAIF responded to claimant's claim for left thumb DeQuervain's tenosynovitis by stating that, based on Dr. Hales' statement that the DeQuervain's tenosynovitis condition was encompassed by the accepted left thumb tendonitis, no amendment of the acceptance would be made. (Ex. 26). Subsequently, Dr. Hales responded to claimant's attorney's inquiry and explained that the DeQuervain's tenosynovitis "is not a separate and distinct entity from the left thumb sprain and left thumb tendonitis, which [SAIF] formally accepted, but the same entity. DeQuervain's stenosing tenosynovitis is a type of tendonitis in the wrist and the base of the thumb." (Ex. 29).

On this record, we find that, although the left thumb DeQuervain's tenosynovitis is a type of tendonitis of the thumb, DeQuervain's tenosynovitis involves a condition other than the condition initially *accepted; i.e.*, "left thumb sprain and left thumb tendonitis." (Ex. 10). Therefore, contrary to claimant's argument, all three *Johansen* criteria are met under the facts of this case. Accordingly, the ALJ properly analyzed the claim for left thumb DeQuervain's tenosynovitis as a new medical condition claim under ORS 656.262(7)(a).

ORDER

The ALJ's order dated January 31, 2001 is affirmed.

Board Chair Bock concurring.

In finding that this claim should have been processed under ORS 656.262(6)(d), the dissent relies on an issue/theory not raised by claimant at hearing or on review. Claimant's sole argument regarding the applicability of ORS 656.262(6)(d) was that the DeQuervain's tenosynovitis was an "omitted condition" under ORS 656.262(6)(d) and, therefore, SAIF had 30 days to process the claim pursuant to that statute. Although the dissent rejects that argument, finding that the DeQuervain's tenosynovitis was not an "omitted condition" because it was first diagnosed after SAIF's acceptance, the dissent creates its own issue/theory to conclude that SAIF's notice of acceptance was "otherwise deficient" and that claimant was entitled to challenge the acceptance on that basis under ORS 656.262(6)(d). Claimant, however, did not raise that issue/theory.

Rather than engaging in an analysis not presented in the parties' stated positions, I agree with the majority's approach of considering only the issues raised by the parties. *See Fister v. South Hills Health Care*, 149 Or App 214, 218 (1997), *rev den* 326 Or 389 1998) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing); *Karl C. Meink*, 53 Van Natta 942 (2001).

Board Member Biehl dissenting.

Based on the following reasoning, I would find that ORS 656.262(6)(d) applies under the facts of this case. Therefore, SAIF had 30 days to process claimant's claim for left thumb DeQuervain's tenosynovitis. Because SAIF failed to process the claim within 30 days without providing a reasonable explanation for that failure, I would assess penalties and attorney fees for SAIF's unreasonable and untimely claim processing. Therefore, I respectfully dissent.

I begin with a summary of the relevant facts. On January 25, 2000, claimant sustained a compensable injury. On February 22, 2000, SAIF accepted disabling "left thumb sprain and left thumb tendonitis." (Ex. 10). Prior to SAIF's acceptance, left thumb DeQuervain's tenosynovitis had not been diagnosed. On March 28, 2000, Dr. Hales, treating orthopedist, first diagnosed left thumb DeQuervain's tenosynovitis.

On April 19, 2000, claimant's attorney notified SAIF that Dr. Hales recommended that claimant undergo a left DeQuervain's tenosynovitis release and requested that SAIF "authorize this surgical procedure as it is directly related to claimant's January 25, 2000 industrial injury." (Ex. 18). On April 26, 2000, a claims adjuster for SAIF responded that claimant's claim "is accepted for left thumb sprain and left thumb tendonitis. * * * Because the proposed surgery is not directed at an accepted condition and because managed care certification has not occurred, I am unable to authorize the surgery at this time." (Ex. 19).

On May 9, 2000, in response to the letter from SAIF's claims adjuster, claimant's attorney communicated in writing to SAIF and made a "claim" for claimant's "DeQuervain's tenosynovitis as a condition that occurred as a result of [claimant's] January 25, 2000 industrial injury." (20). SAIF received that communication on May 11, 2000. (*Id.*)

On May 23, 2000, SAIF inquired of Dr. Hales whether the accepted left thumb tendonitis condition encompassed the diagnosis of DeQuervain's tenosynovitis and reasonably apprised claimant of the nature of the work-related injury. (Ex. 21). On June 30, 2000, Dr. Hales responded that "the accepted left thumb tendonitis certainly encompasses the diagnosis of DeQuervain's tenosynovitis because DeQuervain's tenosynovitis is a form of thumb tendonitis." (Ex. 23). On July 19, 2000, SAIF responded to claimant's attorney's May 9, 2000 letter, stating that "based on the treating physician's indication that the [DeQuervain's tenosynovitis] condition is encompassed by the already accepted left thumb tendonitis, no amendment of the acceptance will be made." (Ex. 26).

ORS 656.262(6)(d) provides:

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

As the ALJ explained, we have held that, under ORS 656.262(6)(d), an "omitted condition" is one which was in existence at the time the carrier accepted the claim, but was not included in and therefore omitted from the Notice of Acceptance. *Mark A. Baker*, 50 Van Natta 2333 (1998). Claimant's DeQuervain's tenosynovitis condition was first diagnosed almost a month after SAIF's acceptance. Therefore, that condition was not an "omitted condition" under ORS 656.262(6)(d).

Nevertheless, as highlighted above, ORS 656.262(6)(d) does not only apply to a condition has been "incorrectly omitted" from a notice of acceptance. It also applies when an injured worker believes "that the notice [of acceptance] is otherwise deficient."

Here, SAIF's claims adjuster declined to approve treatment for the DeQuervain's tenosynovitis condition based, in part, on a contention that the proposed treatment was *not* directed at an *accepted condition*, which the claims adjuster identified as "left thumb sprain and left thumb tendonitis." (Ex. 19). Clearly, at least at that point, the claims adjuster did not consider the DeQuervain's tenosynovitis condition as "encompassed" in the accepted condition.

I acknowledge that, under ORS 656.262(7)(a), a carrier "is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions." Here, however, SAIF's acceptance failed to reasonably apprise even SAIF's own claims adjuster as to "the nature of the compensable conditions" since the claims adjuster did not consider the DeQuervain's tenosynovitis condition as part of the compensable condition. Therefore, it follows that SAIF's acceptance did not reasonably apprise claimant and medical providers of the nature of the compensable conditions. In this way, the notice was "otherwise deficient" and claimant was entitled to challenge it on that basis under ORS 656.262(6)(d). If claimant had not challenged the notice of acceptance, it is entirely possible that SAIF would not have further investigated the matter and would have maintained the claims adjuster's position that the DeQuervain's tenosynovitis condition was not part of the accepted condition.

While I do not agree with claimant that his April 19, 2000 request for authorization for surgical treatment for his DeQuervain's tenosynovitis condition constituted a claim under ORS 656.262(6)(d),[1] I find that his May 9, 2000 written request was such a claim. SAIF received that request on May 11, 2000, and had 30 days from that date "to revise the notice [of acceptance] or to make other written clarification in response." ORS 656.262(6)(d).

Although SAIF did not revise its acceptance, it did "make other written clarification in response" when it notified claimant on July 19, 2000 that the DeQuervain's tenosynovitis condition was "encompassed" in the accepted left thumb tendonitis condition. (Ex. 26). However, that written clarification was made more than 30 days from May 11, 2000, the date SAIF received claimant's written

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[1] I reach this conclusion based on the language in ORS 656.262(6)(d) that "[a]n injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, *first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice.*" (Emphasis added). A request for authorization for a surgical procedure is not an objection to the notice of acceptance.

communication. SAIF does not offer any reason for its untimely response.[2] Under these circumstances, SAIF's claim processing was unreasonable; therefore, claimant is entitled to assessed attorney fees and penalties. Because the majority holds otherwise, I respectfully dissent.

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[2] In addition, although SAIF had only 30 days to provide a written clarification to claimant, SAIF delayed making an inquiry to Dr. Hales for almost two weeks after it received claimant's request. Furthermore, SAIF did not advise claimant that it was investigating the claim or provide any date by which it would make a decision. Instead, SAIF simply ignored the 30-day processing deadline without any communication with claimant until well after that deadline had passed. *Compare Mary A. Egbert*, 52 Van Natta 1457 (2000) (claim processing timely and no assessed attorney fee where, within 30 days from the claimant's request to accept omitted conditions, the carrier responded in writing, stating that it would be gathering information to determine compensability and that it would make a decision by a certain date).

In the Matter of the Compensation of
SUELLEN A. SHOEMAKER, Claimant
WCB Case No. 00-07201
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Gilroy Law Firm, Defense Attorney

Reviewing Panel: Members Phillips Polich, Bock, and Meyers. Member Meyers is concurring in part, and dissenting in part.

The self-insured employer requests review of Administrative Law Judge (ALJ) Marshall's order that set aside its denial of claimant's occupational disease claim for a bilateral wrist and hand condition. On review, the issue is compensability.

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

On review, the employer repeats its argument that claimant's claim is not compensable because she does not have a definitive diagnosis and several "possible" diagnoses have been ruled out, including those explicitly denied in its September 8, 2000 denial. However, as explained by the ALJ, although not providing a definitive diagnosis of claimant's condition, Dr. Lin, treating physiatrist, diagnosed an overuse syndrome, which he attributed in major part to claimant's work activity. In addition, citing *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988), the ALJ found that the lack of a definitive diagnosis was not dispositive on the issue of compensability.

We agree with the ALJ's reasoning with regard to the fact that a definitive diagnosis is not required. Moreover, to the extent that the employer requests that we define a diagnosis, we note that we have previously declined such a request in similar cases. *See Christine Salveta*, 52 Van Natta 1069 (2000); *Robert E. Roy*, 42 Van Natta 2000 (1990), *aff'd Boeing Aircraft Co. v. Roy*, 112 Or App 10 (1992).

In *Roy*, we held that a diagnosis of a condition was not required to establish a compensable claim under the applicable statute. Rather, the only requirement was medical services and/or disability that were caused by the work injury. We further held that, because a condition or diagnosis was not known, the carrier was not being ordered to accept a specific condition. Instead, the carrier was being ordered to accept the medical services and/or disability that were a result of the work injury. In *Salveta*, we applied our reasoning in *Roy* to find compensable an occupational disease claim for a bilateral upper extremity condition.

The court affirmed our decision in *Roy*, finding that the claimant was not required to prove a specific medical diagnosis to support the claim that his pain symptoms reflected a compensable injury. *Roy*, 112 Or App at 14. Moreover, the court held that we had set aside a general denial of the claim, not a denial of responsibility for specific injuries that the claimant did not have and for which he did not make a claim. *Id.*

Here, as in *Roy*, we find that the employer's denial represented a general denial of the claim, in addition to denying various possible diagnoses. In this regard, the denial referred to claimant's "condition" as being noncompensable. Moreover, as in *Roy*, there was no indication that the employer's

decision to deny the claim was incomplete/tentative or that any element of the claim was still being considered. Accordingly, consistent with *Salveta* and *Roy*, in the present case, we conclude that the ALJ properly found that claimant has a compensable occupational disease of the wrists and hands and that the claim should be accepted.

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015- 0010(4) and applying them to this case, we conclude that $1,200 is a reasonable assessed attorney fee for claimant's counsel's services on review, to be paid by the 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 January 22, 2001 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the employer.

Board Member Meyers concurring in part and dissenting in part.

Although I concur with the majority's statement of the law and its application to the facts in this case (with the exception of the ganglion cyst condition as addressed below) I write to express my consternation with the current state of law in this area. In this regard, case law holds that a claimant is not required to establish a specific diagnosis in order to prove a compensable claim. *Boeing Aircraft Co. v. Roy*, 112 Or App 10 (1992); *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988); *Christine Salveta*, 52 Van Natta 1069 (2000). However, when, as here, a "general claim" is made and/or found compensable, it is not sufficiently clear what condition(s) a carrier is required to process.

In *Roy*, the court held that the Board correctly set aside a general denial of a claim. There, the employer complained that claims that lack specificity "'impale the employer on the horns of a dilemma,' unfairly forcing it to risk failing to accept or deny the claim timely on the one hand or exposing itself to liability for a noncompensable condition on the other." 112 Or App at 14. The court responded that "[e]ven if [the] employer has correctly identified the legal effect of those hypothetical facts as a dilemma, it has not raised an issue that we can address," stating that the employer's remedy, if any, lies with the legislature. *Id.* at 15 (footnotes omitted).

Here, as in *Roy*, it appears that the employer's remedy, if any, remains with the legislature. Nonetheless, I point out, as did the court in *Roy*, that potential remedies may be provided by ORS 656.262(6)(a)[1] and the fact that a carrier may make a claim acceptance more specific than the claim is. *SAIF v. Abbott*, 107 Or App 53 (1991); *Roy*, 112 Or App at 15 fn 2.

Finally, I respectfully dissent with the majority regarding the analysis of the bilateral ganglion cyst condition. On this record, I would uphold that portion of the denial that denied the bilateral ganglion cyst condition. Dr. Lin, claimant's treating physician, does not discuss the cause of the ganglion cysts. The ganglion cysts were not present when Dr. Schilperoort, orthopedist, examined claimant on behalf of the employer. Dr. Schilperoort did not find this unusual, since ganglion cysts tend to come and go. Although claimant had ganglion cysts when examined by Dr. Dordevich, examining orthopedic rheumatologist, he associated them with degenerative changes and stated that they were not due to claimant's work activities. Thus, the only evidence regarding the cause of the ganglion cysts stated that they were *not* work-related.

Because the majority sets aside the denial in its entirety, without specifically excepting the denied bilateral ganglion cyst condition, I respectfully dissent.

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[1] ORS 656.262(6)(a) provides in relevant part:

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

In the Matter of the Compensation of
BERNARD LeCANGDAM, Claimant
WCB Case No. 00-00964
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Biehl. Member Biehl chose not to sign the order.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set its denial of claimant's occupational disease claim for left ear hearing loss. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the "Ultimate Findings of Facts."

CONCLUSIONS OF LAW AND OPINION

Claimant, an automobile mechanic, filed an occupational disease claim for bilateral hearing loss in September 1999, allegedly due to noise exposure at work. Claimant first sought treatment on September 20, 1999 for high frequency hearing loss that, according to Dr. Harvey, was industrial in origin. (Ex. 1B).

On December 2, 1999, an audiologist, Dr. Hicks, evaluated claimant's condition on SAIF's behalf. Dr. Hicks concluded that the high frequency configuration of claimant's hearing loss was consistent with noise-induced etiology in both ears, with some form of middle ear pathology for low frequencies in the left ear. (Ex. 8-2). Dr. Hicks further opined that 21.28 percent of the total hearing loss in the left ear of 28.51 percent was low to mid-frequency hearing loss attributable to non-occupational middle ear pathology. According to Dr. Hicks, the remaining 7.23 percent was attributable to occupational high frequency hearing loss. Therefore, Dr. Hicks concluded that the major contributing factor to the left ear hearing loss was middle ear pathology. (Ex. 8-3).

On December 8, 1999, SAIF denied the claim for bilateral hearing loss. Claimant requested a hearing from the denial. SAIF later accepted right ear monaural hearing loss on March 6, 2000.

On March 23, 2000, Dr. Harvey concurred with Dr. Hicks' report. (Ex. 12). Dr. Harvey later issued a follow-up report on April 30, 2000. In that report, he acknowledged that claimant's low frequency loss in the left ear was not due to noise exposure at work, but wrote that SAIF should pay for a hearing aid for the left ear high frequency hearing loss even though it would help the non-occupationally related low frequency hearing loss. (Ex. 14-2).

On July 21, 2000, Dr. Harvey indicated that he agreed with the contents of a letter drafted by claimant's counsel that included a statement that, even if claimant did not have low frequency hearing loss, he would still require a hearing aid for the left ear. Dr. Harvey also agreed with the statement that the major contributing cause of the high frequency hearing loss in the left ear was noise exposure at work. (Ex. 15).

The ALJ set aside SAIF's denial of claimant's hearing loss claim, finding that claimant's work activities were the major contributing cause of high frequency hearing loss in the left ear and of his need for treatment in the form of a hearing aid. In so doing, the ALJ reasoned that claimant only sought compensability of a need for treatment of his high frequency hearing loss in the left ear. The ALJ further reasoned that Dr. Harvey's opinion made it clear that, if claimant only had low frequency hearing loss, he would not need a hearing aid. Thus, the ALJ concluded that the only medical treatment necessary was for the high frequency hearing loss and that there was no "combined" condition triggering application of ORS 656.005(7)(a)(B).

SAIF argues that the claim is not compensable because the majority of claimant's left-sided hearing loss is due to non-occupational middle ear pathology. SAIF contends that the ALJ's order

finding the claim compensable is contrary to cases holding that a claimant may not extract a portion of a disease and claim only that portion which is caused in major part by the work exposure. In this regard, SAIF relies on *John W. Wantowski*, 50 Van Natta 2027 (1998), *aff'd Wantowski v. Crown Cork & Seal*, 164 Or App 214 (1999); *Phillip Taylor*, 51 Van Natta 898 (1999), and *Henry F. Downs*, 48 Van Natta 2094 *recon*, 48 Van Natta 2200 (1996). We find SAIF's contentions persuasive.

In *Downs*, we explained:

> "Claimant is not permitted to extract a portion of the disease (hearing loss) and claim that only that portion is caused in major part by work exposure. Pursuant to ORS 656.802(2)(a), claimant must prove that the major contributing cause of his overall hearing loss was work-related noise exposure." 48 Van Natta at 2096.

In *Taylor*, the claimant argued that he did not have a "combined condition" under ORS 656.802(2)(b) because, according to the medical evidence, his preexisting and age-related hearing loss were separate processes from hearing loss from industrial exposure. The claimant contended that "the claim should be allowed for noise-induced hearing loss because the medical evidence established that industrial exposure was the major cause of Claimant's binaural loss of hearing due to noise."

We rejected that contention, explaining that we considered the "claim" to consist of the claimant's entire hearing loss, and not just any portion that can be attributed to industrial exposure. Thus, whether or not the claimant had a "combined condition," because the medical evidence showed that preexisting hearing loss and age-related hearing loss, rather than industrial exposure, were the major contributing causes of the claimant's entire hearing loss claim, the claimant did not prove compensability. 51 Van Natta at 898.

In *Wantowski*, the claimant argued that presbycusis should not qualify as a "preexisting condition" in determining whether his hearing loss was compensable. We rejected that argument, citing *Downs* and *Willard A. Hirsch*, 49 Van Natta 1311 (1997), where we concluded that it was immaterial whether the claimant's presbycusis was a "preexisting condition" within the meaning of ORS 656.005(24) or whether the claimant's hearing loss was a "combined condition" within the meaning of ORS 656.005(7)(a)(B) or ORS 656.802(2)(b). In *Wantowski*, we agreed with the ALJ's reasoning that the medical evidence established that the claimant's hearing loss was caused in major part by age-related presbycusis, not work-related noise exposure. Therefore, we found that the ALJ properly upheld the carriers' denials. 50 Van Natta at 2027. The Court of Appeals affirmed our decision. *Wantowski v. Crown Cork & Seal*, 164 Or App at 219.

In accordance with our reasoning in the above cases, we again reiterate that a claimant is not permitted to extract a portion of the disease (hearing loss) and claim that only that portion is caused in major part by work exposure. As the previous cases make clear, it is immaterial whether or not a "combined" condition exists or whether non-industrial hearing loss is a separate process from hearing loss caused by industrial exposure. Claimant must prove that work exposure was the major contributing cause of the entire hearing loss, not just the industrially related portion. Because the medical evidence in this case establishes that work exposure is not the major contributing cause of claimant's overall hearing loss, we conclude that claimant has failed to prove a compensable occupational disease claim. Thus, we reverse.

ORDER

The ALJ's order dated January 25, 2001 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
GLENDA G. BRADEN, Claimant
WCB Case No. 00-07986
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Bock.

Claimant requests reconsideration of our July 18, 2001 Order on Review that reversed that portion of the Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial in its entirety. Instead, our order set aside SAIF's denial to the extent that it denied claimant's low back injury claim before September 21, 2000 and upheld it to the extent that it denied the claim as of September 21, 2000. Claimant gives several arguments for challenging our order.

First, claimant asserts that, because the denial was of the entire claim and the parties did not argue that claimant proved compensability for a discrete period, we did not have the "authority" to conclude that claimant proved compensability for a certain period. Claimant further contends that we "improperly entered the arena of claims processing" because SAIF did not issue a denial under ORS 656.262(6)(c).

ORS 656.005(7)(a)(B) provides that, if a compensable injury combines with a preexisting condition, "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 or need for medical treatment of the combined condition." (Emphasis added.) Based on the terms of the statute, disability or the need for medical treatment of the combined condition is compensable only for as long as the compensable injury is the major contributing cause. Consistent with this language, in previous cases, we have set aside a denial of compensability when the claimant proved that the compensable injury was the major contributing cause during a particular period of time. *E.g., Susan Vega*, 49 Van Natta 805 (1997) (the claimant proved compensability of her "combined condition" during a discrete period of time and the denial set aside for that time period); *Kathy A. Zuereher*, 48 Van Natta 2612 (1996); *Danny B. Conner*, 48 Van Natta 1227 (1996).

Thus, we disagree with claimant that we lack "authority" to set aside SAIF's denial for the period before September 21, 2000. We continue to find that the most persuasive medical evidence shows that the compensable injury was the major contributing cause only until September 20, 2000. Based on such evidence, and because ORS 656.005(7)(a)(B) provides that disability and the need for medical treatment of the combined condition is compensable for only "so long as" the compensable injury is the major contributing cause, our decision is justified.[1]

Claimant correctly contends that neither party at hearing or on review specifically argued that compensability was proved for a particular period of time. At hearing, however, claimant challenged SAIF's denial that claimant sustained a low back injury on August 21, 2000. On review, claimant did not dispute the ALJ's application of ORS 656.005(7)(a)(B) in determining compensability.

The Board generally addresses only those issues raised by the parties. *See Fister v. South Hills Health Care*, 149 Or App 214 (1997) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing). Because the issue at hearing and on review was compensability and, specifically, whether claimant proved compensability under ORS 656.005(7)(a)(B), we do not consider our conclusion that claimant carried her burden of proof for a specific time period to be a "new issue." Rather, as discussed above, based on the language of the statute and the medical evidence presented in this particular case, we continue to find that the most appropriate resolution of the compensability issue is to conclude that claimant carried her burden of proof for the period up to September 20, 2000.

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[1] We find no merit to claimant's argument concerning ORS 656.262(6)(c). SAIF had not issued an acceptance for this claim and, its denial was not "pre-closure." *See Croman v. Serrano*, 163 Or App 136 (1999) (carrier must have accepted a "combined" condition in order to properly issue a "pre-closure" denial pursuant to ORS 656.262(7)(b) and ORS 656.262(6)(c)).

Accordingly, we withdraw our July 18, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our July 18, 2001 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
HELEN F. ILES, Claimant
WCB Case No. 98-09479
ORDER ON REMAND
Dennis O'Malley, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

This matter is before the Board on remand from the Court of Appeals. *Iles v. Fred Meyer, Inc.*, 173 Or App 254 (2001). The court has reversed our prior order, *Helen F. Iles*, 51 Van Natta 1504 (1999), that affirmed an Administrative Law Judge (ALJ's) order upholding the self-insured employer's denial of claimant's right wrist injury claim. In reaching our conclusion, we agreed with the ALJ's reasoning that claimant's injury claim was not supported by "objective findings." *See* ORS 656.005(19). Determining that we did not address the evidence of edema contained in claimant's attending physician's chart note and that we failed to explain why the physician's observation and measurement of reduced grip strength was not an "objective finding," the court concluded that our order did not provide a sufficient explanation to allow it to examine our decision. Consequently, the court remanded for reconsideration.

FINDINGS OF FACT

We continue to adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In accordance with the court's directive, we address the evidence of "edema" and reduced grip strength in order to determine whether claimant's injury claim is supported by "objective findings." "Objective findings" are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. ORS 656.005(19). "Objective findings" do not include "physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." *Id; see SAIF v. Lewis*, 170 Or App 201, 212 (2000), *rev allowed* 331 Or 692 (2001) (requirement of objective findings not satisfied by reports of symptoms not presently verifiable by the physician).

Here, we first examine the evidence of edema to determine whether it could constitute an "objective finding" in support of the right wrist injury claim. The only reference to edema is in an August 18, 1998 chart note from Dr. Pribnow, the attending physician. There, Dr. Pribnow stated that there was "some mild edema of the ulnar side of the very distal right forearm." (Ex. 8). However, Dr. Pribnow further stated that this "could just be anatomic variation since it is not over any particular structure." (*Id.*)

Thus, Dr. Pribnow did not relate the finding to the alleged injury, noting that it could merely represent an anatomic variation. Under these circumstances, where edema was not documented in prior or subsequent medical examinations, we do not find that this isolated reference to edema constitutes an "objective finding" in support of the wrist injury claim.[1] *See Lewis*, 170 Or App at 213 (objective finding of "elevated bilirubin total" that a physician stated was only possibly related to toxic exposure was too speculative to prove compensability); *Linda S. Clemens*, 50 Or App 2269 (1998).

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[1] Claimant is correct that we have previously held that edema was an objective finding in *Sandra K. Mitchell*, 51 Van Natta 1837 (1999). However, it does not appear from that order that there was a statement from a physician comparable to Dr. Pribnow's that the edema in this case could represent an anatomic variation. Under these circumstances, we do not find *Mitchell* controlling because it is factually distinguishable.

We now turn to the reduced grip strength findings.[2] Dr. Pribnow noted that claimant's right hand was weaker than her left, but stated that she had no objective findings. (Ex. 10). Dr. Pribnow never described the alleged reduced grip strength as evidence of injury, nor did he attribute it to a work incident. (*Id.*) Moreover, Pribnow noted that claimant's findings were "nonanatomic" on a couple of occasions. (Exs. 4, 7). In addition, Dr. Pribnow concurred with Dr. Weintraub's conclusion that claimant's complaints were not valid. (Exs. 11, 13).

Having considered this evidence, we are not persuaded that the reduced grip strength findings constitute "objective findings."[3] Therefore, we agree with the ALJ that there are no "objective findings" to support the alleged injury.[4] Accordingly, on reconsideration, as supplemented herein, we republish our September 14, 1999 order.

IT IS SO ORDERED.

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[2] We note that the ALJ's order, which we adopted, addressed the question of whether claimant's reduced grip strength was an "objective finding." (O&O page 3, footnote 3). As supplemented herein, we continue to adopt the ALJ's reasoning that the reduced grip strength was not an "objective finding."

[3] Claimant cites *Scott D. Bruce*, 50 Van Natta 694 (1998), in which we found that reduced grip strength was an objective finding. In contrast to *Bruce*, however, where there was no indication from our order that the claimant's findings were invalid or "nonanatomic," in this case there is evidence of invalid and "nonanatomic" findings. Under these circumstances, we do not find that findings of reduced grip strength constitute "objective findings" in support of the right wrist injury claim.

[4] Citing *Jorge Cruz Lopez*, 52 Van Natta 1035 (2000), claimant argues that "objective findings" may exist even in a record obscured by functional overlay. We agree that the existence of functional overlay is not necessarily determinative in an "objective findings" evaluation. Nonetheless, we note that, in *Lopez*, there was an express credibility determination favorable to the claimant that is lacking in this case. Having reviewed this record once more, we are still not persuaded that this injury claim is supported by "objective findings."

August 10, 2001 Cite as 53 Van Natta 1073 (2001)

In the Matter of the Compensation of
ROBERT P. SALE, Claimant
WCB Case No. 99-02183
ORDER ON RECONSIDERATION
Walsh & Associates, Claimant Attorney
Jerald Keene, Defense Attorney

On May 11, 2001, we abated our April 13, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order setting aside the self-insured employer's denial of claimant's injury claim for a low back condition. We took this action to consider the parties' settlement.

The parties have now submitted a "Disputed Claim Settlement" that is designed to resolve all issues raised or raisable between them. Pursuant to the agreement, claimant agrees that the employer's denial "shall be forever affirmed" and that his request for hearing on the denial shall be dismissed with prejudice.

We have approved the settlement, 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
CRAIG R. LUNDY, Claimant
WCB Case No. 00-09374
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl. Member Biehl dissents.

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

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

The ALJ upheld SAIF's denial of claimant's occupational disease claim, finding that the medical evidence from claimant's attending physician, Dr. Wilson, was insufficient to satisfy his burden of proof. Specifically, the ALJ reasoned that Dr. Wilson could not state to a degree of "medical certainty" that work activity outweighed the contribution of other potential contributing factors.

On review, claimant contends that the ALJ erred in requiring that medical evidence be expressed to a degree of "medical certainty." Moreover, claimant argues that Dr. Wilson's opinion, as a whole, is sufficient to prove that his work activities are the major contributing cause of his bilateral hip avascular necrosis.

Claimant is correct that a medical opinion need not be expressed to a degree of medical certainty, only medical probability. *See Robinson v. SAIF*, 147 Or App 157, 160 (1997); *Gormley v. SAIF*, 52 Or App 1055, 1060 (1981). However, claimant must still prove that employment conditions are the major contributing cause of the disease. ORS 656.802(2)(a). "Major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *McGarrah v. SAIF*, 296 Or 145, 166 (1983).

Here, claimant's attorney asked Dr. Wilson on a couple of occasions to address the causation issue. On January 22, 2001, Dr. Wilson opined that he was certain that claimant's occupation had contributed to the degenerative process in his hips. Dr. Wilson stated, however, that it was "impossible for me to say that this particular occupation contributes more than 50% of his current need for surgery given [claimant's] size and other factors that I cannot measure." (Ex. 24). Dr. Wilson further stated that he did not believe that there was any preexisting condition or pathology that had also contributed as an identifiable set of circumstances to the degenerative disease, but that it was "unlikely that work alone caused this problem."

In a subsequent report of February 12, 2001, Dr. Wilson stated that, while claimant's work exposure constituted the most significant causative factor in his current condition, "I absolutely cannot say that it is greater than 50% of the reason for his current degenerative disease." (Ex. 26). Dr. Wilson further observed, however, that work exposure was "much more important than his size and more important than any underlying pathological or congenital problem I can identify." Dr. Wilson concluded by stating that claimant's condition was idiopathic avascular necrosis and that microtrauma was the most likely cause of idiopathic avascular necrosis.

We acknowledge that use of "magic words" is not required when a physician addresses causation. *McClendon v. Nabisco Brands*, 77 Or App 412, 417 (1986); *Sharon L. Catterson*, 53 Van Natta 112, 113 (2001). Having reviewed Dr. Wilson's opinion, however, we conclude that the most reasonable interpretation of his opinion is that, while claimant's work activities were the most significant single factor in claimant's condition, those activities did not contribute more to the claimed condition than all other factors combined. Moreover, we are unwilling to construe Dr. Wilson's opinion as stating that work activity is the major contributing cause of claimant's disease in the face of direct statements by Dr. Wilson that he could not say that employment was a greater factor than all other factors combined.

Accordingly, we conclude that Dr. Wilson's report does not satisfy claimant's burden of proof. Thus, we agree with the ALJ's decision to uphold SAIF's denial.

ORDER

The ALJ's order dated April 11, 2001 is affirmed.

Board Member Biehl dissenting.

The majority concludes that Dr. Wilson's medical opinion is insufficient to satisfy claimant's burden of proving that employment activities are the major contributing cause of his bilateral hip condition. Because I would reach the opposite conclusion, I respectfully dissent.

Initially, I agree with claimant that the ALJ's analysis was seriously tainted by his imposition of a standard of "medical certainty" to the medical evidence. *See Robinson v. SAIF*, 147 Or App 157, 160 (1997) (certainty not required to establish medical causation). Although the majority acknowledges the ALJ's error, I am not convinced that it takes the mistake as seriously as it should because it appears from the ALJ's order that he was requiring more from the medical evidence than was necessary for claimant to satisfy his burden of proof.

This leads me to the crux of my dissent. That is, I believe that, taken as whole, and considering the causal factors for which there is evidence in the record, Dr. Wilson's medical opinion persuasively establishes that claimant's employment activities are the major contributing cause of his bilateral hip condition. A brief review of Dr. Wilson's reports makes this point clear.

On September 6, 2000, Dr. Wilson reported that, even given claimant's rather large size, it would have been unusual for claimant, without a familial or personal history of hip problems, to have developed his hip condition without some contribution from work. (Ex. 16). Dr. Wilson later opined in January 2001 that avascular necrosis was most commonly associated with problems of trauma and microtrauma. (Ex. 24). Because claimant's job activities are the kind of trauma or microtrauma that can cause avascular necrosis, Dr. Wilson stated unequivocally that claimant's work activities contributed to the degenerative process. *Id.* While Dr. Wilson indicated that he could not assign percentages of causation, he explained that his analysis included "other factors that I cannot measure." Because Dr. Wilson was including in his analysis factors for which there was no evidence in the record, it should not be fatal to claimant's case that Dr. Wilson declined to assign percentages to causal factors.

Moreover, Dr. Wilson considered and rejected the idea of a preexisting condition because he stated that "I do not believe there is any preexisting condition or pathology that contributed as an identifiable set of circumstances" to the bilateral hip condition. (Ex. 24). This further shows that Dr. Wilson had considered all potential causal factors in claimant's condition, and while understandably reluctant to definitively rule out non-work factors, the only factors in claimant's condition that he could identify were work-related.

On February 12, 2001, Dr. Wilson concluded his series of causation opinions by again declining to assign percentages to the contribution of work exposure. However, he also explained that, with respect to work exposure, it was "much more important than his size and more important than any underlying pathological or congenital problem that I can identify." (Ex. 26). Dr. Wilson then stated that "microtrauma' on a scientific basis was the most likely cause of idiopathic avascular necrosis. Because Dr. Wilson had previously identified the "microtruama" to which was referring as claimant's job activities, this is a very definitive statement of causation.

Accordingly, having reviewed the medical evidence from Dr. Wilson, a few things are readily apparent. Dr. Wilson did consider the gamut of potential causal factors, even factors for which there is no evidence in the record. He consistently identified work exposure as the most significant factor in claimant's bilateral hip condition. The only impediment to victory for claimant is Dr. Wilson's apparently sincere reluctance to rule out the possible contribution of unidentified factors and unwillingness to use "magic words." Based on Dr. Wilson's statements that result from repeated and careful consideration of the potential causal factors, it is clear in my view that, among the causal factors that can be identified, work exposure is the major contributing cause of the bilateral hip condition. The majority's insistence on precise major contributing cause language does this claimant a great disservice.

For the above reasons, I cannot accept the majority's decision. Therefore, I respectfully dissent.

In the Matter of the Compensation of
SHIRLEE D. MARVIN, Claimant
WCB Case No. 00-08534
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's injury/occupational disease claim for a right knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." We do not adopt the ALJ's "Ultimate Finding of Fact," that claimant's knee condition is compensably related to her work activities for SAIF's insured.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant's knee condition should be analyzed as an occupational disease rather than an injury. The ALJ then relied on the opinion of Dr. Bowman (attending physician) and concluded that claimant had established the compensability of her right knee condition.

Claimant agrees with the ALJ's ultimate conclusion regarding the compensability of her knee condition, but asserts that her claim should be analyzed as an injury. SAIF, on the other hand, agrees with the ALJ's determination to analyze claimant's knee condition as an occupational disease, but contends that Dr. Bowman's opinion is insufficient to carry claimant's burden of proof. We agree with SAIF.

We begin by determining whether claimant's condition should be analyzed as an "injury" or an "occupational disease." An occupational disease stems from conditions that develop gradually over time. ORS 656.802; *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *Catherine F. Hardin*, 53 Van Natta 642 (2001). By contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Mathel*, 319 Or at 240; *Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999); *Valtinson v. SAIF*, 56 Or App 184, 188 (1982); *Hardin*, 53 Van Natta at 642. The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. *Valtinson*, 56 Or App at 188; *Hardin*, 53 Van Natta at 642.

Here, there is no identifiable event. (Tr. 13). Nor did the knee problem arise coincident with a significant change in job duties during a short, discrete period of time. Rather, claimant experienced the gradual onset of pain and swelling in her right knee over a 4 to 6 week period of time while performing essentially the same work duties she had performed for at least five years. Eventually, claimant sought medical attention on August 14, 2000. (Tr. 7, 13; Ex. 2). Under these circumstances, we agree with the ALJ's conclusion to analyze claimant's condition as an occupational disease.[1]

The evidence establishes that claimant's knee condition is a combined condition.[2] To establish the compensability of her knee condition as an occupational disease, claimant must prove that her work activities are the major contributing cause of the "combined condition" and a pathological worsening of the preexisting disease or condition. ORS 656.802(2)(a) and (b); *Vernon L. Mikesell*, 53 Van Natta 127 (2001).

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[1] Claimant offered no quantitative evidence from which we can conclude that her work duties were significantly different in July 2000 from what they had been for the last five years. Consequently, unlike the dissent, we find *Richard L. Ulmen*, 50 Van Natta 1033 (1998), in which the worker's duties increased from two to three hours per day to eight to ten hours per day, distinguishable. Moreover, unlike Ulmen, claimant's problem developed over a 4 to 6 week time period, rather than a two week time period. Under such circumstances, we do not consider the development of this claimant's symptoms to have been "sudden onset."

[2] Dr. Schilperoort, a SAIF-arranged medical examiner, opined that claimant's knee condition was a combination of preexisting degenerative changes in the knee and claimant's work activities, but concluded that claimant's work was not the major cause of the problem. (Ex. 13-6). Dr. Bowman agreed with the bulk of Dr. Schilperoort's report, but opined that the major cause of claimant's problem was her work activities. (Ex. 15-2).

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 condition and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). 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).

Here, Dr. Bowman provides the only expert medical opinion that arguably supports compensability. (Exs. 15-2; 16A). However, Dr. Bowman's opinion regarding causation was expressly limited to causation in relationship to the need for treatment. Because Dr. Bowman did not offer an opinion indicating that claimant's work activities were the major contributing cause of the combined knee condition and a pathological worsening of the preexisting condition of the knee, his opinion is not sufficient to carry claimant's burden of proof for this occupational disease claim. *See Tammy L. Foster*, 52 Van Natta 178 (2000) (merely proving that work activity is the major contributing cause of disability or need for treatment is not sufficient to establish compensability of an occupational disease).

Accordingly, the order of the ALJ is reversed.

ORDER

The ALJ's order dated March 28, 2001 is reversed. SAIF's denial of claimant's right knee condition is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority's conclusion that claimant has failed to establish the compensability of her right knee condition. Most notably, I disagree with the majority's conclusion to analyze claimant's knee condition as an occupational disease rather than as an injury. Therefore, I respectfully dissent.

An injury, in contrast to an occupational disease, is sudden, arises from an identifiable event, *or* has an onset traceable to a discrete period of time. (Emphasis added). *Mathel*, 319 Or at 240; *Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999); *Valtinson v. SAIF*, 56 Or App 184, 188 (1982); *Hardin*, 53 Van Natta at 642. Consequently, even though claimant's knee condition did not arise from an identifiable event, it may, nonetheless, be analyzed as an injury if its onset is traceable to a discrete period of time.

Here, claimant worked steadily as a highway flagger for five years. (Tr. 8). In early July 2000, claimant began working a highway project that was placing fiber optic cable in underground conduit. (Tr. 7-9). Because of the fast paced nature of this project, claimant did much more walking and other physical activity than was required with a typical highway construction project. (Tr. 9-13). After about two weeks of this increased activity, claimant began to notice pain and swelling in her right knee. (Tr. 13-14). Claimant self-medicated by elevating her right leg and applying ice. (Tr. 14). Eventually, claimant's knee problem worsened such that she sought medical attention on August 14, 2000. (Tr. 15; Ex. 1). Thus, claimant's knee condition is traceable to a to a discrete period of time; *i.e.*, a two week period immediately following a significant increase in claimant's physical activity at work.

In *Richard L. Ulmen*, 50 Van Natta 1033 (1998), the Board found the worker's cervical disc protrusion resulting from an increase in driving activities (from two to three hours per day to eight to ten hours per day) over a two week period constituted an injury rather than an occupational disease. Similarly, in *SAIF v. Strubel*, 161 Or App 516 (1999), the court affirmed the Board's conclusion that a worker's neck condition, traceable to a heavier than normal work load over an approximate three week time period, was compensable as an injury. I find *Ulmen* and *Strubel* controlling. Consequently, I conclude that claimant's knee condition is an injury, not an occupational disease. I now turn to the merits of claimant's injury claim.

In order to establish that the right knee condition is compensable as a "combined condition," claimant must show that her work injury (the two week period of increased work activity) was the major contributing cause of her 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 denied*, 326 Or 389 (1998). Because of the possible alternative causes for the right knee 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).

Dr. Bowman, the attending physician, opined that claimant's increased work activity (injury) was the major contributing cause of claimant's need for treatment. (Ex. 8). Dr. Bowman's opinion rest largely on his understanding of the nature of claimant's increased work activities (standing, twisting, turning, and moving signs off the road). (*Id.*) Finding no persuasive reason to do otherwise, I find Dr. Bowman's opinion persuasive.[1] Consequently, I conclude that claimant has established the compensability of her right knee condition.

Accordingly, I would affirm the ALJ's order. Because the majority arrives at a different conclusion, I respectfully dissent.

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[1] I acknowledge that Dr. Schilperoort disagrees with Dr. Bowman. However, because Dr. Schilperoort had an inaccurate history regarding claimant's work history and the nature of claimant's work, I find Dr. Schilperoort's opinion unpersuasive. *See Miller v. Granite Construction Company*, 28 Or App 473 (1977) (medical opinions based on an inaccurate history are entitled to little weight).

In the Matter of the Compensation of
JAMES P. SUTER, Claimant
Own Motion No. 01-0119M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Welch, Bruun & Green, Claimant Attorney

Reviewing panel: Members Haynes and Biehl.

Claimant requests review of the insurer's February 12, 2001, as amended February 21, 2001, Notice of Closure, which closed his claim with an award of temporary disability compensation from March 20, 2000 through January 23, 2001. The insurer declared claimant medically stationary as of January 23, 2001. Claimant contends that he is entitled to additional temporary disability because he was not medically stationary when the insurer closed his claim. Having received the parties' submissions and respective positions, we proceed with our review.[1]

FINDINGS OF FACT

On December 5, 1997, we issued an Own Motion Order, which authorized the payment of temporary disability compensation beginning October 17, 1997, the date claimant underwent a revision of the left total knee replacement. In a July 1999 doctor's report, Dr. Yates, claimant's attending physician, noted that claimant had experienced "increased pain since mid-winter." He postulated that claimant may have suffered a failure of his left knee reconstruction. Dr. Yates also indicated that claimant was not medically stationary.

Claimant underwent an insurer-arranged medical examination (IME) on February 9, 2000. The IME physician noted that claimant's total left knee replacement had developed loosening and that he would require "yet another left knee surgery." The IME physician further noted that claimant was not medically stationary.

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[1] On December 5, 1997, we issued an Own Motion Order, which reopened claimant's 1980 claim for the provision of temporary disability compensation. (Own Motion Case No. 97-0479M). SAIF has issued its April 12, 2001, as amended April 21, 2001, Notice of Closure for that claim.

In September 2000, because Dr. Yates was leaving the area, claimant's care was referred to Dr. Hayden. In a September 27, 2000 chart note, Dr. Hayden reported that claimant's left knee "femoral component" was loose and that he may require additional surgery. He reported that claimant was not medically stationary and transferred his care to Dr. Guyer.

After examining claimant on November 22, 2000, Dr. Guyer reported that claimant's total left knee was loose in the femoral position and he was going to require a revision.

Claimant attended another IME on January 23, 2001. The IME physician, Dr. Schilperoort, noted that claimant's femoral component had demonstrated some loosening and recommended revision of the femoral component in light of pain and the loosening. In response to the insurer's question: "With respect to the injury of October 28, 1980 is claimant's condition medically stationary?," Dr. Schilperoort responded that he was.

Relying on Dr. Schilperoort's report, the insurer issued its Notice of Closure on February 12, 2001, as amended on February 21, 2001, declaring claimant medically stationary as of January 23, 2001.

Claimant's care was then transferred to Dr. Samsell. In a March 28, 2001 chart note, Dr. Samsell reported that claimant's symptoms were "in keeping with loose femoral component." He noted that claimant was a "strong candidate" for a revision of the femoral component of his total left knee. In an April 5, 2001 response to the insurer's inquiry, Dr. Samsell opined that the need for surgery was necessary and it would improve claimant's compensable condition.

On July 2, 2001, the insurer submitted another Own Motion recommendation form, which asserted that it agreed that "[claimant] requires surgery on his left knee and this stems from the total knee replacement, which was covered under this claim." Although the insurer recommended reopening, it contended that claimant was not in the work force at the time of the current worsening.

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 February 12, 2001, as amended February 21, 2001 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, the insurer relies on Dr. Schilperoort's report. However, before and after the February 2001 closure, claimant's attending and examining physicians (including the February 2000 IME physicians) opined that claimant's condition was not medically stationary. These assessments were based on the proposition that claimant required a revision of the femoral component of his total left knee which would materially improve his compensable condition.

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. Yates (as supported by numerous examining and attending physicians). Dr. Yates treated claimant before and after the October 1997 surgery. Moreover, Drs. Yates, Hayden and Guyer had examined and treated claimant prior to the February 2001 claim closure. Finally, Dr. Samsell undertook claimant's care from Dr. Guyer and continued to opine that claimant still required a surgery that was first recommended in February 2000. Under such circumstances, we find Dr. Yates' opinion (as supported by Drs. Hayden, Guyer and Samsell and the February 2000 IME physicians) to be more persuasive than Dr. Schilperoort's January 2001 opinion that claimant's condition was medically stationary.

Consequently, we conclude that claimant was not medically stationary when his claim was closed by the insurer. Accordingly, we set aside the Notices of Closure as premature and remand the

claim to the insurer for further processing in accordance with law. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.[2]

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.

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[2] In light of our finding that the claim was prematurely closed, we have dismissed the July 2, 2001 Own Motion reopening request in a separate order.

In the Matter of the Compensation of
HAROLD F. SCHULTZ, Claimant
Own Motion No. 01-0200M
OWN MOTION ORDER
Martin J. McKeown, Claimant Attorney

Reviewing panel: Members Phillips Polich and Haynes.

The self-insured employer has submitted a request for temporary disability compensation for claimant's compensable 1982 low back condition. Claimant's aggravation rights have expired.

The employer recommends that we authorize the payment of temporary disability compensation under claimant's 1982 claim. Claimant has also filed a "new injury" claim for his back condition with the same employer. (Claim No. 00080647). He has requested a hearing from the "new injury" employer's compensability denial. (WCB Case No. 01-04697).

Relying on *Leslie D. Marcum*, 50 Van Natta 2242 (1998), and *Patrick T. Daggett*, 51 Van Natta 1042 (1999), claimant contends that his 1982 Own Motion claim should be reopened under ORS 656.278. In *Marcum*, we authorized reopening of a claimant's Own Motion claim when the same insurer did not oppose reopening under ORS 656.278, but contested its responsibility for the claimant's "new injury" claim.

In *Marcum*, we noted that, where there are available "administrative" remedies we generally postpone Own Motion action until exhaustion of those administrative procedures. OAR 438-012-0050. For example, when responsibility for a claimant's condition is the only issue, which is contested, the matter is generally referred to the Department for a designation of a paying agent pursuant to ORS 656.307. *James D. Ortner*, 49 Van Natta 257 (1997); OAR 438-012-0032(3).

Here, although compensability is being contested under the "new injury" claim, the employer has accepted "responsibility" under the 1982 Own Motion claim. Additionally, the language of ORS 656.307(1)(a) and OAR 436-060-0180 indicates that the statute and rule apply when there is a responsibility issue involving "more than one insurer" or "two or more employers." By its terms, therefore, ORS 656.307 does not apply to a dispute involving only one insurer of one employer. Because this case does not involve a responsibility dispute among two or more employers and/or insurers, it does not fall within the parameters of the statute. *See James M. Van Natta*, 50 Van Natta 2104 (1998). Thus, claimant is unable to avail himself of the administrative remedies allowed under that statute and OAR 436-060-0180.

Here, as previously explained, the employer is not contesting the compensability and/or responsibility of claimant's current back condition as it relates to the 1982 Own Motion claim. Additionally, the employer acknowledges that surgery is appropriate for the compensable condition. In fact, the employer recommends that we authorize the reopening of claimant's Own Motion claim. Thus, there are no issues in the Own Motion claim for which claimant would need to avail himself of "administrative remedies."

Under these particular circumstances, and consistent with the Marcum rationale, we decline to postpone action on the Own Motion claim pending resolution of claimant's litigation of a "responsibility" issue regarding his current condition under a "new injury" claim. Consequently, we proceed with our review.

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

We are persuaded that claimant's current condition (for which the employer has accepted responsibility under the 1982 claim) constitutes a worsening of his 1982 compensable injury that requires surgery.[1] Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the 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 insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[1] This conclusion is based on the presumption that the employer, under the 1982 claim, will ultimately be held responsible for claimant's condition. In the event that the employer is ultimately found responsible for claimant's current condition under his "new injury" claim, the employer and/or claimant may request reconsideration of this decision under OAR 438-012-0065(3) at that time. *See Marcum*, 51 Van Natta at 2242.

August 14, 2001 Cite as 53 Van Natta 1081 (2001)

In the Matter of the Compensation of
JENNIFER L. POTTER, Claimant
WCB Case No. 00-07984
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) upheld the insurer's denial of claimant's consequential condition claim for a right shoulder condition; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability, penalties, and attorney fees.

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

Claimant seeks to establish the compensability of her right shoulder condition (diagnosed as subacromial bursitis) as a consequential condition of her accepted right wrist fracture.[2] Consequently, claimant must prove that the compensable right wrist injury is the major contributing cause of the subacromial bursitis condition. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411, 415 (1992). To satisfy the "major contributing cause" standard, claimant must establish that her work injury contributed more to the claimed condition than all other factors combined. *See, e.g.*,

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[1] Neither party challenges the ALJ's reasoning regarding the preclusive effect of a December 1999 Disputed Claim Settlement (DCS). Because resolution of that issue is not necessary to reach our decision, we neither adopt nor address this portion of the ALJ's order.

[2] Claimant compensably fractured her right wrist in July 1995. (Exs. 1; 2; 22). Claimant's right shoulder subacromial bursitis was diagnosed by Dr. Lundsgaard (attending physician) in March 2000. (Ex. 31). In August 2000, Dr. Schilperoort (insurer-arranged examiner) concurred with that diagnosis. (Ex. 34-5).

McGarrah v. SAIF, 296 Or 145, 146 (1983). Because of possible alternative causes for her 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).

The only doctor who offered an opinion regarding the relationship of claimant's shoulder condition and her compensable wrist fracture was Dr. Schilperoort.[3] According to Dr. Schilperoort, claimant's shoulder condition is the result of a 1997 wrist surgical intervention for the treatment of avascular necrosis and arm positioning associated with that surgery. (Ex. 34-5; 34-6). Dr. Schilperoort expressly opined that claimant's shoulder condition was not related to her accepted wrist fracture. (Ex. 34-5). Consequently, we agree with the ALJ that, based on this record, claimant has failed to establish the compensability of her right shoulder condition as a consequence of her compensable right wrist fracture.

ORDER

The ALJ's order dated April 2, 2001 is affirmed.

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[3] We acknowledge claimant's assertion that Dr. Lundsgaard offered an opinion that supports the compensability of her right shoulder condition. Dr. Lundsgaard stated: "I am wondering whether her repeated wrist surgeries and immobilization may have contributed to this." (Ex. 31). To the extent that Dr. Lundsgaard's statement represents an opinion on causation, his opinion (absent further explanation) is, at best, expressed only in terms of possibilities, not medical probabilities. As such, his opinion is not sufficient to carry claimant's burden of proof. *See Gormley v. SAIF*, 52 Or App 1055 (1981); *Ted L. Golden*, 51 Van Natta 55, 56 (1999) ("could have" and "may have" indicate only possibility, not medical probability). Moreover, the preponderance of medical opinion supports a conclusion that claimant's compensable wrist fracture was not the major cause for claimant's need for surgery. Consequently, we reject claimant's assertion.

In the Matter of the Compensation of
LINDA A. STOMPS, Claimant
WCB Case No. 00-09206
ORDER ON REVIEW (REMANDING)
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich, Bock, and Haynes. Member Haynes chose not to sign the order.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Otto'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 vacate and remand.

FINDINGS OF FACT

On May 9, 2001, the ALJ convened a hearing; claimant did not appear. On May 10, 2001, the ALJ issued an Order of Dismissal stating that the Request for Hearing was dismissed as abandoned under OAR 438-006-0071(2).

On June 11, 2000, the Board received a letter from claimant which stated, in part, that claimant: (1) wished review of the ALJ's action; and (2) wished to reopen the case.[1]

On July 5, 2000, the Board received another letter from claimant, again seeking reopening of the case. Attached to this mailing was a 6-page medical report from Dr. Browning.

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. *See Olga G. Semeniuk*, 46 Van Natta 152 (1994).

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[1] Claimant's letter was mailed via "Certified Mail" on June 7, 2001.

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. *See Enrique Torralba*, 52 Van Natta 357 (2000). 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. *See James C. Crook, Sr.*, 49 Van Natta 65 (1997).

Here, we find that claimant's letters seeking to "reopen my case" (one of which was accompanied by a medical report regarding claimant's chronic liver condition, including hospitalizations and treatments) constitutes an explanation concerning her failure to appear at the hearing. Thus, claimant's submission is interpreted as a motion for postponement of the dismissed hearing.

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.[2] We emphasize that our order does not address the substance of claimant's allegations and it is incumbent upon the ALJ to evaluate the grounds of the motion.

Accordingly, the ALJ's May 10, 2001 order is vacated. This matter is remanded to ALJ Otto to determine whether to postpone claimant's hearing request. The ALJ shall proceed in any manner that will achieve substantial justice. If the ALJ grants the motion to postpone, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ does not grant the motion to postpone, the ALJ shall dismiss the request for hearing.

IT IS SO ORDERED.

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[2] We note that the ALJ did not issue a "combined order" (*i.e.*, an order giving claimant a period of time to show "good cause" for 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, claimant might have submitted a timely response to the "good cause" component of the "combined order," thereby avoiding remand of this case.

In the Matter of the Compensation of
DAVID VANNUS, SR., Claimant
WCB Case Nos. 00-08605, 00-03278 & 00-00935
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al., Defense Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its *de facto* compensability/responsibility denial of claimant's "new injury" claim for a low back condition; and (2) upheld CNA Insurance Company's (CNA's) denial of claimant's aggravation claim for the same condition.[1] On review, the issues are compensability and responsibility.

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

In August 1999, claimant compensably injured his low back when he tripped while carrying a box of sales brochures. (Ex. 32). CNA accepted the claim as a lumbosacral strain. (Ex. 59). On November 30, 1999, a Determination Order that awarded only temporary disability closed the claim.[2] (Ex. 62).

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[1] Both Liberty and CNA insured the same employer at different times. Liberty became the insurer on January 1, 2000. CNA insured the employer prior to that date.

[2] Claimant did not challenge the Determination Order.

On January 4, 2000, claimant was lifting boxes of sales brochures out of the trunk of a car and had an onset of severe low back pain. (Tr. 20; Exs. 63, 64). As a result, claimant filed an aggravation claim with CNA and a "new injury' claim with Liberty. When both claims were denied, claimant requested a hearing.[3]

The ALJ relied on the opinions of Dr. Shenoy (attending physician) and Dr. Keenan (consulting orthopedic surgeon) and determined that: (1) claimant had a "new injury" on January 4, 2000; and (2) the major contributing cause of claimant's current disability and need for treatment was the "new injury." Consequently, the ALJ set aside Liberty's "new injury" claim denial and upheld CNA's aggravation claim denial.[4]

Liberty asserts that the work event of January 4, 2000 did not result in a "new injury." Specifically, Liberty contends that claimant's onset of pain on January 4, 2000 represents either: (1) an aggravation of the August 1999 claim; or (2) a continuation of claimant's preexisting spondylolysis and degenerative disc disease. For the reasons stated below, we disagree.

The parties agree that the major contributing cause standard applies to this claim. *See* ORS 656.308(1); ORS 656.005(7)(a)(B). Therefore, in order to establish the compensability of his "new injury" claim, claimant must prove that the work event of January 2000 contributed more to the disability or need for treatment of his current low back 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 claimed condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Because of the possible alternative causes for claimant's current low back 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, Dr. Shenoy explained that claimant's current low back condition is a "combined condition" consisting of a preexisting lumbar degeneration process, an on-the-job injury of March 25, 1997, an on-the-job injury of August 1999, and the work incident of January 2000 which caused an acute lumbar strain. (Ex. 80-2). According to Dr. Shenoy, the major contributing cause of claimant's disability and need for treatment of the "combined condition" is the work incident of January 2000.[5] (*Id.*)

Dr. Shenoy based his opinion on his examination findings of: (1) muscle spasm; (2) reduced ranges of motion; (3) tenderness on palpation; and, (4) stiffness. In rendering his opinion, Dr. Shenoy also considered claimant's past radiology findings as well as claimant's history. (*Id.*) Because Dr. Shenoy was also the attending physician for the August 1999 injury, he is in an advantageous position, compared to other examiners, to offer a causation opinion. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). Consequently, we find Dr. Shenoy's opinion persuasive.

In contrast to the opinion of Dr. Shenoy, is the opinion of Dr. Rosenbaum, a Liberty-arranged examiner. Dr. Rosenbaum opined that the January 2000 work incident did not result in a "new injury." (Ex. 89). According to Dr. Rosenbaum, claimant's onset of pain on January 4, 2000, was an exacerbation of unresolved symptoms from his previous job-related injuries and his preexisting degenerative problems. (Ex. 89-4). Dr. Rosenbaum based his opinion on a belief that there were no new objective changes in claimant's condition following the January 2000 incident. (*Id.*) However, in rendering his

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[3] CNA issued its aggravation denial on February 18, 2000. (Ex. 77). Liberty did not issue a written denial. Rather, Liberty orally denied compensability and responsibility at hearing. (Tr. 6).

[4] The ALJ also assessed a penalty for Liberty's failure to accept or deny the "new injury" claim within 90 days after the employer's notice of the claim. Liberty does not challenge the ALJ's determination that a penalty was warranted.

[5] Dr. Keenan agreed with Dr. Shenoy's opinion. (Ex. 81).

opinion, Dr. Rosenbaum does not appear to have considered: (1) the loss of normal lumbar lordosis as reported by Dr. Howe (immediate care physician); or (2) the muscle spasms noted by Dr. Shenoy. Consequently, we do not find Dr. Rosenbaum's opinion persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (a medical opinion which is based upon incomplete information is not persuasive).

In conclusion, based on Dr. Shenoy's persuasive opinion, we agree with the ALJ that claimant has established the compensability of his low back condition as a "new injury" occurring on January 4, 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 $1,950, to be paid by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's uncontested request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 23, 2001 is affirmed. For services on review, claimant is awarded a $1,950 attorney fee, payable by Liberty.

In the Matter of the Compensation of
ANTONIO C. CAZARES, Claimant
WCB Case No. 00-02373
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Gene L. Platt, Defense Attorney
Hilda Galaviz, Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl. Member Biehl chose not to sign the order.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that found that the self-insured employer's denials of his current right shoulder condition was procedurally proper. With its brief, the employer submits a notice of claim acceptance that was not admitted at hearing. We treat the submission as a motion for remand. On review, the issues are remand and the propriety of the employer's current condition denials. We deny the motion for remand and adopt and affirm the ALJ's order.

Our review is limited to the record developed at hearing. ORS 656.295(5). With its respondent's brief, the employer submits a copy of a "post-hearing" January 22, 2001 notice of claim acceptance that was not admitted at hearing. We treat this submission as a motion for remand to the ALJ for further development of the record. *See Judy A. Britton*, 37 Van Natta 1262 (1985).

We may remand to the ALJ if we find that the case has been "improperly, incompletely or otherwise insufficiently developed[.]" ORS 656.295(5). There must be a compelling reason for remand to the ALJ for the taking of additional evidence. *SAIF v. Avery*, 167 Or App 327, 333, (2000). A compelling reason exists when the new evidence (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. *Id.*; *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, the employer submits a copy of its January 22, 2001 acceptance of claimant's conditions, which refers to shoulder tendinitis and impingement, as well as a "'combined condition of right shoulder strain and preexisting AC arthritis' up to the date you were released from care by Dr. Rabie on May 20, 1999." The acceptance was issued after the ALJ issued the order in this case.

On review, the employer acknowledges that the January 22, 2001 acceptance is "beyond the scope of this record" (Employer's br at 3), but it argues that the acceptance is necessary to respond to claimant's argument that the employer's failure to accept the "injury" has precluded him of certain rights. The employer contends that claimant lost no entitlements by the ALJ's order or by the subsequent processing of the claim.

After the June 22, 2000 hearing, the record was held open for depositions and the record was closed on December 11, 2000. Although the January 22, 2001 acceptance was not "obtainable" when the record closed, we find that the document is not reasonably likely to affect the outcome of this case. Accordingly, we find no "compelling" reason to remand and we therefore deny the employer's motion to remand.

ORDER

The ALJ's order dated January 12, 2001 is affirmed.

In the Matter of the Compensation of
DANIEL R. THORNTON, Claimant
WCB Case No. 99-09637
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

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

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

Based on this record, we agree with the ALJ that Dr. Keenen's opinion is more persuasive than that of the examining physicians. In this regard, Dr. Keenen persuasively explains why he believes that the June 1999 work injury, as opposed to the July 5, 1999 motor vehicle accident, caused claimant's L4-5 disc herniation. (Ex. 24-12 to 14). In addition, Dr. Keenen also persuasively explained why there was a delay between the injury and the onset of claimant's lower extremity symptoms. (Ex. 24-8 to 10). Because Dr. Keenen provided the most well reasoned and best explained opinion in the record and because his opinion is also based on complete and accurate information, we rely upon his opinion. *Somers v. SAIF*, 77 Or App 259, 263 (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 $1,200, 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 April 11, 2001 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
MAURICE E. THORNE, Claimant
WCB Case No. 00-08887
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Poland's order that directed SAIF to process claimant's left shoulder claim to closure under ORS 656.268. On review, the issue is claim processing. We affirm.

FINDINGS OF FACT

Claimant was compensably injured on June 10, 1973, when he came in contact with 14,000 volts of electricity and was thrown to the ground onto his left shoulder. (Ex. 3). Claimant filed a claim for an "[e]lectrical shock[.]" (Ex. A). SAIF accepted the claim as a nondisabling injury. (Exs. B, 1).

In May 1989, claimant was diagnosed with degenerative changes of the left shoulder involving the glenohumeral and acromioclavicular joints. (Exs. 2, 3, 5). Dr. Carroll felt that claimant had advanced traumatic arthritis due to the original injury and he recommended surgery. (Exs. 3-2, 4). SAIF sought an opinion from Dr. Stanford regarding causation. (Ex. 6). Dr. Stanford believed that claimant's shoulder surgery should be accepted as part of the 1973 claim. (Ex. 7).

On November 16, 1989, Dr. Carroll performed a left total shoulder arthroplasty and resection of the left distal clavicle. (Ex. 8). He diagnosed osteoarthritis, left shoulder and acromioclavicular joint. (*Id.*)

On February 12, 1990, SAIF sent a letter to the Workers' Compensation Board, which provided, in part:

> "On April 14, 1989, SAIF Corporation received correspondence from [claimant] requesting medical benefits regarding his left shoulder injury. On November 16, 1989, he underwent a left shoulder surgical procedure pre-authorized by SAIF Corporation. [Claimant] has provided proof of his continued participation in the work force. SAIF Corporation continues to accept responsibility for conditions arising out of [claimant's] injury of June 10, 1973, thereby, we recommend reopening of [claimant's] claim for time loss and medical benefits. We respectfully request reimbursement from the Reopened Claims Reserve." (Ex. 9).

On March 1, 1990, the Board issued an Own Motion order that reopened the claim with temporary disability benefits beginning on November 16, 1989, when claimant's surgery was performed. (Ex. 10). The order said that claimant's aggravation rights had expired and the "insurer has accepted responsibility for the surgery and recommends that claimant's claim be reopened for the payment of temporary disability benefits." (*Id.*) Claimant had additional left shoulder surgery on September 13, 1990 and March 13, 1991. (Exs. 11, 12). On April 24, 1992, the claim was reopened under the Board's Own Motion authority with temporary disability commencing with the March 1991 surgery. (Ex. 16).

Claimant had continued left shoulder problems and, in April 1999, Dr. Switlyk recommended further surgery. (Exs. 17, 18, 19, 20). Claimant, *pro se*, wrote to SAIF on August 18, 1999, requesting approval of the surgery. (Ex. 21). One week later, SAIF wrote to claimant, requesting information from his physician "detailing your medical condition and explaining the relationship between your injury of 6-10-73 and your current need for treatment[.]" (Ex. 22). SAIF said that, after it received the requested information, it would be able to advise whether it would cover the proposed treatment. (*Id.*)

SAIF requested review by a nurse consultant, who believed that claimant's proposed surgery was related in material part to the 1973 injury. (Ex. 24). On October 6, 1999, Dr. Switlyk performed a revision of the left total shoulder arthroplasty, replacement of the humeral head and bone grafting with allograft of glenoid bone defects. (Ex. 25). Dr. Switlyk found claimant medically stationary on March 30, 2000 and performed a closing examination. (Exs. 31, 32).

Claimant's attorney wrote to SAIF on August 28, 2000, asking whether SAIF had formally accepted "the arthritis of the left shoulder and the arthritis of the left acromioclavicular joint which necessitated his original surgery in 1989 and the follow-up surgeries 1990, 1991, and 1999." (Ex. 33).

On September 29, 2000, SAIF provided the following response:

> "Please find enclosed a [*sic*] copies of the own motion order dated March 1, 1990, along with the February 12, 1990 letter addressed to the Workers Compensation Board, with attached exhibit list with attachments. This indicates SAIF Corporation continues to accept responsibility for conditions arising out of [claimant's] injury of June 10, 1973, and recommended re-opening. See the exhibit list and attachments for the conditions.
>
> "I believe the conditions mentioned in your August 28, 2000 letter are encompassed in the February 12, 1990 letter to the Workers' Compensation Board." (Ex. 35).

On October 11, 2000, claimant's attorney requested that SAIF process the claim to closure pursuant to ORS 656.268. (Ex. 36). SAIF responded that claimant was limited to benefits under ORS 656.278 and he was not entitled to benefits under ORS 656.268. (Ex. 37). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that he filed a claim on August 28, 2000 for a "new medical condition" of arthritis of the left shoulder and left acromioclavicular joint, and that SAIF had an obligation to process the new medical condition claim to closure under ORS 656.268, pursuant to *John R. Graham*, 51 Van Natta 1740 (1999). SAIF contended, among other things, that the condition referenced in claimant's August 28, 2000 letter was not a "new medical condition" because it was previously encompassed in SAIF's February 12, 1990 letter to the Board. According to SAIF, the February 12, 1990 letter was an acceptance of the left shoulder arthritis that was surgically treated in November 1989, and SAIF asserted that the most recent left shoulder surgery addressed the same condition.

The ALJ assumed, for the sake of argument, that SAIF had accepted the left shoulder condition that was surgically repaired on November 16, 1989. Nevertheless, the ALJ found that, when claimant requested preauthorization of his most recent surgery, SAIF deferred its decision and requested information about causation from claimant and SAIF's own consultant. The ALJ reasoned that compensability of claimant's current left shoulder condition remained in doubt until SAIF expressly accepted that condition in its September 29, 2000 letter.

On review, SAIF argues that the ALJ erred in failing to recognize that SAIF accepted claimant's left shoulder arthritis condition in 1990. SAIF contends that its February 12, 1990 letter to the Workers' Compensation Board constituted an acceptance of conditions arising out of claimant's 1973 injury.

After the ALJ's order issued, we decided *Alvino H. Guardiola*, 53 Van Natta 1009 (2001). In that case, the ALJ directed the carrier to accept and process the claimant's right shoulder bursitis, rotator cuff impingement and tendinitis as new medical conditions, and awarded the claimant's counsel an attorney fee for prevailing against the carrier's denial of those conditions. The carrier contended on review that the claimant was not entitled to an attorney fee under ORS 656.386(1) for obtaining the acceptance of a "new medical condition" claim because the carrier had already accepted the requested conditions in its Own Motion recommendation to the Board. We rejected the carrier's argument, finding that, although the carrier had accepted a nondisabling right trapezius muscle strain, it had never formally accepted the claimant's aforementioned right shoulder conditions. We reasoned that the carrier's Own Motion Recommendation to the Board was just that: a recommendation provided to the Board under its Own Motion authority. We explained that an Own Motion order does not preclude a reopening under ORS 656.262(7)(c), although it might affect temporary disability benefits for the same condition for the same time period (*i.e.*, there may be a possibility of an offset). Furthermore, we found that the carrier's incidental notation on an Own Motion form was not adequate compliance with the requirements set forth in ORS 656.262(7)(a). We concluded that because the carrier's Own Motion recommendation did not qualify as a formal acceptance of the claimant's right shoulder bursitis, it could not function as a prior acceptance that encompassed right shoulder chronic impingement syndrome, rotator cuff tendonitis and tendinopathy involving the right distal supraspinatus.

Here, we begin by addressing the scope of SAIF's acceptance, which is a question of fact. *See SAIF v. Dobbs*, 172 Or App 446 (2001); *SAIF v. Tull*, 113 Or App 449 (1992). Claimant filed a claim for an "[e]lectrical shock[.]" (Ex. A). In a May 9, 1974 letter to claimant, SAIF explained:

> "The claim you filed for the electrical shock you had on June 10, 1973 is accepted. As for the fact you are are [*sic*] having a problem with your shoulder and pain in your chest does not mean the shock caused them. It is necessary that the condition caused it be diagnosed and be medically related to the incident before we would assume responsibility for treatment and any resulting disability.
>
> "Since there is no disability evident at this time from the injury on June 10, 1973, no further action can be taken by us other than to record it.
>
> "At some future time if this injury requires medical treatment or results in disability, you should tell us immediately." (Ex. B).

On May 10, 1974, SAIF issued a notice of acceptance of the June 10, 1973 claim as a nondisabling injury. (Ex. 1). The acceptance did not include a specific condition, but referred to an injury code "700.200[.]" (*Id.*)

Although SAIF's acceptance form referred to the code "700.200[,]" that code did not limit the acceptance. *See Emmert v. City of Klamath Falls*, 135 Or App 209, 212 (1995) (where the carrier did not specify a particular condition in the acceptance, the codes used on acceptance did not limit the acceptance; instead, the acceptance was interpreted as constituting an acceptance of the claim as filed, which was for severe chest pain). We read SAIF's acceptance as constituting an acceptance of the claim as filed, which was for electrical shock. *See id.* Because there are no contemporaneous medical records at the time of the May 10, 1974 acceptance, we find that SAIF's acceptance was limited to "electrical shock" and did not include any left shoulder conditions. Moreover, SAIF's May 9, 1974 letter to claimant specifically declined to include any shoulder or chest problems in the acceptance. (Ex. B).

Nevertheless, SAIF contends that its February 12, 1990 letter to the Board was an unqualified acceptance of conditions arising out of claimant's injury, following the 1989 surgery. For the following reasons, we are not persuaded by SAIF's argument.

SAIF's February 12, 1990 letter to the Board provided, in part:

> "On April 14, 1989, SAIF Corporation received correspondence from [claimant] requesting medical benefits regarding his left shoulder injury. On November 16, 1989, he underwent a left shoulder surgical procedure pre-authorized by SAIF Corporation. [Claimant] has provided proof of his continued participation in the work force. SAIF Corporation continues to accept responsibility for conditions arising out of [claimant's] injury of June 10, 1973, thereby, we recommend reopening of [claimant's] claim for time loss and medical benefits. We respectfully request reimbursement from the Reopened Claims Reserve." (Ex. 9).

We find that SAIF's February 12, 1990 letter to the Board merely recommended reopening of the Own Motion claim. *See Alvino H. Guardiola*, 53 Van Natta at 1009. Although SAIF's February 12, 1990 letter indicates that a copy was purportedly sent to claimant, we find no evidence that claimant received notice that any additional conditions had been accepted. We also note that SAIF's letter did not comply with ORS 656.262(6)(b), which sets forth the information that must be included in a notice of acceptance.

Furthermore, despite the fact that SAIF paid for claimant's surgeries and preauthorized at least the November 1989 surgery, the current statutory scheme is inconsistent with the conclusion that SAIF thereby accepted claimant's left shoulder arthritis conditions. *See Timothy A. Vinton*, 53 Van Natta 979 (2001) (carrier's prior authorizations for the claimant's surgeries for a low back degenerative condition did not constitute an acceptance of his condition beyond its express acceptance of a lumbar strain). To the contrary, ORS 656.262(10) provides that "[m]erely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such

compensation be considered a waiver of the right to question the amount thereof." In *Johnson v. Spectra Physics*, 303 Or 49, 58 (1987), the Court held that an insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). Here, we conclude that SAIF accepted only an electrical shock resulting from claimant's June 1973 injury and the February 12, 1990 letter was insufficient to constitute an acceptance of claimant's left shoulder arthritis conditions.

Alternatively, SAIF argues that the ALJ erred by directing it to reopen the claim under ORS 656.268. SAIF does not dispute that claimant's left shoulder arthritis conditions are compensable. Rather, SAIF contends that own motion claims should not be closed under ORS 656.268 and that *John R. Graham*, 51 Van Natta at 1740, was wrongly decided. In *SAIF v. Ledin*, 174 Or App 61 (2001), the court affirmed our decision in *Larry L. Ledin*, 52 Van Natta 682 (2000), that directed a carrier to reopen the claimant's claim under ORS 656.262(7)(c) for the processing of a "new medical condition," even though the claimant's 5-year "aggravation rights" under the initial injury claim had expired. We decline to revisit our decision in *Graham* and continue to rely on it as controlling precedent. *See, e.g., Duane A. Ferren*, 53 Van Natta 935 (2001); *William L. Adams*, 53 Van Natta 528 (2001); *Michael T. Bergmann*, 52 Van Natta 1931 (2000). We therefore affirm the ALJ's decision that SAIF is obligated to process claimant's new medical conditions under ORS 656.262 and 656.268.

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

ORDER

The ALJ's order dated May 8, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

In the Matter of the Compensation of
MARK L. WOOD, Claimant
WCB Case No. 00-01888
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Sheridan, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial of his current low back condition. The insurer cross-requests review of that portion of the ALJ's order that awarded a $3,000 attorney fee pursuant to ORS 656.386(1) for claimant's counsel's services in setting aside the insurer's denial of claimant's L5-S1 disc condition. On review, the issues are compensability and attorney fees.

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

Claimant argues that the real issue in this case is responsibility and that the insurer is responsible for his current condition under ORS 656.308(1). We disagree. The threshold issue in compensability/responsibility disputes is compensability. *Jacalyn A. Matthews*, 52 Van Natta 1500 (2000); *Joseph L. Woodward*, 39 Van Natta 1163, 1164 (1987). Here, for the reasons expressed by the ALJ, claimant has not established that his current condition is compensable. Accordingly, we do not reach claimant's responsibility arguments.

The insurer argues that the ALJ's award of a $3,000 attorney fee for prevailing over the denial of claimant's L5-S1 disc condition was excessive. The insurer contends that all medical bills and time loss regarding the December 1997 incident had been paid and that not much benefit was obtained for claimant. Claimant argues that obtaining acceptance of the L5-S1 condition was a significant benefit because if claimant requires surgery in the future, it will be covered.

Here, we note that the ALJ specifically considered the limited value of claimant's benefits in determining the amount of the fee under OAR 438-015-0010(4). Based on this record, we agree with the ALJ that $3,000 is a reasonable attorney fee regarding the compensability issue.

ORDER

The ALJ's order dated April 6, 2001 is affirmed.

August 20, 2001 Cite as 53 Van Natta 1091 (2001)

In the Matter of the Compensation of
EVERETT S. WEBB, Claimant
WCB Case No. 00-05188
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Biehl. Member Biehl dissents.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) awarded temporary disability from December 3, 1998 until October 5, 2000; and (2) assessed a 25 percent penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

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

On September 1, 1998, claimant's counsel wrote a letter to Dr. Karasek informing him that the accepted condition for the claim was "lumbosacral strain." Claimant's counsel also asked whether the cause of claimant's need for medical treatment or disability was related to the "accepted condition or conditions." (Ex. 38-1). Dr. Karasek responded affirmatively on September 2, 1998. Dr. Karasek also responded affirmatively to a question about whether there had been a pathological change in any of the "accepted conditions."

Dr. Karasek did not treat claimant after August 19, 1998. His only authorization of temporary disability is on a September 2, 1998 aggravation claim form. (Ex. 39).

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded temporary disability from December 3, 1998 to October 5, 2000, the date of the hearing, finding that an attending physician, Dr. Karasek, authorized temporary disability for a compensable L5-S1 disc condition rather than for an alleged worsening of claimant's compensable lumbosacral strain.[1] Reasoning that Dr. Karasek's temporary disability authorization was "open-ended," the ALJ authorized temporary disability to the date of the October 5, 2000 hearing. The ALJ also assessed a 25 percent penalty, finding the insurer's refusal to pay temporary disability during the disputed period to have been unreasonable.

On review, the insurer contests the ALJ's decision. It cites the September 2, 1998 concurrence report that accompanied Dr. Karasek's aggravation claim form and asserts that it establishes that claimant's temporary disability was due to the lumbosacral strain, not the L5-S1 disc condition. The insurer also argues that, regardless of our decision on the merits of the temporary disability issue, it had "legitimate doubt" regarding its liability for the disputed temporary disability and should not have been penalized. For the following reasons, we agree with both of the insurer's contentions.

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[1] The insurer had denied the aggravation claim based on a worsening of the lumbosacral strain condition. That denial was upheld on March 16, 2000 by a prior ALJ, who found that tile L5-S1 disc condition was compensable.

On his September 2, 1998, aggravation claim form, Dr. Karasek authorized temporary disability, noting "[p]rogression of symptoms to point where neurosurgery may be necessary." (Ex. 39).[2] Dr. Karasek's accompanying September 2nd concurrence report recites that the accepted condition was "lumbosacral strain" and contains Dr. Karasek's confirmation that claimant's present need for treatment and disability were related to the "accepted condition or conditions." (Ex. 38-1).[3] In that report, Dr. Karasek also agreed that there had been a pathological change or worsening in the "accepted conditions."

We conclude that this report establishes that claimant's temporary disability was due to the lumbosacral condition, rather than the L5-S1 disc condition.[4] Because the insurer's denial of the aggravation claim based on the lumbosacral condition was upheld, claimant is not entitled to temporary disability. Thus, we reverse the ALJ's determination that claimant is entitled to temporary disability for the disputed period.

Moreover, because we have reversed that determination, it follows that the insurer's refusal to pay temporary disability was not unreasonable. Thus, we also reverse the ALJ's assessment of a 25 percent penalty based on the insurer's allegedly unreasonable claim processing.

ORDER

The ALJ's order dated February 15, 2001 is reversed in part and affirmed in part. Those portions of the ALJ's order that awarded temporary disability, assessed a 25 percent penalty, and awarded an out-of-compensation attorney fee are reversed. The remainder of the order is affirmed.

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[2] The only other temporary disability authorization in this record is from Dr. Keiper beginning November 22, 2000, after the period in dispute.

[3] As the insurer correctly notes, tile only accepted condition at the time of the September 2, 1998 report was "lumbosacral strain." The insurer did not accept the L5-S1 disc condition until March 30, 2000, after the prior ALJ's order. (Ex. 57).

[4] We acknowledge the reports the ALJ cited that indicate Dr. Karasek was treating tile L5-S1 disc condition, not the lumbosacral strain condition. (Exs. 27, 27A, 31, 33, 35, 36, 37, 48). The fact remains, however, that Dr. Karasek's only express statement on the cause of claimant's disability is contained in the September 2, 1998 concurrence report accompanying tile aggravation claim form. In that report, Dr. Karasek unmistakably attributed claimant's disability to the "accepted condition or conditions." (Ex. 38-1). In that report, the accepted condition was listed as "lumbosacral strain." (*Id.*). Under these circumstances, we conclude that Dr. Karasek authorized temporary disability for the lumbosacral strain. Because the denial of the aggravation claim based on that condition was upheld by tile prior ALJ, claimant is not entitled to temporary disability for that condition.

Board Member Biehl dissenting.

The majority reverses the ALJ's order awarding temporary disability from December 3, 1998 until October 5, 2000. Because, unlike the majority, I would find that claimant's temporary disability authorization was based on the compensable L5-S1 disc condition, I respectfully dissent.

At the outset, I agree with the majority that Dr. Karasek's September 2, 1998 concurrence report casts some doubt on the ALJ's conclusion that claimant's temporary disability was due to the L5-S1 disc condition rather than the lumbosacral condition. However, the aggravation claim form itself notes that temporary disability was authorized and contains Dr. Karasek's comment that claimant's symptoms had progressed to the point where neurosurgery may be necessary. (Ex. 39). Because the record establishes that neurosurgery would not be necessary for the lumbosacral strain, but rather for the compensable disc condition, this form supports the ALJ's conclusion regarding the reason for Dr. Karasek's temporary disability authorization.

Moreover, as the majority acknowledges, the ALJ cited additional medical evidence to support his finding that Dr. Karasek authorized temporary disability for the compensable L5-S1 disc condition rather than the lumbosacral strain. I agree with the ALJ's analysis. In light of this, I would find that the record, as a whole, establishes that Dr. Karasek's temporary disability authorization was based on the compensable L5-S1 disc condition. Thus, I would affirm the ALJ's determination that claimant is entitled to temporary disability for the disputed period.

In the Matter of the Compensation of
ROBERT W. WILCOX, Claimant
Own Motion No. 00-0303M
OWN MOTION ORDER
Malagon, Moore, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing panel: Members Meyers and Biehl.

The SAIF Corporation submitted claimant's request for temporary disability compensation for claimant's 1983 back claim. Claimant's aggravation rights have expired. SAIF opposed reopening on the following grounds: (1) the carrier is not responsible for claimant's current condition; and (2) claimant was not in the work force at the time of disability. In addition, SAIF issued a denial of the compensability of claimant's current condition on which claimant filed a request for hearing with the Hearings Division. (WCB Case No. 00-07754).

On October 27, 2000, we consolidated this Own Motion matter with the pending hearing. If the Administrative Law Judge (ALJ) found that claimant's current condition was 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 21, 2001, ALJ Marshall issued an Opinion and Order, which set aside SAIF's denial. In doing so, ALJ Marshall found that claimant's current low back condition was causally related to the March 23, 1983 compensable injury. The ALJ's order has not been appealed.

Finding that claimant was not in the work force at the time his condition worsened, ALJ Marshall recommended that claimant be denied entitlement to temporary disability benefits pursuant to ORS 656.278(1)(a). Claimant disagrees with the ALJ's recommendation, contending that, despite his willingness to work, his compensable injury precludes him from doing so.[1]

In order to be entitled to temporary disability compensation 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 v. Blakely*, 160 Or App at 244.

In his Own Motion recommendation, ALJ Marshall found that claimant last worked in 1999 when he stopped working because of back pain. ALJ Marshall noted that, although Dr. MacRitchie indicated that claimant was unable to work, she did not opine that efforts to seek work would be futile. The ALJ concluded that, although it was claimant's belief that he was unable to do work, the medical evidence did not demonstrate that it would be futile for him to seek work. Having found that claimant was not in the work force when his condition worsened requiring surgery, ALJ Marshall recommended that claimant's request for temporary disability benefits be denied.

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[1] On July 31, 2001, the Board granted SAIF an opportunity reply to claimant's work force contentions. Inasmuch as the period for submitting that position has now expired, we have proceeded with our review.

In response to the ALJ's recommendation, claimant asserts that he had demonstrated that he was willing to work, but was unable to do so because of his compensable condition. Accordingly, claimant contends that he has satisfied the "work force" requirement.

Whether it would be futile for claimant to seek work is not a subjective standard; rather it is an objective standard determined from the record as a whole, especially considering persuasive medical evidence regarding claimant's ability to work and/or seek work. *Jackson R. Shrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where the record lacked persuasive *medical* evidence establishing that the claimant was unable to work and/or seek work due to the compensable injury); *Janet F. Berhorst*, 50 Van Natta 1578 (1998) (same; Board cannot infer futility). In short, the question is whether the compensable injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

Here, in November 2000, Dr. MacRitchie reported that claimant was unable to work. Nonetheless, Dr. MacRitchie does not opine that a work search would be futile.[2] Thus, no medical opinion supports claimant's current "futility" contentions, nor does the record demonstrate that it would have been futile for him to work or seek work at the time of the current worsening. In conclusion, the record lacks persuasive medical evidence establishing that claimant was unable to work and/or seek work due to his compensable condition. In light of such circumstances, claimant is not entitled to temporary disability benefits.

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

IT IS SO ORDERED.

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[2] We further note that the record does not establish that claimant was willing to work. In this regard, we reiterate that an attorney's assertion, in the absence of supporting evidence, is insufficient to establish a component of the "work force" issue. *See Earl L. Prettyman*, 46 Van Natta 1137 (1994).

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 1095-1148 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH SEPTEMBER 6, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, JULY-SEPTEMBER 2001.

In the Matter of the Compensation of
KAREN L. ARMS, Claimant
WCB Case No. 00-09067
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Reinisch, MacKenzie, Healey, et al., Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the insurer's denial of claimant's current right knee condition. On review, the issues are the procedural validity of the denial and compensability.

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

The ALJ upheld the insurer's denial as procedurally proper, and on the merits. On review, we supplement the order only to address claimant's argument that there has been no proof of a "combined condition."

In order for the "major contributing cause" standard of ORS 656.005(7)(a)(B) to apply, there must be medical evidence proving the existence of a "preexisting condition" that combined with claimant's compensable injury. *Beverly Enterprises v. Michl*, 150 Or App 537 (1997); *Joseph L. Cilione*, 50 Van Natta 1828, 1829 (1998). Claimant acknowledges the medical evidence that she suffers from preexisting degenerative changes in her right knee, but contends that this preexisting condition did not combine with claimant's injury "since the injury." We disagree.

Initially, we note that ORS 656.005(7)(a)(B) states that "If an otherwise compensable injury combines *at any time* with a preexisting condition to cause or prolong disability or a need for treatment, [the major contributing cause standard applies.]" (Emphasis added.) Moreover, claimant's treating physician, Dr. Lundquist, stated that he was treating not only claimant's preexisting degenerative knee arthritis, but also claimant's injury which "combined with that arthritis, which has in fact lengthened her recovery." (Ex. 50A). Based on this statement, we find that claimant's injury combined with her degenerative knee condition since the date of the injury.

ORDER

The ALJ's order dated April 6, 2001 is affirmed.

In the Matter of the Compensation of
JAMES F. KING JR., Claimant
WCB Case No. C011896
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff, Strooband & Ousey, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

On August 10, 2001, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. For the following reasons, we approve the proposed disposition.

The first page of the CDA lists the total due claimant's attorney as $1,000. The agreement also states, on page 1 of the document:

> "$3,000 Total Due Claimant (subject to 4/27/01 Order of State of Oregon: Dept. of Justice)"

ORS 656.234(2)(b) provides: "[m]oneys payable pursuant to ORS * * * 656.236 * * * are subject to an order to enforce child support obligations pursuant to ORS 25.378." Additionally, ORS 656.234(3)(b) provides that the amount of child support obligation subject to enforcement shall not exceed one-fourth of moneys paid under 656.236.

The agreement does not specify the amount to be withheld for child support. However, consistent with the statute, we conclude that it is the parties' intention that no more than one-fourth of the moneys paid under the CDA shall be subject to the order to enforce child support. *See Kerry L. Wrenn*, 50 Van Natta 1749 (1998); *Philip B. Oberman*, 50 Van Natta 1211 (1998).

Under such circumstances, we interpret the CDA as follows: The total consideration for the CDA is $4,000, less a $1,000 attorney fee. In accordance with ORS 656.234(3)(b), one-fourth of the agreement proceeds ($1,000), is subject to child support obligations. The remainder of the $4,000 ($2,000) will be paid to claimant.

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' agreement is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DENA L. McGAGE, Claimant
WCB Case No. 00-04915
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich chose not to sign the order.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's claim for a right wrist condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as a 911 dispatcher and records clerk for the employer since August 15, 1988. (Tr. 4). In September 1999, claimant was given a special assignment which involved increased writing. (Tr. 6). On February 8, 2000, claimant sought treatment for right wrist symptoms with Dr. Holt and his nurse, Ms. Romney. (Ex. 1). Dr. Holt did not examine claimant. Ms. Romney's impression was that claimant had a right wrist ganglion cyst. (*Id.*) A February 8, 2000 x-ray of claimant's right wrist was "normal." (Ex. 2).

On February 11, 2000, claimant filed a form 801 stating that she had noticed a lump on the underside of her right wrist the prior Saturday and alleging that her condition was the result of repetitious writing. (Ex. 3). On April 27, 2000, the employer denied claimant's claim. (Ex. 5).

On September 19, 2000, Dr. Schilperoort examined claimant at the request of the employer. (Ex. 7). Dr. Schilperoort noted that claimant had no current mass on her right wrist. (Ex. 7-3). He diagnosed a right wrist bursitis condition, secondary to claimant's work exposure (*i.e.* writing), resolved. (Ex. 7-5). Dr. Schilperoort opined that claimant's condition was the result of a combination of a preexisting congenital "lack of full pronation" and her work activity. (*Id.*) Dr. Schilperoort reported that claimant's work activity was the major contributing cause of the condition. (Ex. 7-6).

On September 29, 2000, Dr. Holt concurred with a letter from claimant's counsel indicating that claimant's cyst condition arose over a span of one week and that claimant's work activity was the major contributing cause of the condition. (Ex. 8). On February 15, 2001, Dr. Schilperoort concluded that claimant had no permanent impairment secondary to her bursitis condition. (Ex. 9).

Dr. Button examined claimant at the request of the employer on February 23, 2001. (Ex. 10). Dr. Button described claimant as having a "normal examination" of the upper extremities. (Ex. 10-4). On March 7, 2001, Dr. Button agreed with the proposition that because claimant did not experience any increased work activity, her work exposure was not "injurious." (Ex. 11). Dr. Button thought that claimant's work might have caused the symptoms of a minor "bruise-type" injury. (Ex. 11-3).

Also on March 7, 2001, Dr. Schilperoort agreed with a letter prepared by counsel for the employer that stated that claimant's work had caused merely a "symptomatic worsening" of her condition. (Ex. 12). Dr. Schilperoort also agreed that it was not likely that claimant's work activity had "suddenly become injurious" because it had not changed over time. (*Id.*)

The ALJ set aside the employer's denial based on the opinions of Drs. Holt and Schilperoort. On review, the employer contends that claimant did not meet her burden of proving a compensable right wrist condition. We agree.

The ALJ found that claimant had satisfied her burden of proof whether claimant's condition was treated as an injury or an occupational disease. Because claimant's condition came on gradually over time (approximately five months), claimant's condition is more likely an occupational disease. ORS 656.802; *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *see Shirlee D. Marvin*, 53 Van Natta 1076 (2001). However, based on the following reasoning, claimant has not met her burden of proof under either an injury or occupational disease theory.[1] ORS 656.005(7)(a)(B), ORS 656.266, ORS 656.802(2)(a).

Due to the presence of a preexisting right wrist condition and the multiple diagnoses of claimant's condition, this case represents a complex medical question, resolution of which depends on expert medical opinion. *Barnett v. SAIF*, 122 Or App 279 (1993). 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). In addition, absent persuasive reasons not to do so, we generally rely on the opinion of the treating physician. *Weiland v. SAIF*, 63 Or App 810 (1983).

Here, we find persuasive reasons not to defer to claimant's treating physician, Dr. Holt. Dr. Holt never actually examined claimant. Instead, Ms. Romney, a nurse, examined claimant and prepared a chart note. (Ex. 1). Moreover, without providing reasoning for his conclusions, Dr. Holt simply answered "yes," to claimant's counsel's question as to whether claimant's work was the major contributing cause of her condition. (Ex. 8). We find Dr. Holt's opinion entirely conclusory and therefore unpersuasive. *See, e.g., Carol A. Bryant*, 53 Van Natta 795, 796 (2001).

Dr. Schilperoort initially offered a medical opinion supportive of claimant's claim after examining claimant at the request of the employer on September 19, 2000. (Ex. 7). Dr. Schilperoort diagnosed a bursitis at the point of insertion of the flexor carpi ulnaris tendon, secondary to work exposure. (Ex. 7-5). Dr. Schilperoort confirmed that claimant's condition had combined with a congenital lack of full pronation in her right wrist, but that the major contributing cause of the condition was claimant's work activity. (Ex. 7-6).

However, on March 7, 2001, Dr. Schilperoort responded to a letter from counsel for the employer by stating that claimant's work had merely caused a symptomatic worsening of claimant's right wrist condition and had caused no "pathologic damage" to the point of insertion of the flexor carpi ulnaris tendon. (Ex. 12-1). Dr. Schilperoort then concurred with the opinions of Dr. Button that do not support the compensability of claimant's condition. (*Id.*) An unexplained change in medical opinion is unpersuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987); *Van G. Johnston*, 53 Van Natta 1042 (2001). In light of Dr. Schilperoort's later modification of his earlier opinion, we decline to rely on that earlier opinion as supportive of claimant's claim. Even assuming we were to find Dr. Schilperoort's later change of opinion sufficiently explained, the later opinion is not supportive of claimant's claim.

The opinions of either Dr. Holt or Dr. Schilperoort do not establish the compensability of claimant's condition. In light of this conclusion, we need not examine the relative persuasiveness of Dr. Button's opinion because that opinion did not support a compensable relationship between claimant's work and her wrist condition. Consequently, we reverse the ALJ's order setting aside the employer's denial, as well as the ALJ's assessed attorney fee award.

ORDER

The ALJ's order dated April 6, 2001 is reversed. The employer's denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed.

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[1] If claimant's claim is treated as an injury, the medical evidence from Dr. Schilperoort proves that her injury "combined with" a preexisting right wrist condition. (Ex. 7-5). Accordingly, claimant would need to prove that her injury is the major contributing cause of her disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 147 Or App 101, *on recon* 149 Or App 309 (1997), *rev den* 326 Or 329 (1998). If claimant's claim is treated as an occupational disease, she must prove that her work activity is the major contributing cause of the right wrist condition, not merely of its symptoms. ORS 656.802(2)(a). In either case, claimant's burden of proof is one of "major contributing cause."

In the Matter of the Compensation of
ROBERT P. MILLER, Claimant
WCB Case No. 00-09385
ORDER ON REVIEW
Carney, et al., Claimant Attorney
Meyers, et al., Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich chose not to sign the order.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of claimant's "new medical condition" claim for bilateral cervical radiculopathy. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant compensably injured his neck in 1990, while employed at an employer which is not a party to this claim. He subsequently underwent posterior cervical laminectomy, laminotomy and foraminotomy at C5-6 and C6-7 on the right. (Ex. 14). That claim was closed by a June 1991 Determination Order that awarded temporary disability and 14 percent unscheduled permanent disability. (Ex. 19).

In May 1992, claimant sought treatment for a stiff neck that subsided within about 10 days. (Exs. 20, 21).

In June 1994, claimant sought treatment for pain in his left shoulder and arm. A June 1994 MRI revealed post-operative changes and foraminal stenosis at C5-6 and C6-7 on the right, but no encroachment on the left. (Ex. 25). Claimant returned to regular work in July 1994. (Ex. 31).

On January 21, 1997, claimant sought emergency room treatment for right neck pain. (Ex. 34).

On July 11, 1998, claimant sought emergency room treatment for posterior neck discomfort radiating into his right scapular region after he was hit on the head off the job. (Ex. 35). He was diagnosed with a cervical strain and pain in a radicular distribution, but without neurological symptoms. (Ex. 37).

On September 5, 1998, claimant compensably injured his neck while working for the employer. Dr. Roberts treated claimant for neck pain and muscle spasm, greater on the left. (Ex. 38). Dr. Roberts diagnosed a neck strain, possible reexacerbation of old surgical area. (*Id.*)

A myelogram/CT scan revealed a central right disc protrusion at C6-7, for which Dr. Hill requested surgery. (Exs. 42 through 45). Dr. Williams, neurologist, examined claimant for the insurer. After surgical evaluation by Dr. Williams, neurologist, who found no evidence of cervical radiculopathy, the surgery was not authorized. (Exs. 48, 53). Dr. Hill treated claimant conservatively and released him to regular work on January 18, 1999. (Ex. 49, 51, 52).

On January 13, 1999, the insurer accepted a disabling cervical strain. (Ex. 50).

On July 26, 1999, claimant sought treatment for neck pain and left arm numbness that he had experienced for two days. (Ex. 58). On August 10, 1999, Dr. Williams reevaluated claimant for the insurer. (Ex. 60). Dr. Williams found no objective evidence of cervical strain, spasm or neurological deficit and concluded that claimant remained medically stationary. (*Id.*)

On August 11, 1999, claimant sought emergency room treatment for his neck and left shoulder. Claimant was evaluated by Dr. Calhoun, neurosurgeon, who treated him conservatively. (Ex. 62). Dr. Calhoun remarked that the C5-6 disc herniation was on the right. (Exs. 64, 65, 66). Dr. Calhoun referred claimant for pain management, where he treated with Dr. Fiks with epidural steroid injections. (Exs. 67 through 72).

On May 5, 2000, claimant was examined by Dr. Radecki for the insurer. (Ex. 76).

On June 12, 2000, claimant's cervical strain claim was closed with no award of permanent disability. (Ex. 82). On June 19, 2000, Dr. Fiks released claimant to regular work. (Ex. 83).

On July 17, 2000, claimant formally requested acceptance of "cervical radiculopathy." (Ex. 85).

On September 25, 2000, claimant was examined by Drs. Murray and Scheinberg for the insurer. (Ex. 88).

On December 13, 2000, the insurer denied claimant's claim for cervical radiculopathy. (Ex. 92). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that Dr. Fiks' opinion was insufficient to establish compensability because he did not address the role of claimant's preexisting post-operative changes and that he did not persuasively explain why claimant's bilateral cervical radiculopathy was related in major part to his September 5, 1998 injury. Claimant contends that most of the medical evidence confirms the existence of a bilateral cervical radiculopathy condition and that this condition is compensable.

Claimant's argument focuses on that portion of the ALJ's discussion of the medical evidence regarding whether claimant actually had bilateral cervical radiculopathy. Although claimant had reported left arm symptoms after the September 5, 1998 injury, it was not until November 4, 1999, that Dr. Fiks diagnosed claimant's condition as chronic cervical radiculopathy. This is sufficient to establish a diagnosis of this condition.[1] The ALJ's decision, however, was based on the persuasiveness of Dr. Fiks' opinion regarding the compensability of that condition.

Dr. Fiks' opinion is the only opinion that arguably supports compensability. Due to the repeated references in the medical record to the post-operative changes in claimant's neck, the gap in treatment between January and May 1999, and the sudden onset of neck pain and left arm numbness in July 1999, the cause of claimant's bilateral radiculopathy condition presents a complex medical question that must be resolved by expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). 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). Moreover, 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. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Here, Dr. Fiks states that claimant's September 5, 1998 work injury was the major cause of claimant's radicular symptoms and medical treatment. He reasoned that, because no MRI prior to claimant's injury identified a right-sided C5-6 disc herniation, it would be reasonably medically probable that the MRI changes are a direct result of the injury. He also reasoned that, because claimant's left upper extremity symptoms historically occurred after the September 5, 1998 injury, they were related to that injury. However, Dr. Fiks does not address the relative contribution of claimant's post-operative changes and foraminal stenosis at C5-6 and C6-7 that were identified as early as 1994. He also does not address the fact that claimant had been complaining about left arm involvement on a number of occasions prior to the September 1998 work injury. Because Dr. Fiks does not evaluate the relative contribution of the different causes of claimant's condition, his opinion is not sufficient to establish claimant's burden of proof.

ORDER

The ALJ's order dated April 2, 2001 is affirmed.

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[1] A specific diagnosis is not required to establish compensability; instead, the issue is whether claimant's condition is work related, whatever the diagnosis. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992); *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988). Nevertheless, here, claimant filed a new medical condition claim specifically requesting acceptance of "bilateral cervical radiculopathy." (Ex. 85). Claimant has an accepted claim for a disabling cervical strain; that condition is not at issue here.

In the Matter of the Compensation of
PATRICIA E. BAUER, Claimant
WCB Case No. 00-07175
ORDER ON REVIEW
Holly J. Somers, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that found her accepted thoracic strain remained classified as nondisabling. On review, the issue is claim classification. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the third full paragraph on page 2, we delete the third sentence. We do not adopt the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on August 21, 1998, and the self-insured employer accepted a nondisabling thoracic strain. (Ex. 6).

In February 1999, claimant continued to seek medical treatment for right knee, thigh, shoulder, arm and hand pain. (Exs. 9, 10). Dr. Kayser performed a right knee arthroscopy and partial medial meniscectomy on March 8, 1999. (Ex. 18). According to the employer, claimant has not filed a claim for the right knee condition.

On March 18, 1999, the employer issued a Form 1502 that indicated temporary disability benefits were being paid to claimant for the original injury, and that the first payment was made on that date. (Ex. 18A). The employer checked a box indicating that the "[c]laim was previously accepted/nondisabling." (*Id.*) The form showed that the status of the claimant was now "disabling." (*Id.*) Claimant received temporary disability benefits and her medical providers were paid for their medical services. (Exs. 33A, 43). On June 4, 1999, the employer responded to WCD that it was paying temporary disability benefits. (Ex. 33A).

On June 8, 2000, the employer wrote to claimant about the claim classification. The employer stated, in part:

> "On March 13, 1999 we inadvertently issued a 1502 which stated that the above referenced claim was disabling. This was inadvertent misclassification. Your claim is in fact non-disabling.
>
> "As the prior acceptance letter states, your claim of thoracic back strain was always accepted as non-disabling and remains non-disabling." (Ex. 40).

On the same date, the employer issued another Form 1502 that said the claim was nondisabling, noting that "[t]his claim was previously inadvertently misclassified as disabling. The claim is in fact non-disabling." (Ex. 41).

On July 25, 2000, the Workers' Compensation Department (WCD) rejected the employer's reclassification request as untimely. (Ex. 42). As a result, the thoracic strain remained in disabling status. The employer requested a hearing.

The ALJ found that the employer's March 18, 1999 Form 1502 inadvertently reclassified claimant's thoracic strain as disabling and was issued in error. The ALJ reasoned that ORS 656.277 provided that a notice of reclassification shall be mailed to the worker and the worker's attorney, if represented, but found it was unknown whether claimant or her attorney received a copy of the employer's March 18, 1999 Form 1502. Because there was no evidence that the employer complied with

the requirements for reclassification under ORS 656.277, the ALJ concluded that the Form 1502 did not constitute an effective reclassification of the claim. Alternatively, the ALJ found that, even if the employer had complied with the statutory mailing requirements, the employer had established that the March 18, 1999 Form 1502 was filed in error.

Claimant argues that the employer reclassified the claim to disabling on March 18, 1999, and its attempted reclassification from disabling to nondisabling is untimely. Claimant contends that, even if the disabling classification was a "mistake," the employer is bound by its mistake.

We begin by determining which version of ORS 656.277 applies to this case. Claimant's injury occurred on August 21, 1998, and the employer sent the Form 1502 on March 18, 1999. At that time, *former* ORS 656.277 provided:

> "Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:
>
> "(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.
>
> "(2) A claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury shall be made pursuant to ORS 656.273 as a claim for aggravation.
>
> "(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:
>
> "(a) When a notice of claim denial is filed;
>
> "(b) When the status of the claim is as described in subsection (1) or (2) of this section;
>
> "(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon; or
>
> "(d) When otherwise required by the director."

Although ORS 656.277 was amended effective October 23, 1999, we have determined that those amendments do not apply retroactively. *See, e.g., William I. Sergeant*, 53 Van Natta 231 (2001); *Jon O. Norstadt*, 52 Van Natta 1627 (2000).

Effective January 1, 2001, the Director amended the administrative rules pertaining to claim classification. (WCD Admin. Order No. 00-058). The amended rules pertain only to claims with dates of injury on or after October 23, 1999. OAR 436-030-0003(3)(b). Claimant's date of injury was August 21, 1998. OAR 436-030-0003(3)(b) provides that for claims with dates of injury before October 23, 1999, the provisions of OAR 436-030-0045 in WCD Administrative Order No. 97-065 "shall apply until the industry is notified otherwise by the director." Thus, *former* ORS 656.277 and the rules in WCD Administrative Order No. 97-065 apply to this case.

Although the ALJ found that ORS 656.277 required that a notice of reclassification shall be mailed to the worker and the worker's attorney, we find no such requirement in former ORS 656.277. Compare amended ORS 656.277(1) (providing that a notice of reclassification "shall be mailed to the worker and the worker's attorney if the worker is represented").

Nevertheless, *former* OAR 436-030-0045(1) (WCD Admin Order No. 97-065) provides, in part:

> "When an insurer receives notice or knowledge that a nondisabling injury has become disabling, the insurer shall do one of the following:
>
> "(1) If the insurer agrees that the claim is or originally was disabling, an 'Insurer's Report,' Form 440-1502, indicating a change in status shall be submitted to the department within 21 days from the date of receipt of the notice or knowledge. A notice of change in status to disabling shall be sent to the worker, and to the worker's representative, explaining the change in status. * * *"

Although *former* OAR 436-030-0045(1) states that a notice of change in status to disabling shall be sent to the worker, and to the worker's representative, the rule does not refer to any time limits for providing that notice. Claimant contends, and we agree, that she obviously received a copy of the employer's March 18, 1999 Form 1502 because she submitted that exhibit at hearing. Under these circumstances, we find that the employer provided adequate notice pursuant to *former* OAR 436-030-0045(1).

For whatever reason, the employer chose to issue a Form 1502 on March 18, 1999 (within one year of the August 1998 injury), which indicated that the accepted thoracic strain claim was disabling, although it had previously been nondisabling. (Ex. 18A). The employer's Form 1502 indicated it was mailed to WCD on March 18, 1999, and subsequent correspondance from WCD confirmed that the claim was in fact reclassified as disabling. (Exs. 18A, 42).

The employer wrote to claimant on June 8, 2000, stating that it "inadvertently" misclassified the claim as disabling on March 13, 1999. (Ex. 40). Also on June 8, 2000, the employer issued another Form 1502 that said the claim was nondisabling, noting that "[t]his claim was previously inadvertently misclassified as disabling." (Ex. 41). The employer checked a box indicating that there was a "[c]hange in acceptance or disability status[.]" (*Id.*)

As claimant points out, there cannot be a "change" in classification status to nondisabling unless the claim was currently disabling. The employer argues that, although WCD issued an order on July 25, 2000 declining to reclassify claimant's injury to nondisabling status, it did not find that the claim had been reclassified in the first place. We disagree. The employer's March 18, 1999 Form 1502, which changed the claim to disabling, indicates it was mailed to WCD on that date. (Ex. 18A). On July 25, 2000, WCD responded to the employer's June 2000 letter that attempted to reclassify the claim as nondisabling. (Ex. 42). WCD stated that reclassification can occur only within one year from the date of injury and there was "no authority to reclassify this claim from disabling to nondisabling because your action occurred more than one year from the date of injury." (*Id.*) WCD's July 25, 2000 letter supports a conclusion that the employer effectively reclassified the claim as disabling on March 18, 1999, when it submitted the Form 1502 to WCD.

The employer relies on *EBI Insurance Co. v. CNA Insurance Co.*, 95 Or App 448 (1989), to argue that a mere Form 1502 does not constitute a reclassification. We find that the employer's reliance on that case is misplaced. In that case, another carrier argued that the employer had accepted the claimant's new injury claim when it filed a Form 1502 with WCD that said "claim originally denied, now accepted." Two days after filing the report, the employer filed another report explaining that the notation in the earlier report that stated "claim originally denied, now accepted" was a clerical error. A witness testified that the Form 1502 was a report to WCD of the current status of a claim, but it was not a notification to a claimant that the claim was accepted or denied. Under those circumstances, the court concluded that there had been no "back up denial" because there had been no previous acceptance by the employer.

Here, in contrast, there is no question that the employer accepted a thoracic strain. We are not relying on the Form 1502 to determine that the claim was accepted or denied. Instead, we are reviewing the March 18, 1999 Form 1502 to assist us in determining the status of the claim, which is consistent with *EBI Insurance Co. v. CNA Insurance Co.*, 95 Or App at 450.

Former OAR 436-030-0045(4) provides that, "[e]xcept for reconsideration, pursuant to OAR 436-030-0115, the department or insurer shall not reclassify claims from disabling to nondisabling more than one year after the date of injury." *See also DeGrauw v. Columbia Knit, Inc.*, 118 Or App 277, 281 (if an employer chooses to reclassify a claim from disabling to nondisabling, it must do so within sufficient time to permit the claimant to challenge the reclassification within one year from the date of injury), *rev den* 316 Or 527 (1993). This case does not involve reconsideration pursuant to *former* OAR 436-030-0115. Indeed, there has been no determination order or notice of closure issued. As discussed above, we have concluded that the employer effectively reclassified the claim as disabling in March 1999 (within one year of the August 1998 injury), when it submitted the Form 1502 to WCD. The employer's attempt to again reclassify the claim to nondisabling on June 8, 2000, which was more than one year after

claimant's August 21, 1998 injury, was ineffective because it was untimely.[1] Consequently, we conclude that there is no authority to allow the employer to reclassify the claim from disabling to nondisabling. Under these circumstances, we conclude that claimant's thoracic strain remains disabling.

Relying on *Ben E. Conradson*, 52 Van Natta 893 (2000), claimant requests an attorney fee. Because the employer requested a hearing from WCD's classification decision, claimant's attorney is entitled to an assessed fee for services at hearing. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $2,415, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's counsel's statement of attorney fees), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is also entitled to an "out-of-compensation" fee for her services on review regarding the classification issue. ORS 656.386(2). Claimant's counsel is awarded an "out-of-compensation" fee equal to 25 percent of the increased temporary disability compensation, if any, created by this order, not to exceed $5,000, to be paid by the employer directly to claimant's counsel. *See* OAR 438-015-0055(1).

ORDER

The ALJ's order dated April 18, 2001 is reversed. WCD's classification decision is affirmed. For services at hearing, claimant's attorney is awarded $2,415, payable by the self-insured employer. For services on review, claimant's attorney is awarded an "out-of-compensation" attorney fee equal to 25 percent of any additional temporary disability compensation created by this order, not to exceed $5,000, payable directly to claimant's counsel by the employer.

[1] Because the employer's June 8, 2000 reclassification request was untimely, it is unnecessary to address the merits of whether claimant's thoracic strain is disabling pursuant to ORS 656.005(7)(c).

August 21, 2001 Cite as 53 Van Natta 1104 (2001)

In the Matter of the Compensation of
LLOYD CARLTON, Claimant
WCB Case No. 00-06066
ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

On August 3, 2001, we issued an Order on Review that: (1) held that the Hearings Division lacked jurisdiction to consider claimant's hearing request from a Workers' Compensation Division order declining to reclassify his claim (because the order contained an incorrect statement regarding the parties' rights of appeal); and (2) affirmed an Administrative Law Judge's (ALJ's) order that awarded a $4,000 employer-paid attorney fee for a discovery violation. The employer contends that we erroneously applied the amended version of ORS 656.277(1), and because the sole issue at hearing was a penalty/attorney fee for a discovery violation, the ALJ lacked authority to award an attorney fee. Consequently, the employer seeks reconsideration of our decision and the reversal of the ALJ's attorney fee award.

In order to further consider this matter, we withdraw our August 3, 2001 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
CRAIG J. PRINCE, Claimant
WCB Case No. 00-00561
ORDER DENYING RECONSIDERATION
Scott M. McNutt, Sr., Claimant Attorney
Jerald Keene, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Citing ORS 656.382(2), claimant has requested a $2,000 attorney fee for his counsel's services rendered before the Court of Appeals. The insurer has objected to claimant's request, contending that we lack authority to either consider or grant the request. We treat claimant's request as a motion for reconsideration of our September 19, 2000 order. *Craig J. Prince*, 52 Van Natta 1658 (2000). For the following reasons, we deny the motion.

On September 19, 2000, we issued an order that affirmed the Administrative Law Judge's order directing the insurer to reopen and process claimant's claim for L4-5 and L5-S1 disc conditions pursuant to ORS 656.262(7)(c). *Craig J. Prince*, 52 Van Natta 1658 (2000). Thereafter, on October 11, 2000, the insurer petitioned for judicial review.

The insurer subsequently withdrew its petition for judicial review. On June 25, 2001, the court issued an Order of Dismissal and Appellate Judgment. The court's order did not remand the case to the Board.

Asserting that we "would seem to" have "jurisdiction" over this matter, claimant requests that we award a $2,000 attorney fee pursuant to ORS 656.382(2) for services rendered by his counsel before the court prior to the dismissal of the insurer's petition for judicial review. In response, the insurer asserts that it "can find no basis upon which the Board might assume jurisdiction" to award an attorney fee. The insurer further notes that the court did not remand to the Board, but rather issued an Order of Dismissal and Appellate Judgment.

As previously noted, we treat claimant's attorney fee request as a motion for reconsideration of our September 19, 2000 order. We deny the motion. In doing so, we reiterate that the court did not remand this matter to the Board for further action. Rather, it dismissed the petition for judicial review and issued its appellate judgment. The court's order is effective as of the date of the appellate judgment. *See* ORAP 14.05(2)(b). Consequently, the court's dismissal order is final. Under such circumstances, we have no authority to reconsider our prior decision.

In the alternative, there was no finding by the court on the merits that claimant's compensation as awarded by our prior order should not be disallowed or reduced. It is well-settled that one prerequisite for an attorney fee award under ORS 656.382(2) is that there must be a decision on the merits that the compensation award should not be disallowed or reduced. *See Deaton v. Hunt-Elder*, 145 Or App 110, 114-115 (1996); *Strazi v. SAIF*, 109 Or App 105, 107-108 (1991). Here, this prerequisite has not been met because the court dismissed the petition for judicial review without a decision on the merits. Accordingly, even if we had authority to consider the award of an attorney fee, the statutory requirements have not been met and no fee can be awarded.

For the reasons expressed herein, claimant's request is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNY L. SKELTON, Claimant
WCB Case No. 00-09290
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) admitted Exhibits 10 and 11 into evidence; and (2) affirmed an Order on Reconsideration that declined to award unscheduled permanent disability for claimant's mental disorder claim. On review, the issues are the ALJ's evidentiary ruling and extent of unscheduled permanent disability.

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

Claimant objected to the admission of Exhibits 10 and 11, the latter exhibit consisting of handwritten notes from a reviewer (McDonnell) for the Appellate Review Unit documenting his efforts to obtain clarification of the medical arbiter's report and describing the contents of a message the arbiter left regarding the reviewer's inquiry. Exhibit 10 consisted of a "Fax Transmittal Cover Sheet" that contained a letter written to the medical arbiter by McDonnell recounting the contents of arbiter's message. No clarification report from the medical arbiter is contained in the record.

The ALJ admitted the disputed exhibits, reasoning that, because the documents were mere clarification notes made by the appellate reviewer, they were generally reliable and should be admitted. However, the ALJ did not accept them for the same weight as they would hold had the medical arbiter authored them.

On review, claimant contends that the ALJ erroneously admitted the disputed exhibits, arguing that the parties had no opportunity to review, object to, or correct the evidence the appellate reviewer created. For the following reasons, we need not decide whether the ALJ abused his discretion in admitting the disputed exhibits. *See Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995) (review of an ALJ's evidentiary ruling is for abuse of discretion).

Although the ALJ admitted the disputed exhibits, he did not expressly rely on them in discounting the opinion of the medical arbiter (and, in fact, gave them reduced weight). We agree with the ALJ's reasoning that a preponderance of medical evidence (excluding the disputed exhibits) established a level of impairment different from that posited by the medical arbiter. Thus, even if we do not consider exhibits 10 and 11, as claimant urges, we agree with the ALJ's conclusion that claimant does not have permanent impairment as a result of his compensable psychological injury. Therefore, we affirm.

ORDER

The ALJ's order dated April 30, 2001 is affirmed.

Board Member Phillips Polich dissenting.

The majority avoids deciding a difficult evidentiary issue by finding that, even if it did not consider Exhibits 10 and 11, claimant does not have permanent impairment as a result of his compensable psychological injury. I disagree with that conclusion and would instead find that, based on the record excluding the disputed exhibits, claimant has proved permanent impairment due to the compensable psychological injury. Thus, in my view, the only way that SAIF prevails is through consideration of the disputed exhibits. However, for reasons I will explain at the conclusion of my dissent, I also disagree with the ALJ's decision to admit those exhibits. I reason as follows.

Because the majority largely adopts the ALJ's order, it first is necessary to briefly recount the facts of the case. Claimant was originally injured in 1985 when a tank blew up near him at work, requiring that he undergo extensive facial surgery. Unfortunately, claimant was present when a second explosion occurred at work in September 1999. As a result of that incident, Dr. Mathews diagnosed post traumatic stress disorder (PTSD) and advised claimant to seek counseling, which he received from a psychologist, Dr. Myers.

Dr. Myers diagnosed a major depressive disorder, single episode, the condition SAIF eventually accepted. On November 29, 1999, Dr. Mathews reported that claimant's affect was clearly improved and that claimant was anxious to return to work. Dr. Myers, however, kept claimant off work, finding that claimant's PTSD symptoms remained "uncontrolled." Nevertheless, Dr. Myers reported on December 29, 1999 that claimant's symptoms were improving and that claimant would be ready for part-time work after the first of the year.

On February 20, 2000, Dr. Heck, a psychiatrist, examined claimant on SAIF's behalf. Dr. Heck reported that claimant was feeling "pretty good" except for headaches. Diagnosing a dysthymic disorder, Dr. Heck advised that claimant no longer required psychiatric or psychological treatment.

Dr. Mathews concurred with Dr. Heck's findings, but was uncertain whether claimant was medically stationary. Dr. Myers agreed with Dr. Heck's diagnosis in terms of the information that Dr. Heck had. However, Dr. Myers stated that claimant did fit the diagnosis of major depressive disorder and also met the diagnostic criteria for PTSD based on the information presented to him.

In April 2000, Dr. Heck opined that claimant's symptoms did not fit the PTSD diagnostic criteria, but agreed that claimant's condition had stabilized by the end of December 1999.

SAIF then closed the claim on June 9, 2000 with no award of permanent disability. Claimant requested reconsideration, resulting in a November 20, 2000 medical arbiter's examination by Dr. Elder. Disagreeing with Dr. Heck's assessment that claimant was not suffering from PTSD and a major depressive disorder, Dr. Elder concluded that claimant suffered from Class III psychological impairment. In the course of Dr. Elder's examination, claimant reported that he was experiencing panic attacks, sleep disturbance, distressing recollections of the 1999 work event and intense psychological and physical reactions to symbols of the explosion. Dr. Elder did acknowledge, however, that it was "puzzling" that claimant continued to work successfully with Class III impairment. Despite this, Dr. Elder attributed the Class III impairment to the 1999 injury.

The Order on Reconsideration issued on December 5, 2000, awarding no permanent disability. The Appellate Reviewer (McDonnell) found Dr. Elder's findings inconsistent with the remainder of the medical record. As part of his evaluation, McDonnell contacted Dr. Elder's office to obtain clarification of his arbiter's report. Dr. Elder left a message on McDonnell's answering machine. In a fax transmittal cover sheet and in a memo to the claim file (Exs. 10, 11), McDonnell summarized the contents of Dr. Elder's message. According to McDonnell, Dr. Elder indicated that his rating of impairment was "conditional" as he was puzzled about how claimant could function well enough to continue working with a Class III rating.

Claimant requested a hearing, contesting the reconsideration order. Claimant also objected to the admission of McDonnell's memo to the file and fax transmittal cover sheet. As noted by the majority, the ALJ admitted the disputed exhibits, reasoning that they were generally reliable. However, the ALJ did not give them the same weight as a report issued by Dr. Elder. With respect to the merits of the permanent disability issue, the ALJ declined to award unscheduled permanent disability, despite Dr. Elder's Class III impairment rating, concluding that Dr. Elder's opinion was contrary to the preponderance of medical opinion.

As previously noted, the majority declines to decide whether the ALJ properly admitted the disputed exhibits because they conclude that the other admitted evidence supports the ALJ's determination that claimant is not entitled to unscheduled permanent disability. I disagree with that conclusion. In other words, without considering the disputed exhibits, I, unlike the majority, would find that claimant sustained his burden of proving entitlement to a Class III impairment rating for psychological impairment.

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). This preponderance of medical opinion must come from findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We 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).

In this case, I conclude that Dr. Elder; the medical arbiter, provided the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. Dr. Elder conducted an

extensive interview of claimant, evaluated the appropriate legal standards and concluded that claimant was suffering from PTSD and met the criteria for Class III impairment. (Ex. 9). Moreover, Dr. Elder performed the appropriate psychological testing and evaluated Dr. Heck's report, pointing out his disagreement with the latter doctor's evaluative methodology. It should also be noted that Dr. Elder's examination was conducted much closer in time to the reconsideration order and thus represents the most current evaluation of claimant's psychological condition.

The ALJ discounted Dr. Elder's opinion because it seemed inconsistent with the descriptions of claimant's condition contained in Dr. Heck's and Dr. Meyer's reports. However, I find that it is Dr. Heck's report, not Dr. Elder's, that stands in stark contrast to the rest of the record.

While Dr. Heck's report acknowledges some of the symptoms claimant was experiencing, Dr. Heck seemed more influenced by claimant's report that he felt okay and had no stress since January 2000. This report is inconsistent with Dr. Elder's understanding of claimant's condition months later and closer in time to the reconsideration order. Moreover, Dr. Heck's report is also inconsistent with the findings of Dr. Myers, who diagnosed PTSD and noted that claimant experienced symptoms such as waking up screaming and gasping for air. My review of the record indicates that Drs. Elder and Myers paint a consistent picture of claimant's PTSD and continuing residual symptoms. Although Dr. Elder expressed surprise that claimant had been able to return to work, he nonetheless rated claimant's impairment as Class III.

Accordingly, I would find that claimant is entitled to injury-related impairment based on the record without consideration of disputed Exhibits 10 and 11. Even if the disputed Exhibits are considered, I would not be inclined to change my position. Those exhibits do not add a great deal to Dr. Elder's report. However, McDonnell reported that Dr. Elder's hearsay statement that his rating was "conditional." Because that aspect of the disputed exhibits arguably strengthens SAIF's position that Dr. Elder's impairment rating is not persuasive, I will address the propriety of the ALJ's evidentiary ruling that admitted the disputed exhibits.

It is well-settled that the Board reviews an ALJ's evidentiary ruling for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem LeMasters v. Tri-Met, Inc.*, 133 Or App 258 (1995). However, we must keep in mind that, pursuant to ORS 656.283(7), the ALJ must conduct a hearing in a manner that achieves "substantial justice." The concept of "substantial justice" should include the opportunity to comment on or test the reliability of evidence that will be before a decision-maker.

In this case, the parties did not have the opportunity to test the reliability of the hearsay contained in Exhibits 10 and 11 through cross-examination or further development of the record. This, I submit, was contrary to the overriding principle of "substantial justice" that governs all workers' compensation proceedings.

Thus, I conclude that the ALJ abused his discretion in admitting hearsay statements contained in the disputed exhibits. For this reason, the majority should exclude Exhibits 10 and 11 from the record. Because they do not, I find an additional reason to dissent from the majority's position.

In the Matter of the Compensation of
PATRICIA J. HURD, Claimant
WCB Case No. 00-09221
ORDER OF ABATEMENT
Schneider, et al., Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Claimant requests reconsideration of our July 25, 2001 order that remanded this matter to the Administrative Law Judge for further proceedings.

In order to allow sufficient time to consider claimant's motion, we withdraw our July 25, 2001 order. The self-insured employer is granted an opportunity to respond. To be considered, the

employer's response must be filed within 14 days from the date of this order. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

August 22, 2001 Cite as 53 Van Natta 1109 (2001)

In the Matter of the Compensation of
GEORGE D. KOSKELA, Claimant
WCB Case No. 95-08576
ORDER ON REMAND (REMANDING)
Swanson, Lathen, et al., Claimant Attorney
VavRosky, MacColl, et al., Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

This matter is before the Board on remand from the Supreme Court. *Koskela v. Willamette Industries, Inc.*, 331 Or 362 (2000). The Supreme Court has reversed the Court of Appeals' opinion, 159 Or App 229 (1999) that had affirmed our prior order, *George D. Koskela*, 49 Van Natta 529 (1997). In our prior order, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) declined to admit into evidence the testimony of claimant, his physician or his vocational counselor at a hearing regarding his appeal of an Order on Reconsideration; and (2) declined to grant permanent total disability (PTD).

The Court has concluded that allowing a worker, at some meaningful stage of the process, an opportunity for at least some kind of evidentiary hearing will not significantly impede the state's interest in providing a cost-effective process, because hearings can be conducted in a manner that achieve both fairness and efficiency. Consequently, the Court has held that the post-1995 statutory scheme for assessing whether a worker should receive an award of PTD benefits fails to satisfy procedural due process requirements.

In his supplemental brief on remand, claimant raises several evidentiary issues arising from the Court's decision. The employer responds, however, that this matter should be remanded to the ALJ.

After considering the parties' positions, we conclude that remand to the ALJ is appropriate. In reaching our conclusion, we rely on our decision in *Allen Coman*, 50 Van Natta 2230 (1998). In *Coman*, we initially affirmed an ALJ's order that had: (1) denied the claimant's motion to compel the carrier to disclose certain inmates' medical records; and (2) upheld the carrier's denial of the claimant's claim for tuberculosis. Although the Court of Appeals affirmed our order, the Supreme Court reversed and concluded that the records were not absolutely undiscoverable under the statute. Consequently, the Court remanded to the Board with instructions to remand the case to the ALJ to grant discovery of the requested medical records under such circumstances as the ALJ found to be appropriate.

On remand in *Coman*, the parties submitted several arguments regarding the scope of the forthcoming discovery order. Nonetheless, following the Court's directive, we remanded to the ALJ to conduct further proceedings. In doing so, we noted that the claimant had submitted a discovery procedure to "assist the Board" in formulating a discovery order pursuant to the Court's ruling. Nevertheless, we referred the parties' submissions to the ALJ for consideration in conjunction with the Court's mandate. *Id.*

Here, unlike the circumstances presented in *Coman*, the Court has not expressly directed us to remand to the ALJ. Nonetheless, the Court did discuss the role of an ALJ in the PTD evidentiary hearing in conjunction with our statutory authority to review only evidence presented at the hearings level. Consequently, it is apparent that the Court's reference to "further proceedings" in its decision to remand the case is a directive to return this matter to the ALJ for further development of the record. Thus, we find *Coman* to be instructive.

Claimant attempts to distinguish *Coman* on the ground that it involved subpoenas and discovery motions rather than "hearing procedures." However, *Coman* is applicable to the extent that it pertained

to hearing procedures to be followed in a particular case. Similarly, the present case involves evidentiary issues and hearing procedures that are best raised to the ALJ. In this way, the parties may present their arguments regarding the scope of the Court's decision to the ALJ that will conduct the proceedings. Thereafter, the ALJ will address the parties' arguments, render evidentiary rulings, and issue a decision on the merits of claimant's PTD claim. If either party disagrees with the ALJ's eventual final order, that party may then request Board review. In light of such circumstances, we find it premature for us to address these procedural and evidentiary issues at this time.[1]

Consistent with the *Coman* holding, we remand this case to the ALJ. In this way, the parties may present their arguments regarding the scope of the Court's decision to the ALJ that will conduct the proceedings. Thereafter, the ALJ will address the parties' arguments, render evidentiary rulings, and issue a decision on the merits of claimant's PTD claim. If either party disagrees with the ALJ's eventual final order, that party may request Board review.

In conclusion, in accordance with the Supreme Court's directive that an oral evidentiary hearing is required, we remand to ALJ Garaventa for further proceedings consistent with the Court's opinion and this order.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we acknowledge claimant's suggestion that general evidentiary rules be considered. We decline to take such an action at this time. As described above, we consider the appropriate route to follow is to allow the parties to present their respective arguments to the ALJ, who after due consideration of the opposing positions will render a ruling. Such a decision, as well as other subsequent rulings in other litigated cases, may eventually form the basis for future rulemaking activity. However, before such litigation proceeds and rulings are rendered and appealed, it is premature to embark on such an action. Finally, we note that the court has acknowledged our authority to develop legal standards either by formal rulemaking or on a case-by-case basis. *See SAIF v. Campbell*, 113 Or App 93 (1992).

In the Matter of the Compensation of
PAMELA L. DARLING, Claimant
WCB Case No. 00-00719
ORDER ON REVIEW
Swanson, et al., Claimant Attorney
Reinisch, et al., Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that: (1) found that claimant's failure to attend three insurer-arranged medical examinations constituted an unjustified delay in the scheduled hearing pursuant to OAR 438-006-0071(1); and (2) dismissed her request for hearing regarding the insurer's denial of her occupational disease claim for a right shoulder condition. On review, the issue is dismissal.

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

In October 1999, claimant filed an occupational disease claim for right shoulder pain. (Ex. 45). She has a history of emotional and mental health problems, including post-traumatic stress disorder, depression, anxiety, and chronic pain syndrome. Although claimant was taking psychiatric medication at the time her claim was filed, her co-workers reported witnessing claimant engage in strange and unexplainable behavior including erratic mood swings, from crying to hysterical laughter.[1]

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[1] In his initial evaluation of claimant, Dr. Puziss (attending physician) noted "acute anxiety and depression as a result of this injury." (Ex. 69). Because claimant's attending physician opined that claimant's psychological problems were causally related to work activities, it was reasonable for the insurer to seek a psychological evaluation as part of its claim processing.

As part of its claims investigation, the employer scheduled claimant for a December 10, 1999 medical examination by Dr. Binder, a psychologist. (Exs. 67A). By letter of December 3, 1999, claimant refused to be examined by Dr. Binder or submit to any psychological evaluation.[2] (Ex. 67).

The claim was denied on January 20, 2000. (Ex. 68-1). Claimant requested a hearing.

On March 16, 2000, the employer informed claimant that she had been rescheduled for a medical examination by Dr. Binder. (Ex. 69A). On March 31, 2000, claimant again advised the employer that she would not submit to a psychological examination. (Ex. 69D). In May 2000, claimant filed a motion to quash the medical examination. (Ex. 71). In response, the employer moved to dismiss claimant's request for hearing. (Ex. 73).

On June 5, 2000, a prior ALJ issued an Interim Order that: (1) denied claimant's motion to quash; (2) extended an opportunity for claimant to attend a future employer-arranged medical examination; (3) denied the employer's motion to dismiss; and (4) reset the hearing "in the normal course." (Ex. 75-2).

Following the prior ALJ's Interim Order, the employer again rescheduled claimant for a psychological evaluation. (Ex. 79). Claimant did not attend the scheduled examination. (Ex. 79A).

At the start of the "rescheduled" hearing, the employer asserted that claimant had engaged in conduct (failing to attend the above listed psychological evaluations) that resulted in unjustified delay, and moved to dismiss claimant's hearing request.[3] (Tr. 10). Claimant objected to the employer's motion, but stipulated that she had not attended any of the aforementioned psychological evaluations and further stipulated that she had no illness, family emergencies, or extenuating circumstances of any kind at the time of the scheduled examinations. (Tr. 23).

The ALJ determined that claimant's refusal to attend any of the scheduled medical evaluations constituted grounds for dismissal under OAR 438-006-0071(1). Consequently, the ALJ dismissed claimant's request for hearing.

In her appellant's brief, claimant acknowledges that in *Ronald C. Fuller*, 49 Van Natta 2067, 2071 (1997), the Board stated:

> "In sum, consistent with 'the modest level of cooperation' required by ORS 656.325(1), the statutory policy directive of ORS 656.012 that we provide a 'fair and just administrative system,' and in the interests of achieving substantial justice under ORS 656.283(7), we continue to adhere to the Board's long-standing holding that a claimant's failure to attend a 'post-denial' IME may be grounds for a postponement of a scheduled hearing under our applicable administrative rule."

Nonetheless, claimant asserts that the Supreme Court's interpretation of ORS 656.325(1) in *Robinson v. Nabisco, Inc.*, 331 Or 178 (2000), compels us to reexamine *Fuller*.[4] After reviewing the *Robinson* rationale, we continue to adhere to the Fuller holding.

In *Robinson*, the issue before the Court was whether a claimant was entitled to compensation for an injury suffered during a compelled medical examination (CME).[5] The Court concluded that such an injury was compensable because it occurred within the course and scope of the claimant's employment. *Robinson*, 331 Or at 190.

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[2] Claimant did agree to undergo an orthopedic examination. (Ex. 67B-2).

[3] OAR 438-006-0071(1) provides: "A request for hearing may be dismissed if an Administrative Law Judge finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days."

[4] ORS 656.325(1)(a) provides, in pertinent part: "Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director."

[5] The *Robinson* Court described a CME as a medical examination that has been arranged by the carrier and that the claimant is required to attend under ORS 656.325(1)(a).

As a part of its discussion of the "arising out of" prong of the compensability test, the Court noted:

> "ORS 656.325(1) does not state explicitly the purpose of a CME but, in context, the purpose is clear. A CME is designed to provide the director, the self-insured employer, or the employer's insurer with information about claimant's condition from a doctor who has no fiduciary relationship with claimant, such as that of an attending physician. *See* ORS 656.005(12)(b) (defining attending physician, in part, as a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury * * *). An employer or insurer that requests a CME, as in this case, might use the examining doctor's information to protect the employer's legal position on the claim vis-a-vis the claimant, for example, by challenging the continuing compensability of the injury or disease, the extent of any resulting disability, or the nature of medical or psychological treatment that the claimant may require." *Robinson*, 331 Or at 187.

According to claimant, this language relieves her of any obligation to attend a "post-denial" CME. In particular, claimant contends that because the Court did not expressly include "claims investigation after a denial" within the above-quoted examples of the appropriate use of a CME, that ORS 656.325(1) is not applicable after a carrier denies the claim. For the reasons enumerated below, we reject claimant's argument.

First, the issue in *Robinson* is not the same issue that is presented here. Next, nothing in the Court's language indicates that it intended to restrict the uses of a CME to the few examples listed in its opinion. Finally, the Court expressly stated that its discussion of the characteristics of a CME were to demonstrate a "causal link between" an injury occurring during a CME and "a risk connected to a condition of employment." *Robinson*, 331 Or at 187. Consequently, we conclude that Robinson does not alter the *Fuller* rationale.

ORDER

The ALJ's order dated December 27, 2000 is affirmed.

In the Matter of the Compensation of
GAIL A. MORRIS, Claimant
WCB Case No. 00-09156
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Sather, et al., Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that awarded a $300 assessed attorney fee under ORS 656.386(1)(b)(A) for his counsel's efforts in obtaining a rescission of a denial prior to hearing. On review, the issue is attorney fees.[1]

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

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).

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[1] The parties do not dispute that claimant is entitled to an assessed fee under ORS 656.386(1)(b)(A). Rather, the dispute is over the amount of the fee. Claimant seeks more than the $300 awarded. The self-insured employer contends that the fee awarded is appropriate.

When compared to compensability disputes generally presented to this forum, the value of the claim and the benefits secured are below average.[2] The hearing was relatively short, and the medical issues presented were less complex than those generally litigated in the Hearings Division.[3] The parties' respective counsels presented their positions in a thorough and professional manner. No frivolous issues or defenses were presented. Finally, considering the record as a whole, including the employer's denial that palliative care medical services were not causally related to claimant's accepted condition, there was little 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 $300 is a reasonable attorney fee for services at the hearings level in this case.[4] 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 April 2, 2001 is affirmed.

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[2] The compensability issue involved whether specific palliative care medical services were causally related to claimant's accepted low back condition. Claimant stipulated that, for reasons not involving compensability the particular services requested were not reimbursable. (Tr. 3).

[3] The hearing transcript consists of 17 pages. No witnesses were called. The hearing itself took 23 minutes including the time devoted to closing arguments, which were recorded. The hearing record consists of 13 exhibits, only two of which are medical records. Claimant's counsel was not required to generate any exhibits to establish compensability of the requested medical services.

[4] Claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

Board member Phillips Polich dissenting.

I disagree with the majority's conclusion that sum of $300 is a reasonable sum to award claimant's counsel for services in obtaining a rescission of a denial prior to hearing. Therefore, I respectfully dissent.

As a member of the Oregon State Bar, and the only reviewing member on this panel with experience representing clients in Oregon Workers' Compensation cases, I find an attorney fee award of $300 for services in connection with obtaining a rescission of a denial (even if the rescission was prior to hearing) grossly inadequate. Such an amount does not reasonably take into account the attorney's time for the initial client interview, review of the medical records, or hearing preparation, let alone any of the other factors the Board considers pursuant to OAR 438-015-0010(4). Consequently, I would modify the ALJ's order and significantly raise the amount of attorney fee awarded. Because the majority decides otherwise, I dissent.

In the Matter of the Compensation of
KAREN L. ARMS, Claimant
WCB Case No. 01-00957
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Reinisch, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that affirmed an Order on Reconsideration that rescinded its Notice of Closure as premature. On review, the issue is premature closure. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We summarize the relevant facts. Claimant is a custodian for the employer. On January 25, 2000, claimant twisted her right knee in the cafeteria. The insurer accepted the claim for disabling right knee strain. (Ex. 18). Claimant came under the care of Dr. Lundquist, who performed an arthroscopic surgery on June 23, 2000. (Ex. 33). On October 10, 2000, Dr. Marble, who had earlier examined claimant at the request of the insurer, concluded that claimant's preexisting degenerative condition had combined with her acute work injury and constituted the major contributing cause of claimant's current and on-going need for treatment and disability. (Ex. 44).

On October 16, 2000, the insurer issued a Modified Notice of Acceptance accepting a "right knee strain which combined with pre-existing and unrelated degenerative conditions." (Ex. 46-1). On October 17, 2000, the insurer denied the current compensability of claimant's combined condition, alleging that "The major contributing cause of your current condition, need for treatment and disability is no longer the work injury and, rather, relates to your pre-existing and unrelated degenerative conditions." (Ex. 47). The insurer stated that the denial would result in claim closure. (*Id.*)

On October 23, 2000, the insurer issued a Notice of Closure awarding various periods of temporary disability but no permanent disability. (Ex. 49). The insurer stated that there was "no impairment due to accepted condition." (Ex. 49-2). Claimant requested reconsideration, contending primarily that the claim was prematurely closed.

On January 8, 2001, an Order on Reconsideration rescinded the October 23, 2000 Notice of Closure on the basis that the insurer had failed to provide "sufficient information" in terms of "estimated findings" in accordance with OAR 436-035-0007(5). (Ex. 51). *See* ORS 656.268(1)(a). These findings are necessary, the Appellate Unit stated, when a denial of the claimant's current combined condition is issued and claimant's accepted condition is not medically stationary. (Ex. 51-2).

The ALJ affirmed the Order on Reconsideration based on a similar interpretation of the administrative rules.

On review, the insurer first contends that the Director of the Department of Consumer and Business Services (the Director) lacked authority to rescind its Notice of Closure, citing *Ball v. The Halton Co.*, 167 Or App 468 (2000), *rev den* 331 Or 583 (2001). The court held in *Ball* that a closing examination is not a prerequisite to a carrier's closure of a claim pursuant to *former* ORS 656.268(4). 167 Or App at 474.

However, in *Stephanie A. Dys-Dodson*, 53 Van Natta 207 n1 (2001), we distinguished the *Ball* holding because it did not apply the current version of ORS 656.268(1), after the 1999 amendments,

which now requires "sufficient information to determine permanent impairment."[1] 1999 Or Laws ch. 313, sec. 1.[2] The employer acknowledges the statutory amendments after *Ball* but contends that the statute, as amended, still does not provide authority to rescind a notice of closure for insufficient information at closure. We disagree.

OAR 436-030-0135(4) provides specific authority for the Director to rescind the closure. Based on the reasoning below, OAR 438-030-0135(4) consistently implements the statutory authority of ORS 656.268(1)(a) and (b). We conclude that the Director had authority to rescind the insurer's Notice of Closure, notwithstanding the court's decision in *Ball*.

Next, the insurer contends that "sufficient information" exists in the record to close the claim, because a claimant is logically never entitled to a permanent disability award after a carrier has denied the current combined condition. In other words, the insurer contends that "no information" is "sufficient information" in these circumstances. We disagree.

We find that the insurer's (lack of) medical evidence is not sufficient under the statute. Pursuant to ORS 656.268(1)(b), there is still an accepted component of claimant's claim for which the "likely impairment and adaptability" that "would have been due" must be estimated. Contrary to the insurer's contention, ORS 656.268(1)(b) contemplates a "current accepted condition" after a denial of a combined condition; *i.e.*, the originally accepted condition. The language of the statute does not support the insurer's argument that the originally accepted condition is "extinguished" by the denial of the combined condition. At the least, the accepted condition must be processed to closure. ORS 656.268(1)(b).

The insurer's argument also runs contrary to the policy against circumventing the closure process expressed in a line of cases from the Court of Appeals. *See Rogers v. Weyerhaeuser*, 82 Or App 43 (1986); *Roller v. Weyerhaeuser*, 67 Or App 583, *amplified* 68 Or App 743 *rev den* 297 Or 601 (1984). *See also Pamela J. Gentry*, 52 Van Natta 918 (2000) (carrier's denial of the claimant's current combined condition, which stated that "claim closure may result from the issuance of this denial," was an invalid attempt to circumvent the claim closure process). In other words, the logical extension of the insurer's argument that no "accepted claim" remains after a denial of a current, combined condition is that no closure would be required at all. That result does not square with the statute, nor with the policy expressed in the above-cited cases.

Finally, the insurer argues that, if it did not comply with the relevant administrative rules, the rules are inconsistent with the statute and should be found invalid. We disagree.

OARs 436-030-0020(1)(b)[3] and 436-030-0135(4) are not inconsistent with the statutory scheme. ORS 656.268(1)(b) requires the insurer to estimate impairment that would have been due to the current accepted condition. OAR 436-030-0020(1)(b) implements that statutory directive. OAR 436-030-0135(4) merely provides for the logical consequence of a carrier's failure to provide "sufficient information," *i.e.*, "[t]he director will issue an order rescinding the Notice of Closure." OAR 436-030-0135(4)(b).

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[1] ORS 656.268(1)(a) and (b) now provide:

"The insurer or self-insured employer shall close the worker's claim as prescribed by the Director of the Department of Consumer and Business Services, and determine the extent of the worker's permanent disability * * *, when:

"(a) The worker has become medically stationary and there is sufficient information to determine permanent impairment;

"(b) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7). When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition, and there is sufficient information to determine permanent impairment, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated."

[2] Moreover, in *Gloria Garibay*, 52 Van Natta 2251, 2253 n2 (2000), we cited *Ball*, but noted that ORS 656.268(1)(a) does not require a closing examination, only that there be "sufficient information to determine permanent impairment." We concluded that the record in *Garibay* contained "sufficient information" for the insurer to close the claim. *Id.*

[3] OAR 436-030-0020(1)(b) provides that the carrier must issue a Notice of Closure for an accepted disabling claim when:

"(b) the accepted injury/condition is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, there is sufficient information to determine the extent of permanent disability and the worker is not enrolled and actively engaged in training * * *."

ORDER

The ALJ's order dated April 6, 2001 is affirmed.[4]

[4] Inasmuch as claimant waived the filing of a respondent's brief, we do not award an attorney fee pursuant to ORS 656.382(2).

In the Matter of the Compensation of
KATHY A. CLARK, Claimant
WCB Case No. 00-06873
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

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

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

The ALJ found that Dr. Grant had weighed claimant's 17 years of work activities against five months of strenuous off-work activity in her garden, as well as her genetic factors. Nevertheless, the ALJ concluded that Dr. Grant had not properly weighed claimant's off-work gardening activity over the past 18 years. Reasoning that Dr. Grant did not have a complete understanding of claimant's activities, the ALJ concluded that claimant had failed to establish medical causation.

Claimant argues that Dr. Grant's opinion establishes that her work activities were the major contributing cause of her bilateral carpal tunnel syndrome (CTS). She relies on Dr. Grant's deposition testimony to prove that he adequately weighed her off-work activities in determining causation.

In evaluating medical opinions, we may choose to 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. Grant examined claimant on only one occasion. Under these circumstances, we find that Dr. Grant's opinion is not entitled to any particular deference as a treating physician.

Claimant last worked for the employer on December 22, 1999. (Tr. 7). She first sought treatment for CTS symptoms in late April 2000, when she saw Dr. Lichtenstein. He reported that claimant's "fingers get numb and puffy in the morning but using hands a lot more now as off work and working around her home[.]" (Ex. 14-1). On May 17, 2000, Dr. Grant reported that claimant had numbness and tingling in her hands when she drives and holds things and she "especially notes it when she has been working a lot on her five acres (pulling weeds, clearing brush, chopping, etc.)" (Ex. 18-1). He explained:

> "[Claimant] mentions that she did data entry for 11 or more years, but was laid off in 12/99. She denies having any upper extremity symptoms during this period of time. She mentions that since she was off work, she has been doing some even more vigorous work on her five acres including weed pulling, clearing brush, etc. It is during this time that she began noting the onset and progression of her upper extremity symptoms." (Ex. 18-2).

In a June 5, 2000 report, Dr. Grant said that claimant's CTS symptoms did not come on until soon after she quit work "and was involved in some vigorous arm and hand activities[.]" (Ex. 35A). He noted that the vigorous arm/hand activities occurred "after" she left the data entry job. (*Id.*)

In a deposition, Dr. Grant explained that any activity is important in assessing causation of CTS, not just work activity. (Ex. 51-11, -18, -19). He acknowledged that claimant's activities of brush cutting during the period she was off work can increase pressure in the carpal tunnel. (Ex. 51-20). He believed that claimant's outdoor activities were "intermittent" and "more short duration" than her work activities. (Ex. 51-22). He said that the "brush clearing and that sort of thing" were done "more sporadic and over a shorter period of time." (*Id.*) The insurer's attorney asked about Dr. Grant's understanding of claimant's outdoor activities:

> "Q [Insurer's attorney] But I don't see anything in your report that talks about the sporadic or periodic nature of these outside activities; is that something you independently remember from your interview?
>
> "A [Dr. Grant] Well -
>
> "Q You use the words 'a lot' in terms of her work on five acres?
>
> "A Uh-huh.
>
> "Q That would seem to be incompatible with sporadic or intermittent?
>
> "A Okay. Let's say worst case scenario, then, let's say for eight hours a day for the full five months she was pulling weeds, clearing brush and chopping; and for the 17 years prior to that, eight hours per day, five days per week, she was typing, I still would put the major contributing cause to that 17 years and not the five months." (Exs. 51-22, -23).

Later in the deposition, Dr. Grant explained that claimant's keyboarding activities caused a significant increase in pressure and was more of an insult to the median nerve over the years "than any five months of activity she might have done." (Ex. 51-41, -42). Claimant's attorney asked the following questions:

> "Q [Claimant's attorney] Okay. Now, you have clearly weighed the activities?
>
> "A [Dr. Grant] Right.
>
> "Q The non-work, the five months there. But, of course, she's had avocational activities interspersed with her work activities over that six, 11, or 17 years?
>
> "A But not that she did for eight hours a day, or six hours a day or, you know, the other IME documented eight to 11 hours per day over 17 years. I mean, these are definitely apples and oranges, they're very different. And the keyboarding is significantly more traumatic by nature of the years that she did it and the hours per day that she did it.
>
> "I mean, yes, if you told me that she was out clearing brush for eight hours a day for 17 years, I would be jumping on that bandwagon." (Ex. 51-42).

Dr. Grant subsequently referred to the "five months of brush cutting" compared to the "multiple years of use in typing" while discussing the various causation factors. (Ex. 51-46).

After reviewing the record, we are not persuaded that Dr. Grant had an accurate understanding of claimant's gardening activity over the past 18 and one-half years. Dr. Grant's reports and deposition testimony indicate that he believed claimant engaged in brush cutting and gardening activities during the five months *after* she quit working for the employer. (Exs. 18, 51-22, -23, -46). Although Dr. Grant was asked about claimant's "avocational activities interspersed with her work activities" over several years (Ex. 51-42), there is no evidence that he was aware of claimant's off-work activities on her property over the past 18 and one-half years, in addition to the five months after December 1999. Instead, when read as a whole, Dr. Grant's reports and testimony indicate that he understood that claimant's gardening activities occurred intermittently over five months beginning in December 1999. (Exs. 18, 51-22, -23, -46). Furthermore, Dr. Grant's comment that the "worst case scenario" would be pulling weeds and clearing brush for eight hours a day for five months (Ex. 51-23), indicates that he understood those activities occurred only during a five month period, which is inconsistent with claimant's testimony.

Claimant testified that she has lived on a five acre property for 19 years and she raises flowers and vegetables. (Tr. II-14). She generally spends about two to four hours a day working in the garden from February or March to September or October, although not every day. (Tr. II-14, -28). Except for using a lawn mower on a small patch of grass, she uses hand tools, such as rakes, shovels and pitchforks. (Tr. 15). After December 1999, claimant moved piles of brush with a pitchfork, and she explained that it was the same kind of work she does every year, but she had an opportunity to perform it earlier since she was not working. (Tr. 26, 27).

We are not persuaded that Dr. Grant had an accurate and complete understanding of claimant's off-work gardening activity over several years and, therefore, his causation opinion is entitled to little weight.[1] *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, for the reasons discussed above, we are not persuaded by Dr. Grant's opinion because he did not adequately evaluate the relative contribution of claimant's off-work activities in assessing causation. Although work activities that precipitate a claimant's injury or disease may be the major contributing cause of the condition, that is not always the case. *Dietz v. Ramuda*, 130 Or App 397, 401, *rev dismissed* 321 Or 416 (1995). The medical expert must take into account all contributing factors in order to determine their relative weight. *SAIF v. Strubel*, 161 Or App 516, 521 (1999). We agree with the ALJ that Dr. Grant's opinion is not persuasive because he did not adequately consider all the contributing factors in evaluating causation of claimant's CTS condition.

ORDER

The ALJ's order dated May 7, 2001 is affirmed.

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[1] We note that Dr. Grant agreed that he had relied in part on information from the reports of Drs. Button, Neumann and Melson. (Ex. 51-33). However, those reports focused on claimant's gardening activities during the five-month period after December 1999. (Exs. 39, 49). Although Drs. Neumann and Merton commented that claimant's yard work "is not above what she normally did in the past" (Ex. 39-2), they provided no further explanation. We are not persuaded that their comment was sufficient to adequately apprise Dr. Grant of the nature and extent of claimant's gardening activities. Furthermore, Dr. Button reported that claimant "denies being physically active at home, in particular on her property, and states that since May her husband and children have been doing most of the basic housework." (Ex. 49-2). Finally, we note that Dr. Louie reported that claimant "denies any repetitive activity to her hands outside of work using her hands or repetitive trauma to her hands outside of work." (Ex. 34). Thus, we find that the information from other medical reports is insufficient to establish that Dr. Grant had an accurate and complete understanding of claimant's off-work activities.

In the Matter of the Compensation of
ROY N. HANSEN, Claimant
Own Motion No. 66-0200M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

Reviewing panel: Members Biehl and Meyers.

On August 10, 1992, December 15, 1993 and April 7, 1998, we authorized the reopening of claimant's claim for the provision of medical treatment for his compensable May 29, 1959 injury.[1] Claimant was awarded permanent total disability benefits as a result of his compensable injury. On May 9, 2001, the SAIF Corporation submitted claimant's request for medical services in the form of hospitalization and nursing home care, which claimant contends relates to his compensable May 29, 1959 injury. SAIF requested that the Board disallow the payment of those medical services as they are not causally related to his compensable condition.

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[1] As a result of his 1959 work incident, claimant suffered facial injuries, bilateral hip fractures, right shoulder, pelvic fracture, abdominal injuries, dislocation of the right foot and lumbar strain/sprain. Claimant's claim was accepted as a "multiple injury claim" which has also come to include chronic pain syndrome, chronic diarrhea, hypertension and malabsorption syndrome.

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 the Own Motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. *See* 656.278(1).

On May 30, 2001, the Board's staff requested the parties' positions regarding the compensability of the requested medical services. SAIF contends that claimant was hospitalized and required subsequent nursing home care because of pneumonia, which is not a compensable component of his 1959 injury claim. Consequently, SAIF recommends that the requested medical services be denied. Claimant has not responded to the Board's inquiry nor to SAIF's contentions.

With its recommendation, SAIF submitted various medical documents relating to claimant's hospitalization and nursing home care. In an October 21, 2000 chart note, Dr. Ercanbank, a consulting physician, noted that claimant was hospitalized on October 7, 2000 with pneumonia, chronic renal insufficiency and chronic pain syndrome. He detailed how claimant had a history of chronic renal insufficiency and had started having progressive weakness that developed into a productive cough and fevers. At the time of admission claimant had lung infiltrate with fever, cough and elevated white blood count. Dr. Ercanbank recommended a thoracoscopy to alleviate his lung infiltrate.

On November 7, 2000, claimant was discharged from the hospital and transferred to home health care. His discharge diagnosis was: (1) right side pleural effusion; (2) diabetes; (3) right lower lobe pneumonia; (4) Clostridium difficile; (5) renal insufficiency; and (6) empyema.

On December 10, 2000, claimant returned to the hospital for evaluation of "profound weakness." Dr. Heppe, the emergency room physician, noted that claimant had developed rhinorrhea, congestion and a minimal cough. He also noted that claimant had chronic loose stools related to bowel resection from "blunt trauma in the 1950s" with marked worsening recently. Dr. Heppe's assessment was: (1) multifactorial weakness and worsening diarrhea; (2) significant deconditioning; (3) volume contraction; (4) empyema and pneumonia; and (5) diabetes mellitus. Dr. Heppe recommended that claimant be placed in a nursing care facility.

Claimant was discharged from the nursing facility on February 2, 2001. His discharge summary indicated that claimant had: (1) anemia; (2) diarrhea; (3) esophageal reflux; (4) renal failure; (5) hypocalcemia; (6) painful respiration; (7) diabetes; and (7) disacchardiadase deficiency/malabsorption.

After review of the medical record, we find that claimant was first hospitalized for a number of reasons, one of them being pneumonia. After detailing claimant's lengthy history of chronic renal insufficiency, Dr. Ercanbank, one of claimant's treating physicians, reported that claimant sought emergency room treatment after he experienced "progressive weakness" that developed into a productive cough and fevers. When commenting on claimant's "profound weakness," Dr. Heppe, emergency room physician, noted that claimant had chronic loose stools related to a bowel resection from "blunt trauma in the 1950s" with recent marked worsening.

Based on these unrebutted medical reports, we are persuaded that claimant's recent request for medical services for hospitalization and nursing home care is, at a minimum, materially related to his 1959 compensable injury and its residuals. Consequently, the requested medical services are compensably related to the compensable injuries. Accordingly, claimant's claim is reopened to provide the above medical services. *See* OAR 438-012-0037.

This order shall supplement our April 15, 1998, December 15, 1993 and August 10, 1992 orders that previously reopened claimant's 1959 claim for the payment of compensable medical services received by any physician, payment of medications, office visits to and treatment by Dr. Toomey, tests and prescriptions. This authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSEPH MARTINEZ, Claimant
WCB Case No. 00-05126
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

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 a midback and thoracic strain condition. On review, the issue is compensability.

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

The ALJ concluded that claimant had not established an occupational disease by medical evidence supported by "objective findings." Claimant argues that Dr. Dolin's reports, including his diagnosis of recurrent muscle spasm, establish objective findings. For the following reasons, we disagree.

To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of his midback and thoracic strain condition. ORS 656.802(2)(a). The existence of an occupational disease must be established by medical evidence supported by objective findings. ORS 656.802(2)(d). "Objective findings" are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. ORS 656.005(19). "Objective findings" do not include "physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." *Id.*

Claimant relies in particular on Dr. Dolin's April 24, 2000 chart note that listed the diagnosis as "[r]ecurrent muscle spasm." (Ex. 9). At that time, Dr. Dolin reported that claimant "says he still has some stiffness at times[,]" but he was able to play sports and do his work "without difficulty." (*Id.*) His examination findings were: "[h]e's able to bend forward without difficulty. Twist to left and right, tilt to left and right. There is no pain on straight leg raising." (*Id.*) Although Dr. Dolin diagnosed muscle spasm, the April 24, 2000 chart note did not refer to any specific findings of muscle spasm. Moreover, none of Dr. Dolin's other chart notes referred to any findings of muscle spasm, but instead referred to normal mobility, no tenderness and no pain on straight leg raising. (Exs. 3, 7, 9, 10, 11).

At a deposition, Dr. Dolin was asked if claimant had any evidence of permanent disability on the July 10, 2000 exam. (Ex. 20-10). Dr. Dolin replied:

> "No. Well, no. He had been off work for a couple of weeks, and at that time he was doing okay, but he had been off work. And I didn't find anything in examining him, but I'm not sure if I ever really found too much in examining him. I basically had been relying on what he told me about his problems at work." (Ex. 20-10, -11).

When the employer's attorney asked if there were any objective findings during claimant's exams, Dr. Dolin replied:

> "I never really had much in the way of objective findings. In -in March, when I saw him, he complained of some discomfort on twisting and tilting, but, you know, that's -- I mean, that's a very soft objective finding. And, you know, basically he would complain of some discomfort; I mean, reflexes and everything else, you know. That was really, you know - strong objective findings, I never really had any specific objective findings." (Ex. 20-13).

Dr. Dolin was a "little perplexed" as to why claimant could do sports, yet could not do his work. (Ex. 20-15).

In *SAIF v. Lewis*, 170 Or App 201, 203 (2000), *rev allowed* 331 Or 692 (2001), the court held that the requirement of "objective findings" is not satisfied if a medical expert "merely listens to a patient's description of his or her symptoms and, believing the patient and without any verification process, relies

on that description to form a diagnosis." The court stated, with regard to the definition of "objective findings" in ORS 656.005(19), that "[t]he statutory emphasis is on findings made by a medical expert on the basis of a verification process involving trained observation, examination, or testing that produces results -- either physical or subjective responses -- that are witnessed, measured, or can be reproduced." *Id.* at 212.

ORS 656.005(19) provides that "objective findings" are verifiable indications of injury or disease that may include palpable muscle spasm. Even if we rely on Dr. Dolin's April 24, 2000 diagnosis of "[r]ecurrent muscle spasm" (Ex. 9), the chart notes do not refer to any specific findings of muscle spasm and, more importantly, we find no evidence that there was any verification process to support the conclusion that claimant had "objective findings" pursuant to ORS 656.005(19). To the contrary, Dr. Dolin's testimony indicated that there were no "objective findings" and he was relying on *claimant's* description of his symptoms. Furthermore, we are not persuaded that claimant's physical findings were reproducible, measurable or observable. *See Helen F. Iles*, 53 Van Natta 1072 (2001) (where the claimant's edema was not documented in prior or subsequent medical examinations, the isolated reference to edema did not constitute an "objective finding").

The only other medical opinion is from Dr. Grossenbacher, who found no objective findings. (Ex. 18). Under these circumstances, we agree with the ALJ that claimant had not established an occupational disease by medical evidence supported by "objective findings."

ORDER

The ALJ's order dated March 22, 2001 is affirmed.

August 30, 2001 Cite as 53 Van Natta 1121 (2001)

In the Matter of the Compensation of
CAROLYN J. DICKEY, Claimant
WCB Case No. 00-05052
ORDER ON REVIEW
Bernt A. Hansen, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Meyers. Member Meyers chose not to sign the order.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's right carpal tunnel syndrome. On review, the issue is responsibility.[1]

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated April 27, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

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[1] SAIF has moved to strike claimant's respondent's "reply" brief on the grounds that it is not permitted under OAR 438-011-0020(2). In effect, claimant is attempting to submit a "cross-reply." Because she did not file a cross-request for review, she is not authorized to file a reply to SAIF's reply brief. *See Rosalie Naer*, 47 Van Natta 2033 (1995). Accordingly, SAIF's motion to strike is granted.

In the Matter of the Compensation of
CARRIE ABRAMS, Claimant
WCB Case No. 99-09572
ORDER ON REVIEW
Holly J. Somers, Claimant Attorney
Reinisch, MacKenzie, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's occupational disease claim for cervical , shoulder, and back conditions; and (2) awarded a $9,000 assessed attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except the last sentence of paragraph 2, page 4.

Instead, we find that in a November 10, 1999, "check-the-box" concurrence letter, Dr. Solis disagreed with Dr. Schilperoort's report.[1] (Ex. 54). In his chart note of November 11, 1999, Dr. Solis referred to Dr. Schilpoort's report and indicated: "Discussed the work restrictions and paperwork from [the employer] in Portland where she had her review by another doctor. I agree with just about everything except I feel [claimant] is not capable of doing unlimited full duty work at this time."[2] (Ex. 55).

CONCLUSIONS OF LAW AND OPINION

Claimant began working as a machine operator in September 1998. (Tr. 35-36). The work required claimant to repetitively move napkin bundles from one conveyer to another. (Tr. 43-45). In November 1998, claimant began to notice pain in her right shoulder. (Ex. 1). Over the next few months, the pain progressed to her left shoulder, neck, and upper back. (Exs. 2 through 12; 12a).

In August 1999, claimant filed a claim for her pain complaints. (Ex. 19). In November 1999, the employer denied claimant's condition diagnosed as "cervical strain, upper thoracic strain, and bilateral trapezius shoulder strain." (Ex. 53). Claimant requested a hearing.

The ALJ relied on the opinion of Dr. Solis, the attending physician, and concluded that claimant had established the compensability of her cervical strain, upper thoracic strain, and bilateral trapezius shoulder strain conditions as an occupational disease. The ALJ also awarded a $9,000 assessed attorney fee under ORS 656.386.

Because claimant seeks to establish the compensability of her various sprain conditions as an occupational disease, she must prove that her work activities are the major contributing cause of the disease. ORS 656.802(2)(a). 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. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for her strain conditions, 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).

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[1] At the bottom of the concurrence letter, Dr. Solis wrote: "Pt is doing better but I feel she is not capable of returning to full unlimited duty work at this time." (Ex. 54).

[2] The employer argues that Dr. Solis' chart note indicates he agrees with the whole of Dr. Schilperoort's report except for the section dealing with work restrictions. Because Dr. Solis had previously indicated a blanket disagreement with Dr. Schilperoort, and because his chart note indicates that his discussion with claimant was regarding work restrictions and paperwork from the insurer (as opposed to Dr. Schilperoort's report), we reject the employer's argument.

The record contains three medical opinions regarding causation. One is from Dr. Solis, the attending physician. The other two are from employer-arranged examiners: (1) Dr. Schilperoort; and (2) Drs. Fuller and Dordevich. Only Dr. Solis' opinion supports compensability.

When there is a dispute between medical experts, more weight is given to those medical opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Solis opined that claimant's work activities, which required fast repetitive movement of the arms with the neck held in prolonged flexion, were the major contributing cause of the muscle strains in claimant's neck, mid back and low back. (Ex. 71-2). According to Dr. Solis, claimant's arm movement and prolonged flexion of the neck caused muscle fatigue and spasm.[3] (*Id.*) Dr. Solis' opinion regarding the nature of claimant's condition is based on his personal observations of claimant's muscle spasms, decreased ranges of motion, and palpable trigger point knots.[4] (*Id.*) His opinion regarding causation is based on his understanding that claimant: (1) worked 12 hour shifts, changing machines after 6 hours; (2) worked with her arms out in front of her most of the time; and (3) often worked looking down.[5] (Ex. 71-1).

While Dr. Schilperoort believed claimant had a chronic strain, he attributed the major cause of the strain to claimant's "body habitus (only 5 feet tall) and musculoskeletal deconditioning." (Ex. 45-6). Dr. Schilperoort based his opinion largely on his review of videotape purportedly showing an individual (not claimant) performing claimant's job duties. (Ex. 45-2). According to Dr. Schilperoort, the tasks shown on the videotape were insufficient to cause any pathology. (*Id.*)

Subsequent to his initial opinion, Dr. Schilperoort reviewed the chart notes of Dr. Mejo, a psychologist, with whom claimant counseled for anxiety attacks arising out of an abusive first marriage. After reviewing Dr. Mejo's notes, Dr. Schilperoort opined that claimant's "anxiety and/or depression" played a strong role in her pain. (Ex.73-3).

Drs. Fuller and Dordevich viewed the same videotape as did Dr. Schilperoort. (Ex. 70-3). Based on the videotape, their examination of claimant, and their review of Dr. Solis' records, Drs. Fuller and Dordevich opined that claimant's symptoms did not represent muscle strain, but rather physiological fatigue. (Ex. 70-8). After later reviewing Dr. Mejo's chart notes, Dr. Fuller opined that claimant's condition had a strong psychological component. (Ex. 74-3).

All three of the employer-arranged medical examiners (Drs. Schilperoort, Fuller and Dordevich) relied heavily on the videotape as an accurate depiction of claimant's work duties. However, claimant testified that the videotape was inaccurate in several respects: (1) showing the machines operating at a slower speed than what claimant experienced; (2) showing the machines operating with fewer operators; (3) failing to show misfeeds which required additional physical effort to clear; and (4) failing to show the different types of machines on which claimant worked. (Tr. 49-55). Claimant's testimony regarding the inaccuracies of the videotape was not challenged. Consequently, we conclude that the opinions of Drs. Schilperoort, Fuller and Dordevich are based upon inaccurate and incomplete information. As such,

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[3] The employer asserts that Dr. Solis offered no explanation for how claimant's work activities caused the strain conditions. Contrary to the employer's assertion, Dr. Solis related claimant's muscle spasms to fatigue caused by her repetitive arm movement and prolonged flexion of the neck. (Ex. 71-2). Consequently, we reject the employer's assertion.

[4] The employer contends that claimant did not present any objective findings verifying the existence of an occupational disease. Because range of motion and palpable muscle spasm are expressly defined as "objective findings" under ORS 656.005(19), and because no physician expressly contradicts Dr. Solis' findings of muscle spasms, decreased ranges of motion, and palpable trigger point knots, we reject the employer's assertions.

[5] The employer argues that Dr. Solis had an incorrect understanding of claimant's work. Because Dr. Solis' understanding of claimant's job duties (as expressed in Exhibit 71) was consistent with claimant's testimony regarding her job duties, we reject the employer's argument.

The employer also argues that Dr. Solis' opinion is not persuasive because he fails to explain why claimant's condition continued to worsen after claimant was given light duty clerical work. We note that claimant was not given light duty clerical work until February 15, 2000. (Tr. 75). Because Dr. Solis' chart notes reflect improvement in claimant's condition after she began the light duty work (consistent with claimant's testimony), we reject the employer's argument. (Tr. 75; Exs. 69A, 72A).

they are not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Finding no persuasive reason to do otherwise, we defer to the opinion of Dr. Solis.[6] Consequently, we conclude that claimant has established the compensability of her cervical, shoulder, and back conditions.

The employer contends that the ALJ's $9,000 attorney fee award was excessive because the issues were "not particularly complex." Claimant asserts that the medical issues were, in fact, complex, and that the ALJ's fee award was appropriate, considering the time devoted to the case, the value of the claim, and the number of legal issues involving the scope of the denial.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4), as applied to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute at the hearing was the compensability of claimant's cervical, shoulder, and back conditions. Hearings were conducted on two separate days, which together lasted about 7 hours and resulted in approximately 190 pages of transcript. The record consists of about 97 exhibits, including a videotape of claimant's work site, and two medical reports which claimant's counsel obtained in the face of a vigorous defense.

The case involved issues of above average factual and legal complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are about average. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous challenge.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $9,000 is a reasonable attorney fee for services at the hearings level. 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 value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding that issue is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and her counsel's uncontested request), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 10, 2001 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

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[6] We acknowledge the employer's argument that Dr. Solis did not weigh the potential contribution of claimant's alleged psychological condition. Assuming claimant has such a condition, there is no medical evidence indicating that a psychological condition would cause the muscle spasm and palpable trigger points reported by Dr. Solis. Consequently, we are not persuaded that Dr. Solis' failure to weigh the potential effect of an alleged psychological condition renders his opinion unpersuasive.

In the Matter of the Compensation of
HERMAN BEST, Claimant
WCB Case No. 00-06099
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Meyers, et al., Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral hearing loss. On review, the issues are compensability and (potentially) responsibility.

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

ORDER

The ALJ's order dated April 13, 2001 is affirmed.

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[1] Claimant cites the medical opinions of Drs. Krauth and Maples in support of his argument that his hearing loss condition is compensable. (Ex. 9). Although the ALJ did not address the medical evidence from these doctors, we do not find that their opinions satisfy claimant's burden of proof, either individually, collectively, or in conjunction with the other medical evidence. Specifically, we find both opinions conclusory and, hence, not persuasive. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

Board Member Phillips Polich dissenting.

The majority adopts and affirms the ALJ's order upholding the self-insured employer's denial of claimant's occupational disease claim for hearing loss. In so doing, it approves the ALJ's reasoning that the medical evidence from an examining physician, Dr. Hodgson, was more persuasive than that provided by Dr. Murphy, Dr. Maples, Dr. Krauth and audiologist Jewett, the attending physicians. According to the ALJ, Dr. Hodgson's opinion established that age-related changes (presbycusis) were the major contributing cause of claimant's hearing loss. Because I disagree with the ALJ's reasoning and would find the attending physicians' opinions the most persuasive on this record, I respectfully dissent.

Of the medical doctors supporting compensability, Dr. Murphy provided the most comprehensive evaluation of claimant's hearing loss. In his original report of November 7, 2000, Dr. Murphy took a thorough history, performed an audiogram and determined that claimant had a high frequency neurosensory hearing loss with an "upswing" at 8,000 cycles, This, according to Dr. Murphy, was suggestive of noise induced hearing loss. (Ex. 11). Dr. Murphy, however, acknowledged that other factors such as smoking, hypertension and age related changes in hearing were also contributory to claimant's overall hearing loss.

After further consideration of the causation issue, Dr. Murphy issued another report on January 10, 2001. In that report, Dr. Murphy ruled out presbycusis as a factor in claimant's hearing loss, noting that there was no low-frequency neurosensory hearing loss and that claimant's hearing loss configuration was consistent with noise-induced hearing loss. (Ex. 15). After ruling out significant contribution from off-the job activities, Dr. Murphy understandably concluded that claimant's hearing loss was the result of noise-induced factors at work. *Id.*

Having reviewed the medical evidence from Dr. Murphy, I find that his opinion is consistent, well-reasoned and based on a complete and accurate history. Thus, I can think of no reason to conclude that it is other than persuasive. *See Somers v. SAIF*, 77 Or App 259 (1986). I note that Dr. Murphy's opinion is supported by those of Dr. Krauth and Dr. Maples, both of whom also opined that claimant's hearing loss was occupationally related. (Ex. 9).

I would be remiss if I did not also discuss audiologist Jewett's opinion, which supports Dr. Murphy's. Like Dr. Murphy, Mr. Jewett noted, based on an audiogram analysis, that claimant's high frequency hearing loss would be due to work environment and that, if claimant had significant age-related loss, it would be reflected in the lower frequencies on the audiogram. However, no such loss was apparent in the lower frequencies. (Ex. 10A).

Based on the multiple opinions discussed above, I conclude that the evidence is overwhelming that work exposure is the major factor in claimant's hearing loss. The lone opposing opinion is from Dr. Hodgson. However, his opinion is contrary to the substantial expert opinion interpreting the audiographic evidence and was thoroughly rebutted by Dr. Murphy, who appropriately characterized Dr. Hodgson's opinion as being based on drawing lines, not science. (Ex. 17).

In conclusion, I believe the majority errs in affirming the ALJ's order and concluding that claimant's occupational disease claim is not compensable. For this reason, I dissent.

In the Matter of the Compensation of
STARLA GLASS, Claimant
WCB Case No. 01-00483
ORDER ON REVIEW
Schneider, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) declined to award interim compensation from November 13, 2000 through November 16, 2000, and from November 21, 2000 through January 25, 2001; and (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable failure to pay interim compensation. On review, the issues are interim compensation and penalties. We affirm.

FINDINGS OF FACT

On November 7, 2000, claimant was working as a CNA. (Tr. 5). At the end of her shift, she felt pain in her shoulder. (Tr. 6). She left work about one half hour early and sought medical treatment at the emergency room, where she was diagnosed with cervical and thoracic somatic dysfunction. (Tr. 6; Ex. 6). Claimant denied that she had suffered a new injury and did not identify work as the source of the problem. (Ex. 6). Claimant did not work the next two days, indicating she was sick from an old back injury. (Ex. 6A).

On November 13, 2000, claimant was seen by Dr. Swartzel. (Ex. 7). Dr. Swartzel noted tenderness in claimant's left paravertebral area and left trapezius, and diagnosed muscle spasms. (*Id.*) Dr. Swartzel authorized time loss from November 13 through November 20, but did not attribute a cause (work or otherwise) to the medical problem. (Ex. 7A).

On November 21, 2000, claimant filed an 801 form for her shoulder and back pain. (Ex. 8). The same day, Dr. Swartzel authorized time loss from November 21 through December 1. (Ex. 8A). Nonetheless, claimant returned to modified work on November 21 for the same hours per week and rate of pay as her regular work. (Tr. 21; 28).

SAIF paid claimant interim compensation for the period of November 17 to November 21. (Ex. 19).

On November 30, 2000, claimant came under the care of Dr. Adams. (Ex. 9). Dr. Adams diagnosed thoracic back and left trapezius strain; noted claimant's symptoms began at work; approved claimant's modified job duties; and released claimant to modified work (no repetitive lifting over 15 pounds) from November 30 through December 14. (Exs. 10; 11; 12). Claimant, however, was not comfortable with her modified job, and was subsequently terminated for failure to report to work. (Tr. 10; 22-24; 28).

On December 14, 2000, Dr. Adams extended claimant's modified work status through December 20, 2000. (Ex. 13). On December 21, 2000, Dr. Adams released claimant for regular duty work. (*Id.*)

SAIF denied the claim on January 26, 2001. (Ex. 15). Claimant requested a hearing contending, among things, entitlement to interim compensation from November 13, 2000 to November 16, 2000, and from November 24, 2000 through January 25, 2001.[1]

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant had not been totally disabled for a period of 14 consecutive days. Consequently, the ALJ concluded that, based on ORS 656.210(3), claimant was not entitled to interim compensation from November 13, 2000 to November 16, 2000.[2] The ALJ further determined that: (1) claimant returned to work on November 21, 2000 receiving her regular wages; and (2) claimant abandoned the physician-approved job for reasons unrelated to her back condition. Consequently, the ALJ concluded that claimant was not entitled to interim compensation after November 21, 2000.

Claimant contends that her disability began on November 7, 2000, the day she first began to miss time from work. Therefore, claimant reasons that she was totally disabled for 14 consecutive days, and thus entitled to interim compensation for November 13 through November 16, 2000. We disagree.

Interim compensation is paid upon receipt of notice of a claim until the claim is accepted or denied. *See Jones v. Emanuel Hospital*, 280 Or 147 (1977); *Gustavo B. Barajas*, 51 Van Natta 613, 614 (1999). To trigger a worker's entitlement to interim compensation, the attending physician's authorization must relate the worker's inability to work to a job-related injury or occupational disease. *Barajas*, 51 Van Natta at 614; *Robert W. Fagin*, 50 Van Natta 1680 (1998).

Here, although Dr. Swartzel restricted claimant from work, he did not relate the need for that restriction to a job-related injury or disease. Consequently, his time loss authorization of November 13, 2000 did not trigger claimant's entitlement to interim compensation. Absent a triggering authorization from the attending physician, a worker is not entitled to interim compensation. Consequently, we conclude that claimant is not entitled to interim compensation from November 13, 2000 to November 16, 2000.

Claimant asserts that as a result of her work-related back and shoulder pain, she was unable to perform the modified job that she began on November 21, 2000. Consequently, claimant reasons that she is entitled to interim compensation from November 24, 2000 (termination date) to January 25, 2001 (date of denial). We disagree.

A worker who has been fired from work, but otherwise is in the work force, is entitled to interim compensation if the worker has either been absent from work or sustained diminished earning power for such period as is attributable to a work-related disability. *See Lino Villa-Acosta*, 51 Van Natta 211, 214 (1999); *Lisa R. Angstadt*, 47 Van Natta 981, 982 (1995).

Here, the record does not support a conclusion that, after November 24, 2000, claimant was absent from work or suffered diminished earning power due to a work injury. To the contrary, the record supports a conclusion that claimant was released to modified work by Dr. Adams, and that subsequently claimant was absent from work because she was "uncomfortable" with the job. Specifically, claimant's discomfort was not from a physical inability to perform the work, but rather because she did not know what purpose the modified job served and because she was alone in that portion of the employer's premises. (Ex. 10; Tr. 22-23; 27). Additionally, claimant was released to regular duty work on December 21, 2000, and not medically restricted from working thereafter.

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[1] Claimant also challenged SAIF's compensability denial. The ALJ upheld the denial. Claimant does not challenge that portion of the ALJ's order.

[2] ORS 656.210(3) provides:

"No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period."

Consequently, on this record, we conclude that claimant was not entitled to interim compensation from November 24, 2000 to January 25, 2001.[3]

ORDER

The ALJ's order dated May 7, 2001 is affirmed.

[3] Because we conclude that claimant is not entitled to interim compensation, we necessarily conclude that SAIF did not unreasonably resist the payment of compensation by a failure to pay such benefits. Accordingly, a penalty is not warranted.

In the Matter of the Compensation of
EILEEN T. MORAN, Claimant
WCB Case No. TP-01005
THIRD PARTY DISTRIBUTION ORDER
Malagon, Moore, et al., Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The City of Eugene (Eugene), as paying agency, has petitioned the Board for resolution of a dispute concerning its entitlement to recover its entire "third party" lien, as a "just and proper" distribution from a third party judgment. *See* ORS 656.593(1). In response, claimant contends that pursuant to ORS 656.593(1), Eugene's share of the third party judgment is $6,551.51. We agree with claimant's contention.

FINDINGS OF FACT

Claimant was compensably injured in a motor vehicle accident that involved another vehicle driven by a third party. Eugene, a self-insured employer, accepted the claim and paid benefits.

Claimant retained counsel to pursue a third party claim. When the third party offered the sum of $15,000 to settle the third party claim, claimant's counsel sought Eugene's approval of the settlement offer. Because its share of the offer would not satisfy its $12,949.79 lien, Eugene disapproved the settlement.

Thereafter, claimant filed suit against the third party seeking total damages of $24,999.[1] The case proceeded to arbitration where the arbiter awarded claimant $8,240.91 in economic damages and $6,500 in non-economic damages (total award of $14,740.91). Neither claimant nor the third party contested the arbiter's award. Thus, the arbiter's award has become a final judgment.

Claimant's counsel, relying on ORS 656.593(1), tendered the sum of $6,551.51 to Eugene as its share of the third party judgment. Eugene objected to the distribution of the judgment proceeds, and petitioned the Board for resolution of the dispute.[2]

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.

[1] The damage amount claimed was, in part, due to the court's requirement to place claims under $25,000 into mandatory arbitration.

[2] Eugene does not assert that in applying ORS 656.593(1), claimant's counsel erred in calculating Eugene's share of the judgment. Rather, Eugene contends that such an amount is not "just and proper."

Here, claimant was compensably injured as a result of the negligence or wrong of a third party. The claim was accepted by Eugene, which has provided compensation. Because Eugene has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576.

Because claimant elected to seek recovery from a third party for damages resulting from her compensable injury, her cause of action became subject to Eugene's lien as a paying agency. ORS 656.580(2); 656.593(1). This lien attaches to non-economic damages, as well as to economic damages. *Webster N. White*, 45 Van Natta 2068, 2069 (1993); *Kenneth Owens*, 40 Van Natta 1049, 1050-51 (1988).

The statutory scheme for the allocation of damages is precise. *Robert B. Williams*, 38 Van Natta 119, 123 (1986), *aff'd Estate of Troy Vance v. Williams*, 84 Or App 616 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). 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 ORS 656.001 to 656.794. *See* ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Eugene contends that a statutory distribution under ORS 656.593(1) is insufficient compensation in light of the more than $15,000 it will ultimately pay on claimant's behalf. Eugene further contends that claimant's counsel's decision to seek damages in an amount under $25,000, precluded it from ever recovering the entire lien.[3] Consequently, Eugene seeks a "just and proper" resolution of this third party dispute. Eugene reasons that under these circumstances, "a just and proper" resolution awards the entire judgment of $14,740.91 to it; *i.e.*, that claimant and claimant's counsel receive nothing.[4]

Eugene cites neither statutory nor case authority for its position. To the contrary, case precedent regarding the statutory scheme does not support Eugene's contention. In *White*, we reasoned that the "just and proper" language of ORS 656.593(3) did not apply to third party judgments, and rejected a claimant's request to reduce a carrier's statutory lien distribution based on the carrier's alleged conduct during the pre-trial and trial phases of the claimant's cause of action against the third party.[5] *White*, 45 Van Natta at 2070. Inasmuch as the dispute here concerns Eugene's share of a third party judgment, we find *White* controlling, and conclude that the "just and proper" language of ORS 656.593(3) does not apply. Instead, Eugene is entitled to be paid and retain the balance of the third party judgment as provided in ORS 656.593(1)(c); *i.e.*, $6,551.51.

Accordingly, Eugene's request for a share of the third party judgment in excess of its statutory share under ORS 656.593(1) is denied. Claimant is directed to forward to Eugene an amount consistent with ORS 656.593(1) ($6,551.51).

IT IS SO ORDERED.

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[3] Eugene apparently calculated that a verdict amount of $39,000 would be required to fully repay its lien using the distribution method set out in ORS 656.593(1).

[4] In the alternative, Eugene suggests it be allowed to "offset" the unsatisfied balance of its third party lien against future compensation. Eugene cites no case law or statutory authority supporting that proposition. Because ORS 656.593(1), which specifically controls judgment distributions, does not mention offsets against future compensation, and because ORS 656.596 only allows such an offset when no workers' compensation claim has been filed or accepted at the time the worker or the worker's beneficiaries recover damages from the third party, we reject Eugene's suggestion.

[5] 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." (Emphasis added).

In the Matter of the Compensation of
ANDROTTI D. HARRISON, Claimant
WCB Case No. 01-00024
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorney
Hoffman, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) affirmed an Order on Reconsideration award of 31 percent (99.2 degrees) unscheduled permanent disability for cervical and left shoulder conditions; and (2) awarded a $1,500 assessed attorney fee pursuant to ORS 656.382(2). On review, the issues are extent of unscheduled permanent disability and attorney fees.

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

Claimant compensably injured his neck and left shoulder in November 1999.[1] (Ex. 24). In August 2000, the insurer issued its Notice of Closure, which did not award permanent disability. (Ex. 30). Claimant requested reconsideration.

On October 31, 2000, Dr. Berselli performed a medical arbiter evaluation. (Ex. 41). Relying on that evaluation, the Appellate Review Unit issued an Order on Reconsideration that awarded 31 percent unscheduled permanent disability. The insurer requested a hearing.

The ALJ determined that Dr. Berselli's range of motion measurements were valid and that those measurements should be used to rate claimant's impairment. Consequently, the ALJ affirmed the Order on Reconsideration.

The insurer contends that the preponderance of medical evidence establishes a different level of impairment (zero) than that found by the medical arbiter. Specifically, the insurer asserts that the cervical and shoulder range of motion testing by Dr. Duff (insurer-arranged examiner) establish that Dr. Berselli's range of motion testing is invalid. Consequently, the insurer argues that Dr. Berselli's findings should not be used to rate claimant's impairment. For the reasons stated below, we disagree.

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). 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). Where a preponderance of the evidence establishes a different level of impairment, the impairment is established by the preponderance of evidence.[2] (*Id.*)

The issue regarding impairment is whether claimant has established valid loss of cervical and left shoulder range of motion. We have previously held that the validity of range of motion testing must be determined by the medical examiner performing the tests and that any invalid measurements will be identified by that examiner. *See Dana M. Peterson*, 50 Van Natta 1554, 1555 (1998); *Michael W. Webber*, 48 Van Natta 2269, 2270 (1996); *Harvey Clark*, 47 Van Natta 136 (1995).

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[1] The accepted conditions were: (1) cervical strain and contusion; and (2) shoulder strain. (Ex. 24-2).

[2] The preponderance of medical evidence must come from findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). Here, Dr. Thomas, the attending physician, initially concurred with Dr. Duff's opinion that: (1) claimant's cervical range of motion was too variable to be used for rating purposes; (2) claimant's shoulder range of motion was equal bilaterally; and (3) claimant did not have permanent impairment. (Exs. 25 and 28). Shortly thereafter, Dr. Thomas expressly stated that claimant did have objective findings of decreased range of left shoulder motion. (Ex. 33).

Here, Dr. Berselli completed a WCD "check-the-box" form that indicated that claimant's cervical range of motion testing was "within +/- 10% or 5 degrees (whichever is greater)," which is the applicable validity criterion in accordance with the AMA Guides.[3] (Ex. 41-3). Dr. Berselli did not expressly comment on the validity of claimant's left shoulder range of motion testing. He did however, for comparative purposes, perform range of motion testing on claimant's right shoulder and then opined that claimant was limited in his ability to lift/carry and reach overhead due to the left upper extremity. (Ex. 41-2). We note, that with regard to claimant's left shoulder, Dr. Berselli was not asked to explain "valid" findings. Rather, he was asked to explain "invalid" findings. (Ex. 40-5). Consequently, in the absence of an explanation from Dr. Berselli expressing that claimant's left shoulder range of motion is "invalid", we conclude that Dr. Berselli's left shoulder range of motion testing is sufficient to rate claimant's impairment.

Having concluded that Dr. Berselli's range of motion testing measurements can be used to rate claimant's impairment, we further conclude that his measurements should be used to rate claimant's impairment.[4] OAR 436-035-0007(14) (WCD Admin Order No. 98-055). Consequently, we agree with the ALJ's decision to affirm the Order on Reconsideration.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the permanent disability issue 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 and his counsel's uncontested request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 21, 2001 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the insurer.

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[3] OAR 436-035-0007(28) requires that validity shall be established 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 by that reference.

[4] Under *Koitzsch*, only one other evaluation in this record can be used to rate claimant's impairment; *i.e.*, the report of Dr. Duff. Here, Dr. Duff's evaluation was performed approximately 4 months prior to the Order on Reconsideration. In contrast, Dr. Berselli's evaluation was performed 5 weeks prior to the Order on Reconsideration. The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. *See, e.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). However, we have held that a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination. *E.g., James A. Hanson*, 50 Van Natta 23, 24 (1998); *Ronald L. Tipton*, 48 Van Natta 2521, 2522 n. 5 (1996); *David Gonzalez*, 48 Van Natta 376 (1996). Because of Dr. Thomas' subsequent finding of objective shoulder impairment, and because of the significant gap between Dr. Duff's evaluation and Dr. Berselli's evaluation, we find Dr. Berselli's evaluation more persuasive.

In the Matter of the Compensation of
LORENZO LEAKS, Claimant
WCB Case No. 01-01012
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the self-insured employer's denial of claimant's left ankle injury claim. On review, the issue is compensability.

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

On review, claimant argues that the ALJ should not have applied ORS 656.005(7)(a)(B) in deciding that his conditions of anterior impingement syndrome and associated spurring were not in major part caused by a September 17, 1997 compensable injury. According to claimant, because such conditions did not preexist his compensable injury, he is required to prove only that the compensable injury was a material contributing cause of his need for treatment or disability for the disputed conditions. Furthermore, claimant asserts that the opinion of his treating physician, Dr. Pollard, was sufficient to carry his burden of proof.

For the reasons stated in the order, we agree with the ALJ that examining orthopedic surgeon, Dr. Gripekoven, provided the more persuasive opinion. Dr. Gripekoven explained that anterior impingement syndrome results from repetitive dorsiflexion of the ankle under "loading circumstances," such as walking, running, kneeling and squatting. (Ex. 42-5). According to Dr. Gripekoven, the condition is not caused by a single traumatic event but occurs over an extended period of time, usually with athletic participation. (*Id.*)

Based on claimant's active participation in athletics before his injury, Dr. Gripekoven thought that the anterior impingement condition preexisted, and combined with, the compensable injury. (*Id.*) Although the compensable injury may have rendered the left ankle symptomatic, Dr. Gripekoven indicated that the "acute aspects of the contusion would have resolved, and ongoing symptoms of anterior impingement would have persisted due to the preexisting spurring." (*Id.*)

Having found Dr. Gripekoven's opinion more persuasive, and because his opinion is that the anterior impingement syndrome preexisted and combined with the compensable injury, we find that the ALJ appropriately applied ORS 656.005(7)(a)(B). In any case, because the only physician supporting compensability was Dr. Pollard, and we have not found his opinion to be persuasive, claimant did not carry his burden of proof whether or not we apply ORS 656.005(7)(a).

ORDER

The ALJ's order dated June 1, 2001 is affirmed.

In the Matter of the Compensation of
CARLOS MELENDEZ, Claimant
WCB Case Nos. 00-01205, 99-06183 & 99-07492
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Sheridan, et al., Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Meyers. Member Meyers dissents.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its partial denial of claimant's degenerative disc disease and mechanical low back pain; and (2) set aside its denial of claimant's current low back condition. On review, the issues are the procedural validity of the denials and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the finding that claimant sustained a compensable injury on June 16, 1999 while doing a brake job on a truck. Instead, we find that the injury occurred on February 16, 1999.[1] (Ex. 1).

CONCLUSIONS OF LAW AND OPINION

Following its receipt of a June 3, 1999 chart note from Dr. Carpenter (attending physician) indicating that claimant was being treated for "mechanical back pain with pre-existing degenerative disk disease at L3-4," the insurer issued a partial denial of the L3-4 degenerative disc disease. (Exs. 6; 8). Claimant requested a hearing.

On August 20, 1999, claimant requested that the Notice of Acceptance be amended to include "lumbar strain." (Ex. 12A).

At hearing, the insurer amended its denial to include claimant's current low back condition as of June 3, 1999; *i.e.*, "mechanical low back pain" in addition to "pre-existing degenerative disk disease at L3-4."[2] (Tr. 1-2). Additionally, the insurer agreed to amend its claim acceptance to include "lumbar strain." (*Id.*)

The ALJ determined that claimant had not made a claim for degenerative disc disease at L3-4. Consequently, the ALJ concluded that the insurer's partial denial of that condition was procedurally improper. With regard to the "current condition" portion of the amended denial, the ALJ determined that it was an improper "pre-closure" denial. Consequently, the ALJ set aside the amended denial in its entirety.

With regard to the L3-4 degenerative disc disease, the insurer cites ORS 656.262(6)(d) and (7)(a) and acknowledges that a carrier is not required to process a claim for a condition until a written request for such a condition has been made. However, the insurer contends that Dr. Carpenter's chart notes and billings for treatment of the degenerative disc disease constituted such a claim. Consequently, the insurer asserts its partial denial of that condition was procedurally proper. We disagree.

ORS 656.262(7)(a) requires a worker to "clearly request formal written acceptance" of any new medical condition after claim acceptance. Additionally, ORS 656.262(7)(a) provides that such claims "*are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition.*"[3] (Emphasis added).

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[1] The claim was accepted on June 14, 1999 as a nondisabling "thoracic strain." (Ex. 7).

[2] Claimant was initially declared medically stationary with no permanent impairment by Dr. Carpenter on March 18, 1999. (Ex. 3). Claimant sought no treatment until he returned to Dr. Carpenter on June 3, 1999. (Ex. 4).

[3] Here, there has been only one such request; *i.e.*, claimant's letter of August 20, 1999 (Exhibit 12A) requesting acceptance of "lumbar strain."

Thus, under the express provisions of the statute, Dr. Carpenter's billings do not constitute a "clear request" for "formal written acceptance" of degenerative disc disease at L3-4.[4] *See Melba Walker*, 49 Van Natta 1232 (1997). Consequently, the insurer's partial denial of L3-4 degenerative disc disease is a nullity and of no legal effect. *See Altamirano v. Woodburn Nursery, Inc.*, 133 Or App 16, 20 (1995) (in the absence of claim, a denial has no legal effect); *Walker*, 49 Van Natta at 1233.

The insurer notes that the claim is still in "non-disabling" status and thus claim closure is not required. Hence, the insurer reasons that the "current condition" portion of its amended denial cannot be invalid as an improper "pre-closure" denial.

We need not address this argument because this particular record establishes that the "current condition" denied by the insurer is a condition for which claimant has not made a "claim." We base this conclusion on the following rationale. According to Dr. Carpenter's chart notes, claimant's "current" condition, as of June 3, 1999, was "mechanical back pain with pre-existing degenerative disk disease at L3-4." (Ex. 4). For the same reasons as explained with regard to degenerative disc disease, we conclude thatclaimant has not presented a claim for "mechanical back pain." Consequently, based on this particular record, the insurer's "current" condition denial is invalid for the same reasons that its partial denial (of degenerative disc disease) is invalid.

Accordingly, we affirm the ALJ's order that the insurer's denial, as amended at hearing, was procedurally improper.

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, 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated March 1, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the insurer.

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[4] The insurer also argues that claimant's request for hearing constitutes a claim. We disagree. A hearing request contesting a denial that is null and void does not constitute a written request for compensation under ORS 656.005(6). *See Patricia A. Waldo*, 53 Van Natta 536 (2001).

Board Member Meyers dissenting.

I disagree with the majority's conclusion that claimant had not made a claim for "mechanical back pain with pre-existing degenerative disk disease at L3-4." Therefore, I respectfully dissent.

I agree that under the terms of ORS 656.262(6)(d) and (7)(a), a carrier is not required to process a claim for a condition until a written request for such a condition has been made. I also agree that, under the express language of ORS 656.262(7)(a), the carrier's receipt of a medical bill does not constitute a claim for a new medical condition. Here, however, the insurer received more than just Dr. Carpenter's bill. The insurer also received Dr. Carpenter's chart note of June 3, 1999 indicating that: (1) claimant had returned for a "recheck of his lower back"; and (2) Dr. Carpenter had restricted claimant from work.[1] (Ex. 4).

Based on Dr. Carpenter's assessment of claimant's condition and his use of the word "recheck," it is reasonable to conclude (from the June 3, 1999 chart note) that claimant's work related back condition had worsened such that claimant was unable to work. Thus, it is reasonable to interpret Dr. Carpenter's chart note as an authorization of temporary disability. Because Dr. Carpenter's chart note of June 3, 1999 authorized temporary disability for "mechanical back pain with pre-existing degenerative disk disease at L3-4," I conclude that claimant made a claim for those conditions. In other words, in the circumstances presented here, I find that Dr. Carpenter's chart note (which I interpret as having authorized time loss), together with his billing statement, constituted a written request to process a claim for a new condition; *i.e.*, "mechanical back pain with pre-existing degenerative disk disease at L3-4."

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[1] Claimant had last been seen by Dr. Carpenter on March 18, 1999. At that time, Dr. Carpenter declared claimant medically stationary without permanent impairment and released him to regular duty work. (Ex. 3).

Accordingly, I conclude that the insurer's denials (based on the June 3, 1999 chart note) were procedurally valid. Because the medical record does not support an "on the merits" conclusion setting aside the insurer's denials, I would reverse the ALJ's order.

New and omitted medical condition claims present processing complications for both carriers and claimants. If a carrier issues a denial based on information (like Dr. Carpenter's chart note), that in 20-20 hindsight, is ultimately judged not a "written claim," the carrier will have needlessly expended time and money processing a denial that is null and void.[2] On the other hand, if the carrier fails to issue a written denial when presented with a document like Dr. Carpenter's chart note, the carrier's inaction will likely trigger litigation under a *de facto* denial theory.

Additionally, the practice of many health insurers is to refuse to process medical billings in the absence of a workers' compensation carrier's written denial. Consequently, there is strong encouragement for a carrier to issue a denial in cases such as this. To do otherwise can jeopardize: (1) a claimant's receipt of medical services that are legitimately covered by the health insurer; and (2) the medical service providers' prompt receipt of payment.

Rather than automatically issuing a denial or filing a request for hearing, I urge both carriers and claimants to communicate with each other (and the medical providers, if necessary) in order to determine exactly when a claim is being made for a new or omitted medical condition. In that way the time and money associated with litigating denials like the one presented here will be minimized.

[2] In response to such a denial, claimants will likely choose to litigate the procedural validity of the denial (as was done here) to avoid future legal complications regarding the possible preclusive effect of a denial that is not timely challenged.

In the Matter of the Compensation of
TAMITHA A. BARENDRECHT, Claimant
WCB Case No. 00-03972
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Sheridan, Bronstein, et al., Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that awarded claimant additional temporary disability. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured her low back on July 27, 1994. (Ex. 1). In August 1994, claimant underwent a low-back surgery. (*See* Ex. 2-1). She then moved to Colorado. Claimant began treating with Dr. Willingham in Colorado on March 29, 1995. (Ex. 3). On May 8, 1995, Dr. Willingham responded to a form filed with the Colorado Department of Social Services. (Ex. 4). Dr. Willingham checked the box that stated "I find [claimant] disabled for a period of 6-8 months." (Ex. 4-2). Dr. Willingham then included the statement "from present date." (*Id.*) Dr. Willingham further clarified that claimant would be disabled for more than 12 months, counting the time since surgery. (*Id.*)

On October 17, 1995, Dr. Krauth, a neurosurgeon, examined claimant. (Ex. 5-1). Dr. Krauth noted that claimant was over a year out from surgery and that "she is pretty much incapacitated by severe, constant pain in her right buttock that radiates down into the right foot." (*Id.*) Dr. Krauth recommended epidural steroid injections. (Ex. 6-4). On January 8, 1996, Dr. Law, also a neurosurgeon, examined claimant. (Ex. 7). Dr. Law agreed with Dr. Krauth's recommendation for epidural steroids, and recommended counseling for claimant. (Ex. 7-2).

On June 20, 1996, the employer issued a Notice of Closure, finding claimant medically stationary on February 8, 1995, and awarding temporary disability from July 28, 1994 through February 18, 1995. (Ex. 8). A July 25, 1996 Order on Reconsideration rescinded that Notice of Closure. (Ex. 9).

On September 16, 1996, Dr. Law responded to a questionnaire by the carrier by stating that he was still treating claimant, that she had not been released to work, and that she was not medically stationary. (Ex. 10). On April 16, 1997, a prior ALJ issued an Opinion and Order finding claimant not entitled to additional "procedural" temporary disability from February 24, 1995 through December 24, 1995. (Ex. 11).

On February 1, 2000, the employer issued a Notice of Closure awarding claimant temporary total disability from July 28, 1994 through January 16, 1995, temporary partial disability from January 17, 1995 through May 7, 1995, and temporary total disability from May 8, 1995 through July 21, 1998. (Ex. 14). On February 15, 2000, the employer issued a "Corrected" Notice of Closure awarding claimant temporary total disability from July 28, 1994 through January 16, 1995, temporary partial disability from January 17, 1995 through February 8, 1995, and temporary total disability from December 25, 1995 through July 21, 1998. (Ex. 15).

Claimant requested reconsideration. On May 18, 2000, an Order on Reconsideration affirmed the February 1, 2000 Notice of Closure, as corrected on February 15, 2000, in all respects. (Ex. 17-2). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found first that claimant was not barred by principles of claim preclusion or issue preclusion by the prior ALJ's order declining to award additional "procedural" temporary disability. The ALJ then awarded claimant additional temporary disability from March 15, 1995 through December 24, 1995 based on medical evidence from Dr. Willingham.

On review, among other arguments, the employer contends that the record does not contain contemporaneous authorization for temporary disability by claimant's attending physician over that period of time. We agree.

Only the attending physician may authorize temporary disability. ORS 656.245(2)(b)(B); ORS 656.262(4)(a), (h). Temporary disability is not due and payable "for any period of time not authorized by the attending physician." ORS 656.262(4)(g). Claimant's attending physician during the relevant time period, according to the Order on Reconsideration, was Dr. Law. (Ex. 17-2).[1] However, there is no time loss authorization from Dr. Law for the contested period in the record.

The Order on Reconsideration refers to a July 5, 1996 chart note by Dr. Law, but that report is not in the record. (Ex. 17-2). In addition, on September 16, 1996, Dr. Law stated that claimant "has not been released to work." (Ex. 10). However, even assuming that Dr. Law authorized temporary disability benefits as of either July 5, 1996 or September 16, 1996, claimant seeks additional temporary disability only through December 24, 1995. No authorization for temporary disability is effective to retroactively authorize compensation more than 14 days from its issuance. ORS 656.262(4)(g). This "14-day" limitation is applicable to temporary disability entitlement questions, even at claim closure. *See Menasha Corp. v. Crawford*, 332 Or 404 (2001) ("[n]either ORS 656.262(4)(g) nor any other statute that provides context for ORS 656.262(4)(g) makes a distinction between a pending claim and a claim at the time of closing respecting retroactive compensation") 332 Or at 414; *Fred Meyer v. Bundy*, 159 Or App 44 (1999), *rev den* 329 Or 503 (1999).

Moreover, even if we were to assume that Dr. Willingham was claimant's treating physician, her reports do not contain an "authorization" for temporary disability consistent with the statute. Dr. Willingham first examined claimant on March 29, 1995. (Ex. 3). Dr. Willingham's report of that visit contains no statement authorizing time loss as required by ORS 656.262(4)(a) and (h).

Dr. Willingham's May 8, 1995 statement on a Colorado Department of Social Services form indicated that claimant will be "disabled" for six to eight months from that date. (Ex. 4-2). However, we cannot infer from that statement that Dr. Willingham authorized additional temporary disability. *See Vitaliy A. Dikov*, 53 Van Natta 1031 (2001); *Kerry Nguyen*, 52 Van Natta 688 (2000) (Board declined to

[1] For purposes of this review, we have assumed for the sake of argument that Dr. Law could be an "attending physician."

"infer" entitlement to temporary disability benefits from the medical record in the absence of authorization by attending physician). Because the documents authored and/or signed by Dr. Willingham do not authorize temporary disability, we are unable to conclude that the statutory prerequisite for an award of temporary disability has been satisfied.

Similarly, even if we were to find that Dr. Krauth was claimant's attending physician for the relevant time period, we cannot infer an authorization for time loss from his statement that claimant is "pretty much incapacitated by severe, constant pain in her right buttock that radiates down into the right foot." (Ex. 5).

Finally, the ALJ cited to OAR 436-060-0020(6) as authority for "inferring" from medical records a worker's inability to work.[2] However, that rule, by its terms, refers only to "the insurer or the Department." The rule does not therefore provide authority for an ALJ or the Board to infer disability from medical reports. *Kerry Nguyen*, 52 Van Natta at 689.[3] In any event, there are no "surgery reports" or "hospitalization records" in the record that might "reasonably reflect an inability to work," pursuant to the language of the rule. OAR 436-060-0020(6).

In sum, the record does not support a conclusion that claimant is entitled to additional temporary disability. Accordingly, we reverse the ALJ's order.[4]

ORDER

The ALJ's order dated December 4, 2000, as reconsidered on February 7, 2001, is reversed. The Workers' Compensation Division's May 18, 2000 Order on Reconsideration is affirmed. The ALJ's "out-of-compensation" attorney fee award is reversed.

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[2] OAR 436-060-0020(6) provides, in pertinent part:

"The insurer, or the Department at time of claim closure or reconsideration, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician pursuant to ORS 656.262(4)(f) [now ORS 656.262(4)(g)]."

[3] In *Kerry Nguyen*, we also suggested that OAR 436-060-0020(6) might be inconsistent with ORS 656.262(4)(g). 52 Van Natta at 689 n 2. However, we noted that we need not address the issue.

[4] In light of our disposition of the issue on this basis, we need not address the employer's claim preclusion and issue preclusion arguments.

In the Matter of the Compensation of
LINNARD E. BYBEE, Claimant
WCB Case No. 00-07188
ORDER ON REVIEW
Dierking & Schuster, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich chose not to sign the order.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) declined to admit claimant's testimony pursuant to ORS 656.283(7); and (2) declined to abate an Order of Reconsideration and remand the claim to the Director. On review, the issues are evidence and remand.

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

On review, we write only to respond to claimant's argument on review that the regulations "require" the Director to rescind a Notice of Closure that was not closed in accordance with ORS 656.268(1)(b), (c) and OAR 436-030-0020. Claimant cites OAR 436-030-0135(4) to support his argument.

OAR 436-030-0135(4) (WCD Admin Order No. 00-058)[1] provides:

> "The director will issue an order rescinding the Notice of Closure when the director finds, upon reconsideration: "(a) The claim was closed prematurely because the worker's accepted condition was not medically stationary and the claim did not qualify for closure pursuant to ORS 656.268(1)(a); or
>
> "(b) The claim was not closed in accordance with the requirements of ORS 656.268(1)(b) and (c) and OAR 436-030-0020."

OAR 436-030-0135(4)(a) applies when the *Director* finds, on reconsideration, that the claim was closed prematurely because the worker's accepted condition was not medically stationary. Here, the Order on Reconsideration found that claim closure on June 30, 2000 was not premature. (Ex. 17). Consequently, OAR 436-030-0135(4)(a) does not apply.

Similarly, OAR 436-030-0135(4)(b) provides that the Director will issue an order rescinding the Notice of Closure when the *Director* finds, upon reconsideration, that the claim was not closed in accordance with the requirements of ORS 656.268(1)(b) and (c) and OAR 436-030-0020. The Director made no such findings in this case. In claimant's October 2, 2000 request for reconsideration, he argued that the Notice of Closure was postmarked to him on August 14, 2000, when he was on vacation. (Ex. 15-2). The insurer contended that claimant's request for reconsideration was untimely. (Ex. 16). The Appellate Review Unit (ARU) rejected the insurer's argument, finding that the evidence indicated that the June 30, 2000 Notice of Closure was mailed to claimant on August 14, 2000. (Ex. 17-1). The ARU determined that claimant's request for reconsideration was timely because it was mailed on October 2, 2000. (Ex. 17-2). The October 27, 2000 Order on Reconsideration modified the temporary disability award, but otherwise affirmed the June 30, 2000 Notice of Closure. (Ex. 17). There were no findings that the claim was not closed in accordance with the requirements of ORS 656.268(1)(b), (c) or OAR 436-030-0020.

We conclude that, because there is no evidence that the Director found that the claim was closed prematurely or that the claim was not closed in accordance with the requirements of ORS 656.268(1)(b) and (c) and OAR 436-030-0020, neither OAR 436-030-0135(4)(a) or (b) apply to this case. Consequently, we are not persuaded by claimant's argument that the Director was required to issue an order rescinding the Notice of Closure.

ORDER

The ALJ's order dated April 17, 2001 is affirmed.

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[1] OAR 436-030-0003(3) (WCD Admin Order No. 00-058) (eff 1-1-01) provides that these rules take the place of previously adopted rules and that the provisions of several sections, including OAR 436-030-0020 and OAR 436-030-0135, apply to all determinations or claims for workers who became medically stationary after July 1, 1990. Because claimant was found to be medically stationary on August 16, 1999 (Exs. 13, 17), we apply the rules in WCD Administrative Order 00-058.

In the Matter of the Compensation of
JEFFREY L. NELSON, Claimant
WCB Case No: C012001
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Coughlin, Leuenberger & Moon, Claimant Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

On August 21, 2001, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The proposed agreement provides that claimant was working for a noncomplying employer (NCE) at the time of his injury or occupational disease exposure. The claim was referred to Johnston and Culberson, Inc. (JCI), the statutory claims processor, for processing. Signators to the agreement include the Department of Consumer and Business Services (DCBS) and JCI, as well as claimant and claimant's attorney.

The proposed agreement provides, in part:

> "Employer understands and agrees to reimburse the Department of Consumer and Business Services for these settlement proceeds, together with any claim costs, administrative charges, and attorney fees incurred by the Assigned Claims Agent and DCBS in processing the claim, and settlement, in addition to any penalties owed by employer. (ORS 656.054, 656.735-750)[.]" Proposed CDA at 5.

ORS 656.236(9) provides that an NCE is not a "party" to a CDA. Thus, the signature of the NCE is not necessary for Board approval of the CDA. *See, e.g., Norman D. Bailey*, 50 Van Natta 1454 (1998). Here, although the NCE has not signed the CDA, we interpret the aforementioned provision of the CDA as an acknowledgment that the NCE will be responsible, pursuant to ORS 656.054(3)[1], for reimbursement to DCBS for all claim costs, including CDA proceeds. The Director shall recover such costs from the NCE. ORS 656.054(3).

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' agreement is approved.

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

IT IS SO ORDERED.

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[1] ORS 656.054(3) provides:

> "In addition to, and not in lieu of, any civil penalties assessed pursuant to ORS 656.735, all costs to the Workers' Benefit Fund incurred under subsection (1) of this section shall be a liability of the noncomplying employer. Such costs include compensation, disputed claim settlements pursuant to ORS 656.289 and claim disposition agreements pursuant to ORS 656.236, whether or not the noncomplying employer agrees and executes such documents, reasonable administrative costs and claims processing costs provided by contract, attorney fees related to compensability issues and any attorney fees awarded to the claimant, but do not include assessments for reserves in the Workers' Benefit Fund. The director shall recover such costs from the employer. The director periodically shall pay the assigned claims agent from the Workers' Benefit Fund for any costs the assigned claims agent incurs under this section in accordance with the terms of the contract. When the director prevails in any action brought pursuant to this subsection, the director is entitled to recover from the noncomplying employer court costs and attorney fees incurred by the director."

In the Matter of the Compensation of
BRIAN C. SMALLWOOD, Claimant
WCB Case No. 00-08718
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Thye's order that upheld the SAIF Corporation's denial of claimant's headache and pain disorder conditions. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT[1]

On February 11, 1998, claimant broke his neck, suffered a concussion and lacerated his right ear in a compensable motor vehicle accident (MVA). (Exs. 7, 12, 75-1). Claimant's head and neck were immobilized by a halo brace, attached to the skull with pins, until May 6, 1998. (Exs. 11, 75-1). On February 25, 1998, Dr. Koller, claimant's attending physician, reported that claimant "continued" to complain of neck pain and headaches. (Ex. 11). On March 10, 1998, SAIF accepted a right ear laceration, acute C2 spinal fracture and concussion. (Ex. 12).

On June 6, 1998, claimant began treatment with a bone stimulator and physical therapy in order to strengthen his neck muscles and reduce his pain. (Ex. 25). On July 24, 1998, claimant reported that the pain in his neck had become less frequent and intense, but that his headaches had become more frequent. (Ex. 32).

A September 11, 1998 CT scan revealed that the C2 fracture had not healed completely and was contributing to claimant's neck pain. (Exs. 23, 75-2).

In October 1998, claimant continued to report suboccipital headaches that radiated up into his head. Dr. Newby referred him to Dr. Koller, neurologist, for evaluation. (Ex. 36).

On October 30, 1998, claimant reported to Dr. Koller that he was frustrated and depressed with regard to his headache and neck pain symptoms. Dr. Koller found bilateral tenderness at the occiput, going into the trapezius muscles. He diagnosed headaches and depression and opined that claimant's headaches were probably musculoskeletal in origin, stemming from his neck injury and exacerbated by the stress and frustration of his current situation. (Ex. 37). Dr. Koller and Dr. Newby continued to treat claimant conservatively for his headaches and neck pain. (Exs. 40, 41, 44, 48, 53, 54, 56, 57, 59).

On October 20, 1999, Dr. Anderson, a physician, and Ms. Bottomley, occupational therapist, evaluated claimant for SAIF. (Exs. 61, 62). Dr. Anderson attributed claimant's headache condition to the C2 fracture and probable contusion of the occipital nerve. Dr. Anderson admitted a lack of expertise concerning the cause of headaches. (Ex. 61).

On October 21, 1999, Dr. Myers, clinical psychologist, evaluated claimant for SAIF. (Ex. 63). He diagnosed mild reactive depression with anxiety (DSM IV 309.28) and pain disorder associated with psychological factors and general medical condition (DSM IV 307.89). (*Id.*) Dr. Newby concurred with Dr. Anderson's report, except that he did not think that claimant's headaches were due to an occipital nerve contusion. (Ex. 66). Dr. Koller generally agreed with both reports. (Ex. 65).

On December 17, 1999, SAIF issued an Updated Notice of Acceptance at Closure that identified the accepted conditions as "right ear laceration, acute C-2 spinal fracture and concussion." (Ex. 70). On the same date, SAIF closed the claim with awards of temporary disability and 21 percent unscheduled permanent disability for claimant's cervical condition. (Ex. 71). An April 28, 2000 Order on

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[1] In his brief, claimant referred to Exhibits 1 through 6. We have not considered these exhibits because only Exhibits 7, 11, 12, 19, 23, 25, 32, 35-37, 40, 41, 44, 48, 51, 53, 54, 56, 57, 59-90, 90A and 91-93 were admitted at hearing. (Tr. 3). The remaining documents, including proposed Exhibits 1 through 6, were withdrawn by the parties. (*Id.*)

Reconsideration reduced claimant's award of unscheduled permanent disability to 16 percent. (Ex. 77). In an October 3, 2000 Interim Order Remanding to the Director, a prior ALJ remanded the Order on Reconsideration to the Director for consideration of a temporary rule to address claimant's headache and depression conditions as sequelae of his accepted conditions pursuant to ORS 656.268(16). (Ex. 83).

Meanwhile, on September 28, 2000, Dr. Seres, neurosurgeon, and Dr. Glass, psychiatrist, evaluated claimant for SAIF. Dr. Glass diagnosed claimant with Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. (Exs. 81, 82).

On November 8, 2000, SAIF partially denied claimant's claim for headaches, depression and pain disorder[2] on the basis that there was no objective evidence that claimant had those conditions, and, alternatively, that claimant had a preexisting condition that was the major contributing cause of the diagnoses. (Ex. 88). Claimant requested a hearing on the denial. The parties stipulated that the denial also included a denial on the basis that the claimed conditions were not related to claimant's compensable injury.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

On review, claimant attached to his brief a *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) description of the various axes in the multiaxial assessment. We understand claimant's provision of the axes as a request that we take administrative notice of them. First, it is highly questionable whether we can take notice of this submission. Although we may, under limited circumstances, take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," *see Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985), we have generally declined to take administrative notice where the submission constitutes evidence from a source not subject to confrontation and cross-examination. *See, e.g., Michael A. Crause*, 49 Van Natta 1022 (1997) (Board declined to take administrative notice of a submission from the DSM-IV manual because it was taken from a source not subject to confrontation and cross- examination); *Richard H. Olsen*, 41 Van Natta 1300 (1989) (Board did not have authority to consider the most recent version of a medical treatise where the evidence was not admitted at the hearing and not a part of the record). However, we need not resolve this question, because the medical opinions in this case do not establish that the distinctions between the axes in a multiaxial assessment are relevant to the compensability issue.

Compensability-Headache Condition

The ALJ determined that claimant had failed to establish his headache condition as a consequential condition of the 1998 work injury. Consequently, the ALJ upheld SAIF's denial.

Claimant contends that the opinions of Dr. Koller, Dr. Newby, Dr. Anderson, and Dr. Seres persuasively establish that claimant's current headache condition is a consequential condition of the accepted C2 fracture and concussion. We agree that claimant's headache condition is compensable, reasoning as follows.

In order to establish his headache condition as a "consequential" condition of his compensable injury, claimant must prove that the compensable injury is the major contributing cause of the headache condition. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411, 415 (1992). To satisfy the "major contributing cause" standard, claimant must establish that his work 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 condition and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for his current headache 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). Moreover, we generally defer to the opinion of the treating physician, unless there are persuasive reasons not to do so. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to the opinions of Dr. Koller and Dr. Newby.

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[2] Claimant withdrew his request for hearing on other denied conditions at hearing.

We begin with a brief summary of claimant's headache condition. Dr. Newby, claimant's treating neurosurgeon, reported that claimant was "still having headaches" as well as constant neck pain on February 25, 1998, two weeks after claimant broke his neck and suffered a concussion. At this time claimant was wearing a halo brace, attached to the skull with pins, to immobilize his broken neck. After the halo was removed, claimant continued to report headaches, tight neck muscles, and muscle spasms. Dr. Newby stated that claimant's continued neck pain was "normal for patients who have been in a halo for three months as their neck muscles have become significantly weakened and are not used to holding the weight of their head." (Ex. 25). A September 11, 1998 CT scan revealed that the C2 fracture had not yet healed completely and was contributing to claimant's neck pain. Dr. Newby continued to treat claimant for suboccipital headaches.

On October 28, 1998, Dr. Newby referred claimant to Dr. Koller, neurologist, for evaluation of his headaches. Dr. Koller elicited tenderness in the cervical spine at the occiput bilaterally, the same location where Dr. Newby had elicited pain.[3] (Exs. 28, 37-2). Dr. Koller diagnosed chronic headaches, most likely musculoskeletal in origin, stemming from claimant's neck injury and exacerbated by the stress of his inability to return to a normal life. Dr. Koller treated claimant for over a year, trying various medications in an effort to relieve claimant's pain.

Dr. Koller consistently opined that claimant's headaches were musculoskeletal, caused by muscle tension in claimant's neck that resulted from the February 1998 injury to his neck. (Exs. 37, 40, 48, 65, 67, 90). After reviewing Dr. Glass' and Dr. Seres' reports, Dr. Koller did not agree with their evaluations. Specifically, Dr. Koller did not agree with Dr. Glass' conclusion that claimant's current pain problem represented a somatoform pain disorder and did not agree that psychosocial factors were the reason for the severity of claimant's physical complaints and limitations. Dr. Koller stated: "To do so would totally ignore the fact that [claimant] suffered a significant injury to his cervical spine as manifested by the hangman's fracture and a significant concussion. Post-concussion headache disorder[4] is well recognized as a neurologic complication of concussion and the headache can be a chronic problem that takes years to clear. I think it far more likely that [claimant's] headache disorder and pain complaints relate to his significant cervical injury and concussion. I think it is possible that pre-existing personality psychodynamics could be augmenting his complaints to some limited extent." (Ex. 91). Dr. Koller also disagreed with Dr. Seres' conclusion that claimant's headaches stemmed from a phobic reaction attributable to his preexisting personality makeup. Again, Dr. Koller emphasized that claimant's muscle tightness was due to his significant cervical injury that he suffered in the MVA. Dr. Koller opined that that injury was the major contributing cause of claimant's headache disorder. (*Id.*)

Dr. Newby initially opined that claimant suffered from an occipital nerve contusion caused by the C2 fracture, although he apparently withdrew from that view later.[5] Dr. Newby also opined that claimant's ongoing neck pain was 70 percent related to his prior neck fracture and a small component only related to his cervical spondylosis at C4-5. (Exs. 36, 51, 53, 69, 89). But after reviewing Dr. Seres' and Dr. Glass' reports, Dr. Newby stated that he did not believe that claimant's headaches were caused by his industrial accident, and, instead, agreed with their reports that his headaches were caused by his personality psychodynamics. (Exs. 90A, 92). However, after reviewing Dr. Koller's opinion and re-reviewing Dr. Seres' reports, Dr. Newby changed his view. After considering these reports, Dr. Newby opined that it was claimant's chronic pain since his injury that contributed to his emotional state, and that claimant's need for headache medication was directly related to his serious MVA, hangman's fracture and concussion and did not stem from preexisting psychological trauma. (Ex. 93).

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[3] Based on these medical reports, we find that claimant has established objective findings of a headache condition.

[4] "Postconcussion syndrome" refers to "posttraumatic syndrome," which is defined as "a clinical disorder that often follows head injury, characterized by headache, dizziness, neurasthenia, hypersensitivity to stimuli, and diminished concentration." *Stedman's Electronic Medical Dictionary*, vol. 4.0, 1998.

[5] Dr. Anderson opined that, based on claimant's history and review of the medical information, that claimant's headaches are related to a C2 fracture and probable occipital nerve contusion. Although Dr. Anderson's opinion is supportive of compensability, it is insufficient to carry claimant's burden, as she admits that she is not an expert in headaches, and because the medical evidence indicates that claimant probably does not have an occipital nerve contusion.

In contrast to Dr. Koller and Dr. Newby, neither Dr. Seres nor Dr. Glass attributed claimant's headache condition to his 1998 neck fracture or concussion, nor did they discuss the contribution of claimant's posttraumatic concussion disorder. Although Dr. Seres initially diagnosed claimant with muscle-contraction headaches and chronic cervical pain that were residua from his MVA of February 1998 and opined that they were not related in major part to any preexisting condition (Ex. 81), he subsequently changed his opinion and concurred with Dr. Glass, who diagnosed claimant's current pain condition as a somatoform pain disorder that was caused by claimant's tense personality and psychosocial factors. (Ex. 82).

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). Here, we find that neither Dr. Seres nor Dr. Glass adequately addressed the effect of the severity of claimant's neck injury, the concussion and its aftermath, posttraumatic concussion disorder, the fact that the onset of claimant's headaches was at the time of the injury, or weighed those factors in their opinions. Consequently, we do not find their opinions persuasive.

In contrast, Dr. Koller weighed the relative contributions of claimant's neck injury and concussion and the personality and psychosocial factors as presented by Drs. Seres and Glass. Dr. Koller concluded that, in balance, the severity of the 1998 injury, the broken neck, and the concussion were the major contributing cause of claimant's headache condition. Dr. Koller's opinion is supported by that of Dr. Newby, who opined that it was claimant's chronic pain since his injury that contributed to his emotional state, rather than the other way around, as postulated by Drs. Seres and Glass. Dr. Koller also addressed the contribution of claimant's degenerative condition and found that it was a minor factor in claimant's ongoing headache condition.

We conclude that the opinions of Dr. Koller and Dr. Newby are more persuasive that those of Dr. Seres and Dr. Glass. We accordingly find that claimant's headache condition is compensable and reverse the order of the ALJ on this issue.

Pain Disorder

Two doctors examined claimant and diagnosed a pain disorder condition, Dr. Myers, Ph.D., a specialist in Behavioral Medicine, and Dr. Glass, a psychiatrist.

Claimant was first diagnosed with pain disorder on October 21, 1999, by Dr. Myers, who evaluated claimant for SAIF. Dr. Myers diagnosed Pain Disorder Associated With Both Psychological Factors and General Medical Condition (DSM IV 307.89). Dr. Myers assessed claimant as tense, driven, and unaware of his "baseline" stress, which causes pain which then becomes difficult to control without the use of medication. Although Dr. Myers reviewed claimant's medical records and was cognizant of claimant's compensable head and neck injuries, he did not evaluate the relative contribution of the compensable injury and claimant's psychological makeup to his pain disorder. Consequently, we conclude that Dr. Myers' opinion is insufficient to establish compensability of claimant's pain disorder under *Deitz*.

Dr. Glass, who examined claimant for SAIF on September 28, 2000, almost a year after Dr. Myers, made the same diagnosis. Dr. Glass opined that claimant's need for psychiatric treatment or counseling was due to his non-injury preexisting personality psychodynamics. Dr. Glass concluded that claimant was psychiatrically medically stationary for any psychiatric condition directly caused by his motor vehicle accident, but not psychologically medically stationary regarding his subjective pain condition. We infer from Dr. Glass' report that claimant's injury was not the major contributing cause of claimant's diagnosed pain disorder condition. Thus, like Dr. Myers' opinion, that of Dr. Glass is insufficient to establish compensability of a pain disorder.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability of his headache condition. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding this issue is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 23, 2001 is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial of claimant's headache condition is reversed. The denial of the headache condition is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded a fee of $3,500, payable by SAIF. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
BYRON D. SURFACE, SR., Claimant
WCB Case Nos. 00-03935 & 00-00162
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney
Paul Louis Roess, Defense Attorney

Reviewing Panel: Members Phillips Polich, Bock, and Meyers. Member Meyers dissents.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its "omitted condition" denial of claimant's right wrist arthrosis; and (2) set aside its "new medical condition" denial of reflex sympathetic dystrophy (RSD). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant has been employed as a prestressed concrete finisher for 20 years. His work involves strenuous repetitive use of his upper extremities, right greater than left. In June 1997, he injured both elbows and hands when he was drilling a hole in concrete with a two-person drill. (Exs. 2A, 3). In June 1998, he sought treatment for pain in both forearms and his right wrist that had worsened with his ongoing exertion at work. He had previously fractured his right wrist in 1977. (Exs. 1, 2, 11).

On July 2, 1998, Dr. Otten diagnosed bilateral traumatic lateral and medial epicondylitis. (Ex. 2A). Dr. Lynch, orthopedist, diagnosed radiocarpal arthrosis of the right wrist. (Ex. 3).

On July 30, 1999, the insurer accepted disabling bilateral traumatic lateral and medial epicondylitis. (Ex. 7). On August 6, 1999, claimant's claim was closed with an award of 5 percent scheduled permanent disability for each arm. (Ex. 29-5).

On September 8, 1999, claimant was examined by Dr. Wilson, occupational medicine, for evaluation of bilateral elbow and right hand pain. (Ex. 9).

On September 24, 1999, claimant formally requested acceptance of "right wrist arthrosis." (Ex. 10).

On November 19, 1999, Dr. Courogen examined claimant. (Ex. 11). On the same date, Dr. Sultany examined claimant. (Ex. 12).

On December 9, 1999, Dr. Maier, rheumatologist, examined claimant. Based on claimant's history and findings, including a repeat bone scan, Dr. Maier diagnosed claimant's chronic arm pain as reflex sympathetic dystrophy. (Exs. 16, 16A, 16B, 22).

On January 4, 2000, the insurer issued an Updated Notice of Acceptance at Closure that identified claimant's accepted condition as disabling bilateral traumatic lateral and medial epicondylitis. (Ex. 18). On the same date, the insurer partially denied right wrist arthrosis on the basis that claimant's injury was not the major contributing cause of that condition. (Ex. 19).

On February 16, 2000, claimant formally requested acceptance of reflex sympathetic dystrophy of the upper extremities. (Ex. 22).

On February 19, 2000, claimant filed a Form 801 for a new occupational disease claim involving the radiocarpal joints of the wrists. (Ex. 23).

On April 5, 2000, Dr. Dordevich, rheumatologist, evaluated claimant for the insurer. (Ex. 29).

On May 15, 2000, the insurer denied claimant's reflex sympathetic dystrophy claim on the basis that he did not have that condition and that his current complaints were not due to his accepted injury. (Ex. 35). On the same date, the insurer denied claimant's occupational disease claim for bilateral radiocarpal arthritis on the basis that claimant's employment was not the major contributing cause of that condition. (Ex. 36).

CONCLUSIONS OF LAW AND OPINION

Compensability-Right Wrist Arthrosis

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

The ALJ concluded that claimant's "omitted condition" claim for right wrist arthrosis was compensable as a combined condition under ORS 656.005(7)(a)(B). On review, the insurer contends that this condition is not compensably related to claimant's injury. Specifically, the insurer contends that, although the parties agreed that there was only one wrist condition in issue (the right wrist arthrosis was the same as the radiocarpal joint arthritis), there is a logical contradiction in the ALJ's conclusion that the "arthrosis" was compensable and the "arthritis" was not.[1] We do not agree for the following reasons.

At the January 19, 2001 hearing, claimant's counsel identified the issues as the insurer's three denials, including its denial of right wrist arthrosis and its denial of bilateral radial carpal arthritis.[2] The ALJ considered claimant's right wrist arthrosis (arthritis) "omitted condition" claim and found it compensable as a combined condition arising out of the initial injury claim, based on the medical evidence that the injury and the preexisting arthrosis condition had combined and that the major contributing cause of that combined condition and need for medical treatment was the 1997 injury.[3] *See* ORS 656.005(7)(a)(B). Therefore, the ALJ held that claimant's combined right wrist arthrosis condition was compensable as an "omitted medical condition."[4]

Turning to the bilateral radiocarpal joint arthritis claim under an occupational disease theory, the ALJ determined that the medical evidence did not support a finding of a compensable occupational disease. Neither party disputes that finding. There is no contradiction in the ALJ's analysis, as the

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[1] As noted by the ALJ, Dr. Maier testified that arthritis and arthrosis are synonymous.

[2] We interpret claimant's statement at hearing that the denial of the radial carpal arthritis encompasses the right wrist arthrosis (Tr. 4) merely means that the right wrist arthrosis was encompassed by the insurer's denial of the bilateral right wrist condition as an occupational disease and not as a concession that he was no longer pursuing compensability of the right wrist condition under an "omitted condition" theory.

[3] The insurer contends that claimant did not argue at hearing that the right wrist arthrosis was a combined condition. In analyzing the compensability of claimant's "omitted" right wrist arthrosis condition, the ALJ as fact-finder was required to determine the appropriate standard of compensability. *See Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett- Packard Co. v. Renalds*, 132 Or App 288 (1995); *Dibrito v. SAIF*, 319 Or 244, 248 (1994) (it is the Board's obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim)). Thus, the ALJ did not err in determining whether ORS 656.005(7)(a)(B) applied in this case.

[4] Claimant's request for acceptance of the right wrist arthrosis condition is properly characterized as an "omitted" medical condition claim under ORS 656.262(6)(d), because that condition was in existence at the time of the insurer's initial Notice of Acceptance dated July 30, 1999. (Exs. 4, 7). *Mark A. Baker*, 50 Van Natta 2333 (1998).

standard of proof for the "omitted condition" claim is different from that for an occupational disease claim, *see* ORS 656.005(7) and ORS 656.802(2), and claimant has satisfied the standard of proof to establish his "omitted condition" claim for right wrist arthrosis.[5]

Compensability-Reflex Sympathetic Dystrophy (RSD)

Based on the opinion of Dr. Maier, the ALJ concluded that claimant had RSD and found it compensable as a consequential condition. On review, the insurer's sole contention is that the diagnosis of RSD is unsupported by the persuasive medical evidence. We disagree.

Claimant had an accepted claim for bilateral traumatic lateral and medial epicondylitis that arose in June 1997. In December 1999, Dr. Maier, claimant's treating rheumatologist, diagnosed claimant's continuing upper extremity pain and numbness as RSD, right greater than left, which was confirmed by clinical signs of swelling and warmth over the right arm and a bone scan. (Ex. 41-9, -10). Thus, the medical record indicates that claimant's current upper extremity condition has been diagnosed as RSD by a specialist in rheumatology.

Dr. Dordevich examined claimant for the employer on April 5, 2000. In contrast to Dr. Maier's diagnosis, Dr. Dordevich concluded that claimant had no evidence of RSD, and attributed claimant's current *right* hand complaints to a preexisting degenerative arthritis condition in the carporadial joint at the wrist. (Ex. 29-8). Dr. Dordevich, however, did not discuss the swelling in the tissues of claimant's right arm, which Dr. Maier indicated was not a sign of inflammatory arthritis, not did he discuss the cause of claimant's left arm symptoms.

A claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work. *Boeing Aircraft Company v. Roy*, 112 Or App 10 (1991), citing *Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988) (the lack of a definitive diagnosis does not per se defeat a claim). Moreover, it is not a necessary predicate to compensability that the medical experts know the exact mechanism of the disease. *Robinson v. SAIF*, 78 Or App 581 (1986); *Candace M. Griffin*, 42 Van Natta 624 (1990).

Accordingly, the causation issue (as opposed to the question of diagnosis) must be resolved. *Stewart E. Myers*, 41 Van Natta 1985 (1989). Because of multiple potential causal factors, this issue is of sufficient medical complexity to require expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). It is claimant's burden to prove that his alleged RSD condition is compensable. ORS 656.266.

As discussed by the ALJ, the only opinion regarding compensability of the RSD condition was provided by Dr. Maier, who believed that it was medically probable that claimant's continuing *bilateral* arm symptoms (which he diagnosed as RSD) were directly related to the work injury, in which claimant torqued his arms while using the two-person drill. (Ex. 25). Dr. Maier explained that, when claimant presented to him in December 1999, he complained of widespread pain over the right upper extremity, not just right wrist pain. (Ex. 41-9). Dr. Maier opined that claimant's right wrist osteoarthritis did not have much to do with his current complaints or problems, as the soft tissue swelling he noted in claimant's arm was not indicative of arthritic inflammation. (Ex. 41-8, -9). Consequently, we conclude that Dr. Maier's opinion is more persuasive than that of Dr. Dordovich and agree with the ALJ that claimant has established compensability of his current bilateral arm symptoms, which Dr. Maier diagnosed as RSD. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411, 414 (1992).

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[5] Claimant agrees that the ALJ correctly determined that the right wrist arthrosis was compensable as a combined condition. Claimant also contends that the ALJ was correct in finding the insurer's denial to be improper, as the insurer had not accepted a combined condition prior to its denial. Claimant cites *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263 (2000) and *Croman Corp. v. Serrano*, 163 Or App 135 (1999), in support of his position. There is no evidence that this procedural issue was raised at hearing. As a general rule, we do not consider issues that are raised for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *see also Fister v. South Hills Health Care*, 149 Or App 214 (1997) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing). In this case, we find no reason to deviate from our general rule. *See Robin A. Rohrbacker*, 53 Van Natta 51 (2001).

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 February 23, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

Board Member Meyers dissenting.

I respectfully dissent from that portion of the majority's opinion that holds that claimant's RSD condition is compensable, for the following reasons.

Claimant has an accepted claim for bilateral traumatic lateral and medial epicondylitis. This condition was diagnosed by Dr. Fletchall and Dr. Otten. (Exs. 1, 2A). Dr. Lynch, who evaluated claimant's bilateral upper extremity problems in August 1998, diagnosed right wrist arthrosis after a bone scan reveal focal abnormalities in the radiocarpal joint and the STT join in the right wrist. (Exs. 3, 3A, 4). In September 1999, Dr. Wilson found claimant's arms to be "normal in appearance * * * with no warmth or swelling," normal grip strength and normal coloration of the hands. After radiological evidence of arthritis was revealed, Dr. Wilson diagnosed right wrist and bilateral elbow pain on the basis of arthritis of the wrist and elbows, adding that claimant's presenting symptoms were degenerative and more likely related to arthritis than to the accepted injury. (Ex. 9A).

In November 1999, Dr. Courogen, orthopedic surgeon, found no physical deformity of the upper extremities, no strength loss, normal range of motion and no sensory change. (Ex. 11). Dr. Sultany, rheumatologist, who saw claimant the same day, made findings and conclusions that were essentially the same as Dr. Courogen's. Dr. Sultany diagnosed degenerative arthritis of the carpal bone of the right wrist and attributed the symptoms in claimant's right wrist to his underlying arthrosis." (Ex. 12). X-rays taken in December 1999 showed narrowing of the radiocarpal joint of the right wrist consistent with degenerative change. (Ex. 13).

Up to this time, none of the physicians who had evaluated claimant in the preceding 18 months had mentioned RSD as a possible explanation for claimant's complaints.

In December 1999, Dr. Maier noted some soft tissue swelling of the dorsum of the right hand and wrist and found the right hand warmer than the left. He scheduled another bone scan for the purpose of looking for evidence of RSD. Dr. Maier opined that the bone scan results were consistent with mild RSD. (Exs. 16B, 17, 20, 24). After unsuccessfully treating claimant's RSD condition with medication, Dr. Maier prescribed a stellate ganglion block on the right as a "diagnostic and therapeutic intervention." (Ex. 30).

In April 2000, Dr. Mack, to whom Dr. Maier referred claimant for a "diagnostic sympathetic block of the right upper extremity," reported no obvious trophic changes in the hand, normal range of motion in the hand, and "no marked allodynia to temperature, touch or pinprick." Dr. Mack also reported that claimant did not notice any subjective pain relief after the block. (Ex. 30A).

Dr. Dordevich, also a rheumatologist, opined that there was not evidence of RSD, attributing claimant's right hand complaints instead to the degenerative arthritis in his radiocarpal joint. Dr. Dordevich also opined that claimant had not presented with symptoms that would warrant a diagnosis of RSD. (Ex. 37). Moreover, with regard to what Dr. Maier called "equivocal results" of the stellate ganglion block, Dr. Dordevich observed:

> "[Claimant's] current wrist problems are not due to automonic sympathetically mediated pain [RSD] which would be expected to respond to a stellate block. His pain is due to degenerative arthritis which has been diagnosed in his right wrist." (Ex. 39).

The results of the stellate ganglion block performed by Dr. Mack were in accord with Dr. Dordevich's statement. Moreover, after performing the block, Dr. Mack opined: "Based on today's apparently sympathectomy, and the absence of pain relief, it is quite unlikely that there is a sympathetically mediated component to [claimant's] pain." (Ex. 30A). In other words, he thought that claimant did not have RSD.

I would find the opinion of Dr. Dordevich more persuasive than that of Dr. Maier, because it is based on an accurate medical history and because Dr. Dordevich provides a well-reasoned explanation in support of his conclusion. *Somers v. SAIF*, 77 Or App 259, 263 (1986). In addition, Dr. Dordevich's opinion is supported by that of Dr. Mack. For these reasons, I would find that claimant has not carried his burden to prove that his RSD condition is compensable.

September 6, 2001 Cite as 53 Van Natta 1148 (2001)

In the Matter of the Compensation of
PATRICIA J. LATAL, Claimant
WCB Case No. 00-04009
ORDER OF ABATEMENT
Martin L. Alvey, Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

On August 7, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the self-insured employer's denial of claimant's "consequential condition" claim for a low back condition; and (2) declined to asses a penalty for allegedly unreasonable claim processing. Asserting that our interpretation of the opinions from two physicians was erroneous, claimant seeks reconsideration of our decision and reversal of the ALJ's order.

In order to further consider this matter, we withdraw our August 7, 2001 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 proceed with our reconsideration.

IT IS SO ORDERED.

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
1007 Parkway Drive N.W.
Salem, Oregon 97304
Phone (503) 585-5173
Fax (503) 540-0114

UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 1149-1242 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH SEPTEMBER 30, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, JULY-SEPTEMBER 2001.

In the Matter of the Compensation of
JASON GURA, Claimant
WCB Case No. 00-00302
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of his injury claim for C5-6 and C6-7 disc conditions. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, age 27 at the April 2000 hearing, had surgery for a scoliosis condition in 1993, which was performed by Dr. Keenen. (Tr. I-9). The surgery corrected an abnormal curvature of his spine. (Tr. I-10). After claimant recovered from the surgery, he did not have any back pain and was not limited in his physical activities. (Tr. I-10, -11).

In February 1999, claimant saw Dr. Keenen for the first time since 1993, when he sought treatment for right shoulder pain. (Tr. I-16, Ex. 2). Dr. Keenen noted that claimant was able to function without any limitations and he prescribed medication. (Ex. 2).

Claimant did not seek treatment for any back or neck complaints until mid-1999. (Tr. I-16-17). He began working for the employer as a sales representive on May 6, 1999. Prior to his employment, he had a physical examination that included his neck and back. (Tr. I-17). On May 13, 1999, claimant went to a customer's store to pick up two machines used to cut custom window blinds, which weighed about 80 to 90 pounds. (Tr. I-18-19, -26). Claimant testified that it was very difficult to hold the machines and he had to wrestle them into a shopping cart, into his car and then to a storage unit. (Tr. I-20-21). By the end of the day, he had some fatigue and soreness in his back and experienced some soreness in his neck. (Tr. I-20-21, -27). Claimant was still sore the next day, but continued to work. (Tr. I-22).

Claimant sought treatment from Dr. Keenen on May 21, 1999, complaining of back pain. (Ex. 3). Dr. Keenen explained that claimant had changed jobs, and had to do more lifting and twisting activities, which had aggravated his back. (*Id.*) Dr. Keenen prescribed medication. (*Id.*)

On June 3, 1999, claimant went to another customer's store to replace a window blind cutting machine. (Tr. I-22). Because his back was still hurting, claimant asked another employee to help lift the defective machine off a counter and place it on the floor. (Tr. I-23-25). Claimant lifted the new machine from the floor to the counter by himself. (Tr. I-25-26). He had assistance lifting the defective machine and placing it into a cart. (Tr. I-26). Claimant's back and neck were very sore that day and he had a "tightness" in his neck. (Tr. I-27). He had never experienced similar neck pain. (*Id.*)

Claimant was treated by physician's assistant Diaz on June 9, 1999, complaining of right upper and lower back pain. (Ex. 4). Diaz reported that claimant had discomfort in the right posterior cervical and trapezius areas, was tender in the right lumbar area, and occasionally had some lateral thigh numbness. (*Id.*) Diaz diagnosed right posterior cervical and trapezius pain and right lumbar pain, and prescribed medication and physical therapy. (*Id.*)

On June 18, 1999, claimant sought treatment at an urgent care clinic, complaining of "[t]otal back pain." (Ex. 4A). The chart note indicated that claimant had recently changed jobs and had increased activity, soreness and pain. (*Id.*) Claimant indicated he had intermittent back pain with the new job, and the pain occurred when he installed things and lifted items above his shoulders. (*Id.*) Claimant was diagnosed with back strain due to overuse and was prescribed with medication. (*Id.*) He began treating with Dr. Lee on June 23, 1999, and started physical therapy. (Ex. 5).

On July 8, 1999, claimant signed an injury report that referred to the two incidents involving the window blind cutting machines. (Ex. 6). He explained that he had reported the incidents to his supervisor on June 8, 1999, and had experienced a severe injury to his mid, lower and upper back. (*Id.*) Claimant's symptoms progressively worsened and he left work on July 6, 1999. (Tr. I-28).

On July 10, 1999, claimant sought treatment at an urgent care clinic, complaining of back pain. (Ex. 6B). The chart note indicated that claimant had experienced recurrent back pain related to overuse at his job. Claimant had physical therapy the previous day and now had increasing pain in his shoulders and neck, causing headaches. (*Id.*)

Four days later, claimant was treated by Dr. Huun, who reported that he had back pain on May 14, after lifting two 90 pound copy machines. (Ex. 7). He also recommended physical therapy. (*Id.*)

Claimant returned to Dr. Lee on August 5, 1999, who reported chronic pain in the right scapular region, as well as chronic lumbar pain. (Ex. 9). He found that claimant had some paraspinous tenderness in the thoracic region just medial to the scapula on the right and some tenderness in the lumbar region, and diagnosed chronic cervicothoracic and lumbosacral strain. (*Id.*)

Dr. Huun reported on August 17, 1999 that claimant's lumbar discomfort had improved, but his upper thoracic discomfort was still persistent. (Ex. 10A). He found tenderness to palpation in the mid lower cervical thoracic spine and he diagnosed thoracolumbar discomfort. (*Id.*)

On September 4, 1999, claimant sought treatment from Dr. Juster, complaining of back and neck pain. (Ex. 11). Claimant described progressive tightness in the back of his neck over the past month, which progressed up over his head, causing migraine-like pain. (*Id.*) Dr. Juster found kyphosis and tenderness in the posterior cervical thoracic region, and diagnosed muscle tension headaches and chronic neck pain. (*Id.*)

Claimant was treated by Dr. Gambee on September 7, 1999, who reported that he had strained his upper and low back doing some lifting at work. (Ex. 13). Claimant had diffuse spinal pain and described some numbness over the right anterior thigh. Dr. Gambee reported diffuse tenderness in the thoracolumbar spine, as well as a few beats of clonus at the ankles. (Ex. 13-2). He diagnosed a diffuse spinal strain with developing chronic symptoms. (*Id.*)

On September 23, 1999, claimant was examined by Drs. Neumann and Denekas on behalf of the insurer. Claimant told them his low back pain had improved with therapy, but he continued to have upper back and neck pain and migraine-like headaches. (Ex. 14-2). They found that claimant had four beats of clonus bilaterally. (Ex. 14-4). They diagnosed a lumbosacral sprain, which was resolved, and a dorsal strain/sprain related to the work incident, which was still symptomatic. (Ex. 14-6).

The insurer accepted disabling lumbosacral and dorsal sprains. (Ex. 16).

In early October 1999, claimant was treated for a worsening headache, and a CT of the brain was performed, which was normal. (Exs. 17, 18). Later in October, he was treated for a headache and pain radiating down into his neck and back. (Ex. 21). Claimant was diagnosed with a migraine headache. (Ex. 21-2).

Claimant returned to Dr. Keenen in mid-October 1999 because of continued pain in his upper thoracic spine and low back, which claimant felt was related to a work injury in May 1999. (Ex. 19A). Dr. Keenen found that claimant had a marked prominence of his cervicothoracic junction and he referred him to Dr. Long.

Dr. Long first examined claimant on November 2, 1999. At that time, claimant's main complaint involved upper trunk and low cervical pain, with headaches. (Ex. 22-2). Claimant explained that he had developed neck and back pain after a work incident on May 13, 1999 and equipment handling in June 1999. Dr. Long found that claimant had hyperreflexia in the lower extremities and unsustained clonus at both ankles. (Exs. 22-3, 26). He recommended a cervical MRI, which showed small disc herniations at C5-6 and C6-7. (Ex. 23). Dr. Long felt that claimant's cervical pain was probably associated with the C5-6 disc protrusion, and the hyperreflexia was associated with mild cervical myelopathy at C5-6. (Ex. 26-2). He recommended physical therapy and epidural steroid injections.

On January 3, 2000, the insurer issued a partial denial, contending that claimant's C5-6 and C6-7 disc herniations were not related to his work activities or the accepted claim. (Ex. 36).

Dr. Gripekoven examined claimant on March 27, 2000, on behalf of the insurer. (Ex. 40). Claimant reported pain from the base of his neck extending into the interscapular area. (Ex. 40-3). Dr. Gripekoven diagnosed a cervical and lumbar sprain, by history, as well as a C5-6 disc bulge, and clonus of the lower extremities of undetermined etiology. (Ex. 40-5, -6). He concluded that claimant's preexisting scoliosis condition and prior dorsal fusion, and possibly a degenerative process in his cervical spine, were the major contributing cause of his disability and need for treatment. (Ex. 40-7, -8).

Dr. Slack performed epidural steroid injections at C7-T1 and C5-6 and found that the C5-6 segment was the primary source of claimant's pain. (Exs. 28, 34). Because claimant had not experienced major symptom relief with the injections, Dr. Long recommended cervical discography, which was performed by Dr. Slack on March 29, 2000. (Exs. 35, 39, 41). Dr. Slack determined that the C5-6 disc was abnormal. (Ex. 41).

On August 3, 2000, Dr. Keenen performed a C5-6 discectomy and fusion. (Ex. 48). After surgery, Dr. Long reported that claimant's symptoms and pain were diminishing steadily. (*Id.*) He felt that claimant's response to surgery confirmed that his dorsal and lumbar symptoms were symptoms of cervical myelopathy. (Ex. 48-2).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant and his wife were credible witnesses. The ALJ applied a material contributing cause standard, but found that the claim was not compensable. The ALJ found that the medical evidence was sufficient only to establish that it was possible, but not probable, that claimant's two work incidents contributed to the causation of his cervical disc conditions. The ALJ reasoned that claimant's neck pain was relatively minor and was not verified by objective findings of any kind until several weeks after the second incident. The ALJ also found that another problem was the lack of a reasonable explanation as to how a lifting incident produced a disc injury at a level above the point where the leverage of lifting was applied.

On review, claimant relies on the opinions of Drs. Long, Keenen and Slack to establish compensability. Claimant asserts that the ALJ properly applied a material cause standard, and the insurer does not dispute that standard of proof.[1] Claimant argues that, contrary to the ALJ's finding, he suffered neck pain immediately after the June 3, 1999 incident and his testimony was confirmed by contemporaneous medical reports. In addition, claimant contends that the ALJ's finding concerning the leverage of lifting is not supported by any medical evidence and the ALJ erred by substituting his own medical opinion.

The insurer acknowledges that, although the medical reports after the June 3, 1999 incident may arguably support the conclusion that claimant sustained a cervical/shoulder strain as a result of work activities, the lack of objective findings of herniated cervical discs in the weeks following the incidents is inconsistent with the conclusion that the work incidents were causally related to those conditions. According to the insurer, the medical record is not sufficient to establish that claimant had a cervical disc herniation condition present in the weeks following the work incidents.

In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We may 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, we are more persuaded by the opinions of Drs. Long and Keenen, who treated claimant on several occasions, than the opinions of Drs. Gripekoven and Neumann, who each examined him once.

On *de novo* review, we agree with the ALJ that claimant is a credible witness. Based on claimant's testimony, we find that he experienced neck and back pain after the lifting incidents at work on May 13, 1999 and June 3, 1999. He sought treatment for back pain on May 21, 1999 from Dr. Keenen, and on June 9, 1999, he sought treatment for right upper and lower back pain from physician's assistant Diaz. (Exs. 3, 4). Diaz diagnosed right posterior cervical and trapezius pain and right lumbar pain, and prescribed medication and physical therapy. (Ex. 4).

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[1] We note that Dr. Gripekoven said that claimant's scoliosis and prior dorsal fusion predisposed him to injury and was a contributing factor. (Ex. 40-7). On the other hand, he noted that after the 1993 scoliosis surgery, claimant was pain-free and able to perform normal work and recreational activities until May 1999. (Ex. 40-2). Dr. Keenen, who performed claimant's 1993 surgery for scoliosis, strongly disagreed with Dr. Gripekoven, explaining that there was no basis for finding that claimant's scoloiosis or prior surgery had anything to do with his neck symptoms. (Ex. 43). Dr. Keenen found no preexisting condition that had anything to do with claimant's cervical condition. (*Id.*) He reiterated that opinion in his deposition testimony. (Ex. 44-10). We are more persuaded by the opinion of Dr. Keenen, who performed claimant's scoliosis surgery and treated him after the surgery. Accordingly, we apply a material cause standard to determine causation.

On June 18, 1999, claimant sought treatment at an urgent care clinic, complaining of "[t]otal back pain." (Ex. 4A). The chart note indicated that claimant had recently changed jobs and had increased activity, soreness and pain. (*Id.*) Claimant indicated he had intermittent back pain with the new job, and the pain occurred when he installed things and lifted items above his shoulders. (*Id.*)

On July 10, 1999, one day after physical therapy, claimant went to an urgent care clinic for increasing pain in his shoulders and neck, causing headaches. (Ex. 6B). Shortly thereafter, he was treated by Dr. Lee, who reported that claimant had chronic pain in his right scapular region, as well as chronic lumbar pain. (Ex. 9). Dr. Lee's diagnoses included chronic cervicothoracic strain. (*Id.*)

On September 4, 1999, claimant was treated by Dr. Juster for complaints including neck pain. (Ex. 11). Claimant described progressive tightness in the back of his neck over the past month, which progressed up over his head, causing migraine-like pain. (*Id.*) Dr. Juster found kyphosis and tenderness in the posterior cervical thoracic region, and diagnosed muscle tension headaches and chronic neck pain. (*Id.*)

Claimant eventually returned to Dr. Keenen, who referred him to Dr. Long. A cervical MRI showed small disc herniations at C5-6 and C6-7. (Ex. 23). After diagnostic testing, the C5-6 segment was found to be the primary source of claimant's pain. (Exs. 28, 34). On August 3, 2000, Dr. Keenen performed a C5-6 discectomy and fusion. (Ex. 48).

When Dr. Long initially examined claimant in November 1999, he felt the claimant's symptoms were more than an unresolved muscle strain involving the neck and back. (Ex. 22-3). He referred to claimant's neck pain and headache, and the fact that he was hyperreflexic in his lower extremities, and had a sense of weakness or instability in the lower extremities. (*Id.*) He recommended a cervical MRI and further diagnostic testing.

In an April 6, 2000 report, Dr. Long concluded that cervical discography showed that claimant's neck and upper trunk symptoms were coming from disc disruption at C5-6. (Ex. 42-2). He felt that, because there was no evidence that claimant had a symptomatic C5-6 disc lesion prior to May 1999, there was reasonable basis for concluding that the lifting that he did on May 13, 1999 and during June 1999 produced a symptomatic C5-6 disc injury. (*Id.*)

Dr. Long provided further explanation in a February 15, 2001 report:

> "In [claimant's] case, cervical disc disruption produced irritation of the cervical cord. It is quite common for cervical cord irritation to produce distal symptoms, including thoracic and lumbar spine pain, lower extremity pain, hyperreflexia, or sensory disturbance. In [claimant's] case, injury to cervical discs provoked not only cervical pain but also symptoms of mild cervical cord irritability, with lumbar and lower extremity symptoms and physical findings. The fact that the C56 disc lesion did not produce disruption of the posterior longitudinal ligament or gross cervical spinal cord compression does not exclude cervical cord irritation due to local inflammation. We know that [claimant's] C56 disc was abnormal and painful, and that epidural steroid injection gave temporary symptom relief. Elimination of his primary symptom source, the C56 disc, has relieved neck, thoracic, and lumbar pain, has reduced hyperreflexia in the lower limbs, and has relieved urinary frequency and urgency. His symptoms, his physical findings, his surgical findings, and his postoperative course are consistent with the diagnosis of cervical strain injury, with C56 disc disruption, mild cervical cord irritation, relieved by discectomy and fusion." (Ex. 49-1).

In an April 9, 2001 report, Dr. Long disagreed with Dr. Gripekoven's statement that claimant had a "few beats of unsustained clonus and hypperreflexia."[2] (Ex. 54-1; *see* Ex. 50-1). Instead, Dr. Long

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[2] "Clonus" is defined as alternate muscular contraction and relaxation in rapid succession. *Dorland's Illustrated Medical Dictionary* 342 (28th ed. 1994); *see SAIF v. Calder*, 157 Or App 224, 227 (1998) (Board may rely on medical dictionaries to define medical terms). Clonus in the ankle is defined as "a series of abnormal reflex movements in the foot, induced by sudden dorsiflexion of the foot, which causes alternate contraction and relaxation of the triceps surae muscle[.]" *Dorland's* at 342. Dr. Keenen testified that clonus is an indication of irritation of the spinal cord. (Ex. 44-6, -7). He explained that a dorsal or neck condition could cause such irritation. (Ex. 44-7). "Hyperreflexia" is "dysreflexia characterized by an exaggeration of reflexes." *Dorland's* at 800. "Dysreflexia" is a disordered response to stimuli. *Id.* at 519.

said that claimant had marked lower extremity hyperreflexia with sustained clonus documented on multiple occasions. (*Id.*) He explained that, unlike Dr. Gripekoven, he had seen numerous patients with lumbar or lower extremity pain who had excellent relief from cervical surgery. (Ex. 54-2). He believed that claimant's response to surgery confirmed that he had cervical myelopathy[3] in association with the C5-6 disc disruption. (*Id.*)

Dr. Keenen agreed with Dr. Long's opinion on causation. He acknowledged Dr. Gripekoven's comment that claimant did not have significant immediate pain after the two lifting episodes, but instead had a gradual buildup of increasing pain over an extended period of time. (Ex. 43; *see* Ex. 40). Nevertheless, he disagreed with Dr. Gripekoven's conclusion that the injury did not result in the disc condition. Dr. Keenen said that claimant had an injury and the immediate symptoms were less than the later symptoms, but the injury remained the basis for the symptoms. (*Id.*) Dr. Keenen completely disagreed with the opinion finding that claimant's scoliosis or previous scoliosis surgery had anything to do with his neck symptoms. (*Id.*) He explained that claimant's hyperreflexia and clonus were not the result of scoliosis. (*Id.*)

Dr. Keenen adhered to his opinion in a deposition that took place before claimant's cervical surgery was performed. (Ex. 44-9, -10). At that time, Dr. Keenen did not have a clear explanation for claimant's hyperreflexia and clonus, but he said they were caused by spinal cord irritation. (Ex. 44-7, -8).

After performing surgery, Dr. Keenen reviewed Dr. Gripekoven's report, in which he said it was unusual for lumbar pain to be associated with cervical myelopathy, and Dr. Gripekoven said he had not seen specific lumbar pain relieved by cervical surgery. (Exs, 52, 52A). Dr. Keenen agreed with Dr. Gripekoven that relief of lumbar pain and lower extremity symptoms by cervical surgery was unusual. (Ex. 52A). Nevertheless, Dr. Keenen said that, in his experience as a spine surgeon, "some very unique and unusual conditions have arisen and [claimant] fits into that category." (*Id.*)

Based on the opinions of Drs. Long and Keenen, we conclude that claimant's work incidents in May and June 1999 were a material cause of his C5-6 disc condition. Their opinions are supported by the opinion of Dr. Slack, who performed claimant's epidural steroid injections and discography. (Ex. 53). Although the insurer argues that the medical record does not provide reference to "typical" disc herniation findings, the opinions of Drs. Long and Keenen establish that claimant's C5-6 disc condition was unusual. Dr. Keenen specifically considered the fact that claimant's immediate symptoms were less than the later symptoms, and he adhered to the opinion that claimant's C5-6 condition was related to the work incidents. (Exs. 43, 52A). Likewise, Dr. Long discussed the timing of claimant's symptoms and explained that dorsal and lumbar symptoms were frequently a manifestation of cervical spondylosis with myelopathy. (Exs. 48-2, 49). Both physicians believed that claimant's C5-6 disc condition was work-related and caused his symptoms, which included clonus and hyperreflexia. We find that the opinions of Drs. Long and Keenen are sufficient to establish that claimant's work incidents were a material cause of his C5-6 disc condition.

The insurer relies on the ALJ's finding that there was no reasonable explanation as to how a lifting incident produced a disc injury at a level above the point where the leverage of lifting was applied. On the other hand, claimant contends that the ALJ incorrectly substituted his own medical opinion in reaching that conclusion.

The opinions of Drs. Long and Keenen establish that claimant's lifting incidents at work in May and June 1999 were a material cause of C5-6 disc condition. We find no medical evidence discussing the leverage of lifting, or that indicated the work incidents were not capable of causing claimant's disc condition. To the contrary, Dr. Gripekoven's diagnosis of a cervical strain resulting from the work episodes suggests that the incidents were sufficient to cause at least a muscular cervical condition.[4] In *Benz v. SAIF*, 170 Or App 22 (2000), the court held that, although the Board may draw reasonable inferences from the medical evidence, it is not free to reach its own medical conclusions about causation

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[3] "Myelopathy" is a general term denoting functional disturbances and/or pathological changes in the spinal cord. *Dorland's Illustrated Medical Dictionary* at 1090.

[4] The insurer acknowledges that the medical records may support the notion that claimant had a cervical strain as a result of the work incidents.

in the absence of such evidence. *See also SAIF v. Calder*, 157 Or App 224, 227-28 (1998) ("[t]he Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge"). In light of the persuasive opinions of Drs. Long and Keenen, we are not persuaded by the insurer's argument because we find no medical evidence that would allow us to draw a reasonable inference that claimant's work incidents were not capable of causing a cervical disc condition.

Although the insurer relies on the opinions of Drs. Gripekoven and Neumann, we do not find their opinions persuasive.

Drs. Neumann and Denekas examined claimant on one occasion in September 1999. They diagnosed a lumbosacral sprain, which was resolved, and a dorsal strain/sprain related to the work incident, which was still symptomatic. (Ex. 14-6). After reviewing later medical reports, Dr. Neumann opined that claimant's cervical condition was "related to the degenerative disk disease in the cervical spine." (Ex. 48A-1). However, Dr. Neumann did not explain what reports he relied on for diagnosing cervical degenerative disk disease, and we find no such reports in the record.[5] We find that Dr. Neumann's opinion on causation lacks adequate explanation and is entitled to little weight.

Dr. Gripekoven examined claimant on one occasion in March 2001 and reported that claimant was pain-free after his recovery from scoliosis surgery and was able to perform normal work and recreational activities until May of 1999. (Ex. 40-2). Nevertheless, Dr. Gripekoven opined that claimant's preexisting developmental scoliosis and prior dorsal fusion was the major contributing cause of his combined condition and need for ongoing treatment. (Ex. 40-7, -8). He also believed that claimant's current need for treatment was "possibly" related to a degenerative process in the cervical spine. (Ex. 40-8). Dr. Gripekoven did not believe claimant's cervical problems or the clonus in his lower extremities were related to any work exposure. (Ex. 40-8, -9).

As we explained previously, Dr. Keenen, who performed claimant's 1993 surgery for scoliosis, strongly disagreed with Dr. Gripekoven's opinion, explaining that there was no basis for finding that claimant's scoloiosis or prior surgery had anything to do with his neck symptoms. (Ex. 43). Dr. Keenen found no preexisting condition that had anything to do with claimant's cervical condition. (*Id.*) He adhered to that opinion in a deposition. (Ex. 44-10). We are more persuaded by the opinion of Dr. Keenen, who performed claimant's scoliosis surgery and treated him after the surgery. We find that Dr. Gripekoven's opinion that claimant's current condition was related to his scoliosis is entitled to less weight.

Dr. Gripekoven disagreed with Dr. Long's diagnosis of cervical myelopathy, explaining that it was unusual for lumbar pain to be associated with that condition, and noting that he had not seen specific lumbar pain relieved by cervical surgical intervention. (Exs. 50, 52). Again, we are more persuaded by the opinions of claimant's treating physicians, Drs. Long and Keenen, who explained that, although the relief of lumbar and lower extremity symptoms by cervical surgery was unusual, claimant did indeed have cervical myelopathy associated with the C5-6 disc condition, which was relieved by surgery.

In sum, based on the opinions of Drs. Long and Keenen, we conclude that claimant's work incidents in May and June 1999 were a material cause of his C5-6 disc condition. On the other hand, we find that the medical evidence is insufficient to establish that claimant's work incidents are related in material part to his C6-7 disc condition and, therefore, we affirm that portion of the ALJ's order that upheld the insurer's denial of that condition.[6]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the C5-6 disc condition. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's

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[5] We note that, although Dr. Neumann said he was not aware of "cervical symptoms occurring as a result of a myelopathy in the lumbar spine" (Ex. 48A-1), no physician has diagnosed claimant with lumbar myelopathy. Indeed, Dr. Long explained that lumbar myelopathy does not exist because the spinal cord ends at the upper margin of the lumbar spine. (Ex. 49). Instead, claimant has been diagnosed with *cervical* myelopathy.

[6] Dr. Long reported that claimant's cervical discography showed that the C6-7 disc was normal and not painful. (Ex. 42-1).

services at hearing and on review is $7,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated August 30, 2000, as reconsidered May 9, 2001, is reversed in part and affirmed in part. The insurer's denial of claimant's C5-6 disc condition is set aside and the claim is remanded to the insurer for processing according to law. For services on review, claimant's attorney is awarded $7,500, payable by the insurer. The remainder of the ALJ's order is affirmed.

September 7, 2001 Cite as 53 Van Natta 1155 (2001)

In the Matter of the Compensation of
CHRISTINA M. CARRILLO, Claimant
WCB Case No. 00-08120
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the self-insured employer's denial of claimant's injury claim for a cervical condition. On review, the issue is compensability.

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

Claimant compensably injured her right shoulder in September 1999.[1] The claim was closed in April 2000 without an award of permanent disability. (Ex. 55).

In September 2000, claimant requested that the employer amend its acceptance to include cervical strain and cervical radiculitis. (Ex. 80A). When the insurer declined to accept those conditions, claimant requested a hearing.[2] (Ex. 90).

The ALJ determined that Dr. Brenneke (attending physician since June 2000) offered the only causation opinion supporting the compensability of claimant's cervical condition. The ALJ further determined that Dr. Brenneke's opinion was not based on a complete history. Consequently, the ALJ concluded that Dr. Brenneke's opinion was not persuasive, and that claimant's cervical condition was not compensable.

To establish that her cervical condition 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 cervical condition. *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Because of possible alternative causes for claimant's condition condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion.[3] *See Uris v. Compensation Department*, 247 Or 420 (1967).

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[1] The accepted condition was a disabling right shoulder strain. (Ex. 27).

[2] The September 2000 denial was amended on October 27, 2000 to correct a typographical error. (Ex. 94).

[3] We acknowledge that the ALJ found claimant credible. Nonetheless, given the possible causes of claimant's cervical condition, resolution of the causation issue presents a complex medical question. Thus, although claimant's testimony is probative, the causation issue must be resolved by expert medical opinion. *See Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Ted A. Diggs*, 53 Van Natta 1012 (2001).

Dr. Brenneke's opinion is based on a history that claimant has had significant pain in the side of her neck since the September 1999 work incident. (Ex. 66-1). Contrary to that history, the contemporaneous medical records indicated that although claimant reported "some" right sided neck pain on September 23, 1999, her pain had decreased by September 30, 1999. (Exs. 8; 13). Furthermore, on December 2, 1999, claimant had no neck pain. (Ex. 35).

Because the contemporaneous medical records present a history different from the one relied on by Dr. Brenneke, and because Dr. Brenneke acknowledged that he did not have all the records available for review, we conclude that Dr. Brenneke's opinion rests on an incomplete and inaccurate history.[4] (Ex. 103). Consequently, we do not find Dr. Brenneke's opinion persuasive.[5] *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Accordingly, based on this record, we find that claimant's cervical condition is not compensable.

ORDER

The ALJ's order dated March 9, 2001 is affirmed.

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[4] Claimant asserts that Dr. Brenneke did have a "complete" history because he had reviewed the reports of Drs. Woodward and Fuller (employer-arranged examiners), which contain summaries of claimant's history. Assuming that Dr. Brenneke relied on those summaries, his opinion, nonetheless, rests on a foundation that claimant had significant pain in the side of her neck since September 22, 1999. The chart notes of claimant's then attending physician do not support the foundation for Dr. Brenneke's opinion. Thus his opinion is based on inaccurate information; it is, therefore, unpersuasive. *See Michael J. Crouch*, 53 Van Natta 303, 304 (2001) (medical opinion based on inaccurate information entitled to little weight).

[5] We acknowledge claimant's argument that the initial accepted condition (shoulder strain) was misdiagnosed. Rather, claimant asserts that it should have been diagnosed as a cervical strain and cervical radiculitis. We note, however, that there is no medical opinion in the record supporting claimant's "misdiagnosis" theory. Consequently, we reject claimant's argument.

In the Matter of the Compensation of
WILLIAM E. STORMS, Claimant
WCB Case No. TP-01002
THIRD PARTY ORDER OF DISMISSAL
Williams, et al., Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant submitted a petition to the Board seeking resolution of a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. *See* ORS 656.593(3). Thereafter, we approved a Claim Disposition Agreement (CDA) in which the parties documented their agreement regarding the distribution of proceeds from claimant's third party settlement.[1]

The Board's authority in third party cases involving disputes under ORS 656.593(3) is to resolve "[a]ny conflict as to what may be a just and proper distribution[.]" Based on the parties' agreements and the insurer's announcement, it is apparent that such a conflict no longer exists. Consequently, this matter is dismissed.

IT IS SO ORDERED.

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[1] The CDA expressly provides that the "[i]nsurer hereby waives any claim and/or right to recover this settlement sum from the proceeds of a third-party recovery obtained by claimant[.]" Based on the approved CDA, as well as an ALJ-approved Disputed Claim Settlement, the insurer announces that the pending third party dispute is moot because the insurer relinquishes/waives any claim to the disputed sum.

In the Matter of the Compensation of
JOHN K. HARKNESS, Claimant
WCB Case No. 97-08467
ORDER ON REMAND
Gayle A. Shields, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl. Member Haynes concurring.

This matter is before the Board on remand from the Court of Appeals. *Harkness v. SAIF*, 171 Or App 329 (2000), *rev den* 331 Or 692 (2001). The court has reversed our prior order, *John K. Harkness*, 50 Van Natta 2055 (1998), that upheld the SAIF Corporation's "preclosure" denial of claimant's current low back condition. Concluding that we did not make a finding as to whether SAIF's acceptance occurred before its current "combined condition" denial, the court has remanded for reconsideration. Having received supplemental briefs from the parties, we proceed with our review.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with minor changes, which we summarize as follows.

On November 29, 1996, claimant, a mechanic, injured his low back while lifting a rebuilt engine. (Ex. 3). He sought emergency room treatment and was diagnosed with a lumbar strain. (Exs. 2, 3). On December 19, 1996, SAIF accepted a disabling lumbar strain. (Ex. 4).

Claimant returned to work on January 3, 1997, but his symptoms continued. (Ex. 5). On January 13, 1997, Dr. Freistat took claimant off work until January 20, 1997. Although claimant was subsequently released to modified work, there was no such work available. (Exs. 5, 7-2).

On January 26, 1997, claimant lifted his 25-pound grandchild and experienced sudden severe pain in the left lumbar back. (Ex. 7-2). In February 1997, he began treating with Dr. Ward, who determined that claimant had degenerative disc disease and degenerative joint disease in his lumbar spine. (Exs. 7, 8, 8A, 9, 9A, 18, 19). On March 31, 1997, Dr. Ward reported that claimant's lumbar strain had combined with his preexisting degenerative disc disease and degenerative joint disease to prolong his disability or need for treatment. (Ex. 11).

On August 5, 1997, claimant was examined by Dr. Dinneen, on behalf of SAIF. He concluded that claimant was medically stationary and his preexisting degenerative condition was the major contributing cause of the current low back condition. (Ex. 21).

Dr. Ward found that claimant's low back condition was medically stationary on August 8, 1997, and he performed a closing examination. (Exs. 22, 30).

On August 25, 1997, SAIF issued a denial of claimant's current condition. (Ex. 24). SAIF explained that claimant's accepted lumbar strain combined with one or more preexisting conditions and claimant's injury had ceased to be the major cause of treatment and disability of the combined condition. (*Id.*)

On August 26, 1997, SAIF issued a Notice of Closure that awarded only temporary disability benefits. (Ex. 26). A January 5, 1998 Order on Reconsideration affirmed the Notice of Closure. (Ex. 30A).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that SAIF's denial of his current lumbar condition was procedurally improper because it was issued prior to closure and SAIF did not accept a combined condition. The ALJ agreed that SAIF had not accepted a combined condition and, therefore, ORS 656.262(7)(b)[1] did not apply to the claim. The ALJ set aside SAIF's denial as procedurally improper.

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[1] ORS 656.262(7)(b) provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

On review, we reversed the ALJ's order. We relied on *Tracey A. Blamires*, 50 Van Natta 1793 (1998), which was issued after the ALJ's order and was later reversed by the Court of Appeals. *Blamires v. Clean Pak Systems*, 171 Or App 263 (2000). We rejected claimant's argument that SAIF's denial was procedurally improper, reasoning that the accepted injury had combined with a preexisting condition to cause or prolong disability or a need for treatment. We concluded that claimant's preexisting degenerative condition was the major contributing cause of his current low back condition and we upheld SAIF's partial denial of the current low back condition.

Claimant appealed, arguing that SAIF's denial was premature based on *Croman Corp. v. Serrano*, 163 Or App 136 (1999), which was decided after our order issued. The court remanded for us to determine whether SAIF's acceptance occurred before its denial.

In *Croman Corp.*, 163 Or App at 140-41, the court determined that, when ORS 656.005(7)(a)(B) is read with the language of ORS 656.262(6)(c),[2] it was clear that a combined condition must have been accepted before it may be denied under the statute. In *Blamires v. Clean Pak Systems*, 171 Or App at 267, the court explained that "[t]he rule of *Croman Corp.* is that, under the wording of ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition." The court rejected our conclusion in *Blamires* that it was not necessary for the carrier to first accept a combined condition in order to take advantage of the right to deny the claimant's combined condition under ORS 656.262(7)(b).

Here, on remand, SAIF argues that it accepted a combined condition before the August 25, 1997 current condition denial or, alternatively, that its processing of the claim indicated an acceptance of claimant's combined condition prior to its denial. On the other hand, claimant contends that SAIF did not accept a combined condition and that we should affirm the ALJ's order that found SAIF's current condition denial was procedurally improper.

The scope of SAIF's acceptance is a question of fact. *See SAIF v. Dobbs*, 172 Or App 446 (2001); *SAIF v. Tull*, 113 Or App 449 (1992).

On December 19, 1996, SAIF accepted a disabling lumbar strain. (Ex. 4). Thus, the only condition specifically accepted in writing was a lumbar strain. *See Johnson v. Spectra Physics*, 303 Or 49, 58 (1987). SAIF acknowledges that, at that time, there was no evidence of a combined condition.

Nevertheless, SAIF contends that the language in the current condition denial "implies" that the combined condition was accepted because claimant's disability and the treatment for it, at some point in the past, became treatment for a combined condition. SAIF argues that, even though the denial does not specify the date on which claimant's condition became a combined condition, the document is clear that it did combine in the past, and the "obvious implication" is that the combined condition was part of the accepted claim.

SAIF's August 25, 1997 denial stated, in part:

> "You filed a claim for a work-related injury to your back, which occurred on or about November 29, 1996, while you were employed at [the employer]. *That claim was accepted for lumbar strain* and benefits were provided according to law.
>
> "Our information indicates that you continue to seek treatment for your condition. We have investigated the circumstances of your current condition and have determined that it is not compensable for the following reasons:

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[2] ORS 656.262(6)(c) provides:

> "An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

"Your accepted lumbar strain combined with one or more preexisting condition(s). However, your injury has ceased to be the major cause of the treatment and disability of the combined condition.

"Therefore, we must deny the compensability of your current condition.

"This denial will result in claim closure." (Ex. 24; emphasis supplied).

On August 26, 1997, SAIF issued an updated notice of acceptance at closure, which stated that the accepted condition for the November 29, 1996 injury was a lumbar strain. (Ex. 25). *See* ORS 656.262(7)(c) (when the claim qualifies for closure, the carrier shall issue an updated notice of acceptance that specifies which conditions are compensable). Also on August 26, 1997, SAIF issued a Notice of Closure that awarded only temporary disability. (Ex. 26). SAIF's "notice of closure summary" indicated that the accepted condition was a lumbar strain. (Ex. 27).

We are not persuaded by SAIF's argument that the language in the current condition denial "implies" that a combined condition was accepted. To the contrary, SAIF's August 25, 1997 denial specifically stated that the claim was "accepted for lumbar strain[.]" (Ex. 24). Furthermore, SAIF's updated notice of acceptance at closure issued the following day referred to the accepted condition for the November 29, 1996 injury as a lumbar strain, and SAIF's August 26, 1997 "notice of closure summary" indicated that the accepted condition was a lumbar strain. (Exs. 25, 27).

SAIF argues that, even though the denial does not specify the date on which claimant's condition became a combined condition, the document is clear that it did combine in the past. We disagree. Although SAIF's August 25, 1997 denial said that the "accepted lumbar strain combined with one or more preexisting condition(s)[,]" it did not explain when the "combination" occurred, nor did it state that SAIF had actually *accepted* a combined condition. We conclude that the preponderance of evidence establishes that SAIF accepted only a lumbar strain, not a combined condition, before it issued the August 25, 1997 denial.[3] *See Tracey A. Blamires*, 53 Van Natta 701 (2001) (third order on remand) (record did not establish that the carrier accepted a combined condition prior to the issuance of its denials).

Alternatively, SAIF relies on *Mitchell J. Thompson*, 50 Van Natta 289 (1998), and contends that, even if the denial itself does not implicitly express SAIF's acceptance of the combined condition, the record supports the conclusion that claimant's lumbar strain was accepted as a combined condition once the medical records indicated that it had combined.

In *Thompson*, the issue was whether the employer's preclosure denial was valid. The carrier had accepted disabling "cervical radiculopathy" and later denied the claimant's current cervical radiculopathy condition on the basis that the compensable injury was no longer the major cause of the current condition and related disability. We reasoned that, in order to determine whether ORS 656.262(6)(c) applied, it was first necessary to make a factual decision regarding what condition(s) (combined or otherwise) were accepted by the carrier. We found that the acceptance was ambiguous concerning whether or not the carrier voluntarily accepted the claimant's radiculopathy as a combined condition, because the notice of acceptance did not state that the claimant's "radiculopathy" was accepted as a

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[3] SAIF relies on *Jeff E. White*, 53 Van Natta 220 (2001), asserting that an acceptance and denial can occur in the same document. In *White*, the carrier issued a document entitled "Notice of Modified Acceptance and Denial," in which it accepted a "combined condition," effective on an earlier date, and also denied that combined condition. We concluded that ORS 656.262(6)(c) was sufficiently broad to include both the issuance of separate documents evidencing the acceptance and denial of a "combined condition," as well as the acceptance and "later" denial of a "combined condition" in the same document, provided that the time period for the acceptance of the combined condition and later denial was explicit. We found that the carrier's denial was procedurally valid. *See also John J. Shults*, 53 Van Natta 383 (2001) (acceptance of a combined condition and a denial of a combined condition, issued on the same day, but in separate documents, was permissible under ORS 656.262(6)(c)).

In *White*, there was no dispute as to whether the carrier had actually accepted a combined condition. Instead, the dispute was whether ORS 656.262(6)(c) prohibited a carrier from simultaneously accepting and denying a "combined condition" in one document. Here, in contrast, the parties dispute whether SAIF had accepted a combined condition before issuing its August 25, 1997 denial. For the reasons discussed above, we are not persuaded that SAIF accepted a combined condition.

combined condition. We reviewed medical records in existence *prior to the carrier's acceptance* that referred to preexisting degenerative disc disease that combined with the claimant's lifting injury. Under those circumstances, we found that the record supported the carrier's assertion that the claimant's cervical radiculopathy was accepted as a combined condition.

Here, in contrast, SAIF acknowledges that, at the time of the December 19, 1996 acceptance of a lumbar strain, there was no evidence of a combined condition. Unlike in *Thompson*, there are no medical records in existence before SAIF's acceptance that referred to a preexisting condition that combined with claimant's lumbar strain. Therefore, we find that SAIF's reliance on *Thompson* is misplaced.

On remand, we agree with the ALJ that SAIF did not accept a combined condition and, therefore, SAIF's August 25, 1997 "preclosure" denial was procedurally improper. *See Blamires v. Clean Pak Systems*, 171 Or App at 267; *Croman Corp.*, 163 Or App at 140-41.

Penalties

The ALJ found that there was no compensation due at the time SAIF issued the August 25, 1997 denial. Nevertheless, the ALJ assessed a penalty-related attorney fee pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation.

In its previous brief on Board review, SAIF argued that its denial was not unreasonable and, in any event, claimant was not entitled to a penalty-related attorney fee because he made no showing that there was any compensation due which SAIF resisted paying. In light of our previous conclusion that the underlying claim was not compensable, we reversed the penalty-related attorney fee. On appeal to the court, claimant argued that the ALJ properly awarded a fee under ORS 656.382(1).

On remand, we agree with the ALJ that there is no evidence that there are any "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. Under these circumstances, claimant is not entitled to a penalty or penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991).

Attorney Fees

Where a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1). In addition to the attorney fees previously awarded by the ALJ ($3,000), we award a reasonable carrier-paid attorney fee for claimant's counsel's services before the Board (on review and on remand) and the court. We determine the amount of attorney fees by applying the factors 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; the skill of the attorneys; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on Board review, before the court, and on remand is $8,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the "preclosure denial" issue (as represented by claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Claimant's attorney is not entitled to an attorney fee for services concerning the penalty or attorney fee issues. *See Saxton v. SAIF*, 80 Or App 631, rev den 302 Or 159 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

Accordingly, the ALJ's order dated March 18, 1998 is affirmed in part and reversed in part. That portion of the ALJ's order that assessed a $500 attorney fee pursuant to ORS 656.382(1) is reversed. The remainder of the ALJ's order is affirmed. In lieu of the ALJ's attorney fee award, for services performed before the Hearings Division, Board, and court, and on remand, claimant's attorney is awarded a total of $11,000, payable by SAIF.

IT IS SO ORDERED.

Board Member Haynes concurring.

I agree with the lead opinion that SAIF has not established that it accepted a combined condition and that its August 25, 1997 denial was therefore procedurally improper. I write separately to express my concerns about denials issued pursuant to ORS 656.262(7)(b) or 656.262(6)(c).

The interpretation of those statutes has changed over the years. In *Robin W. Spivey*, 48 Van Natta 2363 (1996), we determined that ORS 656.262(7)(b) could not apply unless the accepted condition, whether voluntary or by litigation, was a combined condition. However, in *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998), we disavowed *Spivey* and its progeny to the extent that those cases held that ORS 656.262(7)(b) applied only when the carrier had expressly accepted a combined condition. We concluded that, even if a carrier had not accepted a combined condition, the carrier may avail itself of the "pre-closure" denial procedure in ORS 656.262(7)(b) whenever the medical evidence established that the compensable injury has combined with a preexisting condition to cause or prolong disability or a need for treatment.

The Court of Appeals subsequently decided *Croman Corp. v. Serrano*, 163 Or App 136 (1999), and *Blamires v. Clean Pak Systems*, 171 Or App 263 (2000). Those cases held that, in order for a carrier to have properly issued a preclosure denial under ORS 656.262(7)(b) or 656.262(6)(c), it must have accepted a combined condition. *Blamires*, 171 Or App at 267; *Serrano*, 163 Or App at 141. Thus, unless the Court of Appeals revisits its holding or the Supreme Court rules differently, the rule is that a carrier must first accept a combined condition before it may issue a "pre-closure" denial under ORS 656.262(7)(b) or 656.262(6)(c).

Here, SAIF argues that the language in the August 25, 1997 current condition denial "implies" that the combined condition was accepted because claimant's disability and the treatment for it, at some point in the past, became treatment for a combined condition. Although I would not rule out the possibility that there could be an acceptance of a combined condition implied in a denial in a future case, I agree with the lead opinion that the preponderance of evidence in this case establishes that SAIF accepted only a lumbar strain, not a combined condition, before it issued its denial. In reaching that conclusion, I would like to emphasize that SAIF's argument about an implied acceptance of a "combined condition" is inconsistent with the fact that its updated notice of acceptance at closure referred to the accepted condition as a lumbar strain, and its August 26, 1997 "notice of closure summary" also indicated that the accepted condition was a lumbar strain. (Exs. 25, 27).

ORS 656.262(6)(b)(F) provides that the notice of acceptance shall "[b]e modified by the insurer or self-insured employer from time to time as medical or other information changes a previously issued notice of acceptance." ORS 656.262(7)(c) requires carriers to issue an updated notice of acceptance at claim closure that specifies which conditions are compensable. Thus, ORS 656.262(7)(c) and ORS 656.262(6)(b)(F) indicate that the legislature intended to allow a carrier to modify its notice of acceptance and then clarify the accepted conditions at claim closure by issuing an updated notice of acceptance.

In order to find that a carrier has accepted a combined condition before it issued a "combined condition" denial, the carrier must clearly document the fact that it has accepted a combined condition. In *Gerry L. Schreiner*, 51 Van Natta 1998 (1999), the carrier expressly accepted a "combined condition of cervico-thoracic strain superimposed upon unrelated and pre-existing degenerative disc disease and narrow intervertebral foramina (cervical)." We found that the carrier had accepted a combined condition and, therefore, it was authorized to issue a "preclosure" denial under ORS 656.262(6)(c) and ORS 656.262(7)(b). Similarly, in *Billie L. Lore*, 51 Van Natta 1957 (1999), the carrier modified its acceptance to accept a cervical strain injury combined with preexisting conditions, including degenerative disc disease at C5-6. Because the carrier accepted a combined condition, it was authorized to issue a "preclosure" denial under ORS 656.262(6)(c).

In processing future cases, I urge carriers to provide clear evidence of the acceptance of a combined condition, preferably in a separate document, rather than combined with a denial. *See John J. Shults*, 53 Van Natta 383 (2001); *compare Jeff E. White*, 53 Van Natta 220 (2001). This case illustrates the problems that can result when a carrier does not carefully document the fact that it has accepted a combined condition.

In the Matter of the Compensation of
JAMES M. HILL, Claimant
WCB Case No. 99-07206
ORDER OF DISMISSAL
H. Thomas Andersen (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Fitzwater's order that upheld the SAIF Corporation's denial of his injury claim for a low back condition. Because the record does not establish that the Board received a timely request for review of the ALJ's order, we dismiss.

FINDINGS OF FACT

On January 10, 2000, the ALJ issued an order upholding SAIF's denial of claimant's low back injury claim. 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 Board review must be mailed to the other parties within the 30-day appeal period.

On August 15, 2001, the Board received from SAIF's attorney a copy of claimant's letter requesting Board review. The letter, which is undated, was mailed by regular mail to SAIF's address in an envelope postmarked February 7, 2000.

On August 24, 2001, the Board mailed its computer-generated letter to all parties acknowledging its August 15, 2001 receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

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

Here, the 30th day after the ALJ's January 10, 2000 order was February 9, 2000. Therefore, February 9, 2000 was the final day to perfect a timely appeal of the ALJ's order. Although claimant's undated request for review was mailed to SAIF on February 7, 2000, there is no evidence in the record that the request for review was mailed to the Board at its correct mailing address within 30 days of the ALJ's January 10, 2000 order. *See Sandra E. Post*, 48 Van Natta 1741 (1996), *on recon* 49 Van Natta 22 (1997); *Jean F. Johnson*, 42 Van Natta 922 (1990). Because the request was received by the Board on August 15, 2001, it was "filed" on that date. *See* OAR 438-005-0046(1)(b). Inasmuch as August 15, 2001 is more than 30 days after the ALJ's January 10, 2000 order, the request is untimely.[1] Consequently, we lack authority to review the ALJ's January 10, 2000 order which has become final by operation of law. *See* ORS 656.289(3); 656.295(2); *Argonaut Insurance Co. v. King, supra; Robert G. Ebbert*, 40 Van Natta 67 (1988).

We are mindful that claimant has apparently 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 Worker's 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 E. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

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[1] In the event that claimant can establish that he mailed his request for review to the Board on or before February 9, 2000, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Since our authority to reconsider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible.

In the Matter of the Compensation of
MARGO K. HUNTSMAN, Claimant
WCB Case No. 00-06441
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) directed SAIF to reopen and process claimant's additional left knee conditions under ORS 656.262 and ORS 656.268; and (2) assessed a penalty under ORS 656.262(11)(a) for SAIF's allegedly unreasonable claim processing. On review, the issues are jurisdiction, claim processing and penalties.

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

Claimant compensably injured her left knee on October 9, 1975. Claimant's knee condition worsened in 1997. On November 9, 1997, SAIF filed an Own Motion Recommendation with the Board, recommending that the claim be reopened.

On March 15, 2000, claimant's counsel requested that SAIF expand its acceptance to include claimant's lateral meniscus and left knee arthritis conditions. (Ex. 14). On May 16, 2000, SAIF responded by asserting that it had accepted these additional conditions by virtue of its November 6, 1997 Own Motion Recommendation. On August 25, 2000, claimant requested a hearing alleging that SAIF had failed to process her new medical condition claim. The ALJ directed SAIF to reopen claimant's claim for processing of the additional medical conditions and assessed a penalty for SAIF's unreasonable claim processing in contravention of case law from the Board and Court of Appeals. *See SAIF v. Ledin*, 174 Or App 61, 62 (2001); *John R. Graham*, 51 Van Natta 1740 (1999).

At hearing and on review, SAIF contends that claimant's request for hearing regarding its failure to process claimant's new medical conditions was time-barred under ORS 656.319(6), because it was not made within two years of its November 6, 1997 Own Motion recommendation. SAIF cites to *Delinda S. French-Davis*, 53 Van Natta 389, *on recon* 53 Van Natta 583 (2001).[1] We disagree with SAIF's contention.

ORS 656.319(6) provides: "A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

In *French-Davis*, the carrier stipulated to accept the claimant's claim for a lumbar strain in May 1995. The carrier then issued a notice of acceptance for the lumbar strain condition in December 1997.[2] 53 Van Natta at 390. In October 1998 and April 2000, the claimant specifically requested the carrier to process the lumbar strain condition. We concluded that, in those particular circumstances, we would consider the "alleged action or inaction" to be the carrier's December 1997 notice of acceptance. ORS 656.319(6). We held that the claimant's June 2000 request for hearing alleging that the carrier had not properly processed his lumbar strain condition, which was more than two years after the December 1997 Notice of Acceptance, was time-barred under ORS 656.319(6). *Id.* at 391.

Initially, we note that our decision in *French-Davis* was limited to its particular facts. 53 Van Natta at 390. In other words, a carrier's notice of acceptance may not in all cases constitute the "alleged action or inaction" from which the two-year limitation in ORS 656.319(6) is calculated. Nevertheless, here, in contrast to *French-Davis*, SAIF did not issue a formal acceptance of claimant's claim for the additional conditions of left knee arthritis and lateral meniscus tear. SAIF contends that its November 6, 1997 Own Motion Recommendation to the Board, in which it acknowledged compensability of these conditions, constitutes an "acceptance" that tolls the two-year time limitation in ORS 656.319(6), because the duty to process these conditions under ORS 656.262(7)(c) arose at this time. (Ex. 3-3). We disagree.

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[1] Although SAIF raised this issue in its "Trial Memorandum," the ALJ did not address it.

[2] This acceptance was after the 1997 amendments to ORS 656.262(6)(d) and ORS 656.262(7)(c) in regard to processing of new and omitted medical condition claims.

We note that SAIF acknowledged in its Own Motion Recommendation that "[Claimant's] current left knee condition is compensable." (Ex. 3-1). However, in answer to specific questions on the form, SAIF declared that claimant's "accepted condition" was "medial meniscus tear of the left knee," but identified claimant's "current condition" as "torn lateral meniscus and arthritis of the left knee." (Ex. 3-3). Because SAIF drew a distinction between claimant's "accepted" condition and the "current condition," we are not persuaded that SAIF accepted the torn lateral meniscus and arthritis conditions through its November 6, 1997 Own Motion Recommendation.[3] Claimant was therefore not required to request a hearing within two years of SAIF's November 6, 1997 Own Motion Recommendation. ORS 656.319(6).

Finally, even if we assume that SAIF's May 16, 2000 letter to claimant's counsel constituted an "acceptance" that tolled the two-year limitation in ORS 656.319(6), claimant's August 25, 2000 request for hearing was made well within that time frame. Consequently, we find that claimant's request for hearing regarding processing of her additional left knee conditions was not time-barred under ORS 656.319(6).

On the issue of penalties, SAIF contends that its actions in failing to process claimant's claims under ORS 656.262 and ORS 656.268 were reasonable in light of its petition for review of the court's decision in *SAIF v. Ledin*, 174 Or App 61 (2001). SAIF contends that it relied on a good faith argument for extension or reversal of existing law, citing *Westfall v. Rust International*, 314 Or 533 (1992). We rejected that argument in *William L. Adams*, 53 Van Natta 528 (2001); *see also Raymond L. Presnell*, 53 Van Natta 675 n1 (2001).

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 438-010-0015(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee award for services on review devoted to the penalty issue. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated May 11, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

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[3] SAIF's May 16, 2000 letter to claimant's counsel referenced the November 6, 1997 Own Motion Recommendation, and asserted that "As of November 6, 1997, this [torn lateral meniscus and arthritis of the left knee] is the accepted condition in this claim." (Ex. 19). However, SAIF's own interpretation of its Own Motion Recommendation more than two years after the fact is not persuasive.

We further note that an Own Motion Recommendation does not meet the requirement for a formal Notice of Acceptance under ORS 656.262(6)(b). *See Maurice E. Thorne*, 53 Van Natta 1087 (2001); *Alvino H. Guardiola*, 53 Van Natta 1009, 1010-11 (2001).

In the Matter of the Compensation of
VIRGIL L. MATHIA, Claimant
WCB Case No. 00-08839
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich, Bock, and Meyers. Member Meyers chose not to sign the order.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that: (1) held that SAIF must reopen and process claimant's new medical condition claim under ORS 656.262(7)(c) and ORS 656.268; (2) assessed a penalty under ORS 656.268(5)(d) based on SAIF's allegedly unreasonable failure to close claimant's new medical condition claim pursuant to ORS 656.268; and (3) awarded an assessed attorney fee pursuant to ORS 656.382(1). On review, the issues are claim processing, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation. *See, e.g., William L. Adams*, 53 Van Natta 528 (2001) (Board declines to revisit its decision in *John R. Graham*, 51 Van Natta 1740 (1999); penalty awarded by ALJ was appropriate); *Larry L. Ledin*, 52 Van Natta 680 (2000), *aff'd SAIF v. Ledin*, 174 Or App 61 (2001).

On the penalty issue, SAIF contends that its failure to reopen and close claimant's claim was not unreasonable because it was relying on a good faith argument for extension or modification of existing law, citing *Westfall v. Rust International*, 314 Or 533 (1992). Specifically, SAIF argues that the issue presented in *John L. Graham* had not yet been decided by the Court of Appeals, and it therefore had a legitimate doubt as to its processing obligations. We decided that issue adversely to SAIF in *William L. Adams*, 53 Van Natta at 528, 529. *See also Raymond L. Presnell*, 53 Van Natta 675 n1 (2001).

SAIF also contends that a penalty under ORS 656.268(5)(d) and attorney fee under ORS 656.382(1) are not both awardable for the same instance of "unreasonable" conduct, citing *Cindy A. Schrader*, 46 Van Natta 175 (1994) and *Robert E. Wolford*, 45 Van Natta 573 (1993). We disagree.

ORS 656.268(5)(d) provides as follows:

> "If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, 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."

In *Schrader* and *Wolford*, we awarded both a penalty under ORS 656.268(5)(d) and an attorney fee under ORS 656.382(1). Each case involved separate instances of unreasonable conduct by the carrier. However, in neither case did we hold or suggest that there *must* be two separate instances of unreasonable conduct as a prerequisite to both a penalty under ORS 656.268(5)(d) and an attorney fee under ORS 656.382(1).

To the contrary, we note that unlike ORS 656.262(11)(a), ORS 656.268(5)(d) does not provide that a penalty assessment is "in lieu of an attorney fee." That phrase was the basis for the proposition that the same unreasonable conduct cannot form the basis for both a penalty under ORS 656.262(11) (or its former version, ORS 656.262(10)) and an attorney fee under ORS 656.382(1). *See Martinez v. Dallas Nursing Home*, 114 Or App 453, *rev den* 315 Or 271 (1992). Therefore, because the statutory predicate for the assessment of a penalty pursuant to ORS 656.268(5)(d) has been satisfied, we decline to reverse the ALJ's assessment.

Finally, as previously noted, the ALJ awarded claimant's counsel an assessed attorney fee pursuant to ORS 656.382(1) for an unreasonable resistance to the payment of compensation. On review, SAIF contends that the ALJ's attorney fee award should be reversed because the record does not establish that it resisted the payment of any compensation payable to claimant. However, on review, neither party contests the ALJ's statement that "SAIF does not dispute that claimant's attorney is

entitled to an assessed fee pursuant to ORS 656.382(1) should claimant prevail [on claimant's contention that SAIF unreasonably refused to close claimant's new medical condition claim]." (O&O at 4). In light of the ALJ's undisputed conclusion, we decline to address SAIF's contention.

Claimant's attorney is entitled to an assessed attorney fee for 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 attorney's services on review concerning the claim processing issue is $750, to be paid by SAIF. 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 attorney is not entitled to an attorney fee for services on review regarding the penalty or attorney fee issues. *Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 28, 2001 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
FRANK J. SHERWOOD, III, Claimant
WCB Case No. 00-01610
ORDER ON REVIEW
Swanson, Lathen, et al., Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) found that certain medical billings were causally related to claimant's compensable low back injury; and (2) awarded an attorney fee of $3,000. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

On review, the employer contends that the proper test to prove the need for medical services is the major contributing cause standard, not material contributing cause. We would reach the same conclusion under the "major contributing cause" standard of proof, based on Dr. Van Veen's persuasive opinion. *See* ORS 656.245(1)(a)[1]; *Mohr v. Barrett Business Services*, 168 Or App 579 (2000).

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[1] ORS 656.245(1)(a) provides:

"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."

In reaching this conclusion, we acknowledge that a number of non-work-related factors may have contributed to claimant's current need for medical services. Nonetheless, after reviewing the record, we are persuaded that Dr. Van Veen's opinion that the major contributing cause of claimant's need for medical services is his accepted 1981 low back condition. Dr. Van Veen, who had been treating claimant's low back for many years, opined that claimant's 1981 low back injury was the major contributing cause of his continuing low back pain and treatment when compared with all of the major or minor causes of his back pain. (Ex. 67). There is no contrary medical evidence. Accordingly, claimant has established that his need for medical services is compensable.

Attorney Fee

The ALJ awarded a $3,000 assessed attorney fee for services related to prevailing over the employer's assertion that claimant's medical services were not compensably related to the 1981 injury claim. On review, the employer argues that the ALJ's $3,000 attorney fee award was excessive, because the issue was compensability of medical bills, the hearing was short, and claimant prepared the master index of exhibits on the date of hearing to supplement the exhibits that had already been sent in by the employer. Claimant responds that the attorney fee was appropriate, because the dispute involved questions of compensability and causation regarding a 1981 injury. Claimant provided an affidavit establishing that his attorney devoted 17.6 hours on the case at the hearing level.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4), as applied to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute at the hearing was the compensability of, and the payment of medical bills for, claimant's current low back condition. The hearing lasted one hour and twenty minutes, including closing arguments. The record consists of: (1) a 20-page transcript that included one witness (claimant); and (2) 77 exhibits. The case involved issues of average factual and legal complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are less than average, consisting of medical bills for claimant's current low back condition. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous challenge to compensability.

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 for services at the hearings level. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, the nature of the proceeding, and the risk that claimant's counsel might go uncompensated.

In addition, claimant's attorney is entitled to an assessed fee for services on review relating to the compensability of the medical services issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding this issue is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services related to the attorney fee issue. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated March 6, 2001 is affirmed in part and modified in part. In lieu of the ALJ's attorney fee award for services at hearing, we award $2,500, payable by the self-insured employer. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $500, payable by the employer.

In the Matter of the Compensation of
MICHAEL K. DAVIN, Claimant
WCB Case Nos. 00-02193, 00-02192 & 00-00983
ORDER ON REVIEW
Fontana & Takaro, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney
Julie Masters (Saif), Defense Attorney
Randy Rice, Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) upheld Paula Insurance Company/Valley Enterprises' compensability and responsibility denials of his current low back condition involving L4-5 and L5-S1 disc herniations; (2) upheld the SAIF Corporation/Valley Enterprises' compensability and responsibility denials of the same condition; (3) upheld Liberty Northwest Insurance Corporation/Superior Tire Service's compensability and responsibility denials of the same condition; and (4) declined to assess a penalty for SAIF/Valley Enterprises' allegedly unreasonable failure to accept or deny his claim in a timely manner. On review, the issues are compensability, responsibility and penalties.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] In the first paragraph of the findings of fact on page 1, we replace the last sentence with the following:

> "In October 1998, claimant sought treatment for back pain and was diagnosed with myofascial low back pain. (Ex. 1). The nurse practitioner's chart note said that 'progressively over the last several years [claimant] has had fairly well-localized back pain.' (*Id.*) Claimant did not experience any lower extremity pain or numbness before 1999."

In the first full paragraph on page 4, we change the first citation after the second sentence to "Ex. 49-13." At the end of the second full paragraph on page 6, we add the following citation: "Ex. 49-20." In the second full paragraph on page 8, we change the date in the fourth sentence to "August 1999." On page 9, we change the citation after the second full sentence to "(Ex. 52-15, -16, -35)." In the first full paragraph on page 10, we delete the first sentence.

On review, claimant argues that SAIF's denial was procedurally invalid, based on *Croman Corp. v. Serrano*, 163 Or App 136 (1999), and *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263 (2000). SAIF contends that the Board should not address this issue because claimant raises it for the first time on review.

We find no evidence that claimant challenged the procedural validity of SAIF's denial at hearing. We generally do not consider issues that are not raised at hearing. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). Moreover, we have previously declined to consider a challenge to the procedural validity of a denial raised for the first time on review. *See, e.g., Robin A. Rohrbacker*, 53 Van Natta 51 (2001). We reach the same conclusion in this case and decline to address the procedural validity of SAIF's denial.

ORDER

The ALJ's order dated April 5, 2001 is affirmed.

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[1] We modify the ALJ's order to note that Exhibit 28 was excluded. (Tr. II-3).

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's order that found claimant's L4-5 and L5-S1 disc herniations were not compensable. Because I believe that the ALJ and the majority have misinterpreted the medical evidence, I respectfully dissent.

I begin by reviewing some of the pertinent facts. Claimant's work for both employers involved repairing and servicing car and semi-truck tires that weighed up to 200 pounds. The wheels weighed at least 100 pounds. On February 16, 1999, claimant injured his low back while servicing tires for the employer, who was then insured by Paula Insurance Company (Paula). Paula accepted a low back strain and the claim was closed by an August 16, 1999 Notice of Closure, without a permanent disability award. (Exs. 9, 11).

On July 1, 1999, the employer's workers' compensation insurance coverage shifted to the SAIF Corporation.

On August 20, 1999, claimant injured his back when he attempted to lift a heavy tire weighing about 400 pounds. He felt immediate low back pain, and experienced right leg pain shortly thereafter. Although claimant had some leg symptoms before the August 1999 injury, the pain was now more intense. Claimant's symptoms continued to worsen. A lumbar MRI on November 2, 1999 showed a right paracentral disc herniation at L5-S1 with probable compromise of the right S1 nerve root, as well as a right paracentral disc herniation at L4-5 with a possible compromise of the right L5 nerve root in the lateral recess. (Ex. 20). Claimant eventually sought treatment from Dr. Rohrer, who performed surgery on April 19, 2000, which included right L4-5 and right L5-S1 laminotomies, right L4-5 and L5-S1 microdiscectomies, and a microdissection. (Ex. 40B).

The ALJ (and the majority) discounted Dr. Rohrer's opinion on the basis that he had an inaccurate understanding regarding the onset of claimant's right leg symptoms. Claimant argues that the ALJ incorrectly assumed that, in the absence of radiculopathy, there can be no clinically significant herniation or nerve root compression. In addition, claimant contends that the ALJ misunderstood the variation in and the significance of the leg symptoms he experienced after the August 1999 injury. Claimant is correct.

Dr. Rohrer's opinion is well-reasoned and persuasive, and establishes compensability of his L4-5 and L5-S1 disc herniations. Dr. Rohrer related the disc herniations to when "a patient develops within a reasonable amount of time like symptoms, radicular symptoms or sciatic symptoms in their legs." (Ex. 52-15). He did not believe it was necessary to have the other signs of radiculopathy, including reflex changes, sensory changes and strength changes. (Ex. 52-18). Instead, he said that usually pain is the first presenting problem. (*Id.*) Because claimant had leg pain symptomatic of nerve root irritation in August 1999, and no other explanation for the irritation, Dr. Rohrer dated the herniation and resulting nerve root irritation to that time. (Ex. 52-15 to -18).

Dr. Rohrer initially understood that claimant began to have right leg symptoms after the August 20, 1999 injury. (Ex. 52-15, -16). He later learned that claimant had some leg pain in the weeks before the August 20, 1999 injury. However, claimant's testimony established that the pain after the August 20, 1999 injury was of a different level and nature. Claimant described the symptoms after that injury as "something new" down the back of the right leg that first appeared the day of the injury. (Ex. 23D-12). Claimant's testimony establishes that his right leg pain before August 20, 1999 was not the same pain as he experienced after the injury. It was only after the August 1999 injury that claimant felt radiating pain and from then on, it continued to worsen. (Tr. 68, 71).

Thus, contrary to the finding of the ALJ (and the majority), I agree with claimant that his symptoms before the August 1999 injury were not the same pain and same distribution, and did not indicate nerve root compression caused by disc herniation. The ALJ and majority err by finding that Dr. Rohrer had an inaccurate history regarding the onset of claimant's right leg symptoms. Claimant's L4-5 and L5-S1 disc herniations should be found compensable. Because the ALJ and majority conclude otherwise, I dissent.

In the Matter of the Compensation of
GLORIA GARIBAY, Claimant
WCB Case No. 00-03653
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
VavRosky, MacColl, Olson, et al., Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) reinstated and affirmed a Notice of Closure that awarded 9 percent (28.8 degrees) unscheduled permanent disability for a mid-back condition; and (2) declined to award an attorney fee for claimant's counsel's services at hearing regarding the insurer's request for hearing from an Order on Reconsideration that had rescinded the Notice of Closure. On review, the issues are extent of unscheduled permanent disability and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

On June 28, 1999, claimant injured her mid-back. Her claim was accepted for compression fractures at T-11 and T-12. On February 15, 2000, Drs. Brooks and Woodward examined claimant on behalf of the insurer.

On March 7, 2000, Dr. Pollard, claimant's treating physician, declared her medically stationary with "some permanent residuals from the mild compression fracture at T-11 and T-12 with the 15 degrees of gibbus."[1] (Ex. 19). Dr. Pollard also restricted claimant to medium work. In the examination portion of his report, he noted that claimant's back showed "a little kyphosis at the thoracolumbar junction." (Ex. 19). Dr. Pollard specifically noted that claimant was asked to forward bend to touch her toes, but that claimant "goes only a few degrees and stops there due to subjective pain." *Id.* However, Dr. Pollard further reported that claimant could fully extend both knees in the sitting position and could reach within 10 inches of her toes without pain. According to Dr. Pollard, this suggested some emotional overlay. *Id.* Dr. Pollard did not concur with Dr. Brooks' and Dr. Woodward's report.

The insurer closed the claim by a March 29, 2000 Notice of Closure that awarded claimant 9 percent unscheduled permanent disability for the mid-back. Claimant requested reconsideration, including the appointment of a medical arbiter. (Ex. 23A).

Without benefit of a medical arbiter examination, a May 3, 2000 Order on Reconsideration rescinded the Notice of Closure as having improperly closed the claim for lack of adequate closing information per OAR 436-030-0020(4). (Ex. 24). The insurer requested a hearing.

After finding that Dr. Pollard's closing examination contained sufficient information for the insurer to determine impairment, the ALJ previously concluded that the Department improperly rescinded the insurer's closure notice. The ALJ then vacated the Order on Reconsideration and determined that the March 29, 2000 Notice of Closure remained in full force and effect. The ALJ also ordered that the reconsideration proceedings "continue" pursuant to law. Because the Order on Reconsideration was vacated, the ALJ determined that claimant was not entitled to an attorney fee. Claimant requested Board review.

A medical arbiter report issued on October 3, 2000. (Ex. 26).

On review, we agreed with the ALJ that the Notice of Closure was properly issued. *Gloria Garibay*, 52 Van Natta 2251 (2001). We also interpreted the ALJ's directive to the Director to "continue" the reconsideration proceedings as tatamount to remanding the claim to the Department for a medical arbiter examination. Because there is no authority for such a remand, we vacated the ALJ's order and remanded the matter to the ALJ for consideration of the arbiter's report in addressing the parties' challenges arising from the Notice of Closure.

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[1] "Gibbus" is defined as "extreme kyphosis, hump, or hunch; a deformity of spine in which there is a sharply angulated segment, the apex of the angle being posterior." *Stedman's Electronic Medical Dictionary*, v. 4.0, 1998.

On remand, the ALJ admitted the arbiter's report into evidence (Exhibit 26), reinstated the Notice of Closure that awarded 9 percent unscheduled permanent disability, and concluded that there was no basis for an award of attorney fees. Claimant requested Board review.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability[2]

The ALJ relied on the attending physician, Dr. Pollard's, report to conclude that claimant was not entitled to unscheduled permanent disability greater than that awarded by the Notice of Closure. On review, claimant contends that she should receive an impairment value for lost range of motion and a greater value for adaptability than that awarded by the Notice of Closure.[3]

Where, as here, a medical arbiter is used, 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). In this case, we may not consider the impairment findings made by the examining physicians, Drs. Brooks and Woodward, because the attending physician, Dr. Pollard, did not ratify those findings. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994).

After considering the impairment findings made by the attending physician, Dr. Pollard, and those made by the medical arbiter panel (consisting of Drs. McFarland and James, orthopedic surgeons, and Dr. Morton, neurologist), we conclude that the arbiter panel provided the most thorough evaluation of claimant's impairment. In his closing evaluation, Dr. Pollard opined that claimant had some permanent residuals from the compression fractures with the 15 degrees of gibbus. However, he did not make thoracic range of motion measurements. Dr. Pollard also stated that he "suspect[ed] that claimant will have a permanent tendency to have mechanical back pain if she does heavy work for long periods of time, and I would restrict her activities to medium work category." (Ex. 19).

In contrast to Dr. Pollard, the arbiter panel concluded that claimant did not have a kyphotic deformity. They measured claimant's spinal range of motion with an inclinometer, as endorsed by the AMA in the *Guides to the Evaluation of Permanent Impairment*, 3rd edition (revised), 1990, pursuant to the criteria set forth in Bulletin 239 issued by the Department. The arbiter panel also specifically determined that the range of motion measurements were valid and opined that they were due to the accepted condition. Moreover, although they restricted claimant's lifting, carrying, stooping, crawling, climbing, reaching, crouching, kneeling and balancing, they specifically noted that these would not be permanent restrictions. (Ex. 26). Because the arbiter panel's report is the most thorough, complete and well-reasoned, we conclude that it provides more probative evidence of claimant's disability and, accordingly, rely on it.[4]

Based on the arbiter panel's findings (flexion 14; right rotation 35; left rotation 21), claimant's permanent impairment associated with loss of range of motion of the thoracic spine is 3 percent (3.03 percent rounded). *See* OAR 436-035-0360(17), (18). Pursuant to OAR 436-035-0007(2)(a) and (d), the impairment values for the compression fractures and range of motion are combined, which results in a permanent impairment value of 8 percent of the thoracic spine.

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[2] The ALJ concluded that there was no statutory basis for rating permanent disability in this case because neither claimant nor the employer raised the issue of extent of permanent disability in a request for hearing. Notwithstanding the lack of such a reference in the hearing request, the parties expressly agreed to litigate the extent issue. (Hearing file). Each party asserted that the remedy fashioned by the Board to accommodate claimant's statutory right to a post-reconsideration arbiter examination was correct and that the next step was to proceed to address the merits of claimant's challenges to the Order on Reconsideration, specifically the extent of unscheduled permanent disability. (*Id.*) Each party provided its position on this issue. (*Id.*) When parties litigate an issue by agreement, that issue properly is considered by the ALJ. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990).

[3] Claimant does not dispute the impairment value of 5 percent for her compression fractures. *See* OAR 436-035-0007(2)(d).

[4] Citing *Weiland v. SAIF*, 63 Or App 810 (1983), the insurer argues that we should defer to claimant's attending physician, Dr. Pollard, as he is in the best position to assess the extent of claimant's permanent disability because he has treated claimant since she was originally injured in 1999. We do not agree. Contrary to the insurer's assertion, this case involves the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment, which was provided by the arbiter panel.

Claimant asserts that the medical arbiter panel stated that claimant's residual functional capacity (RFC) is sedentary work. We disagree. Although the arbiter panel stated that claimant should be restricted to sedentary work *at this time*, they opined that these were not permanent restrictions. Claimant was performing medium work at the time of injury. Her RFC, as established by her attending physician's release, is medium work. (Ex. 19). Claimant has not been released to and has not returned to regular work. Accordingly, the value for adaptability is 1. OAR 436-035-0270(4). Assembling claimant's impairment (8), her age and education total (4, which is unchallenged on Board review), and her adaptability of (1), we conclude that claimant is entitled to 12 percent unscheduled permanent disability (38.4 degrees). The order of the ALJ is modified accordingly.

Attorney Fees

Claimant contends that she is entitled to an assessed fee at hearing for services in defending against the insurer's request for hearing on the Order on Reconsideration. We disagree.

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 the employer or insurer, and the [ALJ], 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 [ALJ], 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." (Emphasis added).

Here, the "award" from the Order on Reconsideration (*i.e.*, rescission of the Notice of Closure) *has* been disallowed by the ALJ. Therefore, the statutory prerequisite has not been met and no attorney fee is appropriate under ORS 656.382(2).

Because our order results in increased compensation, claimant's counsel is entitled to an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation, not to exceed $6,000. ORS 656.386(2); OAR 438-015-0055.

ORDER

The ALJ's order dated April 19, 2001 is modified in part and affirmed in part. In lieu of the ALJ's unscheduled permanent disability award of 9 percent (28.8 degrees), claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability for the loss of use and function of her mid back. For services at the hearing level and on Board review, claimant's counsel is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $6,000, payable directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JOYCE J. CARVER, Claimant
WCB Case No. 00-09507
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that reduced the award of scheduled permanent for loss of use or function of claimant's left arm from 20 percent (38.4 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order. *See James v. SAIF*, 176 Or App 337 (2001) (citing *Atkins v. Allied Systems*, 175 Or App 487 (2001) (the Board is not bound by the medical arbiter's opinion and may "reject medical opinions that it finds to be unpersuasive").

ORDER

The ALJ's order dated April 30, 2001 is affirmed.

In the Matter of the Compensation of
REGINA D. MORGAN, Claimant
WCB Case No. 01-00362
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that assessed a penalty pursuant to ORS 656.262(11)(a) for an allegedly unreasonable denial of claimant's claim for a cervical and right trapezius injury. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings.

CONCLUSIONS OF LAW AND OPINION

After concluding that claimant's combined condition was compensable, the ALJ assessed a 25 percent penalty pursuant to ORS 656.262(11)(a). The ALJ concluded that the medical evidence offered by SAIF did not address the threshold issue of compensability of claimant's combined neck condition as of September 27, 2000. Rather, the ALJ believed that the medical evidence, a December 15, 2000 report by Drs. Baker and Duncan, addressed only claimant's current condition as of the date of the report. On this basis, the ALJ concluded that SAIF had no legitimate doubt regarding its liability for the combined condition as of September 27, 2000.

SAIF seeks reversal of the penalty. Claimant argues that the penalty should be upheld. Because we conclude that the medical evidence relied on by SAIF provided it with a legitimate doubt as to the compensability of claimant's combined condition, we reverse. ORS 656.262(11)(a) provides for a penalty if a carrier unreasonably delays or unreasonably refuses to pay compensation. 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).

Here, in issuing its December 22, 2000 denial of claimant's combined condition, SAIF relied on Exhibit 55, a report from Dr. Baker and Dr. Duncan. On page 5 of that report, in the section titled "Discussion and Recommendations," the physicians state:

> " * * * The degenerative disk disease and degenerative joint disease in the cervical spine preceded [claimant's] work injury of September 27, 2000. Indeed, it is our opinion that [claimant] had ongoing symptoms on the date of September 27, 2000, consisting of neck and right shoulder complaints, as outlined by Dr. Graffeo. It is our opinion that her present complaints are very similar to those complaints and most probably are a continuation of those complaints related to the previous injury of February 2000. She may have had symptomatic exacerbation of her symptoms as a result of the work injury of September 27, 2000, but not an objective worsening of her overall condition, in our opinion."

Based on this opinion, we conclude that Dr. Baker and Dr. Duncan did not believe that the injury was the major contributing cause of claimant's combined condition on September 27, 2000.

Rather, they believed claimant's symptoms on and after September 27, 2000 were a continuation of her already existing condition. In addition, the doctors believed that the injury exacerbated her symptoms, but did not worsen her preexisting condition. We also note that the cover letter sent to Dr. Baker and Dr. Duncan by SAIF's claims adjuster asked the physicians to address the major contributing cause of the combined condition. (Ex. 54). The physicians responded that the major contributing cause of the total combined condition was the preexisting condition. (Ex. 55-6).

Based on this evidence, we are persuaded that SAIF had a legitimate doubt regarding its liability for the September 27, 2000 injury. Under such circumstances, we reverse the portion of the ALJ's order assessing a penalty.

ORDER

The ALJ's order dated May 10, 2001 is reversed in part. That portion of the order that awarded a penalty is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID M. SCHMIDT, Claimant
WCB Case No. 00-02881
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes. Member Haynes chose not to sign the order.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its current condition denial to the extent that it denied claimant's current chronic cervical strain condition. Claimant cross-requests review of that portion of the order that upheld the employer's current condition denial to the extent that it denied claimant's current degenerative cervical spine condition. On review, the issues are compensability and scope of the issues to be litigated. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of finding number 13 as it relates to claimant's degenerative pathology in his cervical spine.

CONCLUSIONS OF LAW AND OPINION

Denial of Current Cervical Strain Condition

We adopt and affirm the ALJ's reasoning and conclusions.

Compensability of Degenerative Cervical Condition

Applying ORS 656.005(7)(a)(A), the ALJ upheld the employer's denial of claimant's current cervical spine condition to the extent that it denied claimant's degenerative cervical spine condition. On review, claimant asserts that the ALJ erred in determining compensability of the degenerative cervical spine condition, because it was not identified as an issue at hearing and claimant had stated at hearing that he had made "no claim for any degenerative condition, and there has been no acceptance of a combined condition." (Tr. 4). For the following reasons, we agree with claimant's contention.

When an insurer denies a claim, it must do so in a writing that states the factual and legal basis for the denial. OAR 438-005-0055. An insurer's denial frames the issues for hearing. *Patricia N. Hall*, 40 Van Natta 1873 (1988); *see also Runft v. SAIF*, 303 Or 493, 496, n. 1 (1987).

Here, the employer's denial letter stated:

> "As you know, your 1978 claim was accepted for a cervical strain and that claim has been processed for benefits as provided by law.
>
> "It now appears that your current condition and ongoing treatment are not materially related to the accepted 1978 strain. * * *
>
> "Therefore, without waiving other possible defenses, we hereby respectfully deny compensability of your current condition and ongoing treatment. This is a partial denial only, your 1978 claim for cervical strain remains accepted, but it is our position that that condition has resolved and current and ongoing treatment are not materially related."

Although the employer denied claimant's current condition, its denial did not expressly deny a degenerative cervical condition. At hearing, claimant's attorney framed the issues to be litigated as follows: "[W]e're contesting a denial of current condition/current need for treatment of the neck. It's our position that the issue you need to decide will be the ongoing material causal relationship between [claimant's] cervical strains and his current need for treatment[.]" (Tr. 1). The employer raised no cross-issues. (Tr. 1, 2).

In his opening statement, claimant's attorney stated: "There is some description in the record of some degenerative changes in the neck. * * * *There is no claim for any degenerative condition*, and there has been no acceptance of a combined condition. It is our position that we simply have a chronic cervical strain caused by both of these injuries [1978 and 1990], and so long as those injuries materially contribute to his ongoing medical treatment * * *, that the claims remain compensable." (Tr. 4, 5, emphasis added).

Having reviewed claimant's counsel's "pre-testimony" statements at hearing, we find that claimant expressly clarified that no claim for a degenerative cervical condition was being asserted. Therefore, even assuming for the sake of argument that the employer's denial could be interpreted as denying a degenerative cervical condition, that portion of the denial would be a nullity and would have no effect. *See Stephenson v. Meyer*, 150 Or App 300, 304 (1997) (because no claim was made, the legal predicate for an award of attorney fees did not exist); *Altamirano v. Woodburn Nursery, Inc.*, 133 Or App 16, 19-20 (1995) (because there was no claim that the claimant's current condition required medical treatment or resulted in disability, the employer's attempted denial was ineffective); *Vicki L. Davis*, 49 Van Natta 603 (1997) (carrier's precautionary partial denial of lumbar degenerative conditions was premature and had no legal effect because the claimant had not filed a "new medical condition" claim for the conditions). Under these circumstances, we reverse that portion of the ALJ's order that addressed the compensability of claimant's degenerative cervical condition.

Inasmuch as we have determined that claimant has made no claim for a degenerative cervical condition, the legal predicate for an award of attorney fees under ORS 656.386(1) does not exist. Consequently, claimant has not "prevailed" over a denied claim with respect to the degenerative cervical condition and is, therefore, not entitled to an assessed attorney fee under ORS 656.386(1) on this issue. *See Stephenson v. Meyer*, 150 Or App at 304.

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

ORDER

The ALJ's order dated March 1, 2001 is affirmed in part and reversed in part. That portion of the ALJ's order that upheld the employer's denial to the extent that it could be interpreted as concerning claimant's current degenerative cervical spine pathology is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
MICHAEL R. SHORB, Claimant
WCB Case Nos. 00-03338, 00-03337, 99-09111 & 99-04936
ORDER DENYING MOTION TO DISMISS
Lori Lindley, Department of Justice
H.T. Andersen (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Barrett Business Services (Barrett) requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its compensability and responsibility denials of claimant's new medical condition claim for a cervical condition; (2) upheld the SAIF Corporation's denial of the same condition; (3) dismissed claimant's hearing request regarding denials issued by Liberty Northwest Insurance Corporation (Liberty) and Johnston and Culbertson (J&C); and (4) awarded claimant an assessed attorney fee. Liberty has moved for an order dismissing it as a party to this proceeding on the ground that the parties did not object to the dismissal of the request for hearing in its particular case while the cases were pending before the ALJ. The motion is denied.

FINDINGS OF FACT

Claimant filed hearing requests against Barrett, SAIF, J&C (as processing agent for a noncomplying employer), and Liberty contesting the carriers' denials of his new medical condition and aggravation claims. The hearing requests were consolidated.

Before hearing, without objection from any of the parties, claimant withdrew his hearing requests regarding J&C and Liberty. Those hearing requests were dismissed in the ALJ's July 27, 2001 order (as amended on August 7, 2001) that also set aside Barrett's denial of claimant's new medical condition claim, upheld SAIF's denial of the same condition, and upheld Barrett's denial of claimant's aggravation claim.

Barrett timely requested Board review of the ALJ's order. The Board mailed letters to all parties to the proceeding acknowledging the self-insured employer's request for review. Thereafter, Liberty moved for its dismissal from this proceeding.

CONCLUSIONS OF LAW AND OPINION

Although the ALJ's conclusions and opinions in consolidated cases may be separately stated, if the ALJ's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. *Donald L. Melton*, 47 Van Natta 2290 (1998); *Riley E. Lott, Jr.*, 42 Van Natta 239 (1990); *William E. Wood*, 40 Van Natta 999 (1988). On the other hand, if a party has been dismissed from a proceeding and its dismissal as a party is not contained in the appealed ALJ's order, it is not considered a party for purposes of Board review. *See Jerry R. Miller*, 44 Van Natta 1444 (1992).[1]

Here, the ALJ's dismissals, compensability, responsibility, and aggravation determinations were contained in one final, consolidated order. Inasmuch as that consolidated order has been appealed, we retain jurisdiction over that entire decision, and Liberty remains a party to this proceeding. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47 (1985); *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992); *William A. Franklin*, 53 Van Natta 782 (2001); *Riley E. Lott, Jr.*, 42 Van Natta at 240; *Rual E. Tigner*, 40 Van Natta 1789 (1988). However, considering the parties' apparent lack of objection to claimant's withdrawal of his hearing requests regarding the aforementioned carriers, as well as the lack of objection to the motion for dismissal, as a practical matter, the participation in this case by the "dismissed" carriers will likely be nominal. *Franklin*, 53 Van Natta at 783; *Lott*, 42 Van Natta at 240.

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[1] In *Shawn C. Mann*, 47 Van Natta 855 (1995), we noted that it was entirely appropriate for an ALJ to dismiss parties from a previously consolidated hearing by means of a dismissal order which was separate from the ALJ's Opinion and Order which would address the merits of the claimant's claims against the remaining carriers. Since the "dismissed" carriers would not be "parties" to the separate Opinion and Order, we reasoned that they likewise would not be "parties" on Board review of the appealed Opinion and Order. Here, in contrast to *Mann* and *Miller*, the dismissals of claimant's hearing requests regarding Liberty and J&C were contained in the same order that addressed the merits of claimant's claims with the remaining carriers. Under such circumstances, all parties to the ALJ's order remain parties on Board review of the single, appealed order.

Accordingly, Liberty's motion to dismiss is denied. The briefing schedule will continue as previously implemented. On its completion, this case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSAN L. WILBUR, Claimant
WCB Case No. 0000823
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
VavRosky, MacColl, Olson, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Fulsher's order that upheld the self-insured employer's denials of her right shoulder conditions. On review, the issue is compensability.

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

Claimant was struck on her right side by a pick-up truck on May 11, 1999 while in the course of employment. The claim was accepted for a disabling cervical strain. Claimant later requested that the acceptance be amended to include several additional conditions, including tendonitis/bursitis of the right shoulder. The employer denied the right shoulder claim. Claimant requested a hearing, at which time the parties agreed to litigate the compensability of the denied conditions, as well as a tear of the subscapularis tendon and a subscapularis cyst of the right shoulder.

The ALJ upheld the employer's express and "de facto" denials of claimant's right shoulder conditions. In so doing, the ALJ found the opinion of an attending physician and surgeon, Dr. Walton, unpersuasive with respect to the compensability of the denied right shoulder conditions.

On review, claimant contends that Dr. Walton's opinion is the most persuasive because he performed surgery on claimant's right shoulder and opined that claimant's right shoulder conditions were "traumatic," rather than degenerative, as asserted by examining physicians. Claimant's contentions notwithstanding, we agree with the ALJ's decision upholding the employer's denials.

On April 4, 2000, Dr. Walton evaluated claimant's right shoulder condition and recorded a history that claimant landed on her right shoulder when she injured herself on May 11, 1999. (Ex. 65D). Dr. Walton later received the same history on June 8, 2000 when claimant was admitted for right shoulder arthroscopy. (Ex. 68E). As a result of that surgery, Dr. Walton opined that claimant's right shoulder condition was a "traumatic" condition caused by the May 11, 1999 injury, not the result of a degenerative process. (Exs. 68A, 69).

When there is a dispute between medical experts, more weight is given to those medical opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally give greater weight to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Additionally, if the opinion of the treating physician is based upon his actual surgical findings, the opinion is generally entitled to great weight. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988).

In this case, we find persuasive reasons not to give greater weight to Dr. Walton's opinion. As previously noted, Dr. Walton received a history that claimant landed on her right shoulder during her May 11, 1999 injury. Claimant, however, testified at hearing that she landed on her right *elbow*. (Tr. 6). Moreover, Dr. Walton believed that claimant's right shoulder problems had ongoing right shoulder symptoms after the May 11, 1999 accident. Having reviewed this record, we are not persuaded that this is an accurate history. Instead, it appears that claimant's initial right shoulder pain resolved by June 1, 1999. (Ex. 4). Accordingly, we conclude that Dr. Walton had an inaccurate history and thus that his opinion is not persuasive for this reason. *See Miller v. Granite Construction Company*, 28 Or App 473 (1977) (medical opinions based on an inaccurate history are entitled to little weight). We also agree with the ALJ that Dr. Walton's opinion is conclusory and not well explained. (Exs. 69, 70, 76). This further

reduces the persuasiveness of Dr. Walton's opinion. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

Finally, we find that the medical evidence from Dr. Walton is somewhat contradictory because he at first attributed claimant's right shoulder condition to the May 1999 injury, but subsequently recanted his opinion and reported that he was unable to say whether calcific density/tendonitis was the result of the May 11, 1999 accident. (Ex. 70). However, without explanation, Dr. Walton opined once more in his final report that the May 11, 1999 injury was the major contributing cause of claimant's need for treatment or disability. (Ex. 76). Because Dr. Walton changed his opinion without explanation, we also find that his opinion is not persuasive for this reason. *Kelso v. City of Salem*, 87 Or App 630 (1987).

In conclusion, we agree with the ALJ that claimant has not established the compensability of her right shoulder conditions. Therefore, we affirm.

ORDER

The ALJ's order dated May 11, 2001 is affirmed.

In the Matter of the Compensation of
DANIEL J. CLAUSEN, Claimant
WCB Case No. 00-05943
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorney
Atwood & Associates, Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's denial of his occupational disease claim for a torn left medial meniscus. On review, the issue is compensability.

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

Citing *Weiland v. SAIF*, 64 Or App 810 (1983), claimant contends that the ALJ should have given the opinion of the treating physician, Dr. Baum, greater weight because he had the opportunity to follow claimant's condition over a period of time, performed claimant's surgery for the meniscus tear and was aware of claimant's activities, both on and off-the-job. We disagree.

We have previously indicated that, in light of *Dillon v. Whirlpool Corporation*, 172 Or App 484 (2001), we would continue to observe the general principle of giving greater weight to the opinion of an attending physician where appropriate. *See Darwin B. Lederer*, 53 Van Natta 974 n. 2 (2001). However, in this case, we agree with the ALJ's reasoning that this case involves expert analysis rather than expert observation. Thus, the opinion of the attending physician is not entitled to deference. *Allie v. SAIF*, 79 Or App 284, 287 (1986).

ORDER

The ALJ's order dated June 15, 2000 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's determination that claimant failed to sustain his burden of proving that his left medial meniscus tear is compensable. In so doing, the majority approves the ALJ's reasoning that this is a causation issue that involves expert analysis rather than expert observation and, therefore, the opinion of Dr. Baum, the attending surgeon, is not entitled to special deference. Because I would find the opinion of Dr. Baum the most persuasive on this record, I respectfully dissent.

As the majority notes, we have reaffirmed the general practice of deferring to the attending physician's opinion where appropriate. *See Darwin B. Lederer*, 53 Van Natta 974 n. 2 (2001). This is just such a case where we ought to be applying the customary rule of attending physician deference. Dr. Baum has been claimant's treating physician for a substantial period of time and was able as claimant's surgeon to observe claimant's knee condition during surgery. Dr. Baum was aware of claimant's off-

work activities and considered the contribution of the degenerative condition as well. Because of his first hand exposure to and knowledge of claimant's knee condition, Dr. Baum's causation opinion should be given great weight.

Moreover, Dr. Baum's opinion is clearly more persuasive than that of Dr. Schilperoort, who examined claimant on behalf of the insurer and who attributed claimant's meniscus tear in major part to a degenerative condition. Unlike the ALJ, I am not persuaded that, lacking Dr. Baum's first-hand knowledge of claimant's condition, Dr. Schilperoort can medically distinguish the effects of occupational exposure and that of degeneration. Significantly, Dr. Schilperoort does not explain why, if weight, age and degenernation are the major factors in claimant's condition, claimant's other knee is not affected.

Dr. Baum concedes that he cannot state with "certainty" what caused claimant's meniscus tear. However, a claimant need not prove a case to medical certainty, only medical probability. *See Robinson v. SAIF*, 147 Or App 157, 160 (1997) (certainty not required to establish medical causation). In my view, Dr. Baum's opinion amply satisfies that standard.

In conclusion, the majority errs in affirming the ALJ's order finding that claimant's left medial meniscus tear is not compensable. Because I would reverse the ALJ's order on this record, I respectfully dissent.

September 11, 2001 Cite as 53 Van Natta 1179 (2001)

In the Matter of the Compensation of
KAREN K. HALL, Claimant
WCB Case No: C011815
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

On August 1, 2001, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, for payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

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

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

In the meantime, the statutory 30-day "cooling off" period has expired. Consequently, our prior concerns regarding the "waiver" provision have become moot. Therefore, we have proceeded with our review of the agreement. Having reviewed the CDA, we conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the CDA is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KATHY E. BURTON, Claimant
WCB Case No. 00-09441
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich and Meyers.

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

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

Here, there is no dispute that claimant must establish compensability of her bilateral carpal tunnel syndrome condition as an occupational disease claim under ORS 656.802(2)(a). In other words, claimant has the burden of proving that employment conditions were the major contributing cause of the bilateral carpal tunnel syndrome condition. ORS 656.266; 656.802(2)(a).

Dr. Kulus, claimant's treating D.O., provides the only opinion that supports claimant's occupational disease claim. However, like the ALJ, we do not find Dr. Kulus' opinion persuasive. In indicating that he did not concur with the examining physicians' discussion and conclusions, Dr. Kulus stated that he believed that "work activity is a contributing factor." (Ex. 9, emphasis added). Dr. Kulus offered no explanation for this opinion. Dr. Kulus also agreed with a telephone conversation summary. (Ex. 11). The causation opinion in that conversation summary consisted of a statement that "the major contributing cause (more than 50 percent) of [claimant's] bilateral carpal tunnel syndrome and need for treatment is her work activities at [the employer], where she has worked for nine years as a customer service representative doing primarily computer data entry work." (Ex. 11-2). Dr. Kulus provided no explanation for this statement.

Because Dr. Kulus' opinions are conclusory, we do not find them persuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (rejecting conclusory medical opinion); *see also Marta I. Gomez*, 46 Van Natta 1654 (1994) (whether referred to as a "check-the-box" report or a "concurrence," the persuasiveness of a medical expert's response depends on the explanation that corresponds to the expert's opinion). Thus, notwithstanding any issues regarding the persuasiveness of the examining physicians' causation opinions, claimant has failed to present persuasive medical evidence to meet her burden of proving compensability of her bilateral carpal tunnel syndrome condition.

ORDER

The ALJ's order dated May 17, 2001 is affirmed.

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[1] Although SAIF's respondent's brief referenced Exhibit 13, we note that claimant objected to those references because SAIF withdrew Exhibit 13 following the hearing. SAIF conceded that it withdrew Exhibit 13. In addition, the ALJ did not list Exhibit 13 among the exhibits admitted into the record. Therefore, we have not considered Exhibit 13 in reaching our decision.

In the Matter of the Compensation of
PATRICK J. CALLOW, Claimant
WCB Case No. 97-08869
ORDER ON REMAND
Coughlin, Leuenberger & Moon, Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Meyers. Member Meyers dissents.

This matter is before the Board on remand from the Court of Appeals. *Marvin Wood Products v. Callow*, 171 Or App 175 (2000). The court has reversed our prior order that affirmed an Administrative Law Judge's (ALJ's) order affirming an Order on Reconsideration that: (1) awarded 9 percent (13.5 degrees) scheduled permanent disability for claimant's loss of use or function of the right wrist; and (2) awarded 11 percent (16.5 degrees) scheduled permanent disability for claimant's loss of use or function of the left wrist. Relying on its decision in *Roseburg Forest Products v. Clemons*, 169 Or App 231 (2000), the court held that it was necessary for the Board to determine whether a Department rule, *former* OAR 436-035-0007(27), permitted impairment findings made by an arbiter panel to be used even if there was no explanation for the panel's conclusion that the findings were invalid. Consequently, the court has instructed us to reconsider our decision in light of *Clemons*.

We begin by recounting the factual background and procedural history of the case. As set forth in the court's opinion, claimant has a compensable bilateral carpal tunnel syndrome and tendonitis condition. The Department awarded claimant five percent permanent disability for loss of use or function of each wrist and forearm due to chronic pain. Claimant requested reconsideration by the Appellate Review Unit (ARU), arguing that the disability rating should be based on lost range of motion, lost sensation, and lost strength, in addition to chronic pain. The reconsideration record included the report of a three-member medical arbiter panel and a report by claimant's attending physician, Dr. Warren.

Dr. Warren determined that claimant had full range of motion in his wrists, but was permanently limited in his ability to perform activities requiring repetitive use of his hands and wrists. The medical arbiters, on the other hand, made findings that claimant's injury resulted in reduced range of motion in his wrists. The arbiters also reported, however, that "the panel finds the examination to be invalid." Consequently, the arbiters were "unable to set any limitations on the [claimant's] repetitive ability to use either hand, wrist, or forearm due to the diagnosed chronic and permanent medical condition arising out of the accepted injury." The arbiters did not explain why they found their examination to be invalid.

In the reconsideration order, the ARU rated claimant's permanent disability using Dr. Warren's findings that claimant was limited in his ability to use his hands and wrists repetitively. The ARU also used the arbiters' range of motion findings, noting that, although the arbiter panel found its examination to be invalid, it had not explained that finding. The reconsideration order then increased claimant's scheduled permanent disability award to nine percent for the right wrist and 11 percent for the left wrist.

The insurer requested a hearing, challenging the increased permanent disability award. The ALJ affirmed the reconsideration order, and the insurer sought Board review. We affirmed the ALJ's order, but later clarified our decision in response to the insurer's reconsideration request. Because we affirmed the increased permanent disability rating, the insurer sought judicial review.

Among other issues,[1] the court addressed the insurer's argument that the ALJ and the Board could not rely on the arbiter panel's lost range of motion measurements given the panel's unexplained

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[1] Citing *Koskela v. Willamette Industries, Inc.*, 331 Or 362, 377 (2000), a decision that issued after *Callow*, the insurer argues that the Court of Appeals' analysis of the "burden of proof" issue is incorrect in that Supreme Court stated that the worker has the burden of proof and persuasion, regardless of which party requests reconsideration. Because the Court of Appeals did not remand this case for reconsideration on the "burden of proof" issue, we do not address this issue. In any evern, even if we considered the "burden of proof" issue, our ultimate determination would be unchanged.

finding that its examination was invalid. The court noted that, at the time the permanent disability award in this case was made, *former* OAR 436-035-0007(27) (1996) applied.[2]

It provided, in part:

> "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 * * *. 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. When findings are determined invalid, the findings shall receive a value of zero."

The court identified the significant issue as whether an arbiter's impairment findings may be used at all in rating the disability when the arbiter concludes that the examination was invalid but does not explain the invalidity. The court noted that it had held in *Clemons* that *former* OAR 436-035-0007(27) (1996) itself precluded use of invalid impairment findings if the invalidity was based on a determination that an impairment finding does not satisfy AMA criteria.

Noting that, when we decided this case, we did not have the benefit of the *Clemons* opinion, and incorrectly understood the rule to require consideration of the arbiter panel's impairment findings, notwithstanding their invalidity, if the invalidity was not explained. The court then stated that the starting point should be whether the rule itself permits the impairment findings to be used. That was a determination, the court observed, that we should make in the first instance, consistent with its decision in *Clemons*. Therefore, the court reversed and remanded for further consideration under a correct interpretation of *former* OAR 436-035-0007(27) (1996). *Callow*, 169 Or App at 187.

We now proceed with that consideration. The court in *Clemons* reversed our order in *James E. Clemons*, 50 Van Natta 267 (1998), which, in interpreting *former* OAR 436-035-0007(27), found that, because the medical arbiter had not provided a written opinion based on sound medical principles explaining why the claimant's range-of-motion findings were invalid, the findings could be used even though they did not comply with the AMA validity requirements. The *Clemons* court held that, under *former* 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. *Clemons*, 169 Or App at 240.

This case differs from *Clemons* in that the medical arbiters in this case did not state that claimant's range of motion findings were invalid under AMA criteria. Indeed, both parties agree that, while the AMA guides address range of motion in the wrist, they do not provide for any validity criteria for such findings. However, while the precise holding of *Clemons* is not controlling here, that decision does provide guidance in deciding this case. As the *Clemons* court noted, the question of whether a finding of impairment is ratable is not limited to the question of whether it is valid under the AMA criteria. 169 Or App at 239. Rather, other rules may require consideration of additional factors in determining whether a finding of impairment is ratable. *Id.*

The insurer cites OAR 436-035-0007(1) (1997), which states that findings of impairment are ratable only if they are permanent and were caused by the compensable injury. According to that rule, unrelated and noncompensable findings shall be excluded and not rated. However, we do not find that rule precludes the rating of the range of motion findings in this case.

The medical arbiters did not attribute the range of motion findings to a cause other than the compensable injury. Although they noted that sensory findings were "nonanatomical," they did not indicate that was true of the range of motion measurements. (Ex. 16-2). Granted, the arbiter panel stated that the "examination" was "invalid" in the context of a question regarding the presence of a "chronic condition." However, they did not say that the *range of motion findings* were unrelated to the injury or noncompensable.

The insurer also cites OAR 436-035-0007(13) (1997), which states that, where a medical arbiter is used, impairment is established by the medical arbiter except where a preponderance of medical opinion establishes a different impairment level. However, in our previous order, we agreed with the ALJ's

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[2] The insurer asserts that the court's determination of the applicable administrative rule was erroneous. We accept, however, the court's express legal determination.

reasoning that, in this particular case, the impairment should be established by the medical arbiter. Thus, we do not find that either rule precludes a finding that the range of motion findings in the medical arbiter report are ratable.

Therefore, pursuant to OAR 436-035-0007(27) (1996), the impairment findings pertaining to reduced range of motion shall be rated, unless the physician determines that the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid. In this case, the medical arbiters indicated that their "examination" was invalid. Thus, assuming that comment invalidated the range of motion findings, the panel would still have to provide a written opinion "based on sound medical principles" explaining why the findings are invalid. *Cf. Stacy Frierson*, 53 Van Natta 124, 126 (2001) (finding under 1998 version of rule that a physician's conclusory statement did not provide a written rationale "based on sound medical principles"). The medical arbiter panel provided no such opinion. As previously noted, they provided no explanation why their range of motion findings were invalid. Accordingly, on reconsideration, we continue to adhere to our previous decision affirming the Order on Reconsideration's award of scheduled permanent disability.

Claimant is entitled to an attorney fee for his counsel's services before every prior forum because he has finally prevailed before the Board after remand from the court. *See* ORS 656.388(1). At hearing, the ALJ awarded an assessed fee of $2,000 for services at hearing regarding the insurer's request concerning the Order on Reconsideration's permanent disability award. On review, we awarded an $800 assessed attorney fee for services on review. We reinstate those awards.

Following the insurer's appeal and the court's remand, we have not disallowed or reduced the compensation awarded to claimant and, therefore, his counsel is also entitled to an assessed attorney fee under ORS 656.382(2) for services before the Court of Appeals and before the Board on remand. *See* ORS 656.388(1). Under such circumstances, in addition to the attorney fees previously awarded by the ALJ ($2,000) and in our prior order ($800), we award a reasonable attorney fee under ORS 656.382(2) for claimant's counsel's services (before the court and the Board on remand).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at the court and Board remand level is $4,000, 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 to the court and supplemental brief on remand), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, and as supplemented and modified herein, the ALJ's order dated February 5, 1998 is affirmed. For services before the court and the Board on remand, claimant's counsel is awarded $4,000, to be paid by the insurer. This attorney fee is in addition to the $2,800 granted by the ALJ's order and our prior order.

IT IS SO ORDERED.

Board Member Meyers dissenting.

The majority adheres to its previous order affirming the Order on Reconsideration's award of scheduled permanent disability. In so doing, it concludes that the medical arbiter panel failed to provide a written opinion "based on sound medical principles" explaining why their range of motion findings were invalid. *See former* OAR 436-035-0007(27) (1996). Because I conclude that the medical arbiter report sufficiently complies with the administrative rule, I respectfully dissent.[1]

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[1] Before I address this issue, however, I must note that I agree with the insurer that, because this claim was closed by Determination Order on July 2, 1997, after the February 15, 1997 effective date of the 1997 amendment to OAR 436-035-0007(27), the 1997 version of OAR 436-035-0007(27) applies. OAR 436-035-0003(1) (WCD Admin. Order 96-072, 1997). Although the court held that the version was applicable, I believe that we are not bound by that determination. *See Liberty Northwest Ins. Corp. v. Verner*, 147 Or App 475, 479 (the court's holdings in "*Verner* I and II" did not preclude the Board on remand from reviewing the record and making new findings of fact), *rev den* 325 Or 438 (1997). The 1997 version of the rule is quite similar to the 1996 version reproduced in the majority opinion except that it adds the final sentence: "If the validity criterion are 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." Because the parties agree that there are no validity criterion that applicable in this case, I agree with the insurer that the rule does not even apply. Thus, there was no requirement that the medical arbiter panel explain why their range of motion findings were invalid.

In my view, the medical arbiter's report should be viewed in its entirety. On the first page of the report, the panel noted that claimant developed "global numbness" in June 1996. The panel further noted that an orthopedic surgeon, Dr. Warren, observed "stocking glove sensation." (Ex. 16-1). In the portion of their report that listed the results of the physical examination, the panel documented "non-anatomical" examination of the C6 and C8 distributions and noted "again" that the sensory examination was "non-anatomical." (Ex. 16-2).

Having reviewed the arbiter report in its entirety, I believe that the panel was describing yet "again" nonanatomical findings similar to what was noted in previous records. Thus, when the panel reported that their examination was "invalid," such a conclusion was the logical result of both the physical examination and their review of claimant's history. Under these circumstances, I would conclude that the arbiter report, viewed as a whole, sufficiently explained why their range of motion findings were invalid. Thus, I would find that the panel provided an explanation based on "sound medical principles" such that the requirements of the administrative rule were satisfied.

Because the majority reaches a conclusion that I cannot support, I must part company with their opinion. Accordingly, I dissent.

In the Matter of the Compensation of
LESTER W. HUEY, Claimant
WCB Case Nos. 00-05043, 00-00631 & 99-08464
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's denial of his current low back condition; (2) upheld SAIF's denial of his occupational disease claim for a low back condition; (3) modified an Order on Reconsideration to classify claimant's claim as nondisabling; and (4) declined to assess penalties or attorney fees. On review, the issues are compensability, claim classification, penalties and attorney fees.

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

On page 3 of his order, the ALJ found that claimant was working for a different recreational vehicle company when he was examined by Dr. Arbeene in March 1999. Because the record reflects that, as of the date of the hearing, claimant had last worked on May 19, 1999 for this employer, (Tr. 37), we do not adopt the ALJ's finding that claimant was working for a different employer in March 1999.

Claimant argues that his burden of proof is to produce some affirmative medical evidence that the condition was caused by the work exposure. According to claimant, the employer must then overcome this evidence with more persuasive evidence.

Contrary to claimant's arguments concerning the burden of proof, part of claimant's burden is to produce evidence that persuades the fact-finder. *See Marvin Wood Products v. Callow*, 171 Or App 175, 179-180 (2000) (the burden of proof encompasses both the burden of producing evidence of a particular fact and the burden of persuasion). Thus, the mere fact that claimant has produced some evidence supporting compensability is not sufficient. The evidence must also be persuasive. For the reasons given by the ALJ, we agree that the opinions of Dr. Keiper (with regard to the occupational disease claim) and Dr. Hill (with regard to the current condition claim), are unpersuasive and do not carry claimant's burden of proof.

Because the claim is not compensable, there are no amounts then due upon which to base a penalty or attorney fee.

ORDER

The ALJ's order dated May 22, 2001 is affirmed.

September 13, 2001 Cite as 53 Van Natta 1185 (2001)

In the Matter of the Compensation of
LLOYD CARLTON, Claimant
WCB Case No. 00-06066
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorney
Schwabe, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

On August 31, 2001, we withdrew our August 3, 2001 order that: (1) concluded a June 14, 2000 Determination Order was not final; and (2) affirmed an Administrative Law Judge's (ALJ) order that awarded a $4,000 attorney fee for the insurer's unreasonable discovery violation. We took this action to consider the insurer's request for reconsideration.

The insurer contends that our order applied an incorrect version of ORS 656.277. The insurer asserts that, pursuant to *former* ORS 656.277, the June 14, 2000 Determination Order became final. Thus, the insurer reasons that, because the "sole issue" was the alleged discovery violation, the ALJ lacked jurisdiction (pursuant to ORS 656.262(11)) to consider the penalty issue. Having received claimant's response and the insurer's reply, we proceed with our reconsideration.

Effective October 23, 1999, Senate Bill 220 amended ORS 656.277 such that any party objecting to a reclassification order of the Director was required to request a hearing within 30 days from the date of the order. The amendment of ORS 656.277 was one change of many "relating to closure of workers' compensation claims." Or Laws 1999, ch 313. Under *former* ORS 656.277, a party challenging a reclassification order of the Director was required to request reconsideration before requesting a hearing.

Although the effective date of Senate Bill 220 was October 23, 1999, section 16 provides that the Director is to: (1) phase out claim closure activities in a manner that "minimizes disruption;" and (2) cease claim closure activities "not later than June 30, 2001." Or Laws 1999, ch 313, section 16. Thus the Legislature expressly provided that the claim closure amendments enacted by Senate Bill 220 would gradually be phased in, becoming completely operative not later than June 30, 2001.

Effective January 1, 2001, the Director amended the administrative rules pertaining to claim classification. (WCD Admin. Order No. 00-058). The amended rules, however, pertain only to claims with dates of injury on or after October 23, 1999; for claims with dates of injury before October 23, 1999, the amended rules provide that the provisions of OAR 436-030-0045 in WCD Administrative Order 97-065 "shall apply until the industry is notified otherwise by the director." OAR 436-030-0003(3)(b).

The June 14, 2000 Determination Order that ordered the claim to "remain classified as non-disabling" issued after the effective date of Senate Bill 220, but before the effective date of *amended* OAR 436-030-0003. Consistent with *former* ORS 656.277 and *former* OAR 436-030-0045(12), the Determination Order correctly advised that: "Any party to the claim has the right to request a reconsideration for a period of 60 days from the mailing date of the determination order."[1] (Ex. 45). Moreover, the Determination Order's appeal notice was also consistent with the amended versions of OAR 436-030-0003 and 436-030-0045(12) adopted pursuant to WCD Admin. Order No. 00-058. Under such circumstances, the June 14, 2000 Determination Order was valid.

Here, claimant did not request reconsideration of the June 14, 2000 Determination Order. Rather, claimant requested a hearing seeking, among other things, claim reclassification.

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[1] Claimant's date of injury was March 31, 1999.

The ALJ determined that claimant's hearing request was filed more than 30 days after the date of the Determination Order. Reasoning that the Hearings Division lacked authority to consider the "reclassification" matter, the ALJ denied claimant's "reclassification" request.

Having concluded that the June 14, 2000 Determination Order was valid, we further conclude that, because claimant did not request reconsideration of the Determination Order within the required 60 day time period, the June 14, 2000 Determination Order became final. Consequently, we affirm the ALJ's decision that the Hearings Division lacked authority to consider the "reclassification" issue. This portion of our analysis is in lieu of our prior reasoning.[2]

We turn to the penalty issue. As noted in our prior order, claimant's request for hearing identified the issues of claim reclassification, temporary disability, penalties for allegedly unreasonable claims processing and failure to provide discovery, reimbursement for prescriptions and mileage, and attorney fees.[3] Although we determined that the ALJ lacked authority to consider the reclassification issue, we nonetheless determined that the ALJ was authorized to consider the temporary disability issue. Reasoning that the penalty/attorney fee matter for an alleged discovery violation was not the "sole issue," we thus concluded that the ALJ had jurisdiction to consider the penalty/attorney fee issue.

Our conclusion regarding the ALJ's authority to consider the temporary disability issue was not based on any particular version of ORS 656.277.[4] Rather, our conclusion was based on claimant's request for hearing alleging entitlement to temporary disability after the insurer issued its acceptance. Because the ALJ's authority over the temporary disability issue is not dependent on which version of ORS 656.277 is applicable to this claim (or whether the June 14, 2000 Determination Order had become final), we adhere to our prior order regarding the ALJ's attorney fee award for the insurer's unreasonable discovery violation.

On reconsideration, as supplemented and modified herein, we adhere to and republish our August 3, 2001 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] In other words, it is not necessary for the parties to contact WCD to issue another order with new appeal rights.

[3] The reimbursement for prescriptions and mileage, as well as the unreasonable claim processing issues were resolved before the hearing through the parties' stipulated settlement.

[4] Under either the former or current version of ORS 656.277, the ALJ lacked authority over the reclassification issue.

In the Matter of the Compensation of
HERSCHEL J. COSTA, Claimant
WCB Case No. 00-06704
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl. Member Biehl chose not to sign the order.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) increased claimant's scheduled permanent disability for loss of use or function of the left hand from 8 percent (12 degrees), as awarded by an Order on Reconsideration, to 27 percent (40.5 degrees); and (2) increased claimant's scheduled permanent disability for loss of use or function of the right hand from 8 percent (12 degrees), as awarded by an Order on Reconsideration, to 30 percent (45 degrees). On review, the issue is entitlement to scheduled 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 bilateral carpal tunnel syndrome. A Notice of Closure awarded 13 percent scheduled permanent disability for the left hand and 16 percent scheduled permanent disability for the right hand.

Claimant requested reconsideration. After being examined by medical arbiter, Dr. Ho, the Order on Reconsideration reduced claimant's scheduled permanent disability to 8 percent for each hand.

The ALJ found that claimant was entitled to 9 percent for loss of strength, 16 percent for loss of sensation, 5 percent for a chronic condition, and 3 percent for lost range of motion. After adjusting for an offset, the ALJ concluded that claimant was entitled to 27 percent scheduled permanent disability for the left hand and 30 percent scheduled permanent disability for the right hand.

On review, the insurer disputes claimant's awards for loss of strength and loss of sensation. According to the insurer, Dr. Ho provided the most persuasive evidence concerning impairment and his opinion does not show impairment for either loss of strength or sensation. Claimant responds that the medical evidence shows that claimant has sensory and strength losses, and the physicians' difficulty in measuring those losses should not prevent him from being awarded impairment.[1]

Two physicians provided reports concerning claimant's impairment. Examining hand surgeon, Dr. Nolan, saw claimant in February 2000. (Ex. 45A). Claimant's treating physician, Dr. Coale, concurred with the report. (Ex. 45B). As indicated above, Dr. Ho was the medical arbiter and examined claimant in August 2000. (Ex. 54).

With regard to loss of sensation, Dr. Nolan indicated that "two point discrimination testing is difficult in this man, who sometimes describes two points as being one, but also describes one point as being two, anatomically impossible." (Ex. 45A-2). Dr. Nolan added that, if claimant

> "states that his hands feel 'numb' and he describes two point discrimination of 9mm or greater, then so be it. Although I believe this is primarily subjective and indicative of some symptom embellishment, I have no way of knowing for sure and, thus, I believe it is most pragmatic to consider diminished sensation in the thumb, index and middle fingers of both hands to be 9mm (normal 5-6mm) and close the claim." (*Id.* at 2-3).

Dr. Ho reported that sensation testing "was totally chaotic and erratic" in that, when "testing the same sites at the fingers or the palms repetitively with one or two points there was no consistent pattern of response." (Ex. 54-1). Dr. Ho also indicated, however, that no "findings were considered invalid." (*Id.* at 2).

Both Dr. Nolan's and Dr. Ho's examinations show that sensory testing was inconsistent. Although Dr. Ho noted that findings were not invalid, he did not provide a value or grade, only noting that testing was "totally chaotic and inconsistent responses everywhere." (Ex. 54-4). Dr. Nolan also reported that he believed claimant's responses were "primarily subjective" and showed "some symptom embellishment," but thought it "most pragmatic" to consider claimant as having some diminished sensation.

Based on claimant's inconsistent responses to sensory testing, we find that neither Dr. Nolan nor Dr. Ho provided sufficient evidence for loss of sensation. That is, even if we assumed loss of sensation despite claimant's inconsistent and anatomically impossible responses to testing (as Dr. Nolan seemed to have done), there is insufficient evidence to determine the appropriate value for impairment. Consequently, we agree with the insurer that claimant is not entitled to impairment for loss of sensation.

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[1] Claimant also states that the insurer did not challenge the rating for loss of strength at hearing and so should be precluded from doing so on review. Although the insurer did not specifically discuss loss of strength in its arguments, *claimant* requested the hearing and asserted entitlement to such impairment. The ALJ also addressed the loss of strength issue. Thus, we find that, although the insurer did not respond to the loss of strength issue, the issue was raised at hearing and, consequently, properly before the Board.

Only Dr. Ho noted a loss of strength. In particular, he reported that "muscle strength at both wrists was 4/5 associated with a tremor like effort against resistance associated with discomfort." (Ex. 54-1). Dr. Ho added that the loss of strength was "associated with discomfort at the wrists related to occupational strain and soft tissue irritability related to surgery and not due to loss of muscle, nerve damage, disruption of the musculo-tendinous unit or loss of range of motion." (*Id.*)

OAR 436-035-0110(8)(a) provides that "[v]alid loss of strength in the arm, forearm or hand, substantiated by clinical findings, shall be valued as if the peripheral nerve supplying (innervating) the weakened muscle(s) was impaired, pursuant to this section." Applying the plain language of OAR 436-035-0110(8)(a), if a claimant proves a valid loss of strength, that loss shall be rated "as if" a specific nerve and muscle group were impaired. *E.g., Darlene Corthell*, 52 Van Natta 126 (2000). Thus, claimant need not prove that a valid loss of strength is due to nerve damage.

Here, we find that, based on Dr. Ho's report, claimant showed a valid loss of strength, rated at 4/5. Moreover, we disagree with the Order on Reconsideration that the loss of strength is not due to the accepted condition. Dr. Ho related the loss of strength to discomfort from a strain and soft tissue irritability, which in turn were related to the surgery. Claimant had surgery for bilateral carpal tunnel syndrome, which is the accepted condition. Thus, we find that claimant proved entitlement to 9 percent for loss of strength in each wrist. *See* OAR 436-035-0110(8).

As noted above, there is no dispute with the awards of 5 percent for a chronic condition and 3 percent for lost range of motion. Combining those values with the value of 9 percent results in 16 percent scheduled permanent disability for each hand.[2]

ORDER

The ALJ's April 20, 2001 order is modified. In lieu of the ALJ's awards, and in addition to the 8 percent scheduled permanent disability awards for loss of use or function of each hand (as granted by the Order on Reconsideration), claimant is awarded 8 percent (12 degrees) for the right hand for a total of 16 percent (24 degrees) scheduled permanent disability for the right hand and 5 percent (7.5 degrees) for the left hand for a total of 13 percent (19.5 degrees) scheduled permanent disability for the left hand. The ALJ's attorney fee award is modified accordingly.

[2] As noted by the ALJ, claimant received a prior award of 3 percent for his left hand. Thus, the award for the left hand is reduced to 13 percent scheduled permanent disability.

In the Matter of the Compensation of
EDDIE W. HEIM, Claimant
Own Motion No. 01-0278M
OWN MOTION ORDER
Black, Chapman, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The SAIF Corporation has submitted claimant's request for temporary disability compensation for a left shoulder condition. Claimant's aggravation rights have expired. 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 for SAIF to provide temporary disability compensation beginning August 14, 2001, the date claimant was hospitalized for surgery.[1] When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

[1] In its recommendation, SAIF notes that claimant is presently on modified duty with his current employer due to "another workers' compensation claim." A review of the Department's records indicate that claimant has a 1995 bilateral wrist claim which is presently in open status. Claimant is not entitled to receive double compensation for the same time period. *Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den* 296 Or 350 (1984). Therefore, if claimant's August 14, 2000 hospitalization under this 1994 claim is within the period that he is receiving timeloss for his 1995 bilateral wrist claim, SAIF may petition the Compliance Division for a *pro rata* distribution of payments between the two claims. *See* OAR 436-060-0020(8); *Leroy R. Fowler*, 41 Van Natta 1468 (1989).

In the Matter of the Compensation of
KATHRYN R. LONEY, Claimant
WCB Case No. 00-05987
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes. Member Haynes dissents.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral foot condition. 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 "Finding of Ultimate Fact" that claimant's work activities were not the major contributing cause of her bilateral heel pain.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as a customer service representative for the employer since October 1997. (Tr. 7). During that time, claimant has usually worked 40 to 60 hours per week. (Tr. 9). Claimant's job duties require her to be on her feet 90 percent of the time. (Tr. 11).

In approximately March 1999, claimant began to experience sharp, shooting, intermittent pain in both heels after standing for a couple of hours. (Ex. 2). The pain gradually increased in severity such that claimant sought medical attention from Dr. Kennedy in March 2000. (*Id.*)

On April 24, 2000, claimant filed a claim for her bilateral foot condition. (Ex. 1). When the claim was denied on June 27, 2000, claimant requested a hearing.

The ALJ determined that Dr. Kennedy's opinion (the only opinion supporting compensability) was not persuasive. Consequently, the ALJ concluded that claimant had failed to establish the compensability of her bilateral foot condition and upheld the employer's denial of that condition.

Claimant seeks to establish the compensability of bilateral foot condition as an occupational disease.[1] Therefore, she must prove that her work activities are the major contributing cause of the disease. ORS 656.802(2)(a).

[1] Dr. Kennedy diagnosed claimant's condition as "heel pain syndrome consisting of plantar fasciitis, entrapment of the first branch of the lateral plantar nerve, and calcaneal bone spur." (Ex. 16-2).

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. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for claimant's bilateral foot 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).

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, Dr. Kennedy's experience with claimant predates the onset of the 1999 heel pain.[2] As a general rule, such an opportunity places a physician in an advantageous position to offer a causation opinion. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986).

Dr. Kennedy opined that the major cause of claimant's bilateral heel condition was her work activities.[3] (Ex. 18). His opinion was based on his education, his knowledge, his experience, and his treatment of claimant both for the current condition and prior conditions. (*Id.*) According to Dr. Kennedy, claimant had "all the classic findings for heel pain syndrome to include plantar fasciitis, entrapment of the first branch of the lateral plantar nerve, and calcaneal bone spur." (Ex. 16-2). Dr. Kennedy cited specific medical literature in support of his opinion. (*Id.*) Additionally, Dr. Kennedy had an accurate understanding of claimant's work history and the onset of her current foot problems. Consequently, we find Dr. Kennedy's opinion well reasoned and persuasive.[4]

In contrast to the opinion of Dr. Kennedy are the opinions of Drs. Strum and Bald (employer-arranged examiners). Like Dr. Kennedy, Dr. Bald diagnosed bilateral plantar fasciitis. (Ex. 20-6). Also like Dr. Kennedy, Dr. Bald believed there was a causal connection between claimant's work activities and her foot condition. (*Id.*) Nonetheless, because he believed that claimant's work activities have remained the same over the last 18 1/2 years, he opined that claimant's work was not the major contributing cause. (*Id.*) Contrary to Dr. Bald's understanding, from 1993 to 1997 claimant's work did not require her to be on her feet. (Tr. 7). Because Dr. Bald did not have an accurate understanding of claimant's work history, 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).

Dr. Strum diagnosed "bilateral hindfoot pain, with elements of a mild degree of plantar fasciitis." (Ex. 12-5). Dr. Strum's diagnosis was based on his "finding of diffuse tenderness, * * *, in the absence of any other objective signs or soft tissue or bony pathology." (*Id.*) We note, however, that Dr. Strum reported x-ray findings of "plantar calcaneal osteophytes bilaterally."[5] (*Id.*) (Ex.12-6). As a result, Dr. Strum's opinion regarding the mild nature of claimant's problem appears internally inconsistent with his own reported x-ray findings. Consequently, we do not find Dr. Strum's opinion well reasoned, and as such, it is unpersuasive. *Somers*, 77 Or App at 263; *Christopher W. Wacek*, 53 Van Natta 968, 970 (2001).

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[2] Dr. Kennedy treated claimant for an unrelated bilateral bunion condition. (Tr. 12).

[3] The employer asserts that Dr. Kennedy's "best guess" opinion establishes that the opinion is legally insufficient as it is not based on "reasonable medical probability." We acknowledge that in one of his many letters Dr. Kennedy used the term "best guess." (Ex. 16-3). However, he also used the term "reasonable medical probability." (Ex. 18). After reviewing the whole of Dr. Kennedy's writings, we conclude that his opinion is based on reasonable medical probability. Therefore, we reject the employer's argument.

[4] Because Dr. Kennedy's opinion rested on all these factors, we disagree with the employer that Dr. Kennedy's opinion was based solely on a temporal relationship.

[5] Dr. Kennedy indicated that such an x-ray finding is considered "bony pathology." (Ex. 16-1). Dr. Kennedy also reported that such a finding is caused by the plantar musculature pulling the plantar periosteum away from the bone. (Ex. 16-2).

In conclusion, because we find Dr. Kennedy's opinion persuasive, we conclude that claimant has established the compensability of her bilateral foot condition. Accordingly, the ALJ's order is 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 the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated August 10, 2000 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant is awarded a $5,000 attorney fee, to be paid by the self-insured employer.

Board Member Haynes dissenting.

I disagree with the majority's conclusion that claimant has established the compensability of her bilateral foot condition. In particular, I disagree with the majority's conclusion that Dr. Kennedy's opinion is persuasive. Therefore, I respectfully dissent.

First, because resolution of the causation issue in this case depends more on expert analysis that expert observation, I conclude that Dr. Kennedy's opinion is not entitled to "attending physician" deference. *Allie v. SAIF*, 79 Or App 284, 287 (1986); *Jesse F. Robertson, Sr.*, 52 Van Natta 2221, 2222 (2000). Moreover, unlike the majority, I do not conclude that Dr. Kennedy's prior treatment of claimant for a completely unrelated condition, which is not in any way similar to her present bilateral heel condition, places him in an advantageous position to provide a causation opinion.

Even if I were to assume that Dr. Kennedy's opinion is entitled to some deference, I nonetheless, do not find his opinion sufficient to meet claimant's burden of proof. Although Dr. Kennedy acknowledged that "the exact cause of heel pain is unknown," he nonetheless opined that claimant's work was the major contributing cause of her bilateral foot condition. (Ex. 18; 21-2). In explaining his "best guess" opinion, Dr. Kennedy indicated: "[T]he most logical conclusion is that the work status is what precipitated and is the major contributing cause of [claimant's] bilateral heel pain." (Ex. 21-2). I conclude from this statement that Dr. Kennedy equates "precipitating cause" with "major contributing cause."

Dr. Kennedy does not otherwise explain his opinion regarding causation. Consequently, I find that his opinion supports only the conclusion that claimant's work is the precipitating cause of her bilateral heel pain, not necessarily the major contributing cause. *See Steven M. Kenimer*, 53 Van Natta 6 (2001). The fact that a work event precipitated a condition does not necessarily mean that the work incident was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), rev dismissed 320 Or 416 (1995); *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997); *Elaine M. Baxter*, 51 Van Natta 1898 (1999). Accordingly, I conclude that Dr. Kennedy's opinion is insufficient to meet claimant's burden of proof. ORS 656.802(2)(a).

Because Dr. Kennedy's opinion is the only medical opinion that arguably supports the compensability of claimant's bilateral foot condition, I further conclude that claimant has failed to establish the compensability of her bilateral heel pain. Because the majority reaches a different conclusion, I respectfully dissent.

In the Matter of the Compensation of
TRACY K. CALHOUN, Claimant
WCB Case No. 00-04773
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its denial of claimant's occupational disease claim for right forearm and hand conditions. On review, the issue is compensability.

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

Claimant has worked for the employer as an information systems technician since April 1997. (Ex. Aaa). Typically, claimant spent 60 percent of her time at work typing with a computer. (Tr. 8).

In October 1999, claimant began a six-month special project which resulted in an increase in her computer work to 85 percent of her work day. (Tr. 9-10). The computer work involved more use of claimant's right hand than her left. (Tr. 10).

In December 1999, claimant began to notice pain and numbness in her right hand that at times extended into the right forearm. (Tr. 11). Claimant initially sought medical treatment from Dr. Doerkson on March 15, 2000. (Ex. Aa). Dr. Doerksen's assessment was "early carpal tunnel with some tendinitis extending up into [the] forearm." (*Id.*)

On March 17, 2000, claimant filed a claim for the right hand and forearm condition. (Ex. Aaa). The claim was denied on June 13, 2000. (Ex. C). Claimant filed a request for hearing.

The ALJ relied on the medical opinions of Drs. Wilson and MacRitchie and concluded that claimant had established the compensability of right hand and forearm tendinitis condition. Consequently, the ALJ set aside the employer's denial.

Claimant seeks to establish the compensability of her right upper extremity tendinitis condition, as an occupational disease. Therefore, she must prove that her work activities are the major contributing cause of the disease. ORS 656.802(2)(a). 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. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Because of the possible alternative causes for her tendinitis 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 that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Wilson was the attending physician from April 13, 2000 to July 11, 2000. (Exs. 4-6; 5-3). Based on his examinations of claimant, and his review of the medical record, Dr. Wilson diagnosed a tendinitis condition in claimant's right hand and forearm. (Exs. Ad-1; Ae; 3-10; 3-11). During his examinations of claimant, Dr. Wilson noted tenderness localized in the flexor tendons and extensor digitorum communis of claimant's right hand and forearm, as well as swelling. (Ex. 4-10; 4-12; 4-47). According to Dr. Wilson, the major cause of claimant's tendinitis condition was her typing activities at work. (Exs. Ae; 4-18).

Dr Wilson's opinion is supported by Dr. MacRitchie, who became the treating physician on July 11, 2000. (Ex. 5-3). Like Dr. Wilson, Dr. MacRitchie diagnosed a tendinitis condition, the major cause of which was claimant's typing activities from work (Ex. 5-4; 5-6).

In contrast to the opinions of Drs. Wilson and MacRitchie is the opinion of Dr. Nathan (an employer-arranged examiner). According to Dr. Nathan, claimant merely suffered from "benign exertional myalgia" (muscle discomfort). (Exs. A-9; 3-37). Dr. Nathan's opinion is based on a belief that claimant did not exhibit sufficient findings (specific discomfort in a tendon, redness, heat, swelling, and crepitation) to warrant a diagnosis of tendinitis. (Exs. 3-7; 3-9).

The employer asserts that Dr. Nathan's opinion establishes that Drs. Wilson and MacRithcie did not have the diagnostic criteria to support a diagnosis of tendinitis. Consequently, the employer argues that the opinions of Drs. Wilson and MacRitchie are insufficient to establish the compensability of claimant's right hand and forearm condition. We disagree.

During his deposition, Dr. Nathan indicated that the minimum finding needed to support a diagnosis of tendinitis is discomfort in a particular tendon on activation. (Ex. 3-27). Here, Dr. Wilson expressly noted tenderness (discomfort) localized in particular tendons of claimant's right hand and forearm Additionally, Dr. Wilson noted swelling in claimant's right wrist. Contrary to the employer's assertions, Dr. Nathan's opinion does not establish that Drs. Wilson and MacRitchie lacked the diagnostic criteria to make a diagnosis of tendinitis. Consequently, we reject the employer's argument.

Finding no persuasive reason to do otherwise, we defer to the opinions of Drs. Wilson and MacRitchie. Consequently, we agree with the ALJ that claimant has established the compensability of her right forearm and hand conditions. *Weiland*, 64 Or App at 814.

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, 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 August 14, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the self-insured employer.

September 18, 2001 Cite as 53 Van Natta 1193 (2001)

In the Matter of the Compensation of
CHESTER L. GUNTER, JR., Claimant
WCB Case No. 00-04419
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorney
Julie Masters (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our August 20, 2001 order that affirmed the Administrative Law Judge's (ALJ's) order setting aside SAIF's denial of an injury claim for a bilateral hand condition. Specifically, SAIF asserts that the ALJ erroneously: (1) applied the material contributing cause standard rather than the major contributing cause standard; and (2) found Dr. Warren's (attending physician) causation opinion persuasive. After considering SAIF's arguments, we continue to adhere to our prior order with the following supplementation.

We begin with a brief summary of the procedural history of the claim and the ALJ's order. In January 2000, claimant filed a claim for injury to both hands resulting from a November 24, 1999 exposure to a cleaning solution containing hydrofluoric acid. (Ex. 93). SAIF denied the claim. (Ex. 141). Claimant requested a hearing.

The ALJ relied on the testimony of claimant, claimant's wife, a co-worker, and the co-worker's wife to conclude that: (1) claimant's hands had been exposed to a solution containing hydrofluoric acid on November 24, 1999;[1] and (2) claimant had the onset of hand symptoms (pain and redness) within

[1] SAIF does not dispute that, on November 24, 1999, claimant was using a cleaning solution containing hydrofluoric acid in connection with his work duties. Rather, SAIF contends that the hand condition treated by Dr. Warren was not caused by that event.

minutes of the exposure. The ALJ then relied on the opinion of Dr. Warren (attending physician) and concluded that claimant had established the compensability of his bilateral hand condition.

SAIF contends that claimant's condition is a "combined" condition, and thus the ALJ erroneously analyzed compensability using the material contributing cause standard instead of the major contributing cause standard. In particular, SAIF asserts that claimant had preexisting psychological and drug addiction problems that caused claimant to engage in self-mutilating behavior accounting for his hand problems. In other words, SAIF argues that claimant's bilateral hand condition is the result of intentionally self-inflicted blunt trauma, and not the result of any work place chemical exposure.

Contrary to SAIF's assertions, the medical evidence does not support a conclusion that claimant's bilateral hand condition is a "combined" condition. Dr. Burton (a SAIF-arranged examiner) expressly stated there was no "combining" of a preexisting condition with the occupational exposure. (Ex. 143-17). Additionally, no medical opinion in this record states that claimant's condition is a "combined" condition. Consequently, because claimant's injury is not a "combined" condition, we conclude that the ALJ correctly applied the material contributing cause standard in analyzing the compensability of claimant's bilateral hand condition.

SAIF contends that Dr. Warren's opinion is not persuasive because he failed to consider the likelihood that claimant's prior drug addiction problems would cause "drug seeking" behavior. Contrary to SAIF's assertions and as the ALJ specifically noted, Dr. "Warren cited facts which are inconsistent with drug seeking behavior; such as claimant delaying treatment for two months (despite worsening hand complaints) and reporting complete pain relief from local (and non-narcotic) anesthesia and calcium gluconate. (Ex. 156-5)." (O&O. 9).

Moreover, of the doctors expressing a causation opinion, only Dr. Warren had the opportunity (because of the surgery he performed) to closely examine the nature and extent of the damage to claimant's hands. Dr. Warren expressly stated that his surgical findings of red dry scaly skin with liquefaction necrosis of claimant's nail beds was inconsistent with either blunt or crush trauma. (Ex. 156-2). Dr. Warren further expressly opined that his surgical observations of liquefaction necrosis was most consistent with damage secondary to hydrofluoric acid. (Ex. 152-2). Finally, Dr. Warren cited several articles in the medical literature supporting his opinion that liquefaction necrosis is consistent with exposure to hydrofluoric acid. (Ex. 152). Based on such circumstances, we consider Dr. Warren's opinion to be persuasive. *See Dillon v. Whirlpool Corp.*, 172 Or App 484 (2001); *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 701 (1988).

Accordingly, we withdraw our August 20, 2001 order. On reconsideration, as supplemented, we adhere to and republish our August 20, 2001 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
EDDY MAUPIN, Claimant
Own Motion No. 66-0189M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The SAIF Corporation has submitted claimant's request for medical benefits relating to his August 21, 1962 left knee condition. SAIF recommends reopening of this claim under our own motion for the provision of a new left below-knee prosthetic leg, future supplies in the form of stump socks and repairs of the prosthetic leg for claimant's compensable condition. In addition, SAIF recommends that the claim remain open until medical services are no longer required.

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

We find that the requested medical services are reasonable and necessary and causally related to the compensable injury. Accordingly, the claim is reopened to provide the requested medical services. *See* OAR 438-012-0037.

This order shall supplement our January 15, 1993 order that previously reopened claimant's 1962 claim for the payment of compensable medical services The claim shall remain reopened to provide the requested medical services. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIA JIMINEZ, Claimant
WCB Case No. 99-10209
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of claimant's L3-4 back condition. On review, the issue is compensability.

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

As she did at hearing, claimant asserts that she proved that her condition at L3-4 is compensable as a consequential condition. *See* ORS 656.005(7)(a)(A). Alternatively, based on a previously accepted herniated disc at L4-5, claimant contends that she proved a compensable aggravation. *See* ORS 656.273(1). Claimant relies on the opinion of her treating surgeon, Dr. Zimmerman.

We first note that, in order to prove a compensable aggravation, claimant must show "an actual worsening of the compensable condition[.]" ORS 656.273(1). Here, the previously accepted condition is a herniated disc at L4-5. Because the claim at issue here solely involves the L3-4 level of claimant's low back, claimant did not establish an aggravation of her compensable condition. *See John M. Hyatt*, 52 Van Natta 1050 (2000) (no proof of aggravation when claim for new and different condition from the one accepted).

We also agree with the ALJ that Dr. Zimmerman's opinion was not sufficiently persuasive to prove a compensable consequential condition under ORS 656.005(7)(a)(A). According to Dr. Zimmerman, claimant's 1994 surgery at L4-5 (that was part of the previous accepted claim) accelerated degenerative changes at L3-4, resulting in stenosis that required additional surgery. (Ex. 92-11). Although acknowledging that, pathologically, he could not distinguish between stenosis caused by a previous surgery and stenosis caused by naturally progressing degenerative changes, Dr. Zimmerman's conclusion relied on the fact that claimant underwent surgery in 1994. (*Id.*)

Dr. Zimmerman's opinion was countered by reviewing physician, Dr. Thompson, who found it "somewhat unlikely" that a four-year period dating from the surgery would cause accelerated changes at L3-4. (Ex. 81-3). Dr. Thompson also noted that, if a "fusion effect" acted on the L3-4 level, "one would certainly expect to see accelerated degenerative changes at L5-S1 as well[.]" (*Id.*) According to Dr. Thompson, "degenerative disc changes and the surgical scarring at L4,5, are probably the major cause of her current pain complaints." (*Id.* at 4).

Orthopedic surgeon, Dr. Doerr, similarly found that claimant's low back pain was "secondary to degenerative changes," while acknowledging the possible contribution of a "L4-5 pseudoarthrosis." (Ex. 75-2). Finally, reviewing surgeon, Dr. Battalia, attributed claimant's condition to "pre-existing progressive degenerative disease[.]" (Ex. 90-1).

Dr. Zimmerman provides essentially no reasoning for his opinion in that he only bases his theory of "accelerated degenerative disease" on claimant's 1994 surgery. More specifically, he does not respond to Dr. Thompson's points that the absence of accelerated degenerative changes at L5-S1 and the short time period after the 1994 surgery show that claimant's stenosis at L3-4 is more likely due to her preexisting progressive degenerative disease. Because Dr. Zimmerman's opinion is conclusory, we find it insufficiently persuasive to prove compensability.

ORDER

The ALJ's order dated April 23, 2001 is affirmed.

September 18, 2001 Cite as 53 Van Natta 1196 (2001)

In the Matter of the Compensation of
ROBERT W. McQUEEN II, Claimant
WCB Case No. 00-05187
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
VavRosky, MacColl, Olson, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes. Member Phillips Polich concurs.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that declined to award additional temporary disability benefits from February 25, 1999 to October 11, 1999. On review, the issue is temporary disability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the fourth paragraph on page 4, we change the date in the first sentence to "June 3, 1999." In the sixth paragraph on page 4, we change "multiple left elbow problems" to "ulnar neuropathy."

Claimant, an auto body repairer, performed repetitive elbow and wrist motions as part of his work duties. He filed an occupational disease claim and, on October 19, 1998, the self-insured employer accepted disabling left elbow epicondylitis. (Ex. 8). On April 9, 1998, Dr. Wuest filed a Form 829 indicating that he was claimant's attending physician. (Ex. 2).

On August 26, 1998, the employer issued a Notice of Closure. (Ex. 16-2). Claimant requested reconsideration; a December 14, 1998 Order on Reconsideration issued affirming the Notice of Closure in its entirety. Claimant requested a hearing, raising the issues of premature closure and extent of permanent disability. (*Id.*)

Dr. Wuest remained as claimant's attending physician and continued claimant off work. (Exs. 6, 7, 10, 11).

On January 15, 1999, Dr. McGirr performed anterior transposition surgery on claimant's ulnar nerve. (Ex. 11A). On January 18, 1999, Dr. McGirr provided notice that claimant was under his professional care and that claimant had recently undergone surgery and was unable to work. (Ex. 12). On January 20, 1999, Dr. McGirr continued claimant off work. (Ex. 13). On January 29, 1999, Dr. McGirr continued claimant off work until February 24, 1999. (Ex. 14).

Claimant requested that the employer's acceptance be amended to include ulnar neuropathy. (Exs. 16-3, -4). On February 2, 1999, the employer denied that condition. (Ex. 16-1).

On February 24, 1999, Dr. McGirr reported that claimant was still treating. Dr. McGirr did not authorize temporary disability. (Ex. 15-1). On May 12, 1999, Dr. McGirr noted that claimant was not medically stationary and had pronounced left elbow swelling and decreased range of motion and function in his arm. He referred claimant to Dr. Kosek for pain evaluation. Dr. McGirr did not authorize temporary disability. (Ex. 15-2).

On June 3, 1999, Dr. Kosek evaluated claimant's elbow pain. Dr. Kosek diagnosed ulnar neuropathy and thought it likely that claimant would remain off work for at least another year due to

his on-the-job injury. (Ex. 15A). On October 12, 1999, Dr. Kosek surgically implanted a peripheral nerve stimulator, left ulnar nerve with neuroplasty. (Ex. 15A-6). The employer paid temporary disability beginning on October 12, 1999. (Ex. 24-2, -3).

On October 18, 1999, a prior ALJ issued an Opinion and Order that set aside the employer's partial denial of claimant's ulnar neuropathy condition and remanded the claim for processing according to law. The order also set aside the August 26, 1998 Notice of Closure and the December 14, 1998 Order on Reconsideration as premature and remanded the claim for processing according to law. (Ex. 16-11). This order was affirmed by the Board. (Ex. 16A-1).

On July 10, 2000, claimant filed a request for hearing, raising the issue of the employer's failure to comply with the October 18, 1999 Opinion and Order.

The hearing convened on October 3, 2000 and was continued to allow claimant's counsel to obtain additional information from Drs. McGirr and Kosek regarding claimant's entitlement to temporary disability benefits between February 25 and October 11, 1999.

On October 3, 2000, claimant's attorney wrote to Dr. McGirr regarding clarification of the authorized periods of temporary disability. (Ex. 25). On October 4, 2000, claimant sent Dr. McGirr work status reports to fill out and sign regarding claimant's February 24, 1999 and May 12, 1999 appointments. (Ex. 26). On October 23, 1999, Dr. McGirr clarified that at those times he had been of the opinion that claimant was disabled from work and, although he had not authored work releases, that had been his intention at those times. (Ex. 27). Dr. McGirr signed a Work Status Report stating that claimant was off work as of February 24, 1999, until the next evaluation. (Ex. 27-2). Dr. McGirr signed a Work Status Report stating that claimant was released from work from May 12, 1999 until he was evaluated by Dr. Kosek and that claimant would be off work for an unknown period of time. (Ex. 27-3). On November 15, 2000, Dr. McGirr concurred with Dr. Kosek's June 3, 1999 assessment that claimant would remain off work for at least one year due to his compensable injury. (Ex. 28).

The ALJ found that claimant's attending physician during the relevant period was Dr. McGirr, but concluded that claimant was not entitled to temporary disability compensation from February 25, 1999 through October 11, 1999 because it was not properly authorized. On review, the parties do not dispute the ALJ's conclusion that claimant's attending physician during the relevant period was Dr. McGirr. Claimant, however, contends that claimant should be awarded temporary disability benefits for that period.

We adopt and affirm the ALJ's order and write to address claimant's specific arguments on review.

Claimant first argues that Dr. McGirr, his attending physician, indicated that he had thought that claimant was sufficiently disabled to be unable to work as of the office visits on February 24, 1999 and May 12, 1999, and that he had intended that claimant be off work. Dr. McGirr signed work status reports specifically taking claimant off work on February 24, 1999 until his next evaluation and taking him off work on May 12, 1999 until evaluation by Dr. Kosek. (Ex. 27). Dr. McGirr also concurred with Dr. Kosek's June 3, 1999 assessment that claimant would remain off work for at least one year due to his compensable injury. (Ex. 28). Claimant contends that the doctrine of "nunc pro tunc" should apply under these circumstances so that the statutory requirements for the authorization of temporary disability are met. We disagree.

"Nunc pro tunc" is a phrase applied to acts allowed to be done after the time when they should be done, with a retroactive effect, *i.e.*, with the same effect as if regularly done, but were not because of inadvertence or mistake. *Black's Law Dictionary*, 6th Ed, p. 1069 (1990). We understand claimant's argument to be that Dr. McGirr should have provided contemporaneous authorizations of temporary disability but, because he did not do so because of inadvertence or mistake, we should give retroactive effect to his subsequent authorizations.

ORS 656.262(4)(a) provides that temporary disability compensation shall be paid if authorized by the attending physician. ORS 656.262(4)(g) expressly provides that temporary disability compensation is not due pursuant to ORS 656.268 "for any period of time not authorized by the attending physician,"

and that no authorization of temporary disability compensation by the attending physician shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance. That statute applies to limit the award of retroactive time loss to 14 days regardless of whether the claim was open or pending closure. *Menasha Corporation v. Crawford*, 332 Or 404 (2001); *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, 53, *rev dismissed* 329 Or 503 (1999).

As claimant acknowledges, Dr. McGirr did not contemporaneously authorize any temporary disability benefits for him during the time period in question. Consequently, claimant is seeking our approval of the Work Status Reports provided by Dr. McGirr on October 23, 2000 to the dates of February 24, 1999 and May 12, 1999. Were we to accede to claimant's "nunc pro tunc" argument and approve these Work Status Reports under such circumstances, we would effectively be circumventing the specific language of the statute that prohibits such a retroactive authorization. This we decline to do. Accordingly, we reject claimant's "nunc pro tunc" argument.

Claimant also relies on OAR 436-060-0020(6) (WCD Admin. Order 96-070), to argue that the employer had the duty to process the claim. Claimant asserts that the employer ceased processing the claim by failing to infer temporary disability from the medical records or to request authorization of temporary disability from Dr. McGirr. OAR 436-060-0020(6) provides:[1]

> "The insurer or self-insured employer shall verify and document temporary disability authorization from the attending physician within five days of the insurer's notice or knowledge of the worker's disability or claim. Authorization from the attending physician may be oral or written. The *insurer, or the Department at time of claim closure or reconsideration, may* infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician pursuant to ORS 656.262(4)(f)." (Emphasis supplied).[2]

The rule specifically provides that only the insurer or the Department may infer authorization and that such authority is discretionary; therefore, we do not agree that the rule places an affirmative duty on a carrier to infer authorization of temporary disability benefits from a medical report that does not clearly authorize such benefits. *See, e.g., Mark V. Moser*, 50 Van Natta 221 (1998). Moreover, in previous cases, we have held that OAR 436-060-0020(6) does not require a carrier to affirmatively obtain verification of a worker's temporary disability status. *See, e.g., Roberta F. Bieber*, 49 Van Natta 1543 (1997).

Finally, we address claimant's argument that none of the events allowing the employer to cease payment of temporary disability under ORS 656.268(4)(a) through (d) occurred that would justify the employer's failure to pay temporary disability during the period in question. We disagree.

ORS 656.268(4) provides:

> "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;

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[1] For purposes of addressing claimant's argument, we assume, without deciding, that OAR 436-060-0020(6) is valid. *See Kerry Nguyen*, 52 Van Natta 688, 689 n2 (2000).

[2] ORS 656.262 has since been renumbered and presumably OAR 436-060-0020(6) now refers to ORS 656.262(4)(g), rather than ORS 656.262(4)(f).

"(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."

The employer did not pay claimant temporary disability benefits for the period in question because claimant's attending physician had ceased to authorize temporary disability as of February 24, 1999. Under these circumstances, temporary disability compensation is not due and payable under ORS 656.262(4)(g). This qualifies as an "event" that caused temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4)(d).

In sum, because the record does not include a contemporaneous authorization of temporary disability from an attending physician for the period from February 24, 1999 through October 11, 1999, we agree with the ALJ that claimant is not entitled to temporary disability benefits for that period. Under these circumstances, we have no statutory authority to award claimant temporary disability compensation for that time period.

ORDER

The ALJ's order dated April 17, 2001 is affirmed.

Board Member Phillips Polich concurring.

Although processing time loss is primarily the burden of the insurer, the statutory scheme discussed above shifts part of the burden of processing time loss to the injured worker. The current statutory scheme allocates to the injured worker the burden to provide contemporaneous medical records that document claimant's ability, or inability, to work. In this record, there is no contemporaneous indication by Dr. McGirr that claimant could not work during the claimed time period. Therefore, under the current statutory scheme, claimant is not entitled to temporary disability compensation because he did not meet his burden of proof.

In the Matter of the Compensation of
CHRISTINA M. CARRILLO, Claimant
WCB Case No. 00-08120
ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

On September 7, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of claimant's injury claim for a cervical condition. We have received the employer's September 6, 2001 letter, announcing that the parties have resolved their dispute. Under such circumstances, we treat the employer's submission as a motion for reconsideration of our September 7, 2001 order.

In order to further consider this matter, we withdraw our September 7, 2001 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 further developments.

IT IS SO ORDERED.

In the Matter of the Compensation of
CAROLYN F. WEIGEL, Claimant
WCB Case No. 99-08645
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's injury claim for a back condition. The employer also objects to the admission of Ex. 17. On review, the issues are evidence and compensability. We reverse.

FINDINGS OF FACT

Claimant worked as a waitress for the employer. She testified that on June 17, 1999, between 7:00 p.m. and 8:30 p.m., while lifting a bus tub, she felt the onset of right leg pain from the ankle to the buttock. (Tr. II, 30).[1] Claimant testified that she informed Ali Harless, the manager on duty, that she had hurt herself. (*Id.*) Claimant stated that Harless then told her she would log the injury when she (Harless) caught up with her work. (Tr. II, 31). Claimant finished her shift that night.

On July 11, 1999, one of claimant's supervisors, Debra Monti, made a log book entry that questioned whether "anybody knew what happened to [claimant.]" (Tr. II, 14). Monti also stated that she had seen claimant limping approximately one and a half weeks prior to the July 11, 1999 log book entry, but that claimant said she did not know what had happened to her. (Tr. II, 75).

On July 13, 1999, claimant sought treatment with Laura Neely, a Nurse Practitioner. (Ex. 1). Before that time, claimant thought that she suffered from shin splints, based on what some of her supervisors had suggested. (Tr. II, 32). On July 13, 1999, claimant called Sue Ellen Shidler, restaurant manager, to institute a workers' compensation claim. (Tr. III, 10). Claimant asserted that she had told Shidler of an injury before. Shidler testified that she had not heard of any injury until that day. Shidler testified that claimant told her she needed to see a doctor but did not have the money. (Tr. III, 11).

On July 14, 1999, the employer filed a form 801 on claimant's behalf. (Ex. 2). The 801 stated that "[claimant] claims she injured her legs somehow at work, unsure how or when [,claimant] says she cant [sic] seek medical attn unless WC covers this. Mgr ?'s this claim" (Ex. 2).

On July 19, 1999, claimant sought treatment with Kathleen Puffenbarger, a Nurse Practitioner. (Ex. 3). Claimant was eventually referred to Dr. Amstutz, a neurosurgeon, on August 10, 1999. (Ex. 5). Based on her clinical presentation, Dr. Amstutz felt that claimant had a lumbar disc displacement at L4-5. (Ex. 5-3). On August 21, 1999, Dr. Vessely examined claimant at the request of the employer. (Ex. 6). Dr. Vessely similarly diagnosed an acute herniated disc, related to the June 17, 1999 injury. (Ex. 6-4, -5).

On October 12, 1999, the employer denied claimant's claim on the basis that there was "insufficient and inconsistent evidence that your current condition and need for treatment are related to your work." (Ex. 8). On October 20, 1999, Dr. Amstutz reviewed claimant's MRI scan, and found no evidence of a disc rupture. (Ex. 9-2). Dr. Amstutz and Dr. Vessely both agreed that claimant did not have a disc herniation, and that she had minor disc degeneration, not related to any work injury. (Ex. 10, 11).

Claimant then sought treatment with Dr. Wenner, who diagnosed a work-related "piriformis syndrome." (Exs. 12, 14). On August 23, 2000, Dr. Vessely stated that "piriformis syndrome" was only a possible diagnosis, and that if claimant had had the condition it would have "rapidly subsided." (Ex. 15). In December 2000, claimant sought treatment with Dr. Hagie, who diagnosed a "pelvic obliquity," caused by her work injury. (Ex. 17). Dr. Hagie's manipulations finally resolved claimant's symptoms. (*Id.*)

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[1] The hearing was continued and held on three separate dates. "Tr. I" refers to the transcript for the February 2, 2000 hearing. "Tr. II" refers to the transcript for the September 28, 2000 hearing. "Tr. III" refers to the transcript for the November 29, 2000 hearing.

Claimant requested a hearing to contest the employer's denial. At hearing, three of claimant's managers, Harless, Shidler, and Monti, denied that claimant reported an injury to them (until her July 13, 1999 conversation with Shidler.) Harless denied that claimant had reported an injury to her on June 17, 1999. (Tr. II, 48). Harless testified that she had noticed claimant limping, but stated that claimant did not know "what happened" to cause the limping. (Tr. II, 49). Harless said that claimant stated she "hoped" the injury was on-the-job, because she did not have any "homeowner's" or primary insurance coverage. (Tr. II, 51).

Claimant's boyfriend, Martin, testified that claimant injured herself at work on June 17, 1999 lifting bus tubs. (Tr. II, 22). Martin confirmed that claimant did not seek medical treatment for three to four weeks after the injury. Claimant's neighbor, Childers, testified that claimant had injured herself on June 18, 1999, but thought that claimant sought medical treatment the next day. (Tr. II, 7-11). Claimant's other neighbor, Morganti, was adamant that claimant suffered an injury in 1998, but not in 1999. (Tr. II, 18).

At the time of her injury, claimant had Oregon Health Plan coverage. (Ex. 17-2; Tr. II, 35-36).

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, finding first that claimant had established legal causation based on her "appropriate" and credible testimony. The ALJ also discounted several of the employer's witnesses based on the "inherent fallibility" of the log book, and based on the employer's financial interest in reducing workers' compensation claims.

On review, the employer first contends that claimant did not meet her burden of proving legal causation. The employer argues that claimant was not credible based on inconsistencies between her testimony and the medical record, and the contradictions of several lay witnesses. We agree.

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

It is claimant's burden to prove both legal and medical causation by a preponderance of the evidence. *Harris v. Farmer's Co-op Creamery*, 53 Or App 618 (1981). Legal causation is established by showing that claimant engaged in potentially causative work activities; whether those work activities caused claimant's condition is a question of medical causation. 53 Or App at 621.

The ALJ found claimant credible based on her demeanor and "appropriate" responses. We generally defer to an ALJ's demeanor-based credibility finding. *Erck v. Brown Oldsmobile*, 311 Or 519. 526 (1991). However, where the issue involves the substance of a witnesses' testimony, we are equally qualified to make our own determination of credibility. *Coastal Farm Supply v. Hultberg*, 94 Or App 282 (1987). Here, on *de novo* review of the substantive record, we find claimant's testimony regarding a work injury on June 17, 1999 not to be credible, based on the following reasoning.

At hearing, three of claimant's managers, Harless, Shidler, and Monti, denied that claimant ever reported an injury to them (until her July 13, 1999 conversation with Shidler). Harless denied that claimant had reported an injury to her on June 17, 1999. (Tr. II, 48). Harless testified that she had noticed claimant limping at some point, but stated that claimant professed not to know what happened to cause the limping. (Tr. II, 49). Harless said that claimant stated she "hoped" that the injury happened on the job, because she did not have any "homeowner's" insurance, and had not yet qualified for primary insurance coverage from the employer. (Tr. II, 51).

On July 11, 1999, Monti made a log book entry that questioned whether "anybody knew what happened to [claimant.]" (Tr. II, 14). Monti testified that she had seen claimant limping approximately one and a half weeks prior to the July 11, 1999 log book entry, but that, when questioned, claimant said she did not know what had happened to her. (Tr. II, 75).

Contrary to the ALJ's conclusion, Harless did not state that it she "didn't recall" claimant's reporting an injury to her on June 17, 1999, and that she "may have forgotten" to record it. (O&O at 4). Rather, Harless denied any such conversation. (Tr. II, 48). The employer's witnesses confirmed that it is the company's policy to immediately enter any report of a work injury in the "log book." (Tr. II, 54-55, 73). There is no contemporaneous entry for June 17, 1999. There is an entry for July 11, 1999, by Monti, but the notation simply questioned whether any of the other managers knew "what happened" with claimant.

Moreover, claimant's history is inconsistent in the medical reports and claim forms in the record. The July 14, 1999 801 form stated that "[claimant] claims she injured her legs somehow at work, unsure how or when [, claimant] says she cant [sic] seek medical attn unless WC covers this. Mgr ?'s this claim" (Ex. 2). Although claimant testified to a distinct injury while lifting bus tubs, on August 19, 1999, Dr. Amstutz took a history of a gradual onset of symptoms "toward the end of the shift" after waiting tables and carry dishes. (Ex. 5).

On January 19, 2000, Dr. Vessely confirmed that, contrary to his earlier impression, claimant's MRI was normal, indicating that she did not have a herniated disc. (Ex. 11). Dr. Vessely agreed that claimant's MRI findings were "inconsistent with her clinical presentation." (*Id.*)

Based on the above, we are not convinced that claimant suffered an injury on June 17, 1999. In sum, we find that claimant has not established legal causation by a preponderance of the evidence.

In addition, we find that claimant has not met her burden of proving medical causation. Claimant's only supportive medical opinion comes from Dr. Hagie. (Ex. 17A). However, Dr. Hagie's opinion depends on claimant's suffering a work injury on June 17, 1999. (*Id.*) As explained above, claimant has not proved by a preponderance of evidence that such an injury occurred. Accordingly, claimant cannot meet her burden of proof through Dr. Hagie.[2]

We are therefore not persuaded that claimant's work injury was a material contributing cause of her need for treatment or disability. Consequently, we reverse the ALJ's order and assessed attorney fee award.

ORDER

The ALJ's order dated April 25, 2001 is reversed. The employer's denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed.

[2] In light of our disposition of the ALJ's order on this basis, we need not address the employer's evidentiary argument.

In the Matter of the Compensation of
PAMELA L. DARLING, Claimant
WCB Case No. 00-00719
ORDER ON RECONSIDERATION
Swanson, et al., Claimant Attorney
Reinisch, et al., Defense Attorney

Claimant requests reconsideration of that portion of our August 24, 2001 that affirmed an Administrative Law Judge's (ALJ) order that found claimant's failure to attend three insurer-arranged medical examinations constituted an unjustified delay in the scheduled hearing pursuant to OAR 438-006-0071(1). Specifically, claimant contends that our order failed to adequately explain how a psychiatric evaluation could provide relevant information regarding the compensability of an orthopedic condition. After considering the employer's arguments, we continue to adhere to our prior order with the following supplementation.

Contrary to claimant's assertions, we did provide an "explanation" for our conclusion that it was reasonable for the insurer to seek a psychological evaluation as part of its claim processing. We specifically noted that Dr. Puziss (an attending physician) opined that claimant's psychological problems were causally related to her work activities. Furthermore, our order adopted the ALJ's order that

contained considerable reasoning on this issue. (O&O p. 7). Nonetheless, in response to claimant's motion, we offer the following additional comment.

The record does not support claimant's contention that the allegedly compensable orthopedic condition is completely independent of the psychological condition. Dr. Yarusso (the initial attending physician) reported that: (1) claimant was manipulative; and (2) there was "marked discrepancy" between his objective assessment of claimant's shoulder and her reported inability to move the shoulder. (Exs. 47-1; 57-1). Moreover, Dr. Yarusso diagnosed "hysterical conversion reaction" and requested a neuropsychiatric evaluation "in the face of negative objective findings." (Exs. 57-1; 63-2).

Dr. Yarusso's observations were supported by Dr. McNeill, an orthopedic surgeon (employer-arranged medical record reviewer). Specifically, Dr. McNeill opined that "there appears to be a psychological component to [claimant's] continued treatment of subjective complaints." (Ex. 79A-4).

Based on the comments of Dr. Yarusso, Dr McNeill, and Dr. Puziss, we conclude that, under the circumstances presented in this case, a psychiatric evaluation was a reasonable component of the employer's processing of claimant's right shoulder claim.

Accordingly, we withdraw our August 24, 2001 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our August 24, 2001 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
KEVIN G. BULOW, Claimant
WCB Case No. 00-05134
ORDER ON REVIEW
Gary Borden, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich, Bock, and Haynes. Member Haynes dissents.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's occupational disease claim for a left leg condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,100, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and representation regarding time spent on the case), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 11, 2001 is affirmed. For services on Board review, claimant's attorney is awarded $2,100, payable by SAIF.

Board Member Haynes dissenting.

After reviewing the medical evidence in this case, I am persuaded that claimant has not established compensability and that the denial should be upheld.

Claimant first sought treatment for his left leg from Mike Thompson, FNP, in February 2000. Mr. Thompson noted: "Edema in L calf area of unknown etiology." (Ex. 1-1). Claimant was evaluated for possible left leg thrombophlebitis by Dr. Williamson and Dr. Porter, at SAIF's request. (Ex. 7). After testing, they found no objective evidence of thrombophlebitis. (Ex. 10). SAIF then issued a denial of the claim on the basis that there was insufficient evidence of a work related illness or injury. (Ex. 11).

Claimant returned to Mr. Thompson on May 18, 2000 and was diagnosed with "repetitive stress injury." (Ex. 11A). On June 30, 2000, Mr. Thompson diagnosed continued pain of unknown etiology, and on July 5, 2000, the diagnosis was "cellulitis." (Exs. 11B; 11C).

Claimant was seen at SAIF's request by Dr. Wray, neurologist, and Dr. Linder, orthopedist, on August 18, 2000. These physicians were unable to state a specific diagnosis and indicated they had no strong evidence that claimant's problems were related to his working activities. (Ex. 12-6). Mr. Thompson concurred with the report of Wray and Linder. (Ex. 13). In a later letter, Dr. Linder indicated that claimant's symptoms were somewhat suggestive of a regional pain syndrome; however, Dr. Linder noted that claimant did not have the usual expected physical findings other than hypersensitivity to light touch. Dr. Linder could not relate this to claimant's industrial activities. (Ex. 14).

Dr. Carlson, who supervises Mr. Thompson, opined that the major contributing cause of claimant's disability and need for treatment of the left leg was due to his work activity that required the repetitive pressing of a stout clutch pedal. The basis of his opinion was the lack of evidence of any other contributing cause of the condition. (Ex. 15). Dr. Carlson never examined claimant personally for the left leg problem. (Ex. 16A-14).

Dr. Wray was deposed and opined that if claimant's condition was a repetitive use injury, she would expect it to get better with removal of the repetitive activity, but claimant's condition did not do so. (Ex. 16-12). She disagreed with the diagnosis of a repetitive strain injury because claimant's symptoms were not consistent with a repetitive strain injury. (Ex. 16-13; 16-17). Dr. Wray also indicated that claimant did not have any clinical findings of cellulitis. (Ex. 16-15).

At his deposition, Mr. Thompson agreed with the report of Dr. Wray and Dr. Linder except for their opinion regarding the major contributing cause of claimant's left leg problem. Although he did not know the nature or etiology of claimant's problem, Mr. Thompson believed that the major cause of the problem was claimant's work activity. (Ex. 16B-13).

Because I do not find that the medical opinions of Dr. Carlson and Mr. Thompson establish a compensable injury or disease, I would uphold the denial. In this regard, Dr. Carlson never personally examined claimant and based his opinion apparently solely on the process of elimination. (Ex. 16A-14 to 15). Dr. Wray and Dr. Linder persuasively explain why claimant's symptoms do not appear to match either a repetitive strain injury or a regional pain syndrome. Moreover, it is clear that Mr. Thompson and Dr. Carlson both base their opinion that claimant's symptoms are compensable on the elimination of other potential causes for claimant's symptoms. Such an analysis is contrary to ORS 656.266 and cannot carry claimant's burden of proof.

Because I do not find the opinions of Dr. Carlson and Mr. Thompson sufficient to establish compensability, I offer this dissent. For the foregoing reasons, I believe that the denial should be upheld.

In the Matter of the Compensation of
JOY A. KOSTA, Claimant
WCB Case No. 99-08195
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Biehl. Member Biehl chose not to sign the order.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) denied its request to admit additional evidence into the record; (2) set aside its denial of claimant's right shoulder condition. On review, the issues are evidence and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The hearing was set for May 23, 2000. In a letter of the same date, Dr. Mitchell reported that Dr. Foglesong, in an April 21, 2000 letter, had reported that claimant had severe AC degenerative joint disease in her right shoulder and had recommended surgery. (Ex. 18A). This exhibit was provided to SAIF just prior to the May 23, 2000 hearing.

In response to its receipt of Exhibit 18A, SAIF requested that the record be left open to obtain Dr. Mitchell's deposition, the x-rays from Dr. Foglesong, and Dr. Foglesong's and Dr. Hook's depositions. (Tr. 2 through 5). The ALJ granted SAIF's request to depose Dr. Mitchell and, for purposes of that deposition, to obtain the x-rays and a copy of Dr. Foglesong's April 21, 2000 letter. (Tr. 5, 6). The ALJ denied SAIF's request to depose Dr. Foglesong and Dr. Hook. (Tr. 6).

The parties agreed that the issue was compensability of claimant's right shoulder condition as an occupational disease. (Tr. 7). In his opening statement, claimant specified that his claim consisted of a combined condition (tendinitis/ impingement syndrome combined with AC degenerative joint disease) and a claim for the worsened AC degenerative joint disease itself. (Tr. 8).

SAIF asserted that it was surprised by claimant's claim for AC degenerative joint disease as a separate condition and moved for a postponement or continuance to better develop the medical record.[1] The ALJ concluded that SAIF had no basis for claiming that it was surprised by claimant's claim, as claimant had not changed the basis of her claim, which was an occupational disease claim for the right shoulder. The ALJ also concluded that SAIF would be able to address the compensability of the degenerative condition because he had given SAIF the right to depose Dr. Mitchell and bring in some of the evidence from Dr. Foglesong.

Prior to the reconvened hearing, SAIF obtained two reports from Dr. Hook and one from Dr. Foglesong. SAIF asked the ALJ if it was permissible to ask Dr. Mitchell about those reports. Claimant objected on the basis that it would circumvent the ALJ's prior ruling denying SAIF's request to depose Dr. Foglesong and Dr. Hook. The ALJ agreed.

At hearing, the ALJ declined to admit the submitted medical reports (proposed Exhibits 18B, 18C, and 18D), but allowed them to remain in the record as an "offer of proof." (Tr. II). On the merits, the ALJ set aside SAIF's denial.

SAIF contends that the ALJ abused his discretion by declining to admit proposed Exhibits 18B, 18C and 18D at the continued hearing. SAIF also argues that, even if we only considered the medical records admitted into evidence, the ALJ's decision to set aside the denial should be reversed, contending that there was no persuasive medical evidence in the record that established that claimant's work activities were the major contributing cause of her right shoulder condition.

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[1] Because SAIF's motion occurred after the hearing had commenced, and was in response to what SAIF 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).

We need not decide the evidentiary issue that SAIF raises. That is, even if we considered the excluded evidence, we would still find that claimant failed to prove a compensable occupational disease claim.

To establish the compensability of her occupational disease claim, claimant must prove that her work activities are the major contributing cause of the disease itself. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). If the occupational disease claim is based on the worsening of a preexisting disease or a "combined" condition pursuant to ORS 656.005(7), claimant must prove that her work activities were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b). To satisfy the "major contributing cause" standard, claimant must prove 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. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

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).

There are three medical opinions regarding the cause of claimant's right shoulder condition. Dr. Foglesong is an orthopedic surgeon who treated claimant for her earlier left shoulder condition and for her right shoulder condition on referral from Dr. Schwertzler. Dr. Foglesong diagnosed claimant's condition as a shoulder strain and persistent impingement, which he initially thought was most likely due to work. (Ex. 3). Dr. Foglesong subsequently concurred with Dr. Hook's opinion that claimant's injury was not due to her work activities. (Ex. 9). In a later opinion, Dr. Foglesong opined that claimant's status as a female between the ages of 40 and 50 was a risk factor for causing impingement syndrome. Although Dr. Foglesong concluded that claimant's work activity was the major contributing cause of her need for treatment, he was unable to say whether the major contributing cause of claimant's shoulder strain/impingement syndrome was [due to] her work activities. (Ex. 12-2). Dr. Foglesong's opinion does not satisfy claimant's burden of proof in an occupational disease context, because he concluded that claimant's work activity was the major contributing cause of her need for treatment, as opposed to the major contributing cause of her condition.

Dr. Hook, who saw claimant on one occasion for rehabilitation evaluation, diagnosed claimant with shoulder strain with subjective impingement signs. Dr. Hook was asked by SAIF about claimant's right shoulder condition in an injury context. He relied on a history that claimant initially sustained her injury when she placed her hands in parade rest position at a Boy Scout event. He also reviewed a videotape of claimant's work. He concluded that claimant's injury was not a result of work, although he thought that her recovery may have been prolonged by work. (Ex. 9-2, -3).

Dr. Hook was later queried by SAIF about her subsequent treatment by Dr. Mitchell and studies of her shoulder. Dr. Hook concluded that claimant's degenerative condition in the distal supraspinatus tendon was also not attributable to her injury. When asked about the difference between a shoulder strain, tendonitis and impingement syndrome, he explained that weakness of the rotator cuff muscles could lead to signs of impingement, and that the tendency toward repetitive motion injury noted by Dr. Mitchell in an earlier report would indicate a weakness in the rotator cuff muscles, which could lead to impingement and to tendonitis. Dr. Hook declined to change his earlier opinion regarding causation. (Ex. 17A).

After being advised of Dr. Foglesong's findings of severe AC degenerative joint disease, Dr. Mitchell, claimant's treating family practice physician, diagnosed claimant's condition as impingement/tendonitis, combined with AC degenerative joint disease. He opined that the major contributing cause of the need for treatment in claimant's right shoulder was her work activities as he reviewed them on the video tape. Dr. Mitchell also opined that it was probable that the AC degenerative joint disease was caused or worsened by her work activity. (Ex. 18A).

However, in his deposition, Dr. Mitchell admitted that he had no special expertise in shoulder conditions and that he had not taken a history from claimant regarding her non-work activities. (Ex. 19-6). When asked about claimant's tendency to repetitive motion disease in her shoulders that he had noted earlier and whether she was having problems with the other (left) shoulder, he again remarked that he was not a shoulder expert and that his note should not be taken "literally." (*Id.*)

In discussing the degenerative conditions revealed by the MRI, he again stated that he was not a shoulder expert and was relying on Dr. Erbe's interpretation of the MRI, not his own reading of it. (Ex. 19-11). Dr. Mitchell also deferred to Dr. Foglesong's x-ray findings and analysis of a severe degenerative condition in claimant's right shoulder. (Ex. 19-15).

In discussing the relationship of tendinitis or impingement to the degenerative condition, Dr. Mitchell said they may be entirely separate, or that, he supposed, one could cause the other. (Ex. 19-16). When asked how he concluded that the tendinitis/impingement condition combined with the degenerative condition, Dr. Mitchell stated that he based his opinion on claimant's history that she developed shoulder pain at work and it persisted. (Ex. 19-17). Dr. Mitchell stated that each of these conditions (tendinitis, impingement, degenerative disease) alone could cause persistent pain. (Ex. 19-17, -18). He also admitted that claimant's work activities could be another factor in her continued shoulder symptoms. (Ex. 19-20). However, Dr. Mitchell was unable to sort out which of these conditions was the source of claimant's symptoms or the relative contribution of the different factors. (Ex. 19-19).

Finally, Dr. Mitchell opined that, if the degenerative condition was causing claimant's symptoms, it was worsened by work, which made it symptomatic. (Ex. 19-21). But later in the deposition, Dr. Mitchell admitted that he did not know whether work activity causes AC joint disease, or whether work activities would pathologically or symptomatically worsen AC joint disease. (Ex. 19-23, -24). Dr. Mitchell also opined that, if the tendinitis or impingement was causing claimant's symptoms, [that] the major contributing cause was [caused by] claimant's work. Later, he stated that he believed that tendinitis or impingement can be caused by work. (Ex. 19-24).

After reviewing the medical evidence, we conclude that Dr. Mitchell's confusing opinion, the only opinion that arguably supports compensability of claimant's right shoulder condition, is insufficient to meet claimant's burden under *Dietz*. Moreover, Dr. Mitchell's opinion is insufficient to establish compensability of claimant's AC degenerative condition, as he does not know whether work activity causes AC degenerative joint disease, or whether work activity would pathologically or symptomatically worsen AC joint disease. Consequently, we reverse the ALJ's opinion regarding compensability.

ORDER

The ALJ's order dated April 23, 2001 is reversed. The attorney fee is also reversed.

September 19, 2001 Cite as 53 Van Natta 1207 (2001)

In the Matter of the Compensation of
CATHERINE A. O'HARE, Claimant
WCB Case No. 99-08582
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Bostwick, et al., Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl. Member Biehl chose not to sign the order.

Claimant requests review of Administrative Law Judge (ALJ) CrummΘ's order that: (1) excluded Exhibits 49A, 53A, 54A, 58A, 60 and 61; and (2) upheld the self-insured employer's denials of her injury claims for right shoulder and neck conditions and a right shoulder impingement syndrome condition. In her brief, claimant moves for remand for further evidence taking. On review, the issues are the ALJ's evidentiary rulings, remand and compensability.

We adopt and affirm the ALJ's order, with the following supplementation to address claimant's arguments regarding the ALJ's evidentiary rulings and request for remand.

On February 5, 1999, claimant underwent a diskectomy and fusion at C5-6 and C6-7. Her symptoms resolved and she returned to work at the employer. On May 20, 1999, she experienced right neck and shoulder symptoms after pulling a stuck drawer at work. She filed a claim.

In July 1999, Dr. Whitsel, claimant's primary care physician, and Dr. Gallo, who had performed her neck surgery, evaluated claimant's condition. Dr. Gallo opined that claimant's recent episode of neck pain was not a reinjury, but the expected waxing and waning of symptoms; Dr. Whitsel concurred. The employer denied the claim on September 23, 1999, and claimant requested a hearing.

On October 15, 1999, Dr. Macha evaluated claimant's right shoulder on referral from Dr. Whitsel. Dr. Macha reported that, after the drawer incident at work, claimant had experienced pain with use of the shoulder in forward flexion and abduction and with work at arm's length or overhead. Dr. Macha diagnosed claimant's right shoulder condition as a probable impingement syndrome. In a January 14, 2000 letter, Dr. Macha indicated that the May 20, 1999 work incident was the major contributing cause of claimant's impingement syndrome and her need for treatment.

The hearing, originally scheduled for February 2, 2000, was postponed at the employer's request, in order to respond to Dr. Macha's opinion. Beginning about February 1, 2000, claimant's former counsel requested that the employer obtain and disclose Dr. Macha's chart notes.[1]

On April 5, 2000, the hearing was rescheduled for June 1, 2000.

On April 27, 2000, the employer denied claimant's right shoulder impingement condition. By letter of the same date, the employer stated that it was claimant's responsibility to obtain any further records from Dr. Macha.

In a May 17, 2000 letter, claimant's former counsel moved for an order directing the employer to obtain and disclose Dr. Macha's chart notes.

On May 31, 2000, an unrecorded telephone conference call took place between the ALJ, claimant's former counsel and the employer's counsel. Claimant's former counsel acknowledged that his motion had become moot because he had determined earlier that day that claimant had obtained and provided to him copies of Dr. Macha's chart notes. The parties and the ALJ agreed that the case would be taken off the docket pending probable settlement and that the ALJ would order the record frozen except for depositions of Drs. Gallo and Macha.

On June 19, 2000, the ALJ rescheduled the hearing for September 12, 2000.

On June 22, 2000, the ALJ issued an interim order stating:

> "Pursuant to agreement of counsel during a conference telephone call on May 31, 2000, the medical evidence in this matter should be limited to the existing exhibits plus the depositions of Drs. Gallo and Macha."

In a July 25, 2000 letter, claimant's former counsel requested cross-examination of Dr. Macha, based on the employer's submission of Exhibit 57, a March 29, 2000 letter by Dr. Macha regarding the cause of claimant's impingement syndrome. The deposition was scheduled for October 2, 2000.

On August 24, 2000, claimant's former counsel submitted Exhibits 49A, 53A, 54A, and 58A, consisting of Dr. Macha's chart notes; and Exhibit 60, a letter/response by Dr. Whitsel dated May 16, 2000.

On September 11, 2000, claimant reported settlement. On November 7, 2000, claimant obtained new counsel.

On December 12, 2000, the employer's counsel filed a motion to strike Exhibits 49A, 53A, 54A, 58A and 60 on the basis that the ALJ's June 22, 2000 Interim Order "limited the medical evidence to the exhibits existing as of that date plus the depositions of Drs. Gallo and Macha." (Emphasis in original).

On December 28, 2000, the hearing was rescheduled for March 19, 2001. Dr. Macha's deposition was set for January 31, 2001, but was again cancelled pending settlement.

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[1] Beginning with this paragraph, our findings are based on material contained in the hearing file.

In a February 12, 2001 Interim Order, the ALJ granted the employer's motion to exclude Exhibits 49A, 53A, 54A, 58A, and 60, reasoning that claimant's former attorney, who had received discovery of the disputed documents and was aware of Exhibit 60 at the time of the March 31, 2000 conference call, did not object to the June 22, 2000 Interim Order after it was published and did not offer the disputed exhibits until August 24, 2000.

Sometime during the week of March 5, 2001, claimant began trying to reschedule the deposition with Dr. Macha. The employer had a conflict with the two dates that Dr. Macha had available prior to the March 19, 2001 hearing. Claimant used the time Dr. Macha had available on March 13, 2001 for a conference call regarding matters that would have been covered in the deposition. Claimant prepared a summary of that conference call, which was signed by Dr. Macha on March 14, 2001. On March 15, 2001, claimant's counsel moved to leave the evidentiary record open at the end of hearing for the taking of Dr. Macha's deposition.

At hearing, claimant's counsel moved that the ALJ reconsider the June 22, 2000 and December 12, 2000 Interim Orders and permit Exhibits 49A, 53A, 54A, 58A, and 60 to become part of the evidentiary record. The ALJ denied the motion.

Claimant's counsel also requested that the ALJ consider the motion he filed on March 15, 2000, to leave the evidentiary record open for the taking of Dr. Macha's deposition. Alternatively, claimant's counsel moved that the ALJ accept into evidence Exhibit 61, Dr. Macha's March 14, 2001 response to a telephone conference call. The ALJ concluded that claimant had not exercised due diligence because she had not reached a completed settlement or obtained the requested deposition after the June 1, 2000 hearing was postponed in May 2000. The ALJ denied claimant's motion to continue the hearing for the deposition of Dr. Macha. The ALJ also denied the offer of Exhibit 61 on the ground that it was beyond the scope of the parties' agreement as documented in the June 22, 2000 Interim Order.

On review, claimant contends that the ALJ erred in excluding Exhibits 49A, 53A, 54A, 58A, 60 and 61, and requests remand for additional evidence taking. Because the circumstances surrounding Exhibits 49A, 53A, 54A, 58A and 60 are different from those surrounding Exhibit 61 are different, we analyze them separately.

Although we generally review an ALJ's evidentiary ruling for abuse of discretion, we need not do so in regard to the ALJ's ruling regarding Exhibits 49A, 53A, 54A, 58A and 60 because, even if those exhibits were considered, they are not likely to affect the outcome of the case. Thus, remand for admission of these documents into the record is not warranted. *See* ORS 656.295(5); *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Claimant next contends that the ALJ erred in denying her motion to continue the hearing for the deposition of Dr. Macha. We disagree.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. The statute has been interpreted to give ALJ's broad discretion in admitting or excluding evidence. *See Brown v. SAIF*, 51 Or App 389, 394 (1981); *Jesus J. Ferrer*, 53 Van Natta 703 (2001). We review the ALJ's ruling on a motion for continuance for abuse of discretion. *See, e.g., Jerry D. Thatcher*, 50 Van Natta 888 (1998); *Sharron D. Lemley*, 49 Van Natta 1365 (1997).

OAR 438-006-0091 provides that continuances are disfavored. The rule permits a continuance, however, "[u]pon a showing of due diligence if necessary to afford reasonable opportunity to cross-examine on documentary medical or vocational evidence." OAR 438-006-0091(2). In order for a hearing to be continued, the party requesting the continuance must establish "due diligence." *See SAIF v. Kurcin*, 160 Or App 489 (1999).

Here, the ALJ left the June 1, 2000 hearing record open to receive Dr. Macha's deposition. The deposition was first scheduled for October 2, 2000. On September 11, 2000, claimant reported settlement. The hearing was taken off the docket and the deposition was cancelled.

On November 7, 2000, claimant obtained new counsel. Dr. Macha's deposition was rescheduled for January 31, 2001 and was again cancelled pending settlement. On December 28, 2000, the hearing was rescheduled for March 19, 2001. On or about March 5, 2001, claimant began the process of

rescheduling Dr. Macha's deposition. The employer had a conflict with the two dates that Dr. Macha was available prior to hearing. Claimant used the time Dr. Macha had available on March 13, 2001 for a conference call regarding matters that would have been covered in the deposition. Claimant prepared a summary of that conference call, which was received on March 14, 2001. On March 15, 2001, claimant moved to leave the evidentiary record open at the end of hearing for the taking of Dr. Macha's deposition.

The ALJ denied claimant's motion to continue the hearing for Dr. Macha's deposition, concluding that claimant had not exercised due diligence because she had neither reached a completed settlement nor obtained the requested deposition after the hearing was postponed in May 2000. The ALJ also denied the offer of Exhibit 61 on the ground that it was beyond the scope of the parties' agreement as documented in the June 22, 2000 Interim Order.

Here, a hearing was first set for February 2, 2000, and was postponed four times prior to the March 19, 2001 hearing before the ALJ. Three of the postponements resulted from pending settlement of the case.[2] Dr. Macha's deposition had been postponed on two occasions before claimant obtained her present counsel in November 2000. Although Dr. Macha's deposition was set for the third time for January 31, 2001, it was again cancelled due to settlement negotiations. Thereafter, no further attempts were apparently made by claimant to reschedule Dr. Macha's deposition until about ten working days before the March 19, 2001 hearing.[3] Under the circumstances of this particular case, we conclude that the ALJ did not abuse his discretion in declining to grant a continuance of the hearing for the deposition of Dr. Macha.

Finally, there was no abuse of discretion in excluding Exhibit 61, the summary of claimant's conference call with Dr. Macha. As discussed above, claimant had had several opportunities to depose Dr. Macha. Because the employer was not available within the limited time within which claimant tried to reschedule the deposition, claimant discussed the matter with Dr. Macha and obtained a signed summary of their discussion. This summary, however, clearly violated the ALJ's interim order limiting further evidence to a *deposition* of Dr. Macha. Accordingly, under these particular circumstances, we do not conclude that the ALJ abused his discretion in refusing to admit Proposed Exhibit 61.

In sum, based on our review, we find that the ALJ did not abuse his discretion in denying a continuance for the deposition of Dr. Macha and we deny remand for admission of Exhibits 49A, 53A, 54A, 58A, 60 and 61.

ORDER

The ALJ's order dated April 18, 2001 is affirmed.

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[2] The first postponement was due to the employer's request.

[3] Notice of a pending settlement was not reported to the Hearings Division, seeking neither postponement nor cancellation of the March 2001 hearing.

In the Matter of the Compensation of
LAURA A. HEISLER, Claimant
WCB Case No. 00-00065
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Meyers. Member Meyers chose not to sign the order.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's injury claim for a cervical condition; and (2) awarded an $8,000 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.

Claimant felt the sudden onset of neck and back pain while working as a home health aid in November 1992.[1] (Ex. A). Claimant sought medical services, and filed a claim for Workers' Compensation Benefits. (Ex. E). The claim was accepted without a specification of the conditions accepted. (Ex. T). The claim was closed in September 1993 with an award of 11 percent (35.2 degrees) unscheduled permanent disability.[2] (Ex. 10).

Following a medical arbiter evaluation, a May 1994 Order on Reconsideration increased claimant's unscheduled permanent disability to 18 percent (57.6 degrees). (Ex. 16).

Claimant continued to experience neck and left shoulder pain. From May 1994 through February 1999, claimant had many diagnostic tests, including several MRI scans, selective nerve root blocks, and discography. As a result, claimant requested that the insurer accept "disc derangement at C5-6, disc herniation at C5-6, annular tear at C5-6, and a combined condition giving rise to a need for surgery." (Ex. 56C). When the insurer declined to accept those conditions, claimant requested a hearing. (Ex. 57).

The ALJ relied on the opinions of Drs. Karasek and Hacker and concluded that the major contributing cause of claimant's C5-6 disc condition was the 1992 work injury.[3] Consequently, the ALJ set aside the insurer's denial. The ALJ also awarded an $8,000 assessed attorney fee under ORS 656.386(1).

Because of the possible alternative causes for her cervical disc 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 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).

When there is a dispute between medical experts, more weight is given to those medical opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Denekas, an insurer-arranged examiner, opined that claimant's C5-6 disc condition was in part responsible for her ongoing neck pain. (Ex. 55-7). Dr. Denekas further opined that the major contributing cause of claimant's disc condition and her need for treatment was a "pre-existing cervical spondylitic disease." (Ex. 55-8). Dr. Denekas explained that his opinion was based upon a belief that claimant's pain following the November 1992 work injury had resolved by January 1993.[4] (*Id.*)

Claimant, however, testified that the burning sensation in her neck, as well as her left shoulder and arm pain, have been present since the 1992 work injury. (Tr. 5, 6). Claimant's testimony was not contested. Additionally, a March 23, 1993 chart note by Dr. Panum recorded claimant's history as having "had continued pain since her initial injury in November 1992." (Ex. N). Consequently, we conclude that claimant's pain following the November 1992 work injury did not resolve in January 1993. Having concluded that claimant's neck pain did not resolve in January 1993, we further conclude that Dr. Denekas' opinion is based on an inaccurate history. Consequently, we do not find Dr. Denekas' opinion persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Dr. Donahoo, another insurer-arranged examiner, opined that claimant's C5-6 disc condition is not of consequence. (Ex. 59-12). Rather, Dr. Donahoo, an orthopedic surgeon, opined that claimant's symptom complex represented a chronic pain syndrome, the major cause of which was claimant's "pre-existing personality traits." (Ex. 59-12; 59-13).

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[1] Following a return to regular work in early 1993, claimant's symptoms worsened to include tingling into the left hand and numbness in the left arm. (Exs. L; N; P).

[2] The claim was initially closed in February 1993, but subsequently reopened in March 1993. (Ex. 10).

[3] The parties do not dispute the ALJ's determination that the major contributing cause standard applies to this claim.

[4] In rendering his opinion, Dr. Denekas noted that if there was evidence showing claimant did not have a full recovery from the November 1992 work injury, it is conceivable that her ongoing complaints are related to the 1992 work injury. (Ex. 55-8).

Dr. Donahoo did not identify which of claimant's personality traits caused her chronic pain syndrome. Nor did Dr. Donahoo explain how a personality trait could cause a chronic pain syndrome. Because the record does not contain any medical evidence (other than Dr. Donahoo's statement) that claimant has a psychological or personality disorder, we conclude that, absent additional explanation, Dr. Donahoo's opinion is merely an unsupported conclusion, and as such is not persuasive. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

Dr. Karasek has been claimant's attending physician since January 1998.[5] (Ex. 42A). Dr. Karasek has opined that claimant has a C5-6 discal pain syndrome related to her work her work injury of November 1992.[6] (Ex. 56). According to Dr. Karasek, claimant has a tear in the posterior discal material causing a buckling of the disc centrally at C5-6. (Ex. 61-1). As explained by Dr. Karasek, claimant's continued pain is largely an axial pain syndrome with referred pain to the left arm. (*Id.*) Dr. Karasek further explained that because claimant's arm pain is "referred pain from a skeletal axial pain source," the arm pain does not adhere to strict dermatomal consistency. (*Id.*)

Dr. Hacker, a consulting neurosurgeon, concurred with Dr. Karasek and opined that the major contributing cause of claimant's need for treatment was the 1992 work injury. (Ex. 58). Dr. Hacker described claimant's pain as "cervical brachial pain" consistent with cervical disc injury. (Ex. 60-1).

Considering the medical record as a whole, we find that the opinions of Drs. Karasek and Hacker, taken together, best explain the nature and source of claimant's ongoing neck and arm pain.[7] Consequently, we find their opinions well reasoned and based upon complete information; as such, we find their opinions persuasive. *Somers*, 77 Or App at 263. Accordingly, we conclude that claimant has established the compensability of her C5-6 disc condition.[8]

The insurer argues that the ALJ's $8,000 attorney fee award was excessive, because the hearing was short (about 90 minutes) and the issues involved were of average complexity. The insurer asserts that the fee should not exceed $4,000. Claimant responds that the ALJ's fee award was appropriate, considering that the case involved a medical condition dating back to 1992, the benefit to claimant, the value of the claim, and the number of medical exhibits that claimant's counsel was required to obtain in the face of a vigorous defense.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4), as applied to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute at the hearing was the compensability of claimant's C5-6 disc condition. The hearing lasted about an hour and 25 minutes not including closing arguments. The record consists of about 118 exhibits spanning an 8 year time period.

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[5] Dr. Karasek first saw claimant in February 1997 as a consulting neurologist. (Ex. 45).

[6] Dr. Karasek related claimant's disc problem to her work because her complaints had been continuous since the time of the injury. (Ex. 55). Dr. Karasek did not differentiate between material and major contributing cause.

[7] We note that the opinions of Dr. Karasek and Hacker are consistent with the opinions of Dr. Hunt, an insurer-arranged examiner, and Dr. Slack, a medical arbiter. Dr. Hunt opined in 1993 that something in claimant's cervical spine (a single lesion) may account for all her problems. (Ex. R-6). Dr. Slack opined that claimant C5-6 disc protrusion and chronic neck pain was secondary to on-the-job injury. (Ex. 54B-2).

[8] We acknowledge the insurer's argument that the opinions of Drs. Karasek and Hacker are not persuasive because their opinions fail to account for the absence of a C5-6 abnormality on the 1994 MRI (Exhibit 17). However, in light of Dr. Denekas' statement that the 1994 MRI did in fact reveal a C5-6 abnormality, we reject the insurer's argument. (Ex. 55-4).

The case involved issues of greater than average factual and legal complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are significant, especially considering claimant's need for surgery. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous challenge. *See Robert W. Smith*, 53 Van Natta 313, 314 (2001).

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $8,000 is a reasonable attorney fee for services at the hearings level. 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 value of the interest involved, the nature of the proceeding, and the risk that claimant's counsel might go uncompensated.

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

ORDER

The ALJ's order dated April 12, 2001 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the insurer.

In the Matter of the Compensation of
JOHN B. RILEY, Claimant
Own Motion No. 01-0261M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Welch, et al., Claimant Attorney
Employers Ins. of Wausau, Insurance Carrier

Reviewing panel: Members Haynes and Biehl.

Claimant requests review of the insurer's June 28, 2001 Notice of Closure, which closed his claim with an award of temporary disability compensation from February 10, 1999 through April 6, 2001. The insurer declared claimant medically stationary as of April 6, 2001. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.[1]

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 June 28, 2001 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

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[1] On February 20, 1998, we issued an Own Motion Order, which reopened claimant's 1970 claim for the provision of temporary disability compensation. (Own Motion Case No. 97-0584M). The insurer's June 28, 2001, Notice of Closure pertains to that claim.

Dr. Waldram, claimant's attending physician since 1985, treated claimant for the 1997 worsening which required surgery.[2] Dr. Waldram last examined claimant on May 30, 2000, noting that claimant continued to be totally disabled and warning that future surgery was to be approached with caution. He gave claimant a steroid injection.

Dr. Waldram retired following the May 30, 2000 examination and referred claimant to Dr. Weston for further care. Dr. Weston first examined claimant on January 25, 2001. After conducting an extensive physical examination and reviewing claimant's voluminous medical records, Dr. Weston diagnosed a rigid kyphotic deformity and failed back syndrome. He recommended a back brace to help make claimant "more active" and pool therapy. Dr. Weston also noted that "further surgery is not going to benefit this unless [claimant's] spine shape can be changed markedly." He opined that claimant's condition "should be treated nonsurgically from here on out." Dr. Weston agreed to follow-up with claimant intermittently on an "as-needed basis."

In an April 6, 2001 response to the insurer's inquiry, Dr. Weston agreed that claimant's condition had reached "a plateau" and met the definition of medically stationary; *i.e.* claimant's condition would not materially improve with the further medical treatment or the passage of time. Relying on Dr. Weston's conclusions, the insurer declared claimant medically stationary as of April 6, 2001 and closed his claim on June 28, 2001.

Claimant contends that the insurer should not have relied on Dr. Weston's opinion regarding his medically stationary status because he is not his attending physician. Rather, he contends that he was not medically stationary at the time of closure because "the attending physician has not formally declared him medically stationary," and is entitled to further temporary disability benefits.

For the 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 Clarinda S. Keys*, 52 Van Natta 1472 (2000); *Patricia M. Knupp*, 46 Van Natta 2406 (1994); *Francisco Villagrana*, 45 Van Natta 1504 (1993). Therefore, we reject claimant's contention that Dr. Weston's opinion cannot be considered.[3]

After conducting a detailed review of claimant's medical history and performing an in-depth examination, Dr. Weston provided a thorough analysis of claimant's current condition. Although recommending a back brace and pool therapy, Dr. Weston opined that claimant's condition should be treated nonsurgically in the future. Of most importance, in April 2001, he agreed that claimant's condition was medically stationary and would not materially improve with further treatment or the passage of time.

We rely on Dr. Weston's opinion. In reaching this conclusion, we note that Dr. Waldram last saw claimant in May 2000, when he stated that claimant was "disabled totally" and that further surgery should be approached "with caution." Nonetheless, that opinion does not reflect claimant's medically stationary status in April 2001 (when his condition was considered medically stationary) and June 2001 (when his claim was closed).

In conclusion, based on Dr. Weston's persuasive opinion, we find that claimant's condition was medically stationary on the date his claim was closed. Therefore, the insurer's closure was proper.

Accordingly, the June 28, 2001 Notice of Closure is affirmed.

IT IS SO ORDERED.

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[2] Claimant underwent low back surgery on November 11, 1997.

[3] In any event, the record establishes that Dr. Weston was claimant's attending physician at the time of claim closure.

In the Matter of the Compensation of
LINDA J. JACKSON, Claimant
WCB Case Nos. 00-06506 & 00-04944
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Holtan's order that: (1) found that claimant was medically stationary on May 18, 2000 and was not entitled to temporary disability benefits after that date; and (2) declined to award claimant's counsel an attorney fee under ORS 656.382(2) for the SAIF Corporation's withdrawal of its hearing request. On review, the issues are jurisdiction, temporary disability and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second sentence of the second paragraph on page 5, for which we substitute the following: At the hearing, SAIF withdrew its request for hearing from the Order on Reconsideration. (Ex. 48; Tr. 5-6).

CONCLUSIONS OF LAW AND OPINION

Claimant is a machine operator for the employer. In 1998, she began to experience left arm pain. On June 28, 1999, claimant's family practitioner, Dr. LeBow, diagnosed left lateral epicondylitis. SAIF accepted her claim for left lateral epicondylitis. (Ex. 27).

On May 31, 2000, SAIF issued a Notice of Closure, which found claimant medically stationary as of April 18, 2000 and awarded temporary partial disability from September 11, 1999 through February 9, 2000. SAIF also claimed an overpayment of $2,906.91. (Ex. 42). Claimant requested reconsideration.

On June 29, 2000, claimant requested a hearing, raising the issues of compensability, penalties and attorney fees (WCB Case. No. 00-04944). (Hearing file). On August 15, 2000, claimant amended her request for hearing, raising the issue of procedural entitlement to temporary disability beginning March 24, 2000. (*Id.*)

On August 15, 2000, the Department issued an Order on Reconsideration that rescinded the Notice of Closure as premature. (Ex. 43). On August 25, 2000, SAIF requested a hearing on the Order on Reconsideration, raising the issue of premature closure. (WCB Case No. 00-06506). Claimant did not file a cross-request for hearing on the Order on Reconsideration. At the consolidated hearing regarding claimant's and SAIF's hearing requests, SAIF withdrew its challenge to the Order on Reconsideration. (Tr. 5).

Here, SAIF was the only party to timely request a hearing in regard to the reconsideration order. In her June 2000 request for hearing, as amended on September 11, 2000 (WCB Case No. 00-04944), claimant raised only the issues of compensability (regarding SAIF's denials of a cervical strain, low back strain, and left arm radiculitis); temporary disability after March 24, 2000 (interim compensation related to SAIF's denials); penalties, and attorney fees. Claimant's request for hearing did not appeal the August 15, 2000 Order on Reconsideration, nor did she raise any issues pertaining to the Order on Reconsideration prior to hearing.

As previously noted, at the time of the hearing, SAIF withdrew its hearing request challenging the Order on Reconsideration in its entirety. The ALJ concluded that claimant was medically stationary as of May 18, 2000, and directed SAIF to pay temporary partial disability through that date. The ALJ concluded that there was no overpayment by SAIF between February 9, 2000 and May 18, 2000. Claimant requested Board review.

After SAIF's withdrawal of its hearing request regarding the Order on Reconsideration, there remained no timely request for hearing that would vest jurisdiction over the reconsideration order in the

Hearings Division. Compare *Zigurds Laurins*, 46 Van Natta 1238 (1994) (a non-appealing party may challenge a permanent disability award, even in the absence of a formal cross-request for hearing, provided that the appealing party's request for hearing from the Order on Reconsideration has not been withdrawn or dismissed). Therefore, the ALJ was without authority to address issues arising from the Order on Reconsideration, which had rescinded the Notice of Closure in its entirety.[1] Under such circumstances, those portions of the ALJ's order that addressed issues arising from the Order on Reconsideration, including the offset issue,[2] claimant's medically stationary date and substantive entitlement to temporary disability benefits, are vacated. The Order on Reconsideration setting aside the Notice of Closure is reinstated and the claim remains in open status.

Claimant also argues that she is entitled to an attorney fee because SAIF did not withdraw its hearing request until after the hearing was convened. We disagree.

ORS 656.382(2) authorizes an attorney fee award if a carrier requests a hearing and an ALJ subsequently "finds that compensation to a claimant should not be disallowed or reduced." The ALJ must decide on the merits that the claimant's award of compensation should not be disallowed or reduced. *Strazi v. SAIF*, 109 Or App 105, 108 (1991); *see SAIF v. Curry*, 297 Or 504, 510 (1984) (ORS 656.382(2) authorizes attorney fee award when court actually allows employer's petition for review and decides that awarded compensation should not be disallowed or reduced); *Gerard R. Schiller*, 48 Van Natta 854 (1996).

Claimant argues that the fact that SAIF withdrew its request for hearing after the hearing was convened entitles him to an attorney fee. Even if SAIF withdrew its hearing request after the hearing convened, claimant is not entitled to an attorney fee. The deciding factor is not whether the hearing convened before SAIF withdrew its hearing request. Rather, the deciding factor is that, as a result of SAIF's withdrawal of its hearing request, the ALJ had no authority to decide on the merits that claimant's award of compensation should not be disallowed or reduced. Thus, the terms of ORS 656.382(2) were not met. Accordingly, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2).

ORDER

The ALJ's order dated May 4, 2001 is vacated in part and affirmed in part. That portion of the ALJ's order that addressed issues pertaining to the Order on Reconsideration is vacated. The Order on Reconsideration is reinstated. The remainder of the ALJ's order is affirmed.

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[1] We distinguish the present case from *James S. Franklin*, 43 Van Natta 2323 (1991). In *Franklin*, the insurer requested a reduction of the unscheduled permanent disability award at hearing, but did not file a formal cross-request for hearing. The claimant attempted to withdraw his hearing request on the issue of extent of unscheduled permanent disability, contending that the ALJ was thereby deprived of authority to review that issue. The ALJ disagreed and reversed the Determination Order award of unscheduled permanent disability. On Board review, we held that the claimant's withdrawal of a single issue, while still asserting other issues relating to the Determination Order, did not deprive the ALJ of authority to consider the insurer's challenge to the Determination Order. *See also Judith L. Duncan*, 45 Van Natta 1457, 1459 (1993), *aff'd Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605 (1995).

[2] Claimant initially raised an overpayment issue in her appellant's brief. Subsequently, claimant has indicated, in a July 16, 2001 letter, that there is no longer an overpayment issue. SAIF's respondent's brief also indicates on page 3 that the overpayment issue has been withdrawn by claimant. Claimant does not disagree with this assertion in her reply brief. In any case, because the overpayment issue arose out of the Order on Reconsideration, we lack authority to address this issue for the reasons indicated in this order.

In the Matter of the Compensation of
RAMIRO R. RANGEL, Claimant
WCB Case No. 01-00316
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that awarded an assessed fee under ORS 656.382(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On December 19, 2000, claimant's attorney wrote the insurer requesting that it issue a Notice of Closure within 10 days of receipt of the letter pursuant to ORS 656.268(5)(b).[1] The insurer did not issue its Notice of Closure until at least the 13th day after it received claimant's written closure request.

The ALJ awarded an assessed fee under ORS 656.382(1), finding that the insurer had unreasonably resisted the payment of compensation because of the late closure of the claim. In making this finding, the ALJ reasoned that the late closure probably caused a delay in the payment of compensation because the closure awarded temporary disability. Because the record did not disclose any reasonable basis for the delayed closure, the ALJ concluded the insurer's claim processing was unreasonable.

On review, the insurer challenges the ALJ's attorney fee award because there was no evidence that any compensation was due at the time of the delayed claim closure and, thus, that there could be no unreasonable resistance to the payment of compensation. We reverse.

ORS 656.382(1) provides that, if a carrier "unreasonably resists the payment of compensation," it shall be liable for a reasonable attorney fee. However, there is no unreasonable resistance to payment of compensation if the carrier paid all compensation. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Aetna Casualty Co. v. Jackson*, 108 Or App 253 (1991).

In this case, the record does not establish that there was any compensation due at the time of the delayed claim closure. The ALJ reasoned that, because the closure notice awarded temporary disability, the late closure probably caused a delay in the payment of compensation. However, the closure notice awarded temporary partial disability. The insurer correctly observes that the record does not establish that these benefits were incompletely or untimely paid on a procedural basis at the time of disability. Under these circumstances, with the record lacking evidence of unpaid benefits, we conclude that the insurer did not unreasonably resist the payment of compensation. *See Lloyd A. Humpage*, 49 Van Natta 1784 (1996) (no entitlement to penalty or assessed fee under ORS 656.382(1) for untimely claims processing where no amounts due at time of unreasonable delay (citing *Condon*)).[2]

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[1] As the ALJ noted, that section provides that, when a worker has returned to work, the carrier must issue a Notice of Closure or notice of a refusal to close within 10 days of its receipt of the worker's written request for claim closure.

[2] Claimant cites *Lester v. Weyerhaeuser Co.*, 70 Or App 307, *rev den* 298 Or 427 (1984), and *Georgia Pacific v. Awmiller*, 64 Or App 56 (1983), in support of his contention that the ALJ's order was correct. However, in both of those cases, the employer's failure to seek claim closure resulted in a delayed payment of permanent disability compensation. Here, the record does not establish a delay in payment of compensation; accordingly, there is no statutory authority on which attorney fees may be assessed.

Accordingly, we reverse that portion of the ALJ's order that awarded an assessed fee under ORS 656.382(1).[3]

ORDER

The ALJ's order dated is reversed in part and affirmed in part. That portion of the order that awarded an assessed fee under ORS 656.382(1) is reversed. The remainder of the order is affirmed.

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[3] In *Virgil L. Mathia*, 53 Van Natta 1165 (2001), we affirmed an ALJ's order awarding an assessed attorney fee pursuant to ORS 656.382(1) based on the carrier's allegedly unreasonable failure to close the claimant's new medical condition claim pursuant to ORS 656.268. However, in that case, the carrier did not dispute that the claimant's attorney was entitled to an assessed fee pursuant to ORS 656.382(1) if the claimant prevailed on his contention that it unreasonably refused to close his new medical condition claim. Here, in contrast to the carrier in Mathia, the insurer does contest claimant's entitlement to an assessed fee under ORS 656.382(1).

Board Member Phillips Polich dissenting.

Because I believe that the ALJ appropriately awarded an attorney fee under ORS 656.382(1), I respectfully dissent.

I do not believe that proof of "amounts due" is a prerequisite to an award of attorney fees under ORS 656.382(1). Unlike ORS 656.262(11)(a), the words "amounts then due" appear nowhere in ORS 656.382(1).

Although I note the majority's citations to *SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993) and *Aetna Casualty Co. v. Jackson*, 108 Or App 253 (1991), we have held in several cases that an attorney fee under ORS 656.382(1) is awardable when there are no amounts due upon which to base a penalty under ORS 656.262(11)(a). *Kenneth A. Meyer*, 50 Van Natta 2302 (1998); *Michael W. Koss*, 48 Van Natta 286 (1996) ("Inasmuch as there is no compensation due upon which to base a penalty, claimant is entitled to a separate attorney fee under ORS 656.382(1), provided that there is unreasonable resistance to the payment of compensation.")

Consistent with these cases, I would interpret the term "unreasonably resists the payment of compensation" in ORS 656.382(1) more broadly as encompassing situations such as this one, where the carrier has unreasonably delayed issuing a Notice of Closure, thus resisting the payment of compensation under ORS 656.268(5)(b) and the general statutory scheme. I would affirm the ALJ's attorney fee award under ORS 656.382(1).

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
JOANI CREMER, Claimant
WCB Case No. 00-08740
ORDER ON RECONSIDERATION
Jean M. Fisher, Claimant Attorney
Jerry Keene, Defense Attorney

The self-insured employer requests reconsideration of our August 29, 2001 Order on Review adopting and affirming the Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's injury/occupational disease claim for right shoulder conditions. The employer contends that we impermissibly considered a non-industrial July 2000 right shoulder dislocation as a compensable industrial contributor even though claimant did not file a claim for that incident. Claimant further asserts that the right shoulder claim should fail because no medical expert reported that claimant's work activity constituted the major contributing cause of a pathological worsening of the disease as required under ORS 656.802(2)(b). For the following reasons, we do not find the employer's contentions persuasive.

First, we did not consider the non-industrial July 2000 dislocation to be a compensable industrial contributor. Instead, we agree with the ALJ that Dr. Puziss' opinion is persuasive that claimant's work-related teaching of a "body pump" class caused stress and strain to the ligamentous structures of the right shoulder, and that claimant overstretched the ligaments in her shoulder causing the shoulder to be predisposed to dislocation, including the non-work related July 2000 dislocation. (Ex. 27A). According to Dr. Puziss, claimant's teaching of the "body pump" class was the major contributing cause of claimant's shoulder instability and current need for treatment. Having reviewed Dr. Puziss' opinion, we conclude that it does not consider the July 2000 incident to be an industrial contributor but rather a result of claimant's work-related shoulder instability. (Ex. 20).

Second, the employer is correct that Dr. Puziss never explicitly concluded that claimant's work activity was the major contributing cause of a pathological worsening of the preexisting right shoulder condition. However, the use of "magic words" is not required. *McClendon v. Nabisco Brands*, 77 Or App 412, 417 (1986); *Sharon L. Catterson*, 53 Van Natta 112, 113 (2001). We find that, viewed in its totality, Dr. Puziss' opinion does establish a pathological worsening of claimant's preexisting right shoulder condition.

Accordingly, we withdraw our August 29, 2001 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
ANDY N. COOK, Claimant
WCB Case No. 00-06660
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) declined to award scheduled permanent disability for loss of use or function of the hands; and (2) found that claimant was not entitled to temporary disability for the period of June 7, 1999 through July 22, 1999. On review, the issues are extent of scheduled permanent disability and entitlement to temporary disability.

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

Claimant contends that he is entitled to an award of scheduled permanent disability based on an alleged "chronic condition" documented in the report of Dr. Goodwin, the medical arbiter. Dr. Goodwin opined that "[g]iven the patient's diagnosis of bilateral carpal tunnel syndrome it is reasonable to assume that repetitive use of the hands, wrists, and forearms may cause increased symptoms. However, this is somewhat subjective based on patient complaints." (Ex. 20-2).

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 a body part. Here, we agree with the ALJ that the arbiter's report does not establish that claimant was "significantly limited" in repetitive use of a body part.

Dr. Goodwin's opinion is not sufficient to establish a "significant" limitation on repetitive use because he never opined to a degree of medical probability that claimant had such a limitation. The most Dr. Goodwin could state was that repetitive use "may" cause increased symptoms. Such expressions of medical possibility are insufficient to prove a "significant" limitation in repetitive use. *See Gormley v. SAIF*, 52 Or App 1055 (1981); *Robert C. Victoria*, 53 Van Natta 781 (2001); *Ted L. Golden*, 51 Van Natta 55, 56 (1999) ("could have" and "may have" indicate only possibility, not medical probability).

Moreover, to the degree that Dr. Goodwin believed that claimant needed a limitation, this was due to the possibility of increased symptoms, thus indicating that any restriction on repetitive use was intended to prevent a recurrence of symptoms. Such a restriction is inadequate to support a "chronic" condition award. *See Teena M. Headding*, 51 Van Natta 789, 790 (1999).

Claimant also contends that the ALJ incorrectly eliminated his award of temporary disability from June 7, 1999 through July 22, 1999, arguing that, under OAR 436-010-0210(4), the authorization of temporary disability by a physician's assistant, Mr. Enghauser, was legally sufficient to support the Order on Reconsideration's award of temporary disability for that period. We disagree.

Pursuant to the above rule, a physician's assistant practicing in "Type A, Type B, and Type C rural hospital areas" may authorize payment of temporary disability compensation. However, the evidence in this case does not establish that Mr. Enghauser practiced in a "rural hospital area." Under such circumstances, Mr. Enghauser's authorization was insufficient under OAR 436-010-0210(4) to support a temporary disability award.

ORDER

The ALJ's order dated April 6, 2001 is affirmed.

In the Matter of the Compensation of
PHILLIP G. GARDNER, Claimant
WCB Case Nos. 00-04761 & 00-02245
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Jerry Keene, Defense Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Kemper Insurance Company, on behalf of Continental Can, requests review of that portion of Administrative Law Judge (ALJ) Thye's order that found it responsible for that portion of claimant's work-related hearing loss existing on January 15, 1980. ACE-USA, on behalf of Crown, Cork & Seal, cross-requests review of that portion of the ALJ's order that found it responsible for that portion of claimant's work-related hearing loss incurred after January 15, 1980. On review, the issue is responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

The issue is responsibility for claimant's occupational disease claim for hearing loss. Although claimant worked for the same employer[1] from 1960 until his retirement on May 1, 1996, the employer was insured by several carriers. After some insurers were dismissed from the proceeding, the two insurers remaining were Kemper Insurance Company (Kemper), which insured the employer from July 1, 1973, through December 31, 1982, and ACE-USA, which insured the employer from May 30, 1991 until claimant's retirement in 1996. (Tr. 1-2). At hearing, the parties agreed that the last injurious exposure rule (LIER) applies and that ACE-USA is responsible unless it can show that an earlier insurer is responsible for claimant's hearing loss. (Tr. 2).

Despite the stipulation of the parties, the ALJ did not agree that the LIER applies to this case. Relying on *James River Corp. v. Green*, 164 Or App 649 (1999), the ALJ found that Kemper was responsible for claimant's work-related hearing loss in January 1980, at the time of his first audiogram. The ALJ determined that, based on ACE-USA's "admission" that it was responsible if there had been

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[1] The employer's name changed in 1991. (Tr. 1).

any work-related noise-induced hearing loss since the January 1980 audiogram, ACE-USA was responsible for that portion of claimant's work-related hearing loss that was incurred after January 15, 1980, if any. The ALJ explained that whether or not there was any such hearing loss since January 1980 was a question for claim closure, not this proceeding.

Kemper requests review, arguing that the ALJ erred in failing to apply the LIER to assign initial responsibility for claimant's hearing loss. Kemper contends that ACE-USA is responsible, and there is no persuasive medical evidence that would shift responsibility "backwards" to Kemper. ACE-USA cross-requests review, arguing that Kemper is responsible for claimant's entire work-related hearing loss.

We first address the parties' arguments regarding apportionment of claimant's hearing loss. Kemper relies on *Brent W. Collier*, 53 Van Natta 66 (2001), to argue that the ALJ erred by apportioning claimant's hearing loss among two employers. ACE-USA refers to *RLC Industries v. Sun Studs, Inc.*, 172 Or App 233 (2001), which was issued after the Board's decision in *Collier*. ACE-USA contends that the court did not exclude the application of the LIER to determine responsibility in hearing loss cases, and ACE-USA agrees with Kemper that the ALJ should have applied the LIER instead of apportioning initial responsibility. On the other hand, claimant contends that the ALJ correctly apportioned responsibility rather than applying the LIER. Alternatively, claimant argues that, if the LIER applies, it agrees with Kemper's arguments regarding the assignment of responsibility.

In *Brent W. Collier*, 53 Van Natta at 67-70, we rejected the claimant's argument that we should assign initial responsibility by apportioning his hearing loss among three employers. We reasoned that the cases the claimant relied on, including *James River Corp. v. Green*, 164 Or App at 649, did not address apportionment of initial responsibility among successive employers, but instead addressed the issue of extent of scheduled permanent disability for hearing loss claims where compensability/responsibility had already been determined.

After we decided *Collier*, the court issued *RLC Industries v. Sun Studs, Inc.*, 172 Or App at 233. In that case, RLC argued that it was not responsible for the claimant's hearing loss condition because OAR 436-035-0250(2) allowed an employer to absolve itself of responsibility for a hearing loss by documenting the loss within the first 180 days of employment, and RLC had complied with that requirement. The court acknowledged that OAR 436-035-0250(2) concerned the rating of hearing disability (and was not strictly applicable to the assignment of responsibility). Nonetheless, the court concluded that, in conjunction with the medical evidence (which established that the claimant's entire work-related hearing loss occurred before his hearing test with RLC that had been conducted 5 months after he began working for RLC), the administrative rule (which provides that hearing loss adequately documented by a baseline audiogram obtained within 180 days of a work assignment to a high noise environment) indirectly established that RLC could not have caused the claimant's hearing loss. *Id.* at 236-38.

The court further reasoned that, if it ignored the administrative rule in the responsibility context, the application of the rule when calculating the claimant's permanent disability award would allow RLC to offset 100 percent of the claimant's hearing loss. Noting that such a result would leave the claimant with no compensation because the other potentially responsible employers would have already been absolved of responsibility under the LIER, the court rejected that approach and, instead, applied the LIER in light of OAR 436-035-0250(2), and shifted responsibility to an earlier carrier. *Id.* at 237-38.

In *RLC Industries*, the court referred to *James River Corp. v. Green*, 164 Or App at 652-53, and explained that there is an exception to the LIER if the medical evidence is such that causation is easily apportioned among employers. 172 Or App at 236. That exception applies when "injuries" are so distinct that it is possible to segregate them in terms of causation. *Id.* In *James River*, the court explained that apportionment of responsibility is particularly apt in the context of a claim for hearing loss when the loss attributable to successive employments can be determined by audiograms. 164 Or App at 653. In that case, it was undisputed that the claimant's 1976 audiogram established the hearing loss that was attributable to his employment with one carrier and that the 1995 audiogram established the hearing loss attributable to the claimant's employment with another carrier. *Id.*

Here, we must determine whether the medical evidence is such that causation is "easily apportioned" among the two remaining employers, Kemper and ACE-USA.[2] For the following reasons, we

[2] The parties do not argue that this case involves OAR 436-035-0250(2), which allows a carrier to absolve itself of responsibility for a hearing loss by documenting the loss within the first 180 days of employment.

find that the medical evidence does not lend itself to easy apportionment or distinctive "injuries" that allow for segregation. The primary problem here involves the timing of claimant's audiograms. In particular, the problem is that claimant did not have an audiogram on or about May 1, 1996, when he retired. Instead, he had an audiogram on October 26, 1995, approximately six months before his retirement, and again in January 2000, when he sought treatment for hearing problems from Dr. Anderson.

Drs. Anderson and Hodgson have provided medical opinions on causation of claimant's hearing loss. Dr. Anderson reviewed claimant's audiograms between January 1980 and October 1995, and found that claimant's hearing loss worsened between 1980 and 1995, but the worsening during that period was solely attributable to presbycusis. (Ex. 18). He explained that the degree of hearing loss experienced during that time period was less than would be expected on the basis of presbycusis. (*Id.*) Thus, Dr. Anderson found that claimant had no work-related hearing loss between 1980 and 1995.

On February 28, 2000, Dr. Hodgson examined claimant on behalf of one of the carriers and concluded that claimant's employment exposure was the major contributing cause of his noise-induced hearing loss. (Ex. 8-3). Dr. Hodgson provided other reports regarding the assignment of responsibility. On May 31, 2000, Dr. Hodgson responded to a question from ACE-USA as to whether all of claimant's noise-induced hearing loss occurred before 1980 when he began wearing noise protection:

> "[Claimant] had 240dB hearing loss in the right ear on 1/15/80 for the six frequencies of 500 through 6000 Hz. On the test of 10/26/95, just before his retirement, he also had 240dB hearing loss for these same frequencies. The same is true for the left ear: 260dB in 1980 and 1995. Therefore, all his hearing loss at retirement was present in 1980. It can be said that the use of noise protection beginning in 1980 apparently protected him from any further noise-induced hearing loss and all of it occurred before 1980." (Ex. 14).

Dr. Hodgson concluded that the objective evidence indicated that claimant's hearing loss did not worsen from 1980 to 1995, from any cause. (*Id.*)

On July 17, 2000, Dr. Hodgson responded to questions from Kemper, explaining:

> "[Claimant's] hearing loss did worsen between October 26, 1995 and the February 28, 2000 test that we performed. In 1995, he had 240 dB of hearing loss in both ears. In our test, he had 305 dB of hearing loss in the right ear and 320 dB of loss in the left ear. This is more than could be accounted for by age. Therefore, it is not impossible that the work between the 1995 test and when he retired six months later did not cause any additional hearing loss. In other words, it is possible that the work during that six-month period had some effect on [claimant's] hearing.
>
> "I cannot say that there is any employment period that could be considered the sole cause of [claimant's] hearing loss. This is due to the lack of hearing tests during the employment periods. Without these, I am not able to determine which period would cause the entire amount of hearing loss." (Ex. 19).

On December 4, 2000, Dr. Hodgson responded to a question from another carrier as to whether claimant's work from May 30, 1991 to his retirement in April 1996 contributed to a worsening of his hearing loss. He explained that claimant had more of an increase in hearing loss during the time period in question than could be accounted for by the change in presbycusis. (Ex. 25). Because Dr. Hodgson found no other factors that could be a possible cause, he concluded that claimant's work exposure during that time was the cause of the increased hearing loss. (*Id.*)

Although Dr. Hodgson said in his May 31, 2000 report that all of claimant's hearing loss at retirement was present in 1980 and there was no objective evidence that his hearing loss worsened from 1980 to 1995 (Ex. 14), Dr. Hodgson subsequently changed his opinion. In his July 17, 2000 report, Dr. Hodgson reviewed claimant's October 26, 1995 and February 28, 2000 audiograms and concluded:

> "[I]t is not impossible that the work between the 1995 test and when he retired six months later did not cause any additional hearing loss. In other words, it is possible that the work during that six-month period had some effect on [claimant's hearing]." (Ex. 19).

Even if we rely only upon the medical import of the second sentence of Dr. Hodgson's report, we find that Dr. Hodgson had no information about claimant's hearing loss as of his retirement on May 1, 1996. Instead, he relied on claimant's February 28, 2000 audiogram, which was almost four years after his retirement, to conclude that claimant's work possibly caused additional hearing loss between October 26, 1995 and May 1, 1996. We are not persuaded by Dr. Hodgson's opinion because it lacks adequate explanation. Moreover, he did not explain why he changed his opinion from May 31, 2000, when he said that all of claimant's hearing loss at retirement was present in 1980. Similarly, Dr. Hodgson's December 4, 2000 opinion that claimant had a work-related hearing loss between October 1991 and October 1995 is inconsistent with his May 31, 2000 report. Because we find that Dr. Hodgson's opinion is inconsistent and lacks adequate explanation, 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).

Dr. Anderson did not believe that claimant had work-related hearing loss between 1980 and 1995. However, he did not address whether claimant's employment exposure between October 1995 and his retirement contributed to his hearing loss. Neither the opinion of Dr. Hodgson nor Dr. Anderson is sufficient to establish easy apportionment or distinctive "injuries" that allow for segregation. *Compare James River Corp. v. Green*, 164 Or App at 652-53 (it was undisputed that the claimant's audiograms established the hearing loss attributable to each of two carriers). Therefore, we agree with Kemper and ACE-USA that it is appropriate to rely on the LIER to determine responsibility.

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 (1982). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Id.* at 248. Where a claimant seeks or receives medical treatment for the compensable condition before experiencing time loss due that condition, it is appropriate to designate a triggering date based on either the seeking or receiving of medical treatment, whichever occurs first. *Agricomp Ins. v. Tapp*, 169 Or App 208, 212-13 (2000); *see Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998) (the date of the first medical treatment is the triggering date that dictates which period of employment is assigned initial responsibility for the treatment), *rev den* 328 Or 365 (1999).

Here, claimant first sought treatment for his hearing loss in January 2000, after he retired from the employer. If a claimant is not in potentially causal employment at the "onset of disability," the last such employer is liable. *Bracke*, 293 Or at 245. Since ACE-USA is the last insurer that potentially caused claimant's condition, we assign initial responsibility for the hearing loss to ACE-USA. As the last insurer of the employer, ACE-USA is fully responsible for claimant's hearing loss unless it proves either: (1) that it was impossible for workplace conditions at the time that it insured the employer to have caused the disease in this particular case or (2) that the disease was caused solely by employment conditions at a time when the employer was insured by one or more previous insurers. *Roseburg Forest Products v. Long*, 325 Or 305, 314 (1997).

ACE-USA argues that Dr. Anderson's opinion is persuasive and establishes that Kemper is solely responsible for claimant's hearing loss. On the other hand, Kemper relies on Dr. Hodgson's opinion that it was possible that claimant's work during the six month period before his retirement contributed to his hearing loss. Kemper contends that, based on Dr. Hodgson's opinion, ACE-USA cannot meet its burden of proof to shift liability backwards to Kemper and, therefore, ACE-USA remains responsible. Claimant agrees with Kemper's arguments concerning the application of the LIER.

As we discussed above, we find that Dr. Hodgson's opinion is entitled to little weight. In his May 31, 2000 report, he said that all of claimant's hearing loss at retirement was present at 1980 and there was no objective evidence that his hearing loss worsened from 1980 to 1995, from any cause. (Ex. 14). Moreover, he thought that claimant's use of noise protection beginning in 1980 protected him from any further noise-induced hearing loss. (*Id.*) We previously discussed the confusing nature of Dr. Hodgson's reports. If we rely on Kemper's interpretation of the July 17, 2000 report, Dr. Hodgson believed that claimant's work possibly caused additional hearing loss between October 26, 1995 and his retirement. Dr. Hodgson did not discuss why he changed his opinion from May 31, 2000, when he said that all of claimant's hearing loss at retirement was present at 1980. Dr. Hodgson's opinion is particularly confusing because his May 31, 2000 report referred to the fact that claimant's hearing protection in later years protected him from further work-related hearing loss. We conclude that Dr.

Hodgson's opinion is insufficient to establish whether or not claimant's work after 1980 contributed to his hearing loss.

Although ACE-USA relies on Dr. Anderson's opinion to shift responsibility to Kemper, Dr. Anderson only provided an opinion about claimant's hearing loss between January 1980 and October 1995. (Ex. 18). In a July 10, 2000 chart note, Dr. Anderson referred to claimant's audiograms between January 1980 and October 1995 and said that the worsening of claimant's hearing "between 1980 and 1995 can be solely attributed to presbycusis since the degree of hearing loss experienced during this time period was less than would be expected on the basis of presbycusis." (*Id.*) Thus, Dr. Anderson's opinion can be interpreted to mean that claimant had no work-related hearing loss between January 1980 and October 1995. Nevertheless, Dr. Anderson did not comment as to whether or not claimant's employment exposure between October 1995 and his retirement on May 1, 1996 contributed to his hearing loss. Therefore, we do not agree with ACE-USA that Dr. Anderson reported in July 2000 that claimant's "entire" occupational hearing loss occurred before 1980.

Our findings must be based on medical evidence in the record and the reasonable inferences that can be drawn from the medical evidence. *SAIF v. Calder*, 157 Or App 224, 227-28 (1998). We are not free to reach our own medical conclusions about causation in the absence of such evidence. *Benz v. SAIF*, 170 Or App 22 (2000). Here, we are unable to determine from Dr. Anderson's opinion whether claimant's employment exposure between October 1995 and his retirement on May 1, 1996 contributed to his hearing loss. We conclude that the medical evidence is insufficient to meet ACE-USA's burden of proving either that it was impossible for workplace conditions at the time that it insured the employer to have caused claimant's hearing loss or that the hearing loss was caused solely by employment conditions at a time when the employer was insured by a previous insurer. Consequently, ACE-USA has failed to shift responsibility to an earlier carrier and it remains responsible for claimant's entire hearing loss condition.

Responsibility was the only issue at hearing and on review. Claimant's attorney is entitled to a fee under ORS 656.308(2)(d) for prevailing against ACE-USA's responsibility denial. Claimant neither asserts nor do we find "extraordinary circumstances" warranting an attorney fee in excess of the statutory maximum $1,000 attorney fee. *See Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997). Therefore, after considering the factors set forth in OAR 438-015-0010(4), claimant's counsel is awarded a $1,000 attorney fee for services at hearing and on review, payable by ACE-USA. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs and claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. This award is in lieu of the ALJ's $500 attorney fee awards, to be paid by both Kemper and ACE-USA.

ORDER

The ALJ's order dated April 4, 2001 is reversed in part and affirmed in part. That portion of the ALJ's order that found Kemper responsible for claimant's work-related hearing loss existing on January 15, 1980 is reversed. Kemper's responsibility denial is reinstated and upheld. The ALJ's $500 attorney fee award, payable by Kemper, is reversed. ACE-USA's entire responsibility denial is set aside and the claim is remanded to ACE-USA for processing according to law. In lieu of the ALJ's $500 attorney fee award (to be paid by ACE-USA), claimant's attorney is awarded $1,000 for services at hearing and on review concerning responsibility, payable by ACE-USA. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
RANDI E. HILARY, Claimant
WCB Case No. 00-04617
ORDER ON REVIEW
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant was not a subject worker; and (2) upheld the SAIF Corporation's denials of her bilateral upper extremity condition. With her briefs, claimant has submitted additional documents that were not admitted into evidence at hearing. We treat such submissions as a motion for remand to the ALJ for further proceedings. *Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand, subjectivity and, potentially, compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the first paragraph of the findings of fact, we change the first sentence to read: "Claimant is a 42 year old contractor whose work includes repairing and cleaning apartments."

Remand

With her initial brief, claimant submits several documents that were not admitted at hearing, including earnings statements, W-2 forms and "1099" forms. Claimant also includes a copy of Dr. Layman's November 15, 2000 chart note with her reply brief.[1] We treat claimant's submissions as a motion to remand. *See Judy A. Britton*, 37 Van Natta at 1262. We may remand to the ALJ if we find that the case has been "improperly, incompletely or otherwise insufficiently developed[.]" ORS 656.295(5); *see Bailey v. SAIF*, 296 Or 41, 45 n3 (1983) (Board has no authority to consider newly discovered evidence). There must be a compelling reason for remand to the ALJ for the taking of additional evidence. *SAIF v. Avery*, 167 Or App 327, 333 (2000). A compelling reason exists when the new evidence (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome of the case. *Id.; Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, claimant has provided no reason why the evidence she seeks to have admitted was not submitted at hearing and there has been no contention that the evidence was not available. Claimant was represented at hearing and although her attorney considered offering her payroll stubs into evidence, after SAIF's attorney objected, claimant's then-attorney determined that it was not necessary to submit the payroll stubs because the relevant inquiry had been established through testimony. (Tr. 52-58). We further note that the record on review includes some of claimant's quarterly earnings records and time sheets. In light of the existing documentary and testimonial evidence already present in the record, we find that consideration of the additional evidence would not likely affect the outcome of the case. *See Compton v. Weyerhaeuser*, 301 Or at 646. We therefore deny claimant's motion to remand.

Subjectivity/Compensability

The ALJ determined that claimant was not a subject worker, reasoning that, under ORS 656.027(7)(b), she was conclusively presumed to be an independent contractor. Based on that conclusion, it was not necessary for the ALJ to address the issue of compensability.

On review, we adopt and affirm the ALJ's order with the following alternative analysis. Even if we assume, without deciding, that claimant was a subject worker, we agree with SAIF that the medical evidence is insufficient to establish a causal relationship between claimant's work and her bilateral hand/arm condition.

Claimant asserts that her bilateral tendonitis condition is an occupational disease and was caused by repetitive work activities. She relies on the opinion of Dr. Layman to establish compensability. SAIF denied claimant's bilateral upper extremity condition as both an injury and as an occupational disease. (Exs. 11, 14). Based on the multiple possible causes of claimant's bilateral upper extremity condition, we consider the causation issue to be a complex question and we rely on expert medical opinion to resolve the issue. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

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[1] Because Dr. Layman's November 15, 2000 chart note is already in evidence (Ex. 17), we do not address whether remand is necessary for that document.

We begin by determining the appropriate standard for analyzing compensability. 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.*; *Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999).

Claimant testified that she first had symptoms on November 5, 1999, when she was carrying cleaning supplies to clean an apartment. (Tr. 22, 23). She felt a strain on her wrists, but went to work and was fine. (Tr. 23; Ex. 7B-7). Gradually after that incident, claimant began experiencing sharp pains when she used pressure to scrub items and the sharp pains became more constant. (Tr. 23, Ex. 7B-7, -8). She sought medical treatment on December 29, 1999. (Ex. 2).

Dr. Layman understood that claimant's bilateral wrist pain came on gradually, not with one specific injury. (Ex. 13A-2). Based on claimant's testimony, her upper extremity condition developed gradually over time. Under these circumstances, we find that claimant's upper extremity symptoms related to an ongoing condition with a gradual onset and her condition is most appropriately analyzed as an occupational disease. Thus, under ORS 656.802(2)(a), claimant must establish that her employment conditions were the major contributing cause of her bilateral upper extremity condition.

Claimant first sought treatment on December 29, 1999, from Dr. Wilcox, who diagnosed "tendonitis elbow, wrist pain." (Ex. 2). She recommended wrist braces and elbow straps. (*Id.*)

Dr. Buehler examined claimant in early February 2000, and diagnosed flexor tendon tenosynovitis and bilateral epicondylitis and recommended medication. (Ex. 3). In March 2000, Dr. Fortes diagnosed tendonitis of the flexors of both hands. (Exs. 5, 6). He recommended occupational therapy.

In May 2000, Drs. Williams and Fuller examined claimant on behalf of SAIF. Although claimant complained of pain in the volar forearms and wrist, they found no evidence of tendonitis at that time and no objective findings. (Ex. 10-3, -4). They felt she was medically stationary without impairment. (Ex. 10-5).

Dr. Wilcox referred claimant to Dr. Dickinson in June 2000. Dr. Dickinson explained that claimant's "complaints are so global and vague, affecting both upper extremities, that I know there is nothing that I can offer her." (Ex. 12). He found no diagnosis and could not recommend any treatment. (*Id.*)

Dr. Button examined claimant in July 2000 on behalf of SAIF. He found that claimant's upper extremity examination was normal, but he diagnosed "[s]evere functional overlay/symptom magnification." (Ex. 13-4). He noted that, although claimant had been unemployed since January 2000, her symptoms had not changed significantly. (*Id.*) Dr. Button explained that if claimant's condition was related to over activity, he would expect resolution within a relatively short period of time with rest. (*Id.*)

On August 9, 2000, claimant began treating with Dr. Layman, who became her attending physician. (Ex.13a). He said claimant had "upper extremity pain of undetermined etiology." (Ex. 13a-5). He ordered x-rays, which were normal. (Exs. 13a, 13b, 14a). Dr. Layman recommended hand therapy. (Ex. 14a). In August 2000, he injected her wrists, and claimant had an excellent response. (Exs. 16, 17). He provided another injection in November 2000. (Ex. 17).

Claimant relies on the opinion of Dr. Layman to establish compensability. On November 15, 2000, Dr. Layman provided the following opinion on causation:

> "[Claimant] has further clarified how this all began, stating that the discomfort initially occurred while carrying cleaning supplies at work, and then following that she noted with a lot of the scrubbing activities she is required to do at work she would have recurrence of her pain. She noted that her pain was significantly worse while working, better when off work. She also indicates that the dry wall work that she was doing was work that she was doing while employed for the same employer. It appears that the major contributing cause to the development of her tendinitis would be her work activity." (Ex. 17).

This last statement is Dr. Layman's sole causation opinion. Although his opinion includes "magic words," such as "the major contributing cause," it is conclusory, without explanation. He merely recited claimant's own opinion that her condition was work-related. The causation issue, however, is medically complex and claimant's understanding is insufficient. Dr. Layman did not respond to the concerns of other physicians, who pointed out that claimant's condition should have improved while she was off work, but did not. (*See* exs. 13-4, 15). Moreover, Dr. Layman's statement that it "appears" that claimant's work was the major contributing cause of her condition is not persuasive because it is couched in terms of possibility, not in terms of reasonable medical probability. *See Gormley v. SAIF*, 52 Or App 1055 (1981). Under these circumstances, Dr. Layman's opinion is not persuasive.

There are no other medical opinions that support compensability. In a concurrence letter from SAIF, Dr. Buehler, who had treated claimant, agreed that her bilateral upper extremity condition was not caused in major part by her work for the employer. (Ex. 15). He reasoned that there were no objective findings when he examined her in February 2000, her work activities were too varied and too infrequent to have caused her condition, and her condition should have significantly improved by now since she had not been working. (*Id.*) We conclude that the medical evidence is insufficient to establish that claimant's work activities were the major contributing cause of her bilateral upper extremity condition.

ORDER

The ALJ's order dated March 19, 2001 is affirmed.

September 26, 2001 Cite as 53 Van Natta 1227 (2001)

In the Matter of the Compensation of
GLORIA GARIBAY, Claimant
WCB Case No. 00-03653
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
VavRosky, MacColl, Olson, et al., Defense Attorney

On September 10, 2001, we issued an Order on Review that: (1) awarded claimant 12 percent (38.4 degrees) unscheduled permanent disability for a mid-back condition; and (2) affirmed an Administrative Law Judge's (ALJ's) order that declined to award an attorney fee for claimant's counsel's services at hearing. The parties have now submitted a "Stipulation and Disputed Claim Settlement" that is designed to resolve all issues raised or raisable before the Board and the Hearings Division (WCB Case No. 01-04834). An ALJ has approved those portions of the settlement that pertain to issues pending before the Hearings Division. We treat this submission as a request for reconsideration of our September 10, 2001 order. The request is granted.

Pursuant to the settlement, the parties agree that the Board's September 10, 2001 order "is without any legal effect and will be disregarded by the parties." Further, the parties stipulate that the Order on Reconsideration of May 30, 2001 shall be affirmed and that all requests for hearing shall be dismissed with prejudice.

We approve those portions of the parties' settlement that involve issues pending before the Board, thereby fully and finally resolving this dispute, in lieu of all prior orders.[1] Accordingly, the request for Board review is dismissed with prejudice.

IT IS SO ORDERED.

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[1] This date, we have also approved a Claim Disposition Agreement (CDA) whereby claimant has released all benefits, except compensable medical services. Pursuant to that agreement, the parties have also stipulated that, upon approval of the CDA, all requests for hearing or review shall be dismissed.

In the Matter of the Compensation of
ROBERT E. MONTGOMERY, Claimant
Own Motion No. 66-0421M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

Reviewing panel: Members Biehl and Haynes.

The SAIF Corporation submitted claimant's request for medical services for his August 20, 1962 industrial injury. SAIF recommended that the Board deny the provision of the requested medical services, contending that the "current condition is not related to the industrial injury."

On May 25, 2001, the Board consolidated this Own Motion matter with pending litigation before the Hearings Division in WCB Case No. 01-03527. The Board requested that the parties address at hearing the issues of whether claimant's current low back condition was compensable and, if so, whether SAIF was responsible under the 1962 or 1970 claim. At the conclusion of the hearing, the Board requested that the Administrative Law Judge (ALJ) issue a separate, unappealable recommendation with the respect to the Own Motion matter.

On August 22, 2001, ALJ Howell issued an Opinion and Order, which found that claimant's current low back condition was compensably related to his 1962 Own Motion injury claim and upheld SAIF's responsibility denial for claimant's current low back condition as part of the 1970 injury claim. ALJ Howell also issued a recommendation that the Board exercise its authority under ORS 656.278(1)(b) and authorize medical benefits for claimant's current low back condition under the 1962 injury claim.

On September 13, 2001, the parties submitted their positions regarding ALJ Howell's findings. SAIF declared that it would not appeal the ALJ's order and recommendation and requested that the Board issue its Own Motion order pursuant to ALJ Howell's recommendation. Claimant agreed that he would not appeal the ALJ's order and also requested that the Board proceed with the issuance of an Own Motion order.

Because 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 light of the parties' positions and after review of this record, we adopt as our reasoning and conclusions on these issues the ALJ's conclusions as set forth in his August 22, 2001 recommendation to the Board. Thus, we find that the requested medical services are reasonable and necessary and causally related to the 1962 compensable injury. Accordingly, the claim 1962 injury is reopened to provide the requested medical services. *See* OAR 438-012-0037.

The claim shall remain reopened to provide the requested medical services. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
WAYNE J. ROBATCEK, Claimant
Own Motion No. 00-0319M
OWN MOTION ORDER ON RECONSIDERATION (DISMISSING)
Black, Chapman, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing panel: Members Haynes and Biehl.

On October 27, 2000, we issued an Own Motion Order reopening claimant's claim for the requested Own Motion relief. (WCB Case No. 00-0319M). This action was taken in response to a "Carrier's Own Motion Recommendation," wherein the SAIF Corporation recommended reopening claimant's claim for the payment of temporary disability compensation for his 1980 low back claim. By letter dated September 5, 2001, SAIF contends that claimant's claim was already reopened by a 1999 Own Motion Order and asserts that the current "reopening" is not necessary. We treat SAIF's recent submission as a motion for reconsideration of our October 27, 2000 order.

A request for reconsideration of an Own Motion order must be filed within 30 days after the date the order was mailed, or within 60 days after the mailing date if the requesting party establishes good cause for failing to file the request within 30 days after the mailing date. OAR 438-012-0065(2). In extraordinary circumstances, however, we may, on our Own Motion, reconsider a prior order. *Id.*

Under the particular facts of this case, we find that extraordinary circumstances exist that justify reconsideration of our prior order. In this regard, SAIF acknowledged that it had erroneously requested the October 2000 reopening because claimant's 1980 claim was already in "reopened" Own Motion status pursuant to a 1999 Board order. Furthermore, without objection from claimant, SAIF expressly seeks "withdrawal or rescission" of our prior order. Under these extraordinary circumstances, we withdraw our prior order and issue the following order in its place.

Claimant's aggravation rights expired April 3, 1986. 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 November 30, 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. 99-0424M). In addition, we ordered SAIF to close the claim under OAR 438-012-0055 when claimant was medically stationary. The record does not establish that the claim had been closed pursuant to OAR 438-012-0055 when SAIF sought reopening of the claim in October 2000.

Consequently, the claim was in open status at the time of SAIF's October 2000 request for claim reopening. Therefore, SAIF remained obligated to pay temporary disability to claimant as provided by our November 1999 order and to continue the payment of those benefits until such compensation can be terminated under OAR 438-012-0055.

In light of such circumstances, SAIF's October 19, 2000 recommendation to reopen the claim is moot. Thus, we dismiss the request for Own Motion relief regarding the current claim. (WCB Case No. 00-0319M).[1]

The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] On July 30, 2001, SAIF issued a Board's Own Motion Notice of Closure referencing WCB Case No. 00-0319M. Inasmuch as we have dismissed the October 2000 request for Own Motion relief, we interpret SAIF's July 30, 2001 closure as pertaining to the November 1999 "reopening" under WCB Case No. 99-0424M. By another order issued this date, review of that matter remains pending awaiting the resolution of issues to be litigated before an ALJ.

In the Matter of the Compensation of
DEL SPUNAUGLE, Claimant
WCB Case No. 00-08675
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

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

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

On July 5, 2000, the employer closed claimant's claim by Notice of Closure that awarded temporary disability compensation only. (Ex. 23). Claimant had not returned to treat with Dr. Gerry, attending physician, after May 2, 2000, and claimant's claim was closed administratively without a medically stationary date pursuant to OAR 436-030-0034. Thus, the July 5, 2000 Notice of Closure was the last award or arrangement of compensation.

On review, the employer argues that the ALJ erred in determining that the July 5, 2000 Notice of Closure was the baseline from which to determine whether claimant had sustained an "actual worsening" of his accepted disabling low back strain condition pursuant to ORS 656.273(1). Instead, the employer argues that Dr. Gerry's pre-closure May 2, 2000 chart note is the proper baseline. We disagree.

The clear language of ORS 656.273(1) provides that, to establish a compensable aggravation claim, claimant must prove an "actual worsening" of his compensable condition since the "last award or arrangement of compensation." Here, the "last award or arrangement of compensation" was the July 5, 2000 Notice of Closure. In addition, for the reasons provided by the ALJ, we find that Dr. Gerry's opinion establishes by persuasive medical evidence supported by objective findings an actual worsening of the compensable condition after the July 2000 closure. (Exs. 29, 34).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,100, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 5, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,100, payable by the self-insured employer.

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[1] We correct the ALJ's findings of fact to reflect that claimant has worked for the employer since July 1988. (Ex 7).

In the Matter of the Compensation of
MARGO K. HUNTSMAN, Claimant
WCB Case No. 00-06441
ORDER ON RECONSIDERATION
Malagon, Moore, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our September 7, 2001 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that: (1) directed SAIF to reopen and process claimant's additional left knee conditions under ORS 656.262 and ORS 656.268; and (2) assessed a penalty under ORS 656.262(11)(a) for SAIF's allegedly unreasonable claim processing. Claimant has filed a response to SAIF's request for reconsideration, and has cross-requested reconsideration, seeking an attorney fee pursuant to ORS 656.382(1).

On reconsideration, SAIF contends that a penalty cannot be assessed pursuant to ORS 656.262(11)(a) in the absence of proof of "amounts then due." However, SAIF did not raise this issue in its briefs on review. Nor does the record establish that SAIF made this specific argument at hearing. Consequently, the ALJ also did not address the issue. Under these circumstances, we decline to address this issue on reconsideration. *See Marietta Z. Smith, on recon*, 51 Van Natta 491, 492 (1999); *Martha L. Ladd*, 49 Van Natta 791 (1997).

In her cross-request for reconsideration, claimant contends that she is entitled to an attorney fee pursuant to ORS 656.382(1) in addition to or in lieu of a penalty under ORS 656.262(11)(a). Claimant references her request for hearing, in which she checked the box for "Attorney fee" as an issue. Based on the following reasons, we decline to consider claimant's contention.

To begin, claimant's request for hearing did not refer to a statute in conjunction with the "attorney fee" issue. Secondly, claimant's written Closing Argument[1] stated that:

> "The issue in this case is whether SAIF Corporation is obligated to process [claimant's] 1975 knee claim to closure pursuant to ORS 656.268. In addition to that issue, Claimant asserts that the SAIF Corporation's failure to so process is unreasonable and asks for the imposition of a penalty pursuant to ORS 656.262."

Consequently, the ALJ did not address an attorney fee issue.

More importantly, even if an attorney fee award had been raised at hearing, claimant did not raise the issue on Board review. Accordingly, we decline to address it on reconsideration. *Marietta Z. Smith*, 51 Van Natta at 492.

Finally, claimant requests an additional attorney fee under ORS 656.382(2) for services in responding to SAIF's request for reconsideration. However, as penalties were the only issue raised in SAIF's request for reconsideration, claimant's attorney is not entitled to an additional fee pursuant to ORS 656.382(2). *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

Accordingly, we withdraw our September 7, 2001 order. As supplemented herein, we adhere to and republish our September 7, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] The case was submitted on the documentary record.

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
WCB Case No. 00-0051M
OWN MOTION ORDER ON RECONSIDERATION
Willner, Wren, Hill & Uren, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Haynes, Bock, Biehl, and Phillips Polich. Members Biehl and Phillips Polich chose not to sign the order.

On June 29, 2001, we abated our May 31, 2001 Own Motion Order, *James W. Jordan*, 53 Van Natta 726 (2001), in response to claimant's request for reconsideration. Having received SAIF's response, we proceed with our reconsideration.

In our May 31, 2001 Own Motion Order, we suspended claimant's temporary disability for the period from December 19, 2000 through March 20, 2001. 53 Van Natta at 730. In doing so, we reasoned that claimant had not provided a valid, compelling reason for failing to follow his treating physician's instructions. 53 Van Natta at 728. Under such circumstances, we found that we had the authority in our Own Motion capacity to suspend claimant's temporary disability compensation pursuant to OAR 438-012-0035(5). 53 Van Natta at 728-730. Inasmuch as SAIF had already paid claimant the disputed compensation, we allowed SAIF an offset against future temporary disability benefits under ORS 656.268(13)(a). 53 Van Natta at 730.

On reconsideration, claimant first contends that OAR 438-012-0035(5) is invalid as exceeding the scope of our discretion granted by the legislature. We disagree.

OAR 438-012-0035(5) provides, in pertinent part:

> "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. * * * The insurer shall not suspend compensation under this section without prior written authorization by the Board."

ORS 656.278(1)(a) expressly empowers the Board to "authorize the payment of temporary disability from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board." ORS 656.726(5) authorizes the Board to "make and declare rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review procedures and exercising its authority under ORS 656.278."

In *Edward Hines Lumber Co. v. Kephart*, 81 Or App 43, 46 (1986), the Court of Appeals held that the statutes and rules covering compensation awards are not abrogated by ORS 656.278. In *Kephart*, the Board had awarded the claimant permanent total disability under its Own Motion jurisdiction. 81 Or App at 45. The employer appealed to the court, contending that ORS 656.278 was an unconstitutional delegation of legislative authority and that there was no "rule or standard" to guide the Board in the exercise of its discretion under that statute. In rejecting the employer's argument, the court stated that:

> "Employer overlooks the fact that the other statutes pertaining to disability awards apply equally to own motion orders. The rules and standards contained in the statutes covering awards for temporary and permanent disability are not abrogated by ORS 656.278. Its only effect is to continue the jurisdiction of the Board over a claim on a discretionary basis." 81 Or App at 46.

ORS 656.325(2) provides:

> "For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation, the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal."

ORS 656.325(2) pertains to the authority of the carrier to suspend compensation "with the consent of the director." Typically, prior to the expiration of a claimant's aggravation rights, the source of such compensation arises from an initial or aggravation claim. In contrast, the source of compensation arising from temporary disability awarded under an Own Motion claim is the Board under ORS 656.278. Thus, because the temporary disability award stems from our Own Motion capacity under ORS 656.278, we are likewise authorized to implement a "suspension" procedure for temporary disability arising out of ORS 656.278(1)(a).[1] *See James W. Jordan*, 53 Van Natta at 728 (our original order) (our authority to suspend in OAR 438-012-0035(5) is consistent with the statutory scheme for workers whose aggravation rights have not expired; *i.e.*, ORS 656.325(2)). In other words, if the Board can authorize temporary disability under ORS 656.278(1), it can also suspend a claimant's temporary disability. Therefore, adoption of OAR 438-012-0035(5) is within the Board's authority.

Moreover, the term "reasonably" in ORS 656.726(5) is an "inexact" term that expresses a complete legislative policy. *Schoch v. Leupold & Stevens*, 325 Or 112, 117 (1997) (the term "reasonable" in ORS 656.386(1) is an inexact term that expresses a complete legislative policy regarding attorney fee awards). *See Springfield Education Association v. School Dist.*, 290 Or 217, 224-225 (1980); *Patti E. Bolles*, 49 Van Natta 1943, 1944 (1997). Because it is inexact, the term delegates authority to the Board to determine by rule what is "reasonably required" in the performance of its Own Motion duties. ORS 656.726(5); *Patti E. Bolles*, 49 Van Natta at 1944.

OAR 438-012-0035(5) properly implements the statutory authority of ORS 656.278(1)(a) by providing the Board with a "reasonable" and necessary corollary to our authority to grant temporary disability in Own Motion - the authority to suspend such compensation. Therefore, OAR 438-012-0035(5) is not invalid as exceeding the scope of discretion granted by the legislature.

Claimant next contends that OAR 438-012-0035(5) does not authorize the Board to "suspend" past temporary disability compensation, because a suspension of benefits is prospective in nature. We disagree.

In conducting our review, it was necessary to focus our attention to specific conduct and events which had occurred prior to our decision. Such an evaluation is entirely consistent with any reviewing body that is called upon to examine the parties' actions that prompted the dispute that the parties submit for the reviewing forum's resolution. As with any reviewing body, our examination of the record necessarily transports us to the actions, omissions, and other relevant circumstances that comprise the basis for the request for Own Motion relief. For purposes of this case, the relief requested is "suspension" of claimant's temporary disability. Although the issuance of our decision granting the request and authorizing the "suspension" obviously "post-dated" the objectionable conduct, the actual "suspension" was necessarily effective as of the date of the unjustified conduct and continued until such time as the conduct ceased.

In light of such circumstances, we disagree with claimant's contention that our decision conflicts with OAR 438-012-0035(5). To the contrary, particularly considering our role as a reviewing body, we find our decision to be fully consistent with our "suspension" authority under the rule.

Finally, claimant contends that there has been no proof that claimant's "disability" has been increased by his refusal to cooperate in his attending physician's treatment plans. ORS 656.325(2). We reject claimant's contention.

First, OAR 438-012-0035(5), from which we derive our authority to suspend claimant's compensation, contains no such requirement. That rule provides that, if the own motion insurer believes that temporary disability should be suspended "for any reason," it may make a request for such suspension. Thus, a finding of "increased disability" is not a prerequisite to our suspension of claimant's compensation.

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[1] Our authority to suspend temporary disability under our Own Motion authority is parallel to, but does not derive from, ORS 656.325(2). We note that a reference to ORS 656.325 in the proposed rule that preceded the eventual adoption of this rule was eventually removed from the ultimately adopted rule. See WCB Admin. Order 1-1994. The Order of Adoption commented that "it is apparent that the Board's 'termination' or 'suspension' authority does not derive from that statute. [ORS 656.325]" WCB Admin Order 1-1994, p. 10. In adopting the rule, we cited to ORS 656.278. *Id.*

In any event, even if an "increased disability" finding was necessary to the suspension of claimant's compensation, the record establishes an "increase" in his disability attributable to his failure to seek treatment. On January 5, 2001, claimant's treating physician, Dr. Edelson, reported that claimant had missed his December 19, 2000 appointment. Dr. Edelson further stated that claimant:

> "should be medically stationary with respect to his right knee at this point in time. If he does not return for an appointment, I would consider him medically stationary, without new restrictions."

Based on this letter, we find medical evidence that claimant's period of disability was increased by his failure to cooperate with medical treatment. In other words, claimant's medically stationary date was extended due to his failure to attend necessary medical and physical therapy appointments.[2]

Accordingly, as supplemented herein, we adhere to and republish our May 31, 2001 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] For purposes of this order, we are assuming, but not deciding, that SAIF has the burden of proving that claimant's period of disability has been increased.

In the Matter of the Compensation of
THOMAS WRIGHT, Claimant
WCB Case Nos. 00-07648 & 00-00932
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) declined to admit a medical report from the treating physician; and (2) upheld the insurer's denials of his aggravation claim for a low back condition. On review, the issues are evidence and aggravation.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the third paragraph of the findings of fact on page 2, we change the citation in the third sentence to: "(Ex. 15C)." In the fourth paragraph on page 3, we change the first sentence to read: "On January 25, 2000, claimant was examined by Drs. Williams and McNeill, who said that claimant had no objective neurological deficit, and normal motor and sensory examination and reflex changes. (Ex. 42-8)." In the fourth paragraph on page 4, after the first sentence and citations, we replace the rest of the paragraph with the following:

> "In *SAIF v. Walker*, 330 Or 102, 110 (2000), the court held that 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. 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. *Id.* at 118-119."

We supplement the ALJ's order as follows.

Claimant argues that the ALJ erred by declining to admit Exhibit 64, which was a February 6, 2001 report from Dr. Denker, his treating physician. Claimant contends that, under OAR 438-007-0023, he had the right to the last presentation of evidence.

We need not address claimant's evidentiary argument because the proffered evidence would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused his discretion by not admitting Exhibit 64. *See, e.g., Jose L. Duran*, 47 Van Natta 449 (1995), *aff'd mem Duran v. Reser's Fine Foods*, 142 Or App 311 (1996).

ORDER

The ALJ's order dated May 24, 2001 is affirmed.

In the Matter of the Compensation of
JACK B. ROY, Claimant
WCB Case No. 97-00659
SECOND ORDER ON REMAND
Willner, Wren, et al., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes.

On August 2, 2001, we abated our July 6, 2001 Order on Remand that reversed an Administrative Law Judge's (ALJ's) order that had upheld the SAIF Corporation's "pre-closure" denial of claimant's current left knee condition. We took this action to consider SAIF's contention that claimant's accepted condition was medically stationary at the time of its denial. Having received claimant's response, we proceed with our reconsideration.

Claimant compensably injured his left knee in August 1996. SAIF accepted "left knee strain/contusion." (Ex. 13). In October 1996, claimant reinjured his left knee in a non-work-related incident. On January 9, 1997, SAIF issued the following denial:

> "We have recently received information that you sustained a new off work injury to your left knee on October 25, 1996. The new injury has been diagnosed as a Grade III retear of the posterior horn of the medial meniscus. Since your accepted claim is not the major cause of this new consequential injury, and since the new injury is the major cause of your current disability and need for medical treatment, the new injury and your current condition on and after October 25, 1996 are not compensable in this claim. Therefore, we must issue this denial of your new consequential injury and current condition. SAIF Corporation will continue to provide benefits related to your accepted left knee strain and contusion." (Ex. 28).

On January 10, 1997, SAIF issued an Amended Notice of Acceptance that accepted a "grade III tear of the posterior horn of the medial meniscus, repaired on October 1, 1996, as a result of the work-related injury of 8/14/96." (Ex. 29). On January 13, 1997, SAIF issued a Notice of Closure awarding five percent scheduled permanent disability for loss of the function of the left knee. (Ex. 30).

Claimant requested a hearing, contesting SAIF's denial. The ALJ upheld SAIF's denial of claimant's "new consequential condition" claim and of claimant's "current condition." On review, we affirmed. *Jack B. Roy*, 51 Van Natta 41 (1999). We reasoned that claimant's October 1996 injury resulted in a new meniscal tear that was a "consequential condition" within the meaning of ORS 656.005(7)(a)(A). We further noted Dr. Witczak's unrebutted opinion that claimant's accepted injury was not the major contributing cause of the new meniscal tear or of claimant's subsequent disability or need for treatment. We concluded that it followed that claimant's "current condition" was likewise not compensable, but that SAIF had continued responsibility for any future medical treatment and disability compensably related to the accepted August 1996 injury. *Id.* at 42, 43.

In reversing and remanding our initial order, the Court of Appeals held that it was unaware of any statute that would authorize a carrier to deny a consequential condition claim without also closing the underlying claim. *Roy v. McCormack Pacific Co.*, 171 Or App 526, 535 (2000), *on recon* 172 Or App 663 (2001). Consequently, the court remanded for reconsideration. On remand, we set aside SAIF's "pre-closure" denial as procedurally improper. *Jack B. Roy*, 53 Van Natta 958 (2001). In doing so, we also distinguished *Chaffee v. Nolt*, 94 Or App 83 (1988). We reasoned that, unlike *Chaffee*, there was no medical evidence that claimant's accepted condition was medically stationary at the time of SAIF's January 9, 1997 denial.

On reconsideration, SAIF contends that claimant's accepted condition was medically stationary before its January 9, 1997 denial as a matter of law because its January 13, 1997 Notice of Closure, which provided that claimant's accepted condition was medically stationary on January 6, 1997, had become final. (*See* Ex. 30).[1] Based on that conclusion, SAIF argues that its "preclosure" denial was procedurally proper, citing *Chaffee*. We disagree with SAIF's contention.

Pursuant to the court's analysis, it was improper for SAIF to issue a "pre-closure" denial of claimant's consequential condition. 171 Or App at 526. The fundamental issue here is not whether SAIF's Notice of Closure, issued after the denial, established that claimant was medically stationary as of a date before the denial. Instead, the determinative issue is whether the denial was properly issued before the date of the claim closure.

In addition, *former* ORS 656.268(1)(a) (1997)[2] provided that a claim could be closed when the worker's condition was *not* medically stationary and "the accepted condition is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7)." In those circumstances, "the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated." *Former* ORS 656.268(1)(a).

Here, pursuant to *former* ORS 656.268(1)(a), SAIF could have closed (and apparently did close) claimant's claim whether or not his accepted condition was medically stationary, asserting that the accepted injury was no longer the major contributing cause of the consequential condition. *Former* ORS 656.268(1)(a). Furthermore, under the former law, such closure could have been affirmed regardless of whether claimant's accepted condition was medically stationary. *Id.* In other words, a finding regarding claimant's medically stationary status would not have been essential to either the subsequent Order on Reconsideration or the ALJ's decision issued in relation to the January 13, 1997 Notice of Closure.

Therefore, even if we were to take administrative notice of our eventual order that affirmed the January 9, 1997 Notice of Closure, such order would not affect the determinative issue in this case, *i.e.* the procedural validity of SAIF's "pre-closure" denial of claimant's current consequential condition.

SAIF continues to rely on *Chaffee v. Nolt* for the proposition that its "pre-closure" denial, issued just four days before the Notice of Closure, was appropriate because it did not "shortcut the ordinary process of claim closure." However, we find *Chaffee* distinguishable because it did not involve a "consequential condition" claim. Here, the court specifically stated that it was "unaware of any statute that authorizes an insurer to deny a consequential claim without also closing the underlying accepted condition." 171 Or App at 535.[3]

In the alternative, SAIF moves for an order remanding this case to the ALJ for further evidence taking in regard to claimant's medically stationary date. For the following reasons, we deny SAIF's 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 clearly be shown that material evidence was not obtainable with due diligence at the time of hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Based on the above reasoning, as well as that in our Order on Remand, admission of documents establishing claimant's medically stationary date "as a matter of law" would not affect our conclusion

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[1] SAIF continues to seek administrative notice of the January 1997 Notice of Closure. For the reasons that follow, we need not address that request.

[2] The court noted that the 1997 version of this statute "frame[d] the issue for the Board to decide on remand." 171 Or App at 533.

[3] In this regard, we modify our initial Order on Remand. Whether or not claimant's condition was medically stationary is not determinative here. The critical point, pursuant to the court's analysis, is that the denial could not precede the closure in this "consequential condition" claim. 171 Or App at 535. SAIF's denial was therefore procedurally invalid.

regarding the propriety of SAIF's "pre-closure" denial. Furthermore, with regard to additional medical evidence on claimant's medically stationary status as of January 9, 1997, SAIF has not shown that it could not have obtained such evidence with due diligence at the time of the hearing. Accordingly, we decline SAIF's motion to remand.

Finally, SAIF requests that we modify our Order on Remand to indicate that its January 9, 1997 denial of the new meniscus tear as a consequential condition (as opposed to claimant's current condition that included the accepted condition) is upheld. SAIF contends that the portion of our original Order on Review that upheld its denial of the meniscus tear as a consequential condition on the merits of the medical evidence was not addressed by the court. We decline SAIF's request.

The court's analysis focused on a carrier's ability to deny a "consequential claim" without also closing the underlying accepted claim. 171 Or App at 535. In reaching its decision, the court made no distinction between one part of SAIF's denial and another (nor one part of the claim from another). Instead, the court referenced the denial and claim without qualification or limitation. *Id.* The court's language thus focused on the procedural propriety of a denial of the entire consequential condition claim, which necessarily includes the meniscus tear condition. Accordingly, pursuant to the court's directive, and based on our reasoning above and in our Order on Remand, we adhere to our conclusion to set aside SAIF's denial as procedurally improper.

Claimant's attorney is entitled to an additional fee for services in responding to SAIF's reconsideration motion. After considering the factors set 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 in regard to this Second Order on Remand is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the reconsideration motion (as represented by claimant's response to SAIF's Motion for Reconsideration of our Order on Remand) and claimant's attorney's uncontested attorney fee request. This award is in addition to the attorney fees granted in our previous order.

Accordingly, as supplemented and modified herein, we adhere to and republish our July 6, 2001 Order on Remand.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARLOS MELENDEZ, Claimant
WCB Case Nos. 00-01205, 99-06183 & 99-07492
ORDER OF ABATEMENT
Mitchell & Guinn, Claimant Attorney
Sheridan, et al., Defense Attorney

On August 31, 2001, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's partial denial of claimant's degenerative disc disease and mechanical low back pain; (2) set aside its denial of claimant's current low back condition; and (3) awarded a $4,000 assessed attorney pursuant to ORS 656.386(1). Asserting that our decision regarding the procedural validity of the denials was erroneous, claimant seeks reconsideration of our decision and reversal of the ALJ's order.

In order to further consider this matter, we withdraw our August 31, 2001 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
DAVID L. HAWKINS, Claimant
WCB Case No. 00-04631
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the SAIF Corporation's denial of his current low back condition; and (2) upheld SAIF's denial of his disc herniations at L4-5 and L5-S1. On review, the issue is compensability.[1]

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

The ALJ upheld SAIF's denials of claimant's current low back condition and disc herniations at L4-5 and L5-S1, finding that claimant had failed to sustain his burden of proving compensability. In so doing, the ALJ noted that claimant had the burden of proving that his compensable work injury "was and remains the major contributing cause of his low back condition."

On review, claimant asserts that he did not have the burden of proving that his combined condition "was" compensable because SAIF specifically accepted a combined condition consisting of a lumbosacral strain and L4-5 and L5-S1 degenerative changes. Thus, claimant contends that the ALJ's decision to uphold the denials was erroneous because the medical evidence that the ALJ found most persuasive never acknowledged the existence of a compensable combined condition and, therefore, did not address the point at which the compensable injury "ceased" to be the major contributing cause of the combined condition. *See* ORS 656.262(6)(c).[2]

Claimant's contentions notwithstanding, medical evidence on which the ALJ relied does acknowledge the existence of a compensable combined condition. Dr. Williams, an examining physician, opined that claimant did sustain a compensable lumbosacral strain that combined with severe preexisting degenerative changes. (Ex. 15-5). However, according to Dr. Williams, the lumbosacral strain had resolved by the time of his February 5, 2000 examination, at which time the preexisting condition became the major factor in claimant's condition.

Dr. Young, a radiologist who reviewed relevant medical records, also opined that claimant's injury "combined" with preexisting degenerative disease to cause symptoms, disability and a need for medical treatment, but that the major contributing cause of the need for treatment and disability of the combined condition "is" the preexisting degenerative disease. (Ex. 33-4). Thus, Dr. Young did not state that the compensable injury never was the major contributing cause of the need for treatment and disability of the combined condition, only that it is not currently the major contributing cause.

Accordingly, two medical opinions expressly acknowledged the existence of a "combined condition." Moreover, having reviewed the medical record, we conclude that the compensable injury "ceased" to be the major contributing cause of the compensable combined condition" when, according to the medical evidence, the lumbosacral strain component of the accepted combined condition resolved. Therefore, we find that the ALJ's decision was in accordance with the statutory requirement of ORS 656.262(6)(c) that the otherwise compensable injury "cease" to be the major contributing cause of the combined condition.

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[1] Pursuant to claimant's motion, this matter has been consolidated for review with WCB Case No. 00-09950. As a general rule, we will consolidate when the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. *See, e.g., Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd* 139 Or App 512 (1996). Because the two matters arise out of the same general circumstances and present issues that are inextricably intertwined and because consolidation will further judicial economy and avoid potentially inconsistent rulings, we review the two cases together.

[2] "Under ORS 656.262(6)(c), a carrier may now deny an accepted combined condition at any point if the "otherwise compensable injury ceases to be the major contributing cause of the combined * * * condition." *SAIF v. Belden*, 155 Or App 568, 574 (1998), *rev den* 328 Or 330 (1999).

Claimant contends, however, that the medical evidence relied on by the ALJ is less persuasive than that of Dr. Bert, claimant's attending physician and surgeon, who opined that the compensable injury was the major contributing cause of disc herniations at L4-5 and L5-S1. Claimant urges that we defer to the opinion of the treating surgeon who observed claimant's condition at surgery.

We generally give considerable weight to the opinion of the treating surgeon because of his first hand observation of surgical findings. *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 701 (1988). However, in this case, we agree with the ALJ's reasons for not deferring to Dr. Bert's opinion.

ORDER

The ALJ's order dated February 5, 2001 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's decision upholding the SAIF Corporation's denials of claimant's current low back condition and his disc herniations at L4-5 and L5-S1. In so doing, the majority concludes that the ALJ's decision was in accordance with ORS 656.262(6)(c) and agrees with the ALJ's reasons for not deferring to the medical opinion of Dr. Bert, the treating surgeon. Because I disagree with the majority's reasoning and would find that claimant satisfied his burden of proof, I respectfully dissent.

Pursuant to ORS 656.262(6)(c), a carrier may deny an accepted "combined condition" if the otherwise compensable injury "ceases" to be the major contributing cause of the combined condition. In this case, SAIF accepted a combined condition consisting of a lumbosacral strain and L4-5 and L5-S1 degenerative changes. Therefore, in order for SAIF to properly deny claimant's low back conditions, the medical evidence must acknowledge the existence of a compensable combined condition and address the point at which the compensable injury "ceased" to be the major contributing cause of the combined condition. *See Gregory C. Noble*, 50 Van Natta 1469, 1471 (1998), *aff'd mem Liberty Northwest Ins. Corp. v. Noble*, 159 Or App 426 (1999) (evidence challenging compensability of the claimant's current right knee condition merely addressed the same condition previously denied and did not suggest that the compensable work injury was no longer the cause of the condition).

Although the majority concludes that the medical evidence on which SAIF relies did so, I agree with claimant that the medical evidence does not sufficiently address these crucial issues. Dr. White, a physician who reviewed claimant's medical records on SAIF's behalf, expressed no opinion on the question of whether the compensable injury ever combined with degenerative changes. (Exs. 42, 43). Thus, Dr. White never addressed when or why the compensable injury ceased to be the major contributing cause of the "combined condition." Thus, his opinion does not provide persuasive support for SAIF's denials.

The majority cites portions of medical opinions submitted by Drs. Williams and Young. However, Dr. Williams is the only doctor who arguably addresses when the otherwise compensable injury ceased to be the major contributing cause of the combined conditions. However, Dr. Williams' opinion was not well explained because he never explained how the lumbosacral strain had resolved and the degenerative condition had thus become the major factor in claimant's condition. (Ex. 15-5).

Dr. Young also opined that claimant's injury combined with preexisting degenerative disease to a need for treatment. However, unlike the majority, I do not find the use of the word "is" a sufficiently clear indication that Dr. Young believes that the compensable injury is not currently the major contributing cause of the combined condition. As was true of Dr. Williams' opinion, Dr. Young's is also conclusory and not well explained. (Ex. 33-4).

Having reviewed the medical evidence on which SAIF relies, I find that it is deficient for the reasons cited by claimant. Moreover, it pales in comparison to Dr. Bert's opinion in terms of persuasiveness. The majority agrees with the ALJ's reasons for not deferring to the attending surgeon's opinion. However, I do not find those reasons compelling.

The ALJ discounted Dr. Bert's opinion regarding the existence of disc herniations at L4-5 and L5-S1 because what Dr. Bert visualized during surgery could have been disc "bulges," as posited by SAIF's doctors. Moreover, the ALJ reasoned that Dr. White stated that it was "impossible" for several highly trained doctors to have missed two significant disc herniations after reviewing claimant's MRI scan.

Further, the ALJ stated that, if Dr. Bert saw two large disc herniations at surgery, they could have developed during the period between the January 3, 2000 MRI and the April 11, 2000 surgery. Finally, the ALJ noted that Dr. Bert's operative report did not indicate that what he observed at surgery (be it a "bulge" or a "herniation") was encroaching on a nerve root. Based on these considerations, the ALJ concluded that it was questionable whether claimant suffered disc herniations as a result of the work injury.

Unlike the majority, I do not find this rationale sufficient justification to disregard our long-standing policy of deference to an attending physician, especially one who has been the claimant's surgeon. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988) (treating physician's opinion was given greater weight because of his first-hand exposure to and knowledge of the claimant's condition). It seems to me that if anyone should know whether claimant has disc hernations it is the physician who operated on claimant's lumbar spine. Moreover, I agree with claimant that the ALJ impermissibly inserted his own medical opinion, by inferring that Dr. Bert "should have" included in his operative report a notation on whether the disc material was encroaching on a nerve root. This speculation clearly violates the prohibition on such inferences in *SAIF v. Calder*, 157 Or App 224 (1998).

For all these reasons, I believe the ALJ's order should be reversed and that SAIF's denial should be set aside. Because the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
JOHN K. HARKNESS, Claimant
WCB Case No. 97-08467
SECOND ORDER ON REMAND
Gayle A. Shields, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests reconsideration of that portion of our September 7, 2001 Order on Remand that awarded an attorney fee of $11,000 for claimant's counsel's services at hearing, before the Board (on review and on remand) and the court. Specifically, claimant asks that the attorney fee award be modified to include the $17,082 in fees and $240 in costs awarded by the Court of Appeals for work before the Court.

When 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). Here, the appellate judgment from the Court of Appeals said that "[a]ttorney fees in the amount of $17,082.00 and costs in the amount of $240.00 are contingent on petitioner prevailing on remand." Claimant has indeed prevailed on remand. Consequently, we modify our Order on Remand to award claimant's attorney $17,082 for services performed before the Hearings Division, Board and court, payable by the SAIF Corporation.[1]

In addition, claimant's attorney is entitled to a reasonable fee for services performed on remand. After considering the factors set 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 remand is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the "preclosure denial" issue (as represented by claimant's brief on remand), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, our September 7, 2001 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our September 7, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Although claimant asks that we award $240 in court costs, we have no such authority. *See* ORS 656.388(1); OAR 438-015-0005(4), (6); OAR 438-015-0015.

In the Matter of the Compensation of
DAVID L. HAWKINS, Claimant
WCB Case No. 00-09550
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Phillips Polich. Member Phillips Polich dissents.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed an Order on Reconsideration authorizing the SAIF Corporation to offset allegedly overpaid temporary disability benefits. On review, the issue is offset.

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

ORDER

The ALJ's order dated March 1, 2001 is affirmed.

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[1] Pursuant to claimant's motion, this matter has been consolidated for review with WCB Case No. 00-04631. As a general rule, we will consolidate matters when the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. *See, e.g., Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd* 139 Or App 512 (1996). Because the two matters arise out of the same general circumstances and present issues that are inextricably intertwined and because consolidation will further judicial economy and avoid potentially inconsistent rulings, we review the two cases together.

Board Member Phillips Polich dissenting.

The majority adopts the ALJ's order affirming an Order on Reconsideration that authorized the SAIF Corporation to offset an alleged overpayment of temporary disability. In so doing, it approves the ALJ's reasoning that claimant's challenge to SAIF's offset could not be considered at hearing because it was not raised during the reconsideration proceedings. Because I disagree with the ALJ's reasoning and conclusions, I would not affirm the ALJ's order. For this reason, I respectfully dissent.

ORS 656.283(7) provides that an issue not raised by a party on reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. The ALJ reasoned that, because SAIF's September 14, 2000 Notice of Closure asserted the existence of an overpayment and because SAIF had earlier advised claimant in writing that an overpayment existed and that it might seek to recover it, the offset issue existed prior to and at the time of closure and could have been asserted as an issue at reconsideration.

The ALJ's analysis was incorrect. On August 31, 2000, SAIF issued a modified acceptance notice that officially accepted a "combined condition," consisting of a lumbosacral strain and L4-5 and L5-S1 degenerative changes. The following day, SAIF issued a denial of the entire combined condition. SAIF did not close the claim until September 14, 2000.

I would find that claimant sufficiently raised the issue of overpayment at reconsideration by raising the issue of all payment under the claim closure. (Ex. 29-1). I note that claimant marked each of the boxes on the Workers' Compensation Department's Request for Reconsideration Form. In addition, he submitted an addendum to his Request for Reconsideration in which he specifically contested the medically stationary date. Time loss follows medically stationary status: thus entitlement to payment was sufficiently raised by claimant. What more can claimant do? He submitted both the required form and an addendum for further clarification. (*See SAIF v. Dubose*, 166 Or App 642 (2001)). In addition, claimant included the issue of "combined condition denial" in conjunction with the claim closure. (Ex. 29-2). Therefore, claimant raised the issue of the denial, which necessarily included payments under the closure at the reconsideration proceedings. This is, in my view, sufficient to allow claimant to challenge the alleged overpayment.

Moreover, I agree with claimant that temporary disability payments paid prior to the combined condition denial were in the nature of interim compensation and, thus, were not subject to offset. *See Terrance N. Chase*, 44 Van Natta 1555 (1992). Inasmuch as the Board has jurisdiction over matters concerning a claim under ORS 656.283(1), it could address the issue of whether payments of temporary

disability made prior to the denial were in the nature of interim compensation. Thus, the fact that claimant may not have specifically raised the issue of overpayment at reconsideration should not have precluded him from contesting SAIF's alleged overpayment.

Finally, I question SAIF's claim processing in this matter. SAIF accepted the claim for an acute lumbosacral strain on February 22, 2000 and began paying temporary disability. As previously noted, it denied a combined condition on September 1, 2000 almost simultaneously with accepting the combined condition. SAIF did not close the claim until September 14, 2000 and then claimed an overpayment. SAIF's delay in processing the claim to denial meant it paid interim compensation for a period of time wholly within its control and unrelated to the compensable conditions it had accepted. To assert an overpayment under such circumstances is unwarranted.

For all these reasons, I strongly disagree with the ALJ's order and, therefore, must part company with the majority and dissent.

In the Matter of the Compensation of
TIM L. TRASK, Claimant
WCB Case No. 00-06860
ORDER ON REVIEW
Swanson, et al., Claimant Attorney
VavRosky, et al., Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl. Member Biehl chose not to sign the order.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the self-insured employer's denial of his pneumothorax injury claim. On review, the issue is compensability.

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

Claimant argues that the ALJ incorrectly applied the "major contributing cause" standard to the compensability of his pneumothorax injury because there was no medical proof that claimant had a "bleb" in his pleura. Claimant also argues that we should rely on the opinion of Dr. Imatani rather than Dr. Lewis. We do not agree that the application of the major contributing cause standard was incorrect. Moreover, Dr. Imatani's opinion is insufficient to carry claimant's burden of proof.

A "preexisting condition" means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or *predisposes* a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury. ORS 656.005(24). Dr. Imatani agreed that the fact that claimant had a history of smoking approximately one pack a day of cigarettes was a predisposing factor to the development of pneumothorax. Thus, even without the proven presence of a "bleb," claimant's history of smoking is sufficient to require the application of the "major contributing cause" standard in this case.

Based on his expertise as a pulmonary specialist, Dr. Lewis attributed claimant's pneumothorax to the presence of a bleb. Dr. Imatani also stated that claimant may have had blebs in his lung. However, Dr. Imatani stated that the major contributing cause of the pneumothorax was the Valsalva maneuver without discussing the relative contributions of the bleb(s), the history of smoking, and the Valsalva maneuver. Consequently, his opinion is insufficient to establish compensability. *See Dietz v. Ramuda*, 130 Or App 397, *rev dismissed* 321 Or 416 (1995) (where standard of proof is "major contributing cause, evidence that does not weigh relative contributions of competing causes is insufficient to prove claim).

ORDER

The ALJ's order dated May 2, 2001 is affirmed.

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Cite as 332 Or 404 (2001) August 16, 2001

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Garrett W. Crawford, Claimant.

MENASHA CORPORATION and LUMBERMANS MUTUAL CASUALTY COMPANY,
Respondents on Review,
v.
GARRETT W. CRAWFORD, Petitioner on Review.
(WCB 98-03327; CA A105040; SC S47076)

On review from the Court of Appeals. *

Argued and submitted November 8, 2000.

Mike Stebbins, of Stebbins & Coffey, North Bend, argued the cause and filed the brief for petitioner on review.

Jerald P. Keene, of Reinisch, Mackenzie, Healey, Wilson & Clark, P.C., Portland, argued the cause and filed the brief for respondents on review.

David L. Runner, Lead Appellate Counsel, Salem, filed the brief for *amici curiae* SAIF Corporation, Pape Group, Inc., and Timber Products Company.

G. Duff Bloom, of Cole, Cary, Wing & Bloom, P.C., Eugene, filed the brief for amicus curiae Oregon Trial Lawyers Association.

Before Carson, Chief Justice, and Gillette, Durham, Leeson, and Riggs, Justices. **

GILLETTE, J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

* Judicial review from the Workers' Compensation Board. 164 Or App 174, 988 P2d 451 (1999).

** Van Hoomissen, J., retired on December 30, 2000, and did not participate in the decision of this case; Kulongoski, J., resigned June 14, 2001, and did not participate in the decision of this case; De Muniz, J., did not participate in the consideration or decision of this case.

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332 Or 407> The issue in this workers' compensation case is whether claimant is entitled to receive nearly two years' worth of temporary total disability (TTD) benefits, based on a physician's after-the-fact certification that claimant had been disabled for that period. An administrative law judge (ALJ) and the Workers' Compensation Board (Board) held that claimant was entitled to temporary compensation for the period in question. The Court of Appeals reversed. *Menasha Corp. v. Crawford*, 164 Or App 174, 988 P2d 451 (1999). We allowed claimant's petition for review and now affirm the decision of the Court of Appeals.

The facts are undisputed. On October 11, 1995, claimant reported to his employer that he had suffered an injury to his lower back. The next day, claimant saw Dr. Davis, who confirmed the back injury and released claimant to light work. Eight days later, Davis released claimant to regular work. In the meantime, employer fired claimant. On October 27, 1995, employer's insurer denied claimant's claim for compensation.

Claimant appealed the denial of his claim. On January 16, 1997, an ALJ reversed the denial. On July 15, 1997, the Board affirmed the ALJ's decision. Neither employer nor employer's insurer (collectively "employer") sought further review, and the merits of that adjudication are not before us. As the case comes to us, claimant is a worker who has had a valid claim for an on-the-job injury to his back, which claim was in accepted status after July 15, 1997.

Claimant was referred to and began treating with another physician, Dr. Bert, on December 13, 1995. On September 30, 1997, Bert performed surgery on claimant's back. On December 1, 1997, after an inquiry by claimant's lawyer, Bert certified retroactively that claimant had been unable to work for the period from October 20, 1995 (the date that Davis released claimant for regular work), until September 30, 1997 (the date of surgery).

332 Or 408> On January 27, 1998, Bert released claimant for light work. On February 4, 1998, two physicians retained by employer concluded that claimant's back condition was "medically stationary."[1] Bert concurred.

On March 9, 1998, employer's insurer closed the claim and awarded TTD benefits from September 30, 1997 (the date of surgery), until February 4, 1998 (the date on which claimant was determined to be medically stationary). A later modification added the period from October 12, 1995 (the date of injury), until October 20, 1995 (the date that Davis released claimant for regular work). Claimant was not awarded benefits for the nearly two-year gap between October 20, 1995, and September 30, 1997.

Claimant challenged the award, seeking compensation for the period from October 20, 1995, until September 30, 1997. An ALJ concluded that, although ORS 656.262(4)(g)[2] restricts retroactive awards of TTD during the period of time in which the claim is open, a TTD award for the period from October 20, 1995, until September 30, 1997, nonetheless was appropriate. The ALJ explained:

> "The payment of temporary disability 'pursuant to ORS 656.268,'" as provided in [*former*] ORS 656.262(4)(f) [1995], concerns the payment of temporary disability during the carrier's processing of open claims to closure. Thus, ORS 262.268 refers to procedural temporary disability benefits which may accrue prior to claim closure. ORS 656.268 does not set forth the requirements for substantive entitlement to temporary disability; those requirements are set forth in **<332 Or 408/409>** ORS 656.210 and 656.212. *Kenneth P. Bundy*, 48 Van Natta 2501, 2503 (1996).
>
> "Here, inasmuch as claimant's claim has been closed, the issue is claimant's *substantive* right to temporary disability benefits. A claimant's substantive entitlement to temporary disability benefits, which is set forth in ORS 656.210 and 656.212, is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. * * * Neither ORS 656.210 nor ORS 656.212 contains any language which limits a worker's substantive entitlement to temporary disability to only those periods for which there is contemporaneous authorization by the attending physician. *Bundy, supra.* Therefore, claimant need not show contemporaneous authorization of time loss to be entitled to those substantive benefits."[3]

(Citations omitted; emphasis in original.)

As noted, the ALJ relied on the Board's earlier decision in *Bundy*. In that decision, the Board had held that ORS 656.262(4)(g) applies only to "procedural" obligations. That was true, the Board stated, for two reasons: First, the verbs in ORS 656.262(4)(g) are in the present tense, implying that the statute applies only when the claim is open. Second, when the legislature added what is now ORS 656.262(4)(g), it did not revise ORS 656.210 and ORS 656.212, the statutes that authorize TTD and temporary partial disability compensation (TPD), respectively. Neither of those statutes specifically limits TPD and TTD only to those periods for which a physician has issued a contemporaneous authorization. As a result, the Board held in *Bundy* that ORS 656.262(4)(g) does not apply to a claim at closure. 48 Van Natta 2501, 2503 (1996).

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[1] "Medically stationary," as defined in ORS 656.005(17), means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time."

[2] The statute that was in effect at the commencement of this case, ORS 656.262(4)(f) (1995), was renumbered in 1997 as ORS 656.262(4)(g), but was not otherwise changed. 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."

Unless otherwise noted, all statutory citations refer to the current version of the Oregon Revised Statutes.

[3] "Time loss," as used herein by the ALJ, the Board, and the Court of Appeals, is a shorthand for temporary disability compensation under ORS 656.210 and ORS 656.212.

On review in the present case, the Board affirmed, again asserting (as it had in *Bundy*) that a claimant's "substantive" entitlement to temporary disability benefits is <332 Or 409/410> determined when the claim is closed. Citing its earlier decision in *Bundy*, the Board concluded that a worker substantively is entitled to temporary disability benefits for those periods during which the worker is able to prove that he or she was unable to work as a result of a compensable injury and that substantive entitlement to such benefits is not contingent on contemporaneous authorization of time loss by the attending physician. *Garret W. Crawford*, 51 Van Natta 1 (1999). One member of the Board concurred specially, opining that the substantive/procedural distinction on which *Bundy* depended was eliminated when the legislature enacted former ORS 656.262(4)(f) (1995) and former ORS 656.268(3)(d) (1995),[4] and that the statute required a physician to authorize any award of temporary disability. The member declined to dissent, however, because the Board's decision in *Bundy* still was the law. *Id.* at 2.

Shortly after the Board issued its *Crawford* decision, the Court of Appeals, in an *en banc* decision, reversed *Bundy*. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, 978 P2d 385 (1999).[5] In *Bundy*, the Court of Appeals described the issue as "whether ORS 656.262(4)(g) applies to only procedural obligations to pay temporary disability while a claim is open, or whether it also applies to the substantive entitlement to benefits at claim closure." 159 Or App at 49.

We examine the Court of Appeals' decision in Bundy at length, because it squarely presents the legal issue that we address in the present case. A majority of the full Court of Appeals concluded that ORS 656.262(4)(g) does not permit a physician to make an award of temporary compensation retroactive for more than 14 days. The majority rejected the Board's conclusion that ORS 656.262(4)(g) applies only to pending "procedural" claims: "On its face, ORS 656.262(4)(g) is not limited to benefits that are due and payable during the time that the claim is open." *Bundy*, 159 Or App at 50. In the majority's view, the fact that "the verbs in the statute are in <332 Or 410/411> the present tense does not negate the possibility that the statute also applies to awards of time loss [*i.e.*, temporary disability] made at claim closure." *Id.* (footnote omitted). In addition, "the reference to ORS 656.268 in both sentences [of ORS 656.262(4)(g)] is a reference to a statute that addresses the process of claim closure." *Id.* The Court of Appeals majority ultimately concluded that ORS 656.262(4)(g) is ambiguous and proceeded to examine the legislative history of the statute. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993) (establishing that paradigm of statutory interpretation). From that review, the majority concluded that ORS 656.262(4)(g) prevents a physician from authorizing retroactive benefits more than 14 days into the past. 159 Or App at 50-54.

Judge Wollheim, joined by Judges De Muniz and Armstrong, dissented. The dissent noted that the substantive/procedural distinction on which the Board relied was not found in the workers' compensation statute but, rather, existed in the Court of Appeals' case law. Specifically, the dissent argued that

> "[s]ubstantive time loss is the temporary total disability award, which the injured worker is entitled to receive at the time of closure by virtue of proof that the injured worker experienced a period of temporary total disability before claim closure."

159 Or App at 55 (Wollheim, J., dissenting). Conversely,

> "[a]n injured worker's procedural entitlement to time loss is the temporary total disability benefits that the employer or insurer is obligated to pay on an open claim by virtue of the procedures of claim processing before the injured worker becomes medically stationary."

Id.

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[4] In 1999, *former* ORS 656.268(3)(d) (1995), was renumbered as ORS 656.268(4)(d), but was otherwise unchanged.

[5] This court accepted review in *Bundy*, 329 Or 318, 994 P2d 122 (1999), but later dismissed review as improvidently allowed, 329 Or 503, 991 P2d 1058 (1999). The order of dismissal did not disclose the reasons for the court's decision to dismiss.

The dissent in *Bundy* maintained that ORS 656.262(4)(g) concerns only open claims and procedural benefits, *i.e.*, "when payment must be made, when payment is not due and payable, and when payment may be unilaterally suspended." *Bundy*, 159 Or App at 57 (Wollheim, J., dissenting). The dissent then asserted that ORS 656.268, which is cross-referenced in ORS 656.262(4)(g), is a procedural statute **<332 Or 411/412>** that describes the process for awarding temporary benefits on a claim at the time of *closure*. *Id.* at 57-58. According to the dissent:

> "The first sentence of [ORS 656.262](4)(g) is expressly limited to temporary disability benefits not due and payable 'pursuant to ORS 656.268.' That statute is only a procedural statute. Because temporary disability benefits suspended under the first sentence of subsection (4)(g) are, by definition, being paid *pursuant to* ORS 656.268, this sentence is limited to the procedural entitlement to temporary disability benefits. The second sentence of subsection (4)(g) expressly refers to an attending physicians's authorization of temporary disability benefits 'under ORS 656.268.' The explicit reference to ORS 656.268 limits the application of this sentence of (4)(g) to the procedural entitlement of temporary benefits while the claim is open. * * * Thus, like the first sentence, the second sentence of subsection (4)(g) is also limited to the procedural entitlement to temporary disability benefits."

Id. at 60-61 (citation omitted; emphasis in original). The dissent concluded, without reaching the legislative history, that ORS 656.262(4)(g) does not establish any temporal limit on the temporary compensation that might be paid when a claim is closed. *Id.* at 56-63.

On employer's petition for judicial review in the present case, the Court of Appeals reversed the Board's decision and remanded for reconsideration in light of *Bundy*. *Menasha Corp. v. Crawford*, 164 Or App 174, 988 P2d 451 (1999). We allowed claimant's petition for review.

The issue before us turns on the meaning of ORS 656.262(4)(g) and is a question of the legislature's intent. As did the Court of Appeals, we examine the text and context of the statute to determine that intent. *PGE*, 317 Or at 610. If the legislature's intent is clear from the text and context, further inquiry is unnecessary. *Id.* at 611. For convenience, we again set out ORS 656.262(4)(g):

> "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 **<332 Or 412/413>** 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."

The authorization of the attending physician triggers the duty to pay temporary disability benefits. Subsection (4)(a) of ORS 656.262, provides:

> "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.*"

(Emphasis added.) Subsection (4)(d) of the same statute provides:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control."

Viewed in light of subsections (4)(a) and (4)(d), the first sentence of subsection (4)(g) is clear. It describes two additional sets of circumstances in which temporary disability compensation is *not* due and payable: (1) after the claimant's attending physician ceases to authorize such compensation; and (2) for any other period of time "not authorized by the attending physician."

The first sentence leaves open this question: Should a worker receive TTD when an attending physician belatedly concludes that the worker is temporarily totally disabled? The second sentence of subsection (4)(g) answers that question: The attending physician's authorization of temporary total disability payments can be retroactive for up to 14 days -- but no more.

332 Or 414> The foregoing statutes state the positive law basis for awarding TTD. TTD benefits are not due and payable if the claim does not meet the qualifying statutory criteria.

ORS 656.268, the statute twice cross-referenced in ORS 656.262(4)(g), sets out the procedures for terminating TTD benefits. That statute provides, in part:

> "(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."

As did the dissent in *Bundy*, claimant here argues that the text of ORS 656.262(4)(g) applies only to open claims, not to circumstances in which a claim is being closed and an award is being finalized. As our examination of that statute in context demonstrates, however, the text and context of ORS 656.262(4)(g) do not permit such an interpretation: Neither ORS 656.262(4)(g) nor any other statute that provides context for ORS 656.262(4)(g) makes a distinction between a pending claim and a claim at the time of closing respecting retroactive compensation.[6]

332 Or 415> The workers' compensation statutes provide for TTD in ORS 656.210[7] and for TPD in ORS 656.212.[8] To be payable, such compensation must have both a physician's initial and continuing

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[6] The *Bundy* dissent purported to find such a distinction, based on the difference in wording between ORS 656.262(4)(g) ("not due and payable") and ORS 656.268(4)(d) ("suspended, withheld, or terminated"). The two statutes are harmonizable, however, when one recognizes that benefits are "terminated" when they no longer are due and payable.

[7] ORS 656.210(1) states:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser. Notwithstanding the limitation imposed by this subsection, an injured worker who is not otherwise eligible to receive an increase in benefits for the fiscal year in which compensation is paid shall have the benefits increased each fiscal year by the percentage which the applicable average weekly wage has increased since the previous fiscal year."

ORS 656.210(2)-(4) further defines the methods of calculating temporary total disability benefits.

[8] ORS 656.212 states:

> "When the disability is or becomes partial only and is temporary in character:
>
> "(1) No disability payment is recoverable for temporary disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period.
>
> "(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive for an aggregate period not exceeding two years that portion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary total disability pursuant to ORS 656.210."

authorization. "The first installment of temporary disability compensation shall be paid * * * if the attending physician[9] authorizes the payment of temporary disability compensation." ORS 656.262(4)(a). An attending physician may authorize payment of disability benefits and payment may continue only for the period of time authorized by those sections. ORS 656.262(4)(h). An employer may suspend payment of TTD or TPD at the end of the period until the attending physician reauthorizes the temporary disability. ORS 656.262(4)(h). Such compensation is not due and payable for any period for which the attending physician cannot verify the worker's inability to work, if the insurer or self-insured employer has requested verification of that inability. ORS **<332 Or 415/416>** 656.262(4)(d). Further, if the insurer or self-insured employer has requested, but has not received, some form of verification from the attending physician, that physician's services are not compensable until the physician submits such verification. ORS 656.262(4)(f).

ORS 656.262(4)(g) applies in conjunction with ORS 656.268, the statute that determines a claimant's entitlement to claim closure as well as the claimant's entitlement to TTD. Consistent with the first sentence of ORS 656.262(4)(g), ORS 656.268 provides that TTD continues until the attending physician advises the claimant and documents in writing that the claimant is released to return to regular employment. ORS 656.268(4)(b). In addition, that same subsection provides that TTD shall continue until "[a]ny other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under *ORS 656.262(4)* * * *." ORS 656.268(4)(d) (emphasis added).

In sum, the statement in ORS 656.262(4)(g) that "[n]o authorization * * * shall be effective * * * retroactively * * * more than 14 days" establishes that the legislature did not intend to permit physicians to certify retroactive temporary compensation for a period greater than 14 days. Context does not alter that fact: No related statutory provision states that ORS 656.262(4)(g) applies only to certain kinds of claims but not to others, or that the statute applies to claims while they are pending but not to claims at the time of their closure. The statutory text viewed in context is unambiguous. We need not examine legislative history to determine the legislature's intent. *PGE*, 317 Or at 611.

Application of the statute to this case is straightforward. On October 20, 1995, Davis released claimant for regular work. Under ORS 656.262(4)(g), temporary disability benefits no longer were due and payable to him, because the "attending physician cease[d] to authorize temporary disability." Later, Bert retroactively certified claimant as fully disabled from October 20, 1995, but Bert's later certification is, as we have shown, subject to the clearly worded limitation in the second sentence in ORS 656.262(4)(g). The Court of Appeals thus properly remanded the case to the Board to recalculate claimant's award of TTD benefits.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

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[9] An attending physician generally is a licensed physician who primarily is responsible for treating a worker's compensable injury for the earlier of 30 days from the date of first visit on the initial claim or 12 visits. ORS 656.005(12)(b)(B); *see also* ORS 656.245(5) (authorizing certain nurse practitioners and physician assistants who practice in rural areas to authorize payment of temporary disability compensation for 30 days from date of first visit on claim).

Cite as 175 Or App 78 (2001) June 27, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joseph H. Keller, Claimant.

JOSEPH H. KELLER, Petitioner,
v.
SAIF CORPORATION and ALAN BOWDISH, INC., Respondents.
98-09663; A109170

En Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted January 3, 2001; resubmitted en banc April 11, 2001.
Lauren Paulson argued the cause and filed the brief for petitioner.
Jerome P. Larkin argued the cause and filed the brief for respondents.
Before Deits, Chief Judge, and Edmonds, Landau, Haselton, Armstrong, Linder, Wollheim, Kistler, Brewer, Judges, and Lipscomb, Judge *pro tempore*.
WOLLHEIM, J.
Affirmed.
Lipscomb, J. *pro tempore*, dissenting.

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175 Or App 80> Claimant seeks review of an order of the Workers' Compensation Board, asserting that the Board erred in concluding that his claim for a work-related injury was barred as untimely. We conclude that the Board did not err and therefore affirm.

The facts are undisputed. Claimant twisted his ankle at work on October 23, 1997. He did not notify employer or seek medical attention because he thought that the injury was minor and would heal on its own. Employer was aware that claimant had injured his foot but did not know that the injury had occurred at work. Claimant continued to experience pain, however, and in December 1997 he sought medical attention. On October 20, 1998, claimant filed a claim and thereby notified employer that the injury was work-related. Employer denied the claim as untimely. An administrative law judge (ALJ) and the Board upheld the denial, and claimant seeks review.

The case turns on an interpretation of ORS 656.265. As relevant, that statute provides:

> "(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer, but not later than 90 days after the accident. * * *
>
> " * * * * *
>
> "(4) Failure to give notice as required by this section bars a claim under this chapter unless *the notice is given* within one year after the date of the accident and:
>
> "(a) The *employer had knowledge* of the injury or death[.]" (Emphasis added.)

Although claimant acknowledges that he did not file his claim within 90 days, he asserts that his claim is not barred because it satisfies the exception stated in ORS 656.265(4)(a).

Claimant's argument raises two distinct issues under the statute. The first issue that we address is the time within which the employer must have had knowledge of the **<175 Or App 80/81>** injury. In claimant's view, the knowledge requirement is satisfied if the employer learns of the injury any time within one year after the date of the accident. Thus, in claimant's view, the delayed notice, filed within one year of the date of the accident, can give knowledge of the injury. In employer's view, the employer must have knowledge of the injury within the 90-day period for filing notice of the claim. We agree with employer. In the first place, this court has implicitly held, in *McNett v. Roy-Ladd Const. Co.*, 46 Or App 601, 613 P2d 47, *rev den* 289 Or 588 (1980) (knowledge exception inapplicable because knowledge acquired after 180-day deadline for giving notice of claim did not prejudice employer), that knowledge gained after the initial notice period does not satisfy the exception.

Secondly, an analysis of the statute under the template of *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993), confirms our interpretation. Contrary to the view expressed by the dissent, the statutory language is not unclear as to when the employer must gain knowledge of the injury. Although ORS 656.265(4)(a) does not explicitly state a time period within which the employer must have acquired knowledge of the injury, the conclusion that knowledge of the injury must be gained within the 90-day period for filing a claim is the only plausible reading of the statute. The text of ORS 656.265(4)(a) requires that the employer "had knowledge" of the injury, implicitly requiring that the knowledge came *before* the delayed notice permitted by ORS 656.265(4). Further, the context of subparagraph (4)(a), in its logical flow from subsection (1), requires the conclusion that the employer's knowledge must have been gained within the 90-day period set forth in subsection (1). Subsection (1) provides that notice of an accident resulting in injury "shall be given immediately * * * but not later than 90 days after the accident." Subsection (4) provides that a claim is *barred* if the required notice is not given, unless one of the exceptions is applicable. The exception described in subparagraph (4)(a) requires that notice be given within one year of the accident and that "the employer had knowledge of the injury or death." Although no specific time period for the acquisition of knowledge is set forth in subparagraph (4)(a), the logical sequence of the language suggests that the knowledge of the **<175 Or App 81/82>** injury must be gained by the employer during the initial notice period set out in subsection (1) and to which the exception applies. Thus, a claimant is excused from giving formal notice within 90 days, so long as the employer had actual knowledge of the injury during that same 90-day time period and the claimant gave formal notice within one year.[1]

Finally, claimant's reading of the exception stated in ORS 656.265(4)(a) would, essentially, swallow up the rule stated in ORS 656.265(1) and (4). If, as claimant asserts, a claim is not barred and is permitted to go forward when, within one year of the injury, a notice of claim is filed and the employer acquires knowledge of the injury, then there would be no need for subsection (1) or for the first clause of the first sentence of subsection (4) ("Failure to give notice as required by this section bars a claim under this chapter[.]"). We will not construe a statute in a way that renders its provisions superfluous. ORS 174.010. In giving effect both to the 90-day requirement of subsection (1) and to the exception set forth in subparagraph (4)(a), we conclude that the statute must be read to require that the employer have knowledge of the injury within 90 days of the accident.[2]

The second issue that claimant's petition raises is the extent of the knowledge required by ORS 656.265(4)(a). In claimant's view, it is sufficient that employer knew, within 90 days after the accident, that claimant had injured his foot, although it was unaware of the possibility that the injury was work-related. We reject the contention. In *Argonaut Ins. Co. v. Mock (A41801)*, 95 Or App 1, 768 P2d 401, *rev den* 308 Or 79 (1989), this court said that the employer's "knowledge of the injury" under ORS 656.265(4)(a)

> "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 **<175 Or App 82/83>** 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." 95 Or App at 5.

Thus, this court has previously required that the employer have knowledge of not merely an injury but also of the injury's possible relationship to the employment. *See also Wilson v. Roseburg Forest Products*, 113 Or App 670, 673-74, 833 P2d 1362 (1992). Here, it is conceded that employer had no knowledge of the injury's potential work connection until the date when claimant filed his claim, almost one year after the injury.

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[1] As the dissent points out, subparagraph (4)(b) provides an additional exception if the worker dies within 180 days after the date of the accident and notice is given within one year of the date of the accident. We do not venture to speculate why the legislature considered 180 days to be appropriate in that context.

[2] To the extent that *dictum* in our opinion in *Allied Systems Co. v. Nelson*, 158 Or App 639, 646, 975 P2d 923 (1999), suggests that the knowledge may be gained within one year of the injury, that language is disapproved.

The dissent points out that ORS 656.265(4)(a) has been amended since we decided *Mock*. However, the changes did not alter the language that we considered in *Mock* or that is under consideration here, and we are not persuaded that the changes have any bearing on the issue of what type of knowledge the employer must have. Then, as now, the employer must have had "knowledge of the injury."

Further, we disagree with the dissent's assertion that our pre-*PGE* analysis in *Mock* must be reevaluated. It remains precedential in the aftermath of that decision. *See Kambury v. Daimlerchrysler Corporation*, 173 Or App 372, 379, 21 P3d 1089 (2001). Even if we were to reevaluate *Mock*, however, it withstands scrutiny. As the dissent notes, subsection (1) of ORS 656.265 provides that "[n]otice of *an accident resulting in an injury or death*" shall be given immediately, but not later than 90 days after the accident. Subsection (4) lists two exceptions to the 90-day limitation, including the one alleged to be applicable here, that "[t]he employer had knowledge of *the* injury or death." (Emphasis added.) It is apparent that the legislature intended the two subsections to work together. Subsection (1) describes the time limitation for giving notice of "*an accident resulting in injury*," and subparagraph (4)(a) provides for an exception to that requirement when the employer receives notice within one year and **<175 Or App 83/84>** had "knowledge of *the* injury." "Knowledge of *the* injury" as used in subsection (4) can only mean knowledge of the injury referred to in subsection (1) as the alleged result of an accident, and necessarily includes knowledge of the *alleged* work relationship.[3] *See Osborn v. PSRB*, 325 Or 135, 142, 934 P2d 391 (1997) (analyzing use of different modifiers in different statute). The dissent mistakenly reads "the injury" as used in subsection (4) in isolation from and without regard to its original reference in subsection (1) and thereby would reach the unintended result that the statute is satisfied if the employer has knowledge of an injury, even if the employer had no knowledge that the injury was possibly work-related.

In summary, the Board correctly upheld employer's denial of the claim on the ground that it is untimely.

Affirmed.

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[3] Contrary to the dissent's suggestion, we do not hold that the employer must have knowledge of the *compensability* of the claim, only of the alleged work relationship.

LIPSCOMB, J., pro tempore, dissenting.

The majority reaches the wrong result in this case because it applies the wrong analysis. In holding that the result in this case is unaffected by the 1995 statutory amendments to ORS 656.265, the majority principally relies on a preamendment case interpreting that statute. *Argonaut Ins. Co. v. Mock*, 95 Or App 1, 768 P2d 401 (1989).[1] The majority's reliance on *Mock* cannot be justified for three reasons.

First, the reason offered by the majority for its reliance on *Mock* is that the 1995 amendments did not alter the specific language under consideration in this case. Thus, in its interpretation of the statutory phrase, "the employer had knowledge of the injury or death," the majority isolates that phrase from its statutory context. Doing so enables the **<175 Or App 84/85>** majority to ignore the 1995 statutory amendments to ORS 656.265 which changed that context. However, as Supreme Court held in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993), a reviewing court must consider *both* the text *and* context at the initial level of statutory construction. As noted below, a more faithful application of the *PGE* methodology leads to a different interpretation of the statutory language in its appropriate context.

Second, the majority's reference to this court's recent decision in *Kambury v. Daimlerchrysler Corp.*, 173 Or App 372, 21 P3d 1089 (2001), in support of the proposition that this court's pre-PGE analysis of ORS 656.265 "remains precedential in the aftermath of that decision" is unpersuasive in this

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[1] The majority also makes brief reference to an earlier case, *McNett v. Roy-Ladd Const. Co.*, 46 Or App 601, 613 P2d 47 (1980), as one which "implicitly" supports its reading of this statute. The reference is inapposite. In *McNett*, the employer had no knowledge of the impairment at all prior to filing of the tardy claim. Nevertheless, the claim was still found compensable because the employer failed to prove prejudice from the tardy claim filing under the then applicable version of the statute. There is, accordingly, simply nothing in *McNett* that supports the majority interpretation here, "implicitly" or otherwise.

case. At most, *Kambury* stands for the proposition that this court's pre-*PGE* decisions should stand unless they are "plainly wrong" under the principles announced in *PGE*. *Kambury*, 173 Or App at 379.[2]

In this case, however, the statute in question has been amended significantly. Thus, the issue here is not whether *Mock's* construction of the old statute would be "plainly wrong" under the principles announced in PGE, but rather whether the *Mock* decision retains continued validity under the amended statute when that new statute is interpreted pursuant to the methodology of *PGE*. *See, e.g., State v. Vasquez-Rubio*, 134 Or App 646, 653, 897 P2d 324 (1995), *aff'd* 323 Or 275, 917 P2d 494 (1996) (reexamining the continued validity of Court of Appeals precedent in light of subsequent statutory changes). And where, as here, the earlier decision relied upon the then existing statutory context in formulating that court's interpretation of the phrase in question, a major change to that statutory context certainly should not be ignored by a later court in reviewing the application of the amended statute in a new case.[3]

175 Or App 86> Third, when properly analyzed within the context of the 1995 statutory amendments to ORS 656.265, it becomes apparent that *Mock* should have no continued validity as an authoritative interpretation of the statutory language in subsection (4)(a). While the issue in *Mock*, as here, was what degree of knowledge of an injury will excuse an otherwise untimely notice, plainly the result in *Mock* was a judicial response to a practical concern for timely notice of claims. As the *Mock* court stated:

> "The issue is what knowledge will excuse an otherwise untimely notice. In *Colvin v. Industrial Indemnity*, 301 Or 743, 747, 725 P2d 356 (1986), the court said:
>
> "'Timely notice "facilitates prompt investigation and diagnosis of the injury. It assures the opportunity to make an accurate record of the occurrence, and decreases the chance for confusion due to intervening or nonemployment-related causes." *Vandre v. Weyerhaeuser Co.*, 42 Or App 705, 709, 601 P2d 1265 (1979).'
>
> "It follows that the 'knowledge of injury' must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury." 95 Or App at 5.

At the time it was decided, *Mock* made practical sense. Before the 1995 amendments, ORS 656.265(4) provided no legislative time limits at all on submitting tardy claims. So long as either "the employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice * * *,"[4] claims that would otherwise be untimely under subsection (1) could still be submitted at any time thereafter.

Accordingly, at the time *Mock* was decided, a judicial concern for stale claims was a valid consideration. "Knowledge of the injury or death" was therefore construed in *Mock* as if it actually read "knowledge of enough facts as to lead a reasonable employer to conclude that workers' compensation **<175 Or App 86/87>** liability is a possibility and that further investigation is appropriate." *Mock*, 95 Or App at 5.[5] This was quite a stretch of the actual legislative language, but it was justified by the *Mock* court as necessary to guard against stale claims. Moreover, the methodology of *PGE* had not yet been articulated as the standard test for statutory interpretation in this state.

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[2] Certainly there is nothing in *Western Helicopter Services v. Rogerson Aircraft*, 311 Or 361, 811 P2d 627 (1991), the case relied upon by the *Kambury* court, that supports a different conclusion. *Western Helicopter* involved a certification request to the Supreme Court from the United States District Court. The Supreme Court's opinion in *Western Helicopter* simply points out that on questions of state law the federal district courts, like the state trial courts, should accept the decisions of this court as "controlling precedent."

[3] Plainly, the amendments to ORS 656.265 contained in Oregon Laws 1995, chapter 332, section 29, reset the overall legislative balance between the interests of the employers and their employees with respect to the filing of claims. The ordinary claim period provided for in subsection (1) was extended from 30 days to 90 days. At the same time, the previously unlimited time period for giving tardy, but still valid, notices under subsection (4) was cut off at one year.

[4] ORS 656.265(4) (1993).

[5] In *Mock*, the employer appears to have had notice of the automobile accident producing the injury almost immediately, so the only issue was "what" the employer knew about its employment connection, not "when" it knew it.

In 1995, however, the legislature amended the statute to alleviate such "prompt notice" concerns. Added to subsection (4) was a specific statutory requirement that unless notice of the claim was given "within one year after the date of the accident" it was forever barred. Thus, the 1995 legislature itself provided a specific one-year limit which answered the *Mock* court's concern for sufficiently prompt notice to avoid stale claims. Of course, once the justification for the ruling in *Mock* has disappeared, there is no longer any need for that rule to continue any longer, particularly in the current, post-*PGE* environment.

One other provision added to the statute by the 1995 amendments further shows that the majority opinion cannot withstand careful scrutiny. Subsection (4)'s savings clause for tardy notices now contains an additional new basis for excusing late notices of claims (provided, of course, that the notice is eventually filed within the newly added one year cut off period). Subsection (4)(b) provides that, if a "worker dies within 180 days after the date of the accident," a notice given with subsection (4)'s one-year grace period will not be barred.

The majority's construction of subsection (4) creates a singularly anomalous effect. Under that construction, a worker's claim, which becomes untimely under subsection (1), is not saved under subsection (4)(a) unless the employer had knowledge of the compensable nature of the injury within 90 days. (The claim would simply be barred despite subsection (4)'s new one-year grace period.) Nevertheless, that very same worker's claim suddenly comes back to life under subsection (4)(b) in the event that the injured worker happens to die of any cause within the next 90 days (180 days **<175 Or App 87/88>** total). By the clear terms of subsection (4)(b), if that same worker's claim is thereafter filed within the one-year statutory grace period it must then be upheld.

There is no good reason for reading those two new subsections in isolation, thereby forcing such a bizarre result out of the 1995 amendments to ORS 656.265. The 1995 statutory amendments, and the entire statutory scheme, must be read in context as a whole and harmonized whenever possible to give effect to the overall legislative intent.

Under *PGE*, the "text and context" of the statute provides the only proper basis for determining legislative intent as to the appropriate meaning and application of the actual language of the law, unless the statute remains "ambiguous" after the text and context are consulted. 317 Or at 610-11. Neither the text of the statute nor its statutory "context" support the majority's reading or create significant ambiguity in this case.

The phrase in question, "the employer had knowledge of the injury," is not itself particularly ambiguous. The words "knowledge" and "injury" are words of common usage, and should be given their plain, natural and ordinary meaning unless the context otherwise requires. *PGE*, 317 Or at 611. Nor does the context create any significant degree of ambiguity.[6] *See Lipscomb v. State Board of Higher Ed.*, 305 Or 472, 485 n 13, 753 P2d 939 (1988) ("Even a numerical reference, by nature unambiguous when viewed in isolation, may prove erroneous and require interpretation in its legislative context.").

Two contextual "clues" are particularly telling. First, although the majority would equate "injury" in subsection (4)(a) with "compensable injury," the statutory context demonstrates that the legislature expressly distinguishes between those terms. ORS 656.005(7) defines "compensable injury" as an accidental injury "arising out of and in the course of employment." The legislature's avoidance of that term in subsection (4)(a) is suggestive: If the legislature had **<175 Or App 88/89>** meant "compensable injury," it could easily have said so. It did not. Accordingly, proof of the employer's knowledge of the injury, without more, should be sufficient under this legislative scheme to support an injured worker's reliance on subsection (4)'s one-year claim period.

Second, as noted above, *see* 175 Or App at 87, subsection (4)(b) clearly allows claims to be processed without any prior knowledge of the injury, provided that the claimant dies within 180 days of the accident and so long as notice is thereafter provided within one year of the accident. Thus, at least in those circumstances, the statute explicitly compels the same result that the majority opinion deems untenable.

Finally, even assuming some degree of ambiguity remains after construing the statutory text in context, examination of the 1995 legislative history does not support the majority's reading of the amended statute. Indeed, the opposite is true.

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[6] Ambiguity is sometimes assumed to be a dualistic, categorical, all-or-nothing concept. Usually, however, it is a matter of degree, a relative concept, often dependent on the particular circumstances under which the language was employed.

The 1995 amendments to this statute were contained in section 29 of Senate Bill 369, a major legislative overhaul of the workers' compensation system. None of the legislative history contains any in-depth discussion of section 29, and there is no specific discussion of the meaning of the "knowledge of injury" requirement set forth in subsection (4)(a). However, one of the bill's chief sponsors, Senator Gene Derfler, prepared the following written summary as an exhibit for the Senate Committee on Labor & Government Operations files, which generally describes the operation of section 29 as follows:

> "**ORS 656.265 Extends time for initial claim filing and establishes ultimate time limit for filing new claim.** Amendments to this section deal with the time in which a claim must be filed. The time for claim filing is extended from the current 30 days to 90 days, with a further extension to one year if the employer had knowledge of the injury. The time limit is also extended to one year if the worker died within 180 days of the date of the accident. Existing statute states that the time to file a claim is unlimited if the employer had knowledge of the injury or if the insurer had begun payments on the claim. These latter provisions are deleted." Testimony, Senate Committee on **<175 Or App 89/90>** Labor & Government Operations, SB 369, January 30, 1995, Ex A (bold in original).

Senator Derfler's summary was reiterated in the House Committee on Labor staff's bill summary as well. Moreover, the Workers' Compensation Division of the Department of Consumer and Business Services submitted a similar general summary of its own before the House Committee on Labor on section 29 of Senate Bill 369.

> "Changes the time for notice of an accident resulting in injury or death by a worker or dependent of an employer from 30 days to 90 days after the accident. Changes the provisions which bar claims for failure to notify employer unless the notice is given within one year after the accident and the employer had knowledge of the injury or death or the worker died within 180 days after the date of the accident. Deletes the requirement that the worker must establish at hearing that the worker had good cause not to file notice within 30 days. Provides that the worker[']s claim shall not be defeated by failure to use the proper form, so long as the claim is made in writing." Testimony, House Committee on Labor, SB 369, March 8, 1995, Ex A.

This is essentially all the legislative history bearing on this issue. Plainly, there is no justification to be found in this legislative history for continuing to read "knowledge of the injury" as if it were actually "knowledge of enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate," *Mock*, 95 Or App at 5, despite the legislature's broad restructuring of the statutory notice provisions.[7] To the contrary, the legislative history simply underscores that the language used by the legislature should be given its normal meaning.

In short, the language of the 1995 amendment to ORS 656.265 should be held to mean no more and no less than it says.[8] In cases like this one where the worker proves **<175 Or App 90/91>** that the employer had actual knowledge of the injury, a formal claim filed within one year of the accident under subsection (4)'s savings clause should not be barred by subsection (1) of the statute. I submit that this analysis is consistent with the language actually employed by the legislature in ORS 656.265. It is also faithful to the methodology of *PGE*, as decreed by our Supreme Court. And I would respectfully suggest that the majority opinion in this case is not consistent with either.

I would reverse and remand with instructions to order employer to process the claim.

Haselton, J., joins in this dissent.

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[7] "When I make a word do a lot of work like that," said Humpty Dumpty, "I always pay it extra." Lewis Carroll, *Through the looking Glass, in The Annotated Alice*, 270 (Forum ed 1971).

[8] *See* ORS 174.010, which provides:

> "In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all."

Cite as 175 Or App 92 (2001) June 27, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CRAIG R. HANSON, Appellant,
v.
VERSARAIL SYSTEMS, INC., an Oregon corporation, fka Halvorsen Industries, Inc., dba Baerts Metal Products, Respondent,
and SETH A. McNAIR, Defendant.
9810-07146; CA A107956

Appeal from Circuit Court, Multnomah County.
Thomas M. Christ, Judge *pro tempore.*
Argued and submitted September 18, 2000.
Gerald C. Doblie argued the cause for appellant. With him on the brief was Doblie & Associates.
Alan Gladstone argued the cause for respondent. With him on the brief were Paul R. Xochihua and Abbott, Davis, Rothwell, Nullin & Earle, P.C.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Affirmed.

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175 Or App 94> Plaintiff brought this tort action to recover from his supervisor and his employer for injuries he sustained when his supervisor hit him. Plaintiff's employer moved for summary judgment, arguing that the exclusive remedy provisions of the workers' compensation laws barred plaintiff's tort claims against it. The trial court agreed. Plaintiff appeals, and we affirm.

Because this case comes to us on summary judgment, we recite the facts in the light most favorable to plaintiff, the nonmoving party. Plaintiff works as a painter for defendant Versarail Systems, Inc. (VSI). While at work, plaintiff was involved in a heated argument with his supervisor, defendant McNair. During their argument, McNair struck plaintiff on the side of the head.[1] Plaintiff reported the incident to the appropriate VSI officials. A few days later, plaintiff, McNair, a VSI superintendent, and another senior VSI official met to discuss the incident and an appropriate course of action. Although the employee handbook provided for the immediate termination of any employee involved in a fight, VSI declined to take any action against either plaintiff or McNair.

After receiving workers' compensation benefits for his injuries, plaintiff brought an action against McNair and VSI, alleging that McNair was directly liable for assault and battery and that VSI was vicariously liable for McNair's conduct. VSI moved for summary judgment, arguing that the exclusive remedy provisions of the workers' compensation laws barred plaintiff's tort claims against it. VSI acknowledged that ORS 656.156(2) authorizes a worker to bring a tort claim against his or her employer for injuries that the employer deliberately intended. It argued, however, that the requirement that the employer deliberately intend the injury prevented plaintiff from relying on the doctrine of *respondeat superior* to bring an action against it under that subsection. Plaintiff responded that nothing in the workers' compensation laws precluded him from relying on that doctrine. As the **<175 Or App 94/95>** parties framed the issue before the trial court, the only question was whether plaintiff could rely on the doctrine of *respondeat superior* to come within the deliberate injury exception.[2] The trial court agreed with VSI, granted its summary judgment motion, and entered judgment in its favor. *See* ORCP 67 B.

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[1] Plaintiff suffered an inner ear concussion as a result of the blow and, as treatment for his injuries, underwent several surgeries.

[2] Not only were the parties' written submissions limited to the application of *respondeat superior* in this context, but their oral arguments were too. VSI's counsel began his oral argument before the trial court by explaining, "The sole issue in this case is whether plaintiff's vicarious liability claim against his former employer, defendant [VSI], is barred by the exclusive remedy provision of the workers' comp law." Plaintiff did not argue in response that there was some basis other than vicarious liability for bringing a claim against VSI. Rather, plaintiff explained why, in his view, he could rely on the doctrine of *respondeat superior* to bring a tort claim against his employer.

On appeal, plaintiff argues that his claims against VSI come within the terms of ORS 656.156(2). That statute provides:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker * * * may take under this chapter, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes."

Plaintiff advances two arguments on appeal why he may pursue a tort claim against VSI under that exception. He argues primarily, as he did below, that nothing in the workers' compensation laws precludes him from relying on the common-law doctrine of *respondeat superior*. Alternatively, plaintiff appears to argue that his supervisor is his "employer" for the purposes of ORS 656.156(2). We address plaintiff's *respondeat superior* argument first.

Workers who are injured in the course and scope of employment are entitled to receive certain benefits from their employers, and, with some notable exceptions, those benefits are exclusive of all other remedies that would otherwise be available to the worker. ORS 656.018; *see also Nicholson v. Blachly*, 305 Or 578, 581, 753 P2d 955 (1988). The workers' compensation scheme involves a *quid pro quo*, in which the employer gives up the right to defend against certain actions involving workplace injuries, while receiving **<175 Or App 95/96>** the benefit of a limit on potential damages. Conversely, the employee is compensated for injuries regardless of whether the employer would be liable in tort, while giving up the right to pursue other statutory or common-law remedies. *See Shoemaker v. Johnson*, 241 Or 511, 518-19, 407 P2d 257 (1965) (discussing "the present-day needs of society [to] provid[e] a means whereby an employee was guaranteed a monetary recovery" but spared certain costs and risks associated with litigation). *But see Smothers v. Gresham Transfer, Inc.*, 332 Or 83, 23 P3d 333 (2001) (recognizing constitutionally mandated exceptions to that statutory principle).

The exceptions to the exclusive remedy rule include the one at issue here--the deliberate and intentional injury exception found in ORS 656.156(2). Similarly, ORS 656.018(3)(a) allows separate actions by an injured worker against fellow employees, contracted agents, officers, and directors of the employer "[w]here the injury * * * is proximately caused by willful and unprovoked aggression." Taken together, these statutes allow an injured worker to bring a separate action against the employer where the employer has intentionally injured the worker and against certain individual tortfeasors in comparable circumstances.[3] The primary reason for exempting these types of injuries is that they do not fit within the *quid pro quo* rationale described above. An employee does not expect to be intentionally injured as part of the employment contract, and an employer should not expect to be shielded from liability for such conduct. Put differently, the statute provides relief from the exclusive remedy rule where the employer should be held fully responsible for its misconduct. *See Jenkins v. Carman Mfg. Co.*, 79 Or 448, 453, 155 P 703 (1916) (stating that statute's use of "deliberate" intent denotes "design and malignity of heart").

With that backdrop, we turn to the question whether ORS 656.156(2) permits the use of *respondeat superior* to attribute a co-worker's acts to the employer. As with any other **<175 Or App 96/97>** case involving statutory construction, we seek to ascertain the legislature's intent by first examining the statute's text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). By its terms, the statute creates an exception to the general exclusive remedy rule by allowing a separate action when the employer intended to injure the worker. Textually, the exception applies when the employer, not an employee, has acted deliberately and intentionally.

In reviewing the text and context of a statute, we also look to the cases that have interpreted it. *See Holcomb v. Sunderland*, 321 Or 99, 105, 894 P2d 457 (1995). The exception in ORS 656.156(2) was part of the original workers' compensation laws passed in 1913, *see Kilminster v. Day Management Corp.*, 323 Or 618, 630, 919 P2d 474 (1996), and the court has consistently construed the exception narrowly, *Bakker v. Baza'r, Inc.*, 275 Or 245, 253, 551 P2d 1269 (1976); *see also Jenkins*, 79 Or at 453-54; *Lusk v. Monaco Motor Homes, Inc.*, 97 Or App 182, 186-89, 775 P2d 891 (1989). In *Bakker*, the plaintiff brought an action against

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[3] Because this appeal involves only plaintiff's action against VSI, our opinion is limited to ORS 656.156(2). The "willful and unprovoked aggression" exception in 656.018(3)(a) applies only to a "person otherwise exempt *under this subsection*" (emphasis added). Because "this subsection" refers to subsection (3), the "willful and unprovoked aggression" exception in ORS 656.018(3)(a) does not apply to VSI, which is exempt from liability under subsections (1) and (2) of ORS 656.018.

her employer based on a fellow employee's alleged battery, arguing that the claim fell within the intentional injury exception in ORS 656.156(2). The plaintiff alleged that the employee was acting within the course and scope of his employment and that the employer had "ratified" the conduct. The court concluded that:

> "It should be apparent from the facts of this case that plaintiff's injury did not result from the 'deliberate intention' of her employer as the term has been interpreted by this court. In this case there is no evidence that the defendant employer ever intended to injure anyone. Moreover, unless the injury 'results' from the employer's conduct, the injured employee's cause of action does not fall within the statutory exception set forth in ORS 656.156(2). It is difficult to see how any injury could be said to result from a subsequent ratification of the tortious conduct which produced it. Similarly, a subsequent ratification of the tortious conduct cannot evidence a 'deliberate intention * * * *to produce* such injury,' since, necessarily, the ratification occurs after the injury has been sustained. Thus, we conclude that plaintiff has not brought herself within the statutory exception set forth in ORS 656.156(2)."

175 Or App 98> *Id.* at 254 (emphasis in original). The court then quoted a well-known treatise on workers' compensation:

> "'Unless the employer has commanded or expressly authorized the assault, it cannot be said to be intentional from his standpoint any more than from the standpoint of any third person. Realistically, it to him is just one more industrial mishap in the factory, of the sort that he has a right to consider exclusively covered by the compensation system.'"

Id. at 254 n 7 (quoting Arthur Larson, 2A *The Law of Workmen's Compensation Law* section 68.21 (1976)).

The court's analysis in *Bakker* forecloses plaintiff's argument that the doctrine of *respondeat superior* applies under ORS 656.156(2).[4] Nonetheless, plaintiff argues that, in opinions after *Bakker*, the Supreme Court and this court have indicated an increased willingness to apply a *respondeat superior* analysis to this exception. For example, in *Kilminster*, a deceased worker's personal representatives brought a wrongful death action against the decedent's employer based on injuries sustained while falling from a radio tower. 323 Or at 621. In their complaint, the representatives alleged that the decedent's employer, a corporation, acted intentionally in causing the injuries. *Id.* at 632. The court held that this allegation was sufficient to defeat a motion to dismiss.

> "In this case, plaintiff has alleged facts sufficient to meet the foregoing standard for deliberate intent to injure or kill. Plaintiff alleges that DMC [the corporate employer] *knew* that decedent or someone who did the same work as decedent *would* be injured from a fall from the tower; that DMC decided to forego taking safety procedures, *knowing* that, by so doing, serious injury or death *would* result; and that DMC told decedent to climb the tower or lose his job.
>
> "* * * * *
>
> **175 Or App 99>** "Reading all the allegations together, in the light most favorable to plaintiff, a finder of fact reasonably could infer that DMC determined to injure an employee, that is, specifically intended 'to produce [decedent's] injury or death.'"

Id. (emphases in original).

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[4] If vicarious liability were sufficient to bring a claim within the exception in ORS 656.156(2), then the *Bakker* court would not have said that it was "apparent from the facts of th[e] case that plaintiff's injury did not result from the 'deliberate intention' of her employer as that term has been interpreted by this court." 275 Or at 254. Rather, the court would have held precisely the opposite.

Similarly, in *MacCrone v. Edwards Center, Inc.*, 160 Or App 91, 980 P2d 1156 (1999), *vacated on other grounds*, 332 Or 41 (2001), the plaintiff brought an action for intentional infliction of emotional distress against her employer based on the conduct of a manager who refused to come to the plaintiff's rescue during an attack. In response to the employer's argument that its manager did not act with the requisite intent to come within the exception, we held that

> "a jury reasonably could infer that the manager wished to inflict more emotional distress on plaintiff, knowing that she was suffering severe emotional distress because of the attack. Such an inference suffices to meet the requisite intent under * * * ORS 656.156."

Id. at 99.

Although these cases, at first blush, appear to support plaintiff's argument, neither explicitly calls into question the holding in *Bakker*; indeed, the court's opinion in *Kilminster* cites *Bakker* favorably in articulating the test for deliberate intent under ORS 656.156(2). 323 Or at 631; *see also Lusk*, 97 Or App at 188 (discussing statute's requirement that the "*employer* has had an opportunity to weigh the consequences and to make a conscious choice among possible courses of action, and also that the *employer* specifically 'intend to produce * * * injury'") (internal quotations omitted and emphases added).

Moreover, both cases contain important differences from the present case. In *Kilminster*, the plaintiff alleged in the complaint that the defendant corporation acted with deliberate intent and directly caused the injury, and, therefore, the allegation did not rest on a vicarious liability theory. *Id.* at 632. Because the appeal came to the court on a motion to dismiss, the court accepted as true those allegations regarding the defendant employer's intent. *Id.* at 633 (concluding that "[a] reasonable finder of fact could infer that **<175 Or App 99/100>** DMC acted as it did because it wished to injure or kill decedent. * * * We need not consider whether plaintiff can *prove* that defendants had the alleged specific intent to injure") (emphasis in original).

In *MacCrone*, the defendant corporation did not argue that its manager's intent could not be imputed to it for purposes of ORS 656.156(2); rather, as we phrased it, defendant argued "that its *manager* [did not act] with the requisite intent." *Id.* at 99 (emphasis added). It appears that the defendant accepted that its manager's acts and mental state could be imputed to the defendant employer, and thus the issue with which we are confronted here was not presented in that case.[5]

In our view, the cases cited by plaintiff do not indicate a new, post-*Bakker* approach to ORS 656.156(2). Furthermore, we are not persuaded by plaintiff's argument regarding the applicability of *respondeat superior* in this context, given the statute's requirement of intentional conduct on the part of the employer and the purpose of the exception within the overall workers' compensation scheme. In contrast, the "doctrine of *respondeat superior* is applied as a policy of risk allocation," whereby an employer is held vicariously liable for certain injuries caused by an employee. *Farris v. U.S. Fidelity & Guaranty*, 273 Or 628, 637, 542 P2d 1031 (1975) (italics added). The underlying rationale is that "the [employer] rather than the innocent injured plaintiff is better able to absorb and distribute the risk." *Id.* (citing William L. Prosser, *The Law of Torts*, 459 (4th ed 1971)).[6] Liability in these instances "is not based upon any concept that the [employer] **<175 Or App 100/101>** has committed a morally wrongful act," *id.* at 636-37, which stands in stark contrast to the rationale behind the deliberate and intentional injury exceptions, *see Jenkins*, 79 Or at 453 (referring to deliberate intent to injure another as requiring

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[5] Plaintiff also cites *Palmer v. Bi-Mart Company*, 92 Or App 470, 758 P2d 888 (1988), where we held that, based on the conduct of the plaintiff's supervisor, a jury could infer that the defendant Bi-Mart had intended to cause the plaintiff severe emotional distress. However, our holding in that case was based on the plaintiff's allegation that "Bi-Mart failed to stop a continuing course of intentional conduct * * * after being informed of it." *Id.* at 476. Here, plaintiff has alleged that VSI became aware of the alleged assault after it occurred.

[6] The Supreme Court has held that vicarious liability will be imposed on the employer when the employee's conduct was within the scope of employment, which involves three inquires, each of which must be met: (1) the conduct occurred substantially within the time and space limits of the employment; (2) the employee was motivated, at least in part, by a purpose to serve the employer; and (3) the act was of the kind that the employee was hired to perform. *Chesterman v. Barmon*, 305 Or 439, 442, 753 P2d 404 (1988).

premeditated "design and malignity of heart"); *see also* Arthur Larson and Lex K. Larson, 6 *Larson's Workers' Compensation Law* section 103.06[4], 103-50 (2000) (discussing the exception's basis of moral culpability as opposed to vicarious liability via *respondeat superior*, which is not based on the shifting of moral or ethical responsibility).[7] The trial court correctly held that plaintiff could not rely on the doctrine of *respondeat superior* to come within the exception in ORS 656.156(2).

Plaintiff appears to advance an additional argument on appeal. He suggests that, even if VSI may not be held vicariously liable for McNair's intentional acts under ORS 656.156(2), McNair should still be regarded as the "employer" for purposes of ORS 656.156(2). As we understand plaintiff's argument, he would convert every "supervisor" into an "employer" for the purposes of ORS 656.156(2). To the extent that plaintiff advances that argument on appeal, he failed to preserve it. As noted above, plaintiff's complaint alleged that VSI was vicariously liable for McNair's intentional acts, and the issue before the trial court on defendant's summary judgment motion was whether plaintiff could rely on the doctrine of *respondeat superior* to come within the deliberate injury exception.[8] Plaintiff is limited on **<175 Or App 101/102>** appeal to the issue that he raised below. *See Miller v. Salem Merchant Patrol, Inc.*, 165 Or App 266, 272-73, 995 P2d 1206 (2000).

Affirmed.

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[7] Plaintiff argues that, if he cannot rely on *respondeat superior* to come within ORS 656.156(2), the statute will have no application to corporate employers. Not only is the exception in ORS 656.156(2) not limited to corporate employers, as plaintiff's argument assumes, but we have recognized in other contexts that a limited group of persons may be regarded as the corporate employer for the purposes of liability for intentional torts. *See Walters v. Gossett*, 148 Or App 548, 552-57, 941 P2d 575 (1997); *accord* 6 *Larson's Workers' Compensation Law* section 103.07 at 103-52. We need not decide whether that group or a different group of persons should be regarded as the "employer" for the purposes of ORS 656.156(2). It is sufficient for the purposes of plaintiff's *respondeat superior* argument to say that the term "employer" has some content without the application of *respondeat superior*, even when applied to a corporate employer. Plaintiff's argument provides no reason to disregard the text and context of ORS 656.156(2).

[8] The issue that the parties litigated below assumed that McNair was not the employer for the purposes of ORS 656.156(2) but that his acts could be attributed to the employer. The alternative issue that plaintiff raises on appeal assumes that McNair is the employer for the purposes of the deliberate injury exception.

Cite as 175 Or App 112 (2001) June 27, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert Dubray, Claimant.

ROBERT DUBRAY, Petitioner,
v.
SAIF CORPORATION, PAT LEAMY, and TED SHARP, Respondents.
99-02514; A110816

Judicial review from Workers' Compensation Board.
Argued and submitted May 30, 2001.
R. Adian Martin 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.
PER CURIAM
Reversed and remanded for reconsideration.

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175 Or App 113> Claimant seeks review of an order of the Workers' Compensation Board affirming an order of an Administrative Law Judge (ALJ) that determined the amount of claimant's permanent partial disability. He argues that the ALJ found that the existing rules do not cover his condition and that the ALJ should therefore have remanded the case to the Director for the promulgation of a temporary rule. *See* ORS 656.726(4)(f)(C); *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 863 P2d 530 (1993). SAIF argues that the ALJ correctly concluded that the existing rules apply to claimant's condition and that claimant failed to prove that he was entitled to additional compensation under those rules.

The difficulty with this case is that it is possible to read the ALJ's order to support both parties' interpretations. The ALJ may have concluded as a matter of law that he had no authority to remand the case because the director had expressly addressed the question of the adequacy of the existing rules. Alternatively, the ALJ may have determined as a matter of fact that the existing rules were adequate because they address claimant's disability. The first conclusion would raise a serious legal question under *Gallino*; the second could require review for substantial evidence. Because we do not know what the ALJ decided, we cannot review the order. On remand, the ALJ and the Board are to clarify the basis for the decision.

Reversed and remanded for reconsideration.

Cite as 175 Or App 141 (2001) July 5, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Judy A. Bell, Claimant.

JUDY A. BELL, Petitioner,

v.

SPIRIT MOUNTAIN GAMING and EBI INSURANCE COMPANY, Respondents.

99-03656, 99-02441; A111340

Judicial Review from Workers' Compensation Board.

Argued and submitted June 7, 2001.

James W. Moller argued the cause and filed the briefs for petitioner.

Deborah L. Sather argued the cause for respondents. With her on the brief were Tracy J. White and Sather, Byerly & Holloway.

Before Landau, Presiding Judge, and Brewer and Schuman, Judges.

LANDAU, P. J.

Reversed and remanded for reconsideration.

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175 Or App 143> Claimant seeks review of a final order of the Workers' Compensation Board upholding employer's denial of her claim for a lower back condition. We reverse and remand for reconsideration.

The facts relevant to the disposition of the case are undisputed. Claimant injured her lower back at work on February 22, 1998. Employer accepted her claim for lumbar strain. Employer arranged an independent medical examination on June 16, 1998. The examiner conducted range of motion testing, during the course of which claimant experienced a sudden onset of severe left leg pain. An MRI later disclosed a herniated disc at L4-5.

Claimant requested a hearing on employer's de facto denial of the L4-5 herniated disc. At the hearing, claimant relied on the testimony of Dr. Buza, who testified in support of compensability. Employer relied on the testimony of Dr. Young, who testified that the major contributing cause of claimant's condition was a preexisting degenerative disc condition. The Board ultimately found Buza unpersuasive. It offered a number of reasons and then concluded that it could not determine

> "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."

Instead, the Board found Young's opinion persuasive and upheld employer's *de facto* denial.

Claimant sought review of the Board's decision. In the meantime, the Supreme Court issued its opinion in *Robinson v. Nabisco*, 331 Or 178, 11 P3d 1286 (2000), in which it held that an injury that occurs during an employer-"compelled" medical examination may itself be sufficiently employment-related to be compensable.

Claimant now argues that the Board's decision reflects the application of a legal standard at odds with **<175 Or App 143/144>** *Robinson*. In particular, claimant points to the Board's evaluation of Buza's testimony and the extent to which the testimony failed to establish that claimant's low back condition was caused by the earlier February 1998 work injury, not the later June 1998 injury during the course of the compelled medical examination.

Employer argues that, even if the Board erred in characterizing the appropriate legal standard by which to evaluate Buza's testimony, we nevertheless should affirm, both because the Board had other legitimate reasons to discount that testimony and because it affirmatively found Young's testimony persuasive.

Claimant is correct that the Board's order reflects the application of an incorrect legal standard. It may well be that, on remand, the application of the proper legal standard will not affect the Board's decision. That is up to the Board to decide on remand. *SAIF v. Cessnun*, 161 Or App 367, 375, 984 P2d 894 (1999).

Reversed and remanded for reconsideration.

Cite as 175 Or App 214 (2001) July 5, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

TIM A. PHILLIPS, Appellant,
v.
WALTER E. BOHNSTEDT and BARRETT BUSINESS SERVICE CORPORATION, Respondents.
9908-08768; A110069

Appeal from Circuit Court, Multnomah County.
Michael H. Simon, Judge *pro tempore*.
Argued and submitted March 19, 2001.
Scott M. McNutt, Jr. argued the cause and filed the brief for appellant.
Barbara L. Johnston argued the cause and filed the brief for respondents.
Before Linder, Presiding Judge, and Brewer, Judge, and Ceniceros, Senior Judge.
LINDER, P. J.
Affirmed.

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175 Or App 216> Plaintiff initiated this negligence action against defendants Bohnstedt and Barrett Business Services Corporation (Barrett) to recover damages incurred when he was injured in a motor vehicle accident at work. The trial court granted summary judgment in favor of defendants, and plaintiff appeals. We review the trial court's ruling to determine whether there are genuine issues of material fact and whether defendants are entitled to judgment as a matter of law. ORCP 47 C. The only issue on appeal is one of statutory interpretation: whether Barrett is exempt from tort liability under the terms of ORS 656.018(5)(a), which relates to temporary service providers. We affirm.

The facts are not disputed. On September 3, 1998, plaintiff was injured when he was hit by a vehicle driven by Bohnstedt while they were at work. At that time, plaintiff was working directly for Portland Auto Auction, and Bohnstedt was working for Barrett, a company that provides temporary workers to Portland Auto Auction and to other clients. Pursuant to an agreement between Barrett and Portland Auto Auction, Barrett was responsible for providing workers' compensation coverage for its temporary employees, including Bohnstedt. Barrett charged Portland Auto Auction a fee for its services, which included an amount that covered the workers' compensation premiums. Although Barrett retained direction and control over Bohnstedt in terms of hiring, firing, and discipline, Bohnstedt was otherwise under the direct supervision of Portland Auto Auction. Portland Auto Auction separately provided workers' compensation coverage for its other employees, including plaintiff.

After the accident, plaintiff applied for and received workers' compensation benefits. He then sued both Bohnstedt and Barrett seeking to obtain further recovery for his injuries. Plaintiff's theory of liability was that Bohnstedt was negligent and that Barrett was therefore vicariously liable. Defendants moved for summary judgment on the ground that they were exempt from tort liability under ORS 656.018. The trial court granted their motion and entered a judgment accordingly. On appeal, plaintiff challenges only the trial court's conclusion regarding Barrett's liability, arguing that **<175 Or App 216/217>** ORS 656.018(5)(a) does not operate to exempt it from tort liability.

In determining the scope of ORS 656.018(5)(a), our task is to discern the legislature's intent. Here, the text and context of the relevant portion of the statute provide a complete answer as to its meaning. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993) (a statute's text and context are the starting point for its interpretation). ORS 656.017 requires employers that are subject to ORS chapter 656 to provide workers' compensation coverage for subject workers. ORS 656.018 then declares, in relevant part:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of injuries, diseases, symptom complexes or similar conditions arising out of and in the course of employment that are sustained by subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such conditions or claims resulting therefrom * * *.
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> "* * * * *

> "(2) The rights given to a subject worker and the beneficiaries of the subject worker under this chapter * * * are in lieu of any remedies they might otherwise have * * * against the worker's employer * * *.
>
> "(3) The exemption from liability given an employer under this section is also extended to the employer's insurer, the self-insured employer's claims administrator, the Department of Consumer and Business Services, and the contracted agents, employees, officers and directors of the employer, the employer's insurer, the self-insured employer's claims administrator and the department * * *.
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> "* * * * *
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> "(5)(a) *The exemption from liability given an employer under this section applies to a temporary service provider, as that term is used in ORS 656.850,* [1] *and also extends to the* **<175 Or App 217/218>** *client to whom workers are provided when the temporary service provider complies with ORS 656.017.* "

(Emphasis added.) The statute's terms are plain, and its meaning is simple and straightforward. Under paragraph (5)(a), temporary service providers enjoy the same exemption from tort liability that employers generally enjoy under the workers' compensation statutes. Also, the client of a temporary service provider enjoys that same immunity as long as the temporary service provider satisfies the requirements of ORS 656.017.

In this case, Barrett is a temporary service provider, Portland Auto Auction is its client, and Portland Auto Auction is plaintiff's employer. Those facts are not disputed. Likewise, it is undisputed that Barrett and Portland Auto Auction complied with ORS 656.017. Under the unambiguous provisions of ORS 656.018(5)(a), neither Barrett nor Portland Auto Auction is subject to liability for plaintiff's work-related injury beyond the liability that is imposed by the workers' compensation statutes.

In arguing to the contrary, plaintiff relies on one of our prior decisions interpreting the scope of the workers' compensation exclusive remedy provisions that similarly involved a temporary service provider. *Perry v. Express Services, Inc.*, 143 Or App 321, 923 P2d 673 (1996), *rev den* 324 Or 560 (1997). *Perry*, however, involved the 1995 version of ORS 656.018, which did not include temporary service providers within the "limited universe" of entities to whom ORS 656.018 (1995) extended the exemption from tort liability. *Id.* at 327. As noted above, ORS 656.018(5)(a) now specifically does so, pursuant to a subsection added by the legislature in 1997. Or Laws 1997, ch 491, sections 1, 2. Therefore, plaintiff's reliance on *Perry* is misplaced.

Finally, plaintiff also argues that the statute was amended in 1997 merely to eliminate the distinction that ORS 656.018 formerly made between "worker leasing companies" and "temporary service providers." Specifically, before the 1997 amendments, the statute did not extend tort immunity to *clients* of temporary service providers, although it did extend tort immunity to clients of worker leasing companies. *See Baugh v. Maintenance and Machine Erectors,* **<175 Or App 218/219>** *Inc.*, 157 Or App 128, 968 P2d 392 (1998). Plaintiff is correct that the 1997 addition of paragraph (5)(a) served to correct that anomaly. *Id.* at 131-32 n 2. Paragraph (5)(a), however, is not limited to issues of the client's liability. As already discussed, its express terms apply the employer's exemption from liability to a temporary service provider who has provided workers' compensation coverage for any temporary employees as required in ORS 656.017. Thus, contrary to plaintiff's position, the fact that there is no employer/employee relationship between an injured worker--here, plaintiff--and a temporary service provider--here, Barrett--is of no moment. Liability for both Barrett and Portland Auto Auction is limited to that incurred pursuant to the workers' compensation statutes.

For those reasons, we conclude that defendants are entitled to judgment as a matter of law. The trial court therefore correctly granted their summary judgment motion.

The parties' remaining arguments do not require discussion.

Affirmed.

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[1] ORS 656.850(1)(c) provides that a "'[t]emporary service provider' means a person who provides workers, by contract and for a fee, to a client on a temporary basis."

Cite as 175 Or App 252 (2001) July 5, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Margaret A. Bengtson, Claimant.

CURRY EDUCATIONAL SERVICE DISTRICT, Petitioner,
v.
MARGARET A. BENGTSON, Respondent.
96-00487; A105309

Judicial Review from Workers' Compensation Board.
Argued and submitted December 12, 2000.
George W. Goodman argued the cause and filed the brief for petitioner.
James C. Coffey argued the cause and filed the brief for respondent.
Before Haselton, Presiding Judge, and Wollheim, Judge, and Ceniceros, Senior Judge.
WOLLHEIM, J.
Affirmed.

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175 Or App 254> In this workers' compensation case, employer seeks review of a Workers' Compensation Board (Board) order setting aside employer's revocation of acceptance and "back-up" denial of the compensability of claimant's previously accepted condition. ORS 656.262(6)(a).[1] The parties stipulated that the issue on appeal is whether the correction of a mistake in diagnosis can constitute "later obtained evidence" under ORS 656.262(6)(a). We review for errors of law, ORS 183.482(8)(a), and affirm.

The material facts, as found by the administrative law judge (ALJ) and adopted by the Board, are not in dispute. In January 1995, claimant injured her back when she slipped and fell at work. After claimant's injury, but before acceptance by employer, claimant had an x ray and an MRI scan of her back. Drs. Neumann and Rich interpreted the x ray and the MRI and diagnosed an "end-plate compression fracture on the L4 vertebra" and attributed the condition to the January 1995 incident. Employer then accepted a claim for a compression fracture at the L4 level.

After employer's acceptance of the claim, employer sent claimant to Dr. Dickerman for a compelled medical examination (CME).[2] As part of that CME, Dickerman reviewed claimant's previously taken spinal x ray. Based on that review, Dickerman concluded that claimant had not suffered a compression fracture and that her current low back condition was not causally related to the January 1995 incident. Rather, Dickerman concluded that the MRI suggested **<175 Or App 254/255>** that claimant had a Schmorl's node,[3] a preexisting and degenerative condition. As a result, employer issued a current condition denial. Following that denial, employer had Drs. Thompson, Young and Warnock review claimant's x ray and MRI. All three physicians agreed that claimant, in fact, had a Schmorl's node and not a compression fracture as originally diagnosed. Employer then issued the back-up denial, which is the subject of this appeal. That back-up denial stated:

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[1] ORS 656.262(6)(a) provides, in part:

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

[2] In *Robinson v. Nabisco Inc.*, 331 Or 178, 181, 11 P3d 1286 (2000), the Supreme Court referred to a medical examination such as this as a CME. In light of that decision, we will also refer to claimant's examination with Dickerman as a CME.

[3] A Schmorl's node is defined as the "prolapse of the nucleus pulposus through the vertebral body endplate into the spongiosa of the vertebra." *Stedman's Medical Dictionary*, 1215 (26th ed 1995).

> "[I]t appears that the diagnosis of the 'L4 compression fracture' was in error and that you have never experienced such condition, no less experienced one resulting from the alleged January 5, 1995 incident. Therefore, under ORS 656.262(6)(a), it is the employer's position that, based upon later obtained evidence, it is not responsible for an L4 compression fracture. The acceptance of that claim is, therefore, hereby revoked, and the L4 compression fracture is hereby denied."

Claimant requested a hearing, challenging employer's back-up denial. Employer argued that it was not until after it accepted the claim that it learned that an L4 compression fracture never existed. Thus, because the medical reports of Dickerman, Thompson, Young and Warnock were not available until after employer accepted the claim, those reports were later obtained evidence within the meaning of ORS 656.262(6)(a). The ALJ disagreed with employer and set aside the back-up denial. The Board affirmed, concluding that the back-up denial was procedurally invalid:

> "The requirement of 'later obtained evidence' in the statute refers to new material--that is, something other than the evidence that the carrier had at the time of the initial acceptance. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 286[, 850 P2d 396] (1993). A reevaluation of known evidence, for whatever reason, is not 'later obtained evidence' under ORS 656.262(6)(a). *Id.*
>
> "* * * * *
>
> **175 Or App 256>** "We agree that the medical opinions from these physicians were not rendered until after the acceptance and, thus, were not available to the employer at the time of acceptance. * * * [H]owever, the opinions from these physicians for the most part relied upon the same information available to the employer when it accepted the L4 compression fracture. *See Greenbriar Ag Management v. Lemus*, 156 O[r] App 499[, 965 P2d 493] (1998)[, *rev den* 328 Or 594 (1999)]. * * * Thus, we consider the medical opinion reports generated after the acceptance as constituting a re-evaluation of the existing evidence rather than 'later obtained evidence.'"

On judicial review, the narrow issue before us is whether the correction of a mistake in diagnosis, based on an x ray and MRI that were available to employer *before* it initially accepted the claim, constitutes "later obtained evidence" within the meaning of ORS 656.262(6)(a). Employer continues to contend that the medical reports indicating a mistake in diagnosis that were received after acceptance of claimant's claim constitute later obtained evidence. Claimant, on the other hand, argues that later obtained evidence should not be construed to include a new analysis of the same information the insurer knew or should have known of at the time it accepted the claim. We agree with claimant.

> In *Magnuson*, we interpreted the term "later obtained evidence" and held that,
>
> "[t]he legislature intended that evidence warranting a retroactive denial 'come about' after the insurer's original acceptance. * * * [T]he statute requires new material, i.e., something other than the evidence that the insurer had at the time of the initial acceptance. * * *
>
> "* * * However, a reevaluation of known evidence, for whatever reason, is not 'later obtain[ed] evidence' under ORS 656.262(6)." 119 Or App at 286.

Here, the medical reports that employer argues constitute "later obtained evidence" are not based on any information not known to employer at the time it accepted the claim. Rather, those medical opinions simply re-evaluated the information in existence and known to employer at the time of claim acceptance--*i.e.*, the x ray and the MRI scan. Medical opinions based on pre-acceptance tests are not later obtained **<175 Or App 256/257>** evidence under our holding in *Magnuson*. *See also Freightliner Corp. v. Christiensen*, 163 Or App 191, 195, 986 P2d 1263 (1999) ("In light of employer's acknowledgment that it was aware of the possibility that claimant had herniated discs at the time it issued its acceptance of the claim, there was no error on the part of the Board in rejecting employer's assertion that the claim could be denied on the basis of newly discovered evidence."); *Lemus*, 156 Or App at 506-07 (claimant's complete medical record of which employer was aware at the time of claim acceptance did not constitute later obtained evidence).

Employer argues that the meaning of the phrase "later obtained evidence" is clear and unambiguous. Specifically, employer argues that, under ORS 656.262(6)(a), "new evidence must show that the claim was not compensable at the time that the claim was accepted." Because the corrected mistake in diagnosis is evidence and it was obtained after employer accepted the claim, it is later obtained evidence under the plain meaning of the statute. Although employer's position is superficially plausible, it misses an essential point: The x ray and MRI re-interpreted by Dickerman, Thompson, Young and Warnock after acceptance are the same x ray and MRI mistakenly interpreted by Neumann and Rich before acceptance. Thus, the evidence that is the basis of the re-diagnosis antedated acceptance. The evidence is not "newly discovered," only the diagnosis is.

Therefore, we hold that the correction of a mistake in diagnosis under the facts of this case is not later obtained evidence because the correction came about after several physicians re-evaluated information already in existence at the time of acceptance.

Affirmed.

Cite as 175 Or App 265 (2001) July 5, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gary S. Fox, Claimant.

GARY S. FOX, Petitioner,
v.
ROSS BROS. & COMPANY, INC., and SAIF CORPORATION, Respondents.
99-01031; A109773

Judicial Review from Workers' Compensation Board.
Argued and submitted January 22, 2001.
Michael Strooband argued the cause for petitioner. With him on the briefs was Bischoff, Strooband & Ousey, P.C.
James W. Moller argued the cause and filed the brief for respondents.
Before Landau, Presiding Judge, and Brewer and Schuman, Judges.*
SCHUMAN, J.
Affirmed.

* Schuman, J., *vice* Linder, J.

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175 Or App 267> An administrative law judge (ALJ) directed SAIF, claimant's employer's insurer, to pay claimant 51 percent unscheduled permanent partial disability (PPD) and a penalty against SAIF for unreasonably having failed to do so. The Workers' Compensation Board (Board) reversed, and claimant petitions for judicial review. We review for errors of law, ORS 656.298(7); ORS 183.482(8), and affirm.

Claimant compensably injured his back in February 1995. He became medically stationary in June 1996, and a determination order closed his claim and awarded him 38 percent PPD. On reconsideration, the award was reduced to 13 percent. Claimant sought review, and an ALJ increased his award to 51 percent. That award became final in September 1997.

SAIF, however, refused to pay the 51-percent award because, at the time the ALJ issued it, claimant was enrolled in an authorized training program (ATP). SAIF interpreted ORS 656.268(9) (1995) (hereinafter "subsection (9)") to allow suspension of PPD benefit payments to claimants while they were in such programs and to re-evaluate them after they finished.[1] Indeed, shortly after claimant finished the ATP, SAIF **<175 Or App 267/268>** re-evaluated him and issued a notice of closure that reduced his PPD to 34 percent. SAIF paid that amount.

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[1] ORS 656.268(9) (1995) provided:

"If, after the determination made or notice of closure issued pursuant to this section, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the determination or closure shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Consumer and Business Services shall redetermine the claim pursuant to this section if the worker is medically stationary or if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7). The redetermination shall include the amount and duration of temporary total or temporary partial disability compensation. Permanent disability compensation shall be redetermined for unscheduled disability only. If the worker has returned to work or the worker's attending physician has released the worker to return to regular or modified employment, the insurer or self-insured employer may redetermine and close the claim under the same conditions as the issuance of a determination order by the Department of Consumer and Business Services. The redetermination or notice of closure is appealed in the same manner as are other determination orders or notices of closure under this section."

For purposes of this opinion, our citations to statutes in ORS chapter 656 are to the 1995 version. Although many of those statues have since been amended, the amendments do not affect our analysis.

While claimant was enrolled in the ATP, he requested and received a hearing before an ALJ seeking to compel SAIF to pay the 51-percent award. He also sought attorney fees and a penalty against SAIF for unreasonably refusing to pay the award. The gist of claimant's argument was that subsection (9) did not authorize SAIF to suspend payment of a PPD award during the time claimant was in the ATP, if the PPD award resulted from an *appeal* of a determination or notice of closure as opposed to the determination or notice itself. Claimant made no reference to SAIF's obligation to continue paying at the 51-percent level *after* completion of the ATP, or to SAIF's authority to re-evaluate him. However, by the time the ALJ decided claimant's case, claimant had finished his ATP. The ALJ therefore held that "the issue of whether SAIF must commence payments while claimant is in the ATP is moot. The question must be resolved, however, as it is the underlying question to the other issues claimant has raised," *i.e.*, penalty and fees. Accordingly, in the process of deciding that SAIF *did* unreasonably refuse to pay PPD during the ATP, the ALJ also necessarily and explicitly decided that nothing in subsection (9) authorized this refusal. Subsection (9), according to the ALJ, authorized suspension of payments only if they were specified in a determination or notice of closure, not if they were specified in an order from an ALJ or from the Board on review of a determination or notice of closure. SAIF appealed to the Board. The Board agreed with the ALJ that the issue of whether SAIF was authorized to suspend PPD during the ATP was moot, but it reversed the ALJ on the penalty.[2] The Board concluded that, under some of its earlier decisions, SAIF's refusal to pay was reasonable. Claimant did not appeal that decision.

Shortly thereafter, claimant requested another hearing on SAIF's refusal to pay the 51-percent award. This **<175 Or App 268/269>** claim assertedly differed from the one litigated in the earlier proceeding because it focused on SAIF's claim processing decisions *after* completion of the ATP, where the first proceeding dealt only with issues relating to SAIF's *suspension* of benefits *during* the ATP. Claimant argued that subsection (9) did not authorize SAIF to disregard the final, valid 51-percent award in favor of the later 34-percent award. He requested payment of the 51-percent award and a penalty. SAIF responded that, first, claimant's cause was barred by claim preclusion, and, second, in any event, it was wrong on the merits. The ALJ held in favor of claimant on both issues: the claim was not precluded, and it was meritorious.

SAIF took the case to the Board. The Board agreed with the ALJ that the claim was not precluded but, on the merits, ruled that the 51-percent award was not enforceable. Claimant petitioned for judicial review. On review, claimant argues that subsection (9) did not permit the 34-percent award to "supersede and negate" the 51-percent award in the ALJ's order. SAIF counters that it does and that, in any event, the claim is barred by claim preclusion.

To resolve the issue raised by claimant's assignment of error we must interpret subsection (9). Our objective in statutory interpretation is to discern the intent of the legislature. To do so, we begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). Common words in the text of the statute are "given their plain, natural, and ordinary meaning." *Id.* at 611. The context of a statute includes "other provisions of the same statute and other related statutes." *Id.* If text and context clearly establish the legislature's intent, no further inquiry is necessary. *Id.*

Subsection (9), set out in note 1, used several Workers' Compensation Law terms of art. A "determination" is an order from DCBS closing a worker's claim and establishing his or her level of further compensation, if any. ORS 656.268(2), (5). A "notice of closure" is an order from an insurer that performs the same function. ORS 656.268(4). "Training" refers to vocational assistance of the kind claimant entered in this case--an ATP. Thus, the first sentence of **<175 Or App 269/270>** subsection (9) provided that an insurer should suspend payment of permanent disability benefits if the worker entered an ATP after the determination or notice of closure issued. The second sentence provided that, once the worker had completed the training, his or her degree of disability had to be redetermined. Each of these sentences specified that certain consequences follow on the occurrence of certain preconditions. In the first sentence, the event triggering the consequences is *enrollment* in an ATP after claim closure. The consequence that this event triggers is suspension of payments "due under the determination or closure" for the duration of the ATP. In the second sentence, the triggering event is *termination* of the ATP. The consequence is redetermination of the claim.

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[2] The issue of whether the Board correctly determined that the claim was moot is not before us, and we express no opinion on it.

On review, claimant does not expressly argue that SAIF lacked authority to suspend payment of the 51-percent award while claimant was enrolled in the ATP. However, claimant's argument that the 34-percent award cannot supersede or negate the earlier 51-percent award is based on the premise that the 51-percent award was due when it became final during claimant's ATP and that SAIF had no authority to suspend payments. We must therefore begin by interpreting the first sentence of subsection (9) to determine whether SAIF properly suspended payment of the 51-percent award while claimant was enrolled in the ATP.

For us to interpret the first sentence of subsection (9) to mean that SAIF was not authorized to suspend payment of the 51-percent award, we would need to reason (as claimant did at the earlier proceeding) that the insurer can suspend only those payments that are "due under," or specified in, a "determination" or a "notice of closure," but not payments specified in an order from an ALJ or the Board following review of the determination or notice of closure. If such review occurs, any revised payments are "due under" the ALJ order or Board order, and subsection (9) does not permit suspension. By the same logic, relief due under a judgment would be the relief specified by the trial court and not the relief that an appellate court ultimately determines should have been specified under the facts as they existed at the time of trial.

175 Or App 271> We find this to be a strained and illogical reading of the statute. The plain language of due "under" in this context is not so narrow.

"Under" means "required by : in accordance with : bound by." *Webster's Third New Int'l Dictionary*, 2487 (unabridged ed 1993). Examples include such phrases as "under contract to deliver" and "rights under law." The determination or notice of closure described in subsection (9) generally confirmed that, at a particular time, the worker was medically stationary, and it also specified the amount of his or her permanent disability based on existing facts. ORS 656.268(1); ORS 656.268(2)(a); ORS 656.268(4)(a) and (b); ORS 656.268(5). ORS 656.268 also provided for multiple reviews of this determination, all based on the worker's status at the time of the original determination. ORS 656.268(4)(e), (5)(b), and (6)(f); ORS 656.319(4); ORS 656.283; ORS 656.289(3); ORS 656.295; ORS 656.298. An ALJ or Board order that contains a PPD award different from the one contained in the original determination or notice of closure sets the payment that should have been awarded in the original determination order or notice of closure in the first place. The 51-percent award issued by the ALJ in August 1997 set the amount that was due under (or in accordance with, or required by) the circumstances as they existed at the time the determination order was issued. The amounts that result from review of the original award all trace back to, or have their source, in the status of the claimant at the time that the original determination occurs. They are, therefore, "under" that original determination. Thus, the 51-percent award was due under the original determination order in this case, and subsection (9) authorized SAIF to suspend payments of that award.

SAIF also had authority under the second sentence of subsection (9) to redetermine claimant's claim. In *SAIF v. Coburn*, 159 Or App 413, 977 P2d 412, *rev den* 329 Or 527 (1999), a notice of closure awarded claimant 42 percent PPD, and it became final. After an ATP, the award was reduced to 19 percent. Claimant argued that his 42-percent award was final and could not be reduced. This court held that, "pursuant to ORS 656.268(9), there *must* be a reevaluation of the **<175 Or App 271/272>** worker's extent of disability upon completion of an ATP, even if the original award has become final." *Coburn*, 159 Or App at 417 (emphasis in original). *Accord SAIF v. Sweeney*, 115 Or App 506, 839 P2d 254 (1992), *modified on recons* 121 Or App 142, 144-45, 854 P2d 487 (1993) ("We adhere to that portion of our earlier opinion that holds that an employer may re-evaluate a permanent disability award after the completion of [an ATP]."). The only distinction between this case and *Coburn* or *Sweeney* is that here the final determination was an ALJ order, whereas in those cases a determination order or notice of closure became final without ALJ or Board review. As we have explained, that distinction is legally irrelevant.

Claimant also maintains that subsection (9) "does not state that awards in litigation orders (Board and ALJ decisions) shall be redetermined upon cessation of ATP. The statute only refers to determinations and notices of closure." That is not correct. The second sentence, the one governing redetermination, provided that DCBS "shall redetermine *the claim*" (emphasis added), not that DCBS shall redetermine the determination order or notice of closure. Thus, the phrase "due under the determination or closure" applied only to what could be suspended, not to what could be redetermined.

Finally, our interpretation of subsection (9) is consistent with evident legislative intent. This court has stated that "the legislature apparently recognized that the extent of a claimant's disability may change as a result of participation in a vocational rehabilitation program," and, when that happens, re-evaluation and possible reduction of the pretraining PPD are appropriate. *Sweeney*, 115 Or App at 511. Claimant's interpretation of the statute would preclude redetermination whenever a claimant began an ATP while the award in the determination order or notice of closure was in the process of being reviewed. He suggests no logical reason for such an outcome and we can conceive of none.

In the present case, the ALJ issued the 51-percent award, and the ALJ's order became final during claimant's participation in the ATP. When claimant completed the ATP on February 28, 1998, subsection (9) required redetermination of the claim. Because payment of the 51-percent award **<175 Or App 272/273>** was only "suspended" by operation of subsection (9), SAIF also had an obligation to pay the award once the ATP ended. That obligation, however, did not ripen until 30 days after the end of the suspension. OAR 436-060-0150. *See Sweeney*, 121 Or App at 145 (participation in an ATP tolls insurer's 30-day grace period). Because the new notice of closure issued on March 11, 1998, before SAIF was obligated to pay at the 51-percent award, the Board did not err in holding that claimant could not enforce the 51-percent award.[3]

Affirmed.

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[3] Because we uphold the Board's decision, we do not find it necessary to address SAIF's cross-assignment concerning claim preclusion.

Cite as 175 Or App 487 (2001) August 1, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gorden L. Atkins, Claimant.

GORDEN L. ATKINS, Petitioner,
v.
ALLIED SYSTEMS, LTD., Respondent.
99-04079; A109516

Judicial review from Workers' Compensation Board.
Argued and submitted March 2, 2001.
Robert K. Udziela argued the cause and filed the brief for petitioner.
Jerald P. Keene argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Haselton and Kistler, Judges.
EDMONDS, P. J.
Affirmed.

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175 Or App 489> In this workers' compensation case, claimant seeks judicial review of an order of the Workers' Compensation Board (Board). The Board concluded that claimant had not suffered any permanent impairment as the result of a work-related injury to his left elbow and awarded no permanent partial disability (PPD) benefits. Claimant contends that the Board was not authorized, in the absence of other medical evidence or opinions, to disregard the medical arbiter's report in this case that contained a finding of permanent impairment. We review for errors of law and to determine whether there was substantial evidence to support the Board's determination, and we affirm.

Claimant's left arm was injured at work, and his claim for compensation was accepted by his self-insured employer. After a short hiatus from work, claimant returned to light-duty work under the supervision of his treating physician, Dr. Yarusso. Claimant did not achieve the kind of recovery that Yarusso expected, and he filed an aggravation claim and also underwent surgery by Dr. McWeeney. After surgery, claimant was evaluated by McWeeney, who released him to full-duty work. In his final report, McWeeney declared claimant medically stationary and reported that claimant "has a slight deficit of weakness that I think is accurate." Claimant's compensation claim was then closed by employer without any award for PPD. Claimant requested reconsideration and was examined by Dr. Ho, a medical arbiter, pursuant to ORS 656.268(7)(a). The arbiter found that claimant's strength was impaired in his injured arm, that the impairment was related to his discomfort and the need for additional treatment, and that claimant was "significantly limited in his ability to repetitively use the left elbow because of left lateral epicondylitis arising out of the accepted condition."

The appellate review unit issued an order on reconsideration that adopted Ho's determination and awarded claimant 13% PPD. Employer requested a hearing before the hearings division, asking for the reduction or elimination of the PPD award on the ground that the information contained in Ho's report did not support the director's award. **<175 Or App 489/490>** Employer's main contention was that, if claimant was able to return to full-duty employment, an award for permanent impairment "defie[d] logic." The administrative law judge (ALJ) affirmed the director's order. Employer appealed to the Board. The Board adopted the ALJ's findings of fact but rejected Ho's finding of impairment on the ground that it did not demonstrate any permanence in claimant's condition. It also rejected McWeeney's opinion as a basis on which to award PPD, because it found that opinion insufficiently precise to establish impairment.

On review, claimant's sole contention is that "only two people may make findings concerning a worker's impairment--the attending physician at the time of claim closure, and a medical arbiter appointed pursuant to ORS 656.268(7)" and that the Board improperly substituted its own findings for those of the arbiter and the treating physician. His argument is premised on OAR 436-035-0007(14), which provides:

> "Impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0280 except where a preponderance of medical opinion

> establishes a different level of impairment pursuant to ORS 656.726(3)(f)(B). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence."

Claimant contends that, "if the Board majority wanted to reject the medical arbiter's opinion on th[e] issue [of impairment,] it would have to look to the only other medical opinion in the record, that of Dr. McWeeney." Claimant relies on our decision in *Snyder v. Barrett Business Services, Inc.*, 147 Or App 619, 939 P2d 47 (1997), in support of his interpretation of the rule.

Employer, in response, relies on OAR 436-035-0005(10). That rule provides:

> "'Preponderance of medical evidence' or 'opinion' does not necessarily mean the opinion supported by the greater number of documents or greater number of concurrences; **<175 Or App 490/491>** rather it means the more probative and more reliable medical opinion based upon factors including, but not limited to, one or more of the following:
>
> "(a) The most accurate history;
>
> "(b) The most objective findings;
>
> "(c) Sound medical principles; or
>
> "(d) Clear and concise reasoning."

According to employer, this rule provides a preface to the application of OAR 436-035-0007(14), and it directs the Board to evaluate "both the relative persuasiveness and intrinsic persuasiveness of the medical opinions on each element of proof." Therefore, it reasons, "the Board is free to find even unrebutted impairment findings in an attending physician or medical arbiter's report unpersuasive, and therefore decline to award PPD."[1]

We begin our analysis by observing what is not in dispute. Claimant does not argue that OAR 436-035-0007(14) is invalid or that the department has exceeded the statutory authority given to the director to adopt such a rule. Thus, the only issue before us is the meaning of the rule. In undertaking that analysis, we treat an administrative rule like a statute, *Perlenfein and Perlenfein*, 316 Or 16, 20, 848 P2d 604 (1993), and our first level of inquiry is the examination of text and context. As set forth above, the text of the administrative rule provides alternative sources for the establishment of impairment. The rule was written in parallel structure to cover two different types of situations. The first sentence covers an initial determination of impairment and provides that the Board must rely on the attending physician's report of impairment as evidence of impairment unless a preponderance of *other medical evidence* establishes otherwise. The second sentence covers cases on reconsideration in which a medical arbiter is used. It provides that, in those cases, the Board must rely on the medical arbiter's report of impairment as its evidence of impairment, unless other, more persuasive medical evidence establishes a different level. The final sentence, **<175 Or App 491/492>** which applies to either of the situations addressed by the first two sentences, clarifies that when the Board chooses not to use the treating physician's or medical arbiter's reports, but instead relies on "a preponderance of [other] medical opinion," the other medical evidence must rise to a preponderance before it can be used to establish impairment.

The rule is in the nature of a limitation on the evidence the Board may use to determine impairment. Contrary to claimant's argument, the rule does not require a choice of adopting "one or the other" of the arbiter's or treating physician's opinions, because the last sentence clearly allows the use of other medical evidence. Moreover, each sentence of the rule provides how impairment is "established." To "establish" means "to settle or fix after consideration." *Webster's Third New Int'l Dictionary*, 778 (unabridged ed 1993). Consequently, the text does not answer the question of whether the Board is authorized to reject all medical opinions about impairment and to refuse to award PDD benefits because it is not persuaded by the medical evidence.

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[1] Employer does not argue that the Board is authorized to set a different degree of impairment without medical evidence from some source that would support a different finding.

We turn to the context of the rule. The context here includes other rules and statutes as well as prior cases interpreting those rules and statutes, including OAR 436-035-0005(10), which defines preponderance of the evidence, and ORS 656.283(7), which governs burdens of production and persuasion. ORS 656.283(7) provides in part that "[a]ny finding of fact regarding the worker's impairment *must be established by medical evidence that is supported by objective findings.*" (Emphasis added). By limiting the kind of evidence that suffices to support an award of impairment to that which is supported by objective findings, the legislature has necessarily decided that some medical evidence or opinions of impairment will not suffice to establish impairment cognizable under the Workers' Compensation Act. For instance, when ORS 656.287 is read with OAR 436-035-0007(14), impairment must be established by objective medical evidence by a preponderance of the evidence. It follows that if the medical evidence does not meet those requirements, no award for impairment is authorized.

Other rules support the understanding that there are limitations on what evidence can be used to find an **<175 Or App 492/493>** impairment. Specifically, OAR 436-010-0280 provides that, when a treating physician performs a closing examination, he or she must "provide all objective findings of impairment pursuant to these rules and in accordance with OAR 436-035-0007." OAR 436-035-0007(2)(a) provides that the physician shall "describe the current total overall findings of impairment," and the remainder of that rule sets out detailed instructions to physicians about how to craft their opinions and findings regarding impairment. Each of these rules confirms that the Board is authorized to reject medical opinions that lack certain requirements.

Additionally, interpreting OAR 436-035-0007 to authorize the Board to reject medical evidence that it does not find persuasive is consistent with the overall role of burdens of production and persuasion that are made part of Board review by ORS 656.266 and ORS 656.283(7). ORS 656.266 provides:

> "The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker."

ORS 656.283(7) provides:

> "[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."

In fact, if we were to adopt claimant's interpretations, the rule about establishing impairment would be inconsistent with the statute placing the burden of proof on claimant.[2]

Finally, claimant argues that our holding in *Snyder* demonstrates a different understanding of the rule. In *Snyder*, the injured worker had been evaluated by both a **<175 Or App 493/494>** treating physician and a medical arbiter. The treating physician initially undertook treatment of two conditions, a knee injury and a low back condition. In his final report, he did not mention the back condition at all, and he opined that the knee injury caused a slight permanent impairment. The injured worker objected to the notice of closure and was examined by a medical arbiter. The arbiter found that the worker's knee condition warranted a permanent partial disability award and also found that his lower back was impaired. An order on reconsideration issued awarding the worker compensation for both the back and knee condition, and the employer appealed from that order. The ALJ ruled for the injured worker, concluding that the arbiter's examination was a more complete assessment of his condition than the treating doctor's assessment. The employer appealed to the Board, which reversed the ALJ. The Board held that it could disregard the medical arbiter's report because it conflicted with the treating doctor's apparent belief that the back condition was completely resolved and because its findings of permanent impairment were not based on objective findings about the worker's limitations.

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[2] *See Marvin Wood Products v. Callow*, 171 Or App 175, 14 P3d 686 (2000), for a detailed discussion of how the burdens of proof and persuasion are allocated throughout the processing of a workers' compensation claim.

On review, we examined OAR 436-035-007(9) (1993) which is identical in all material respects to OAR 436-035-0007(14). We said,

> "The rule sets forth the methodology for analysis when there are multiple, conflicting reports about impairment. There is no evidence that [the treating physician] undertook to evaluate claimant's low back on September 23, and it is not clear how the Board interprets the rule. Nonetheless, there was no evaluation of impairment within the meaning of the rule by the attending physician that was 'different' from and could be weighed against the arbiter's evaluation. The only report that addressed the issue of impairment of claimant's low back was the arbiter's report, which found impairment. Thus, the Board's reliance on the rule and on [the treating physician's] evaluation as a basis on which to conclude that claimant had not demonstrated permanent disability from his low back injury is misplaced. Because we cannot tell from the Board's opinion what its conclusion about the weight of evidence would have been, had it not considered [the treating physician's] report and **<175 Or App 494/495>** the rule, we remand to the Board for reconsideration." *Snyder*, 147 Or App at 624-25.

Our analysis and ultimate holding in *Snyder* are consistent with our conclusion that the Board is authorized to reject medical opinions that it finds to be unpersuasive. In *Snyder*, once we determined that the treating physician's report did not contain an opinion about the claimant's back impairment (rather than containing an implicit finding of no impairment), the only remaining medical opinion on the issue of his back impairment was that of the arbiter. Instead of instructing the Board to adopt the findings of the arbiter, however, or reinstating the award based on the arbiter's opinion, we remanded, stating, "We cannot tell from the Board's opinion what its conclusion about the weight of evidence would have been." *Snyder*, 147 Or App at 625. Our holding in *Snyder* meant that the Board was entitled to weigh even uncontroverted evidence to determine if it satisfied the claimant's burden of persuasion. *See also Agripac, Inc. v. Beem*, 130 Or App 170, 172, 880 P2d 966 (1994) ("The Board chose not to accept [the treating physician's] opinion, which was the only opinion indicating that claimant had permanent impairment. It can do that."); *Libbett v. Roseburg Forest Products*, 130 Or App 50, 52, 880 P2d 935 (1994), *rev den* 320 Or 507 (1995) ("We did not hold, as claimant contends, that the Board is required to *accept* the opinion of the attending physician, or that it may not consider other, non-medical evidence[.]" (emphasis in original)).

Here, the Board was not persuaded by Ho's or McWeeney's report of the permanence of claimant's impairment. Under the applicable statutes and rules, the Board was authorized to reject those medical reports that it did not find persuasive. Also, there is substantial evidence in the record to support the Board's determinations in that regard. Consequently, the Board did not err in ruling that claimant was not entitled to PPD.

Affirmed.

Cite as 175 Or App 532 (2001) August 1, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Audencia Montez, Claimant.

AUDENCIA MONTEZ, Petitioner,
v.
ROLOFF FARMS, INC., SAIF CORPORATION, ROLOFF BROS., INC., and PAULA INSURANCE CO., Respondents.
99-06577 and 99-02429; A110500

Judicial Review from Workers' Compensation Board.
Argued and submitted April 6, 2001.
R. Adrian Martin argued the cause and filed the brief for petitioner.
Jerome P. Larkin argued the cause and filed the brief for respondents Roloff Farms, Inc. and SAIF Corporation.
Richard D. Barber and Sheridan, Bronstein & Levine filed the brief for respondents Roloff Bros., Inc. and Paula Insurance.
Before Edmonds, Presiding Judge, and Kistler and Schuman, Judges.
SCHUMAN, J.
Reversed and remanded.

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175 Or App 534> While picking cherries at Roloff Farms, Inc. (employer), claimant fell from a ladder and fractured a finger. She applied for workers' compensation. Employer's insurer, SAIF, found that she was not employed by employer at the time of the injury and denied her claim. At the hearing on that denial, the sole issue was whether employer had "engaged [claimant] to furnish services for remuneration" under ORS 656.005(30). The administrative law judge (ALJ) and subsequently the Workers' Compensation Board affirmed SAIF's denial. We reverse and remand.

The parties presented conflicting testimony before the ALJ concerning claimant's participation in employer's hiring process for farm workers. SAIF argued that claimant and her son applied for work together on June 11, 1999, but because her son did not have proper identification with him at the time, claimant was told to return with her son's identification and then watch a safety video before beginning work. Claimant testified that she was never told to watch a video; rather, she was told to go to work immediately after completing the application forms. The parties agree that claimant filled out the application forms, did not watch the video, and did not return with her son's identification. Instead, she went to the orchard and began picking cherries. She continued to pick cherries at employer's farm for six to seven days before she was injured.

Claimant also presented uncontradicted evidence that employer's foreman and other supervisory employees showed her where to pick, instructed her not to bruise or drop the cherries, supplied her with the necessary ladders and boxes, told her when to stop working each day, and paid her for her work under her husband's picking number.

Thus, claimant presented two arguments to the ALJ: first, that she was an employee because she successfully completed the hiring process and was, in fact, hired on June 11, 1999; and second, that she was an employee by virtue of an implied contract arising out of her work for employer, with its knowledge, for six or seven days after the disputed hiring process took place. *See Oremus v. Ore. Pub. Co.*, 11 Or App **<175 Or App 534/535>** 444, 446, 503 P2d 722 (1972) (implied contract sufficient basis for conclusion that a person is a covered worker). The ALJ apparently rejected both of those theories, finding that

> "the employer was not even aware that claimant and her son were picking cherries and, further, claimant and her son had never completed the hiring process. The evidence is overwhelming that the claimant and her son were never hired by this employer. The evidence is also clear that the employer had no knowledge that the claimant and her son were picking its cherries."

On review of the ALJ's order, the Board concluded:

> "Here, the parties agree that claimant completed her W-4 and I-9 forms, with Mr. Roloff's help, on June 11, 1999. Claimant testified that Mr. Roloff then told her to go to work. Mr. Roloff testified that he did not hire her at that time because 'she hadn't seen the video.'
>
> "Mr. and Mrs. Roloff and Irene Nunez, the employer's translator, testified that claimant was informed that she must watch a safety video before going to work. Mrs. Roloff and Ms. Nunez also stated that they specifically instructed claimant to go home and get her son's identification, then return and watch the video before going to work.
>
> "Thus the evidence relevant and material to the employment relationship issue is conflicting--specifically, regarding whether claimant satisfied the employer's requirements and conditions for employment. We cannot say that one [party's] version of the events on June 11, 1999 is more persuasive or compelling than the other. Consequently, we find the evidence to be in equipoise. Under these circumstances we are unable to find that claimant has carried her burden of proving that she engaged to furnish services for the employer[.]" (Citations omitted.)

The Board did not explicitly address claimant's argument based on implied contract.

On judicial review, claimant argues that the Board erred in relying exclusively on the circumstances surrounding the hiring process on June 11, 1999, to determine whether the parties entered into a contractual employment relationship. Claimant argues that such a contract may be either express or implied and points to testimony regarding **<175 Or App 535/536>** the parties' subsequent course of conduct that supports a finding of an implied contract. In this respect, claimant refers to uncontradicted testimony that claimant picked employer's cherries for six to seven days with the full knowledge of employer's foreman and other supervisory employees.

Claimant's argument is well taken. A contract for hire that satisfies the "engagement" requirement of ORS 656.005(30) may be based on either an express or implied contract. *Oremus*, 11 Or App at 446. In *Staley v. Taylor*, we explained the various permutations of the term "implied contract":

> "The term 'implied contract' can refer either to a contract implied-in- fact or to one implied-in-law. The two concepts differ substantially, and the failure to distinguish them has sometimes led to confusion. An implied-in-fact contract is no different in legal effect from an express contract. *The only difference between them is the means by which the parties manifest their agreement.* In an express contract, the parties manifest their agreement by their words, whether written or spoken. *In an implied-in-fact contract, the parties' agreement is inferred, in whole or in part, from their conduct.* Other than questions of proof, the two types of contracts have the same legal effect. In both an express contract and an implied-in-fact contract, the plaintiff is ordinarily entitled to recover benefit of the bargain damages.
>
> "The term implied contract has also been used to refer to contracts that are implied-in-law or quasi-contracts. 'A quasi contractual obligation is one that is created by the law for reasons of justice, without any expression of assent * * *.' 1 *Corbin on Contracts* section 19 at 46. The category includes a variety of types of contractual obligations that are implied to prevent injustice, and the remedy for an implied-in-law contract may be less than the benefit of the bargain damages ordinarily available for breach of an express or implied-in-fact contract." 165 Or App 256, 262, 994 P2d 1220 (2000) (emphasis added; internal citations omitted).

It is apparent from her arguments to the Board and on review that claimant asserted the existence of an implied-in-fact contract based on the parties' course of conduct. The conduct that is relevant to the inference of assent is not limited **<175 Or App 536/537>** to the parties' actions at the commencement of the alleged relationship; such a limitation would belie the very nature of the implied-in-fact doctrine as recognizing that parties may manifest their assent to an agreement through their actions over an extended period of time. *See Hix v. SAIF*, 34 Or App 819, 579 P2d 896 (1978) (examining the parties' conduct over the course of an entire summer to determine whether there was sufficient evidence of either an express or implied contract).

In light of claimant's arguments to the ALJ and the Board, the Board's general conclusion that claimant was not a covered worker must encompass two particular conclusions: first, that claimant did not successfully complete the hiring process on June 11, 1999; and second, that claimant did not become a worker by virtue of an implied contract based on the parties' course of conduct after June 11. The "findings of fact" contain findings that support the implied contract theory, but they do not address the crucial fact on which the existence or nonexistence of an implied contract would depend: whether employer's supervisory employees, whose knowledge may be imputed to employer, *Tri-Met, Inc. v. Odighizuwa*, 112 Or App 159, 164, 828 P2d 468 (1992), knew that claimant was working for, being directed by, and receiving compensation from employer. The Board's only reference to employer's actual or constructive knowledge on that issue appears in the Board's "conclusions of law" where it briefly repeats the conclusion of the ALJ that "the employer was not even aware that claimant and her son were picking cherries." Even if we were to construe that reference as an adoption of the ALJ's finding, that statement either refers to Mr. Roloff himself, in which case it is irrelevant if his supervisory employees were "aware," or, if it refers to the supervisory employees, lacks not only substantial evidence in the record but any evidence whatsoever. Further, the Board's "Conclusions of Law and Opinion" is silent as to the implied contract theory.

In fact, despite this single sentence regarding employer's awareness, the Board focused exclusively on the interactions between claimant and employer on June 11, as the following excerpt from the conclusions of law makes clear:

> **175 Or App 538>** "Thus, the evidence relevant and material to the employment relationship issue is conflicting--specifically, regarding whether claimant satisfied the employer's requirements and conditions for employment. *We cannot say that one [party's] version of the events on June 11, 1999 is more persuasive or compelling than the other. Consequently, we find the evidence to be in equipoise.*" (Emphasis added.)

The evidence that is "in equipoise" is, "specifically," the evidence dealing with whether or not employer asked claimant to watch the video as a condition of employment and other "events on June 11, 1999." There is no discussion of whether claimant and employer established an implied contract by virtue of employer's imputed knowledge of her work and remuneration.

Our standard of review precludes us from re-evaluating the evidence before the Board and drawing our own factual findings from that evidence. Under ORS 656.298(7), we review orders of the Board for errors of law, ORS 183.482(7), and for substantial evidence, ORS 183.482(8). *Garcia v. Boise Cascade Corp.*, 309 Or 292, 296, 787 P2d 884 (1990); *see also OR-OSHA v. Jeld-Wen, Inc.*, 163 Or App 418, 424, 988 P2d 418 (1999) ("Clearly, there is evidence in the record that is contrary to the Board's findings. Nonetheless, the question on review is not whether substantial evidence supports petitioner's version of the facts but whether, after considering the whole record, substantial evidence supports the Board's findings.").

However, that standard does not require us to disregard the fact that the Board did not make the findings necessary to support its legal conclusions or did not adequately explain the factual and analytic basis for them. Rather, we require a Board's order to be a "reasoned opinion based on explicit findings of fact" and to contain an "explanation of why facts supported by evidence lead to its conclusion." *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 207, 752 P2d 312 (1988). *See, e.g., Cameron Logging v. Jones*, 109 Or App 391, 393, 820 P2d 8 (1991). Moreover, if it is apparent that the Board failed to consider evidence relevant to the issues before it, remand is appropriate to allow the Board to **<175 Or App 538/539>** reconsider claimant's claim "in light of the entire * * * record." *Franke v. Lamb-Weston, Inc.*, 165 Or App 517, 525, 997 P2d 876 (2000). That is what happened here. The Board did not consider claimant's implied contract theory, particularly whether employer had imputed knowledge that claimant worked for, was directed by, and received compensation from employer. It should have.

Reversed and remanded.[1]

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[1] The Board's order affirmed both SAIF's denial of the claim against Roloff Farms, Inc., as well as a separate denial by PAULA Insurance of a claim against Roloff Bros. Inc. Claimant has not challenged PAULA's denial. On remand, the Board should limit the scope of its order to reconsideration of the claim against Roloff Farms, Inc.

Cite as 175 Or App 603 (2001) August 8, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Craig A. Maddux, Claimant.

CRAIG A. MADDUX, Petitioner,
v.
SAIF CORPORATION and PEPSI-COLA BOTTLING, Respondents.
98-08061; A109043

Judicial Review from Workers' Compensation Board.
Argued and submitted November 6, 2000.
Rex Q. Smith argued the cause and filed the brief for petitioner.
Jerome P. Larkin argued the cause and filed the brief for respondents.
Before Haselton, Presiding Judge, and Deits, Chief Judge,* and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

*Deits, C. J., *vice* De Muniz, J., resigned.

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175 Or App 605> In this workers' compensation case, claimant petitions for review of an order on reconsideration of the Workers' Compensation Board that adhered to a prior order affirming SAIF's denial of claimant's knee claim. Claimant argues that the Board erred in holding that claimant did not meet his burden of proving that the right knee condition was compensable. The issue is whether substantial evidence supports the Board's finding that the medical evidence failed to prove that claimant injured his right knee at the same time that he injured his right ankle. We review for substantial evidence, ORS 183.482(8)(c), and affirm.

The following facts are not in dispute. In August 1997, claimant compensably injured his right ankle while walking backwards to help a truck driver guide a truck into a loading dock. While claimant was walking backwards, he stepped on a crack in the cement, rolled his right ankle, and fell. Soon after the accident, claimant had a physical examination and x-ray taken by his family physician, Dr. Tollerton, who diagnosed a fracture of the lateral malleolus of the right ankle. Tollerton dictates his chart notes in front of his patients 90 to 95 percent of the time.

The two workers' compensation forms claimant completed regarding his claim referred only to an injury to his right ankle. SAIF accepted a right ankle sprain and cortical avulsion of the right lateral malleolus in September 1997.[1] Claimant continued to see Tollerton several times throughout September and October. During a visit on September 2, 1997, Tollerton made a chart note stating, "[D]epending on how he holds his foot[,] it will hurt either at the knee or inside the cast."

Claimant was declared medically stationary in October 1997. In December 1997, claimant underwent a compelled medical examination (CME)[2] with Dr. Anderson. That **<175 Or App 605/606>** same day claimant also underwent a physical capacities evaluation (PCE). During the PCE, claimant complained of knee pain. However, both Anderson and the physical capacities evaluator agreed that any knee impairment was related to a previous unrelated right leg injury. Tollerton concurred with Anderson's report.

A notice of closure issued in January 1998. Later in January 1998, claimant returned to Tollerton complaining of knee pain. Tollerton's chart note from that January 1998 appointment stated that the knee pain, which manifested itself only when claimant was walking, began shortly after his October 31, 1997, appointment with Tollerton. The chart note went on to state, "Knee pain, more than likely secondary to ankle injury. However, I feel that pt. should be seen by a specialist to determine this for

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[1] *Stedman's Medical Dictionary*, 174 (26th ed 1995), defines "avulsion" as "[a] tearing away or forcible separation." A "lateral malleolus" is defined as "the process at the lateral side of the lower end of the fibula, forming the projection of the lateral part of the ankle[.]" *Id.* at 1057.

[2] *See Robinson v. Nabisco Inc.*, 331 Or 178, 181, 11 P3d 1286 (2000).

sure." Tollerton referred claimant to Dr. Fax. Claimant told Fax that his knee had been bothering him since the initial August 1997 ankle injury. Fax diagnosed a medial meniscus tear and stated it was likely that claimant twisted his knee at the same time he twisted his ankle.

SAIF wrote a letter to Tollerton inquiring about claimant's knee injury. Specifically, the letter asked whether Tollerton believed that claimant's knee injury occured when the ankle was injured and why claimant did not complain about his knee until four months later. In response, Tollerton stated that he did not know. He also stated that "it is entirely possible that he might have injured [his knee] otherwise. Both [Fax] and I do feel that there is some difficulty in explaining why he waited four months to complain of his knee." Claimant was then referred by SAIF to Dr. Fuller, who noted knee effusion, which could be caused by a number of factors. Claimant also saw Dr. Rinehart, who concurred with Fuller's opinion, found no sign of a meniscus tear, and diagnosed a degenerative condition.

SAIF denied claimant's right knee claim in July 1998. At the hearing, claimant testified that his knee hurt from the time of his ankle injury. The administrative law judge (ALJ) concluded that there was no record of any knee complaints in the emergency room or in Tollerton's notes. Nor was there any reference to a knee injury in the workers' **<175 Or App 606/607>** compensation forms claimant completed soon after the August 1997 accident. Although the ALJ found claimant and his witness credible, he found the evidence insufficient to overcome the deficiencies in claimant's reporting of his knee problems.

Claimant sought review by the Board, arguing that the ALJ failed to consider Tollerton's September 2, 1997, chart note referring to knee pain and also Tollerton's January 20, 1998, chart notes stating that claimant's knee pain is most likely secondary to his August 1997 ankle injury. The Board adopted and affirmed the ALJ's opinion with supplementation. The Board concluded that Tollerton's change of opinion regarding the compensability of the right knee condition demonstrated that the attending physician no longer believed that the knee condition was compensable. In addition, the Board discounted the opinions of two physicians who initially supported compensability because the reports were based on an inaccurate history. No other physician stated that the knee condition was compensable. The Board concluded that claimant did not meet his burden of proof.

Claimant requested reconsideration, and the Board adhered to its original opinion. On judicial review, claimant continues to make the same argument: The Board failed to explain why it gave such weight to Tollerton's subsequent opinion that he doubted claimant's knee injury arose out of the August 1997 accident. Claimant argues that the uncontradicted evidence is that he complained of knee pain three weeks after the accident.

We review the Board's order for substantial evidence. *See Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990). "[T]he court must evaluate evidence against the finding as well as evidence supporting it to determine whether substantial evidence exists to support that finding. If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence." *Id.*

There is evidence of knee pain as noted by Tollerton a few weeks after the accident. In addition, Tollerton's initial observation in January 1998 was that claimant's knee injury **<175 Or App 607/608>** was secondary to his ankle injury. However, substantial evidence supports the Board's conclusion that claimant did not meet his burden of proof. Specifically, Tollerton's statement regarding the possible connection between claimant's knee and ankle injury was only an initial observation. His chart note goes on to state, "I feel that pt. should be seen by a *specialist to determine this for sure.*" (Emphasis added.) Later Tollerton wrote that he "doubted" any causal relationship between claimant's compensable ankle condition and the knee condition. Furthermore, although the September 2 chart note mentioned knee pain, Tollerton's subsequent chart notes show that claimant did not again complain of knee pain until January 1998. According to that chart note, claimant himself stated that his knee began to hurt shortly after his October 31, 1997, appointment with Tollerton. The Board examined those opinions both supporting and opposing the connection between the two injuries and concluded that claimant did not meet his burden of proving compensability.

There is substantial evidence in this record to support the Board's conclusion that claimant's injury did not cause the knee injury.

Affirmed.

Cite as 175 Or App 609 (2001) August 8, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John W. Wantowski, Claimant.

JOHN W. WANTOWSKI, Petitioner,
v.
CROWN CORK & SEAL and CIGNA INSURANCE COMPANY, Respondents.
98-08420, 98-07743; A108424

Judicial Review from Worker's Compensation Board.
Argued and submitted January 3, 2001.
Nicholas M. Sencer argued the cause and filed the brief for petitioner.
Vera Langer argued the cause for respondents. With her on the brief were Scheminske & Lyons, LLP.
Before Haselton, Presiding Judge, and Wollheim, Judge, and Lipscomb, Judge *pro tempore*.
WOLLHEIM, J.
Reversed and remanded for reconsideration.
Lipscomb, J. *pro tempore*, concurring.

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175 Or App 611> Claimant seeks review of an order of the Workers' Compensation Board that upheld employer's denial of claimant's aggravation claim for a low back condition. After the Board issued its decision, the Supreme Court established a different test for determining whether an injured worker's compensable condition actually worsened. *See SAIF v. Walker*, 330 Or 102, 996 P2d 979 (2000). Accordingly, we reverse and remand for reconsideration.

The facts are uncontested. Claimant worked for employer for over 30 years. Between 1976 and 1996, claimant filed a series of workers' compensation claims, each accepted by employer. As a consequence of claimant's compensable workplace injuries, claimant underwent six separate lumbar spinal surgeries. The last sequence of claims included a February 1993 L4-5 disc herniation claim. Following surgery to remove extruded disc material, the claim was closed in July 1994 with an award of 12 percent unscheduled permanent partial disability (PPD) for claimant's low-back injury and 5 percent scheduled PPD for loss of use or function in his right foot. In March 1996, claimant filed, and employer accepted, an aggravation claim for a recurrent L4-5 disc herniation that resulted in further surgery to repair the injury. The aggravation claim was closed in April 1997 and, in September 1997, an order on reconsideration awarded claimant 12 percent unscheduled PPD for his low-back injury.

In April 1998, claimant experienced an acute back strain and returned to his attending physician, Dr. Schmidt. Claimant's strain improved slightly after that visit. However, claimant returned to Schmidt in June 1998 complaining of increased pain in his low back, pain in his right leg and calf, and numbness in his right big toe. Schmidt's file notes from that appointment reveal that claimant's right knee jerk was diminished and that both ankle jerks were absent. Schmidt also noted that claimant developed pain at 45 degrees of straight-leg raising on the right. Schmidt ordered diagnostic testing that included an MRI, a CT scan and an x-ray.

175 Or App 612> Claimant then underwent a compelled medical examination (CME) that was requested by employer pursuant to ORS 656.325(1)(a).[1] The CME physicians reported a waxing of claimant's symptoms but concluded that no objective evidence existed of an actual worsening of claimant's condition.

After examining claimant's test results, Schmidt referred claimant to Dr. Waldram, a surgeon, to explore the possibility of lumbar fusion surgery. Waldram's physical exam revealed that claimant had a limited back range of motion as well as some dysesthesias and decreased sensation in his right foot.[2]

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[1] *Robinson v. Nabisco, Inc.*, 331 Or 178, 181, 11 P3d 1286 (2000).

[2] *Stedman's Medical Dictionary*, 431 (23rd ed 1976), defines "dysesthesia" as "1. Impairment of sensation short of anesthesia. 2. A condition in which a disagreeable sensation is produced by ordinary stimuli."

Waldram also noted that claimant's diagnostic tests indicated that claimant suffered from severe degenerative changes at L4-5 and L5-S1 with laminectomy defects at both levels. Waldram concluded that claimant's only reasonable chance of improvement would come through a fusion.

Employer denied claimant's aggravation claim in September 1998. The administrative law judge (ALJ) affirmed the denial. In the opinion and order, the ALJ explained:

> "Claimant has not worked since August and may well be less able to work in the broad field of general occupation without undergoing the fusion recommended by [Waldram]. However, I am unable to find objective evidence to support an actual worsening of claimant's compensable condition.
>
> "* * * Now, according to his history, he is unable to work without [a fusion]. Claimant may be worse, but this is based only on what he says, not on objective findings.
>
> "Both [Waldram] and [Schmidt] concurred with letters written by claimant's counsel which stated that there was an objective basis for an actual worsening of claimant's condition. However, when [Schmidt's] deposition was taken, his testimony was not consistent with that concurrence. **<175 Or App 612/613>** Claimant's neurological findings are not worse, and diagnostic testing does not support a finding of worsening. Claimant's range of motion reduction is equivocal. In concluding that claimant is worse, his physicians have relied on his complaints of increased pain and numbness. Claimant's physicians believe claimant. So do I. However, these are not objective findings to support a conclusion of an actual worsening of claimant's condition even if his symptoms have worsened sufficiently to conclude that his condition has worsened. [*SAIF v. Walker*], 145 Or App 294[, 930 P2d 230] (1996). Consequently, claimant has failed in his burden of proof and the denial must be affirmed."

On reconsideration, the ALJ disagreed with claimant's description of the holding in *Walker*, noted that *Walker* did not explicitly address the objective findings requirement for aggravation claims, and explained that he rejected the MRI results as not constituting objective findings because the post-operative changes identified by those results could not be dated. On review, the Board adopted and affirmed the ALJ's order with one minor factual addition.

On judicial review, claimant assigns as error the Board's conclusion that claimant's physicians improperly relied upon claimant's worsened symptoms in determining that claimant's condition had actually worsened and determined that there were no objective findings to support a conclusion that claimant's condition had actually worsened. Claimant argues that, after the Board reached its conclusion, the Supreme Court issued *Walker*, which established a different test for aggravation claims from the one followed by the Board. *Walker*, 330 Or at 105. In addition, claimant argues that there are sufficient objective findings in the record to support his physicians' conclusions that claimant's condition has actually worsened. Employer argues that the Board correctly concluded that claimant failed to establish a compensable aggravation claim. Specifically, employer contends that claimant failed to prove a symptomatic worsening by medical evidence supported by objective findings and that the Board's conclusion that there were no objective findings to support the aggravation claim is supported by substantial evidence.

We review the Board's legal determinations for errors of law. ORS 183.482(7). At issue here is whether the **<175 Or App 613/614>** Board applied the correct test when it denied claimant's aggravation claim.

ORS 656.273 describes the aggravation claim:

> "(1) 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. * * *
>
> "* * * * *

> "(3) * * * The claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury."

"Objective findings" is defined in ORS 656.005(19):

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

See also SAIF v. Lewis, 170 Or App 201, 12 P3d 498 (2000), *rev allowed* 331 Or 692 (2001).

In *Walker*, we interpreted the relevant language of ORS 656.273(1) and concluded that the legislature did not intend for the term "actual worsening" to include symptomatic worsening and that proof of a *pathological* worsening was required to sustain an aggravation claim. 145 Or App at 305. That was the test applied by the Board. However, after the Board's order, and before our review here, the Supreme Court reviewed our *Walker* decision, and it established a substantially different test for aggravation claims. The Supreme Court said that "evidence of a symptomatic worsening may support a physician's conclusion that the underlying compensable condition itself has worsened." *Walker*, 330 Or at 105. **<175 Or App 614/615>** Specifically, the Supreme Court noted that recent amendments to ORS 656.273 did "not limit the admissibility or relevance of competent evidence of worsened symptoms or their disabling effects." *Id.* at 117-18. It further explained:

> "What the 1995 amendments to ORS 656.273(1) introduced was the requirement that a worker prove, through medical evidence supported by objective findings, that the compensable condition itself actually has worsened. In that context, evidence of worsened symptoms, while relevant, is not sufficient by itself to meet the proof standard created by ORS 656.273(1) (1995). However, because evidence of worsened symptoms is relevant to the question whether the compensable condition actually has worsened, and might in some cases be the best evidence regarding that fact, a physician may rely upon that kind of evidence in determining whether the compensable condition has worsened and in opining on that question to the factfinder or to the Board. In other words, the 'medical evidence * * * supported by objective findings' that is required under ORS 656.273(1) (1995) and ORS 656.273(3) to prove an 'actual worsening of the compensable condition' may include a physician's written report commenting that the worker's worsened symptoms demonstrate the existence of a worsened condition." Id. at 118.

In *SAIF v. January*, 166 Or App 620, 998 P2d 1286 (2000), we explained our understanding of the standard set forth by the Supreme Court in *Walker*. We explained 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.' [*Walker*, 330 Or at 118.] To be sure, evidence of a symptomatic worsening, in and of itself, does not permit a factfinder to infer an actual worsening. But if *medical* evidence--*i.e.*, a physician's expert opinion--establishes that the symptomatic worsening represents an actual worsening of the underlying condition, then such evidence may carry the worker's burden. That is precisely the opinion that claimant's treating physician provided in this case. Whether that opinion is persuasive was for the Board to determine. But in all events, a medical expert's opinion that an increase of symptoms signifies an actual worsening of a **<175 Or App 615/616>** particular compensable condition satisfies the actual worsening standard." *January*, 166 Or App at 624 (emphasis in original; citations omitted).

Here, the Board did not consider the medical opinions of Schmidt and Waldram that the increase in claimant's symptoms indicated an actual worsening of his condition. Instead, the Board relied solely on objective findings in the record--findings that even Schmidt conceded could not independently satisfy the actual worsening standard. That approach was inconsistent with the Supreme

Court's opinion in *Walker* and our opinion in *January* and constituted legal error. Consequently, we reverse and remand for the Board to apply the proper test to determine whether claimant has proven a compensable aggravation claim under ORS 656.273(1).

Employer raises the issue of whether there were any objective findings to support an actual worsening of claimant's compensable condition. The Board found none. Although the Board's order addressed why it discounted the MRI and range of motion test results, it failed to explain why the results of the x-ray and CT scan, straight leg test, knee-jerk test and claimant's documented numbness in his right toe and foot did not constitute objective findings under ORS 656.005(19). Consequently, we are unable to adequately review the Board's conclusion that no objective evidence supported claimant's aggravation claim. *Iles v. Fred Meyer, Inc.*, 173 Or App 254, 21 P3d 195 (2001). On remand, if the Board makes a similar finding, it needs to provide a sufficient explanation why evidence that in other contexts constitutes objective findings does not satisfy the requirements of ORS 656.005(19) in this instance.

Reversed and remanded for reconsideration.

LIPSCOMB, *pro tempore*, concurring.

The result we reach today is legally correct, and therefore I concur. However, the process, I submit, needs some adjustment.

The record indicates that claimant needs a surgical fusion. The record further indicates that he has been unable to work until he gets the surgery he needs. A notice of claim **<175 Or App 616/617>** for aggravation was filed June 28, 1998. The employer's denial in this case was issued on September 23, 1998. The administrative law judge (ALJ) issued an order on April 1, 1999. His subsequent order on reconsideration is dated June 10, 1999. The Board, in turn, reviewed the decision of the ALJ and issued its order on review on November 4, 1999. We now reverse the Board's order on review, and remand for reconsideration and a new determination by the Board.

One of the underlying public policy justifications for our workers' compensation system was to provide for a prompt determination of claims as an alternative to "long and costly litigation." *See* ORS 656.012(b). It has already taken more than three years to get to this juncture, however, and claimant has yet to receive a final answer on his claim. There is no reason that the review process for our workers' compensation system cannot function better than this, particularly where, as here, the issues are relatively simple and straightforward.

That review process necessarily involves multiple institutions and several stages, and this court is only one part of the entire system of review. However, much of the delay between, and within, those several stages could be, and should be, eliminated wherever it may appear.

Cite as 175 Or App 618 (2001) August 8, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Mark D. Stapleton, Claimant.

MARK D. STAPLETON, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and AVISON LUMBER COMPANY,
Respondents.
98-09077; A108343

Judicial Review from Workers' Compensation Board.
Argued and submitted January 16, 2001.
James O. Marsh argued the cause for petitioner. With him on the brief was Carney, Buckley & Hays.
David O. Wilson argued the cause for respondents. On the brief was Alexander D. Libmann.
Before Haselton, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
WOLLHEIM, J.
Reversed and remanded for reconsideration.

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175 Or App 620> Claimant seeks review of an order of the Workers' Compensation Board that concluded that claimant did not timely file an aggravation claim before his aggravation rights expired. We review the Board's legal determinations for errors of law and factual issues for substantial evidence. ORS 183.482(7), (8). Because the Board failed to explain why range of motion measurements documented in the physician's report accompanying the aggravation claim did not constitute objective findings, we reverse and remand for reconsideration.

The facts are uncontested. Claimant suffered a compensable injury to his right elbow in 1992. That claim was accepted as a nondisabling injury. Two years later, insurer announced that it had knowledge that the injury had become disabling and accepted the claim as disabling. In 1995, claimant's claim was closed by a determination order that awarded claimant permanent partial disability (PPD) and that notified claimant that his aggravation rights would expire five years from February 6, 1992.

On January 8, 1997, claimant's physician, Dr. Greenleaf, completed an aggravation claim form and wrote a chart note following an examination of claimant. The pertinent portions of the chart note explained:

> "[Claimant] has been experiencing some residual problems in his right elbow, with radiating pain from the anterior portion of the elbow down into the [illegible], as well as some tenderness over the olecranon fossa.
>
> "On examination, range of motion is from about 3-135 degrees. Gross motor and sensory exam is intact. Forceful flexion and extension produce tenderness both in the anterior and posterior portions of the elbow. Pronation and supination are full. There is no evidence of elbow instability.
>
> "Repeat xrays do not show any evidence of new loose bodies or osteochondrosis."

175 Or App 621> The aggravation claim form and the chart note were mailed together to insurer. Insurer received the documents on February 3, 1997, before the February 6, 1997, expiration date for claimant's aggravation rights.

After requesting further information from Greenleaf, insurer accepted claimant's aggravation claim in April 1997. After claimant underwent surgery, insurer issued an updated notice of acceptance, which noted that the accepted aggravation condition was post-traumatic osteoarthritis of the right elbow. A March 1998 notice of closure awarded claimant temporary disability benefits and 17 percent scheduled PPD for claimant's right arm.

In October 1998, almost 18 months after insurer formally accepted the aggravation claim, insurer wrote to claimant advising him that his claim had been processed incorrectly. Insurer explained that claimant's attending physician had not properly perfected an aggravation claim before claimant's aggravation rights had expired and that the claim should have been classified as an own motion claim.[1] Insurer later wrote to the Board and requested own motion relief for claimant. The Board subsequently issued an own motion order reopening the claim and then another order awarding temporary disability benefits. At claimant's request, the Board abated the own motion order and postponed action until pending litigation was resolved.

Claimant requested a hearing to review the "denial" of his aggravation claim. At that hearing, claimant argued that insurer had improperly issued a back-up denial of his previously accepted aggravation claim and sought penalties and attorney fees. Insurer argued that the Hearings Division did not have jurisdiction over the matter and that the request for hearing should be dismissed. In her opinion and order, the administrative law judge (ALJ) first addressed the issue of jurisdiction and explained:

> **175 Or App 622>** "[C]laimant contends that [Greenleaf's] chartnotes show limited range of motion findings and pain complaints. Claimant argues that because there were no pain complaints at the time of closure, [Greenleaf's] chartnotes establish a worsening.
>
> "After reviewing [Greenleaf's] chartnotes, I conclude that they are insufficient to establish objective findings that claimant has suffered a worsened condition attributable to the compensable injury. [Greenleaf] found no evidence of elbow instability and reported that repeat x-rays did not show any evidence of new loose bodies or osteochondrosis. Additionally, [Greenleaf's] assessment was 'ruleout continued degenerative areas in elbow.' In light of such comments, and without further explanation by [Greenleaf], I am unable to find that the report was [sic] satisfies the requirements of ORS 656.273(3).
>
> "Under the circumstances, I conclude that claimant did not perfect an aggravation claim prior to his aggravation rights expiring."

The ALJ then addressed the issue of whether insurer's letter informing claimant that the claim had been improperly process constituted a back-up denial. She concluded that the letter did not constitute a back-up denial because it did not deny compensation to claimant.

On review, the Board summarily adopted and affirmed the ALJ's reasoning and conclusion that Greenleaf's report did not satisfy the requirements of ORS 656.273(3), explaining that claimant had not perfected an aggravation claim before his aggravation rights expired. The Board's order then further analyzed claimant's back-up denial arguments and affirmed the ALJ's order.

Claimant seeks judicial review and makes three assignments of error. First, claimant argues that the Board erred in concluding that claimant did not perfect the filing of his aggravation claim before the expiration of his aggravation rights. Second, claimant argues that the Board erred when it concluded that insurer was not estopped from rescinding its prior acceptance of claimant's aggravation claim and reclassifying that claim into own motion status. Finally, claimant argues that the Board erred when it did not **<175 Or App 622/623>** conclude that insurer's letter rescinding the acceptance of claimant's aggravation claim constituted a back-up denial of claimant's previously accepted claim. Because we reverse and remand on the first assignment of error, we do not address the second or third assignments.

ORS 656.273 sets out the requirements for filing an aggravation claim and provides, in part:

> "(2) To obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the insurer or self-insured employer. * * *

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[1] ORS 656.278 provides that the Board may, upon its own motion, modify, change or terminate former findings, orders or awards under certain circumstances. Subsection (5) of that provision also authorizes insurers or self-insured employers to "voluntarily reopen any claim to provide benefits or grant additional medical or hospital care to the claimant."

> "(3) A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative. The claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury.
>
> "(4) * * *
>
> "(b) The claim for aggravation must be filed within five years after the date of injury, provided that the claim has been classified as nondisabling for more than one year after the date of injury * * *."

Thus, for an aggravation claim to be perfected, the statute requires claimant to contact insurer in a timely manner, to provide insurer with the proper aggravation claim form, and to include with the claim form a physician's report that establishes "by written medical evidence supported by objective findings that the claimant has suffered a worsening condition attributable to the compensable injury." ORS 656.273(3). "Objective findings" is defined by ORS 656.005(19):

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, *range of motion*, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." (Emphasis added.)

175 Or App 624> Insurer received the documents at issue in a timely manner.[2] Those documents included a notice of claim for aggravation of occupational injury or disease as prescribed by the Department of Consumer Business and Services in accordance with ORS 656.273(3). That form was signed by claimant and the physician. The form included an instruction to the physician to "[s]ubmit this form to the insurer within five days of your receipt, along with your written report of medical evidence supported by objective findings of the worsened condition attributable to the compensable condition." The accompanying written report consisted of the chart note quoted above.

At issue is whether the chart note satisfied the requirements of ORS 656.273(3). The Board concluded that there were no objective findings contained in the report. The Board's analysis emphasized those things that Greenleaf explained were *not* present in the record, *i.e.*, there was no evidence of elbow instability or new loose bodies or osteochondrosis in the elbow. However, the Board failed to explain why the chart note's range of motion measurements, which by statute constitute objective findings, did not constitute objective findings in this instance or otherwise did not satisfy the requirements of ORS 656.273(3). Consequently, we reverse and remand for the Board to consider whether the chart note's range of motion measurements constitute objective findings and, if they do not, to explain why not. *See Iles v. Fred Meyer, Inc.*, 173 Or App 254, 258, 21 P3d 195 (2001) (Board's order must provide a sufficient explanation of its reasoning to allow a reviewing court to examine the agency's action). If the range of motion requirements do constitute objective findings, then the Board needs to consider whether the filing requirements of ORS 656.273 were met by claimant.

Reversed and remanded for reconsideration.

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[2] The parties stipulated that insurer's claims department received, on February 3, 1997, an aggravation claim form, Greenleaf's chart note quoted above, and a second chart note. The parties also stipulated that insurer received, on February 5, 1997, an analysis of claimant's MRI scan, conducted by Dr. Perry.

Cite as 176 Or App 337 (2001) August 29, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sherrie J. James, Claimant.

SHERRIE J. JAMES, Petitioner,
v.
SAIF CORPORATION and ARC OF UMATILLA COUNTY, Respondents.
99-04340; A109613

Judicial Review from Workers' Compensation Board.
Argued and submitted January 18, 2001.
R. Adian Martin argued the cause and filed the brief for petitioner.
Jerome P. Larkin 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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176 Or App 339> A medical arbiter found that claimant was entitled to permanent partial disability (PPD) for a concussion that she suffered, and the Appellate Review Unit issued an order to that effect. The Workers' Compensation Board declined to award claimant PPD for that injury because it was not convinced by the arbiter's opinion. Claimant seeks review of the Board's order. We affirm.

On July 2, 1997, claimant fell from a deck when a guardrail gave way. She sustained injuries to her head and left wrist. Employer accepted her claim for a concussion and left wrist fracture, and later for cervical and thoracic strains. Claimant's physician declared her medically stationary on September 14, 1997, and suggested that an independent medical examiner (IME) panel rate her disability. The IME panel found that claimant was entitled to disability for the injury to her left arm but not for her head injury. Claimant's physician concurred with the IME panel, and employer awarded claimant two percent PPD for her left wrist.

Claimant requested reconsideration. A panel of medical arbiters found that she was entitled to three percent PPD for her left arm and 18 percent PPD for impaired range of motion of her spine. As part of the arbiters' examination, Dr. Deborah Syna examined claimant to determine whether her head injury had resulted in any permanent impairment. Syna found that claimant had a Class 1 post-concussion syndrome, which carries with it an award of 10 percent PPD. See OAR 436-035-0390(10). Based on the arbiters' findings, the Appellate Review Unit issued an order awarding claimant three percent scheduled PPD for her left arm, 18 percent unscheduled PPD for her impaired range of motion, and 10 percent unscheduled PPD for her head injury. It combined the last two awards for a total award of 26 percent unscheduled PPD. *See* OAR 436-035-0007(15) and (18); OAR 436-035-0320(4).

Employer requested a hearing. The administrative law judge (ALJ) found that, although claimant was entitled to an 18 percent award for lost range of motion, she had not suffered any permanent impairment as a result of her head **<176 Or App 339/340>** injury and deleted that portion of the award. He explained the basis for his finding:

> "The independent panel found that claimant did not have any impairment related to her concussion and that conclusion was concurred with by her attending physician. * * * [U]p to the point when claimant saw Dr. Syn[a] in the medical arbiter process, there was no medical evidence of any permanent impairment related to claimant's concussion.
>
> "When claimant saw Dr. Syn[a], the only neurological problem that she described with any specificity was a once a week headache that resolved with medications. It is apparently that finding or report that Dr. Syn[a] relied upon to conclude that claimant was entitled to an award of impairment for a Class 1 brain injury. * * * I do not find Dr. Syn[a]'s medical report sufficient to support the award. There is no explanation from the doctor as to how and whether the periodic headaches constitute an episodic neurological

> disorder rateable under the standard. * * * There is no indication that the headaches are a permanent type of impairment. * * * While I certainly accept that headaches can be disabling and there is no reason to discount claimant's history of episodic headaches, I do not believe the medical evidence is sufficient to support the award of permanent brain impairment, related to the injury, based upon the headaches."

The ALJ concluded that Syna's opinion was

> "not supported by any objective evidence or any evidence of restrictions on claimant's activities of daily living attributable to her concussion or any description of any impairment related to her concussion which was permanent."

The Board adopted the ALJ's order and affirmed. On review, claimant notes that the Board found Syna's opinion insufficient because it failed to explain the basis for her conclusion. Claimant argues that the "Board erred in creating an additional requirement for proving that an impairment is rateable." Claimant reasons that Syna was not required to explain "how or whether the periodic headaches constitute an episodic neurological disorder rateable under the standard." Rather, claimant argues that Syna was required only to apply the criteria set out in the rule and decide whether **<176 Or App 340/341>** claimant suffered from a permanent impairment. OAR 436-035-0390(10).[1] Claimant concludes that, because Syna applied those criteria,[2] her opinion was both sufficient to support an award of disability and necessarily required the Board to uphold the award.

Syna's opinion may have been sufficient to support a disability award, *see Hewlett-Packard Co. v. Toy*, 174 Or App 275, 279 n 1, 23 P3d 1015 (2001), but the Board was not required to accept Syna's opinion or find it persuasive, *Atkins v. Allied Systems*, 175 Or App 487, 495, ___P3d___(2001) (the Board is not bound by the medical arbiter's opinion and may "reject medical opinions that it finds to be unpersuasive"). Here, the Board found the stated basis for Syna's opinion--that claimant suffered from weekly headaches--insufficient to convince it that claimant had sustained any permanent impairment.[3] In the absence of any other stated basis for Syna's opinion and in light of the attending physician's opinion that claimant suffered no permanent impairment as a result of her head injury, we cannot say that the Board erred in finding Syna's opinion unpersuasive. *See id.*

Affirmed.

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[1] OAR 436-035-0390(10) provides, in part:

> "(10) Impairment for injuries that have resulted in damage to the brain shall be determined based upon a preponderance of medical opinion which *applies and/or describes the following criteria.*"

(Emphasis added.) The rule then sets out the criteria for six classes of impairment.

[2] Syna's opinion states:

> "In this examiner's opinion, head brain injury impairment would be defined as Class I with episodic headaches, which are well controlled with medication."

[3] Claimant does not argue that the Board erred in concluding that weekly headaches do not satisfy the criteria for proving impairment under OAR 436-035-0390(10). Rather, she argues that the mere fact that Syna applied the criteria in the rule and determined that she suffered an impairment required the Board to award her PPD for her injury. As explained above, our opinion in *Atkins* refutes the assumption that underlies claimant's argument.

Cite as 176 Or App 431 (2001) September 5, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Andrea E. Henwood, Claimant.

SAIF CORPORATION and HEALTH FUTURE, LLC, Petitioners,
v.
ANDREA E. HENWOOD, Respondent.
99-06187; A110815

Judicial Review from Workers' Compensation Board.
Argued and submitted May 2, 2001.
Jerome P. Larkin argued the cause and filed the brief for petitioners.
Robert F. Webber argued the cause for respondent. With him on the brief was Black, Chapman, Webber & Stevens.
Before Landau, Presiding Judge, and Brewer and Schuman, Judges.
SCHUMAN, J.
Affirmed.

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176 Or App 433> Health Future, LLC, and its insurer, SAIF (collectively "employer"), seek judicial review of a Workers' Compensation Board (Board) order finding claimant's occupational disease compensable and assigning responsibility to employer even though an earlier out-of-state employment was the major contributing cause of the disease. We review for errors of law, ORS 656.298(7) and ORS 183.482(8)(a), and affirm.

Claimant developed carpal tunnel syndrome (CTS) from work performed for a California employer and received benefits under California's workers' compensation statutes. Subsequently, she moved to Oregon and went to work for employer, where, in 1998 and 1999, the working conditions contributed slightly to a recurrence of her CTS. Using the forms appropriate for an "initial claim," she sought benefits for an occupational disease. Employer denied the claim, informing claimant: "The disease you claim is a preexisting disease or condition. Your work exposure is not the major contributing cause of the combined condition or of a pathological worsening of the disease."

Claimant requested a hearing, and the administrative law judge reversed. On appeal to the Board, employer argued that the claim was noncompensable under ORS 656.802(2), which sets compensability standards for occupational diseases and provides, in part:

> "(a) The worker must prove that employment conditions were the major contributing cause of the disease.
>
> "(b) 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."

Employer further argued that, if the claim was compensable, responsibility never shifted from the California employer under ORS 656.308(1), which provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future **<176 Or App 433/434>** 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."

The Board rejected employer's arguments, concluding, first, that ORS 656.802(2)(a) did not render claimant's disease noncompensable because that subsection deems an occupational disease to be compensable if "employment conditions were the major contributing cause," and here the parties stipulated to the fact that "claimant's current bilateral CTS was due in major part to her work activities in California," that is, that the disease was employment-related; second, that ORS 656.802(2)(b) did not apply to determine compensability because the California-based CTS was not a "preexisting disease"; and third, that ORS 656.308(1) did not apply to assign responsibility because that statute could not be used to assign responsibility to an out-of-state employer. Instead, the Board applied the "last injurious exposure rule." That rule

> "imposes full responsibility on the last employer, from the time of the onset of the disability, if the claimant was exposed there to working conditions that could have caused the type of disease suffered by the claimant. *Runft v. SAIF*, 303 Or 493, 499, 739 P2d 12 (1987). The last injurious exposure rule is both a rule of proof and a rule of assignment of responsibility. *Id.* at 500." *Roseburg Forest Products v. Long*, 325 Or 305, 309, 937 P2d 517 (1997).

The rule is a "rule of proof" in that it can be used to establish that a claim is compensable by proving that the disease results from all of the claimant's employment, including out-of-state jobs; it is a "rule of responsibility" in that it can be used to assign liability for that claim as between the claimant's employers. *Reynolds Metals v. Rogers*, 157 Or App 147, 153, 967 P2d 1251 (1998), *rev den* 328 Or 365 (1999); *Silveira v. Larch Enterprises*, 133 Or App 297, 302-03, 891 P2d 697 **<176 Or App 434/435>** (1995). Here, the parties stipulated that employment conditions in California were the major contributing cause of claimant's CTS. The Board also found that claimant's work activity for employer in Oregon contributed slightly to her current need for treatment and that claimant's current condition could not be attributed to off-work activity. Based on those findings, the Board concluded that claimant's condition was compensable and employer was responsible. On judicial review, employer renews its arguments that, under the appropriate statutes, as opposed to the last injurious exposure rule, claimant's disease is not compensable, and, if it is, employer is not responsible.

We begin by addressing compensability. The parties stipulated that working conditions at claimant's earlier California employment were the major contributing cause of her CTS. The Board found that working conditions in Oregon under employer contributed slightly to claimant's CTS and that off-work activity did not contribute at all. There is substantial evidence to support all of those findings. Therefore, under the last injurious exposure rule, the claim is compensable. *Silveira*, 133 Or App 302-03 (under the rule, a disease is compensable if it results from all of a claimant's employments, including out-of-state employment).

Employer, however, argues that ORS 656.802(2), and not the last injurious exposure rule, provides the appropriate standard for determining compensability. We need not decide whether the statute applies here to the exclusion of the last injurious exposure rule, because the outcome is the same in either case: Claimant's disease is compensable.

ORS 656.802(2)(a) provides the general compensability standard for determining whether an occupational disease is compensable: "The worker must prove that employment conditions were the major contributing cause of the disease." The Board found this to be the case. Under subsection (2)(a), then, claimant has a compensable claim.

ORS 656.802(2)(b) creates an exception to the general rule expressed in subsection (2)(a) for a particular class of occupational disease claims. ORS 656.802(2)(b) provides:

> **176 Or App 436>** "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."

Employer argues that claimant's current CTS is noncompensable because it is a claim based on a worsening of her preexisting California condition, and conditions at the *employer* were not its major contributing cause:

> "[B]ecause her claim in Oregon was based on a worsening of her preexisting condition from California, claimant must prove that her work activities at Health Future [*i.e.*, her Oregon employer] were the major contributing cause of the combined condition and of a pathological worsening of her preexisting disease."

Even if employer is correct that subsection (2)(b) applies because the condition from California is a "preexisting condition"--another issue we do not address--employer's interpretation of subsection (2)(b) is incorrect. An occupational disease based on the worsening of a preexisting disease is compensable if the worker can prove that "employment conditions" are the major contributing cause of both the combined condition and the worsening; the worker does not have to prove that *current* employment conditions are the major contributing cause of the combined condition. The statute uses the phrase "employment conditions" without qualifiers. Employer's reading would require insertion of the word "current" into the statute before "employment conditions." We will not insert into a statute what has been omitted. ORS 174.010; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611, 859 P2d 1143 (1993). When there are two employers, subsection (2)(b) more obviously and coherently applies when a worker seeks compensation for the worsening of a preexisting disease and factors unrelated to employment exist. It has no application where the preexisting disease and the worsening are both employment-related.

ORS 656.802(2)(b), then, does not require claimant to prove that her Oregon employment is the major contributing cause of her current condition; it only requires her to **<176 Or App 436/437>** prove that *any or all* working conditions were the major contributing cause of her current condition and of the worsening. That is the same standard, in this case, imposed by the last injurious exposure rule and subsection (2)(a)--a standard claimant meets. This claim is compensable.

We turn to employer's argument that the Board should have assigned responsibility pursuant to ORS 656.308(1). Employer maintains that the California CTS was a "compensable injury" so that the California employer "remains responsible" because claimant's Oregon CTS is not a "new compensable injury involving the same condition." The Board rejected this argument, relying on its own decisions for the proposition that initial responsibility cannot be assigned to a previous out-of-state employer. *See, e.g., John I. Jett*, 46 Van Natta 33 (1994) (reasoning that, because the out-of-state employer did not appear to be subject to Oregon workers' compensation laws, ORS 656.308(1) could not appropriately be used to determine responsibility). We agree with the Board.

SAIF v. Yokum, 132 Or App 18, 887 P2d 380 (1994), is instructive. In that case, the claimant made two occupational disease claims against two employers. The Board applied the last injurious exposure rule, fixing responsibility on the second employer. On review, the second employer argued that the Board should have applied ORS 656.308(1) so as to assign responsibility to the first employer. This court rejected the employer's argument, holding that ORS 656.308(1) did not apply because the statute

> "begins from the premise that there is an employer that is responsible to pay for a particular compensable condition. There is no responsible employer until there is an accepted claim and a determination of responsibility, if there is more than one potentially responsible employer. Thus, for the statute to be triggered, there must be an accepted claim for the condition, for which some employer is responsible." *Yokum*, 132 Or App at 23.

The principle underlying *Yokum* is applicable here as well: Where multiple employers contribute to an occupational disease, ORS 656.308(1) applies to shift responsibility from the earlier to the later employer only when an earlier claim has **<176 Or App 437/438>** been accepted *by some employer who can be held responsible for it*. If those criteria are not met, the claim is an initial claim, and "ORS 656.308(1) does not apply." *Id.* at 24. In *Yokum*, those criteria had not been met because there was no accepted prior claim. Here, those criteria are not met because, although there is an accepted prior claim in California, it is not a claim for which an employer can be held responsible under Oregon law. *See Progress Quarries v. Vaandering*, 80 Or App 160, 165, 722 P2d 19 (1986) ("[A] finding of liability under Oregon law would not have operated against [the out-of-state] employer and the claimant would not have been compensated for an admittedly employment related condition.");[1] *The New Portland Meadows v. Dieringer*, 153 Or App 383, 957 P2d 190, *on recons* 157 Or App 619, 622, 973 P2d 352 (1998), *rev den* 328 Or 365 (1999) (holding that initial responsibility cannot be assigned to an out-of-state employer).

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[1] Further, in an occupational disease context, a claimant need not demonstrate a failed attempt to receive compensation out of state in order to take advantage of the rule. *Progress Quarries*, 80 Or App at 166.

A close reading of the workers' compensation statutes supports this understanding from our case law. Although the term "initial claim" is not defined by statute, it appears in ORS 656.005(24), the definition of "preexisting condition":

> "[A]ny * * * disease * * * 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.*" (Emphasis added.)

Thus, an occupational disease claim that is based on a preexisting condition is either an initial claim or a claim for worsening pursuant to ORS 656.273. That statute, in turn, establishes procedures for filing aggravation claims, and it clearly does not encompass claims based on the worsening of diseases incurred in out-of-state employment. ORS 656.273(4), for example, specifies time limits for filing aggravation claims, and the triggering event for beginning the limitation period is expressed in terms of Oregon law. ORS 656.273(4) provides:

> **176 Or App 439>** "(a) The claim for aggravation must be filed within five years after the first notice of closure made under ORS 656.268; or
>
> "(b) The claim for aggravation must be filed within five years after the date of injury, provided that the claim has been classified as nondisabling for more than one year after the date of injury or more than 60 days after the date of first classification by the insurer or self-insured employer, whichever is later."

By its terms, this statute applies to claims that have been processed under Oregon law and according to Oregon's classification system. Thus, because claimant's claim is not and could not be a claim for worsening pursuant to ORS 656.273--that is, a claim for worsening of a condition caused by Oregon employment--it is an initial claim, and ORS 656.308(1) does not apply.

Although construing the statutes so as to deem this claim "initial" creates the possibility of a double recovery in some circumstances involving prior out-of-state injuries, construing the statutes as employer suggests creates the possibility of no recovery at all for a work-related injury. This court has held that "the policy to make certain that Oregon workers are compensated for their injuries, *see* ORS 656.012, outweighs the concern about double recovery." *Silveira*, 133 Or App at 303 n 3. We therefore hold that claimant's claim for an occupational disease caused in part by a prior out-of-state employment is an initial claim for purposes of Oregon's workers' compensation system, and that ORS 656.308(1) does not apply.

Because ORS 656.308(1) does not apply, we rely instead on the last injurious exposure rule to assign responsibility. *Yokum*, 132 Or App at 24. Our decisions in *The New Portland Meadows* control the outcome here. In our original opinion in that case, we indicated that the claimant first worked in Washington and then in Oregon. The Oregon employer denied her claim because it was based on a preexisting condition. *The New Portland Meadows*, 153 Or App at 385. In our opinion on reconsideration, we applied the last injurious exposure rule and decided that initial responsibility could not attach to the out-of-state employer. We relied on **<176 Or App 439/440>** *Progress Quarries* for the proposition that we could not assign initial responsibility to the out-of-state employer over which this state had no jurisdiction and on *Silveira* for the proposition that the last injurious exposure rule applies even if there is only one employer subject to Oregon's jurisdiction. *The New Portland Meadows*, 157 Or App at 622. Under these precedents, we conclude here that employer is responsible for claimant's compensable occupational disease.

Affirmed.

Cite as 176 Or App 490 (2001) September 12, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Olive M. Bonham, Claimant.

EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY, Petitioner,
v.
OLIVE M. BONHAM, Respondent.
97-10265; A108160

Judicial Review from Workers' Compensation Board.
Argued and submitted November 28, 2000.
Jerald P. Keene argued the cause and filed the brief for petitioner.
G. Duff Bloom argued the cause for respondent. With him on the brief was Cole, Cary, Wing & Bloom, P.C.
Before, Haselton, Presiding Judge, and Wollheim, Judge, and Ceniceros, Senior Judge.
WOLLHEIM, J.
Affirmed.

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176 Or App 492> Employer seeks judicial review of a Workers' Compensation Board order that concluded that claimant had established the compensability of a herniated disc claim. Employer argues that claimant's herniated disc claim was precluded by principles of issue and claim preclusion. We affirm.

Claimant suffered a compensable low-back strain in May 1993. A subsequent MRI contained indications of disc space narrowing, slight to moderately severe spinal stenosis, and a disc bulge. In June 1993, Dr. Perry diagnosed lumbar strain with associated mild to moderate L4-5 disc herniation. A determination order closed the claim with an award of temporary compensation in August 1993.

In September 1996, claimant had a medical evaluation for chronic low-back pain. An MRI taken in November 1996 showed that claimant had severe spinal stenosis and a central disc herniation. Claimant saw several physicians during the last months of 1996 and the first several months of 1997. Employer denied claimant's aggravation claim in March 1997 and amended the denial in June 1997. The basis for employer's amended denial was that it found that claimant's "current condition (lumbar stenosis) and need for medical treatment" was unrelated to claimant's May 1993 low-back strain. Claimant requested a hearing from both denials.

In June 1997, a hearing was held before Administrative Law Judge Hazelett. In October 1997, Hazelett issued an opinion and order that upheld both denial letters on the basis that claimant did not prove that her accepted strain injury was the cause of her current condition. Claimant did not appeal that order.

In November 1997, claimant began treatment with Dr. Misko. Misko reviewed claimant's MRIs, had flexion-extension "stress" films taken of claimant's back, and diagnosed claimant with a herniated disc.[1] Misko then filed an **<176 Or App 492/493>** aggravation claim form. In December 1997, employer denied that claim on the basis that there was "no medical evidence that there ha[d] been a change in [claimant's] medical condition due to the industrial injury" since the March 1997 and June 1997 denials were issued. Claimant requested a hearing on that denial. In January 1998, Misko performed surgery for a large disc herniation at L4-5. In July 1998, claimant requested that employer accept a new condition claim for a herniated disc that arose as a consequence of the May 1993 industrial injury. In September 1998, employer denied the L4-5 disc herniation claim on the basis that the medical evidence did not establish that the condition was caused by the industrial injury and that "it was previously determined that your 'current condition' was not caused by the industrial injury" of May 1993. Claimant again requested a hearing.

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[1] Both parties, at various times, refer to the L4-5 condition as a herniated disc and as a disc protrusion, sometimes within the same document. For consistency, we refer to the condition as a L4-5 herniated disc throughout this opinion.

In January 1999, Administrative Law Judge Menashe issued an opinion and order that affirmed employer's December 1997 and September 1998 denials. Menashe concluded that Hazelett "determined [that] the issue was compensability of the current condition and not just spinal stenosis." Therefore, Menashe explained, because claimant's then current condition included the L4-5 disc herniation, issues concerning the L4-5 disc herniation were or could have been litigated at the June 1997 hearing. Consequently, Menashe concluded that the compensability of claimant's L4-5 herniated disc claim was precluded from further litigation. Claimant sought review of Menashe's order.

In a divided opinion, the Board reversed Menashe's order but adopted Menashe's findings of fact. It agreed that Hazelett had decided the compensability of claimant's entire current low-back condition and not just the spinal stenosis condition. However, the Board disagreed with Menashe over the application of preclusion principles to claimant's case. After summarizing the general rules governing claim and issue preclusion, the Board construed the language of ORS 656.262(7)(a) and concluded that the legislature created an exception to claim preclusion when it enacted that statute.[2] Then, after explaining that the legislature did not create a statutory exception to issue preclusion in ORS 656.262(7)(a), **<176 Or App 493/494>** the Board concluded that issue preclusion did not apply to claimant's current claims because the compensability of claimant's L4-5 disc herniation had not been "actually litigated and determined" in the proceeding before Hazelett. The Board then turned to the merits of claimant's herniated disc claim. It found Misko's opinion persuasive and concluded that claimant had established the compensability of her L4-5 herniated disc and had also met her burden of proving a compensable aggravation claim.

Employer seeks judicial review. First, employer assigns as error the Board's failure to rule that the doctrine of issue preclusion barred claimant from relitigating the compensability of her L4-5 herniated disc condition. Second, employer argues that the Board erred when it concluded that ORS 656.262(7) legislatively overruled the doctrine of claim preclusion as it applies to new medical condition claims. Claimant responds that the Board did not err in either instance and that we should affirm the Board's decision.

As a preliminary matter, we note that both issue preclusion and claim preclusion generally apply to workers' compensation proceedings. *Drews v. EBI Companies*, 310 Or 134, 142, 795 P2d 531 (1990). At issue here is how those doctrines apply to new medical condition claims and whether any of the exceptions to the rules of issue and claim preclusion are applicable in this instance. *See id.* at 149 (concluding existence of statutory exception to issue and claim preclusion for aggravation claims exists in specific instances).

We first address the issue of whether the Board erred in holding that ORS 656.262(7)(a) provides a statutory exception to the judicial doctrine of claim preclusion for new medical condition claims. In *Rennie v. Freeway Transport*, 294 Or 319, 323, 656 P2d 919 (1982), the Supreme Court described claim preclusion as follows:

> "[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one **<176 Or App 494/495>** sought earlier, and is of such a nature as could have been joined in the first action."

Importantly, claim preclusion requires neither that an issue of law or fact be actually litigated nor that the determination of an issue be essential to the final or end result of the proceeding. *Drews*, 310 Or at 140. What is essential for application of the rules of claim preclusion is that the particular issue was present in a proceeding that afforded the parties an opportunity to litigate that issue in a forum that rendered a final determination. *Id.*

Turning to the statute at issue here, ORS 656.262(7)(a) provides:

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[2] ORS 656.262(7)(a) is set out later in this opinion.

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

Employer argues that ORS 656.262(7)(a) was intended to protect a worker's right to raise or initiate new medical conditions "at any time" without regard to other *statutory* provisions that might otherwise prohibit the worker from initiating a claim. Employer contends that, because claim preclusion is an independently derived *judicial* doctrine and not a statutory provision, ORS 656.262(7)(a) does not prevent the application of claim preclusion principles after a new claim has been initiated. In support of its argument, employer posits that principles of preclusion (both claim and **<176 Or App 495/496>** issue) are an essential feature of litigation in our system of jurisprudence. Employer further posits that whenever the legislature decides to create statutory exceptions to preclusion principles, it uses unambiguous language to do so. Claimant responds that ORS 656.262(7)(a) unambiguously creates an exception to claim preclusion and that, even if the language were ambiguous, the legislative history demonstrates a legislative intent to protect an injured worker's right to file a new medical condition claim despite principles of claim preclusion.

We begin by examining the text and the context of ORS 656.262(7)(a), giving words of common usage their "plain, natural, and ordinary meaning." *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, 859 P2d 1143 (1993). If the statute is ambiguous after that first level of analysis, we turn to the second level of statutory analysis, legislative history, and if the statute still remains ambiguous, then to the third level of analysis, maxims of statutory construction. *Id.* at 612-13. Our task is to discern the intent of the legislature. *Id.* at 610. The statutory language at issue here is the sentence, "Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

The core of the sentence are the words "the worker may initiate a new medical condition claim at any time." Its plain meaning is unambiguous and does not need a labored analysis. The terms "claim" and "worker" are defined at ORS 656.005(6) and (30) and the ordinary meaning of the term "initiate" is to begin.[3] None of those terms is unusual or exceptional. Likewise, the term "new medical condition" is well established within context of workers' compensation claims. The operative language here is "at any time." We conclude that the legislature intended those words to mean what they expressly state--that a worker may begin a claim for a new medical condition *at any time.*

The beginning phrase the sentence reinforces and expands the notion that a new medical condition claim may be filed at *any* time. The meaning of "notwithstanding any other provision of this chapter" is similarly unambiguous. The function of that "notwithstanding"phrase is to except the remainder of the sentence from other provisions of law contained in ORS chapter 656. *O'Mara v. Douglas County*, 318 Or 72, 76, 862 P2d 499 (1993). Thus, the "notwithstanding" clause expands the scope of the remainder of the sentence by insulating it from restrictions that might otherwise be imposed by other provisions in ORS chapter 656. Consequently, the legislature's intention to allow new medical condition claims to be filed at *any* time is reinforced by the "notwithstanding" clause.

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[3] ORS 656.005(6) defines "claim" as "a written request for compensation * * * or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(30) defines "worker" as "any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer[.]"

We therefore conclude that the text of ORS 656.262(7)(a) unambiguously allows a claimant to initiate a new medical condition claim at any time. Furthermore, we find nothing in the context of that provision that would indicate a different legislative intent. Because the legislature's intent is clear from our examination of the text and context of the statute, our inquiry ends there. *PGE*, 317 Or at 611.

Having concluded that ORS 656.262(7)(a) unambiguously allows a claimant to initiate a new medical condition claim at any time, the issue arises whether that language bars application of the rules of claim preclusion to a new medical condition claim. We hold that it does. Employer argues that, because claim preclusion is a *judicial* doctrine, the "notwithstanding" clause, with its specific reference to *statutory* provisions, does not bar the application of claim preclusion. We disagree. The legislature has the authority to adopt a statutory exception to the doctrine of claim preclusion. *Drews*, 310 Or at 141-42. Our role is to ascertain the intent of the legislature and to give effect, if possible, to all provisions within a statute. ORS 174.010; ORS 174.020. The express language of the statute provides that a worker may initiate a new medical condition claim at *any* time. That express language is contrary to the underlying principle of claim preclusion that, if a party could have raised an issue in a prior proceeding and did not, that party is precluded from raising it in a subsequent proceeding. There is nothing in the text or context of ORS 656.262(7)(a) that indicates that the legislature **<176 Or App 497/498>** did not intend, as the express language indicates, for the statute to bar the application of claim preclusion principles to new medical condition claims. Indeed, to belabor the point, the legislature intended for a worker to be able to initiate a new medical condition claim at *any* time. If we were to adopt the employer's interpretation, we would not be giving effect to the explicit "at any time" language that the legislature chose to use, because a worker would be *prevented* from initiating a new medical condition claim any time that the worker had an opportunity to initiate that claim in an earlier proceeding. Adopting that interpretation would, in effect, allow a court-created doctrine to overrule the explicit language of the statute and be contrary to the legislature's intent. We therefore hold that ORS 656.262(7)(a) bars the application of claim preclusion principles to new medical condition claims and affirm on the second assignment of error.

We next address the issue of whether the Board erred in holding that claimant's new medical condition claim for an L4-5 herniated disc was not barred by issue preclusion. Issue preclusion precludes future litigation on a particular subject issue only if that issue was "actually litigated and determined" in a context where the determination of that issue was essential to the final decision reached. *Id.* at 139. The rules of issue preclusion can apply equally to issues of fact and issues of law. *Id.* at 140. The Board concluded that principles of issue preclusion can apply to new medical condition claims. We agree.

Unlike the case with claim preclusion, the text and context of ORS 656.262(7)(a) do not indicate a legislative intent to bar application of issue preclusion principles. Because issue preclusion requires the *actual* litigation of an issue--in this instance, the new medical condition claim for an L4-5 herniated disc--there is no conflict between the application of the statute and the judicial doctrine of issue preclusion. The overriding purpose of ORS 656.262(7)(a) is for new medical condition claims to be litigated. In order for issue preclusion to apply, a new medical condition claim must not only be initiated, the claim must also have been fully litigated. The application of issue preclusion principles is entirely consistent with the purpose and application of ORS 656.262(7)(a). Understood in a different manner, once a new **<176 Or App 498/499>** medical condition claim has been initiated and fully litigated, a later claim for that *same* medical condition is no longer "new" and the concerns expressed by ORS 656.262(7)(a)--that new medical condition claims not be prevented from being litigated--are no longer pertinent. Consequently, we hold that applying principles of issue preclusion to new medical condition claims is not barred by ORS 656.262(7)(a).

Turning to the case before us, the issue becomes whether claimant's L4-5 herniated disc condition was actually litigated in the proceeding before Hazelett. The Board found that it was not, but employer argues that it was. Whether claimant's herniated disc constituted a new medical condition is a question of fact for the Board to determine. *SAIF v. Tull*, 113 Or App 449, 832 P2d 1271 (1992) (what is a condition is a question of fact that the Board must decide). *See also Ware v. SAIF*, 7 Or App 571, 572, 492 P2d 484 (1972) (determination of whether a claimant suffers from a particular condition is a question of fact). We review that determination for substantial evidence. "Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c). We conclude that substantial evidence exists in the record to support the

Board's conclusion that, although Hazelett's opinion addressed claimant's lumbar stenosis and current condition, claimant's L4-5 herniated disc condition was not part of that current condition determination. Consequently, claimant's L4-5 herniated disc condition was not "actually litigated and determined" at the first hearing, nor was it essential to the final decision reached by Hazelett. We therefore hold that issue preclusion did not bar claimant's new medical condition claim for an L4-5 herniated disc and affirm.

Affirmed.

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